



Access and Discontinuity of Care at an Outpatient Mental Health Service for Older People in South Western Nigeria

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Abstract

We examined frequency and reasons for dropout from follow-up care at an outpatient mental health service for older people in South-Western Nigeria. This was a cross-sectional study. Administrative reviews of 201 case records of clinic attendees who received a psychiatric diagnosis that required follow-up consultations were conducted. Records were those of patients seen between January 2015 and December 2017. Chart extraction was followed by Key Informant Interview (KII) to explore the reasons for drop out and partial non-attendance. We identified 37(18.4%) regular clinic attendees, as well as 147(73.1%) and 17(8.5%) dropout and partially attending patients, respectively. Approximately 45.6% of the dropouts occurred after the first consultation. In KII, distance from the hospital, long waiting times and financial constraints were the common reasons for dropout. The findings of this study should inform the development of strategies to improve access to mental health services in Nigeria and other low- and middle-income countries.

Keywords Dropout · Partial non-attendance · Outpatient services · Mental health service gap · Mental health services · Psychogeriatric services · Older adults · Low/middle income countries · Sub-Saharan Africa

Introduction

Patients with mental health conditions often require repeated follow up consultations. However, a common observation is that many patients do not keep to scheduled appointments and some may eventually discontinue the use of available follow-up services before completing the recommended course of treatment (Shamir et al. 2010). Missing scheduled appointments is considered as part of low engagement in healthcare. The term “Missed appointment” is generally used to capture situations in which the patient is offered an appointment but does not attend and fails to notify the staff of a cancellation (Mitchell and Selmes 2007a). This phenomenon is particularly common in outpatient services for mental health conditions (Killaspy et al. 2000). Of particular concern is the finding suggesting that the rate of non-attendance of scheduled mental health consultation is about twice those reported for other medical specialities (McGlade

et al. 1988). This situation is a major setback in providing effective mental health care services as missing scheduled appointments could result in deterioration of patients condition, need for more intensive treatments at higher economic costs.

Two important sub-categories of missed appointments are dropout patients and those with partial non-attendance. The latter captures situations in which individuals occasionally miss their follow up appointments without fully disengaging while the former captures those who disengage totally from follow-up. (Mitchell and Selmes 2007b). Dropout from treatment has also been defined as termination of treatment before resolution of symptoms or without completing the agreed treatment plan (Rossi 2002). Only a handful of studies (Adelekan and Ogunlesi 1990; Makanjuola 1985) have been conducted to determine the pattern of attendance at outpatient mental health services in Nigeria. These studies suggest that non-attendance, and subsequent dropout from follow up services, is common and represent an obstacle to the provision of effective mental health services. An important gap in the literature is the dearth of information in relation to the older population using mental health services in Nigeria. In the present study, we sought to, (1). Determine the pattern of clinic attendance among older patients

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attending outpatient mental health services at the Geriatric Centre of the University College Hospital (UCH), Ibadan, Nigeria, and (2). Examine the reasons for drop out and partial non-attendance.

Methods

This was a cross-sectional study incorporating both qualitative and quantitative approaches in data acquisition. It was carried out at the psychiatry outpatient clinic of the Geriatric Centre of the University College Hospital (UCH), Ibadan, Nigeria. The Geriatric Centre was established in 2013. The centre is a regional referral facility in Southwestern Nigeria. It is dedicated to providing physical and mental health services to persons who are 60 years and above. Specialist services available at the centre include Neurology, Physiotherapy, Ophthalmology, Gynaecology, Endocrinology, Dentistry and Psychiatry. The psychiatry outpatient service receives an average of 56 new patients annually.

Study Population

The study population comprised all new enrollees at the psychiatry outpatient service of UCH geriatric centre from 1, January 2015 to 31, December 2017. A total number of 207 patients and their case records were identified and included in the study.

