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.

STEFFAN DAVIES

Mapperley Hospital
Nottingham NG3 6AA

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.

O. JUNAID

Mapperley Hospital
Nottingham NG3 6AA

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