widely discussed" is perhaps misleading. It has been aired as an issue in a variety of ways and there is a growing body of literature on the subject reflecting the concern and anxiety which it quite rightly provokes. What is needed to ensure that it is widely discussed, and in particular with regard to the risks to junior psychiatrists and our colleagues in other specialities, is systematic and well constructed research to form the foundation to support the argument for change.

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Reply

DEAR SIRS

Dr Humphreys overestimates the modest aims of our study. There has been much recent focus on assaults to staff, including an editorial in the *British Medical Journal* and features in the *Health Service Journal* and *BMA News Review*. Our intent was to discover whether violence at work was also an important issue to junior doctors working in psychiatry, and whether elementary Health and Safety Executive guidelines were being met. The intensity of the responses we received left us in no doubt that many doctors were extremely concerned (Stark & Kidd, 1991), and that guidelines were unevenly applied.

Dr Humphreys identifies correctly the limitations of retrospective studies. We did not include discussion of retrospective study design as readers were likely to be familiar with the methodological difficulties. There are many other problems inherent in a retrospective postal questionnaire survey but, as always, the art of critical reading of the literature involves deciding what practical conclusions can be drawn from a study despite innate design constraints.

The difficulty in applying operational definitions to a retrospective self-completion survey was a concern to us, although we designed the questionnaire taking into consideration the Health and Safety Executive's definition of violence, "any incident in which an employee is abused, threatened or assaulted by a member of the public in circumstances arising out of the course of his or her employment". We were careful not to imply that we had reliable data on the incidence of assaults. Demonstrating that many doctors had felt in danger of assault, or had actually been physically assaulted (the wording used in our questionnaire) was sufficient to meet our aims.

Our purpose in stressing the number of incidents reported, and the number after which counselling was offered, was not as transparent as we had hoped. We wished to demonstrate the shortfall in reporting episodes, and consequently in doctors receiving support and guidance after potentially serious events. Lack of counselling was not solely caused by junior doctors failing to report episodes. Several doctors described senior colleagues who felt that feedback was neither desirable nor necesssary.

Alcohol is a common component in violent crime. The literature on antecedents of violent behaviour in hospitals is extensive, however, and alcohol is not implicated in the majority of assaults. It is evident that limited reliance should be placed upon predictors of dangerousness (Monahan, 1989). Rather, as we have stressed in the past, hospitals should strive to create systems which make the working environment as safe as possible for both staff and patients (Stark & Kidd, 1991).

It is sobering that Dr Humphreys feels that research into the field may strengthen negative stereotypes. The enthusiasm other public services bring to the issue offers a striking contrast to our hesitancies. Awareness of violence and expertise in dealing with potential incidents protects both staff and patients. We should resist any impulse to lower the profile of safety within the NHS.

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A full list of references is available on request to Dr Kidd.

Clozapine-related seizures

DEAR SIRS

We would like to add to the recent correspondence in the *Psychiatric Bulletin* (Launer, 1992, **16**, 45–46 and Rigby & Pang, 1992, **16**, 106) concerning patient compliance with clozapine treatment by

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