

The validity and reliability of multistation Objective Structured Clinical Examinations (OSCEs) has been tentatively established.<sup>2</sup> Despite the appeal of the long-case examination, it has poor interrater and test-retest reliability when systematically evaluated;<sup>3</sup> its continued use in high-stakes professional examinations is difficult to justify. However, it is very concerning that many candidates are surprised when failing a supposedly objective examination after 3 years of practising psychiatry. Can it be that so many intelligent and diligent psychiatry residents have a severe lack of insight into their own abilities? This seems implausible. It is more likely that postgraduate training programmes are failing to equip residents with the skills they need to pass the CASC. Given that these are predominantly consultation and interpersonal skills, it is difficult to escape the conclusion that residents receive inadequate feedback on clinical skills in their initial years of practice, even before commencing formal preparation for the CASC.

The College dropping the Part 1 OSCE shifted responsibility for evaluating first-year residents' core clinical skills to postgraduate training programmes by means of the workplace-based assessment (WPBA) system. This approach is not effective: there are multiple flaws in the current WPBA system<sup>4</sup> and its suitability for assessing and developing core clinical skills is even more questionable than the long-case examination.<sup>5</sup> These observations are supported by our own experience of delivering CASC training: many candidates are surprised to receive in-depth feedback on difficulties in interpersonal and consultation style. After 3 years of practising psychiatry to their best of their ability with little criticism or coaching, it is no wonder that they are disappointed when the first piece of negative feedback they receive is failing the CASC. This affects UK-trained and non-UK-trained candidates alike and to focus on discrepancies detracts from the issue that the current pass rate is too low for all candidates.

This leads us to the conclusion that a substantial share of responsibility for low CASC pass rates lies not with the Royal College of Psychiatrists, but with the postgraduate training programmes. It is of course important that the CASC is continuously evaluated and improved, but there are more pressing issues. First, we suggest that training programme directors collect and publish data on CASC pass rates and urgently improve support and training for residents at risk of failing. Second, preparation for the CASC must start in the first year of psychiatric practice, in the form of in-depth consultation skills training beyond the WPBA system. Finally, we recommend that current and prospective psychiatry residents use all available information regarding the quality of clinical skills and CASC training when choosing a postgraduate training programme.

#### Declaration of interest

A.T. and D.H. deliver CASC revision training although do not profit from it. D.H. is author of *Deconstructing the OSCE*, due to be published in 2013 by Oxford University Press.

- 1 Kashyap G, Sule A. MRCPsych CASC exam: is there a better choice? *Psychiatrist* 2012; **36**: 197.
- 2 Hodges BD, Regehr G, Hanson M. Validation of an objective structured clinical examination in psychiatry. *Acad Med* 1998; **73**: 910–2.
- 3 Leichner P, Sisler GC, Harper D. A study of the reliability of the clinical oral examination in psychiatry. *Can J Psychiatry* 1984; **29**: 394–7.

- 4 Menon S, Winston M, Sullivan G. Workplace-based assessment: attitudes and perceptions among consultant trainers and comparison with those of trainees. *Psychiatrist* 2012; **36**: 16–24.
- 5 Kahn MJ, Merrill WW, Anderson DS, Szerlip HM. Residency program director evaluations do not correlate with performance on a required 4th-year objective structured clinical examination. *Teach Learn Med* 2001; **13**: 9–12.

**Alex B. Thomson**, locum consultant liaison psychiatrist, Central and North West London NHS Foundation Trust, email: alex.thomson@nhs.net, **Duncan Harding**, NIHR Clinical Lecturer, Department of Forensic and Neurodevelopmental Sciences, Institute of Psychiatry, King's College London

doi: 10.1192/pb.36.8.314b

#### The need for age-appropriate forensic services

Dr Connolly has rightly pointed out that planning for the development of mental health services requires an understanding of the changing demographics in the country.<sup>1</sup> We feel every directorate within psychiatry will need to prepare for the demographic transition through thoughtful planning in service development that can provide quality as well as appropriate care to the elderly. Within forensic services, serious thought should be given to development of geriatric forensic service.

