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No-Show at a Forensic Psychiatric Outpatient Clinic: Risk Factors and Reasons

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Abstract

Nonattendance for and late cancellations of scheduled appointments, that is no-show, is a well-known phenomenon in psychiatric outpatient clinics. Research on the topic of no-show for initial and consecutive appointments in the field of forensic psychiatry is scarce. This study therefore aims to determine the prevalence and causes of no-show and to explore reasons for nonattendance. The study was carried out in an outpatient clinic in northern Netherlands. Telephone interviews were administered to 27 no-show clients, 84 follow-up no-show clients, and 41 attendees of 18 years and older. A no-show rate of 24.9% and a follow-up no-show rate of 9.8% was found. The majority of appointments missed were in the beginning phase of clinic contact. No-show clients were younger than their attending counterparts and more often dropped out from clinic contact. Also, less family social support was experienced by nonattendees. Reasons for nonattendance were having forgotten about appointment and work commitments.

Keywords

ambulatory care, drop-out, forensic psychiatry, outpatient characteristics, Netherlands

Introduction

Nonattendance for and late cancellations of scheduled appointments, also called “no-show,” are a fairly common and frustrating phenomenon encountered in many...
health care organisations (Cohen, Dreher, Vardy, & Weitzman, 2008; Stone, Palmer, Saxby, & Devaraj, 1999; Waller & Hodgkin, 2000). The bulk of the literature on no-show deals with prevalence and risk factors affecting no-show for initial or consecutive appointments at general community mental health centers and psychiatric and paediatric clinics (Barrett et al., 2008), such as clinical/referral characteristics, illness related, environmental, and demographic factors (Compton, Rudisch, Craw, Thompson, & Owens, 2006; Kruse & Rohland, 2002; Mitchel & Selmes, 2007). No-show rates found in psychiatry range from 10% to 40% (Killaspy, Banerjee, King, & Lloyd, 2000; Kruse & Rohland, 2002; Mitchel & Selmes, 2007; Peeters & Bayer, 1999) and are suggested to be almost twice as high as those found in most other medical specialties (Mitchel & Selmes, 2007). In contrast, little research has been done on analysing rates, reasons, and predictors of no-show at forensic psychiatric outpatient clinics. The few studies found in forensic psychiatry demonstrated no-show rates of 25.6% (Hambridge, 1990) and 28.3% (Dalton, Major, & Sharkey, 1998) and assessed risk factors such as age, gender, geographical proximity to the clinic, and type of referral, though results were inconclusive. Moreover, only few studies uphold a distinction between those who miss their first, intake, appointment (no-show) and those who miss follow-up appointments (follow-up no-show; Kruse & Rohland, 2002; Mitchel & Selmes, 2007). Therefore, a cross-sectional study was carried out to investigate the phenomenon of no-show for initial as well as follow-up appointments at a forensic psychiatric outpatient clinic. The objectives of this study were (a) to describe prevalence and patterns of no-show for initial and consecutive appointments, (b) to identify risk factors of no-show, and (c) to explore reasons for no-show as given by clients.

More insight into no-show in the field of forensic psychiatric care is important, as disengagement or discontinuity of forensic outpatient care heightens the probability of mental relapse, criminal (re)offending (i.e., reducing public safety), and (re)conviction of clients (Coid, Hickey, Kahtan, Zhang, & Yang, 2007; Compton et al., 2006; Killaspy et al., 2000; Mcmurran & Theodosi, 2007; Nelson, Maruish, & Axler, 2000). Besides, no-show reduces cost-effectiveness and efficiency as missed appointments are only partially compensated for by insurance companies, waste staff time, and deny treatment to other clients in need (Baars, van Merode, & Arntz, 2007; McIvor, Ek, & Carson, 2004).

Several studies assessed prevalence and risk factors for no-show and for initial and consecutive mental health appointments. However, they have yielded inconsistent results (Sparr, Moffitt, & Ward, 1993). Because of differences in definitions of no-show, the prevalence rates found in literature vary widely and are difficult to compare (Wierzbicki & Pekarik, 1993). In a review of Deyo and Inui (1980), no-show rates for appointments at adult general medical clinics were found ranging from 15% to 30%, whereas others found early withdrawal/attrition rates of about 47% across various settings (Garfield, 1994; Sparks, Daniels, & Johnson, 2003; Wierzbicki & Pekarik, 1993).

