British Journal of Psychiatry (1989), **155**, 263–270

Correspondence

Editor: Ian Pullen

Contents: Use of seclusion in Scotland/Attitudes to seclusion in Virginia/Australian depression/Obstetric liaison/Practical administration of ECT/Haslam's schizophrenics/Compulsive water drinkers/Risk factors in schizophrenia/Antidepressant toxicity/Attitudes to anxiety/The epileptic arsonist/Treatment of extrapyramidal side-effects/Spontaneous orgasms – any explanations?

Use of seclusion in Scotland

SIR: Angold (*Journal*, April 1989, **154**, 437–444) provides a very useful review of the present state of knowledge about seclusion, and rightly emphasises the need for further research into its use. It is perhaps worth reporting that during 1985 the Mental Welfare Commission for Scotland undertook a review of the use of seclusion in psychiatric practice in Scotland, and for the purposes of its enquiry defined seclusion as: "removing a patient during daylight hours from the company of his fellow patients and staff and placing him, against his will, alone, in some form of constraining environment from which he cannot, of his own wish, remove himself".

The findings, described in the Commission's Annual Report, showed that in seven NHS psychiatric hospitals, containing some 4500 beds, seclusion was permitted, while in 14 psychiatric hospitals, containing some 9200 beds, seclusion was not permitted. The Commission made a variety of recommendations regarding the use of seclusion policies by Health Boards and the recording and reporting of incidents of seclusion.

In the following years it became apparent that hospitals were changing their policies and their use of seclusion, to the extent that when a further review was carried out in 1988, four of the hospitals previously using seclusion were no longer doing so, one hospital had seen only one episode of seclusion during the 3 years, and in only two hospitals was seclusion still made use of in any regular way. More recently still, Commissioners have met clinicians and Health Board representatives from these two hospitals, and it seems that a stage has been reached where in one of these hospitals seclusion is no longer being used, and in the other the practice of seclusion is being carefully re-examined.

Following its initial enquiry, the Commission found it hard to understand why seclusion should be used frequently in some psychiatric hospitals while in others, dealing with similar clinical problems, seclusion should have fallen into total disuse. The virtual disappearance of seclusion from all Scottish mental illness hospitals, with the exception of the State Hospital, makes it evident that this procedure is no longer a necessary part of the care of patients in ordinary psychiatric hospitals.

W. D. BOYD

Mental Welfare Commission for Scotland
25 Drumsheugh Gardens
Edinburgh EH3 7RB

Attitudes to seclusion in Virginia

SIR: Angold (*Journal*, April 1989, **154**, 437–444) states that it appears that the majority of patients dislike being locked up on their own. In a recent study (Wise *et al*, 1988) 111 current psychiatric patients were queried about their attitudes towards the use of seclusion rooms; 70% stated that it was a safe and secure room. Only 19% indicated that such rooms are torture, while the majority agreed that such rooms are helpful to patients in them. It is of interest that patients without a history of seclusion indicated stronger adverse feelings. In a follow-up study of 191 subjects (Wise *et al*, 1989), comparing patients on a unit with sequestered seclusion rooms with those on a unit with integrated seclusion rooms, patients in the latter group were more likely to agree that patients are often cured in such rooms. Both studies concluded that patients generally had positive attitudes about the utilisation of such treatment, and endorsed fairly realistic attitudes towards the experience.

It would be useful to discuss the role of seclusion with all patients during their orientation to the unit; this should reduce the distortions and fears of

https://doi.org/10.1192/bjp.155.2.263b Published online by Cambridge University Press

patients who will not utilise such facilities and also of those who may wish to utilise them.

LEE S. MANN
Fairfax Hospital
Department of Psychiatry
Falls Church, VA 22046
USA

THOMAS N. WISE
Georgetown University School of Medicine
Department of Psychiatry
Washington, DC 20007

References

WISE, T., MANN, L., MURRAY, C. *et al* (1988) Attitudes of non-secluded patients toward seclusion rooms. *General Hospital Psychiatry*, **10**, 280–284.

——, ——, LEIBENLUFT, E., *et al* (1989) Isolated versus visible seclusion rooms: attitudes of psychiatric patients. *Psychiatric Quarterly* (in press).

Australian depression

SIR: It does seem better to be treated for depression in Australia (Lee & Murray, *Journal*, July 1989, **155**, 123–124). In our cohort there were 22 patients who presented with depression but in whom the final diagnosis made on the index episode was either schizophrenia, schizoaffective disorder, or organic psychosis. They were not included in any further follow-up studies. It is fortunate that we made the correct diagnosis at the beginning of the study.

We agree that we misinterpreted the first paragraph on p. 746 of Lee & Murray (1988). To be strictly comparable, we should have excluded our nine unnatural deaths from the bottom line of the first part of our Table IV. When we do so, the pattern of clinical criteria outcome for the remaining Sydney patients is more favourable, but the comparison with the Maudsley patients ($\chi^2=2.35$, d.f. $=2$, NS) remains non-significant. The second part of the table remains unaltered, and on the Lee–Murray criteria the Sydney patients did do better. Thus the conclusions drawn from Table IV (Kiloh *et al*, 1988) remain unchanged: being admitted to hospital in 1970 for depressive illness was, even in Australia, an event of serious import.

L. G. KILOH
G. ANDREWS
M. D. NEILSON
Clinical Research Unit for Anxiety Disorders
299 Forbes Street
Darlinghurst, NSW
Australia 2010

References

KILOH, L. G., ANDREWS, G. & NEILSON, M. D. (1988) The long-term outcome of depression. *British Journal of Psychiatry*, **153**, 752–757.

LEE, A. S. & MURRAY, R. M. (1988) The long-term outcome of Maudsley depressives. *British Journal of Psychiatry*, **153**, 741–751.

Obstetric liaison

SIR: We were most impressed with the description given by Appleby *et al* (*Journal*, April 1989, **154**, 510–515) of the establishment of an obstetric liaison clinic. However, while appreciating that the main focus of their work was the identification of those women at risk for post-natal depression, we were nevertheless disappointed that they did not take a broader view in their discussion of further directions for the service, particularly in relation to substance misuse.

The catchment area served by their unit has a high prevalence of illicit drug users. Following the development of a Community Drug Team (CDT), we have witnessed an increase in the number of women presenting for treatment, with 38% of our total patient population being women, one-third of whom were caring for one or more children. This contrasts with a quarter of our patient population being women in previously published reports from our unit, and with the national figures from the Home Office Addicts Index (1989), in which 29% of new addicts in 1988 were female.

In the past two years, we have seen 20 pregnant women addicted to opiates in a cohort of 372 addicts who have been resident in the CDT catchment area (population 213 000). This indicates an annual incidence rate for pregnant opiate addicts of at least 4.0 per 100 000 catchment population, or 3.0 per 1000 births.

During this same period, we have witnessed the rapid spread of HIV through the drug-using population. The advent of HIV has increased the necessity to draw this high-risk population into contact with services. The ante-natal clinic, labour ward, and post-natal ward are areas where drug users are already being seen, although often without identification (or with late identification) of their drug problems. Staff in these services should make more of the opportunities for earlier identification and intervention.

There is now a pressing need for closer links between drug services and obstetrics services in an effort to limit the vertical spread of HIV and to provide appropriate support and help. The psychiatrist in the obstetric unit will be a vital link in this

https://doi.org/10.1192/bjp.155.2.263b Published online by Cambridge University Press