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 antispychotic and therefore should be useful in any psychotic illness. I describe a case of acute mania which was

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successfully treated with olanzapine in the community.

The patient, a 37-year-old, single, female, civil servant, had a history of manic depression dating from the 1980s with manic episodes characteristically accompanied by anxiety. The last two clearly documented episodes of mania, both requiring hospitalisation, occurred in 1986, needing 800 mg a day of chlorpromazine, and in 1987 when 140 mg of droperidol a day was required.

This time she was irritable and paranoid after a trip overseas. She declined admission and was prescribed thioridazine 200 mg per day, but was unable to take this because of headaches and a dry mouth. She expressed paranoid ideas dating back to her trip abroad and felt that she was attractive to powerful people when ill. She exhibited pressure of speech, irritability and anxiety. She asked for medication with no side-effects and anxiolysis. She agreed to take olanzapine 10 mg daily and clonazepam 0.5 mg daily for anxiety.

She was monitored in an out-patient department and by a community psychiatric nurse, and over four weeks the paranoia and grandiosity disappeared and the anxiety lessened. There was some drowsiness so the clonazepam was reduced to 0.25 mg per day. There was continued pressure of speech and irritability and the olanzapine was increased to 15 mg.

Over the next six weeks her mood was stable with some pressured speech. She reported an absence of side-effects and was able to read a great deal. Over the next two weeks the irritability went but she became more drowsy so that clonazepam was stopped. She remained euthymic and the olanzapine was reduced to 10 mg a week later and to 5 mg a week after that. It was stopped two weeks later but she took 2.5 mg nocte for two nights on her return to work, full-time, a week after.

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