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.

References

APPLEBY, L., SHAW, J., AMOS, T., *et al* (1999) *Safer Services. Report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness*. London: Department of Health.

DEPARTMENT OF HEALTH (1999*a*) *Saving Lives: Our Healthier Nation*. London: HMSO.

— (1999*b*) *National Service Framework for Mental Health*. London: Department of Health.

LINGHAM, R., CANDY, J. & BRAY, J. (1996) *The Report of the Inquiry into the Treatment and Care of Raymond Sinclair*. Kent: West Kent Health Authority and Kent County Council.

MISHCON, J., DICK, D., WELCH, N., *et al* (1995) *The Report of the Independent Inquiry Team into the Care and Treatment of Kenneth Grey*. London: East London and the City Health Authority.

MORRIS, R., GASK, L. BATTERSBY, L., *et al* (1999) Teaching frontline health and voluntary workers to assess and manage suicidal patients. *Journal of Affective Disorders*, **318**, 77–83.

RITCHIE, J., DICK, D. & LINGHAM, R. (1994) *The Report of the Inquiry into the Care and Treatment of Christopher Clunis*. London: HMSO.

ROYAL COLLEGE OF PSYCHIATRISTS (1996) *Assessment and Clinical Management of Risk of Harm to Other People*. Council Report, CR53. London: Royal College of Psychiatrists.

Acknowledgements

We would like to thank the clinical directors who completed their questionnaires.

Sue Davies Research Associate, **Tim Amos** Clinical Research Fellow, ***Louis Appleby** Professor of Psychiatry, National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, PO Box 86, Manchester MA0 2SF, e-mail: Louis.Appleby@man.ac.uk

Psychiatric Bulletin (2001), **25**, 219–222

ADRIAN WORRALL AND ANNE O'HERLIHY

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.

https://doi.org/10.1192/pb.25.6.219 Published online by Cambridge University Press

original papers

In-patient child and adolescent mental health services treat and care for the most severely ill and disturbed young people. NHS provision is insufficient to meet the need and as a result children and young people are often admitted to independent sector units or inappropriately to adult psychiatric wards or paediatric wards. Although it is accepted that units are diverse in terms of their admission criteria and models of care, there is little information about the service available. The Department of Health has responded to this by funding the National In-patient Child and Adolescent Psychiatry Study (NICAPS), a comprehensive and detailed review of these services in England and Wales.

Previous reviews, which included in-patient services (NHS Health Advisory Service, 1986, 1995; Audit Commission, 1999), identified two key themes: (a) a lack of services for those aged 16–18; and (b) a need for better coordination of services and joint working. Other themes included problems with staffing, proximity of services to patients' homes and provision of emergency services. The provision of emergency beds, staffing and outcomes for specific disorders have also been identified as issues for in-patient services (Cotgrove & Gowers, 1999).

The first stage of NICAPS was a survey of members of the child and adolescent faculty to obtain their views about the key issues for these services.

Method

A questionnaire was sent to all 474 members of the Royal College of Psychiatrists' child and adolescent faculty with addresses in England or Wales. A single question was asked: "Briefly, what do you think are the main issues relating to child and adolescent psychiatric in-patient services?" A follow-up letter was sent 4 weeks after the first forms were posted.

A content analysis was conducted on the responses. First, the free text replies were broken down into component statements or 'text units'. The two authors reviewed the statements and independently created a coding frame that would fit these qualitative data. The two coding frames were then compared and a final version was negotiated. The authors then independently coded the statements and any discrepancies in the coding of text units were discussed and resolved.

Results

Two-hundred and seventy-four forms were returned. These included 29 that were returned with no comment, giving a total of 245 usable replies. Further investigation indicated that addresses were incorrect for approximately 10% of non-responders and we adjusted the denominator to 454 members, resulting in a 60% response rate.

The 245 usable replies provided 1033 distinct statements. A total of 38 themes were derived from these statements. These formed the basis of the coding frame. There was consensus between the raters regarding the coding of statements.

Table 1 displays the range of commonly occurring themes and the frequency with which they were identified by respondents. The most frequently reported were lack of emergency beds and facilities (36%); insufficient number of beds (25%); poor provision for severe or high-risk cases (24%); and poor liaison with other services (20%).