Risk factors that have most often been associated with no-show in various fields are sex (male; Farid & Alapont, 1993; Fuciec, Mohr, & Garin, 2003); low social economical status (Berrigan & Garfield, 1981; Farid & Alapont, 1993; Lief, Lief, Warren, &
Heath, 1961; Van der Wouden, Rijnders, & Trijsburg, 1994); low educational level (Grunebaum, Luber, Callahan, Leon, Olfsen & Portera, 1996; Lief et al., 1961; Lim, Poo, Lein, & Chew, 1995; Noonan, 1973); long time interval from referral or appointment to next appointment (Carpenter, Morrow, Del Gaudio, & Ritzler, 1981; Compton et al., 2006; Kruse & Rohland, 2002; Lim et al., 1995; Raynes & Warren, 1971); and vague or evasive problem definitions (Gould, Paulson, & Daniels-Epps, 1970; Grunebaum et al., 1996; Noonan, 1973; Van der Wouden et al., 1994). Either no association or a positive association has been found between no-show and young age (Adler, Goin, & Yamamoto, 1963; Carpenter et al., 1981; Farid & Alapont, 1993; Hillis & Alexander, 1990; Killaspy et al., 2000; Kruse & Rohland, 2002; Lim et al., 1995), marital status (single or divorced; Adler et al., 1963; Hillis & Alexander, 1990; Lim et al., 1995, 1996; Noonan, 1973), and unemployment (Deyo & Inui, 1980; Killaspy et al., 2000; Lim et al., 1995). Research on the reasons given by clients for their nonattendance show more consistency: forgetting, overslept, other commitments, improvement of psychiatric illness, or feeling too (physically) ill are frequently cited reasons (e.g., Carpenter et al., 1981; Fuciec et al., 2003; Killaspy et al., 2000; Lim et al., 1995).

Also in the field of forensic psychiatric outpatient care, studies on the relationship between predictors of nonattendance have yielded mixed results. One study by Hambridge (1990), conducted at an outpatient forensic psychology service in the northwest of England, found that males younger than age 30 years were less likely to attend an appointment. This finding was not confirmed by Dalton et al. (1998), who studied clients at a Forensic Mental Health Service in East London. Hambridge (1990), and to some extent Dalton et al. (1998), suggested that clients who had aggression problems were worse attendees than clients referred by courts/solicitors or clients who had child sex problems. Both studies also revealed that time spent on the waiting list or geographical proximity did not affect nonattendance. Insight into the reasons for nonattendance of forensic psychiatric clients as well as insight into the prevalence of late cancellations of initial and follow-up appointments were not assessed in these forensic studies.

This article contributes to the literature by addressing the phenomenon of no-show for initial as well as follow-up appointments and by elaborating on the rates, reasons, and risk factors of no-show at a forensic psychiatric outpatient clinic. To reveal the predictors of no-show a questionnaire based on the theory of planned behaviour (TPB) was developed (Ajzen, 1991; Fishbein and Ajzen, 1975). The TPB is a widely used theoretical model for predicting rationally motivated (intentions to perform) behaviour across different settings. The theory links attitudes, subjective norms, and perceived behavioural control to a desired behaviour via behavioural intentions. Here, the desired behaviour is attendance of appointments at the forensic outpatient clinic; personal attitudes towards keeping appointments are concerned with an individual’s positive or negative evaluation of the appointment; the subjective norm is concerned with an individual’s perception of social normative pressures, or the extent to which relevant other’s belief that an individual should or should not attend forensic psychiatric appointments; perceived behavioural control in adherence to appointments is related to
the individual’s perceived ease or difficulty of performing the behaviour of visiting or attending the appointments at the clinic; and intentions are an individual’s readiness to attend appointments.

