

away from an attacker and gain time to escape from a violent incident. The concentration on technique means that most people can successfully use these skills irrespective of size and strength. An added bonus is the safety of patients who are much less likely to suffer permanent damage – a real risk considering some of the more ‘traditional’ strategies described to me in the past. While obviously only a part of the more general strategy outline in the CTC Report, this was invaluable training for the occasions when more general measures fail and an assault begins.

This was a two-day course with an instructor/pupil ratio of one to ten requiring no equipment other than a suitably equipped gymnasium with floor mats and a padded wall. It can be run inexpensively in terms of capital, instructor and study leave costs and should be much more widely available to all staff in mental health services.

The CTC Report’s recommendations are to be welcomed but without pressure from juniors, clinical tutors and the College, provision nationally will continue to be extremely patchy and juniors and consultants will continue to be exposed to unnecessary or reducible risks.

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### Involving junior trainees in audit

DEAR SIRs

In the article ‘A study of the use of log books in the training of psychiatrists’ (*Psychiatric Bulletin*, April 1991, 15, 214–216), Drs Cole and Scott ask, “Are there methods for making audit of more interest to junior trainees or should experience of audit be postponed until senior training?”. I suggest that it is not only possible but also relatively easy to increase junior trainees’ interest and understanding of the audit process.

In Nottingham, junior trainees are exposed to a sectorised mental health service. One of the audit activities involves a sector auditing another sector’s activity. Randomly selected cases are analysed by the other sector at joint meetings between all members of the multidisciplinary teams for both sectors. Although there was an initial reluctance to include juniors in these activities, they now constitute an important part of the process. Although junior trainees are actively involved in this audit activity, their own clinical work is not subjected to analysis.

There is, therefore, the opportunity to observe varying clinical practice, to appreciate different views and, perhaps most importantly, to realise that information recorded in case notes on management strategies that juniors initiate might one day be similarly audited. This serves to encourage improvement in individual practice while learning the process of audit.

It is obvious that this method of involving juniors in audit does not place further demands on the already over-stretched junior trainee. It is both efficient in terms of cost and time as these audit activities often take the place of regular team meetings. Perhaps this is a form of audit activity suitable for junior trainee which should become more widely utilised. Having seen it work in practice and having benefited from being involved, I would certainly hope this would be the case.

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### Section 5(2) audit

DEAR SIRs

The section 5(2) (S52) audit reported by Joyce *et al* (*Psychiatric Bulletin*, April 1991, 15, 224–225) prompted us to respond with our own figures for the same period, as we already have a single nominated deputy for the RMO during the day. Also we share their experience that the Mental Health Act Commission make judgements about acceptable numbers of detentions, in the absence of formal numerical guidelines.

Since patients of S52 that become informal do not get the benefit of a second opinion, or the right of appeal, we based our audit on the 37% of cases that fell into this group from the 101 S52 detentions in 1989.

Of the group that were further detained, only one quarter of them were on S52 for 48 to 72 hours, whereas of those that became informal, four-fifths were detained for a similar period. Of this sample, 70% had a medical entry in the case notes during their detention, although audit was complicated by the fact that doctors recorded their name and the date, but not the time of assessment – important with S52 as it commences from the time it is received by the managers.

In 44% of cases a Section 12 approved doctor made an entry, but did not then either further detain, or regrade the patient.

We found that these patients were more likely to have a diagnosis of psychosis (ICD-10 groups F2 and F3) at the time of detention (52%) than on admission (35%) or discharge (30%).

At detention, 15% of this group were recorded as having suicidal ideation, 45% as posing a risk to

their health, and 85% with a non suicidal risk to themselves of others.

Our conclusions were, firstly, that a full-time nominated deputy of the RMO, who had to be a junior doctor, was an acceptable system which paradoxically prevented more senior practitioners having a role in S52. Secondly, there was a need for pilot audit studies such as these to identify valid audit parameters, and clarify the 'numbers' issue. Thirdly, despite the informal outcome it was reassuring to note that good grounds for detention were clear despite the informal outcome.

We are currently unsure as to the reasons why patients destined to become informal are on S52 longer than those further detained, but it appears likely that any attempt to reduce the average duration of S52 in this group will result in more people being detained for longer.

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### *Which psychotherapy?*

DEAR SIRS

The paper 'The future of psychotherapy services' (*Psychiatric Bulletin*, March 1991, 15, 174-179) carefully side-steps the question of which psychotherapy services should be developed for which type of patient. It blandly states that 'psychotherapy' is the main or adjunctive treatment for a long list of psychiatric disorders. For most of these the authors are presumably referring to behavioural-cognitive and similar problem-solving psychotherapies which have been effective in many controlled studies (apart from personality disorders, for which little has been of help). Fewer than 2% of consultant psychotherapists are expert in such effective methods, 98% being trained in dynamic methods with far less controlled research to show their value. This imbalance is risible. The authors express a commendable desire for audit and the use of performance indicators, but these are no substitute for controlled trials.

The article suggests that consultant psychotherapists should be responsible for a full range of psychotherapy services, but they have rarely played such a role. Behavioural-cognitive methods have usually been developed by general adult psychiatrists, nurse therapists and psychologists rather than by consultant psychotherapists. The appointment of psychiatrists as consultant psychotherapists (behavioural) may be blocked on the grounds of too little dynamic training, though very few consultant psychotherapists have adequate behavioural cognitive experience.

Posts with a Special Interest or Special Responsibility in Psychotherapy are less suitable for dynamic

therapists (due to their length of training) than for Specialists in Behavioural Cognitive Psychotherapy. Posts which train and meet service needs in behavioural cognitive psychotherapy can be well integrated with general adult psychiatry.

We welcome the President's initiative in setting up a group to examine the training and appointment of specialists in behavioural cognitive psychotherapy and the representation of such interests in the College.

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### *Revival of Psychotherapy Section, Irish Division*

DEAR SIRS

I would like to report on the revival of the Psychotherapy Section of the Irish Division of the Royal College of Psychiatrists. A meeting was held in Ardee, County Cavan on 22 March 1991. Speakers were invited to outline the current psychotherapy training in Ireland.

Dr Michael Fitzgerald spoke on training South of the border. There are Master of Medical Science degree courses in Psychotherapy and Family Therapy in Dublin and, although in great demand generally, the interest from general psychiatrists has been poor. Support from child psychiatrists in child psychotherapy training has been more substantial. Representations have been made to College to put pressure on the scheme for General Adult Psychiatry, but this had not borne fruit. Dr Fitzgerald hoped that the revival of the Psychotherapy Section would provide a forum for concentrating on these issues, and making further representation to improve training.

Dr Alderdice spoke about current training North of the border. He was more optimistic about the interest of general psychiatrists and felt that the role of the Psychotherapy Section should be more one of providing a forum for academic presentations and co-ordination of different interests. Although there had not been a meeting of the section, the situation with regard to training had improved in recent years with the appointment of a consultant psychotherapist.

Debate on whether the needs and interests of the North and South differed to such a degree that there should be separate sections ensued. This has been an issue for the Royal College in Ireland because of the differences in hospital services and training schemes. There is a separate Northern Ireland Section of the