Thus there were only four patients who had not received lithium, lorazepam or anticonvulsants and even they were tested over a range of 3–24 months after starting clozapine. It is acknowledged that 60% of patients take a year to respond to clozapine (Meltzer *et al*, 1989) and it is therefore possible that even these four patients had not had a long enough trial of the drug.

My own experience of lithium and clozapine was one patient who, after the lithium was stopped, went on to pass school examinations and recommence driving. He remains well on clozapine monotherapy after nearly three years.

I would suggest that there is no conclusion to be drawn from this paper, except that it is impossible to 'dissect' the causes of cognitive deficits in polypharmacy patients (taking preparations such as lithium) who may also have brain damage. Clozapine not only improves the psychiatric symptoms but also it has been demonstrated over long-term use (13 years) that 39% of treatment-resistant schizophrenic patients found employment, compared with 3% before the clozapine was started (Lindstrom, 1989).

MELTZER, H. Y., BASTANI, B., KWON, K. Y., *et al* (1989) A prospective study of clozapine in treatment-resistant schizophrenic patients. *Psychopharmacology*, **99**, S68–72.

LINDSTROM, L. H. (1989) A retrospective study on the long-term effect of clozapine in 96 schizophrenic and schizo-affective patients during a 13-year-period. *Psychopharmacology*, **99**, 84–86.

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Mentally ill sex offenders

SIR: We read with interest Craissati & Hodes' article on mentally ill sex offenders (*Journal*, December 1992, **161**, 848–849). We have published a paper concerning a series of patients with schizophrenia who had sexually assaulted young women in direct response to command hallucinations (Jones *et al*, 1992). We would like to stress the importance of careful examination of the mental states of schizophrenic patients who are charged with such offences, and that this needs to be done as soon as possible after the offence. Craissati & Hodes suggest that within their group of patients, the majority having schizophrenia, the offences were primarily driven by feelings of sexual disinhibition; recent work from Canada might suggest an alternative hypothesis.

Rogers *et al* (1990) studied a forensic population which included a group of patients who were found by the research team to exhibit command hallucinations. In 50% of cases the patients had not reported these symptoms, or denied having them, to the original assessment team. Many patients (44%) reported that they frequently responded to hallucinatory commands with unquestioning obedience. We would agree that patients with schizophrenia might commit offences driven indirectly by their psychosis via disinhibition. It is also important to exclude direct effects of their psychosis on offending behaviour via delusions and hallucinations.

It may appear that a patient with schizophrenia has committed a sex offence due to sexual disinhibition. An alternative hypothesis might be that they had command hallucinations at the material time of the offence and this has been missed, or the patients had actively tried to hide these symptoms from the assessment team.

JONES, G. H., HUCKLE, P. L. & TANAGHOW, A. (1992) Command hallucinations, schizophrenia and sexual assaults. *Irish Journal of Psychological Medicine*, **9**, 47–49.

ROGERS, R., GILLIS, J. R., TURNER, R. E., *et al* (1990) The clinical presentation of command hallucinations in a forensic population. *American Journal of Psychiatry*, **147**, 1304–1307.

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Mabi bark tea

SIR: I wish to comment on Drs Hassiotis & Taylor's paper (*Journal*, September 1992, **161**, 404–407). We have published results of our phytochemical studies of mabi bark tea (Seaforth & Mohammed, 1988; Seaforth *et al*, 1992). We have not yet found any "quinoline alkaloids" in mabi bark tea.

Drs Hassiotis & Taylor stated that the subject "C had boiled it (mabi bark) in water along with sugar and nutmeg", and that she was consuming about two-thirds of a pint of the drink daily during the week before admission. Perhaps the nutmeg could have been responsible for the ill-effects of this particular drink.

The literature describes nutmeg/mace (*Myristica fragrans*) as the source of hallucinogenic agents! (see Schultes & Hofmann, 1980; Der Marderosian &

Liberti, 1988) should not nutmeg/mace be considered as the cause of the illness and not the mabi drink?

DER MARDEROSIAN, A. & LIBERTI, L. (1988) *Natural Product Medicine*. Philadelphia: Stickley.

SCHULTES, R. E. & HOFMANN, A. (1980) *The Botany and Chemistry of Hallucinogens*. Springfield, Illinois: Thomas.

SEAFORTH, C. E. & MOHAMMED, S. (1988) Some constituent of mabi bark. *Journal of Agriculture of the University of Puerto Rico*, **72**, 625–626.

——, MOHAMMED, S., MAXWELL, A., *et al* (1992) Mabioside A, a new saponin from *Colubrina elliptica*. *Tetrahedron Letters*, **33**, 4111–4114.

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Genetic basis for transsexualism

SIR: In their brief report on a female monozygotic twin pair discordant for transsexualism (*Journal*, December 1992, **161**, 852–854), Garden & Rothery have drawn the surprisingly sweeping conclusion that "this case ... refutes the notion that there is a simple genetic basis for the disorder". Their evidence shows a much more modest conclusion, namely that in this single case of transsexualism, genetic factors are irrelevant.

Garden & Rothery go on to offer a "psychodynamic hypothesis" to explain this case, namely that "in the father's absence, the mother uses the child as a confidante". As the child in question was a mere five years old when he first noticed that he was really a boy, he was hardly old enough to be his mother's "confidante".

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'Hidden' spending on community services

SIR: As a clinician manager in our mental health directorate, I was interested to read James Raftery's article (*Journal*, November 1992, **161**, 589–593). I work in a district general hospital (DGH) and all the psychiatric in-patient facilities are concentrated there, all the community services reach out from there, and we have had no dependent link upon Hellesdon Hospital in Norwich for eight years. My registrar and I hold six clinics a week in a community hospital 15 miles away, and I and another consultant in general psychiatry hold clinics in nearby general practices. Our community psychiatric nurses (CPNs) have personal attachments to local practices, are hospital-based for coordination, but work from three (hopefully soon five) community resource centres which host weekly multidisciplinary meetings of the community mental health teams.

We are aware that our community facilities are comparatively well developed, so I was surprised when performance indicator figures for the East Anglian region put us in the lowest ranking insofar as money is spent on working in the community.

Being a budget holder now, and since we are attached to a hospital trust, I winced at the information and looked into it. We are not a community unit but provide virtually all the community services with some help from voluntary bodies and local social services. The Health Authority puts money into two of the day centres and into a Drugs and Alcohol Advisory Service. It seems that that is the only part of our budget deemed to be devoted to community work. My salary and those of our CPNs and my consultant colleagues are all designated as hospital costs – not community – although our DGH is not outside the community but very much part of the community it serves. If 80% of my salary was listed as devoted to community work, which is a correct reflection of how my time is spent, this then would be a more accurate performance indicator.

Our beds are not 100% full, and as I transfer patients to CPN care with periodic out-patient reviews, my clinic numbers may fall and the problems of misinformation may expand. There are not many finished clinical episodes (FCEs) because we have an extensive rural network of support for those in need of long-term care.

Hence, I feel that James Raftery, when he writes "Direct spending on mental health services remains largely in-patient based and has not fallen with bed numbers", has failed to unravel the problems accountants and information systems have of keeping track of where the work is really done.

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Professional scepticism towards multiple personality disorder

SIR: The diagnosis of multiple personality disorder (MPD) remains controversial and the correspondence (Fahy, *Journal*, August 1992, **161**, 268–270), in