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

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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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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*

Commission 1983–85 (HMSO, 22 October 1985), it is stated that "... *in some cases it has been necessary to defer issuing a second opinion until genuine involvement of other disciplines has been initiated...*" (section 11.5(c), page 40). It is not necessary to be a cynic to identify the Kafkaesque bureaucracy behind that statement.

There is a clear anomaly in the legal requirement for such an opinion in the absence of universal clinical indications for the involvement of a further professional as defined.

It is not clear in Dr West's article whether the opinions on ECT given by the social worker and the nurse were volunteered or sought; if the latter this is surely improper—the SOAD should not seek opinions which if given would be outside the professional competence of those consulted. That questions of this type are asked on occasion can be substantiated from my own experience. A physiotherapist was asked by the SOAD in one hospital where I have worked if a particular patient should be given ECT; she rightly considered that she should not have been asked for this opinion.

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Increased demand for psychiatric beds in the London metropolitan area

DEAR SIRS

Due to the increased demand for psychiatric beds in the London metropolitan area, duty psychiatric registrars attending to emergencies, either in the Accident and Emergencies department or brought in by the police under Section 136 of the Mental Health Act, often spend hours on the telephone trying to find available beds for suitable patients. In central London, this problem is made worse by itinerant patients from distant parts of the country attracted to the 'inner city'.

Almost all psychiatric hospitals in London operate on a 'catchment area' basis and it is usually quite simple to ascertain a patient's catchment area hospital by ringing the Maudsley Emergency Clinic (703 6333) any time of the night or day, provided one has an address. The problem arises when these hospital beds are full. It then becomes a test of endurance trying to convince another hospital to accept such patients temporarily.

This sort of 'crisis' could be alleviated to some extent if representatives from various London hospitals could meet and agree to form a 'Bed Bank' such as other medical and surgical services sometimes have. Such a scheme would necessarily involve the larger mental hospitals situated in the Greater London area, which usually have more available beds. Most hospitals would find an arrangement of this sort mutually beneficial.

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Guidelines on the prescribing of benzodiazepines

DEAR SIRS

We are endeavouring to produce district guidelines, for both hospital and community use, on the prescribing of benzodiazepines. It is our aim to restrict the use of such drugs to clearly defined clinical needs and to stop the unnecessary, but all too common practice, of routinely prescribing night sedation on general wards.

May we therefore, through the columns of the *Bulletin*, enquire as to whether any similar guidelines exist elsewhere in the UK.

Any help and information will be greatly appreciated.

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Guardianship Orders

DEAR SIRS

We are writing to ask if any other members of the Royal College of Psychiatrists have experienced difficulty implementing Guardianship Orders (Section 7–10 of the Mental Health Act, 1983).

We have found that Social Services in the Wirral are of the opinion that the Guardianship Order does not allow them to convey a patient from hospital or any other place to the place where the Guardianship Order requires them to live (Section 8(1)). They are thus reluctant to implement Guardianship Orders on patients in hospital or unsuitable accommodation because they feel that the Order as it stands does not provide any mechanism for conveying the patient to the desired residence if the patient is unwilling to go there.

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Plight of female child psychiatrists

DEAR SIRS

Dr Hardwick's article on Occupational Agarophobia (*Bulletin*, July 1987, **11**, 230–231) caused a lot of amusement in our overwhelmingly female household but was thought (as with most articles by men) to grossly understate the plight of women in general and female child psychiatrists in particular. I am led to believe that in all but the most exclusive and expensive dress shops there is a communal changing room in which women of all ages can be observed in their underclothes or even totally naked if they happen to be trying on bras and panties. It is apparently at these moments of *deshabillé* that the female child psychiatrist is most likely to be observed or hailed by her most difficult and