

It seems to me that the question of leave for patients who are detained under the Mental Health Act, even those who are restricted, is a question for clinical judgement and that a blanket restriction from the Secretary of State is inappropriate. It also serves to detract from the notion that a Hospital Order is for treatment rather than punishment.

I think there is a very real question about whether psychiatrists should agree to be bound by a directive of this nature, especially since it raises the possibility of future directives of a more restrictive nature.

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### Seclusion of control and restraint?

Sir: The *Code of Practice* (HMSO) states that "seclusion is a last resort", "its sole aim ... is to contain severely disturbed behaviour which is likely to cause harm to others". Upon seclusion it recommends that a doctor attend "immediately". If seclusion continues, it requires documented reports every 15 minutes, two nurses reviewing the patient every two hours, and a doctor reviewing every four hours. Prolonged seclusion requires a senior doctor, nurses, and other professionals to review the case. Detailed clinical notes and separate seclusion records must be kept while managers are required to monitor the use of seclusion. However, advice on other forms of restraint is less detailed. Although the code requires a "senior officer" to be informed of restraint lasting over two hours it does not require involvement of medical staff, the keeping of specific records, or frequent reviews of the need for continued restraint.

'Control and restraint' (C & R) is a widely used form of restraint. It derives from the martial art *aikido* where manipulation of the joints is used to provide 'locks' which restrain the violent patient. C & R is performed by specially trained nursing staff who operate in teams of three or more. It is an effective way to restrain a violent patient in the short term but is not without its drawbacks. It involves considerable invasion of the patient's 'personal space' and an almost total restriction of movement. A patient who struggles while in C & R 'locks' experiences considerable pain in the wrists and other

joints. Physical injuries such as bruising, sprains and 'carpet burns' have occurred.

In some psychiatric units prolonged C & R is used in circumstances where seclusion would previously have taken place. This arises either because C & R is felt to be preferable, or because a seclusion room is no longer available. It is my concern that prolonged or repeated use of C & R is a potential abuse of the patient, but is not always subject to the same strict monitoring as seclusion. Prolonged or frequent C & R deserves similar monitoring procedures to those used with seclusion. The code implies that seclusion is more extreme than other forms of restraint like C & R, but at times the reverse is true. Increased use of prolonged or frequent C & R should be viewed with caution.

DEPARTMENT OF HEALTH AND WELSH OFFICE (1993) *Code of Practice. Mental Health Act 1983*, London: HMSO. Pp 74–85.

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### Is this an article too far?

Sir: There is a series in the *Psychiatric Bulletin* whose place remains a mystery to me. When I first read Dr Culliford's 'Wisdom' articles, I requested him to explain what 'wisdom' was (Azuonye, 1992), but he was unable to do so, "It is difficult to be definitive on the question of what wisdom is" (Culliford, 1992). Without demonstrating that he possesses a clear notion of what 'wisdom' means to *him*, he has continued to write about it.

The latest 'Wisdom' article (Culliford, 1994) is one of the worst pieces I have come across in a scientific journal. Taking the surprising view that emotions are "... pleasing (positive) [or] noxious (negative) ...", he states that a person who is not sad is happy, one who is not anxious is calm, one who does not feel guilty is in a state of pure-minded innocence; and, most staggeringly, that a person who is not feeling angry is in a state of Wisdom! He fails to recognise that human emotions are expressed on a spectrum, and that there exists an 'all right' feeling, neither sadness nor happiness, which is the normal emotional state of most of us.

The compassionate understanding which is the essence of psychiatry is a religious phenomenon. Contributions which possess a religious or philosophical content therefore have a place in a journal of trends in