Chart Extraction

The study was conducted in two phases. In the first phase, we audited the case records of a total of 207 patients who were first seen at the psychogeriatric outpatient service between January 2015 and December 2017. We included records of those with a psychiatric diagnosis that requires at least a second consultation (follow up appointment) after the initial assessment. Records of patients ($N=6$) who had been discharged from the service were excluded. A purpose-designed semi-structured questionnaire was used to extract data on socio-demographic and clinical characteristics, frequency and duration of scheduled appointments. The questionnaire also contained a section that could be administered to participants over the telephone. In line with a previous study in Nigeria, we defined dropout from treatment in patients who missed a scheduled appointment and did not re-established follow-up visit for at least 6 weeks after the appointment date (Adelekan and Ogunlesi 1990). Partial nonattendance was defined in patients who missed a scheduled appointment but re-establish follow up within 6 weeks of the appointment date (Adelekan and Ogunlesi 1990).

Telephone Contacts

Participants identified through their case records were contacted by phone, informed about the study, and assured of the safety of their data and of the benefit of participating in the study. They thereafter gave consent for the study based on the information provided. The telephone administered section of the study questionnaire enquired about the reasons for dropout or partial non-attendance, and whether participants meeting criteria for dropout or partial non-attendance might be willing to participate in a Key Informant Interview (KII). For those with diagnoses of severe dementia, their caregivers provided relevant information on their behalf after providing proxy consent.

Key Informant Interviews

In the second phase of the study, KIIs involving patients and caregivers of those with dementia were conducted. Participants for the KIIs were those who met the criteria for dropout and partial non-attendance and who provided consent for KII in the first phase of the study. Using the method of purposive sampling, we included 20 participants thought to represent the diversity, in terms of age and gender of patients and caregivers, as well as clinical diagnoses of patients attending the outpatient clinic in the KIIs. The KIIs were used to facilitate collection of more detailed information about participants' understanding, perceptions, and reasons for drop out or partial nonattendance.

The KIIs were conducted in the participants' homes by an experienced qualitative researcher with doctoral level training in the conduct of qualitative research. Participants were interviewed individually following an interview guide designed for the purpose of the study. The interview guide consisted of questions about scheduled clinic attendance, challenges in utilizing the services at the clinic and reasons for not keeping to scheduled appointment. In line with the explorative nature of the study, the questions were few and open-ended to stimulate dialogue about the overall study's main objective. The interview was conducted in the preferred language (English or Yoruba) of participants. The interviews were audiotaped.

Data Management and Analyses

The data extracted from the case records were analyzed using Statistical Package for Social Sciences (SPSS VS 20.0). Descriptive statistics were used to analyse demographic and clinical characteristics. Summary statistics such as means, frequency tables and standard deviations were produced and the rate of dropout and partial

non-attendance were determined. All recordings of KIIs were transcribed verbatim and recordings done in the local language were back translated into English Language by an experienced linguist who was not part of the study. An inductive content analysis approach was taken in analyzing the qualitative data. The lead author and co-author AA reviewed the transcripts while listening to the recordings, checked against notes for accuracy and identified the primary themes that emerged which were subsequently used to develop the initial core set of codes.

The core set of codes was thereafter revised until a final set of codes was achieved. Identification of other subthemes, searches for outlier factors as well as triangulation with other data sources (case record and telephone interview) were carried out. The data was reconciled by the authors in order to come to a consensus opinion on the issues that were raised in the discussion with specific quotes from the participants reported.

Ethical approval was obtained from the Joint University of Ibadan/University College Hospital ethical review board.

Results

Table 1 shows the demographic and clinical characteristics of the patients and their association with clinic attendance.