Method

Setting and legal context

This cross-sectional study was executed at a forensic psychiatric outpatient clinic sited in Groningen, a major city in northern Netherlands. The outpatient clinic provides ambulatory individual and group treatment programmes for clients aged 18 years or older who (a) have been diagnosed with a psychiatric disorder and/or show serious antisocial behaviour and (b) who have already broken the law or are highly likely to do so.

Dutch outpatient forensic clinics foremost provide court-mandated treatment to mentally disturbed offenders (De Ruiter & Trestman, 2007). However, in the Netherlands as well as in some other European countries, it is also possible to send offenders, who are at risk of (re)offending and/or who are a risk to the safety of other persons or goods, to forensic outpatient clinics voluntarily by referral from the police, mental health care practitioners, or general practitioners (van Marle, 2000). Voluntary treatment is also available for defendants who want to stay in treatment at the end of the mandatory period as well as for those who are in need of help after prison release (Drieschner & Boomsma, 2008).

Participants

This study comprised 152 clients of a forensic psychiatric outpatient clinic, divided into three subgroups, namely, clients who did not attend initial (intake) appointments and who omitted to cancel these appointments more than 24 h before the initial appointment was scheduled (no-show), clients who did attend their initial appointment but neither attended nor canceled their consecutive appointments more than 24 h before this appointment was scheduled (follow-up no-show), and clients who attended generally all consecutive appointments (follow-up show). Clients were eligible for participation in the study if they had a good knowledge of the Dutch language and were able to respond adequately to questions. Clients who only received forensic psychiatric care at home or who received group treatment especially aimed at clients with a subnormal intelligence were excluded.

The no-show and follow-up no-show groups were compared to a group of clients who attended generally all appointments at the outpatient clinic during the study period, that is, follow-up show clients. The follow-up show clients were identified by asking each therapist to list and score their clients by means of a scale ranging from 1 (very weak therapy adherence) to 7 (very strong therapy adherence). All clients with a score of 6 or higher were classified as follow-up show.
Table 1. Overview of Response and Nonresponse

<table>
<thead>
<tr>
<th></th>
<th>Sample</th>
<th>Untraceable</th>
<th>Refusal</th>
<th>Five trials</th>
<th>Interviewed</th>
<th>Rate of those traceable (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No-show</td>
<td>61</td>
<td>19</td>
<td>8</td>
<td>7</td>
<td>27</td>
<td>64</td>
</tr>
<tr>
<td>Follow-up no-show</td>
<td>139</td>
<td>23</td>
<td>8</td>
<td>24</td>
<td>84</td>
<td>72</td>
</tr>
<tr>
<td>Follow-up show</td>
<td>60</td>
<td>7</td>
<td>6</td>
<td>6</td>
<td>41</td>
<td>77</td>
</tr>
<tr>
<td>Total</td>
<td>260</td>
<td>49</td>
<td>22</td>
<td>37</td>
<td>152</td>
<td>72</td>
</tr>
</tbody>
</table>

At the end of the study period it was also evaluated how many of the clients had unilaterally or bilaterally terminated their treatment at the forensic psychiatric clinic, in other words, who disengaged from clinic contact (drop-out).

Procedure

All clients of the forensic psychiatric outpatient clinic were informed about the research project by means of posters in the waiting room and information leaflets that were sent with the intake letter. During the study period, basic data on those clients who did not attend appointments, for example, names of the client and the therapist, type of treatment, and time of appointment, were updated daily by the secretaries of the outpatient clinic. Also, the number of eventual consecutive (follow-up) no-shows was recorded for all clients. Within 24 hr after the client’s nonattendance, the client was called by the first author and invited to take part in a short telephone survey. A maximum of five calls were made to contact clients, each call at a different time and day. The follow-up show clients were called at a convenient time.