Traditionally, it is believed that there is a low crime rate in the elderly. However, studies have shown that there is an increase in criminal behaviour among those 60 or over,<sup>2</sup> and the number of people in prison over the age of 60 has grown from 1.3 to 2.4% in England.<sup>3</sup>

A study by Needham-Bennett *et al* concluded that there is a high prevalence (28%) of psychiatric disorders in alleged offenders in the community aged 60 years and over.<sup>4</sup> Studies done in the prison populations have shown that the prevalence of psychiatric disorders among remanded male prisoners aged 55 years and over was 50%<sup>5</sup> and in sentenced male prisoners 53%.<sup>2</sup>

Moreover, up to a half of elderly offenders with psychiatric disorders have a physical illness. In addition, they may have visual impairment, auditory impairment, mobility problems and cognitive impairment. Currently, forensic mental health units with long-term rehabilitation wards provide care for elderly individuals. This longer-term admission is usually due to ongoing risks combined with difficulties in rehabilitating this patient group because of 'institutionalism' or ongoing mental health issues. We wondered whether such units were equipped to be able to deliver care for older individuals with increasing physical comorbidities or those who develop certain organic conditions such as dementia. Another issue that needs consideration is the use of risk assessment tools such as Historical Clinical Risk Management 20 (HCR-20) in the older age group in forensic units that are generally used for working-age individuals. It is our view that the current psychological treatment programmes such as the sexual offending treatment programme will need modifications for this client group.

We feel that the complex needs of elderly mentally disordered offenders appear to fall within the domains of geriatric psychiatry services and forensic psychiatry services, but they may not be met by either service alone. Consideration should be given to setting up specialist tertiary forensic geriatric psychiatry. There has been some initiative in the independent sector in this matter.

- 1 Connolly M. Futurology and mental health services: are we ready for the demographic transition? *Psychiatrist* 2012; **36**: 161–4.

- 2 Fazel S, Hope T, O'Donnell I, Jacoby R. Hidden psychiatric morbidity in elderly prisoners. *Br J Psychiatry* 2001; **179**: 535–9.
- 3 Home Office. *Prison Statistics England and Wales 2002*. Home Office, 2003.
- 4 Needham-Bennett H, Parrott J, MacDonald AJD. Psychiatric disorder and policing the elderly offender. *Crim Behav Ment Health* 1996; **6**: 241–52.
- 5 Taylor PJ, Parrott JM. Elderly offenders. A study of age-related factors among custodially remanded prisoners. *Br J Psychiatry* 1988; **152**: 340–6.

**Dr Pratish B. Thakkar**, consultant forensic psychiatrist, Tees, Esk and Wear Valleys NHS Foundation Trust, Ridgeway, Roseberry Park Hospital, Middlesbrough TS4 3AF, email: pratish.thakkar@tevv.nhs.uk; **Dr Ipsita Ray**, specialty doctor, **Dr Laavanya Damodaran**, registrar, both at Tees, Esk and Wear Valleys NHS Foundation Trust, Roseberry Park Hospital, Middlesbrough.

doi: 10.1192/pb.36.8.315

### The psychiatrist and the interpreter

I am glad to see such a positive response to the editorial on interpreting practice.<sup>1</sup> Psychiatry and speech and language therapy are two of the most challenging areas of practice for interpreters.

Australia has an honourable tradition in the field of language support for its diverse population, as I experienced in New South Wales a few years ago. Andrew Firestone's description of using a triangular seating arrangement but having changed to sitting the interpreter next to him is interesting.<sup>2</sup> I have found that if I sit next to either the clinician or the patient, problems in the doctor–patient relationship can still occur. If closer to the patient, it is more likely that they will address questions directly to me, trying to draw me in 'on their side', such as 'Are you married?' or 'Do you have children?' If closer to the clinician, my impartiality can seem to the patient to be compromised.