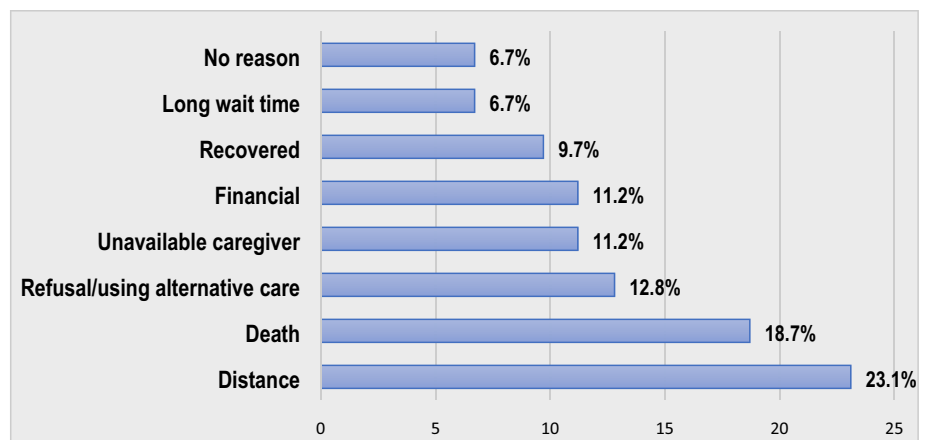
Of the 201 case records examined, only 37(18.4%) were regular clinic attendees. The frequency of dropout was 147(73.1%). Another 17(8.5%) were partial non-attenders. Participants who dropped out or attended partially were more likely to be on outpatient observation (receiving no specific treatments) or living with a family caregiver.

Of the 164 participants who were not regular with clinic appointments (dropout and partial non-attenders), 134(81.7%) were contacted on phone. Others could not be contacted because they provided inaccurate telephone contact details in their case records. The various reasons

Table 1 A table showing the association between patients' characteristics and outpatient clinic attendance (N=201)

Patients' characteristic	Clinic attendance		P value
	Regular N (%)	Dropout/partial non-attendance N (%)	
Age (years)			
60–69	14(23.7)	45(76.3)	0.413
70–79	13(17.6)	61(82.4)	
≥80	10(14.7)	58(85.3)	
Gender			
Male	16(18.2)	72(81.8)	0.942
Female	21(18.6)	92(81.4)	
Educational status (number of years)			
<60 years	6(15.4)	33(84.6)	0.682
≥60 years	28(18.2)	126(81.8)	
Living arrangements			
Living alone	7(33.3)	14(66.7)	0.039
Living with caregivers	23(15.1)	129(84.9)	
Marital status			
Married	21(18.6)	92(81.4)	0.836
Widowed/divorced	15(17.4)	71(82.6)	
Type of treatment			
No treatment	0(0.0)	31(100.0)	0.04
Pharmacotherapy/psychotherapy	37(21.8)	133(78.2)	
Duration of illness before presentation			
≤6 months	12(16.7)	60(83.3)	0.740
>6 months	23(18.5)	101(81.5)	
Clinical diagnosis			
Dementia + MCI	20(20.6)	77(79.4)	0.763
Mental health complication of a physical health condition	3(11.5)	23(88.5)	
Mood and anxiety disorders	9(18.4)	40(81.6)	0.954
Psychotic disorders	5(17.2)	24(82.8)	0.898

Fig. 1 Reasons for dropout and partial non-attendance among participants contacted on telephone N = 134



given for dropout and partial nonattendance during telephone interviews are provided in Fig. 1.

Of the participants that dropped out of treatment, 134(91.16%) had less than six hospital visits before dropping out with 67(45.58%) having dropped out after the initial visit, 37(25.85%) after the second visit, 19(12.93%) after the third visit and 13(8.84%) had within the range of 5–12 hospital visits before dropping out of treatment.

In KIIs, the most commonly expressed reasons for partial non-attendance and dropout were, distance from the hospital, long waiting times and financial constraints.

I stopped coming because of the stress of queuing to assess all services at the clinic; paying for service, waiting to see the doctor and collection of medication. (72-year-old woman with delusional disorder)

My dad states that he would prefer a private doctor to come home to see him and we arranged for that because he doesn't like the stress, he goes through each time he comes here. (30-year-old female caregiver of dementia patient)

One caregiver of a patient with dementia felt the efforts at bringing the patient was not yielding much improvement as expected in the patient's condition.