Table 1 provides an overview of the responders and nonresponders per group. In this study, an overall response rate of 58.5% was found and a response rate of 72% was found if examined as a proportion of those clients traceable. Two no-show clients only partially finished the telephone interview. Forty-nine clients (18.8%) were untraceable: 19 of the no-show clients (31.3%), 23 of the follow-up no-show clients (16.5%), and 7 of the follow-up show clients (11.7%) could not be traced because either their phone number was not provided or was incorrect or because the clients were (re-)imprisoned. Of those clients who were classified as nonresponders \((n = 59)\), 37 (62.7%) could not be reached within five trials and 22 (37.3%) refused to take part in the survey. Main reasons for refusing were as follows: not interested in surveys \((n = 8)\), denial of nonattendance \((n = 4)\), and personal reasons \((n = 4)\). The nonresponders did not differ significantly from responders on age, marital status, gender, socio-economic status (SES), or involuntary legal status, that is, whether clients are obligated by probation services to visit the outpatient clinic.
Measures

The methodology consisted of a self-constructed questionnaire, which focused on the gathering of data on four categories in line with the theory of planned behaviour (Ajzen, 1991; Fishbein & Ajzen, 1975): clients’ attitudes towards appointments, family or friend’s social support concerning appointments, perceived or actual behavioural control, and intentions to attend an appointment. Also socio-demographic characteristics as well as data on the extent of no-show were assessed. The overall attitude towards appointments was measured by the question “What do you think of appointments at the clinic in general?” Respondents could answer this question on three semantic differentials that enquired respectively the rational (important–unimportant), moral (good–bad), and emotional (like–dislike) evaluation of appointments. The three differentials were summed and divided by 3 to keep the initial 5-point Likert-type scaling. The internal validity of this combined measure was .74. In line with the theory of planned behaviour, perceived social support from family and friends was measured by multiplying the subjective likelihood that a specific referent group (family or friends) thinks the clients should or should not attend appointments at the clinic by the client’s motivation to comply with the expectations of referents. Data on SES—a measure of the social status of a zip code—were obtained from the Netherlands Institute for Social Research. SES is a combined measure composed of three elements: income, educational level, and employment. The scores for SES were standardised by using factor analysis (principal component analysis) and can be read as factor scores with a mean of zero. Hereby a score of 1 or −1 has to be read as 1 times the standard deviation below or above average. Furthermore, the follow-up no-show and no-show clients were asked for their reasons for nonattendance. The questionnaire was piloted for comprehension and adequacy on 12 (follow-up) no-show clients. Based on the results of this pilot and the comments of clients, some minor amendments were made.

Analysis

To compare the groups on socio-demographic and other characteristics, statistical tests were used. For continuous variables, Mann-Whitney U tests were used to investigate differences between two groups, whereas Kruskal-Wallis tests and F tests were used to examine the difference between the three groups. Chi-square tests were used to analyze dichotomous or categorical variables. For all tests, a p value of .05 or less was considered significant.

Results

No-Show Data

During the study period from March 30, 2009, to June 30, 2009, a total of 245 new appointments were made, of which 61 were missed (a no-show rate of 24.9%). Of the
1,423 clients who made a follow-up appointment, 139 clients failed to attend this appointment (a follow-up no-show rate of 9.8%). Of all clients in the sample, 31 clients (11.9%) missed none of their appointments whereas 122 clients (46.9%) missed their appointment only once and 107 clients (41.2%) missed two to a maximum of eight appointments. Of those clients who missed an appointment \((n = 229)\), 50 clients (21.8%) cancelled all their appointments—though less than 24 hr before it was scheduled—whereas 47 clients (20.5%) cancelled at least one but not all of their missed appointments \((\leq 24 \text{ hr before it was scheduled})\) and 132 (57.6%) clients did not cancel any of their appointments. The majority of missed appointments by no-show and follow-up no-show clients \((n = 115, 57.5\%)\) was scheduled in the beginning phase of clinic contact, that is, appointments regarding intake, information session, psycho-diagnostic test, or treatment advice. Significant differences were found for age and the amount of appointments missed, \(F(4, 255) = 4.76, p < .001\). Bonferroni post hoc tests showed that clients who attended all appointments were significantly older than clients who missed one or more appointments. The age differences increased with the amount of appointments missed (the mean differences were 5.73, SD = 2.14, \(p < .01\), for 0 and 1 appointment missed; 6.88, SD = 2.37, \(p < .01\), for 0 and 2 appointment missed; 8.26, SD = 2.71, \(p < .01\), for 0 and 3 appointment missed; and 12.82, SD = 3.16, \(p < .01\), for 0 and \(\geq 4\) appointment missed). There were no significant differences found for clients with and without an involuntary legal status and the amount of appointments they missed or cancelled.