In the UK almost all interpreters in the public sector are independent freelance workers. Being seen by the service user as directly employed by a state institution, whichever it is, can cause them to distrust our interpretation, especially if they have arrived from a totalitarian state. Seating the interpreter at the apex of an isosceles triangle, in which the clinician and patient are closest together and directly facing one another, allows eye contact to be maintained between them, and keeps the interpreter out of direct line of sight. Interpreters who are taking notes will be busy with their notebooks and not available for eye contact. They still need to be able to see the speakers' faces, of course.

It would be interesting to know whether interpreters and clinicians maintain direct speech during clinic sessions, such as 'How are you feeling?' rather than 'Ask her how she feels'. This is another way of keeping the interpreter out of a direct relationship with either party during the interview. It is very important that the interpreter introduces themselves and briefly explains how they work, at the beginning of the session. This, and everything else that is said, should be done in both languages. If the patient is reminded at the outset that 'I will interpret everything I hear' and 'I will speak to you as the doctor does, with "I" and "you"; they are his words', ownership of what is said remains with the primary interlocutors, not the interpreter.

- 1 Cambridge J, Singh SP, Johnson M. The need for measurable standards in mental health interpreting: a neglected area. *Psychiatrist* 2012; **36**: 121–4.
- 2 Firestone A. The psychiatrist and the interpreter. *Psychiatrist* 2012; **8** June ([http://pb.rcpsych.org/content/36/4/121/replypbrcpsych\\_el\\_14509](http://pb.rcpsych.org/content/36/4/121/replypbrcpsych_el_14509)).

Jan Cambridge, interpreter, interpreter trainer, Warwick Medical School, UK, email: jancambridge@uwclub.net

doi: 10.1192/pb.36.8.316

### Death and risk in adolescent anorexia nervosa

Responding to Robinson's article on avoiding hospital deaths from anorexia nervosa,<sup>1</sup> the most helpful context to consider this in relation to teenage patients is to place it within a broader concern about risk. Robinson states that a 'very unwell' patient should be admitted, but crucially, the definition of that is still not sufficiently clear. How risk is perceived, including what is severely disabling as well as what may be 'life-threatening', is a key issue.

Using death certificate data provided by the Office for National Statistics about 18 years ago, I observed 112 certified deaths in England and Wales over a 5-year period; however, only 7 of these individuals had been below their 18th birthday. Notwithstanding the uncertainty of death certificate methodology,<sup>2</sup> in this instance, suggested by the observation that a third of the 112 deaths had occurred after the person's 65th birthday, these 7 deaths approximate to only around 1 in 5000 adolescents with anorexia – an important finding to set in context fears about these young patients.

That death-data enquiry had been to establish a better empirical understanding about risk following our team's decision (which I supported) to recommend the de-commissioning of a psychiatric in-patient unit that had often provided long-term treatment for teenagers with anorexia. It had previously participated in the UK's first prospective multicentre study of adolescent psychiatric admissions, which demonstrated disappointing treatment effects for those with anorexia nervosa.<sup>3</sup> But without such a facility, might there be a local increased risk of fatal outcomes for this condition? Reassured that the probability of death was unlikely to be significantly increased by closing the unit, a substantial change in practice was possible, relocating therapeutic skills to enhance outpatient treatment capacity. Gower *et al*'s subsequent treatment study<sup>2</sup> confirmed our view that without hospitalisation the disorder should not usually be regarded as hard to treat, untreatable or life-threatening.

Declining death rates observed for anorexia nervosa over the past two decades have been attributed to its more effective and earlier introduced treatment, but not necessarily because the treatment was hospital based.<sup>4</sup> A careful review of the literature provides two lessons less prone to grab media headlines than premature deaths. First, in adolescence at least, chronicity rather than death is by far the more likely adverse outcome of failing to effectively treat the condition. In comparison with adults, in whom medical complications are not uncommon and excess mortality rates have been observed compared with the normal population, the only significant medical complication (as opposed to biological adaptation to starvation) during adolescence is progressive loss of bone mineralisation. Yet published studies on adolescent admission imply that hospitalisation was most often considered essential