

Correspondence

Senior emergency department staff also need mental health training

As a junior doctor who has moved to psychiatry after previously spending 2 years training in emergency medicine, I read Dr Gordon's article with interest.¹ The survey clearly highlighted a need for mental health training of new doctors working in the emergency department. During one of my training posts in emergency medicine, I completed an audit which showed that 75% of patients presenting to the department with self-harm were being seen by junior medical staff and highlighted the need for increased training and supervision of junior emergency department doctors. In addition, many such patients present out of hours when access to senior support and psychiatric services may be more limited.

I think that it is also important to consider the knowledge, skills and attitudes of senior doctors working in the emergency department. Assessment and treatment of the patient presenting with self-harm and behavioural disturbance does form part of the College of Emergency Medicine curriculum. However, in my experience, many senior doctors working in emergency medicine – with some exceptions – have little interest in assessing and treating patients who present with self-harm or other mental health problems. As my audit showed, many such patients are left to junior doctors to see. When asked for advice about such patients, a common response from senior doctors is to advise that the patient should be referred to 'psych', without any meaningful discussion or assessment of the patient; this is in contrast to patients presenting with other problems such as trauma or minor injuries, when a senior doctor may show more interest in seeing the patient and teaching their junior staff.

It would be beneficial for patients if links between emergency departments and psychiatric liaison services were improved and if increasing the amount of mental health training available for all grades of doctors working in emergency departments was considered.

1 Gordon JT. Emergency department junior medical staff's knowledge, skills and confidence with psychiatric patients: a survey. *Psychiatrist* 2012; **36**: 186–8.

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Simulation training: a tool to improve junior doctors' confidence

We read Dr Gordon's paper¹ with great interest as it echoes our own work while surveying the confidence of junior doctors new to psychiatry. Like Dr Gordon, we felt there was a specific need to combat their self-perceived lack of confidence, particularly in the out-of-hours environment, as often more senior supervision is based off site. However, we do feel that Dr Gordon's recommendations for 'mental health training of new doctors working in the emergency department' should perhaps be expanded to all those new to psychiatry, as the identified difficulties are not unique to the liaison service.

This issue has potential effects on patient safety, which is substantiated by a third of foundation year 1 respondents in the British Medical Association's study reporting that they had been asked 'to undertake tasks which they felt were beyond their capabilities' during their placements.²

In our own work, we expressly aimed to target this situation, consequently designing and implementing a simulation-based programme as part of the induction process of our trust. Simulation-based training has been recommended as a risk-free and efficient way of improving the quality of junior doctors' training.³ Junior doctors new to psychiatry participated in a range of complex, clinical, out-of-hours simulated scenarios under the observation of experienced consultants and patient representatives. Timely focused feedback was given by the observers, and the doctors had an opportunity to discuss their performance within clinical supervision sessions using recorded video. We received positive feedback from the participants, including a self-reported increase in their confidence when this was measured in follow-up sessions. They also felt that this would have an impact on their performance with real patients. The patient representatives gave a unique viewpoint and they felt that there were clear improvements in trainees' performance following the first session.

We recently presented our small-scale pilot in a London Deanery 'Quality and innovation' conference, where it was well received. It generated interest from other trusts that were keen to potentially implement similar programmes locally.

We ultimately hope that our project will be used to increase and focus supervision in out-of-hours work, while also improving patient safety using engaging and interactive learning through simulation.

1 Gordon JT. Emergency department junior medical staff's knowledge, skills and confidence with psychiatric patients: a survey. *Psychiatrist* 2012; **36**: 186–8.

2 British Medical Association. *Cohort Study 2006: Medical Graduates (Third Report)*. BMA, 2009.

3 Temple J. *Time for Training: A Review of the Impact of the European Working Time Directive on the Quality of Training*. Medical Education England, 2010.

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CASC candidates need better preparation

Kashyap & Sule are right to express outrage at the low pass rates for the Royal College of Psychiatrists Clinical Assessment of Skills and Competencies (CASC), and concern over the difference between UK-trained candidates and those trained elsewhere.¹ They offer good suggestions for improvement. However, by focusing on the examination itself rather than the quality of CASC preparation in UK postgraduate training programmes, their outrage may be misdirected.