they prescribe and feel that they would be better off as a result. Whether this should be enforced by legislation is another matter.

Compulsory treatment in the community raises important issues, several of them discussed in the original article by Moncrieff & Smyth (*Psychiatric Bulletin*, November 1999, **22**, 544–546). Many mental health workers are justifiably concerned about the implications of CTOs for the relationship between professional and patient as well as for individual patient rights. I do not think that Llewellyn-Jones & Donnelly offer persuasive arguments in their favour.

SARGANT, W. W. (1967) *The Unquiet Mind: the Autobiography of a Physician in Psychological Medicine*. London: Heinemann.

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Help cards for patients

Sir: We wish to report our experience of developing a help card for patients who commit deliberate self-harm (DSH) attending a general hospital. A previous local study identified difficulties with assessments and planning interventions (Gordon & Blewett, 1995). In Bristol the effectiveness of offering access to specialist telephone help following DSH has been examined with variable outcome between subgroups (Evans *et al*, 1999) demanding further study and replication. We propose a slightly different intervention as part of a broader strategy. We asked casualty doctors to offer a pocket-sized card with numbers and hours of availability comprising the Samaritans, Relate, a local alcohol and drugs agency, a line for young people, Rape and Incest crisis, and the National Debt line.

As a first step to understanding its impact we wrote to people discharged from an accident and emergency department after committing DSH. Forty-eight patients returned a questionnaire, of whom 20 reported receiving a card. Of these, 15 thought it a good idea, and six of the seven who used a line said that they found it helpful.

If a voluntary sector based card could be shown to be effective, the implications for joint working are obvious: currently there is a paucity of evidence for voluntary sector DSH interventions generally, and a variety of arrangements between statutory and voluntary sectors have grown up in different localities. The objective value of our findings is limited to an impression of user acceptability. In an attempt to examine the effect on repetition of DSH, the card is now subject to a randomised controlled trial, and forms part of our patients' management delivered by a specialist DSH team. We would value the opportunity to share our experience with others interested in treating this patient group.

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Use of Section 62 in clinical practice

Sir: Like Johnson & Curtice (*Psychiatric Bulletin*, April 2000, **24**, 154), we have also audited the use of Section 62 (urgent treatment). We studied all Section 62 forms completed at St Andrew's Hospital during 1997. A total of 55 forms were audited, 53 authorising medication and two authorising electroconvulsive therapy (ECT). This contrasts with Johnston & Curtice who found Section 62 was used exclusively for ECT. These findings are likely to be due to differences in patient characteristics between the two studies. St Andrew's has many tertiary NHS referrals including forensic patients, whereas Johnson & Curtice were studying patients of a local psychiatric service.

In our audit, aggression towards self or others and generally disturbed behaviour were the most common reasons for using Section 62. Antipsychotics followed by benzodiazepines were the most frequently administered medicines. In 33 instances patients receiving treatment authorised by Form 39 urgently required additional medication to that certified. Fourteen patients withdrew their consent to treatment at the same time displaying an urgent need for medication. A disproportionate number of Section 62 cases involved adolescent female patients. In virtually all cases treatment authorised by Section 62 appeared genuinely urgent.

We are concerned about the Government Green Paper *Reform of the Mental Health Act 1983*. It proposes that the threshold for administering emergency medication be increased such that merely preventing violence or self-harm would not be sufficient grounds to authorise urgent treatment. This raises concern about staff and patient safety particularly in forensic settings. Psychiatrists will no longer be able to give urgent ECT to patients who lack capacity or do not consent but must wait for authorisation from a second opinion appointed doctor (SOAD). In our audit SOADs took a mean of 4.8 days to visit and complete Form 39 after Section 62 had been used. If made law this measure is likely to increase the suffering and morbidity of severely depressed patients.

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Changes to the MRCPsych examinations

The MRCPsych Examinations were analysed by a professional educationalist, Dr Helen Mulholland, in 1998 and a working party, chaired by the Dean, was set up to examine what changes would be desirable to increase the reliability and validity of the Examination, and to ensure it is in keeping with the principles of 'adult learning'. In June 1999 the working party agreed that an option appraisal should be made of the alternatives proposed, and that this should be subject to a wide ranging consultation process with all relevant parties. The final recommendations were considered and agreed by the Court of Electors in December 1999.

Part I Examination

At present the Part I MRCPsych Examination consists of a multiple choice

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questionnaire (MCQ) examination and a clinical examination. It is taken after at least 12 months' experience in psychiatry.

MCQ examination

The main issues to be addressed when considering the current format of the MCQ paper were that the 'stem' technique often results in non-discriminatory questions, and the format inhibits the testing of competence in diagnosis and aetiology. The peer-referenced marking procedure penalises average candidates in a good cohort. The following modifications have, therefore, been agreed:

(a) With effect from Autumn 2001, the format of all MCQ questions will be modified into Individual Statements, reducing the total number of questions from 250 to 200.

