PTSD among our forces should not blind us to the devastating effects on the Iraqi troops.

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DEAR SIRS

The two highly topical articles on factors contributing to military casualty rates and the demand for psychiatric services as a result of the Gulf War (*Psychiatric Bulletin*, April 1991, **51**, 199–203) are noted with great interest.

In this connection the facilities of the Ex-Services Mental Welfare Society are relevant. They are available as a contribution to the overall community care of ex-Service personnel to which all such patients are entitled to be considered.

The Society was formed in 1919. The record shows that it has cared for almost 50,000 former Service men and women in its 72 year history. Some 3,000 veterans of World War II and of the several campaigns since 1945, are currently provided for by the Society which has a network of eight Regional Welfare Officers and two Rehabilitation/Treatment units at Leatherhead, Surrey and Scotland respectively. In addition, we have a Veterans Home at Kingswood Grange, Surrey.

Referrals should be made direct to me and further administrative information about the Society can be obtained from the Director (081 543 6333).

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Management of violent incidents

DEAR SIRS

As psychiatrists in higher training, we welcome the recent report of the Collegiate Trainees' Committee Working Party on the training of junior psychiatrists with respect to violent incidents (*Psychiatric Bulletin*, April 1991, **15**, 243–246).

The report mentions that an informal survey of trainees in two regions showed that formal training in the management of violent incidents was almost universally absent. This observation is extended by our own survey conducted approximately 18 months ago in which we sent questionnaires to 37 members of the Collegiate Trainees' Committee. The questionnaires asked about training received in several aspects of the management of violence. We received 27 replies which provided information about 28 training schemes throughout the whole United Kingdom. The replies indicated that in three schemes there was no formal training in the assessment of dangerousness, in 12 schemes there was no training in the emergency use of medication, in 15 schemes there was no training in talking with aggressive patients, in 21 schemes there was no teaching in the use of physical restraint and in 22 schemes there was no formal training in the use of seclusion. Several respondents commented that they had been expected to learn about these management approaches simply through "experience".

It is obvious from our survey that the interventions least well covered in psychiatric training are the more physical interventions which are, of course, those used in the most dangerous and difficult situations. Appropriate use of these interventions requires an accurate (and often speedy) assessment of the situation, a knowledge of the available management options and, importantly, confidence on the part of the psychiatrist making the decisions. Unfortunately, training for junior psychiatrists in the use of these "physical" interventions comes almost exclusively from having to deal with violent emergencies while on call. While it is important to obtain this type of practical experience, it would be of great benefit to patients, junior psychiatrists and other staff if the junior psychiatrists were given better preparation to deal with such emergencies.

We believe that every hospital should organise an induction course for new junior psychiatrists in which there is teaching about and discussion of practical aspects of managing psychiatric emergencies. All too often hospital managers content themselves with handing out a pile of operational policies which may satisfy their solicitors but make no contribution to improving patient management or to training junior doctors. We hope that the College report will help to bring about major improvements in this neglected but vital aspect of psychiatric training.

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DEAR SIRS

In response to the 'Report of the Collegiate Trainees' Committee Working Party on training of junior psychiatrists with respect to violent incidents' (*Psychiatric Bulletin*, April1991, **15**, 243–246), I would like to detail a training course recently made available to junior psychiatrists in Nottingham entitled 'Coping with Violence and Aggression at Work'. It concentrated on practical breakaway and self-defence techniques for use in violent situations in and out of hospital. The course, covered by the Department of Health guidelines, was developed from the control and restraint training designed for the Prison Service and extended by way of the Special Hospitals to the NHS psychiatric services. The moves and holds are intended to allow one to quickly and effectively break

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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Acknowledgement
Thanks to Mr A. Maughan, C&R Instructor and Course Organiser, Plains Training Centre, Mapperley Hospital, Nottingham, for background information and advice.

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