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BRIEF REPORTS

PSYCHOTHERAPY APPOINTMENT NO-SHOWS: RATES AND REASONS

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Patients who frequently miss or do not show for their scheduled psychotherapy appointments create administrative and clinical difficulties, and may not be receiving effective treatment. Prior research has predominately focused on either identifying demographic and administrative factors related to patient no-show rates or evaluating the effectiveness of administrative procedures for reducing no-shows. This paper attempts to identify rates of missed appointments in clinical practice and explore more specific clinical process factors related to patient no-shows. Psychotherapists (N = 24) and their patients (N = 542) in the outpatient department of a public safety-net hospital were surveyed to examine how frequently patients missed scheduled psychotherapy appointments and for what reasons. Findings indicate that the majority of missed appointments were accounted for by patients with occasional absences (approx. 1 per month), while only a small percentage of patients missed appointments with high frequency. Patients missed their psychotherapy appointments for a number of reasons, including clinical symptoms, practical matters, motivational concerns, and negative treatment reactions.

Keywords: psychotherapy compliance, no-shows, missed appointments, cancellations, therapy process

Last minute cancellations and no-shows for mental health care appointments are a vexing problem for providers. High no-show rates in treatment settings create barriers to community mental health treatment access and escalate financial burdens (Delaney, 1998; LaGanga & Lawrence, 2007) which may be passed along to other patients in the form of increased treatment service costs. Missed appointments create additional collateral work for clinicians and administrative staff in contacting and rescheduling patients, and may induce frustration or demoralization. During psychotherapy, patients who frequently or regularly miss their appointments may not be receiving ideal treatment, leading to premature termination (Berrigan & Garfield, 1981) or reduced treatment

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efficacy (Delaney, 1998; Edlund et al., 2002; LaGanga & Lawrence, 2007; Leichsenring & Rabung, 2008). To develop effective solutions for reducing psychotherapy no-shows, missed appointment rates and reasons must be identified.

Studies of missed appointment rates have typically compounded data from a broad range of medical service settings, finding that rates vary widely across health care settings, patient populations, geographic regions, and medical specialties (LaGanga & Lawrence, 2007; Rust, Gallups, Clark, Jones, & Wilcox, 1995). A major meta-analysis of studies reporting attendance for general medical service appointments and psychosocial treatment appointments (Macharia & Leonard, 1992) reported a mean appointment compliance rate of only 58%, with a range spanning from 8% to 94%.

Other studies have explored demographic variables correlated with missed appointments (Centorrino et al., 2001; Lacy, Paulman, Reuter, & Lovejoy, 2004; Meyer, 2001; Ogrodniczuk, Piper, & Joyce, 2006; Wang et al., 2005). Factors identified relate to the ease of access to mental health services across demographic groups. Individuals with greater barriers to care such as those who are younger, ethnic minorities, living farther away from treatment settings, poorly insured, less educated or of lower socioeconomic status have greater no-show rates.

Psychiatric severity has demonstrated links with missed appointment rates, but mostly at the extreme ends of the symptomatic spectrum; patients who are acutely ill or those who are low in symptomatic and interpersonal distress are more likely to miss scheduled treatment appointments. Active substance use is also a significant detractor from regular appointment attendance. Contrary to clinical lore, patients with personality disorders appear to be as or more likely to attend appointments than patients without a personality disorder diagnosis (Centorrino et al., 2001; Ogrodniczuk et al., 2006). Previous nonattendees, however, remain at highest risk of no-showing for a scheduled appointment.

Approaching the no-show problem from a different perspective, Garuda et al. (1998) discourage the exploration of general demographic factors related to treatment noncompliance in favor of identifying more specific underlying reasons behind patient no-shows. Some commonly identified reasons for missed appointments can be categorized as related to the logistical (limited access to transportation, difficulty leaving work or getting childcare, illness), the administrative (longer lag-times between appointment scheduling and the date for which an appointment is to occur, longer waiting times on arrival at the clinic, poor understanding of the scheduling system, perceived disrespect from health care providers/administrators), or the personal (forgetting, skepticism of health care service efficacy, and emotional discomfort or embarrassment; Centorrino et al., 2001; Lacy et al., 2004; Meyer, 2001; Wang et al., 2005). However, these investigations overlook any ongoing clinical process factors contributing to no-show behavior.

The aims of this brief report are twofold: 1) to prospectively examine missed appointment rates in a more targeted population of patients attending ongoing outpatient psychotherapy and 2) to explore clinicians' conceptualizations of their patients' no-show behavior.