At the end of the study period, a total of 38 of the 260 clients in the sample dropped out from clinic contact (14.6%). No-show clients significantly more often dropped out than follow-up no-show and follow-up show clients (Table 2). No significant differences were found between those who dropped out and those who did not on socio-demographic characteristics such as age, gender, marital status, SES, educational level, or employment status. The involuntary legal status of clients also did not affect drop-out rates.

### Table 2. Drop-Out per Group

<table>
<thead>
<tr>
<th>Drop-out</th>
<th>No-show, (n = 61) (n [%])</th>
<th>Follow-up no-show, (n = 139) (n [%])</th>
<th>Follow-up show, (n = 60) (n [%])</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>22 (36.1)</td>
<td>14 (10.1)</td>
<td>2 (3.3)</td>
</tr>
<tr>
<td>No</td>
<td>39 (63.9)</td>
<td>125 (89.9)</td>
<td>58 (96.7)</td>
</tr>
</tbody>
</table>

\(\chi^2(2) = 30.9, \text{ Cramer's } V = 0.35, p < .01\).

### Socio-Demographic and Legal Characteristics

The characteristics of the study population are given in Table 3. Of the 152 clients interviewed, 139 (94.4%) were men, 104 (69.8%) were single or divorced, 83 (56.1%) clients had attained very low to low education levels, that is only primary school or
Table 3. Socio-Demographic Characteristics of the Study Population per Group

<table>
<thead>
<tr>
<th></th>
<th>All interviewed clients (n = 152)</th>
<th>No-show clients (n = 27)</th>
<th>Follow-up no-show clients (n = 84)</th>
<th>Follow-up show (n = 41)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>139</td>
<td>94.4</td>
<td>25</td>
<td>92.6</td>
</tr>
<tr>
<td>Female</td>
<td>13</td>
<td>8.6</td>
<td>2</td>
<td>7.4</td>
</tr>
<tr>
<td>Age in years, M</td>
<td>33.97</td>
<td>30.60</td>
<td>33.07</td>
<td>38.0</td>
</tr>
<tr>
<td>Marital status</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married/living together</td>
<td>45</td>
<td>30.2</td>
<td>13</td>
<td>50.0</td>
</tr>
<tr>
<td>Single/divorce</td>
<td>104</td>
<td>69.8</td>
<td>13</td>
<td>50.0</td>
</tr>
<tr>
<td>Missing</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>–</td>
</tr>
<tr>
<td>Educational level</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very low (primary school)</td>
<td>28</td>
<td>18.9</td>
<td>6</td>
<td>23.1</td>
</tr>
<tr>
<td>Low (secondary school)</td>
<td>55</td>
<td>37.2</td>
<td>10</td>
<td>38.5</td>
</tr>
<tr>
<td>Moderate (more than secondary school)</td>
<td>39</td>
<td>26.4</td>
<td>5</td>
<td>19.2</td>
</tr>
<tr>
<td>High (college/university)</td>
<td>26</td>
<td>17.6</td>
<td>5</td>
<td>19.2</td>
</tr>
<tr>
<td>Missing</td>
<td>4</td>
<td>1</td>
<td>3</td>
<td>–</td>
</tr>
<tr>
<td>Socio-economic status</td>
<td>−1.15</td>
<td>−1.45</td>
<td>−1.1</td>
<td>−1.03</td>
</tr>
<tr>
<td>(SD = 1.1), M</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employment status</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employed</td>
<td>84</td>
<td>56.8</td>
<td>17</td>
<td>65.4</td>
</tr>
<tr>
<td>Unemployed</td>
<td>64</td>
<td>43.2</td>
<td>9</td>
<td>34.6</td>
</tr>
<tr>
<td>Missing</td>
<td>4</td>
<td>1</td>
<td>3</td>
<td>–</td>
</tr>
</tbody>
</table>

