Correspondence

Discharges by Mental Health Tribunals

DEAR SIRS

I am grateful to Dr Aaronricks (Correspondence, *Bulletin*, June 1987, **11**, 206) for widening the area of my original article (*Bulletin*, March 1987, **11**, 96–97) to include the most important and controversial matter of the appropriate use of Sections 2 and 3. I agree with Dr Aaronricks that when, "... The diagnosis is already known and the patient's treatment and management predictable..." Section 3 is the appropriate section. This, however, is not a universal view and I have met dissenters from this view both among my approved Social Worker colleagues and among members of the Mental Health Act Commission. The Commission suggested that a possible distinction might be whether the patient was in hospital or in the community. If the patient was in hospital, then Section 3 would be appropriate; if he had been in the community for some time circumstances might have changed and so another period of assessment under Section 2 might be appropriate.

Both the Commission and approved Social Workers advise me to be guided by a policy of taking the least restrictive measure and add caution against implementing a Section 3 that might be kept in operation longer than the interests of patients would dictate. I believe this advice is not in keeping with good clinical practice. When the diagnosis is known and the management and treatment are predictable, further assessment is not appropriate; neither are repeated frequent and hastily convened appeal tribunals, especially when there is no statutory duty for after care and when discharge, when granted, is likely to be immediate. The argument that one should not use Section 3 for fear that one might abuse it, i.e. allow it to run on after the patient has recovered sufficiently to be treated informally, surely does not hold up as a guideline of good practice; I for one would welcome a statement from the Commissioners on this matter and would hope that their recommendations would be along the lines set out by Dr Aaronricks.

Important though this matter is, I do not believe it addresses the question of the infrequency with which tribunals recommend delayed discharge as an aid to the multidisciplinary team organising after care for patients on Section 2.

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Section 136 and the Police

DEAR SIRS

Drs John Dunn and Tom Fahy's article (*Bulletin*, July 1987, **11**, 224–225 and 236) made for interesting but harrowing reading. It was disappointing that only 23% of Metropolitan Police Stations managed to respond. If this was a representative view, of particular interest is the fact that 61% of respondents felt inexpert in dealing with mentally disordered individuals yet the overwhelming majority, 90%, reported that this part of the Mental Health Act was not in their opinion overused! When viewed concomitantly with the evidence that as much as 22% of individuals detained under this Section of the 1983 Mental Health Act (Dunn & Fahy, unpublished report 1987) did not have a mental disorder that warranted detention under the Act, there is a strong suggestion that the problem of 'dumping' 'unsociable' individuals in mental institutions continues.

Clearly, the Mental Health Commission needs to set out an unambiguous Code of Practice to be used by the Police in the assessment of alleged mentally disordered individuals. The cry also needs to be echoed for mental institutions to forge links with their local constabulary, to improve relationships and communication.

In the current climate of increased 'litigiousness' it may not only be a prudent fiscal policy but, hopefully, help to improve care and reduce suffering.

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ECT practice – failed seizures

DEAR SIRS

Drs Pippard and Ellam reported their disturbing findings in their survey of ECT in Great Britain[1] and emphasised the importance of consultant supervision of ECT facilities. They suspect that the standards of ECT practice are falling again.[2] This view seems to be shared by some practitioners I talked to recently.

Drs Snaith and Simpson recently reported a 20% incidence of failed seizures using the new constant current apparatus at lower pulse frequency – ECT 1 at 4 seconds.[3]

I, however, wish to report that during my recent York ECT study the failed seizure rate during 1984 was considerably lower at 5.5% (945 ECT applications and 52 failed seizures using mainly lower pulse frequency ECT 1 at 4 seconds on the new Constant Current Apparatus – Duopulse model).

The incidence of failed seizures was higher at 5.9% using bilateral and 4.8% using unilateral electrode placement (NS). No patient below the age of 50 years (34 patients) had any failed seizures. This compared with 15 out of 52 patients over the age of 50 years having failed seizures. A quarter of all ECT patients were males, who accounted for nearly half of all failed seizure patients.

It is difficult to explain the higher incidence of failed seizures reported by Drs Snaith and Simpson, possibly

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the mechanical difficulties encountered with the new apparatus and its application may account for some of these differences.

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REFERENCES

[1]PIPPARD, J. & ELLAM, L. (1981) *Electroconvulsive Treatment in Great Britain, 1980*. London: Gaskell (Royal College of Psychiatrists).

[2]——, & WEST, E. (1987) ECT practice. *Bulletin of the Royal College of Psychiatrists*, **11**, 101.

[3] SNAITH, R. P. & SIMPSON, K. (1987) ECT practice. *Bulletin of the Royal College of Psychiatrists*, **11**, 203.