Methods

Clinicians from the outpatient psychiatry department of a primary care safety-net hospital were invited by departmental communication to participate in an internal quality-review project exploring individual psychotherapy patient no-shows. Following completion of the project, suggestion that the data collected might be used for external research purposes led to retrospective internal-review approval for publication of de-identified results. Our final sample consisted of 24 clinicians: 12 departmental staff clinicians and 12 nonlicensed therapist trainees. In the heavily burdened public health system, response rate is expected to be low when compensation for participation is unavailable, and indeed, this sample of clinicians represented about 15% of the eligible clinicians in the outpatient department. We identified a 3-month study period (11/13/06–02/02/07), during which medical record appointment attendance data were collected on 542 patients from the participating clinicians' caseloads. Each week, clinicians completed a form asking for the number of their appointments missed or canceled during the week and for brief open-ended responses to the two following questions: "What was the patient's stated reason for missing the appointment?" and "Do you have any thoughts about why the patient missed the appointment?"

To code the open-ended responses regarding reasons appointments were missed, we consulted

Elliott, Fischer, and Rennie's (1999) guidelines for qualitative analysis and utilized an Interpretative Phenomenological Analysis (IPA; Smith, Flowers, & Larkin, 2009) approach in which responses are grouped according to conscious and descriptive themes as opposed to theory-grounded causal relations. Coding proceeded through a number of stages. Initially, the second author examined all responses and identified 29 unique response categories. The first author then categorized these responses into four general themes which were reviewed by and agreed upon by all authors. The first and fourth author then coded each response into one of six categories (described in the results section below and consisting of the four conceptual themes, one category for "unknown" responses by the clinician, and a final category for "other" responses that fit none of the developed categories). The Kappa reliability statistic for the response codings is in the substantial range (Landis & Koch, 1977) at .71. Percentages for each response category presented below represent the average of the two coders.

Results

Missed Appointment Rates

A total of 2,338 individual psychotherapy appointments were scheduled during the study period. A large majority of those appointments were completed (85%). Of noncompleted appointments, we identified appointments that were either cancelled with less than 24 hours notice or where the patient did not show up for their appointment, referred to from here forward as "Missed Appointments" (MAs). Thirteen percent of the scheduled appointments were nonattended MAs. One hundred eighty-nine patients had at least one MA.

The majority of patients missing appointments had only one MA (21% of total sample). Seven MAs was the maximum total from any individual patient. A few individuals missed appointments with a relatively high frequency (four or more MAs during the 3-month period; 13% of total sample). Notably, patients who missed appointments sporadically, with two or three MAs over the 3-month study period (27% of total sample), made up a disproportional majority of raw missed appointment incidences.

Reasons for Missed Appointments

The explanations provided for missed appointments grouped into four broad content themes: Clinical Problems, Practical Matters, Motivational Issues, and Negative Treatment Reactions.

Clinical problems. Twenty-eight percent of MAs were attributed to a variety of clinical reasons, including medical and psychiatric concerns. Physical illness emerged as the most frequently provided reason. Physical illnesses included a range of responses, from reports of the common cold, the need for an urgent dental visit, to an emergency room visit for an acute medical problem. Most often, it was the case of a patient simply stating, "I'm sick." The remaining reasons given reflected psychiatric concerns, including inpatient/partial hospital admissions, fatigue/oversleeping, feeling overwhelmed, and substance abuse.

Practical matters. Twenty-six percent of MAs were attributed to a variety of practical problems. Work conflicts accounted for a large proportion of these MAs. Other practical concerns included: patient out of town, other schedule conflicts, family commitment/illness of a family member/childcare issues, transportation problems, dealing with the death of a loved one or the need to attend a funeral, schedule confusion/disruption, and inclement weather.

Motivational issues. Clinicians reported that outright motivational problems accounted for 17% of MAs. This category included: low motivation for treatment; patient often misses; patient forgot appointment; or patient has difficulty prioritizing self-care and setting limits with others.

Negative treatment reactions. Reports of treatment issues accounted for only 13% of missed sessions, describing some treatment-related issues that captured various ways in which the patient and/or the clinician encountered difficulties in the context of the treatment situation. Negative treatment reactions identified included: frame disruption (when a patient was consciously or unconsciously motivated to miss sessions in reaction to a disruption in their therapy schedule—as when a clinician canceled or rescheduled a previously arranged session); therapy process reaction (when a patient reacted negatively to a diagnosis given, a method of treatment recommended or employed, or a specific therapeutic intervention attempted); and psychological avoidance (when difficulties tolerating some aspect of the treatment were observed such as the

patient avoiding intimacy or emotionally laden content).

Reason unknown. "Unknown" explanations occurred 11% of the time. This reflects that clinicians did not know much about the missed appointment by the week's end when they were asked to submit their data. In some cases, "unclear" indicated that the patient did not offer a reason to the clinician for missing and the clinician did not inquire or speculate.

