Training and supervision of deliberate self-harm assessments

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Over a decade has now elapsed since the last national guidelines from Government health departments about the management of deliberate self-harm, although the scale of the problem has remained unchanged. Three years ago the Royal College of Psychiatrists issued a consensus statement which set standards for suitability of staff, particularly with regard to training, experience and supervision, the available facilities for assessment, the range of appropriate management options, communication of these and management of services. This postal questionnaire study in one health region of England of all senior house officers and registrars working in psychiatry found that levels of training and supervision varied widely and often fell below those suggested.

Deliberate self-harm (DSH) is a major public health problem accounting for 11% of all medical admissions in London (Fuller *et al*, 1989). There are at least 100 000 episodes of DSH a year in England and Wales (Hawton & Fagg, 1992). Reports of any decline may be biased by use of admission data which omits an increasing number of patients who are discharged directly from accident and emergency departments (Owens, 1990). There is an increased risk of suicide following DSH, 1% dying this way in the first year, the risk being especially high in the first six months (Hawton & Fagg, 1988). Repetition is common with up to 15.8% repeating in one year, 9.4% in the first three months (Bancroft & Marsack, 1977).

Despite this DSH is relatively neglected at many levels. At a Government level, although suicide reduction is targeted by 'Health of the Nation', the Mental Health *Key Area Handbook* has little to say about the management of DSH (Department of Health and Social Security, 1994) and current Government guidelines are now 14 years old. Research funding is sparse (Owens & House, 1994) and services vary significantly with the establishment of few multi-disciplinary DSH teams (Butterworth & O'Grady, 1989). Clinically, one-third (Owens, 1990) to a half of patients may be discharged directly from accident and emergency departments, and many are likely to have had an inadequate assessment (Black & Creed, 1988). When referral for specialist opinion is made, assessments are usually "left to junior doctors on psychiatric or general practice training schemes, working under indifferent supervision and seeing referrals between other duties" (Owens & House, 1994). These authors point out that by halving the suicide rate in the year following an episode of DSH the 'Health of the Nation' target of an overall reduction in suicide rate by 15% could be met (Royal College of Psychiatrists, 1994). The potential importance of DSH is acknowledged by some nations, and policies to improve assessment and management are incorporated into national suicide prevention strategies (Taylor *et al*, 1997).

In 1994 the Royal College of Psychiatrists published a consensus statement concerning the management of adult DSH. This set standards for available assessment facilities, the suitability of staff in all disciplines and specialists for the task, especially in terms of training, experience and supervision: the range of available management options and communication of assessment and management, which could all be audited. This study set out to examine the level of training and supervision that junior doctors working in psychiatry have received in comparison with these standards. These standards are:

(a) Someone new to the task should undertake observed assessments – that is, assessing the patient under direct supervision – until judged competent. In at least five cases the supervisor should make face to face contact with the patient during the course of the trainee's assessment.
(b) Relevant literature should be pointed out to new staff (or copies provided), for example concerning well-established facts about risk of suicide and repetition.
(c) During the first six months of carrying out assessments, every case should be supervised. Out of hours assessments should routinely be discussed with the on-duty consultant or senior registrar.
(d) For those rotational senior house officers (pre-MRCPsych Part 1 SHO) who have previously undertaken work of this kind, not every case need be discussed in detail, but a brief discussion of management

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should take place with a designated supervisor in every case. Registrars (post-MRCPsych Part 1 SHO) in psychiatry should have the experience to decide when to discuss management with a more senior person (Royal College of Psychiatrists, 1994).

Targeting this group seems appropriate since they seem to carry out the majority of specialist assessments following DSH (Butterworth & O'Grady, 1989; Owens & House, 1994).

The study

A questionnaire was sent to all senior house officers (SHOs) and registrars in psychiatry and general practitioner trainees working in adult or old age substantive posts in the Trent Region. Names were requested from postgraduate secretaries in each hospital and clinical tutors approached. Questionnaires used alternate and multiple choice items along with requests to estimate for example percentage of cases supervised and space for open ended replies. Because of anonymity of replies, repeat mailing of non-responders was not possible. (A copy of the questionnaire is available upon request from the author.)

Findings

Sixty-five of the 105 questionnaires were returned (62%). Of these four were unratable. Twenty-nine doctors (48%) worked in services in which assessments were undertaken by a multi-disciplinary team; 11 of these had never been involved with assessments of DSH. The results are therefore based on the remaining 50 replies, although these contained occasional omissions. Doctors had spent an average of 23.4 (s.d.=20.5) months working in psychiatry.