DEAR SIRS

Dr Bhatnagar draws attention to the important topic of failed convulsion during ECT and we wish to draw attention to some of the many causes for this. First, the electrical energy may be too low; this was seldom the case with sine waveform but with pulse waveform the setting may be critical. When we first acquired the Ectron Duopulse Constant Current apparatus we routinely used a low energy setting with the high failed convulsion rate referred to by Bhatnagar. We now used the 40 pulse per second (ECT 2) setting for 3 seconds (175 millicoulombs) and bitemporal electrode placement; the failure rate has been reduced but in a recent cohort of 50 patients seven had a failed convulsion at some stage in their treatment and the elderly were particularly at risk which confirms Bhatnagar's experience and also the study of Pettinati and Nilsen.[1]

Electrode placement is the next factor. For unilateral placement the College guidelines on ECT administration recommended the Lancaster position but this requires the second electrode to be placed above the hair line with inevitable increase of impedence; in the temporo-frontal placement the electrode perimeters are too close together and, when we do administer unilateral ECT, we recommend the position in which the second electrode is placed three centimetres above the tip of the mastoid process.[2] Electrode plates encrusted with dried electrolyte solution are another cause of failed convulsion.[3] In the period when low electrical energy was in use in our Unit, Wood[4] studied causes for failure and found that insufficient pressure of the electrodes on the head by the doctor administering ECT was a potent cause for failed convulsion. All doctors administering ECT in our Unit are now instructed to apply firm pressure.

Concurrent drug therapy may be a cause of failed convulsion. In our Unit it was confirmed that the duration of the convulsion was negatively correlated with the level of benzodiazepine metabolite.[5] Carbamazepine is now frequently used as an antidepressant drug and we have regularly observed failed convulsion in patients prescribed this drug. The anaesthetic itself may be the cause. Recently Propofol (Diprivan) was introduced as an anaesthetic with quick recovery and may be widely used in ECT practice. However we noted that the failed convulsion rate was high during its use and one of us (KS) reported that it was not to be recommended for use in ECT anaesthesia; the report will appear in *The British Journal of Anaesthesia*.

We should like to comment that our standard practice, in the case of a failed convulsion, is to re-oxygenate the patient and repeat the application at a higher time setting (usually 4 seconds) although occasionally we have used the maximum (6 seconds) at the same session. Only very rarely has this procedure failed but when it does fail a careful appraisal, including concurrent drug therapy, is recommended to the Responsible Medical Officer.

Incidentally even prolonged pulse waveform administration seems to lead to very little amnesia or post-treatment confusion as compared with sine waveform. This is not surprising since the electrical energy, even at the maximum 6 second setting, is less; we should like to hear from others of their experience. We would bring attention to one recent study[6] which compares the two waveforms in both bilateral and unilateral placement; this concluded that memory defect was considerably less with the pulse waveform and not, in fact, significantly higher than with a non-treatment control group. It is for this reason that we continue the routine use of bilateral electrode placement.

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REFERENCES

[1]PETTINATI, H. M. & NILSEN, S. M. (1987) Increased incidence of missed seizures in the elderly male. *Convulsive Therapy* **3**, 26–30.

[2]HALLIDAY, A. M., DAVISON, K., BROWNE, M. W. & KREEGER, L. C. (1968) A comparison of the effects on depression and memory of bilateral ECT and unilateral ECT to the dominant and non-dominant hemispheres. *British Journal of Psychiatry*, **114**, 997–1012.

[3]SNAITH, R. P. (1982) Care and maintenance of ECT electrodes. *Bulletin of the Royal College of Psychiatrists*, **6**, 204.

[4]WOOD, S.M. (1985) An investigation into the predictive value of electrical and other factors in the success of seizure induction in electro convulsive therapy. Dissertation for Master of Medical Science Degree.

[5]STANDISH-BARRY, H. M. A. S. et al. (1985) The relationship of concurrent benzodiazepine administration to seizure duration in ECT. *Acta Psychiatrica Scandinavica*, **71**, 269–271.

[6]WEINER, R. D., ROGERS, H. J., DAVIDSON, J. R. T. & SQUIRES, L. R. (1986) Effect of stimulus parameters on cognitive side effects. *Annals of the New York Academy of Sciences*, **462**, 315–325.

Detained patients

DEAR SIRS

One can only support the views of Drs West and Stanley (*Bulletin*, September 1987, **11**, 300–302 and 314) regarding the problems surrounding the requirement for the second opinion approved doctor (SOAD) to consult with someone who is neither a doctor nor a nurse before completing Form 39. In the *First Biennial Report of the Mental Health Act*

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