Other. Other codings were assigned to 5% of MAs and included responses such as missed communication between clinician and patient, registration difficulties, and reschedules.

Discussion

Missed psychotherapy appointments and last-minute cancellations contribute to financial burdens, reduced scheduling efficiency, and lowered effectiveness of the psychotherapeutic services delivered. Prior research has identified a range of no-show rates across different medical treatment settings, yet few studies exist that explore clinicians' conceptualizations of how no-show behavior is related to the clinical process.

Along the guidelines described by Garuda et al. (1998) we explored missed psychotherapy appointment incidences within a select treatment setting, an outpatient psychiatry department located within a safety-net hospital. From a sample of clinicians treating patients with a wide range of diagnostic severity, missed appointment rates were calculated, and information about patients' stated reasons and clinicians' hypotheses about missed appointments were collected.

A large portion (over one third) of patients in this sample missed at least one psychotherapy appointment during the 3-month period studied. While interventions with patients who consistently no-show are clinically indicated, patients who miss more appointments than they attend were few and accounted for only a small portion of overall missed appointment occurrences. Our results seem to illustrate some of the distressful and disruptive effects of psychopathology. Physical and emotional problems accounted for the greatest proportion of appointments missed. Another frequent reason for missed appointments was managing scheduling conflicts with family commitments, transportation problems, and work obligations. While some prior studies indicate that patients with more severe psychiatric illness attend less frequently, this finding suggests that those who are functioning well enough to hold a job also account for a high number for MAs. Finally, a number of patients miss appointments related to clinical process factors such as low motivation for treatment, negative reactions to the clinical interventions provided, or therapeutic alliance ruptures.

Limitations

While practice-based research in community treatment settings can make valuable contributions to clinical research and practice, there are numerous obstacles to methodological rigor in conducting research at these sites (Zayas, McKee, & Jankowski, 2004). As such, there are a number of limitations in our survey data collection and analysis. First, the time period studied was limited to three months during a winter in the greater Boston area. It is possible that during this time physical illnesses, holiday disruptions and weather events were disproportionally represented from what they would be at other times of the year. Also, studying psychotherapy attendance over a longer period of time may have allowed for more in-depth analysis of no-show behavior patterns occurring across different phases of treatment.

Second, the clinician participation rate was low, which raises questions of generalizability. In an already overburdened public health care environment, asking clinicians to take extra time to gather, track, and submit longitudinal data without additional compensation is a tall order. Still, there were an equal number of participating staff and trainee clinicians drawn from a range of outpatient psychotherapy programs, suggesting an adequate sampling of our clinical department.

Third, there were significant limitations on the availability of demographic and diagnostic variables. Ideally, there would be a more extensive collection of reliable data allowing for the analysis of any possible differences in patient variables such as race/ethnicity, socioeconomic status, global assessment of functioning, psychiatric symptoms, medication compliance and psychotherapy services.

Finally, the informal methods of data aggregation and analysis contribute to the interpretation of findings as being more exploratory than definitive. Data was originally conducted as part of an internal quality-review survey project where empirical rigor and generalizability outside of the department was not a primary consideration. Clinicians' conceptualizations of why patients

missed their appointments are largely inferential. An ideal method would employ independent raters using standardized rating systems to assess information gathered from different reporters (patients, therapists, and independent observers of the therapeutic process) about why appointments were missed. However, these ratings do allow for examination of how clinicians actually think about their patients and reduce possible defensive processes or self-presentational biases common in patient reports of treatment behavior (Westen & Weinberger, 2005).

Implications

Clearly, psychotherapy no-shows are overdetermined phenomena. The no-show problem has global, local, and individual health care cost and efficacy implications, with interventions for improving psychotherapy adherence needing to occur at each level. Prior research has linked demographic factors to missed appointments as well as having identified barriers to accessing mental health care services. Administrative policies at the clinic level such as reminder phone calls and improved scheduling procedures have been implemented and evaluated with varying degrees of success. From an administrative standpoint, our findings suggest that interventions might be more effectively geared toward patients who miss sporadically (about once per month), as they contributed a disproportionate amount of missed appointment incidences in this sample. Quality health care services along with improved transportation access and assistance with scheduling and balancing obligations might improve patient treatment adherence and therapeutic outcome.

Mostly overlooked in prior research, this survey of no-show behaviors within our clinic illustrates the prominent role of individual clinical process factors that contribute to no-show behaviors. Our findings highlight the importance of careful clinical attention to patient motivation, collaborative treatment evaluation, negative treatment response, and therapeutic alliance ruptures. Future research should look in a more rigorous manner toward evaluating these psychotherapy process elements and effective clinical technique for addressing no-show behavior.

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