and the only published examples are the sample papers distributed by the Royal College. Dr Puri and Dr Sklar's interpretation is not that of the College. It may be useful to emphasise that the only guidance issued by the Examinations Office is that in the Regulations and the Sample Question Papers.

Dr Sheila A. Mann
Chief Examiner

Predicting new patient non-attendance

Dear Sirs

We were interested to read Dr Woods' study (*Psychiatric Bulletin*, January 1992 **16**, 18–14) suggesting that psychiatrists are poor at predicting non-attendance on the basis of the patient's referral letter. We have data suggesting that, within a particular clinic, more accurate prediction may be possible.

Recently, the rate of non-attendance at the new patient general psychiatry clinic conducted by the authors has been found to be in excess of 30%. We compared the referral letters of 18 non-attenders with those of 18 patients who had attended during the same three month period.

The two groups did not differ in age, sex, time of appointment offered, length of time between referral and appointment or in whether an urgent or routine appointment had been requested.

Marked differences were evident in the content of the referral letters, cross-tabulations using the SPSS system revealing significant associations between the patient not attending and the following four factors:
(a) the letter being addressed to 'first available clinic' rather than to a named consultant ($P<0.05$)
(b) the referral letter being handwritten ($P<0.001$)
(c) the letter containing no reference to a diagnosis, no matter how approximate or vague ($P<0.01$)
(d) the letter containing no reference to the possible reasons for the patient's problems, nor to their social situation or background ($P<0.01$).

In addition, a highly significant association was found between non-attendance and the patient not responding to a request, sent with details of their appointment, to confirm, by phone or letter, that they would be attending their appointment ($P<0.001$).

Stepwise logistic regression analysis suggested that the two most influential of these factors were the patients not confirming their intention to attend and the referral letter containing no reference to the reasons for, or context of, their difficulties. Taken together, these two factors correctly predicted whether the individual would have attended in 35 out of the 36 cases.

The strong correlations between non-attendance and elements in the referral letter may not have a simple explanation; however we suggest that there may be a relationshp with the psychiatric skills of the referring general practitioner, the handwritten referral letter, devoid of information other than the patient's symptoms, reflecting a hurriedly-made referral, possibly after a difficult interchange with the patient, who is himself uncommitted to the referral and who consequently ignores the letter he receives from the hospital.

A new patient non-attendance rate of 30% is undoubtedly costly in time and resources. These findings suggest that an effective way of reducing this wastage may be to identify patients at high risk of non-attendance by screening new patient referral letters for the four elements identified above and requesting information from patients of their intention to attend. Extra efforts could then be made, which may involve the GP, to contact these patients prior to their appointment. More radical approaches, possibly appropriate in view of the recent changes in the NHS, may be to include in contracts a charge for non-attendance or to make the new patient appointment, in non-urgent cases, conditional on confirmation from the patient.

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In conversation with Ivor Browne

Dear Sirs

The interview by David Healy with Professor Ivor Browne (*Psychiatric Bulletin*, January 1992, **16**, 1–9) was most interesting and rewarding. As an Ulsterman, I was honoured to be Chairman of the Irish Division for a period during the past decade. At times I felt "all at sea" when chairing meetings in the Republic, coming from, and working in, the NHS system in the North. Now I understand more of the undercurrents medico-politically and thank those colleagues "in the know" for guiding me through hazardous waters. I could sense antagonism between protagonists, yet all were courteous, and none more so than Ivor who occasionally appeared to steer a course at odds with other viewpoints.

In an "off the cuff" conversation memory can lapse. That must surely have happened to Ivor about the University chair in Belfast. The late John Gibson became Professor of Mental Health at Queens University, Belfast in 1957, and developed psychiatry in N. Ireland for 17 years before his untimely death in 1974, to be followed by George Fenton, and now Roy McClelland.

Ivor is right when he alludes to worries which psychiatrists in N. Ireland had in the '70s which were why

I set up, with unanimous support from colleagues, the N. Ireland Section of the Irish Division. The NHS provisions and changes which we had been able to monitor and follow when there was the Irish Division of the RMPA necessitated a continuity of linkup through the Irish Division of the new Royal College. It seems this Irish solution to an Irish problem has worked, our colleagues in the south realising that, although NHS involvement is only in a small area of the total island, the population of N. Ireland is just about half of that of the Republic.

Ivor has stuck to his vision of community psychiatry development over the years. I have nothing but admiration for this, seeing it from a close viewpoint without personal involvement, when others have held equally sincerely opposing views. Ireland has produced several distinguished psychiatrists but it is pleasant to see one who has given such admirable service at home honoured by a special place in the *Bulletin*.

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Mental handicap training

DEAR SIRS

Reading 'Training Psychiatrists for Work in the Community' (*Psychiatric Bulletin*, **16**, 23–24) there is evident similarity between the issues now being looked at in community psychiatry and those looked at in community mental handicap services at the beginning of the '80s. Perhaps this reflects the current position of mental handicap on the spectrum between biological and social disorders, it being considered more of a social problem than general psychiatry despite its more obvious organic roots.

Trainers in general psychiatry might look at mental handicap training to see how issues of the hospital v. community, multidisciplinary team working, and clinical role v. organiser, have been worked out within the community mental handicap services. Many senior registrars in mental handicap spend time within a hospital service and time within community services as part of community mental handicap teams, and through this community service gain experience within the full range of community settings.

Community settings are less structured than hospital settings and it is easy to get sucked into managerial and organisational meetings and while these have their value, trainees must learn how to protect clinical time; it is knowledge of patients which informs these other roles of the consultant. Most problematic has been the relationship between the consultant and other team members, and no doubt this is one of the major issues within community psychiatric services. There is much written on this topic and many models have emerged. The understanding of other disciplines is an essential part of training as this allows the consultant to take some over-view and not become bogged down in interdisciplinary dispute.

If general psychiatry trainers are wondering how to give trainees organised and supervised experience in community psychiatric settings, it may be worth looking at the local mental handicap services for part-time sessional input which might be of mutual benefit to both services and training.

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Psychiatric training in Singapore

DEAR SIRS

Robertson *et al's* article on psychiatric training in Singapore (*Psychiatric Bulletin*, January 1992, **16**, 36–38) stated that "suicide remains an offence under Singaporean law, but no action is taken for deliberate self-harm, unless it is related to national service". This implies that some form of disciplinary action will be taken in cases of deliberate self-harm related to national service, which is not entirely accurate.

Based on my experience as a psychiatrist in the armed forces, all cases of deliberate self-harm are reported. A board of inquiry will be convened and its findings submitted to a review board. The review board sits to discuss the findings and these reports are routinely circulated to the psychiatrist for an opinion on the soldier's mental competency (Lim & Ang, 1992). Depending on the causes, appropriate action will then be taken. Disciplinary action is not the only means of disposal. Very frequently, the soldier concerned is referred for counselling, or to a psychiatrist for treatment of an underlying psychiatric problem.

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Reference

LIM, L. C. C. & ANG, Y. G. (1992) Parasuicide in the male conscripts – a Singapore experience. *Military Medicine* (in press).

Senior registrar in psychotherapy

DEAR SIRS

Competition for public sector funds will set medical psychotherapists against others, especially clincal psychologists. Other disciplines will compete very favourably, on price. They will also often compete