about 4 years of secondary school, and the mean age was 34 years. The unemployment rate in the study population was 43.2% (95% CI = 35.2-51.2), compared with 4.6% for the general population in the Netherlands. The SES of the interviewed clients was below average; the SES level for all interviewed clients was −1.15 times the standard deviation below the Dutch average (SD = 1.1). A comparison of the three study groups on socio-demographic characteristics showed only a significant difference for age, $F(2, 149) = 4.50, p = .01$. Bonferroni post hoc tests showed that clients in the follow-up show group were significantly older than clients in the no-show group (mean differences = 7.37, SD = 2.66, $p < .05$). A comparison of age of the
follow-up show and follow-up no-show group nearly reached significance (mean difference = 4.93, SD = 2.04, p = .05).

Of those clients interviewed, 62 (40.8%) attended the appointments at the forensic clinic based on an involuntary legal status (probation supervision). More than half of the clients were interviewed, and 90 (59.2%) visited the clinic voluntarily, that is, clients who stayed in treatment after the mandatory treatment period had been ended as well as clients who were referred from the police, general practitioner, or mental health practitioners on a “voluntary” basis.

**Intention and Attitude Towards Appointments**

Of those clients interviewed, 120 (78.9%) indicated that they intend to visit the forensic psychiatric clinic the next time they would have an appointment, 23 (15.1%) clients were unsure whether or not they would attend the next appointment, and 9 (5.9%) clients indicated that it was highly unlikely that they would attend the next appointment offered. Although no differences were found between the three groups regarding intention to visit during the next appointment, significant differences were found for drop-out clients. Drop-outs expressed less often to intend to visit the clinic the next time than those clients who did not drop-out (Mann-Whitney U test = 677.50, z = −2.08, p = .04). Marked differences were found between the three groups and their attitude towards appointments. Follow-up no-show clients had a significantly more negative attitude towards appointments than follow-up show clients (Mann-Whitney U test = 563.5, z = −2.08, p = .04). No significant differences were found for the amount of times a client had not attended appointments at the clinic and their attitude towards appointments.

**Perceived Social Support**

The majority of clients told their friends and family about their appointments at the forensic psychiatric clinic. Of the 152 clients interviewed, a total of 118 clients (77.6%) told their family and 101 clients (66.4%) told their friends about their appointments. Of the 113 clients who experienced social support, many clients (n = 76, 67.3%) experienced high family social support and 35 clients (31.0%) experienced moderate family social support, whereas 2 clients (1.8%) experienced low family social support. A comparison of the three groups demonstrated a significant difference for perceived family social support (Kruskal-Wallis test = 6.61, p = .04). The follow-up show clients experienced more family social support than their nonattending counterparts. Concerning the perceived social support from friends, more than half of the 91 clients who experienced social support experienced high to very high social support (n = 59, 64.8%), 30 clients (32.9%) experienced moderate social support and 2 clients (2.2%) experienced low social support. No significant differences were found between the three groups for perceived friends’ social support.
Perceived and actual behavioural control was measured by distance to the clinic, involuntary legal status (probation supervision), time of appointment, and waiting time to get the first appointment. There were no significant differences found between the no-show and follow-up no-show clients for time of appointment, that is, in the morning between 0900 hr and 1330 hr or in the afternoon between 1330 hr and 1800 hr. Distance to the clinic or involuntary legal status as well did not show significant differences between the three no-show groups. Also, no-show and follow-up no-show clients had not experienced longer waiting times than attendees.

**Reasons for Missing an Appointment**

Table 4 provides the reasons given by clients for their nonattendance of an appointment. The main reason for nonattendance was forgetting about the appointment (about 22%). Other reasons commonly cited by no-show and follow-up no-show clients were work commitments (respectively 18.5% and 9.5%), other commitments/occupations (respectively 11.1% and 17.9%), and feeling too (psychiatrically) unwell (respectively 11.1% and 13.1%).
Discussion

The aim of this study was to provide more insight into the prevalence and patterns of no-show for initial and consecutive appointments as well as to identify risk factors of and reasons for no-show. The most striking findings in this study are that the no-show rates were lower than those found in literature, that most clients missed appointments in the beginning phase of clinic contact, that no-shows were younger than attendees and more often dropped out from clinic contact, as well as that no-show and follow-up no-show clients experienced less family social support and had a more negative attitude towards appointments than follow-up show clients.