(b) At the end of the Autumn 2000 MCQ Examination, candidates will be asked to complete a pilot examination consisting of 10–15 Extending Matching Items (EMI) which will not contribute to their examination result. An evaluation will then take place of the performance of EMIs against the standard MCQs with a view of phasing in EMIs as appropriate.

(c) The present peer-referencing procedure of marking will be replaced by fairer criterion referencing of MCQ and EMI scores.

(d) Questions where candidates' responses correlate poorly with their overall performance will be removed and the paper will be re-marked without these questions.

Clinical examination

The Working Party agreed that it was essential to continue to include a long case in the MRCPsych Examination despite its inherent variability. It was concluded that this assessment should be included in the second part of the examination, and that the Part I clinical examination be replaced by an Observed Structured Clinical Examination (OSCE). The OSCE format is suitable for assessing a range of essential core skills that a psychiatrist should possess but is not so effective in the assessment of more complex abilities which must be tested in the Part II Examination.

OSCEs have the advantage of being able to test clinical competence using a number of different scenarios in a relatively short period of time in a well-standardised format. A minimum of 12 stations will be used comprising clinical scenarios including written vignettes, simulated patients and video material. It should be possible to examine 400 candidates in three or four centres using between 50 to 60 examiners.

As the introduction of OSCEs is a major undertaking, a new OSCE Working Party has been set up to oversee this process. Several pilot OSCE examinations will be required and they will not be introduced into the Part I Examination until Spring 2003.

Part II Examination

In view of the increasing number of candidates taking the Examination and the difficulties in finding sufficient clinical centres and examiners, it has been agreed that from Autumn 2001 screening criteria for the written papers in the Part II Examination will be introduced to determine eligibility to progress to the clinical examination.

MCQ papers

In order to address similar concerns to those raised in relation to the Part I – MCQ Paper, it has been agreed that the Basic Sciences and Clinical Topics Papers will be amalgamated to produce one MCQ paper comprising of 200 individual statements, with an emphasis on clinical topics questions.

If EMIs are shown to be successful in Part I, it is proposed that EMIs are also phased into the Part II MCQ Paper in Spring 2003.

As in Part I, the present peer-referencing procedure of marking will be replaced by criterion referencing of MCQ and EMI scores, and all questions with negative biserial correlations with overall score will be removed and the paper will be re-marked without these questions.

Essay paper

The key aim of the essay paper is to test candidates' ability to marshal evidence, synthesise and interpret the facts to present a coherent and logical argument. In order to give a greater opportunity to achieve this, it has been agreed that from Autumn 2001 candidates will be asked to write a single essay in 90 minutes with a choice of five topics requiring the integration of knowledge from the subspecialities with themes from general psychiatry.

A new Essay Panel will be established to mark scripts using a standardised marking scheme.

Critical review paper

This part of the Examination is relatively new and it is too soon to make a clear appraisal of any changes which may be required. However, it will be kept under regular review. It has also been agreed that the peer-referenced marking of this paper will be replaced by criterion referencing of scores.

Individual Patient Assessment (IPA)

There are similar problems with the Individual Patient Assessment (IPA) as in the Part I Clinical Examination. In addition, there is currently an excessive emphasis on history-taking and insufficient scope to test clinical reasoning and decision-making. However, it was agreed that it is essential to retain a single case presentation in this part of the examination. In order to address the problems identified, the following changes to the IPA examination have been agreed.

The time of examination of the candidate by the examiners will be increased from 30 to 40 minutes with effect from Spring 2003. In the interview with the examiners:

(a) there will be less time spent on the delivery of the history and greater stress placed on differential diagnosis and management;

(b) there will be an exploration of aetiological factors in more depth and discussion of psychodynamic formulation.

Patient Management Problems (PMP)

At present the vignettes presented to candidates in this part of the Examination are not sufficiently structured, and much of the material presented could be examinable by written paper.

It has been agreed, therefore, that the present PMP Examination will be replaced by a Structured Oral Examination. Standardised vignettes, which will include suggested probes for examiners, will be developed by a new Structured Oral Examination Panel. These will test diagnostic skills, the clinical application of knowledge, basic science and clinical reasoning. Changes to the PMP component will take effect from Spring 2003.

It is hoped that, through careful planning and development of the new examination, candidates and tutors will not be adversely affected, and a more robust instrument will be established for the assessment of candidates' core knowledge and the ability to apply it in the assessment, management and treatment of patients with psychiatric illnesses.

Provisional dates for implementation of changes to the MRCPsych examination

February 2000

MRCPsych course organisers and College tutors informed of approved proposed changes.

