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?

I. CLARK

County Hospital
Stornoway, Isle of Lewis
PA86 2EP

References

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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.

PHIL HUCKLE

Glanrhyd Hospital
Bridgend, Mid Glamorgan

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