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Improving attendance in outpatient clinics

Sir - The study reported by Munjal and colleagues in the Irish Journal of Psychological Medicine (11: 182-4) suggests that the process of asking families to confirm child mental health appointments using questionnaire and stamped addressed envelope (sae) may improve attendance. We set out to see whether their scheme was cost effective in routine clinical practice and also to compare the use of such questionnaires to simple appointment letters (which they did not do). A questionnaire (with s.a.e) was sent to every alternate referred child mental health patient. It invited one of three responses: i) will attend, ii) want a different appointment date, and iii) no longer require an appointment. A design with alternate letters was favoured to random allocation which would have been less likely to control for shifts in waiting time and the effects of weather variations on attendance. The study was continued for a full calendar year collecting information in a similar way to Munjal and colleagues.

Over the year 137 new patient referrals were received. Of these, 99 were from general practitioners, 14 from paediatricians and community medical officers, 11 from other psychiatric consultants, and the remaining 13 from psychologists, community psychiatric nurses and educational welfare officers. There was an average of 27 days between the date of receipt of the referral to the date of the first appointment, with a range of 6-61 days. There were no significant differences between the two groups in terms of broad age groups, sex, source of referral or length of wait.

Questionnaires were sent to 69 newly referred patients. Eight were not returned, 54 replied to confirm attendance and 7 to cancel. Six of those cancelling requested a new date and 1 indicated that an appointment was no longer required. Overall, 92(67%) of the 137 patients attended a first appointment; a further 23(17%) cancelled the appointment, and 22(16%) did not attend (DNA).

Receipt of the questionnaire significantly affected attendance at the first appointment. Of the questionnaire group 53(77%) attended their first appointment while 39(57%) of the 68 in the non-questionnaire group attended. This was a significant difference ($p = 0.013$).

Forty five patients did not attend the first appointment and of these 20 attended a subsequent appointment. Eight out of 16(50%) in the questionnaire group attended subsequently, and 12 of the 29(41%) in the non-questionnaire group attended a subsequent assessment (no significant difference). Overall 112(82%) patients attended at some stage after referral, 61(88%) from the questionnaire group and 51(75%) of the other group ever attended ($p = 0.043$). Sixty one patients returned the questionnaire and 50(82%) of these attended an assessment. Only three (37%) of the non-returners attended ($p = 0.01$).

Previous studies have sought to explore why patients do not attend child mental health clinics[1,2] and the interactive effects of factors such as age, sex, maternal employment and marital status have been explored.[3] This study confined itself to the more pragmatic concern of improving attendance. The cost of running the trial involved a very small amount of extra secretarial time and the £13.80 spent on stamps. It was easy to set up and run. At the very least it merits a one year trial within teams to assess usefulness. We found that it reduced non-attendance without substantial extra cost.

References
1. Cottrell D, Hill P, Walk D, Dearnley J, Ierotheou A. Factors influencing non-attendance at child psychiatry out-patient appointments. Br J Psychiat 1988; 152: 201-14.
2. Gould MS, Shaffer D, Kaplan D. The characteristics of dropouts form a child psychiatry clinic. J Am Acad Child Psychiat 1985; 24: 316-28.
3. Dowdney L, Rogers C, Dunn G. Influences upon attendance at out-patient facilities - the contribution of linear logistic modelling. Psychol Med 1993; 23: 195-201.

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Gastrointestinal presentations of Munchausen's syndrome: three case reports

Sir - The syndrome of factitious disorders with physical symptoms was named Munchausen's syndrome by Richard Asher in 1951, after the eponymous dramatic, well travelled Baron.[1]

The principle features are uncontrollable pathological lying, with the presentation of the history in a dramatic, vague and inconsistent manner; evidence of prior treatments, including extensive hospital records and multiple scars; medical sophistication; disruptive hospitalisation, where the rules and regulations of the hospital are openly flaunted; symptoms that shift from one organ system to another; tolerance of painful and invasive procedures without complaint; demands for analgesic medication without signs of withdrawal on discontinuation and either the absence of visitors or one visitor who colludes in the behaviour.[2-4] There is often an inordinate desire for privacy. Symptoms are not in keeping with the results of examination, blood tests or diagnostic procedures.

As is to be expected, these patients are diagnosed only after a series of investigations where no abnormality is detected and as such represent a significant drain on hospital resources. Subjects known to one medical institution frequently present at another, where a similar investigative procedure is conducted.

It appears from the literature that the incidence of Munchausen's syndrome is unknown. There is a justifiable reluctance to diagnose the condition, lest it deprive a patient of his/her right to treatment for a serious medical condition. In addition, there is an extensive use of aliases by these patients.

We report a series of three cases which presented in an urban general hospital within an eight month period, all