the international English-speaking psychiatric community actively participated in the conference. Or, the selection of papers is unbiased and constitutes a truly representative sample of the contributors. Perhaps the truth lies on a continuum between the two tending towards the latter. Evidence to support this is provided by the membership of the organising committee who are also the editors of the Supplement, all five women are from the Institute or the Maudsley. The fact that two further conferences have been held at the Institute suggest lessons have not been learnt and that this trend is likely to continue.

It is important to acknowledge the achievements of the organisers in organising conferences, stimulating "yet more discussion and research", in an important but neglected subject. I hope that in future attempts are made to encourage active participation from outside the widely acknowledged "centre of excellence". Changing the venue for the third conference may be a step in the right direction.

O. JUNAID

*Mapperley Hospital*
*Nottingham NG3 6AA*

DEAR SIRS

We welcome the interest with which Dr Junaid has examined the supplement from our conference. We support the notion that such conferences could be organised elsewhere in other "centres of excellence" and we, in fact, would encourage this. Five international speakers were invited, but were unable to attend and four out of the 11 speakers came from the Institute of Psychiatry. All speakers were, of course, asked to contribute to a conference publication. As Dr Junaid is no doubt aware, speakers are not always eager to transfer lectures into publications. The Supplement contains some of the conference material, along with papers from others working in the field. Two subsequent conferences were organised by other colleagues at the Institute, and again, had good national and international representation among speakers and audience. We hope Dr Junaid's suggestions are noted and that further conferences on the topic are organised at other venues and we would support anyone doing so.

We feel there is a danger in emphasising the geographical origin of the papers in our supplement rather than evaluating their content and quality.

THE EDITORS

WOMEN AND MENTAL HEALTH SUPPLEMENT
*Institute of Psychiatry*
*London SE5 8AF*

## *Clozapine and Part IV of the Mental Health Act 1983*

DEAR SIRS

The Mental Health Act Commission understands that clozapine (Clozaril, Sandoz) is being increasingly used for the treatment of some in-patients with schizophrenia resistant to other treatments. Clozapine is being given to some detained patients whose consent to treatment has been certified by the RMO under Section 58 of the Mental Health Act 1983 on Form 38, and some who are not consenting, whose treatment is authorised by a doctor appointed under Part IV of the Act (on Form 39). It is accepted that this treatment necessarily involves regular haematological screening, initially on a weekly basis. There may be occasions when the patient will agree to take the tablets but will not agree to the necessary monitoring. The position is similar in principle to that involved in lithium treatment. The steps to be taken to secure the blood samples and the likely effect on the patient of this procedure has to be considered by the RMO in recommending the treatment, by the clinical team administering the treatment, as well as the Section 58 Approved Doctor when the treatment falls within the provisions of Part IV of the Act.

In describing drug treatment regulated by the Consent to Treatment provisions, the Code of Practice (paragraph 16.11) states that "the RMO should indicate on the certificate the drugs proposed by the classes described in the British National Formulary". Clozapine is an anti-psychotic drug (BNF 4.2.1). In view of the special conditions attached to treatment with clozapine, the Commission recommends that some modification of this guidance is now necessary. Specifically, when the patient is certified as consenting by the RMO on Form 38 and the treatment includes clozapine, this should be explicitly stated on the certificate by adding "including clozapine" to the description "anti-psychotic drugs, BNF 4.2.1". The same guidance is being given to Section 58 Approved Doctors in relation to Form 39.

The Commission has responsibility for keeping under review the implementation of the Code of Practice and for making recommendations to the Secretary of State as to possible changes and this guidance will be incorporated in these recommendations in due course.

WILLIAM BINGLEY

*Mental Health Act Commission*
*Maid Marian House*
*56 Houndsgate*
*Nottingham NG1 6BG*

## *Use of clozapine*

DEAR SIRS

We read with interest Launer's account of his experience with clozapine (*Psychiatric Bulletin*, April 1991, **15**, 223–224).

