

Choice of neuroleptics in epilepsy

Sir: McConnell *et al* provide a first-rate overview of the difficulties associated with the use of neuroleptics in patients with comorbid seizure disorders (*Psychiatric Bulletin*, October 1997, **21**, 642–645). However, we feel that the difficulties associated with clozapine use in such patients are often overemphasised. Although clozapine is known to lower the seizure threshold and commonly produces non-specific electrocardiogram changes, clinical data would suggest that seizures are rarely an insurmountable obstacle to its use.

While pre-marketing studies did find clozapine to be associated with a relatively high incidence of seizures, post-marketing surveillance by the Clozaril Patient Monitoring Service (CPMS) does not appear to confirm this. Data collected by the CPMS on 99 502 patients between 1988 and 1994 found a seizure rate of 1.3% in the USA (Pacia & Devinsky, 1994; Honigfeld, 1996). Of those patients who did have seizures, half were concurrently receiving other medications known to lower the seizure threshold and a third had prior history of seizures. Only 0.4% of all patients had recurrent seizures, the others were isolated single events during initial dose titration, and three-quarters of these patients were able to continue taking clozapine with more gentle dose titration or the addition of an anti-convulsant. Thus, only one in a thousand patients had to discontinue clozapine therapy due to intractable seizures.

Since the prevalence of epilepsy in the general population is thought to be 3–4%, the above data allow us to estimate that fewer than 10% of patients with a history of epilepsy had even a single seizure while taking clozapine and, at most, 3% of patients with epilepsy had to discontinue clozapine therapy due to an unmanageable exacerbation of their pre-existing seizure disorder. European studies have found even lower seizure rates (Naber *et al*, 1992).

The use of clozapine does require special precautions and increased vigilance, particularly in patients with seizure disorders, and it would certainly not be a first-choice neuroleptic in such patients. However, it would be unfortunate if patients suffering the devastating consequences of treatment-resistant schizophrenia were denied the unique benefits of clozapine because of excessive concern about its possible adverse effects.

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Care Programme Approach

Sir: As the Care Programme Approach (CPA) dictates a particular form of doctor–patient relationship it is an active treatment technique rather than a neutral administrative tool. As such it should be practised within the bounds of experience, research and common sense.

Good assessment, discussing treatment options with the patient, communicating with involved colleagues and an interest in follow up are good practice. One of the most essential cornerstones of the assessment process is the decision as to whether or not the patient can and should take responsibility for their own behaviour, including their health-seeking behaviour. For most patients we assess them as able to hold that responsibility. This does not mean that these patients are less ill, less disabled or less in need of well-resourced treatment plans than those on the highest level of CPA or indeed that they are less capable of suicide and/or murder than the general population. For many patients it is important to remind them that they do retain responsibility for their actions in case in the heat of their distress or the disorder of their personality they have forgotten.

CPA as presently designed is too blunt a tool, too uni-axial and too all inclusive to be helpful. A small group of patients can benefit from CPA but there is a danger that psychiatrists will breed hostility to it because it is an irrelevant process for the majority of their patients. For some patients, particularly those with personality problems, CPA is contraindicated. Hearing even the slightest hint that someone else may be held responsible for their behaviour would be enough to destroy any hopes of a therapeutic relationship. CPA also seems at odds with the ethos of many of the psychological therapies.

Rather than universal CPA we need reasonable resources: with those we can serve the best needs of all our patients.

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Unfitness to plead in Scotland

Sir: The procedure for dealing with cases of 'insanity' in Scotland was changed fundamentally

by the Criminal Procedure (Scotland) Act 1995. Among the changes was a requirement to hold an examination of the facts if an accused person is found by the court to be unfit to plead. The previous legislation contained no such provision and any person facing charges on indictment who was found unfit to plead was required to be made the subject of a hospital order together with a restriction order without limit of time. The case which we wish to report illustrates the value of the new legislation and the interface between mild learning disability and fitness to plead.

The patient in this case was aged 31 years at the time when he appeared in the high court facing two charges of rape. He was a man who had spent a number of years in a learning disability hospital and who, since discharge from hospital, had lived in various learning disability hostels and supported accommodation. He was at the lower end of the mild range of learning disability with an IQ of around 55, and there was no evidence of associated mental illness. Since his late teenage years there had been recurrent concerns regarding his sexual propensities, with allegations that he was exploitative and opportunistic and relatively indiscriminate in his choice of partner with whom he engaged or endeavoured to engage. Children were among the groups he targeted. He had convictions for sexual offences but all were of a relatively minor nature and attracted only community disposals. He was already on a probation order when he was charged with a further summary offence of lewd and libidinous conduct with children, a plea of guilty was accepted by the Crown and sentence was deferred. Before this case was finally disposed of, however, he was charged with the rape offences and after a brief period in custody he was admitted on remand to a secure psychiatric hospital.

At the time of trial, medical opinion was divided as to whether or not he was fit to plead to this serious charge but the trial Judge, Lord Macfadyen, agreed with the two consultant psychiatrists who gave evidence for the defence, that the accused was 'insane' and unfit to plead. In the judgement delivered by Lord Macfadyen there was the following passage.

"It seems clear to me that at a certain superficial level the accused is able to understand the nature of the charge which he faces; is, at least on some occasions and to a skilled interviewer, able to give an account of the episode in question; is able to make clear that he denies the charge; and understands in simple terms the difference between pleading guilty and pleading not guilty. He has from his previous experience a basic understanding of court procedures. I am persuaded, however, that he would not fully understand the import and significance of the evidence as it unfolded. I do not consider that

the inability could practically be overcome by slowing the proceedings down and conducting them in simplified language or using an intermediary to assist with communicating the evidence to the accused and eliciting from him any response to it. The consequence, in my view, would be that there could be no assurance that he could give proper instructions as the trial proceeded".

He concluded that "on the balance of probabilities the accused is insane and unfit to plead . . . and I shall accordingly sustain the plea in bar of trial".

The court then moved to an examination of facts at which the judge decided that there was insufficient evidence to support a conviction on the charges of rape and they were accordingly dismissed. There was by then, however, considerable anxiety about the patient's sexual behaviour in the light of all the information that had emerged during the proceedings and when he returned to court for final disposal of the earlier summary conviction he was made the subject of a hospital order with restriction to a secure hospital.

This case illustrates the new procedures in the Criminal Procedure Act in relation to fitness to plead. Previously where an accused facing charges on indictment was found 'insane' and unfit to plead, there was a mandatory disposal of a hospital order with a restriction order without limit of time. This could place the examining psychiatrist in the position of arbiter of both fact and disposal and denied an accused person the right to be found not guilty. Psychiatrist colleagues may in the past have found a significantly mentally disordered person 'sane' and fit to plead to allow them an impartial trial even where there was very real doubt about their ability to follow the proceedings and instruct counsel. The examination of fact procedure represents a great improvement in natural justice in that it allows a mentally disordered person who is 'insane' and unfit to plead the benefit of an impartial judicial finding of fact. Lord Macfadyen in his judgement also helpfully clarified the interface between learning disability and fitness to plead.

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Olanzapine in the treatment of acute mania in the community

Sir: Olanzapine is licensed for schizophrenia only (*British National Formulary*, 1997). It is described as an atypical antipsychotic and therefore should be useful in any psychotic illness. I describe a case of acute mania which was