continue medication by arranging full blood counts to be done locally. Our main concern at present is the large bore of the needles supplied in the blood testing kits. Patients frequently comment on this and we wonder if full blood counts could not be done using a more humane size of needle. In view of the high cost of the monitoring service, we also wonder if patients established on the drug might eventually move to having their blood monitored by local haematological services (our local service have said they would be willing to do so).

In summary we have found that although the routine of the "Monday queue" of patients waiting to have their blood taken can be an annoying interruption to work routine, trainees have a central role in the management of a group of patients who by definition have previously proved very difficult to treat.

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Reference

LIEBERMAN, J., SALTZ, B., JOHNS, C. *et al* (1991) The effects of clozapine on tardive dyskinesia. *British Journal of Psychiatry*, **158**, 503–510.

The Hospital Anxiety and Depression Scale

DEAR SIRS

The study by Meakin (*British Journal of Psychiatry*, February 1992, **160**, 212–216) draws attention to use of this brief self-assessment scale which was introduced for the purpose of screening for emotional disorder in patients with somatic disorders and for differentiating between the concepts of depression and anxiety in such disorders. It is also useful in community studies and as a monitor for progress in treatment of emotional disorder in psychiatric practice. It was provided free of charge by Upjohn but that service was withdrawn and it is now available in a convenient printed format with scoring device and chart for record of progress. The printing has been undertaken by Leeds University. A small charge is necessary for bulk supply but a sample of the material and other information will be sent free of charge. A stamped addressed A4 envelope should be sent.

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Senior registrar in psychotherapy

DEAR SIRS

Dr Ryle raises many controversial issues about different theoretical models in relation to appropriate senior registrar training in psychotherapy (*Psychiatric Bulletin*, January 1992, **16**, 34–35). These are to be discussed fully within the College as the Dean acknowledges in a postscript.

I would like to comment on the rather flattened view taken of aspects of psychoanalytic training, reducing them to literal terms so that their real value is in danger of being missed. The time involved is intensive but what occurs during that time is given no real credence. My own experience from the effects of psychotherapy at the beginning and later analysis is that the time taken has the indirect effect of making time in other areas in the long run, often years later.

He refers to 'trimming' the consultant contract but is this fair when the advantages of part-time posts are tried and tested? Half-time effectively means three-quarters if commitments are to be fulfilled, so the NHS benefits, while if analysts are to apply their skills fully then there has to be time available outside the contract to practise psychoanalysis. Within the NHS then, once a week psychotherapy is available for as many patients as possible and one of the attractions about the Portman Clinic is the treatment case load each consultant can carry.

To accommodate this complementary practice, a common pattern would be the appointment of a previously full-time senior registrar to a part-time consultant post just at the point when, late on in the analytic training, the demands in terms of time become maximal (taking a second training case).

Finally, if lack of exercise is a problem, I can recommend getting a bike.

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Prediction of non-attenders

DEAR SIRS

I enjoyed Dr Woods article 'Can psychiatrists predict which new referrals will fail to attend?' (*Psychiatric Bulletin*, January 1992, **16**, 18–19).

If I understand his figures correctly, the average mean score for all doctors was 3.2 out of a possible 20. This would seem to suggest that the psychiatrists are able to detect non-attenders at a rate less than chance! Thus their predictions would seem to be negatively correlated with attendance.

As far as I am aware, there have been no studies specifically looking at the impact of using a straightforward screening device to evaluate motivation for patients attending an out-patient clinic.

In my own practice, the introduction of a screening device for both adult and child assessments has effectively reduced non-attendances rates dramatically. Following the completion of some background developmental history and behavioural profiles for

the children and screening devices such as the General Health Questionnaire for adults, patients are asked to return the forms to the clinic. They are then allocated an appointment date. While having significantly reduced no-show rates to less than 1%, this device has also enabled "low motivation" or "crisis orientated" referrals, which make up approximately 25% of overall referrals, to be selected out.

Straightforward screening approaches such as these may be particularly important if my observations are reproducible in other clinical settings, as Dr Wood's article suggests that psychiatrists' ability to predict "no-shows" would appear to be extremely poor indeed!

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Columbus' egg

DEAR SIRS

Welcome, Italians, to the world of computer interviewing! Dr Stratta and colleagues encountered great difficulties in applying their computerised general health questionnaire (correspondence *Psychiatric Bulletin*, January 1992, **16**, 46–47). Perhaps the reasons for their failure are not hard to see?

Patients' attitudes to a computer interview are greatly affected by the status of the person who introduces them to the computer (a GP had much more success than his nurse: Dove *et al*, 1983). "Interactive" interviews, where the computer appears to make conversation with the patient, have been shown to be very acceptable, more so than straight questionnaires. Also, patients particularly appreciate being able to conduct the computer interview in privacy at their own speed – it is unfortunate that Dr Calvarese remained present during the Italian interview. Finally, a computer "training session" at the beginning of the procedure is essential. Our *Assessor* and *Elicitor* interviews have now been used on thousands of patients without difficulty: for several minutes at the start of the interview the computer trains the patient on the use of its keys, and checks for his comprehension. If he does not understand, further examples and exercises are repeated.

I am grateful to Dr Stratta and colleagues for reminding us that automating a questionnaire is not a simple procedure.

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Reference

DOVE, G. A. W. *et al* (1977) The therapeutic effect of taking a patient's history by computer. *Journal of the Royal College of General Practitioners*, **27**, 477–481.

Creation of The Royal Free Trust

DEAR SIRS

We have learnt from recent experience that what is known in Trust jargon as "disaggregation of assets" can be extremely complicated and disruptive to staff. In our case, the creation of The Royal Free Trust resulted in a situation where four parties: the Royal Free Medical School, University of London; the Royal Free Trust; Hampstead Health Authority; the Tavistock and Portman Clinics Special Committee, found themselves engaged in the unravelling of complicated funding arrangements about an academic and research post. The subsequent Trust moves and "disaggregation" caused substantial difficulties, and so I am writing to warn colleagues, whose institutions may have similar arrangements, to take the greatest care over contracts and finances in this area, preferably before the inevitable disruption occurs.

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Music therapy

DEAR SIRS

As a Registered Music Therapist I found the article 'Music Groups for Psychiatric Patients' (Brown & Schofield, *Psychiatric Bulletin*, 1991, **15**, 349–350) most encouraging in its humane and creative approach. I too have seen how music may be the one avenue of communication for those who are withdrawn and unhappy and those who are dementing.

There were, however, three points on which I take issue:

(a) *The comment that music therapy is non-analytical.* Many practitioners do work non-analytically but there are others whose work is based on psychodynamic principles.

(b) *The comment that music therapy is non-verbal.* My work focuses on counselling techniques in which significant music is used to facilitate the resolution of blocked grief, using a combination of music, familiar and improvised, with verbal interaction to achieve a positive outcome. The use of words is, for some patients, crucial. Music assists in this process, e.g. when a song associated with a lost relationship gives the person "permission" to do emotional griefwork and then talk through, as a cognitive strategy, the reasons why the blockage occurred.

(c) *The remarks about universal perception of major music as happy, minor music as sad, and the "instinctive" nature of this response.* My recent research on cultural aspects of music therapy