the columns

correspondence

Recruitment and selection into specialty training

Recruitment into specialty training in psychiatry has been a bruising and demoralising experience for both trainees, fearful of their employment opportunities, and their seniors, concerned for the future of specialty training in the UK (*Psychiatric Bulletin*, November 2007, **31**, 401–403).

We conducted an online survey of trainees in psychiatry in the North East rotation scheme. We obtained 56 responses (out of 150) from trainees of different grades. The majority (70%) reflected that the new single application for training programme through Modernising Medical Careers was unfair. Slightly more than half of the trainees (54%) would prefer structured interview as a method of selection, compared with knowledge-based tests (14%), work experience (14%), academic records (5%) and other means of selection, for example a mixture of the above (13%). Almost all of the trainees (95%) thought that Modernising Medical Careers was rushed and poorly communicated. The majority (82%) believed that specialty recruitment should be managed at a local basis at deaneries and more than half (54%) did not agree that the application process through a national IT system is a good technical solution.

The selection process into specialty training should be introduced gradually, with effective piloting and adequate resources. It is essential to support trainees who faced difficulties when the system came into effect last year.

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Pain and self-harm

Some older people with pain-related physical problems are at high risk of suicide (*Psychiatric Bulletin*, March 2008, **32**, 92–95). This is a neglected field of research.

We carried out a retrospective case note study of all individuals admitted to a general hospital after presenting to accident and emergency with self-harm and concurrent medical problems. Pain contributed to the episode of self-harm in 4% of cases. The mean age of these individuals was 46 years; 60% had experienced pain for over 6 months and 35% had a history of psychiatric disorder. They had a significantly higher suicidal intent associated with their acts of self-harm than those with non-painful physical problems (44% *v.* 30% respectively).

We recommended closer collaboration between general hospital services and local pain clinics for treating individuals with painful disorders who self-harm. Furthermore, we would encourage all clinicians to assess suicidal ideation and risk of self-harm when prescribing for this group. This is particularly important when considering prescribing analgesics or tricyclic antidepressants.

Further reading

THEODOULOU, M., HARRISS, L., HAWTON, K., *et al* (2005) Pain and deliberate self-harm: an important association. *Journal of Psychosomatic Research*, **58**, 317–320.

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Supplementary prescribing by nurses

Nurse supplementary prescribing can improve patient care (*Psychiatric Bulletin*, April 2008, **32**, 136–139). It can provide greater patient choice and a better use of nurses' skills and knowledge (National Prescribing Centre, 2005). Although it is not clear where supplementary prescribing will be most useful, community settings (crisis team or memory clinics) seem the most appropriate places where supplementary prescriber can work independently. In these settings the nurse prescriber can, based on the clinical management plan, repeat prescriptions, adjust dose, switch and stop the medications (Gray *et al*, 2005).

Nurse prescribing in acute in-patient setting is more complex. New Ways of Working suggests that a consultant should focus on more complex cases where delegation of medical work would fall outside the competence of even the most highly trained nurse. The in-patient bed reduction and strengthening of community services by the crisis resolution and first-episode psychosis teams have ensured that only the individuals with the most complex illnesses are now admitted to acute psychiatric in-patient units. Surely their management should be a consultant's responsibility?

At the same time there is an increasing shift towards the functional model of working. The in-patient units are now more likely to have a dedicated consultant. They may limit the role of nurse supplementary prescriber, who may in turn increasingly take on the role of psychiatric trainees. This can lead to role confusion within clinical practice. There is also a risk that, in the in-patient units, supplementary prescribing may be used as a short cut to shore up differences caused by the reduction in junior doctor hours or even replace traditional roles of junior medical staff.

The complex shift patterns on the in-patient unit are another issue. In order to ensure a 24-hour nurse prescribing cover, a larger number of qualified nurses might need to be trained, and that may not be feasible.

As the number of supplementary prescribers increases and more sound research becomes available, it will become clearer which practice settings are most useful for supplementary prescribing.

NATIONAL PRESCRIBING CENTRE (2005) *Improving Mental Health Services by Extending the Role of Nurses in Prescribing and Supplying Medication. Good Practice Guide*. NPC.

GRAY, R., PARR, A. & BRIMBLECOMBE, N. (2005) Mental health nurse supplementary prescribing: mapping progress 1 year after implementation. *Psychiatric Bulletin*, **29**, 295–297.

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