willing to accept treatment, or pose such a high risk that secure accommodation is required. No crisis alternative has demonstrated any impact on rates of compulsory hospital admission.

Four challenges can be identified for community crisis alternatives to thrive in modern mental health systems, as detailed below.

Rapid response. In many countries, lack of bed availability can lead to delays in admissions, or patients being admitted far from home. In principle, though, referral routes to inpatient wards are clear and new patients can be accepted rapidly at any time. Community alternatives, in order to provide a genuine crisis service, must seek to match this. Yet in England, for example, crisis resolution teams' response time targets for initial assessment of patients referred in crisis vary from one hour to one week⁶.

Managing acuity. While community alternatives must set responsible limits on levels of risk which can be safely managed, an ability to accept acutely ill and distressed patients, even where some risks are present, is essential. Referral processes, staffing levels and skill mix, the physical environment, and organizational culture have been identified as modifiable barriers to successful management of acuity in community crisis services⁷.

Role clarity. Community alternatives may offer either comparable treatment to inpatient wards in an alternative setting, or distinctly different care from psychiatric hospital. Crisis resolution teams typically emphasize the former, providing clinical treatment from a multi-disciplinary team to all those for whom hospital admission might be averted. Residential crisis houses may seek a more niche role, to provide different, innovative and potentially more appropriate care for a specific demographic or clinical group. The Soteria model of crisis houses provides the best known example of this. Developed in California in the 1970s, Soteria houses offer a minimum medication-use, non-hierarchical residential treatment setting for people with first-onset psychosis in crisis⁸. Being perceived by local commissioners and service planners as having a clearly defined role is a key factor influencing the sustainability and survival of crisis alternatives⁷.

Implementation. Community crisis alternatives face the common challenge of replicating the benefits observed from early adopters and initial evaluations, when scaled up. The English

experience of implementing crisis resolution teams nationally exemplifies this. Reductions in inpatient admissions anticipated from trials have not been consistently reproduced⁹ and implementation of national policy guidelines has only been partial⁶. High model specification, rigorous assessment of adherence, and programmes to support implementation may be required to maximize the benefits of crisis alternatives.

Potential unintended consequences of crisis alternatives should also be considered. Outcomes for rare adverse events, such as suicides, are poorly evaluated by individual studies. Community alternatives may attract skilled staff away from inpatient wards and, by accepting the more compliant, less high-risk patients, may raise the overall levels of disturbance and acuity on acute wards. Increasing the complexity of local acute care systems presents challenges to maintaining continuity of care. Overall length of stay in acute care could be increased, if crisis alternatives were commonly used as a "step down" provision from inpatient wards.

Community crisis alternatives, which offer a cheaper alternative to inpatient admission, as well as a potentially less frightening, stigmatizing and socially dislocating experience, have a positive role to play in sustaining deinstitutionalization. Yet, there is little consensus within or across countries about optimal acute service configurations. The next challenge for researchers is to move beyond evaluating individual service models to system level evaluation, which can identify service components and configurations which provide the best outcomes for patients within mental health acute care systems.

Brynmor Lloyd-Evans, Sonia Johnson

Division of Psychiatry, University College London, London, UK

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Drop-outs in psychotherapy: a change of perspective

Research including almost 84,000 adult psychotherapy patients from 669 randomized controlled and uncontrolled trials shows that almost 20% of patients prematurely terminate psychotherapeutic treatments, with no differences in drop-out rates among the different approaches (e.g., cognitive-behavioral, humanistic or psychodynamic)¹.

No differences between diagnostic groups seem to exist, except for personality and eating disorders showing higher drop-out rates. Rates were also found to be higher in patients

not receiving their preferred treatment, in treatments that are not time-limited or manualized, in psychotherapy performed by trainees, in effectiveness studies (as opposed to efficacy studies) and in younger patients¹. A recent meta-analysis found that almost 29% of children and adolescents dropped out from cognitive-behavioral therapy².

There are different ways to operationalize and measure drop-out¹. In randomized controlled trials, for example, patients who unilaterally do not finish the prescribed treatment

protocol are usually considered as drop-outs. More generally, premature termination or drop-out occurs when a patient decides to discontinue treatment before reaching a sufficient reduction of the problems that initially led him/her to seeking therapy^{1,3}.