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September 2000
Proposed new examination material to be included in MRCPsych courses.

October 2000
Pilot EMI questions at end of Part I Written Paper. (These will not count towards final marks at this stage.)

October 2001
First Individual Statements in Part I and Part II Examination. Introduction of new Essay Examination. Introduction of screening criteria for written papers to determine eligibility for entry into the clinical part of the examination.

June 2002
OSCE: Pilot I.

October 2002
OSCE: Pilot II.

Spring 2003
EMIs to be phased into both parts of the examination. OSCEs to replace the Part I Clinical Examination. Changes to IPA and PMP examinations to be implemented.

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Comments on An Bille Meabhair-Sláinte 1999 (Mental Health Bill 1999)

The Royal College of Psychiatrists offers the following comments on the Mental Health Bill 1999. We trust that overall they will be accepted as both considered and helpful advice. The Royal College of Psychiatrists is pleased that the long overdue upgrade of the mental health legislation is being enacted.

Good mental health legislation is the guardian of civil rights

The omission of both Adult Care Orders, Chapter 8 and protecting mentally disordered patients, Chapter 10, of the White Paper is a serious omission (Department of Health, Government of Ireland, 1995).

The absence of proposed legislation in relation to mentally disordered offenders would appear to breach both the European prison rules – recommendation number R (87) 3 of The Committee of Ministers, Council of Europe, 1987, and the United Nations Standard Minimum Rules for the Treatment of Prisoners (resolution adopted 30 August 1955, at the first UN Congress of the Prevention of Crime and the Treatment of Offenders).

The Department of Health states that: “The [prison] medical services should be organised in close relation with the health administration of the community or nation”.

Adult Care Orders

The College is seriously concerned that there are no comments in the Bill in relation to Adult Care Orders. This absence affects the most vulnerable patients with a mental disorder living in the community. It is necessary to provide appropriate care and protection for those who may be vulnerable from abuse, exploitation or neglect. We hope this matter will be addressed.

Some legal mechanism needs to be established for guardianship, such as a Court of Protection and an official solicitor. There is also an absence of legislation in relation to the establishment of community care and the direction of Government policy in this area.

Mentally disordered offenders

We are concerned at the absence of any referral to mentally disordered offenders as contained in Chapter 7 of the White Paper *A New Mental Health Act 1995*. We need to know what alternative legislation is being considered to address this serious omission.

Definition of mental disorder

Part 1, Section 3
We understand that the definition of ‘mental disorder’ relates primarily to involuntary admission to an ‘approved centre’ as defined in the Mental Health Bill.

The College would advise that the term “significant mental handicap” is both incorrect and not acceptable under current international classification of diseases. We would suggest that “significant mental handicap” be renamed ‘significant mental impairment’.

For the purposes of mental disorder in children, it is the view of the College that conduct disorder should be excluded from involuntary admission similarly to the exclusion of personality disorder in adults.

Involuntary admission

Part 2
Paragraph 11, Section 1: The phrase “The member *may* either” would be better worded as “the member *shall* either”.

In addition the College has concerns about the recommendation that ‘approved centres’ send staff in to the community for the purpose of admitting involuntary patients. This is both therapeutically and clinically inappropriate.

It would be useful if each step of the process of involuntary admission be both separate and distinct. The last step being the acceptance of the patient by the admitting ‘approved centre’.

Part 2, Section 8 (1)(a)
The application for involuntary admission by a spouse or relative of a patient does not address the issues of ‘disqualifications of spouses in dispute’ as contained in paragraph 3.1.3 of the White Paper. This stated that

> “the Government would propose a new legislation to disqualify a spouse from making an application for the detention of his/her partner where the couple separated or is in the process of separating or where an order has been sought or granted under Family Law (Protection of Spouses and Children) Act, 1981.”

Part 2, Section 8(8)
‘Authorised Officer’: it is unclear who the ‘authorised officer’ may be, or whether they should hold an appropriate professional qualification.

Second opinions

Section 22: The College would advise that there may be practical difficulties on occasions, in rural areas especially, in obtaining a second consultant opinion within the 24-hour period referred to in the Act.

Relationship between Mental Health Commission and Inspector of Mental Health Services

Part 3
We understand that the Inspector will be employed by the Commission and are therefore puzzled that the Inspector’s Annual Report can be independent of the Commission. The roles and division of responsibilities between the Mental Health Commission and the Inspector of Mental Health Services is unclear and needs clarification.

The College is concerned that members may have to take ‘an oath’ before appearing before the Mental Health Commission.

Mental Health Commission

Part 3, Section 31
The powers of the Commission need to be clearly defined.

We note the proposed membership of the Commission but would request

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