reporting our experience of a patient with schizophrenia who developed myoclonic-atonic seizures during treatment with clozapine. This distressing but remediable side effect almost led to her discontinuing treatment.

The patient was a 23-year-old woman with treatment-resistant schizophrenia who had no past history or prior EEG evidence of epilepsy and no known predisposing cause or family history of seizures. Clozapine dosage was increased at a rate of 50 mg per week. After six weeks of treatment above a daily dose of 300 mg she began to experience alarming drop attacks with sudden loss of muscle tone in her legs. At a dose of 500 mg clozapine per day she developed frequent myoclonic jerks. An EEG recorded numerous spike discharges synchronous with body twitching and a diagnosis of myoclonic-atonic seizures was made. Clozapine dosage was immediately reduced to 350 mg per day with complete resolution of her epileptiform symptoms. The patient refused further EEG examination and needed considerable persuasion to continue clozapine treatment. However she finally agreed and went on to make an impressive recovery from her chronic psychotic symptoms without further seizures.

Most reports of clozapine related seizures document generalised convulsions. Myoclonic epilepsy has previously been reported in two patients receiving clozapine at doses above 600 mg per day (Povison *et al*, 1985 and Haller *et al*, 1990). This appears to be a dose-related side effect. The diagnosis may have gone unrecognised in a large retrospective study of patients receiving clozapine in which several patients experienced episodes in which their legs suddenly felt too weak to continue standing (Lindstrom *et al*, 1988). We suggest that awareness of this complication of clozapine treatment and prompt management by dose reduction can prevent potentially beneficial treatment being abandoned unnecessarily.

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Section 48: an underused provision?

Dear Sirs

The case described by Dr Exworthy and colleagues (*Psychiatric Bulletin*, February 1992, **16,** 97–97) highlights one of the many difficulties in diverting mentally abnormal offenders from the criminal justice system. In particular, persons accused of serious offences often fall foul of the technicalities of Part 3 of the Mental Health Act 1983. Forensic psychiatrists are only too familiar with the inapplicability of section 36 (remand for treatment) to those accused of murder. A common solution to such problems is for the court to make a bail order, with a condition of residence in a secure psychiatric setting, such as a Regional Secure Unit. As in this case, however, it is difficult to persuade a magistrate to make such an order where the charge is serious, even though the court can specify on the bail sheet that the accused does not leave the hospital premises.

The suggested solution – of transfer to hospital under "section 48" – is rarely made at the time of court appearance, as it requires the direction of the Secretary of State, rather than the court. There is usually a delay of one to two days, and in any case the Home Office may not agree to the recommendations, if, for instance, there is concern about the level of security in the suggested hospital. In the meantime, the defendant must be remanded in custody, often to a distant prison.

It would be interesting to know how these bureaucratic problems were overcome in the case cited.

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Reply

Dear Sirs

Dr Sugarman's letter raises, and alludes to, a number of pertinent points in relation to the workings of the current Mental Health Act. The bureaucracy in the case we described proved to be relatively easy to overcome. The whole process began well because the catchment area consultant was able to make his assessment while the defendant was still at the Court. This was helped by the hospital and Court being in relatively close proximity – certainly closer than the remand prison was. With liberal use of the telephone and fax machine and negotiating at a sufficiently senior level in the Home Office (as well as informing the remand prison) the transfer warrant was issued that same afternoon. What ultimately defeated the transfer from taking place on the same day was the lack of any transport arrangements and the defendant had to be returned to prison overnight.

Another point raised by Dr Sugarman is the obvious concern for the degree of security offered by

the receiving hospital. It should be borne in mind that this concern must be appropriate to each individual defendant and not merely because he happens to be in custody (which is not necessarily related to the gravity of the offence). In the case we described the person was admitted to the acute admissions (open) ward and although the question of security was raised by the Home Office it did not become a particular issue. A review of the prisoners transferred from our local remand prison under the provisions of Section 48, Mental Health Act in the last six months reveals that most, but not all, went to some form of locked facility. However, over half (12/21) were admitted to the intensive care ward rather than the Regional Secure Unit or a Special Hospital. Nonetheless, it is recognised that most defendants will require some degree of security, at least in the early phase of their admission. As Dr Smith and her colleagues point out (Smith *et al*, 1992) Regional Secure Units (and, I would add, other admission facilities) should be resourced to a level that allows them to operate just below full capacity and thus have the reserve to accept, at short notice, section 48 admissions that by definition require urgent treatment.

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Reference

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The profession of adult psychotherapist in the NHS

DEAR SIRS

I am a clinical nurse specialist in liaison psychiatry, currently doing psychotherapy training at the Tavistock.

I was delighted to read Dr Temples' article (*Psychiatric Bulletin*, February 1992, **16**, 116–119) concerning the development of a new profession of trained lay psychotherapists.

As the paper points out, there is an increase in demand for psychotherapy within the NHS. A new profession with a recognised training and career structure is vitally important to ensure that sufficient treatment resources are available to meet the demands. Trained lay psychotherapists would complement work done by people in the core professions who specialise or have an interest in psychotherapy but do not necessarily have a formal training.

The article outlined a strong argument for a new profession along the lines already established in child psychotherapy. It also recognised there would be possible recruits from nursing for the new profession. A list of core professions were suggested that might constitute a working party to take the matter further but I was disappointed to find that nursing was not included. This seems ironic as nursing is by far the biggest core profession involved in psychiatry. I wondered what logic was employed when drawing up the list or whether unconscious processes were at work.

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Junior publications in 'The British Journal of Psychiatry'

DEAR SIRS

A publication record can be an important determinant of career success for junior doctors (*Psychiatric Bulletin*, 1991, **15**, 478–480). But how does one publish in a major journal while in an everyday, regular clinical post? To identify the factors contributing to successful authorship I have reviewed three years publications (1989 to 1991) in the *British Journal of Psychiatry* and present data on those whose authors include British and Irish junior doctors not in identified research or academic posts. It is hoped lessons can be drawn from this study of previous success.

'Major' papers (papers, annotations, reviews etc). Of 619 major papers within the study period, 92 (14.9%) include a junior doctor as an author. The average number of co-authors in addition to the index junior was 2.4.

In 50 papers (54%) one or more university academics were co-authors. Only 14 (15.2%) had neither an academic nor a consultant as a co-author.

Of the juniors publishing major papers, 60% were senior registrars – the others were in lower training grades.

Of these papers, 5% were case reports/case conferences and 8% review articles. The other study designs divided approximately equally between retrospective, prospective and cross-sectional studies.

Brief reports. Of 211 brief reports over the same three year period, 73 (34.6%) had a junior author. The average number of co-authors of the index junior was 1.2. In 21 (28.8%) brief reports the co-authors include at least one academic.

Of the juniors, 41% were senior registrars and the others were in lower grades.

Of the study designs, 83.5% were of a case report and literature review nature.

Sole authors. Publications of which the junior doctor was the sole author were 18 brief reports and nine papers. Four of the nine papers were reviews.