Reducing Dropout from Therapy in a Community Mental Health Center


Research suggests that four out of five children with mental health problems do not receive specialty services. Even among those who do access services, premature withdrawal from treatment is a serious concern. Estimates of dropout from therapy in the field of children's mental health range from 30% to 75%. There is considerable work to be done to ensure that the needs of families who receive mental health services are being met, and that resources are used more effectively and more efficiently. Much of the research investigating dropout from therapy has focused on client characteristics such as socioeconomic status and race. While knowledge of such predictors of dropout is important, it is essential to investigate possible interventions to address this problem. For example, there is some evidence that the extent to which service users 'know what to expect' influences dropout from therapy. The purpose of this study was to develop and evaluate an intervention designed to improve the accuracy of caregivers' expectations of child therapy, and thus to increase attendance at therapy sessions. The researchers anticipated that caregivers with a better understanding of their child’s therapy would be less likely to drop out.

As the model of the study illustrates below, participating families were in one of three groups: (1) no preparation received, (2) information given by a brochure, (3) information given by a thirteen-minute video and brochure. Families were allocated to groups on a rotational basis.

**Model for the Study**
A total of 149 families participated in the study. This was 81% of the eligible participants, defined by the researchers as the primary caregivers of a child, aged 3-10 years, receiving treatment at a non-profit community mental health center, located at two sites in a Midwestern metropolitan area. Comparison of participating and non-participating families revealed no significant differences in gender, race, age of the child, or child’s emotional and behavioral assessment at intake. During the study, the participating families attended the center for an average of ten weeks and five sessions.

The main finding of the study was that the combined use of a video and brochure to prepare caregivers (group 3) resulted in more accurate expectations of child therapy. Pre-intervention measures revealed no differences among the groups, and there was no change in the other two groups. However, there were no differences in therapy attendance rates among the three groups. Thus the researchers’ prediction that intervening to increase the accuracy of caregivers’ expectations would increase therapy attendance was not supported. As the model above shows, there was an attempt to explore patterns of attendance by collecting separate data on broken, canceled, and kept appointments as well as the total number of scheduled appointments. The study did find weak, but statistically significant, associations between accurate expectations of therapy and both kept appointments and canceled appointments, but not for broken appointments. There was no effect of stress (as measured by the Parenting Stress Index) on attendance.

As discussed by the authors attendance is a complex issue to research. Existing research on dropout rates indicate that there is a mismatch between the services provided, and the needs of many families who access treatment. It is important to ensure that caregivers receive information about their children’s treatment in a form that is useful to them. Evaluation of interventions is a useful means of advancing understanding of why families leave treatment. In addition to improving information for caregivers, there are a number of other ways in which families could be involved in the design of systems of service delivery so that there is a better match between services and the needs of families.