offer virtually no security—which in essence is what the care of so many itinerant and disturbed psychotics demands. Until such time as the interim Butler Committee recommendations[8] are implemented and more secure units are made available this practice will continue and very likely increase.

What stands out in the report is the degree to which the prison medical service takes care—and takes good care—of substantial numbers of society's sore thumbs—alcoholics, difficult epileptics, drug-addicts, psychopaths, and psychotics, particularly chronic schizophrenics. In this respect prisons take second place only to mental hospitals. Indeed, what seems an obvious step to take is to pool the resources of these two vital if unglamorous services. Happily there is evidence that this symbiosis is already beginning and is a two-way process. Several prison M.O.s with psychiatric qualifications and experience are now undertaking sessional work in the National Health Service clinics in London, Winchester, Cardiff, and on the Isle of Wight. Conversely, the number of visiting psychotherapists to the prisons rose from 50 in 1971 to 60 in 1973, most of whom are consultant psychiatrists in the National Health Service. Furthermore, there is a slow but steady increase in the appointment of joint consultants in forensic psychiatry who divide their time between the Prison Service and the National Health Service or university departments. The next logical step forward is to pool not only personnel but premises.

[1] Home Office, *Report on the work of the Prison Department*, 1973, Cmnd. 5767. London, H.M.S.O., 1974.
[2] *British Medical Journal*, 1967, **1**, 317.
[3] *British Medical Journal*, 1969, **3**, 426.
[4] *British Medical Journal*, 1970, **3**, 537.
[5] *British Medical Journal*, 1971, **3**, 443.
[6] *British Medical Journal*, 1972, **4**, 129.
[7] *British Medical Journal*, 1973, **4**, 438.
[8] Home Office and Department of Health and Social Security, *Interim Report of the Committee on Mentally Abnormal Offenders*, Cmnd. 5698. London, H.M.S.O., 1974.

Health Education in the Reorganized N.H.S.

Our failure to make any real impact on the epidemic of cigarette-induced disease in nearly 25 years has been partly due to lack of resources devoted to health education but also to the isolation of the public health services responsible for health education from the main medical services in hospital and general practice. The reorganization of the N.H.S. has made it possible to extend health education and, perhaps, begin to control the great modern epidemic diseases. If this opportunity is to be grasped there are three main needs. Clinicians and all other health service staff have to be convinced that health education could be effective in the prevention of disease. Secondly, training will be needed: training of health education officers to take charge of district health education units, training of specialists in health education and specialists in epidemiology, training of health service staff, especially clinical doctors and nurses, in the part that they should play in health education, and the training of future staff by including health education in the basic training of medical students and other health professions. Finally, there will have to be adequate resources in both materials and staffing.

The D.H.S.S. acted with commendable speed in giving advice[1] to area health authorities on health education in March 1974. Regrettably, little action followed this initiative, because salary scales for health education officers have not yet been decided by the Whitley Council, and in the absence of agreement the Department of Health has not permitted area health authorities to appoint such staff. Furthermore, a recent D.H.S.S. staff training memorandum[2] has shown that there have been fewer applications than expected for places on the various training courses provided (at D.H.S.S. expense) for health education officers and other health service staff. Apparently area health authorities have not taken advantage of the chance offered to train staff so badly needed in this field.

In these times of financial stringency it is all too easy to postpone action, especially as most of the ex-public-health doctors with experience in health education are now overburdened with administrative problems in their new roles in the reorganized N.H.S. The present neglect of health education is not unique; other branches of preventive medicine are suffering equally for similar reasons. Has not the time perhaps come for the D.H.S.S. to correct the flight from the field in preventive medicine which the reorganization of the N.H.S. has caused? Experienced staff at present sitting at their desks in the Department, the regions, and the areas, are needed to provide the skilled manpower for preventive medicine in the districts.

[1] National Health Service, *Reorganization of National Health Service and of Local Government*, HRC (74) 27. London, Department of Health and Social Security, 1974.
[2] Department of Health and Social Security, *Staff Training Memorandum*, STM (74) 37. London, D.H.S.S., 1974.

Treatment for Cataplexy

Cataplexy is part of the syndrome of idiopathic narcolepsy and manifests itself as a brief attack of muscular weakness. (The term should be distinguished from catalepsy, which refers to the maintenance of unnatural postures.)

The cataplectic attack is nearly always a response to sudden emotion, most often laughter or anger, less often elation, sexual excitement, or fear; and it is always the same one or two emotions that are characteristic for any particular patient. The attack may affect the whole body, with collapse on to the floor, or at other times involve only a sagging of the jaw or trembling and slight buckling of the knees. It usually has a duration of seconds but in rare cases may last for several minutes. The narcoleptic's spells of irresistable sleep usually precede the first cataplectic attack by some years.

When the normal person falls asleep he spends the first hour in non-rapid eye movement (N.R.E.M., orthodox, or E.E.G. slow-wave) sleep. A pathognomonic feature of idiopathic narcolepsy is the frequent and immediate passage from wakefulness into rapid eye movement (R.E.M. or paradoxical) sleep.[1] The latter state includes a profound loss of muscle tone[2] and abolition of the H-reflex[3] (the knee-jerk elicited by direct electrical stimulation of the tibial nerve). Cataplexy is, therefore, today regarded as a partial manifestation of R.E.M. sleep: indeed the patient may slip into R.E.M. sleep during his cataplectic attack, as Guilleminault *et al.*[4] have recently reported. Some of the tricyclic drugs prevent the appearance of R.E.M. sleep, and among these the most powerful is clomipramine,[5] which has proved particularly successful in the prevention of cataplexy.[6]

Most narcoleptic patients find the spells of daytime sleep to be their greater problem, but there are some in whom cataplectic attacks recur several times a day and so constitute a major disability. Guilleminault *et al.* selected five patients