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