Discussion

The single open question proved an effective method of obtaining psychiatrists' views. The alternative of providing categorised response options might have influenced or constrained respondents' replies.

There are some limitations to the study. First, the response rate was only 60%. We do not therefore claim the results to be representative, but rather illustrative of the range of issues relevant to faculty members. Second, the frequency of the responses is dependent upon the coding system, for example we could have combined lack of beds with staffing or funding problems in a more frequent general resources theme. Third, the most important comments may not necessarily have been the most often reported.

Emergency beds/facilities

Provision of emergency facilities was the most frequently reported theme among the psychiatrists surveyed. Respondents who raised this theme commonly expressed concerns about the admission of young people in crisis to paediatric or adult psychiatric wards. Statements typically referred to the 'need for emergency beds' and the 'lack of emergency admission services'. The lack of quantifiable estimates of need for emergency services has been previously highlighted as an important related problem (Cotgrove, 1997). This is particularly pertinent in light of the recent finding that over one-third of trusts felt they could not respond effectively to young people presenting in a crisis (Audit Commission, 1999).

Numbers of beds

Some respondents referred to the fact there were no child and adolescent psychiatric in-patient services available in their area. They reported that even for routine admissions patients were often accommodated in either paediatric wards or adult psychiatric wards until they could be placed out of the area or were well enough to be otherwise discharged.

Provision for adolescents appears to be a particular concern (NHS Health Advisory Service, 1986). The Audit Commission has reported that one in five health authorities are 'unclear' about the age ranges covered by their services and one in three commission services only for those up to the age of 16. They conclude that "despite several specific reviews of adolescent care, services for young people remain patchy".

https://doi.org/10.1192/pb.25.6.219 Published online by Cambridge University Press

original papers

Liaison with other services

Many respondents commented that effective communication between local services is important to 'ensure timely admissions and discharge with effective follow-up'. Others reported the difficulties they experienced establishing joint working with other agencies and locally-based services. Problems integrating with local services were attributed to the fact that 'most units are regionally focused'.

Previous reports have highlighted problems of joint working (NHS Health Advisory Service, 1986, 1995; Audit Commission, 1999). The Audit Commission commented specifically on the difficulties when several health authorities fund a unit.

Provision for severe or high-risk cases

Many respondents were concerned about the inadequate provision for those who are severely ill and in need of secure accommodation. Statements that typify this concern include "units are unable to admit seriously disturbed young people" and "there is a need for more forensic services or secure and semi-secure services". It is likely that at least some young people admitted to adult psychiatric wards are those with severe psychiatric illnesses whose needs cannot be met by in-patient child and adolescent mental health services. One respondent commented that in-patient services only offer a "modified residential provision of Tier 3 services" and that "they do not cater for the urgent placement of very disturbed or forensic patients".

Many respondents (17%) emphasised a need to increase the range of specialised units catering for severe or high-risk cases. In particular, specialist units for 'acute psychiatric' conditions were reported to be lacking, as were facilities for children suffering from conduct disorder and children suffering from psychiatric problems and learning difficulties. Concern about lack of provision for severe or high-risk patients and the lack of specialist services was not specifically identified in previous reports.

A joint working group of the adult and child and adolescent faculties is considering the problem of admission of young people to adult psychiatric wards, which relates to the three most common themes reported. The *National Service Framework for Mental Health* (Department of Health, 1999) refers to the admission of adolescents to adult wards and recommends protocols should be agreed locally between adult and child and adolescent mental health services.

There may be no solution to the lack of beds generally and the lack of specialist and emergency provision other than to provide more resources. Communication between agencies, however, might be more amenable for more local action.

As a result of this survey several changes were made to the design of NICAPS. For example, NICAPS will now look more closely at emergency referrals made to child and adolescent in-patient services and other local services. Concern about poor provision for high-risk cases will be explored by asking for the reasons why young people are not admitted and are turned away. Also, information will be obtained during site visits about the units' liaison with the patients' local services.

Conclusion

The survey identified a range of themes that have served to focus NICAPS on pertinent issues. It has also informed the design of the data collection tools. The data collected throughout the course of NICAPS will enable further exploration of the issues raised both by this survey and by previous reports.

