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.

HAKEEM KAZEEM, *Mossley Hill Hospital, Park Avenue, Liverpool L18 8BU*

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.

*ROBIN GONZAGA, NICK S. BROWN and PRAKASH C. NAIK, *Solihull Healthcare NHS Trust, Mental Health Services, Solihull Hospital, Solihull, West Midlands B912 2JL*

*Correspondence

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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