I stopped bringing her because of the stress and we get less at the end of the day for the efforts. (45-year-old female caregiver of dementia patient)

Two participants pointed to frequent industrial actions by hospital staff as one of the reasons for dropping out.

There was a strike, I came about 3 times and during that period I was very sick, such that I could not even speak, then my child took me to Ilorin. (72-year-old woman with recurrent depression)

Other reasons given include wrong dating of scheduled appointment, financial constraint and unavailability of caregiver to accompany the patient to the hospital.

It was my children who told me my appointment is in three months' time but the doctor give me 1month on small paper. (71 year old woman being managed for depression)

My daughter is busy and I can't come alone. (75-year-old woman with dementia)

It's more of finances that made me stop coming. (69-year-old woman with dementia)

Some participants did not see any reason to attend follow up because symptoms had resolved and they were stable.

I felt my health was not deteriorating and there was no need for me to come. (72-year-old man with Mild Cognitive Impairment)

I was unaware that I should have kept coming despite that my health issues have resolved. (77-year-old woman with depression)

Excluding a caregiver, all other caregivers interviewed reported having challenges by accompanying the patient to clinic. The long period of time spent in the hospital was one of the challenges mentioned. The process was described as time consuming, and affecting other schedules.

Coming with her costs me the whole day. (45-year-old female caregiver of patient with dementia)

There are times I have to go for business trips and I can't go because I have to be with him through the process. I have to wake early which I don't do on a normal day and I have to dedicate the whole day to

the process. (30-year-old female caregiver of patient with dementia)

The process of accompanying the patient to clinic was also described as tiring.

It is challenging because it affects my day and when I return, I'm always tired. (40-year-old male caregiver of patient with dementia)

Discussion

The present administrative data taken from an outpatient mental health service for older people in Nigeria found a frequency 73.1% for dropout from follow-up care over approximately 2 years. Only 18.4% attended clinic regularly. Financial difficulties, distant location of services and long waiting times were the main reasons given for drop out.

The frequency of dropout observed in the present study is higher than the average rate of 37.1% often quoted in studies examining psychiatric outpatient clinic attendance globally (Swift and Greenberg 2012; Wells et al. 2013; Wierzbicki and Pekarik 1993). However, most previous studies examining this phenomenon have been based on general population samples and audit of child and adolescent mental health clinics. In one of the few outpatient clinic audits identified to compare dropouts in the general and older population, frequency of dropout among older United Kingdom (UK) National Health Service (NHS) users was higher by a factor of between 15% for all older attendees and 32% for those with dementia (Dockery et al. 2001). While the result from the NHS study demonstrates that older people are generally more likely to drop out, the frequency of 73.1% found in the present study is still substantially higher than prevalence proportions of between 27% and 44% reported for older persons in the NHS study.

Outpatient clinic audits in the general Nigerian population have often quoted an average dropout rate of approximately 50% (Adelekan and Ogunlesi 1990; Makanjuola 1985). Compared with the global average of approximately 37% for dropout from general psychiatric outpatient clinics, the prior Nigerian studies would also suggest that dropout may be more likely in Nigeria. It therefore seems that older adult outpatients in the Nigerian context tend to drop out more than among the general population because of peculiarities such as greater difficulties with accessing clinics due to age-related disabilities, as well as reliance on family or other categories of caregivers to facilitate clinic attendance (Uwakwe et al. 2009).

