obtain best value for money. Naturalistic trials are needed to address the problem of different approaches to treatment seen in clinical trials and clinical practice.

References


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Attendance at child psychiatry clinics

Comparison with attendance at child medical and surgical clinics

Selim M. El-Badri and Paul McArdle

A widespread perception exists that attendance at child psychiatry clinics is especially poor. The reported rate of non-attendance at a child psychiatry outpatient clinic is 61%. However, other child health clinics also suffer a high rate of non-attendance. In this paper we examine the hypothesis that rates of non-attendance are higher in child psychiatry than in other child health out-patient clinics.

Previous studies have suggested that non-attendance and poor clinic compliance is a common problem in child health services and children clinics (Cooper & Lynch, 1979; Novick et al, 1981; Gould et al, 1985; Potter & Darwish, 1996). Some authors have suggested that there may be special factors influencing attendance at child psychiatric clinics. These include parental expectations of treatment offered (Plunkett, 1984), disadvantageous family structure, and the characteristics of presenting problems, especially those with antisocial behaviour (Garralda & Bailey, 1988). Non-attendance may create inefficiencies for mental health care providers and suffering for children, which may have effects on patients’ care and cost-effectiveness. This study therefore investigates whether attendance at child psychiatry clinics is poorer than at other child health clinics.

The study

Two large city centre general practices known to refer to child psychiatry were approached and their collaboration agreed. These provide services for approximately 25 000 Newcastle residents. Data pertaining to patients referred from the two general practitioner practices to (a) a child and adolescent psychiatry unit, (b) ear, nose and throat (ENT) clinic and (c) a general paediatric clinic were obtained. Hospital case
notes and general practitioner records of all
patients (n=86) referred from the two practices
to the three hospital services over a period of six
months were studied and the information re-
corded in a structured proforma. Referred cases
were identified from visits to the general prac-
tices. The proforma covered the following in-
formation: socio-demographic data; specific data
concerning attendance/non-attendance at the
clinic; nature of the clinical problem and its
extent; and, in order to evaluate the impact on
attendance of different waiting-list times, the
length of time lapsed between referral and
appointment. The rate of attendance among
children and families referred to child psychiatry
clinic was compared with the rate of attendance
of referred children and families to ENT and
paediatric clinics.

**Findings**

The demographic characteristics of patients are
shown in Table 1. There were no significant
differences in gender ratio between the three
groups and there was no significant difference in
delay prior to first consultation. However, child
psychiatry patients were significantly older than
those attending other clinics. Also, child psy-
chiatry patients were significantly less likely
than paediatric patients to be living with two
biological parents.

In the child and adolescent psychiatry group,
12 (48%) had neurotic problems, 3 (12%) had
conduct problems and 8 (32%) presented with
mixed neurotic and conduct difficulties. In 2 (8%)
of this group, the diagnoses were uncertain due
to lack of adequate information. Of the referred
patients, 13 (52%) in this group had presenting
problems which were confined only to home, and
6 (24%) of them had problems that involved their
schools as well.

In the psychiatric group, neurotic problems
were over-represented in children with two
parents as opposed to conduct difficulties in
children with single parents. This is consistent
with literature evidence that conduct disorders
are more frequent among children from broken
homes.

Attendance in the three groups is shown in
Table 2. There was no difference in rates of initial
attendance between the three groups. There was
a trend for a higher rate of subsequent non-
attendance in the child psychiatry than in either
of the other two groups. Similarly, a somewhat
smaller proportion of child psychiatry patients
completed treatment. However, findings were not
statistically significant. There were greater num-
bers of conduct and behaviour problem patients
who defaulted follow-up than patients with
neurotic problems, but the difference was not
statistically significant.

**Comment**

Child psychiatry patients show a high rate of
attendance at first assessment interviews.

---

**Table 1. Demographic characteristics of patients**

<table>
<thead>
<tr>
<th></th>
<th>Child and adolescent psychiatry patients</th>
<th>Ear, nose and throat patients</th>
<th>General paediatric patients</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(n=25)</td>
<td>(n=28)</td>
<td>(n=33)</td>
</tr>
<tr>
<td>Male:female ratio</td>
<td>12:13</td>
<td>10:17</td>
<td>15:18</td>
</tr>
<tr>
<td>Mean age</td>
<td>10.96</td>
<td>7.11</td>
<td>4.94</td>
</tr>
<tr>
<td>Two parents</td>
<td>7 (28%)</td>
<td>-</td>
<td>18 (54.5%)</td>
</tr>
<tr>
<td>Other family structure</td>
<td>13 (52%)</td>
<td>-</td>
<td>4 (12.1%)</td>
</tr>
<tr>
<td>Missing family structure data</td>
<td>5 (20%)</td>
<td>28 (100%)</td>
<td>11 (33.3%)</td>
</tr>
</tbody>
</table>

1. One way ANOVA test indicating significant mean age difference (P<0.0001).
2. $x^2<0.05$.

---

**Table 2. Attendance of general practitioner referred patients at three hospital child health clinics**

<table>
<thead>
<tr>
<th></th>
<th>Child and adolescent psychiatry patients</th>
<th>Ear, nose and throat patients</th>
<th>General paediatric patients</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(n=25)</td>
<td>(n=28)</td>
<td>(n=33)</td>
</tr>
<tr>
<td>Initial non-attendance</td>
<td>1 (4%)</td>
<td>2 (7.1%)</td>
<td>1 (3%)</td>
</tr>
<tr>
<td>Failed to attend subsequent appointments</td>
<td>7 (28%)</td>
<td>1 (3.6%)</td>
<td>1 (3%)</td>
</tr>
<tr>
<td>Completed treatment</td>
<td>13 (52%)</td>
<td>19 (67.9%)</td>
<td>22 (66.7%)</td>
</tr>
<tr>
<td>Missing data</td>
<td>4 (16%)</td>
<td>6 (21.4%)</td>
<td>9 (27.3%)</td>
</tr>
</tbody>
</table>

---

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However, attendance may subsequently decline at a greater rate than at other paediatric clinics. Of the factors we examined, the high rates of disruptive behaviour disorders in the children of unsupported parents, and the older age of the children, are likely to be relevant. Therefore, the high rate of defaulting from follow-up appointments in the psychiatric patients despite a high rate of attendance at first appointment may be due to parental or child dissatisfaction with the first consultation. However, it may also be due to the greater age of child psychiatry patients, so that their views unlike those of much younger paediatric or ENT patients need to be taken into account by parents. It may also be due to the different family structures of child psychiatry patients so that there is less parental support for further attendance in this group. This is consistent with previous reports that parental separation had no effect on first attendance but significantly increased the rate of defaulting from follow-up appointment (Cottrell et al. 1988).

Children with disruptive behaviour disorders showed the highest rate of non-attendance in this study and are known to default at a high rate from clinics relying on psychological treatments alone (Kazdin, 1990). Future studies need to take into account the effect on clinic attendance of the recent rise in use of medication, especially of stimulant agents for these patients. Clearly a focus on other elements of client satisfaction that influence decisions to attend is required.

Further, while only 4% of the child psychiatry group did not attend at all, it is inevitable that this leads to failure to investigate such smaller groups of patients and families who do not attend even their initial appointment. This tends to exclude them from such studies. Therefore, in order to identify factors that might contribute to initial and subsequent non-attendance (e.g. the lack of crèche facilities especially for unsupported single parents), larger samples are needed. In this way it may be easier to engage perhaps the most vulnerable referred families and children and maximise efficient and cost-effective child psychiatric care.

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**References**


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