psychiatric disorder. Forty replied, a response rate of 74%. The purpose was to determine their present practice and attitudes and what they required of a screening instrument. This complements MacKenzie's questionnaire with less detailed but more wide ranging information.

In summary, the results were:

(a) 77.5% screened as the opportunity arises
(b) 50% use ancillary staff, though this group still did screening themselves
(c) 60% said they screened for dementia and 47.5% for depression. Only 12.5% used a validated instrument for the assessment of dementia while no-one used an established depression scale
(d) 72.5% said they had 5 minutes or less to assess mental condition; this rises to 87.5% if a cut off of 7 minutes is used
(e) only 5% thought such screening would 'be of no use' with 32.5% thinking it 'very useful'
(f) brevity and patient acceptability were the most important qualities for screening instruments.

It has been shown (Iliffe *et al*, 1991) that ancillary staff can identify psychiatric morbidity but it is clear that GPs do much of the screening themselves. It is likely that positive findings from ancillary staff are passed on to the GP for action. These factors emphasise the importance of increasing GP awareness and knowledge of psychiatric disorder. Regular use of validated screening instruments may improve their ability to identify psychiatric morbidity and raise their awareness of psychiatric disorders in the elderly.

We have therefore set ourselves the task of finding or devising simple measures of cognition and mood which the GP can use within the constraints of his brief consultations.

I agree with Dr MacKenzie that screening the elderly cannot be rationally encouraged without prospective outcome studies. To my knowledge none has specifically addressed mental illness but those that have looked at a wider range of interventions have used crude outcome measures such as mortality and hospital bed occupancy and produced equivocal results. The tools for evaluative research of this kind, e.g. clinical outcome indicators and measures of cost are increasingly available.

The expanding academe of old age psychiatry is well placed to use such methods to provide a rational basis for service development.

CHRIS HALLEWELL

Withington Hospital
West Didsbury
Manchester M20 8LR

Reference

ILLIFE, S., HAINES, A., GALLIAN, S. *et al* (1991) Assessment of elderly people in general practice. 1 Social circumstances and mental state. *British Journal of General Practice*, **41**, 9–12.

Emergency assessment clinics

DEAR SIRS

The report by Huckle & Nolan (*Psychiatric Bulletin*, February 1992, **16**, 82–83) does not address a number of problems which surround the operation of emergency assessment clinics (EAC). Some were reviewed by myself (Clark, 1982a) and others referred to by Neilson (*Psychiatric Bulletin*, 1992 **16**, 112).

These clinics are usually major gateways to psychiatric in-patient care yet their operations are not always supported in a meaningful way by senior psychiatric staff. Between 1975 and 1978, 80% of admissions to psychiatric in-patient care in one Tayside district were arranged through an EAC. I found in this clinic that junior doctors were reluctant to seek help from their seniors, especially at night. The range of options for alternative management available to junior doctors out of hours can be very limited and the option of reviewing the circumstances which led to the referral usually impossible. This is especially important if situational distress, marital conflict or even a lack of awareness of home based drug treatment possibilities by the general practitioner are involved. I interviewed GPs who had referred patients to an EAC in Tayside in 1979 and suggested that what many were looking for was someone to take over the handling of the crisis rather than advice about how they might manage it themselves. Where doctors did want such advice they were not impressed by an opinion from a senior house officer. Junior doctors are also unlikely to be able to provide much information about home treatment strategies.

Feedback from this gateway to care to referring agents is variable. If it is carried out by senior house officers it is unlikely to influence GPs' referral practices. Diagnoses made by junior doctors may be influenced by a need to legitimate their decisions to admit, especially when a high proportion of patients are admitted. Of 3,391 patients seen at the Dundee EAC in a three year period, only 84 were not given a formal psychiatric diagnosis and only 1.7% sent away.

In a different study (Clark, 1982b) attenders at an EAC were of lower social class with more serious diagnoses than those attending an out-patient clinic. More patients attending the out-patient clinic were considered to have no psychiatric diagnoses. Out-patient attenders were seen by consultants and/or senior registrars; EAC attenders were seen by senior house officers or registrars.

EACs appear to offer the expertise of the most junior psychiatric medical staff to the most acutely disturbed lower socio-economic status patients in a

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

CLARK, I. (1982a) Psychiatric emergency: concepts and problems of organisational structure. *Sociology of Health and Ilness*, **4**, 75–85.

—— (1982b) Social class and diagnosis in outpatient and emergency clinic attenders. *Health Bulletin*, **40**, 140–144.

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