period 2 (n=113) so we calculated three inadequate seizure ratings (expressed as a percentage of the total number of first stimulations) for each series: 'minimum' (all incompletely documented seizures assumed to be adequate); 'known' (only completely documented seizures rated) and 'maximum' (all incompletely documented seizures assumed to be inadequate).

There were no significant differences between period 1 and period 2 patients for age (means 74.3 and 85.9), sex, concurrent treatment with medication with anti-convulsant properties, mean number of treatments (7.2 and 8 respectively), incidence of missed seizures (4 and 3% of first stimulations) and global clinical outcome. There were, however, significant differences (P<0.05, 2 tailed t-test) in the minimum, known and maximum inadequate seizure ratings for period 1 and period 2 (means 30, 47, 66% and 14, 14, 44% respectively), failed treatment session ratings (27% and 17%) and incidence of partial seizures (19% and 3%).

Our findings suggested that two apparently identical E2 machines were not equally effective in inducing adequate seizures. We were aware that there are two possible versions of the E2 (Pippard, 1992) – the unmodified version (E2), which would have a power output at the standard setting used ('ECT 1' × 4 seconds of 106 mQ), and the modified version (E2+), with an output of 149 mQ at the same setting (both output figures are quoted in units of charge, milliCoulombs, and assume a 200 ohm impedance load). The manufacturers confirmed that the inherited machine had been returned for modification in the mid-1980s.

Our audit findings were comparable with Pippard's findings in his audit of ECT in two health regions where an estimated 22% of applications were considered therapeutically ineffective (Pippard, 1992). Two interrelated factors contribute to the problem: underpowered ECT machines and ignorance on the part of the operator which amplify the problem.

PIPPARD J. (1992) Audit of electro-convulsive treatment in two National Health Service regions. *British Journal of Psychiatry*, **160**, 621–637.

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Mental Health Review Tribunals and the Home Office

Sir: We much appreciate the comments by Agarwal & Kumar (*Psychiatric Bulletin*, 1994, **18**, 649–650) about our letter on Mental Health Review Tribunals (*Psychiatric Bulletin*, 1994, **18**, 374).

We do agree with Agarwal & Kumar that the Home Office passes the buck. Perhaps it does so deliberately.

In considering whether civil servants "hundreds of miles away at the Home Office should ever make decisions about complicated and dangerous patients", Agarwal & Kumar open up the whole question of whether the system of Home Office control of patients detained under section 41 orders is the best one.

We are aware that these civil servants do not wish to have a psychiatrist among them, preferring to judge questions of parole, transfer and discharge from hospital of restricted patients from the points of view of intelligent and informed lay people. In the current climate of concerned public response to tragedies associated with psychiatric patients in the community, the civil servants are all the more likely to delegate decisions about restricted patients to Mental Health Review Tribunals.

We know too that in Scotland the Mental Welfare Commissioner, who is a psychiatrist, keeps in close contact with the medical officer responsible for restricted patients by visiting him and discussing the relevant issues; in Canada patients detained indefinitely as 'Not Criminally Responsible' are under the jurisdiction of a Provincial Review Board comprising a Judicial Chairman and psychiatric and lay members; and countries in Europe and states in the USA have their own different provisions for governmental control of dangerous mentally abnormal offenders.

Has anybody done worldwide research on procedures in other countries for mentally abnormal patients requiring restrictions?

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Delegation of section 5(2) Mental Health Act 1983 II

Sir: The issue of who acts as the consultant's nominated deputy continues to crop up. It is a

cause of uncertainty who accepts this responsibility.

Crichton & Townsend (*Psychiatric Bulletin*, 1994, **18**, 176) draw attention to two important issues again highlighted by Prettyman (*Psychiatric Bulletin* 1994, **18**, 508).

(a) The Code of Practice suggests that only consultant psychiatrists should nominate deputies. Is it then sufficient to say that in the non-psychiatric setting consultants can nominate deputies?

From personal experiences this question has created problems between consultants and junior doctors.

(b) Prettyman (*Psychiatric Bulletin*, **18**, 508) states that Paragraph 8.6 of the Code of Practice seems to indicate that, on non-psychiatric wards, an individual seen by a junior psychiatrist is, for the purpose of the Mental Health Act, a "psychiatric patient and the (duty) Consultant Psychiatrist is the responsible doctor".

I feel this is a wrong interpretation and that the nominated deputy is the junior doctor of the consultant who is responsible for whatever ward the patient is on.

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Antidepressant prescribing – are doses really that important?

Sir: In the article on antidepressant prescribing by Robert J. Thompson (*Psychiatric Bulletin*, 1994, **18**, 461–462), he concluded that tricyclic antidepressants were prescribed in inadequate doses by primary health care practitioners.

We would like to share the results of an audit carried out in the South Borough of Solihull which has a population of 115,000. We studied antidepressant prescribing by general practitioners (GPs). All referrals were studied over a one month period, October–November 1994. There were a total of 74 referrals; 26 patients (35% of all the referrals) had been commenced on antidepressants by their GPs. Of these, 15 (56%) were SSRIs and 11 (44%) were tricyclics. In our study, GPs were significantly ($P<0.001$, χ^2 25.8, d.f. 1) more likely to prescribe SSRIs when compared to that in Thompson's study. If the trend towards prescribing SSRIs continues, then the conclusion made by Thompson may not be so important, as the starting dose for SSRIs is also the recommended effective treatment dose.

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General practitioner awareness of learning disabilities

Sir: Bernard & Bates (*Psychiatric Bulletin*, 1994, **18**, 205–206) suggest that considerable confusion exists among general practitioners regarding the role of the psychiatrist in learning disability. Sandwell has a population of approximately 300,000 people and has two consultants, several junior medical staff and four community learning disability teams (CLDT) offering services comparable to those in Bromley. In the past two years, there have been several GP awareness seminars on learning disabilities with presentations from members of the multidisciplinary teams.

Prior to the most recent meeting, a questionnaire was distributed to the 14 GPs in attendance to gather information on GPs' perception of the learning disability psychiatrist. Eleven (79%) had heard of the CLDT compared with 23% of the Bromley sample. Seven had received training in learning disability, again considerably higher than the Bromley sample. Thirteen of the GPs were aware that they had patients with learning disabilities on their lists.

The Sandwell GPs appeared to have more understanding of the role of the psychiatrist and in turn their own role, i.e. to provide general medical care for people with learning disabilities, with only one respondent suggesting that the psychiatrist should perform this task.

This admittedly small survey suggests that GP awareness seminars and other educational events can enhance GP knowledge on the subject of learning disabilities thereby ensuring that patients receive appropriate care. While GPs who attend such seminars may have pre-existing knowledge and expertise, this is an area worthy of further evaluation. We are currently producing an information booklet for GPs to provide details

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