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Eagles continues, stating that conclusions and recommendations do not stand up in the absence of these data, since any consultant not in a sufficiently populated, effective team would not survive in a progressive role.

My initial response is to state that we indeed did collect data about the size of the respondent's team. These data weren't included in this paper as submitted to keep the length down to publishable level. In common with many national studies, the original dataset for this project is vast and contains several hundred variables. We are forced to choose not only which to analyse in depth, but must create a subset of those to submit for publication in peer-reviewed journals. I can report, however, that team size was included as a predictor in some of our univariate (the larger the respondent's team, the higher their reported satisfaction level [$P<0.05$]) and multivariate (the larger the team, the lower the respondent's General Health Questionnaire – version 12 score ([$P<0.05$], and the less they suffer from depersonalisation [$P<0.01$]) analyses. My second point concerns Dr Eagles' interpretation of the findings more generally. I feel that Dr Eagles has rather missed the point of this paper: the progressive model can only ever work where the consultant has a motivated, effective multidisciplinary team. A progressive role, by reference to its defining characteristics, cannot be achieved without it. Further, the more important point here is that a consultant cannot change in isolation: as we point out in the paper, any change of role is potentially dangerous unless carried out as part of a whole-systems approach to change, a restructure, where due consideration is given to ensure that any reduction in workload is not merely passed onto other team members, rendering them liable to stress and burnout.

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Partners in care. Who cares for the carers?

Mike Shooter, President of the Royal College of Psychiatrists has highlighted an important aspect of psychiatric care in his recent editorial 'Partners in care. Who cares for the carers?' (*Psychiatric Bulletin*, September 2004, **28**, 313–314).

This is very relevant to the developing countries as many clinicians depend heavily on relatives or carers with regard to various aspects of a patient's management, as social services and other supportive systems are poorly developed. For instance in many in-patient units in Sri Lanka, relatives or carers are encouraged to stay with the patients. Sometimes relatives take turns to stay with the patients to minimise the burden and disturbance. This helps 'overworked staff members' to alleviate the burden at least to some extent. When the patient is discharged from the in-patient unit, administration of medication and rehabilitation programmes are done with the help of the carers. Carers are further distressed prior to the admission of a patient for assessment or treatment. For instance as the existing mental health act does not address the admission policy comprehensively in Sri Lanka, relatives or carers have to play a major role in accommodating the disturbed patient until taken to a hospital for assessment/treatment/admission.

The other important area is the rapidly increasing elderly population in developing countries. At the moment many elderly people are looked after by their family members. For example, in Sri Lanka about 80% of the elderly population are living with their children and the main caregivers are female (National Council for Mental Health, Sahanaya, 2002). We are bound to see more and more people with dementia and other disorders encountered in old age. Services for the elderly are not well developed compared with the West and the families, particularly females, are expected to look after their elderly relatives.

The other important area that needs to be highlighted is the introduction of community care without many resources. Management of mentally ill people in the community without resources will add to the burden on the carers. It is noteworthy that the crisis assessment teams are either poorly developed or non-existent in many developing countries.

We totally agree that the concept of 'caring for the carers' should be further emphasised and the undergraduate and postgraduate medical and nursing curricula must be strengthened with regard to this aspect of care.

NATIONAL COUNCIL FOR MENTAL HEALTH, SAHANAYA (2002) *Community Mental Health Care, Issues and Challenges.* Colombo: National Council for Mental Health, Sahanaya.

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Irish Psychiatric Association survey of psychiatric services in Ireland

The article by O'Keane *et al* (*Psychiatric Bulletin*, October 2004, **28**, 364–367) provides a valuable insight into the deficiencies present in mental health in the Eastern Regional Health Authority (EHRA) in Ireland. Unfortunately the data presented do not represent 'a national survey'. The consultant sample is only 8.2% of the 281 consultant psychiatrists employed in Ireland (Walsh, 2004) and hence the results of this survey are limited to only the EHRA respondees. The wide variation in the socio-economic and demographic profiles in different regions in Ireland noted by the authors and elsewhere (Central Statistics Office, 2003) alongside the variation in the management style, and political function of the various health boards, and differences in regional infrastructure also make the EHRA results non-generalisable to Ireland as a whole without further data.

The paper is a good start at examining the inequities of Irish mental healthcare but data including regions very different from Dublin and the East coast are essential in such a survey.

CENTRAL STATISTICS OFFICE (2003) *Measuring Ireland's Progress. Volume 1, 2003; Indicators Report*. Dublin: Stationery Office (Government of Ireland).

WALSH, D. (2004) *Report of the Inspector of Mental Hospitals for 2003.* Dublin: Stationery Office (Government of Ireland).

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The objective structured clinical examination

The letter by Haeney (*Psychiatric Bulletin*, October 2004, **28**, 383) raises an interesting conundrum.

I have recently been advising a number of my colleagues, who will be undertaking the clinical examination for Part II MRCPsych. A significant number undertook the Part I MRCPsych OSCE exam, so have not had experience of the unobserved long case.

With the introduction last year of the OSCE exam and its widespread use in undergraduate teaching, a large proportion of trainees have no experience of long case examination. As was mentioned in the letter by Haeney, candidates struggle with the uncontrollable variables of patient and examiners. My own feeling about this is that, with experience, candidates can often handle these situations better. During my undergraduate training, I was examined using the traditional long case format, and I believe this exposure to the format gave me greater confidence when dealing with long cases in both Part I, and more recently, in Part II examination.

