years of treatment (Revicki *et al*, 1990; Drummond & Davies, 1993). It is this evidence that should be used to educate managers and purchasers to demand that patients who suffer from treatment resistant schizophrenia receive clozapine as part of an overall treatment package for this disabling illness.

At present the prescription of clozapine is restricted to 20 patients in our district. The Department of Health, the BMA and the Royal College of Psychiatrists have all condemned this rationing of care. One possible solution to this restriction would be to vary the price of in-patient and out-patient care to take into consideration the cost of clozapine. We are looking into this possibility.

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Antidepressant prescribing by GPs

Sir: R. J. Thompson's study on antidepressant prescribing among general practitioner referrals to a community mental health unit in New Zealand (*Psychiatric Bulletin*, 1994, **18**, 461–462) and K. R. Linsley's comment (*Psychiatric Bulletin*, 1994, **18**, 703) suggested that sub-therapeutic prescribing might have to do with longer intervals between consultations related to the fees New Zealand residents have to pay to see their GP.

My survey of antidepressant prescribing among GPs referring clients to a community mental health centre in Keighley suggests that sub-therapeutic prescribing is also common in the UK where residents do not pay consultation fees (albeit many pay a fee per prescription). To determine whether GPs prescribe antidepressants in adequate dosage once they have established an indication for their use, I collected data from referral letters of 100 consecutive clients referred for depression while on antidepressants. Where dosage was not mentioned, the GP practice was contacted to clarify the dose at the time of referral.

The referrals consisted of 26.6% of a total of 376 referrals by GPs received during 18 months from April 1993. Seventy-six were women aged 17–61, and 24 men aged 22–55. Just over half were on tricyclic and related antidepressants of which the most widely prescribed was dothiepin (34/52). Applying the consensus statement of Paykel *et al* (1992), 75% (39/52) of clients on tricyclics were on sub-therapeutic doses (i.e. less than 125 mg daily), 69.2% (36/52) taking 75 mg or less. This is well after the launching of the Defeat Depression campaign, a disappointing result.

In stark contrast to Dr Thompson's sample, where few were prescribed selective serotonin re-uptake inhibitors (SSRIs), almost half of clients in Keighley were on these drugs, mostly fluoxetine (32/48). According to guidelines of manufacturers, 87.5% (42/48) of clients on SSRIs were on the minimum dose. Although this dose is said to be therapeutic, experience in psychiatric practice suggests that higher doses are frequently needed. It may be that GPs could treat many patients more effectively using higher doses of SSRIs.

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Leave for restricted patients

Sir: A letter dated 5 September 1994 and addressed to "All responsible medical officers in special hospitals, secure units and other psychiatric hospitals" from the Head of C3 Division at the Home Office indicates that the Secretary of State has "decided that ... he will normally no longer give consent for restricted patients to have escorted or unescorted leave of absence from hospital for holidays or holiday-type activities".

I read this with concern and when I discussed it with my immediate colleagues I found that this concern was shared. I would be interested in wider views of this (especially from forensic psychiatrists) and whether the forensic section of the College has any views.

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