Cook *et al* (1988) have identified the problems of recruitment into clinical trials. Similar problems beset us as we identified three patients who had

unremitting psychoses. The criteria for the Sandoz trial were not met by two of these patients who had experienced grand mal convulsions and a third who failed to meet the DSM–III–R criteria for schizophrenia. A further patient refused to have regular blood tests required for the monitoring procedures.

We have since identified 12 patients with intractable schizophrenia, nine men and three women, with an age range of 21 to 62, who might benefit from clozapine. Of these, five patients, four men and one woman, declined to have the regular blood tests which are mandatory for the continuation of treatment due to the risk of neutropenia. Other reasons for patients unsuitability for clozapine are as follows:

(a) A 62-year-old man was undergoing investigation for deteriorating gait and upper limb incoordination.

(b) A 40-year-old man refused on the advice of his sister who suggested he wait until "an analogue" without the haematological side effects had been developed.

(c) A 55-year-old woman coincidentally suffering from bullous pemphigoid, which was felt to be a contraindication in view of the potential effects of the drug on the immune system.

(d) A 26-year-old male patient developed a tooth abscess within days of starting medication but had normal neutrophilic response. The drug was discontinued but we intend to reinstate this once the dental problems have resolved.

(e) A 21-year-old male patient was commenced on the drug while in a locked ward and initially made a good response. When returned to the open ward his mental state deteriorated and his delusional beliefs that part of his body were being stolen extended to the blood being taken for monitoring. He refused further testing and the drug had to be stopped.

(f) A 26-year-old man dislikes the blood testing and, currently at the third week of treatment, is reluctant to continue

(g) A 23-year-old woman developed malaise, tremor and hypersalivation within three days of starting the medication (75 mg a day) and experienced a grand mal seizure on 100 mg of clozapine on day 4. The drug was discontinued.

Four of the patients were detained under Section 3, including (e), (f) and (g), together with a woman who refused regular blood tests. She had given delusional reasons for not taking her conventional medication and was incapable of giving informed consent to taking clozapine.

Clozapine is novel in its requirement for weekly blood tests for monitoring side effects. Lithium is the only commonly used psychiatric medication which comes close in this respect. The giving of clozapine without informed consent, even if the patient agrees to the blood test, remains an issue to be clarified. We would have been prepared to ask the Mental Health Act Commission for a second opinion prior to the introduction of clozapine to the treatment regime of the patient unable to give informed consent. We did not feel justified in restraining the patient for weekly blood tests when she refused to have these.

The current limited use of clozapine and its reputation for dangerous side effects is perhaps to deny its advantages for many suitable subjects. Colleagues in Germany (Gabel & Gallhoffer, personal communication) report the extensive use of clozapine in a wide variety of patients with great success. The lack of extrapyramidal side effects make it more acceptable to patients, and tardive dyskinesia does not seem to be a long term sequelae (Casey, 1989).

Gabel & Gallhoffer identify well motivated and compliant patients as being ideal for treatment with clozapine and will use it as a first line treatment.

Our experience is at odds with that of Launer (1991) since we have had great difficulty in starting and maintaining our most seriously disturbed patients on this drug at a time when the issue of consent is far from clear. Nevertheless we look forward to the wider use of clozapine with its many potential benefits.

CHRISTOPHER J. BALL
*United Medical and Dental Schools*
*Guy's Campus*

MAURICE LIPSEDGE
*Guy's Hospital*
*St Thomas Street*
*London SE1 9RT*

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## *Assessment of parenting*

DEAR SIRS

Reder & Lucey provide a timely consideration of some key ideas in an interactional framework for the assessment of parenting (*Psychiatric Bulletin*, June 1991, **15**, 347–348) and with the rapid incorporation of some of the Children's Act provisions into our practice, the era of impressionism as regards assessment of parenting ability must needs pass.

In addition to the logical progression expounded by Reder & Lucey, three further headings ought to be borne in mind, even if as child psychiatrists we honestly say we do not know their full import.