not the way to reach them. This is the crux of the problem, however, as this group is not made up solely of people who are not in need of psychiatric treatment. The patient who has committed acts of deliberate self harm is a case in point, as an underlying disorder may need urgent treatment.

The relationship between diagnosis and non-reply and non-attendance may not hold so clearly in child and adolescent psychiatry. Neither does non attendance at the child and family clinic identify a group less in need of intervention. Partly for this reason the West Glamorgan Child and Adolescent Psychiatry Clinics ran a project to try to improve DNA rates, which were considered unacceptably high at around 30%.

The county was divided along geographical lines into three sectors. In the first the family was telephone prompted whenever possible one to two days before the appointment was due, to enquire whether they intended to keep the appointment; in the second a community nurse attempted to visit the family beforehand to inform them about what to expect, encourage them to attend and enquire whether they intended to keep the appointment, and the third group received the standard appointment letter and a map with directions to the clinic. In the first group telephone prompting led to a fall in the DNA rate from 26% to 16%; in the second the rate fell from 38% to 25%; in the third group the non-attendance remained at approximately 30%. In the era of NHS trust and GP fundholders, we will be required to become more efficient and offer 'value for money', particularly in aspects of practice which the hospital managers find easy to measure. No longer will it be sufficient to put high non-attendance down to a peculiarity of psychiatric patients. Like Dr Baggaley we have found that DNA rates can be improved.

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DEAR SIRS

Although I agree there was a trend towards fewer patients actually being seen in the experimental group (61% compared with 72%), it was not statistically significant ($\chi^2 = 1.41$, $P = 0.23$, odds ratio = 1.64, 95% C.I. 0.72 to 3.76).

It is possible that a few patients might have attended using the conventional system but did not because of having contact to department first. Some might be too ill to request an appointment but might attend if given one. Others might decline to request an appointment from irritation at the extra effort required. This should not, however, be a problem, provided appropriate and prompt action is taken with those who do not reply. I would suggest that in cases of non reply in a set time period (and before they would have been offered an appointment if they had replied), the referring agency and/or the referred should be contacted and, if the referral is still considered necessary and appropriate, then an alternative such as a home assessment considered.

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DEAR SIRS

I read with interest Martin Baggaley's article on improving the attendance rates for new psychiatric out-patient referrals (*Psychiatric Bulletin*, June 1993, **17**, 347–348). His conclusion is that non-attendance at clinics can be reduced by asking people if they want to be seen, but that an alternative method of service provision is needed for those who are referred but neither reply or attend.

While non-attendance at appointments was reduced, the actual percentage of people seen fell from 72% of those referred in the control group, to 61% in the experimental group! This may be a more "efficient service" from the point of view of the psychiatrist who has to waste less of his "valuable time", but I can see little benefit from the point of view of patients, referrers or even hospital managers.

In the Borders region, non-attendance for new referrals runs at about 5%. I believe these statistics are accurate and that the low rate is due to routinely offering people appointments at home. This view is supported by early results of a controlled trial in London where an experimental team saw people at home with a co-therapist within two weeks and compared this to standard care. Early results showed 8% failure to show in the experimental group, compared to 22% in the standard care group (Burns, 1990). This supports my view that if an alternative method is needed, it should be the offer of home assessment and if it is not possible to predict who is going to attend or who needs to be assessed, routine home assessment of new referrals should be offered to all.

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Reference

BURNS, T. (1990) The evaluation of a home based treatment approach in acute psychiatry. *In Public Health Impact of Mental Disorder* (Editors D. Goldberg and D. Tantam), pp. 197–205. Toronto: Hogrefe & Huber.

DEAR SIRS

Dr Taylor is quite correct to point out that only 61% of patients referred, who were asked to request an

https://doi.org/10.1192/pb.17.11.687-b Published online by Cambridge University Press

appointment, were actually seen. I would disagree, however, that it is only the psychiatrist who gains from this system. For the same rate of referral, patients who do wish to be seen will be given an earlier appointment than under a conventional system, as slots are not wasted by individuals failing to attend. Apart from getting patients seen faster, the referrer will benefit by being informed quickly that the individual has not requested an appointment, thereby allowing an alternative plan to be devised. The hospital manager too should benefit from a more efficient utilisation of an expensive resource and from increased satisfaction from referrers and patients.

I would agree that a home assessment may be an excellent alternative option for those patients whom the referrer still wishes to be seen and who have declined the option of an out-patient appointment. I do not believe, however, that a home assessment should be offered to all to improve non-attendance, as this method of service provision has a number of significant disadvantages.

(a) It is more expensive than an efficiently run out-patients as it involves unproductive travelling time and requires at least two members of the team to assess a single patient for reasons of safety.
(b) The environment at home is often more difficult to control. There may not be a suitable quiet area free from distractions such as children, dogs and television. Physical examinations and relevant investigations are less easily performed. Therefore a home assessment may take longer or be less complete than the equivalent in out-patients.
(c) There is an argument that if an intervention is too readily available and involves no effort from the patient, it may not be valued as greatly and therefore may be less effective.
(d) There are some feckless patients who are as unreliable at being in as they are at attending out-patients.

I would suggest that a home assessment is a sensible solution only when there are positive reasons to justify the extra cost and difficulty. Apart from those who do not request an appointment when offered one, indications for home assessment might include particular diagnostic groups such as panic disorder with agoraphobia (who may find attending very difficult) or patients in whom a first hand knowledge of their social environment would be especially valuable.

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Trainees and research

DEAR SIRS
We enjoyed reading Atkinson and Coia's article 'Trainees and Research' (*Psychiatric Bulletin*, June 1993, **17**, 355–356) but we would question one of their hypotheses explaining an apparent lack of research effort among trainees. They hypothesise that trainees "are not hungry enough". Is it possible that many trainees – far from being not hungry enough – are actually starved of opportunity to do research?

The emphasis placed on the relevance of the article to trainees outside the main centres may be misplaced. There is little or no evidence to back up the idea that the problems of most trainees attempting to complete research are less onerous in the centres than in the periphery. The discriminators determining shortlisting for SR interviews for Central London training rotations have been examined (Lewis, 1991; Katona & Robertson, 1993) but we are not aware of any systematic studies which examine career progression of trainees in peripheries compared with 'main centres'.

Also, we think, that there is confusion stemming from the question "Does everyone need to do research?" One of the conclusions, "that wider perspective needs to be taken on what counts as research and this should include audit" is, we think, largely informed by the prevailing ethos of 'publish or perish' even though the paper asks whether it would be better to accept that some trainees are not interested in pursuing research. Perhaps more consistent with the discussion would be a recommendation that activities which lie outside the traditional remit of research, for example audit, management interests or teaching ability, may be included in a wider perspective of what is valued and therefore valuable for career progression?

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KATONA, C. L. E. & ROBERTSON, M. M. (1993) Who makes it in psychiatry: CV predictors of success in training grades. *Psychiatric Bulletin*, **17**, 27–29.

Reply

DEAR SIRS
We wholeheartedly support Drs Bowen and Cox in the sentiment "that activities which lie outside the

https://doi.org/10.1192/pb.17.11.687-b Published online by Cambridge University Press