When compared with completers, patients who drop out of psychotherapy show poorer treatment outcomes⁴. Thus, it is important to address this phenomenon.

Taking research findings into account^{1,3,5}, several strategies may be helpful to address the issue of drop-outs. Most of these strategies not only apply to psychotherapy, but to pharmacotherapy as well. A first group of strategies includes measures which psychotherapists can already apply at present. A second group encompasses issues to be addressed in future research.

First of all, dropping out of treatment is related to problems in patient expectations and the therapeutic alliance⁵. Thus, better preparing the patient for psychotherapy may help to reduce drop-out rates. In a socialization interview, for example, patients should be informed about the disorder and the treatment, including the roles of patient and therapist. These are important steps for establishing and fostering a therapeutic alliance. Shared decision making also contributes to fostering the alliance. Ruptures in the alliance need to be adequately addressed⁶.

Several additional strategies fostering the therapeutic alliance may help to prevent dropping out of treatment, such as conveying a sense of understanding, acceptance and respect, setting goals, conveying realistic hope, reviewing what has already been achieved, recognizing that the patient has made some progress towards the jointly set goals, or that he/she is becoming more and more able to use the “tools” of the treatment (e.g., challenging cognitions in cognitive-behavior therapy or core conflictual relationship themes in psychodynamic therapy)⁷.

Addressing ambivalence, doubts and resistance towards therapy early in treatment is another promising strategy, an approach consistent with motivational interviewing. In addition, patient preferences for treatments need to be taken into account⁵. Risk for non-response and drop-out may also be reduced by continuous feedback on patient progress⁵.

All of these strategies may be particularly important for younger patients, trainees, and patients with personality or eating disorders. In the psychotherapeutic work with children and adolescents, it is essential to take the concept of the dual working relationship (i.e., the relationship of the therapist with the patients as well as their parents) into account, to prevent inappropriate expectations from parents as well as a conflict of loyalties for the patients, factors that may increase drop-out from psychotherapy.

For younger patients, it is also important to take into account the adaptability and competence of parents to support the child's development during psychotherapeutic treatment – parents may justify a drop-out by arguing that it is a “good decision” and “in

favor” of the family even though the consequences for the patient may be negative. Thus, addressing potential fears, ambivalence and resistance of parents is an important aspect of psychotherapy with younger patients. In the case of adolescent patients, wishes for increasing autonomy may also be a reason for dropping out.

Further research is needed in this area. The reasons for dropping out need to be further explored, and patient characteristics associated with dropping out need to be more comprehensively identified. For this purpose, qualitative interviews may be useful. Furthermore, up to date, it is unknown what happens to patients who drop out of treatment, as they are usually lost from follow-up assessments. Future trials may be designed offering alternative treatments (so-called switch trials) to participants not responding to treatments or at risk of dropping out^{8,9}.

Up to now, dropping out of treatment has had a negative connotation. A shift in perspective may be helpful: in research, unexpected results are sometimes of particular interest. Drop-outs both inspire and force us to develop treatments that work for a broader range of patients. Further, as only about 50% of patients respond to psychotherapy and even less patients show a remission, at least some patients may have made a good decision when discontinuing a treatment that does not seem to be helpful to them. In addition, examining the relationship between drop-outs and side effects can be useful – the latter represent another neglected issue in psychotherapy.

Drop-outs represent a challenge for psychotherapy (and pharmacotherapy). Seen from a different perspective, they provide a chance to learn more about our treatments, for whom they work and for whom they do not, why and how they work and why not. They can inform us about limitations and *non-curative* factors of psychotherapy. For these reasons, a paradigm shift may be needed, regarding drop-outs (and non-responders) as important informants.

Falk Leichsenring¹, Lea Sarrar^{2,3}, Christiane Steinert^{1,2}

¹Department of Psychosomatics and Psychotherapy, Justus-Liebig-University, Giessen, Germany; ²Department of Psychology, Medical School Berlin, Berlin, Germany; ³Department of Audiology and Phoniatrics, Charité-University Medicine Berlin, Berlin, Germany

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