Only 5 (10%) had undertaken observed assessments during the first month assessing DSH and 33 (66%) remember being directed to relevant literature. Seven (14%) were directed to chapters in a book or articles in journals and 13 (26%) were given handouts. In the first six months the median level of supervision was 30% (range 0–100%) of cases seen both in and out of working hours. Fourteen (28%) felt they had needed more supervision in working hours. Five found senior cover unavailable but none suggested that senior cover was unapproachable, although seven specified no reason for not being able to get more supervision and two could only receive delayed supervision. Out of hours the situation was similar with 29% (12 of 42) feeling they had needed more supervision but a specified problem was only mentioned in one reply. Although those who had wanted more supervision had a median of 25% (range 0–75%) of cases supervised compared with a median of 50% (range 1–100) for those who felt they had been adequately supervised there was no statistical difference between them (Mann–Whitney *U*-test). Those, the start of whose training pre-dated the consensus statement, were supervised on 22.5% (range 0–95%) and 10% (range 0–60%) of cases in and out of working hours respectively in the first six months of their training compared with 33% (range 5–100%) and 30% (range 0–100%) respectively of those starting after. This improvement was not statistically significant (Mann–Whitney *U*-test).

Of the 50, 39 (78%) were in a post in which they currently assessed DSH. The average experience in psychiatry of these was 22.3 months (s.d.=21.5). The median levels of supervision were 25% (n=37, range 0–100%) and 20% (n=35, range 0–100%) of cases seen, during and out of working hours respectively. SHOs with more than six months' experience (n=16, mean experience of 23.3 months) were supervised on a median of 22.5% (range 1–100%) and 10% (range 0–50%) of cases in and out of hours, respectively, whereas registrars (n=9, mean experience of 46.6 months) were supervised on 25% (range 0–90%) and 20% (range 0–50%) of cases respectively.

Examination of experience and level of supervision showed no correlation (Spearman's rank order correlation, R=0.07, NS). Only five felt they had needed more supervision either in or outside working hours, although four of these had received greater than the median level of supervision.

Fifty-four per cent of those responding felt that there was a satisfactorily private and safe room in which to interview patients following DSH in accident and emergency and 79% on the general ward.

Comment

The response rate was comparable with other questionnaire studies of trainees (for example, Herriot *et al*, 1994). Anonymity precluded comparison of those who responded with those who did not, but since the majority felt adequately supervised the sample is unlikely to be biased towards those who did not.

There were more doctors working with multi-disciplinary teams than would be expected by the 14% of health authorities reporting to be using teams in 1989 (Butterworth & O'Grady, 1989). This may suggest an increased use of teams since then or it may be that centres with teams may be larger and therefore have a greater number of doctors. Alternatively, since 11% indicated that both teams and junior doctors were involved in assessments, perhaps a number of doctors worked in parallel to teams of other

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professionals. Only five doctors had undertaken observed assessments, although four of these had been in services with multi-disciplinary teams. This may reflect a higher priority given to DSH by some services resulting in both the development of teams and better training. Although a majority had been directed to or given literature concerning facts about risk of suicide and repeated DSH, 34% had not. Enquiry about other training before undertaking such assessments was not examined but may be lacking.

Levels of supervision varied greatly. Although retrospective estimates may be inaccurate, it was clear that in the first six months very few doctors were supervised routinely. Indeed only 9 and 7% reported 75% or more of cases discussed in and out of working hours respectively. The subjective need for more supervision related poorly to the level of supervision received in the first six months and there was no correlation between experience and current level of supervision. The latter finding may have been affected by those with significant experience in psychiatry who are working in services with multi-disciplinary teams whose first experience of DSH assessments is at this stage of their training. There is still no correlation if doctors working in multi-disciplinary teams are excluded ($R=-0.05$, $n=22$). There are a number of doctors with little experience and little supervision.

Perhaps junior doctors are poor judges of their need to discuss cases and part of the learning process is understanding when to ask. Perhaps more junior doctors are less confident about asking, although senior cover did not seem unapproachable. Alternatively, regular discussions may be regarded as an additional unwanted intrusion into a busy day or perhaps as unhelpful. Although there may have been some recent improvement, the common practice of 'call me if there is a problem' is probably inadequate and services need to be organising to enable routine proactive supervision to occur.

Eleven doctors were excluded because they had no experience of assessing DSH because they were not part of a DSH team. Sixty-four per cent of these were general practitioner trainees gaining their six months' psychiatric training. This represents 39% of all general practitioner trainees who responded. Since up to 30% of DSH patients do not reach hospital (Kennedy & Kreitman, 1973) this may be significant, although no enquiry was specifically made about the training they had received.

This study focused on limited training and supervision standards for junior doctors working in psychiatry. Many of these findings are perhaps of little surprise but should not be devalued as a result. The difference good assessment would make could be argued since to date it is unclear if any intervention influences rate of repetition or eventual suicide. The studies on which such an argument would be based, however, are of low power and have found improvements in other outcome measures. In addition good assessment to engage the patient is a prerequisite to enable any intervention a chance to succeed. The consensus statement provides an impetus to change. Wider knowledge of the existence of it, particularly in the absence of central Government strategy gives direction to the development of these important services and standards for purchasers and for local audits.

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