Reply

DEAR SIRS

I am grateful for the opportunity to explain some examination procedures.

It is intended that if possible, no candidate for the MRCPsych examination should be examined by someone with whom they have worked or trained, nor at the same centre or by the same examiner as on previous attempts. In respect of the clinical examinations therefore, those candidates most difficult to place are those with previous attempts.

In order to organise the clinical examination, we need to know all eligible candidates. Although the closing date is sometime before the examination, a considerable number of candidates, tutors and sponsors fail to complete forms correctly or to include necessary documentation. The responsible member of the examinations staff has to pursue these deficiencies and usually information is only complete three or four weeks before the examination date. It is only then that the complicated business of planning the timetable can begin; candidates are informed of date and venue as soon as possible.

With regard to the results, the Examinations Sub-Committee (ESC) feels that, in view of the importance of the examination, every candidate deserves to have the results scrutinised and any queries (whether from candidate, organiser or examiner), investigated. All results for Part I and Part II are scrutinised by the ESC, and, in Part II, by the Court of Electors. Where there is any doubt or disagreement, papers are re-marked by a third examiner. The performance of all candidates on their last attempt is examined in detail. This all takes time, especially as members of the ESC and examiners are not seconded to examine but are in psychiatric practice, as I believe appropriate.

I am fully aware of the anxieties of candidates and there are ways of speeding up procedures which we could consider. We could reject all candidates whose documentation is inaccurate or incomplete; we could be less scrupulous in checking queries and results. I would be reluctant to pursue either course.

We are, however, looking at the forms to see if they can be made clearer to candidates and tutors. Although the number of candidates entering for the examinations has increased sharply, there has not been a commensurate increase in examinations staff, who are under very great pressure. We are considering whether to propose an increase in staff, but are conscious that to do so, given that the examination must break even financially, might mean an increase in the entry fee.

Dr Bende and her fellow candidates can be sure that we are aware of their concerns, and will continue to seek improvements. I hope that this explanation has been helpful.

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Chief Examiner

Out-patient non-attenders

DEAR SIRS

In Dr Baggaley's article 'improving attendance for new psychiatric out-patient referrals' (*Psychiatric Bulletin*, June 1993, **17**, 347–348), while the attendance rate for appointments made in the experimental group was 97%, the overall attendance rate for those originally referred fell from 72% to 63%. Many factors contribute to non-attendance but it should be assumed that referrers consider referral necessary and appropriate. The characteristics of the extra non-attenders with this method of appointment allocation are unknown though the author suggests their diagnoses may be similar to other non-attenders.

Surveys comparing attenders with non-attenders have shown varying results and Frankel *et al* (1989) concluded that the form of service delivery is more important than patient factors in determining non-attendance. Diagnosis did not differentiate between attenders and non-attenders according to Shah & Lynch's survey (1990) and neither did symptom severity (Thapar & Ghosh, 1991). The extra non-attenders are therefore likely to be a heterogeneous group and may contain a severely ill sub-group for whom being required to contact the department for an appointment tipped the balance into non-attendance.

While I agree that improving efficiency by reducing non-attendance is worthwhile, if it results in fewer of the referrals being assessed and treated any increase in suffering caused is of major importance unless, as Dr Baggaley suggests, an alternative method of service provision could be offered to non-attenders.

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References

FRANKEL, S., FARROW, A. & WEST, R. (1989) Non-attendance or non-invitation? A case control study of failed out-patient appointments. *British Medical Journal*, **298**, 1343–1345.

SHAH, A. K. & LYNCH, S. (1990) Characteristics of patients in a psychiatric follow-up clinic. *Psychiatric Bulletin*, **14**, 153–154.

THAPAR, A. & GHOSH, A. (1991) Non-attendance at a psychiatric clinic. *Psychiatric Bulletin*, **15**, 205–207.

DEAR SIRS

Dr Baggaley states that non attenders represent a group that either do not need specialised psychiatric intervention or that out-patient appointments are

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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