Like Drs Hellewell & Pugh I deplore the waste of resources implicit in a non-attendance rate of over 30%. In the present resource-starved climate this state of affairs cries out for remedial action. Nevertheless, the strongest association with non-attendance reported by the authors was with a failure by patients to confirm their appointment. However revealing this might be, it is not a feature of the referral process itself and in combining this with the latter in a regression analysis they overstate the case for scrutinising referral letters routinely as a means of improving efficiency.

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Reply

DEAR SIRS

Our study was carried out as a practical response to the problem of non-attendance at our new patient clinic. It is a small study, although we do not accept that there are major methodological shortcomings and the statistical treatment is, we consider, entirely appropriate for the data. Our findings are not only statistically significant but also of practical relevance. It may also be of interest to note that, unlike Dr Weich, our colleagues expressed no surprise at our findings.

In an examination of new patient non-attendance it is necessary to examine the whole process of referral, from individuals first consulting their doctor to their eventual presentation at the clinic. As it was our practice to request confirmation from our patients of their intention to attend then it is entirely appropriate that this element be included in the regression analysis.

Clearly, there is a need for further research into this problem. We are shortly to begin a more comprehensive prospective study; however, until newer findings are available, we would commend to readers our earlier suggestion that those patients likely not to attend may be identified with some reliability by requesting confirmation from patients and examining their referral letters.

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Diogenes syndrome

DEAR SIRS

I read Dr Coakleys letter (*Psychiatric Bulletin*, February 1992, **16,** 111) surprised that in the context of depression he is so prepared to devolve responsibility for self neglect to the housing department and public health. Ignoring a mental disorder in favour of a description of a patient's domestic chaos receives no professional credibility or sanction by calling it the Diogenes syndrome.

Dr Coakley seems to believe that self neglect and mental illness are mutually exclusive categories. In MacMillan & Shaw's (1966) seminal paper on senile squalor, over 50% suffered from psychoses, mainly dementias, chronic paranoid schizophrenia and manic depression. Of the "normals" 32% had "reactive depression", 58% "grief" and 32% clearly developed after bereavement; 15% were severely immobile, 29% severely deaf and 20% blind or visually impaired. Clarke *et al* (1975), who coined the term Diogenes syndrome, selected their sample on the basis of acute medical presentations and found 50% to be suffering from mental disorders, mainly dementias and schizophrenia, with multiple nutritional deficiencies and severe physical illness.

The diagnostic and prognostic heterogeneity of Diogenes labelled patients makes the term of limited value (Cybulska & Rucinski, 1986). Though patients often do badly after hospitalisation, possibly because they are so ill by this time (Cybulska & Rucinski, 1986), Roe (1987) discharged 16 of a 25 patient sample with 9 returning to their own homes "where they lived reformed lives". Clarke *et al* (1975) discharged 13 of 30 patients with 5 returning home and 8 settling into residential homes "with no regrets".

The use of a catchy, eponymous description of people's inability to care for themselves while mentally ill is of no value to psychiatrists on their patients. The patient described in our letter (*Psychiatric Bulletin*, 1991, **15.** 574) was re-admitted within three month of discharge with persecutory delusions and threatening behaviour toward her neighbours. She is currently receiving ECT under section 58. Digoenes was not able to help.

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