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How much risk training takes place in mental health services?†

A national survey of training and policies

AIMS AND METHOD

The main aim of the study was to establish the proportion of hospital trusts in England and Wales in which training in the assessment of suicide risk and risk of harm to others is available to mental health professionals. A questionnaire was sent to clinical directors covering training on these subjects and in mental health legislation, details of training and the existence of risk-related policies.

RESULTS

Seventy-six per cent of trusts said they provided training in suicide risk assessment for junior psychiatrists; for hospital and community nurses, the figure was just over 50%. Between 50% and 60% of trusts said they provided training in the assessment of risk of harm to others. Provision of training in mental health legislation was said to occur in most trusts. In some key areas of risk management, hospital policies were uncommon.

CLINICAL IMPLICATIONS

Despite the current importance of risk assessment in mental health services, many hospital trusts do not provide their staff with relevant training.

Training in risk assessment has become an important area of clinical practice in mental health. *Saving Lives: Our Healthier Nation* (Department of Health, 1999*a*) sets a new suicide prevention target (20% reduction by 2010) and states that training is a key element of suicide prevention. The recent National Service Framework for Mental Health highlights the need for training in risk management (Department of Health, 1999*b*). Many of the local inquiry reports after homicides by those who have had contact with mental health services highlight problems in risk assessment and recommend training (Lingham *et al*, 1996; Mishcon *et al*, 1995; Ritchie *et al*, 1994). It is the policy of the Royal College of Psychiatrists that there is an induction training in risk assessment for new staff and continuing training for established staff (Royal College of Psychiatrists, 1996). We therefore conducted a survey to establish how widespread training in risk assessment is in mental health services in England and Wales. To our knowledge there has been no previous national review of the amount and content of such training.

The study

A questionnaire on training and policies was sent to clinical directors in the 193 trusts in England and Wales providing mental health services within the NHS. The survey was conducted during 1998. The questionnaire was constructed to cover three main areas of training: the assessment of suicide risk, the assessment of risk of harm to others and mental health legislation. It enquired about the availability of training to three groups of staff: junior psychiatrists, community psychiatric nurses and hospital ward nurses. Questions about the content of risk assessment training made specific reference to the learning of assessment skills as well as the provision of information. On mental health legislation training, there were questions on discharge planning – there is a high risk of suicide on discharge from in-patient care (Appleby *et al*, 1999) – the Care Programme Approach and the supervision register. Additional questions concerned the frequency of training, the availability of follow-up training and whether courses were compulsory (see Tables 1–3).

A fourth section to the questionnaire asked whether trusts had written policies covering aspects of the clinical management of high risk patients including responses to non-attendance and non-compliance (see Table 4).

Clinical directors were asked to complete all sections of the questionnaire, if necessary after consultation with colleagues, and to exclude from their replies general professional courses, such as MRCPsych courses, because the study was examining training within the NHS.

Findings

We received replies from 159 trusts – a response rate of 82%. The main findings were as follows. Seventy-six per cent of trusts provided training to junior psychiatrists on suicide risk assessment but only approximately half provided such training to community psychiatric or ward nurses. Just over half the trusts provided training in the assessment of risk of harm to others for all three professional groups. Most trusts provided training in mental health legislation. Most risk assessment training was said to include skills as well as information. It was usually provided at least once a year but was generally not compulsory. Follow-up training occurred in approximately half the trusts. The existence of written policies varied. Almost all trusts had policies on the observation of in-patients. Only one-third had policies on responding to non-compliance and non-attendance.

Additional comments made by respondents followed three themes. First, training was provided but it was not compulsory and so attendance by staff was low, often because staff were unable to take time off

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original papers

Table 1. Training in assessment of suicide risk

	Junior psychiatrists (*n*=149)	Community psychiatric nurses (*n*=152)	Ward nurses (*n*=149)
Does your trust provide training in suicide risk assessment for the professional groups mentioned?	113 (76%)	79 (52%)	80 (54%)
Which of these courses run once a year (or more often)?	107 (95%)	58 (74%)	61 (77%)
Is the training run by outside agencies?	8 (7%)	26 (33%)	22 (28%)
Do you provide follow-up training after initial training?	67 (59%)	41 (53%)	40 (51%)
Does training include teaching on risk factors for suicide?	112 (99%)	74 (95%)	74 (94%)
Does training include information on how to assess suicidal ideas?	109 (96%)	71 (92%)	75 (95%)
Does training include risk assessment skills?	80 (71%)	61 (79%)	63 (80%)
Is training compulsory?	71 (63%)	24 (31%)	26 (33%)

Table shows number of trusts responding positively to each question. The percentage for the first question is calculated using the number of replies as the denominator, but in the following questions the denominator is the number of trusts known to provide training.