It would be of interest to get an idea of how candidates who are now undertaking Part II are dealing with the lack of exposure to the long case. This would particularly apply to any proposed change in the Part II examination. Having reviewed previous articles it would appear that

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while most have highlighted the need for changes in the Part I clinical examination, there is little mention of what changes, if any, can be made to improve the Part II clinical examination.

It is my opinion that, having initiated the change to the OSCE format for the Part I clinical exam, the College would, inevitably have to review the current long case format in the Part II exam. The debate, I hope, will start sooner rather than later.

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Psychiatric secrets of success: who wants to be a specialist registrar?

Naeem's excellent and informative article (*Psychiatric Bulletin*, November 2004, **28**, 421–424) provided useful tips and advice for trainees aiming for higher specialist training as specialist registrars. However, we would like to point out certain factual inaccuracies which require further clarification.

First, the College's *Higher Specialist Training Handbook* (Royal College of Psychiatrists, 1998) clearly states that higher specialist trainees in lecturer posts who do five or six clinical sessions become eligible for a single certificate of completion of training (CCT) (formerly CCST) after 3 years. It is only when they do 4 clinical sessions that the single CCST is after 4 years.

Second, overseas doctors who are non-European Economic Area nationals and do not have indefinite leave to remain in the UK, are also eligible to apply in open competition for type I specialist registrar training programmes leading to CCT (Department of Health, 1998). If appointed, they are provided with a visiting national training number (VNTN). They can then also apply to the Immigration and Nationality Directorate (IND) of the Home Office for permit-free training leave to remain in the UK. This can be further extended by up to 3 years at a time depending on the training needs of the individual and satisfactory progress (UK Visas, 2004). The VNTN automatically becomes a NTN once the doctor gains indefinite right to remain in the UK. Overseas doctors without UK indefinite residence leave therefore are not limited to taking up fixed-term training appointment (FTTA) or type 2 posts, which do not lead to award of CCT, and conversely FTTAs are not limited to overseas doctors without residency rights.

DEPARTMENT OF HEALTH (1998) *A Guide to Specialist Registrar Training*. Leeds: NHS Executive.

ROYAL COLLEGE OF PSYCHIATRISTS (1998) *Higher Specialist Training Handbook*. Occasional Paper OP43. London: Royal College of Psychiatrists.

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the college

The psychiatrist, courts and sentencing: the impact of extended sentencing on the ethical framework of forensic psychiatry

Council Report CR129, June 2004

Professor Nigel Eastman, Professor John Gunn and Dr Mike Shooter, on behalf of the Royal College of Psychiatrists, provided a College response to the consultation paper on extended sentences, issued by the Sentencing Advisory Panel in June 2001. This followed a ruling by the Court of Appeal that sentencing guidelines should be issued to judges on the use of extended sentences. Sections 80 and 85 of the Power of Criminal Courts (Sentencing) Act 2000 replaced certain sections, dealing with extended sentences, of two previous acts namely the Crime and Disorder Act 1998 and the Criminal Justice Act 1991. The Power of Criminal Courts (Sentencing) Act 2000 gave powers to courts to impose additional supervision or a longer than commensurate sentence on sexual and violent offenders 'to protect the public from serious harm from the offender'. The College response was met with a wide spectrum of opinion within the Forensic Executive. The Executive therefore determined to have a seminar on the role of psychiatrists in court, concentrating particularly on the use of psychiatric evidence where longer than normal sentences are being considered. That seminar was held on 6 December 2002 at the Commonwealth Institute and involved: the Executive of the Forensic Faculty, the Ethics Committee, Royal College of Psychiatrists and the Confidentiality Committee, Royal College of Psychiatrists.

The seminar was structured around four presentations: In what circumstances should psychiatrists attempt to predict violence by the mentally disordered? Science and ethics, Nigel Eastman; Risk psychiatry and the courts, Tony Maden; Psychiatric evidence in the court room, John O'Grady; Psychiatrists in the court: black robes and white coats, Gwen Adshead.

There followed a wide range of discussion by participants at the seminar. This paper seeks to gather together these presentations and discussions and presents a summary based around various themes. Particular points or views are not credited to any particular person and the four presentations are amalgamated into the body of this report rather than being individually reported.

The issues raised were profoundly complex and, not surprisingly, where issues of personal morality and ethics were concerned, there was a wide variation in individual executive members' response. There was a common feeling of intense unease in relation to our work with courts and public protection agencies. What clearly emerged was that there is no current adequate ethical framework to address the profound issues we face in our interface with public protection/criminal justice system. This is of very particular concern to forensic psychiatrists but we believe that the issues we face, because of our day-to-day interaction with the criminal justice system, will not be confined to forensic psychiatrists only but will be of concern to all psychiatrists. There was representation from the Child and Adolescent Faculty at our meeting and they confirmed that child psychiatrists equally face profound ethical dilemmas in their everyday work, particularly when issues of child protection reach the courts. These concerns are likely to be amplified greatly for all sections of the College if the proposals of the new Mental Health Bill reach Parliament and eventually form the basis of a new Mental Health Act.

Why are there ethical dilemmas?

The basic dilemma that faces forensic psychiatrists is their dual role. Most forensic psychiatrists act as catchment area forensic psychiatrists responsible for comprehensive services to a specified geographical area, and with gatekeeping functions in regard to secure services (both National Health Service and private). However, in the interaction with the criminal justice system, the forensic psychiatrist is also responsible to courts and other criminal justice agencies when they provide reports on their behalf.

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