setting removed from the original crisis. There may be few disposal options and no significant critical feedback/feedback to referring agents. Many patients enter psychiatric in-patient care through such clinics. The worst of all possible worlds?

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DEAR SIRS

Dr Clark raises some important points regarding the functions and roles of an emergency assessment clinic. He says that clinics are not always fully supported by senior psychiatrists. This is not our experience in Cardiff; the junior medical staff are able to seek advice from a senior registrar at any time and actively seek advice particularly if the junior decides that admission is not appropriate.

All referrals to the Cardiff EAC are accepted after the GP has spoken to the duty doctor so that issues such as current medication, the GP's previous contact with the patient and life events, can be obtained.

Dr Clark focuses particularly on GPs quite rightly as most referrals to EACs come from them. We noticed that other professional groups such as social services and the Samaritans also refer clients to our EAC. It is difficult to envisage a different type of service that could offer prompt assessment facilities for these client groups.

Dr Clark mentions that it is the most junior medical staff who are asked to see the most disturbed patients in EACs. This is a recurring theme in medicine, it is no different to the set-up in most accident and emergency departments for example.

The role of an EAC seems to be the assessment but mainly the acceptance of clinical responsibility for the patient from the GP. Most of the referrals to the Cardiff EAC were patients with acute or chronic psychosis.

Even with recent community psychiatry developments it is difficult to envisage an alternative method of assessing urgent psychiatric problems that is both readily available and cost-effective. Domicillary visits are not always appropriate in general psychiatry, out-patient clinics cannot respond to urgent need and our community mental health centres being developed in South Glamorgan are open from 9 am to 5 pm Monday to Friday. Two-thirds of the referrals to the Cardiff EAC were either after 5 pm at night or at weekends.

The future of the Cardiff EAC is uncertain. In the county's ten year development plan it is not mentioned as the admission facilities are moved from the big psychiatric hospital to smaller DGH units.

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Experience with clozapine

DEAR SIRS

We were pleased to read Drs Rigby & Pangs' letter 'Clozapine: a worm's eye view' (*Psychiatric Bulletin*, February 1992, **16**, 106) – although we would take exception to the title. We would like to comment on our experience with clozapine over the past year in this unit.

We have been involved in the management of ten schizophrenic patients on clozapine. Of this group, one had to be withdrawn from treatment due to his non compliance with oral medication and difficulties in getting him to attend for blood monitoring after discharge. Most of the others have improved considerably since beginning on the drug and all bar one are now being managed as out-patients.

We would agree that trainees take on a major role in the management of these patients – greater than in patients on more conventional neuroleptic treatment – usually seeing the patient at least weekly in the initial stages. We also feel that this high frequency of contact with services during treatment is a factor in the unexpectedly good compliance that our patients have demonstrated in attending for blood tests and to collect medication. There are few groups of patients that receive such an intensive level of support and monitoring.

In our patients the main side effects that they complained of were drowsiness and weight gain. Overall, both patients and doctors felt that there was a marked qualitative and quantitative reduction in side effects over previous treatments. We also noticed considerable improvements in the dyskinetic movements of two patients with long-standing tardive dyskinesia (see also Lieberman *et al*, 1991).

Rigby & Pang mention several patients with apparent "supersensitivity" psychosis. We also had experience of a patient who, after a lengthy period of stability, suffered a catastrophic relapse three days after stopping the drug abruptly. Although restarted on clozapine almost immediately, it has taken this patient a considerable time to regain her previous stability.

We have also had difficulties in patients requesting to go on holiday (itself a measure of their vast clinical improvement). We have found the monitoring service very accomodating and have managed to

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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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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

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