Table 2. Training in assessment of risk of harm to others

	Junior psychiatrists (*n*=146)	Community psychiatric nurses (*n*=148)	Ward nurses (*n*=143)
Does your trust provide training in assessment of risk of harm to others for the professional groups mentioned?	87 (60%)	78 (53%)	77 (54%)
Which of these courses run once a year (or more often)?	75 (86%)	58 (74%)	60 (78%)
Is the training run by outside agencies?	17 (20%)	28 (36%)	26 (34%)
Do you provide follow-up training after initial training?	51 (59%)	39 (50%)	40 (52%)
Does training include teaching on risk factors for harm to others?	81 (93%)	71 (91%)	70 (91%)
Does training include information on how to assess ideas of harm to others?	74 (85%)	64 (82%)	64 (83%)
Does training include risk assessment skills?	67 (77%)	61 (78%)	60 (78%)
Is training compulsory?	48 (55%)	26 (33%)	25 (33%)

Table shows the number of trusts responding positively to each question. The percentage for the first question was calculated using the number of replies as the denominator, but in the following questions the denominator is the number of trusts known to provide training.

Table 3. Mental health legislation

	Junior psychiatrists (*n*=147)	Community psychiatric nurses (*n*=150)	Ward nurses (*n*=148)
Does your trust provide training in the use of the Mental Health Act and other relevant legislation for the professional groups mentioned?	132 (90%)	128 (85%)	137 (93%)
Which of these courses run once a year (or more often)?	120 (91%)	108 (84%)	118 (86%)
Is the training run by outside agencies?	42 (32%)	52 (41%)	49 (36%)
Do you provide follow-up training after initial training?	95 (72%)	99 (77%)	105 (77%)
Does training include the use of the Care Programme Approach?	113 (86%)	118 (93%)	174 (91%)
Does training include the use of the supervision register?	107 (81%)	115 (90%)	118 (86%)
Does training include discharge planning, including Section 117?	117 (89%)	117 (91%)	126 (92%)
Is training compulsory?	79 (60%)	67 (52%)	76 (56%)

Table shows the number of trusts responding positively to each question. The percentage for the first question was calculated using the number of replies as the denominator, but in the following questions the denominator is the number of trusts known to provide training.

from their clinical commitments. Second, training was said to be planned for the future in many places where it was not currently taking place. Third, staff also received training elsewhere, in particular, on the wards as part of their routine clinical work or on specific courses, for example, MRCPsych.

Comment

The response rate in this study was satisfactory and the questionnaires provided a simple way of recording information. However, we do not know how accurately they were completed. Clinical directors may have overstated

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Table 4. Mental health policy

Written policies on:	*n* trusts responding positively to each question (%)
How the results of risk assessment should be communicated to other health professionals (*n*=151)	55 (36)
How staff should respond to non-compliance (*n*=149)	46 (31)
How staff should respond to non-attendance (*n*=146)	50 (34)
Multi-disciplinary case review after suicide (*n*=152)	102 (67)
Observation on in-patient wards (*n*=151)	144 (95)
Informal leave of patients (*n*=149)	93 (62)
How staff should respond to absconding patients (*n*=150)	133 (89)

n=the number of replies.

the availability of training because of what they believed to be the case, or may have reported training that was available but poorly taken up because of other demands. These sources of error may have inflated our figures and the lack of training in risk assessment may be more widespread than our findings suggest. If so, this should be a source for concern. Nursing staff in particular appear to have fewer opportunities for training than their medical colleagues. There is evidence that such training can improve skills (Morris *et al*, 1999) and front-line staff need opportunities to develop and maintain their knowledge and skills in these key areas.

It appears from this survey that the recommendations on training from the Department to Health and College reports, as well as from homicide inquiries, are not followed in many trusts. We would support a national programme of regular, possibly compulsory, training for front-line professionals funded by regional education training consortia and other postgraduate educational sources.

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Psychiatrists' views of in-patient child and adolescent mental health services: a survey of members of the child and adolescent faculty of the College

AIMS AND METHOD

To obtain a prioritised list of psychiatrists' concerns relating to in-patient child and adolescent mental health services. Four-hundred and fifty-four members of the child and adolescent faculty of the Royal College of Psychiatrists were asked to list their main concerns.

RESULTS

Two-hundred and seventy-four members responded. The most reported themes included lack of emergency beds; lack of services for severe or high-risk cases; lack of beds in general; poor liaison with patients' local services; lack of specialist services; and poor geographic distribution of services.

CLINICAL IMPLICATIONS

The range of themes identified from this survey have served to focus the National In-patient Child and Adolescent Psychiatry Study (NICAPS) and several design changes have been made to NICAPS as a result.

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