of learning disability services in Sandwell and how they can be accessed.

GERALDINE CASSIDY, MEERA ROY and THOMAS MLELE, *Sandwell Mental Health Service, Newton House Community Unit, 20 Heath Lane, West Bromwich B71 2BD*

Publication of MRCPsych examination results

Sir: I passed the MRCPsych Part I examination held in Autumn 1994 and would like to mention certain doubts which were commonly expressed by the candidates.

First, we are at a loss to understand why it takes the College as long as four weeks to publish the results, particularly since fellow associations like the Royal College of Surgeons, and the Royal College of Physicians are far quicker with their results, with a far larger pool of candidates. The MCQ Paper probably gets corrected by the computer in a matter of days. The clinical part, according to general opinion, gets decided on that day itself, or at the very latest, by the next day. One can understand the delay in publishing the results of the Part II examination, since that involves essay type questions and short answer questions. However, regarding the Part I, one fails to comprehend the reason for the delay. Secondly, I went to a revision course before the examination, where we were told that for the clinical examination, according to College guidelines, separate marks were allotted respectively for history, mental state examination, physical examination, interviewing in front of the examiners, differential diagnosis, aetiology, and investigations. However, in the examination proper, I found that I was not asked a single question about either aetiology or investigations. This obviously led to a lot of soul-searching on my part as to where I had gone wrong. Many candidates had a similar experience and had to wait a month in suspense before their doubts were resolved.

The Membership examination is a stressful experience and the mental state of candidates could be improved, both during and after the examination if the College published the results earlier, and also ensured that its guidelines are enforced more strictly.

PIYAL SEN, *North West London Mental Health NHS Trust, Central Middlesex Hospital, Acton Lane, London NW10*

Working with young offenders: a contribution to forensic training in child psychiatry

Sir: Specialist forensic training posts in child psychiatry are on the increase. However, in a survey of all child and adolescent psychiatry training schemes in the United Kingdom, Reder & Lucey (1990) found that training with regard to young offenders was virtually absent. The rise in juvenile crime rates together with a contraction in services equipped to deal with antisocial young people, has led to increasing concern among psychiatrists about the health of young offenders: there are particular concerns about suicides among young offenders and about a core group of recidivist offenders.

There is therefore a clear need for specialist training placements which include involvement with young offenders. One such placement exists in North West Thames. The post is equally divided between a children and families department and the regional forensic out-patient department and includes an attachment to Feltham Young Offenders Institution (YOI) for one session of consultation per fortnight.

The placement offers many unique opportunities. First, the modes of presentation of disorders and the difficulties faced in treating them can be seen. Secondly, an insight into the lives of young offenders is gained, which provides a valuable understanding of the routes they have followed into crime and into prison. Finally, the trainee begins to comprehend the influence of a prison environment on prisoners and on therapeutic relationships through the experience of the establishment and through knowledge of a different government department, namely the Home Office.

These experiences are an invaluable assistance in carrying out individual assessments of young offenders for the courts, by helping one think about the impact of prison life on young people, and the level of psychiatric disturbance that can be managed effectively in prison. In addition, the knowledge and skills obtained are particularly relevant when considering consultation work with prison professionals.

In view of the increasing role of child and adolescent psychiatrists in the assessment and management of young people who commit crimes, this area of training can no

longer be ignored. A placement such as this is time-efficient and provides many unique training opportunities. It is strongly recommended to all senior registrars interested in forensic adolescent psychiatry, and would also provide an important adjunct to any broad based training scheme for senior registrars in child and adolescent psychiatry.

REDER, P. & LUCEY, C. (1990) Child and adolescent psychiatry training schemes: recent developments. *Psychiatric Bulletin*, **14**, 615–617.

A. J. HILL-SMITH, *North West Thames Child Psychiatry Training Scheme, Adolescent Unit, Hill End Hospital, St Albans AL4 0RB*

The experience of psychiatry in general practice trainees

Sir: I would like to relate the findings of a study into the attitudes of general practice trainees who are completing a six month hospital training post in psychiatry. I feel the relevance of the training must be assessed due to recent changes in the organisation of the NHS and the increasing proportion of patients being cared for in the community. Indeed, Kendrick *et al* (1994) suggest that "General practitioners could use their frequent contacts with long-term mentally ill people to play a greater role in monitoring the mental state and drug treatment of this group".

In order to evaluate attitudes to training within the field of psychiatry, GP trainees were asked to complete a postal questionnaire during the last month of their placement, covering issues of formal teaching, supervision, and community experience. Completed questionnaires were received from 12 of the 16 trainees who completed hospital posts throughout the Mersey region between February and August 1994.

All trainees attended regular formal teaching sessions including a regional day release training course, and most trainees felt adequately supervised in all aspects of their placement.

Of particular note was trainees' general lack of knowledge of the community services available and uncertainty in the management of psychiatric patients in this setting. Over half of the trainees also felt that liaison with general practitioners was unsatisfactory with regard to referral of patients and their long-term follow-up care.

While only a small study I feel that it highlights some points of reference, particularly in view of the current changes in general practice. It is possible that experience should not merely include the acute hospital care of the in-patient, as is the case in many units at present, but should be broadened, enabling the trainee to gain a wider insight into care of the mentally ill in the primary care setting.

I feel that there may be a need for a re-evaluation of some aspects of the training and that a more widespread survey of psychiatry for general practice trainees may also be appropriate.

KENDRICK, T., BURNS, T., FREELING, P. & SIBBALD, B. (1994) Provision of care to general practice in patients with disabling long-term mental illness: a survey in 16 practices. *British Journal of General Practice*, **44**, 301–305.

STEPHEN NOBLETT, *Parkside Hospital, Macclesfield, Cheshire SK10 3JF*

Weather the whether?

Sir: Man's emotional weather is as variable as the climate. Predictions about both are subject to error. Public reaction to these errors depend upon the subject. The British are resigned to being caught by the weather, whether or not they are forewarned. An unexpected shower is shrugged off, heavy snow or strong winds lead to inconvenience and grumbles, but rarely litigation, and even severe and possibly fatal events such as lightning strikes are accepted as acts of God, but then we cannot change the weather.

In spite of a massive data base and high technology, weather forecasting is probabilistic and its value limited to a few days by the 'chaos' of nature (Glieck, 1988; Palmer, 1992). What then of the psychiatrist's forecasts of human behaviour? His data may be limited and the technology low. Yet human intrapsychic and group behaviour is no less dynamic than the weather, and no less subject to the non-linear implications of 'chaos'. Even state of the art predictions in psychiatry are limited, and further diminish in value with forward projection. Like the weather, psychiatric problems vary from say a squall of verbal abuse, through a storm of physical violence (directed to self or others), to the