I would like to try and take the training issue forward. The College is to be congratulated on its stance. However the balance between senior registrars and more junior trainees may need to change. It would be difficult for senior registrars to give up their hard won privileges, but surely the emphasis in training ought to be on the least experienced not most.

The new funding arrangements for training posts should allow some principles to be established about the division between service and training. In Sheffield, as roughly half of the funding for SHO/registrars will come from Trent Postgraduate, at least half of their time will be allocated to training. For the moment, we will continue to regard senior registrars as "supernumerary".

I am hopeful that the new Dean of the College will introduce some new thinking on training in psychiatry. This is not a criticism of the current or past Deans, who I know have successfully countered arguments like those of the Maudsley consultants.

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Crisis intervention

DEAR SIRS

I was interested to read Dr Parkes' articles on the crisis intervention service in Tower Hamlets. (*Psychiatric Bulletin* 1992, **16**, 748–753).

Redbridge, about ten miles from Tower Hamlets, has had a similar small multidisciplinary crisis intervention service operating during office hours since 1984. This complements the traditional in-patient, out-patient and CPN services and offers brief individual psychotherapy and family therapy supplemented where appropriate with medication. Similarly, psychiatrists do not see all cases. However, unlike Tower Hamlets, most cases are seen in the crisis team's office and self referrals are accepted.

We retrospectively examined all 119 patients referred from a single catchment area in 1989. Twenty-two per cent failed to attend with the remaining 78% attending for an average of 3.2 sessions. Only 10% were self referral, most being referred from psychiatrists or their GPs. Similar to Parkes' findings, there was a larger proportion of younger women with those in the 20 to 35 age group making up 36% of all those referred. Eighteen per cent of men and 33% of women were receiving psychotrophic medication on referral.

We followed up the group, an average of three years later, in mid 1992. Only seven patients had renewed contact with the crisis team during this period and five had attended psychiatric out-patients; 27% were on psychotrophic medication, usually a benzodiazapine or an antidepressant, although surprisingly this showed minimal correlation to use of medication in 1989. Of those who remained with their GPs, 41% were in regular contact for mental health problems. However, most of these had had no contact with any other psychiatric service in the previous six months.

Separately, as part of audit, we found a high level of patient satisfaction with this service.

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Section 5(2) – following the rules?

DEAR SIRS

We audited the use of the Mental Health Act section 5(2) and found that we were not very good at following the workings of the Act of the Code of Practice. Forty-one per cent of our episodes involved patients who had been on the ward less than 12 hours, which raised questions about our definition of an in-patient (Code paragraph 8.4). This was complicated by the fact that patients were assessed for admission on the acute wards and not in the A & E department. Most applications (73%) were made by a senior house officer but only 18% sought advice, which the Code says should be done wherever possible. Approved social workers were involved only if a recommendation for admission under the Act was made, which the Code considers *not* to be good practice. Twenty per cent were 'allowed to lapse' after the second assessment which is contrary to the Act and receives regular criticisms from the Commission.

Our social work colleagues are more keen than we are to follow the letter of the legislation. Perhaps our priorities are different, evidenced by their frequent reference to paragraph 1.1 of the Code, that failure to follow the Code could be referred to in evidence in legal proceedings. They are in favour of policies and guidelines, and some have even suggested a maximum of six hours for the second assessment to be completed. As psychiatrists, our clinical freedom is *within* the Act and Code and my concern is that if we do not follow them more closely, more restrictive and rigid interpretations will be imposed. This would *really* affect our clinical freedom. We see this too often in social services and nursing; new untoward incidents lead to new policies.

Most Section 5(2)s are done by very junior trainees (41% were made by SHOs in their first psychiatric posts). When I asked junior trainees in two hospitals