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

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