The no-show (24.9%) and especially the follow-up no-show rate (9.8%) found in this study are lower than those rates found in most literature concerning general psychiatric outpatient clinics. At an outpatient psychiatric clinic in Great Britain (Killaspy et al., 2000), no-show and follow-up no-show rates of respectively 36% and 40% were found. Also at another outpatient clinic a no-show rate of 36% was found (Kruse & Rohland, 2002). In turn, in the field of forensic psychiatry, Hambridge (1990) found only a slightly higher no-show rate of 25.6%, whereas Dalton et al. (1998) found a no-show rate of 28.3% and a considerably higher follow-up no-show rate of 27.8% (Dalton et al., 1998). In line with previous studies higher no-show rates than follow-up no-show rates were found (Killaspy et al., 2000; Mitchel & Selmes, 2007). It is plausible that the relatively low (follow-up) no-show rates found in this study are effected by a Hawthorne effect (Bloombaum, 1983), that is, that the behaviour of clients concerning adherence to appointments was influenced by the attention given to their behaviour through leaflets, posters, and by the study itself. Unfortunately it was not possible to assess whether such an effect had occurred, as initial measures of no-show and follow-up no-show rates were lacking. Another partial explanation for the low rates found in this study is related to the involuntary legal status (i.e., probation supervision) of about 40% of the clients interviewed, which could have prevented some clients from attending clinic appointments. However, the follow-up no-show rate in this study may be an underestimation of the real rate, as the follow-up no-show rate was examined as a proportion of the total caseload of the forensic psychiatric clinic and not as a proportion of the quantity of appointments that were offered during the study period.

The majority of the no-show and follow-up no-show clients in the sample did not show up during one of their first appointments, that is, appointments regarding intake/information sessions, psycho-diagnostic tests, or treatment advice. Also, in other studies, it has been found that clients are more likely to miss initial appointments and are difficult to engage in the beginning phase of clinic contact (Barrett et al., 2008; Killaspy et al., 2000; Peeters & Bayer, 1999). Moreover, in this study, it has been found that no-show clients more often drop out from clinic contact than follow-up no-show and follow-up show clients. Possible explanations for the difficulties to engage and retain clients, especially at first contact, are that clients disagree with their referral, have less insight into the severity of their problems and their need for treatment,
vague or evasive problem definitions, or are sceptical about the kind of treatment they can expect from therapists at the forensic psychiatric clinic (Gould et al., 1970; Grunebaum et al., 1996; Killaspy et al., 2000; Noonan, 1973). This last explanation is in line with another finding in this study, namely, that follow-up no-show clients have a less positive attitude towards appointments at the clinic than follow-up show clients. Also in a study concerning mental health treatment of clients in the United States and Ontario, Canada (Edlund et al., 2002), it has been found that those clients who experience treatment as ineffective have a greater chance of no-show and dropping out. Besides, clients who feel uncomfortable about receiving mental health care more often drop out from clinic contact (Edlund et al., 2002). Another explanation that may account for the difficulties to engage and retain clients in treatment is related to the involuntary legal status of clients, that is, probation supervision. Most clients (about 60% of the clients interviewed) do not have probation supervision and also more than half of the drop-out clients are not obligated to visit the clinic.

A significant difference was found between the three groups on age, indicating that clients in the follow-up show group were significantly older than clients in the no-show group and nearly significantly older than clients in the follow-up no-show group. This finding is in line with previous research in various fields (Carpenter et al., 1981; Farid & Alapont, 1993; Hambridge, 1990; Kruse & Rohland, 2002). The most plausible explanation for the relationship between age and attendance may be related to experiences with previous psychiatric treatment, which is associated with attendance (Hillis & Alexander, 1990). An alternate explanation for this finding could be that a selection effect has occurred in favour of older clients, as therapists were free to select therapy conscience clients out of their caseload.