Reasons provided in KIIs may serve to further support the above hypothesis about earlier dropout. The most mentioned reason for drop out was relocation of the patient to another city or a region that is quite a distance from the

hospital. In the setting of our study, many elderly people live with their children and sometimes their care responsibility is shared among the children, necessitating being moved in turns among the children. This arrangement is sometimes associated with changes of location, and depending on how far the new location is, this sometimes affect continuity of care. Long distances from the hospital makes it difficult for patients to access the hospital; this coupled with the bad states of our roads in Nigeria, poor road networks, and non-availability of means of transport. Previous studies have shown that distance from hospital affects number of outpatients visits among the elderly (McCarthy and Blow 2004) and practical reasons such as treatment facility being difficult to get to could lead to disengagement from mental health services. (Dixon et al. 2016).

It was surprising to observe in the present study that nearly half of those who dropped out did so after the first consultation for assessment, diagnosis and treatment. This is as general population studies in Nigeria and other developing countries have reported dropout after more consultations than observed in the present audit of an outpatient mental health service for older people (James et al. 2014; Adeosun et al. 2012; Singla et al. 2015). Yet, the global trend is for dropouts to occur at the earlier stages of treatment (Agarwal 2012; Henzen et al. 2016; Wells et al. 2013). The one-time consultation for assessment, diagnosis and treatment before dropout, as identified in the present study, is unlikely to be enough for older patients to benefit from mental health interventions. However, an important reason for dropout after a one-time consultation for clinical assessment, diagnosis and treatment in the context of the present study is financial constraint. There is low health insurance coverage in Nigeria (Animasahun and Chapman 2017). As such, patients and their families are commonly required to make out-of-pocket payment for access to healthcare (Adisa 2015). In these circumstances, poorer patients and their families, who constitute the majority of our study population, may drop out of treatment earlier. Many previous studies report that socio-economic factors account for the greater likelihood of older people in low/middle income countries (LMICs) to dropout from outpatient care compared with their peers in more developed social and healthcare contexts (Berghofer et al. 2002; Edlund et al. 2002; Khazaie et al. 2013; Pelkonen et al. 2000; Ribeiro et al. 2012). Another important factor for drop-out after a one-time consultation among older adults include the realisation that some conditions, for example dementia, may run a chronic and deteriorating course with little expectation of complete cure. The dashed expectation of cure from biomedical mental health services leads patients and their family to seek complementary and alternative health care. Complementary

and Alternative healthcare Providers (CAPs) offer culturally acceptable causal explanations for mental health conditions and often promise complete cure (Uwakwe et al. 2009).

The present clinic audit has important limitation. The study relied on information documented in the case records of participants enrolled at an outpatient mental health service for older people in a developing country. We observed some incomplete records, and as such, our sampling frame for the qualitative phase did not include all eligible participants. This limitation could have introduced bias in the scope of possible reasons for dropout. Also, as the study was conducted in a single site at a tertiary hospital in South west Nigeria, it would be difficult to generalise findings to other parts of Nigeria. Nevertheless, our study found quite a range of reasons which could guide policy to improve access to mental health services for older people in Nigeria and similar social, economic and cultural context globally.

Conclusions

Older people with mental health conditions in Nigeria dropout from continued care because of health system and economic factors. The findings of the present study would suggest that mental health care for older people in Nigeria should be tailored to align with realities of the care setting. There is a particular need to address dropout from continued care at the initial stage of treatment in order to ensure continuity of care. As a first step to lower the identified barriers to access and continuity of mental health care in our outpatient clinic, we hope to introduce a modified assertive monitoring of our patients wherein nurses and social workers will visit patients and caregivers at home for continued psychosocial support and intervene in cases of emerging health problem in both caregivers and patients. Other recommended measures include the introduction of awareness programs that will encourage non-governmental organizations to show more interest in activities related to mental healthcare for older people.

Authors' Contributions All authors contributed to the study conception and design. Material preparation, data collection and analysis were performed by O.E., A.O., A.A. and O.G. The first draft of the manuscript was written by O.E. and all authors commented on previous versions of the manuscript. All authors read and approved the final manuscript.

Compliance with ethical standards

Conflict of Interest The authors declare that they have no conflict of interest.

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