conforming to a set standard, but technical on-the-spot expertise in order to cope with maintenance and minor faults if and when these arise. One other point not apparently generally realized is that an identical video-tape is not necessary for use in every examination centre. After all the patients whom the candidates are asked to examine are by no means identical, but vary widely. With video-tapes variation is by no means a disadvantage; indeed it may allow economies to be made in that a tape used in one centre can subsequently be used in another.

In summary I would recommend as follows:

In the *Preliminary Test* the exam should consist of a multiple choice questionnaire only. The existing essay paper should be dropped. If a test of literacy is thought to be desirable, then a properly designed written test examination should be devised in order to test this quality without regard to factual information. Expert help in this matter should be sought.

In the Membership Examination consideration should be given to replacing the essay paper by short-answer questions provided these can be shown to fulfil a function other than that covered by the multiple choice questionnaire. Secondly, in the clinical examination a way should be found of allowing one or both examiners to spend sufficient time with the candidate during the time he is actually examining his patient. Thirdly, there should be an additional oral examination, again of about 20 minutes duration, in which video-tape excerpts should be shown. Finally, a detailed analysis of the results of all parts of the Membership Examination should continue as at present.

Mental Health Guardianship—a Change for the Better?

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The 1959 Mental Health Act has provided the legal framework for psychiatric practice in the UK for the past two decades. The Mental Health (Amendment) Bill (DHSS, 1981) currently before Parliament proposes to update the Act by improving the safeguards for detained patients, clarifying the position of staff looking after them, and by the removal of uncertainties in the law. The Bill incorporates changes relating to the compulsory care of Mentally Disordered patients in the community whereby a person may be accepted into Guardianship on the grounds that he or she is suffering from a Mental Disorder. Once accepted into Guardianship, the person or body named as Guardian has the power to exercise control over the person as if he or they were the father of the patient, and the patient was under 14 years of age.

In its Report, the Percy Commission (DHSS, 1957) envisaged that Guardianship would be useful for persons with mild or chronic forms of Mental Illness as an alternative to prolonged hospitalization. In practice Guardianship has been used predominantly for the Mentally Handicapped, and only rarely for the Mentally Ill. Its use has declined over the years, and in the 12 months ending March 1978 only 37 patients in England and Wales diagnosed as Mentally Ill were made subject to Guardianship, compared with over 18,000 compulsory admissions to Mental Hospitals (DHSS, 1981).

Although much has been written on the principles of compulsory care of Mentally Disordered patients in the community, and in support of the retention of such a facility (Royal College of Psychiatrists, 1979; BASW, 1977; Gostin, 1975), there has been little published research into its decline and disuse. Unlike Treatment or Observation Orders, Guardianship invariably places responsibility on Local Authorities. The extent to which Guardianship is used, therefore, depends largely on the attitude and policy of the relevant Authority.

In an attempt to establish the position of Local Authorities with respect to Guardianship, a questionnaire was sent to the Directors of Social Services of 29 randomly selected Local Authorities representing one in four London, Metropolitan, and Non-metropolitan Authorities in England and Wales. Enquiries were made regarding the extent of current usage, trends in usage, the type of patient supervised, policy regarding use or restrictions on use and practical difficulties encountered in supervision.

Twenty replies were received including five letters declining to comment or referring the matter to the Association of Directors of Social Services. The 15 replies varied considerably both in information provided and in attitude towards Guardianship. Approximately half of the Departments had not accepted a patient into Guardianship over recent years, notably since the reorganization of Local Government in 1974. Although most Authorities expressed major reservations regarding Guardianship, only three admitted to having a firm policy of avoiding its use. Most Departments had fewer than three clients under supervision, the patient invariably being Mentally Handicapped. Most Authorities felt that the precise powers conferred by the Act were unclear, and if anything, rather limited. The Order merely provided the legal authority without the practical

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means of ensuring the interests of the patient. Without effective sanctions difficulties had been experienced in influencing the individual's behaviour with respect to residence, attendance for therapy, treatment, etc. Most Authorities took the view that if a person was amenable to the powers of Guardianship, he or she could be managed equally well on an informal basis. Although it was accepted that Guardianship would intensify the Local Authority's responsibility for the client, the Order could be seen as restrictive on the individual. It was felt that there was a distinct relationship with the provision of resources, and that Guardianship would be of little value if facilities such as accommodation to cater for the client's assessed needs could not be found. Social Service Departments therefore were reluctant to become party to legal control over individuals in the community.

Despite these reservations approximately a third of the Authorities expressed the view that Guardianship should be retained. Its use had meant that patients with longstanding difficulties, particularly post-psychotic defect states, could be discharged from hospital and maintained in the community by supervising their physical standards of care in their homes, and monitoring their finances with respect to the payment of rent, rates, the purchase of clothing, etc. Thus by the administratively simple supervision of material resources, patients who might otherwise require (re)admission to hospital through self-neglect or non-compliance with tenancy agreements, could be maintained in the community. It was felt that Guardianship might be of use also to those patients who appear to exist below the accepted poverty level through failure to take up welfare benefits, and those who have no fixed abode or security of tenure.

The decline in use of Guardianship appears to be attributable to three main objections by Local Authorities—uncertainties regarding Guardianship powers, the impracticality of effectively controlling an individual's behaviour without sanctions, and the acquisition of responsibility without adequate resources. Despite these difficulties the information obtained suggests that Guardianship can and does work effectively in certain situations. The future use of Guardianship, therefore, would seem to be dependent on how far the proposed legislation will remove uncertainties in the law, and encourage the re-orientation towards community care originally envisaged two decades ago.

The present Bill replaces 'parental powers' with more specific 'essential powers' requiring the patient to live at a specified place, to attend places specified by the Guardian for treatment, occupation or training, and to ensure that a doctor, social worker or other specified person can see the patient at his own home. Thus whilst the Bill clarifies the legal position, the 'essential powers' refer to control of the patient's behaviour—measures which have hitherto been considered impractical by Local Authorities. It would appear that the new legislation will have little effect in encouraging future use of Guardianship, and the omission of provisions in the Bill for the control of the patient's material resources may prove to be an added disincentive.

If Guardianship is to provide a viable, less restrictive alternative to compulsory admission, practical legal changes must be accompanied by a meaningful change in attitude of Local Authorities towards compulsory community care. Such changes will have inevitable resource implications. In anticipating the need for additional resources, the Consultative White Paper (DHSS, 1978) concludes that '(Guardianship) powers would be permissive, and as such, would be expected to be used only as Local Authority resources permit'. The facilities provided for the Mentally Disordered in the community by Local Authorities since the introduction of the Mental Health Act have, at best, been disappointing, and are unlikely to be radically improved (Early and Nicholas, 1981). The potential change for the better presented by the Amendment Bill with respect to Community Care of the Mentally Ill, and Guardianship in particular, may result therefore, in little or no beneficial change at all.

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