

the Henderson, in providing a full out-patient psychotherapy service locally, as well as a national service for in-patient therapeutic community treatment with individual psychoanalytic psychotherapy, and the only in-patient family therapy unit in the country. The survey confirms this split between the hospital's role as a local out-patient psychotherapy recourse for GPs in the area (64% GP referrers identifying this as the most useful service); and as national tertiary referral centre for consultant psychiatrists and psychotherapists in locations as far apart as the north of Scotland and the Isle of Wight (95% of referrer psychiatrists thought the in-patient services were the most useful).

The questionnaire was sent out to referrers in the previous year in the summer of 1990, along with a letter explaining that the survey was to gain some view of the change in demand for the service following the internal NHS changes. Of the 135 respondents, 41% were psychiatrists, 37% general practitioners, 22% other categories, including psychologists, social workers and lay psychotherapists. In the sample, 63% said that they would continue to use the services in the internal market, 4.5% said they would not, and 32% were undecided. Encouragingly, there was a willingness to put pressure on managers to fund treatment that was thought clinically appropriate, with 74% saying they would do this, 3% saying they would not, and 31% being undecided. These figures were relatively stable over the different professional groups.

One aspect of the responses to the questionnaire was a sense of camaraderie among clinicians, perhaps due to there being a necessity to struggle for clinical autonomy within the new perspective of financial restraint. This may have led to an unacceptable bias had a question about satisfaction with the service as a whole been included. Instead, respondents were asked to criticise the service, and comment on ways that it could be improved. The most common comment was about resources, with the suggestion that the service should be expanded with more places available in ongoing therapy and shorter waiting lists (mentioned 78 times in completed questionnaires). Many suggested that communication of information to the referrer could be improved, and that the service could be more "user friendly" (mentioned 23 times). Several respondents suggested that treatment priorities should be changed, for example GPs advocating more out-patient work, and one psychiatrist arguing a case for priority for patients under the auspices of the Mental Welfare Commission. Many commented that the hospital should publicise itself more actively, by producing and circulating a brochure or newsletter about services offered (45 respondents), or be more active in research and publication and presentation (12 respondents). Some suggested that the hospital

should expand its teaching and supervisory role, by organising Balint type groups for local GPs, and becoming involved in local GP vocational and psychiatric training schemes.

It remains to be seen how the changes in the health service will affect the whole spectrum of psychiatric care, not only the more labour intensive specialities. We in the psychotherapy services believe that treatment of neurotic and personality disordered patients enables them to develop a lifestyle that much reduces the need for repeated crisis admissions, which in the long run represents a considerable saving for health boards. The anxiety is that short-term financial considerations by managers may obscure this, and alter the clinically appropriate care of patients. There appears to be healthy resistance to this, among referrers from all groups in this study.

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Working with clozapine

DEAR SIRS

C. Adams and M. A. Essali have provided a timely and informative outline on the benefits of clozapine treatment in resistant schizophrenic patients (*Psychiatric Bulletin*, June 1991, 15, 336-338). With regard to the risk of agranulocytosis, it may be worth noting that clinical judgement can be suspended often in the best interest of the patient when a little reflection might clarify the problem. I would like to report on one such case.

A 19-year-old unemployed male with treatment-resistant schizophrenia since the age of 13 had several admissions to hospital. Different antipsychotic regimes in large doses were prescribed without satisfactory relief of symptoms. Clozapine was commenced in July 1990, two days later he developed pyrexia, sore throat and headache. His WBC and neutrophils dropped sharply. Clozapine was stopped immediately. Next day he developed a maculopapular rash on arms and chest. Chickenpox was diagnosed. The reason for the drop in WBCs and neutrophils became apparent and he was restarted on clozapine 12 days later. Response to medication was good in a matter of days. He became symptom free. He has been on medication for about 11 months. Monotherapy has been achieved and no readmission since clozapine was commenced.

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