Finally, it has to be mentioned that it was hard to compare the general body of literature with the findings of our study because of the varying and inconsistent findings for risk factors and prevalence rates of no-show across various fields (Hatchet & Park, 2003; Wierzbicki & Pekarik, 1993). In addition, the group of forensic clients is already a highly selective group; characteristics of no-show clients in general are foremost also characteristics of the group of forensic clients as a whole, such as sex (male), low SES, marital status (divorced and single), and unemployment. Further specifications and within-group comparisons were therefore not possible or meaningful.

Strengths

To our knowledge, this is one of the first studies assessing rates and risk factors of no-show at a forensic psychiatric outpatient clinic, as well as reasons given by clients for their nonattendance and the extent of late cancellations (Hamilton et al., 2002). Clients were contacted within 24 hr after their no-show, which made it more likely that clients still knew the reason for their nonattendance, that is, avoiding recall bias. Moreover, in contrast with many other studies, this study assessed and compared nonattendance for initial as well as consecutive appointments at once (Dalton et al., 1998; Hambridge, 1990; Kruse & Rohland, 2002). In addition, this study adhered to
the theoretical framework of the theory of planned behaviour for selecting and analysing risk factors for no-show. Even though the small sample size in this study did not make it possible to test the framework, it is believed that the topic of no-show is amenable for more and systematic study within a theoretical framework.

**Limitations**

There are also some methodological limitations of this study that merit consideration. First, the low overall response rate of 41.5% may have caused nonresponse bias. However, as the focus of this study was on nonattending clients, it was expected that nonresponse would be a problem. By trying to contact clients at different times of day and up to a maximum of five times, it was tried to minimise the nonresponse rates. In comparison to other studies in the field of psychiatry, the nonresponse rate of this study did not appear to be exceptionally high. Other studies have found nonresponse rates of 39% and 40% (Hillis & Alexander, 1990; Kruse & Rohland, 2002). Although socio-demographic data were gathered from all clients, a comparison of the response and nonresponse groups did not show significant differences between the two groups. Second, all variables are based on client’s reports, with potential answering bias as a consequence. Client assessment seemed most adequate and feasible, given the general goal of this study. Telephone interviews can be quickly arranged and offer more personal safety, and the anonymity of the telephone makes it easier to talk about personal feelings (Carr, 1999; Carr & Worth, 2001). Previous studies have examined the comparability of face-to-face and telephone-administered interviews for obtaining data on health status or psychiatric symptoms (Carr & Worth, 2001; Hermens et al., 2006). These studies indicate that telephone-administered interviews are at least as valid as data obtained from face-to-face interviews. Third, some variables of importance could not be assessed, for example, diagnostic variables as well as institutional factors such as the client–therapist relationship. In several studies, these factors have been found to be associated with nonattendance (Compton et al., 2006; Grunebaum et al., 1996; Kruse & Rohland, 2002). Clearly, there are many factors that affect no-show other than those assessed in this study. However, depending on the setting and the factors known from literature to affect nonattendance, choices have to be made about how to assess no-show.

**Policy Implications**

Based on the outcomes of this study, some implications for policy at forensic outpatient clinics are suggested. First of all, as clients mostly miss appointments at the beginning of clinic contact, it is advised that intervention efforts to reduce no-show problems should begin as early as possible. This could be achieved by already visiting the clients in prison or in secure clinics, that is, some time before the client leaves prison and has to attend the forensic outpatient clinic. In addition, a more recent Cochrane review (Reda & Makhoul, 2001) found evidence that a telephone or written prompt delivered
24 hr before a clinic appointment may encourage attendance (Mitchel & Selmes, 2007). Finally, as low family support has been found to affect nonattendance, it is suggested to organise meetings for relatives at the clinic to inform them about forensic care as well as to make them aware of the necessity of social support.

**Conclusion**

This is one of the first studies providing insight into the reasons and risk factors for no-show at a forensic psychiatric outpatient clinic. In line with previous studies in the field of outpatient psychiatry, the characteristics of the sample suggest that especially younger clients who experience low family social support and who are in the first phase of clinic contact are hard to commit to clinic treatment. Research on how those clients, who are at risk of nonattendance, can be reached and engaged into treatment is needed.

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