Table 1. Range and frequency of commonly occurring themes, as reported by Child and Adolescent Faculty members

Rank	Sub-theme	Frequency *n* (%)
1	Lack of emergency beds and facilities	89 (36)
2	Lack of beds	61 (25)
3	Poor provision for severe or high-risk patients	58 (24)
4	Insufficient liaison with the patients' local services	50 (20)
5	Poor geographical proximity	45 (18)
6	Need for increased range of specialist services	41 (17)
6	Admission criteria too selective	41 (17)
7	General poor planning of services – geographic distribution of services	40 (16)
8	Difficulties finding a bed and long waits for admission	35 (14)
9	Funding problems	32 (13)
10	Concern about where to manage conduct disorder and 'social admissions'	30 (12)
11	Problems recruiting nursing and multi-disciplinary staff	27 (11)
13	Need for standards and guidelines	25 (10)
14	Need for training – maintaining a high level of skill including therapeutic skills	23 (9)
15	General problems with treatment – need for a wider range of treatments	22 (9)
17	Problems with patients' length of stay – impact of inadequate local services	20 (8)
17	Managing patients in other settings	20 (8)

Only themes that were reported by more than 20 members are included in the table.

https://doi.org/10.1192/pb.25.6.219 Published online by Cambridge University Press

original papers

References

AUDIT COMMISSION (1999) *Children in Mind: Child and Adolescent Mental Health Services*. London: Audit Commission.

COTGROVE, A. (1997) Emergency admissions to a regional adolescent unit: piloting a new service. *Psychiatric Bulletin*, **21**, 604–608.

— & GOWERS S. G. (1999) Use of an adolescent in-patient unit. *Advances in Psychiatric Treatment*, **5**, 192–201.

DEPARTMENT OF HEALTH (1999) *National Service Framework for Mental Health. Modern Standards & Service Models*. London: Department of Health.

NHS HEALTH ADVISORY SERVICE (1986) *Bridges Over Troubled Waters. A Report from The NHS Health Advisory Service on Services for Disturbed Adolescents*. London: NHS Health Advisory Service.

— (1995) *Together We Stand*. London: NHS Health Advisory Service.

***Adrian Worrall** Senior Research Worker, **Anne O'Herlihy** Research Worker, The Royal College of Psychiatrists' Research Unit, 83 Victoria Street, London SW1H 0HW

Psychiatric Bulletin (2001), **25**, 222–225

VIBHORE PRASAD AND DAVID OWENS

Using the internet as a source of self-help for people who self-harm

AIMS AND METHOD

To describe the information and help available on the internet for people who self-harm. We searched the internet using a meta-search engine. We visited sites and followed up links with e-mails and letters. We also searched bibliographic databases, seeking published material about the internet and self-harm.

RESULTS

The support that we found largely took the form of information about suicide, self-injury and psychological issues. Less often, sites offered e-mail support and online discussions. We found little information about self-poisoning, and most about self-injury. There is little published research about self-harm and the internet.

CLINICAL IMPLICATIONS

The unregulated sites of the internet contain much material about self-injury. Although it is not possible at present to weigh up risks and benefits, many individuals and organisations plainly regard internet information about self-harm as a valuable service.

Hospital contacts for self-harm in the UK are higher now than at any time (Hawton *et al*, 1997) and may account for more than 150 000 hospital attendances in the UK each year. Many more episodes do not lead to hospital attendance. In recent years the internet has been a growing resource for information and communication, used increasingly by patients. Aware that many people who undertake self-harm seek and find ways of reducing their distress, we wanted to investigate, characterise and describe to medical professionals the help resources available on the internet for people who self-harm. We attempted to search the internet systematically, rather as one might undertake a conventional systematic review of published literature.

The study

Web searching

Our first step was to use the search engine metacrawler (http://www.metacrawler.com). This is a 'meta'-search engine that works by querying the other search engines, organising the results into a uniform format, ranking them by relevance and returning them to the user. It combines the results of several search engines (about.com, altavista, excite, goto.com, infoseek, looksmart, lycos, thunderstone, webcrawler and yahoo!). We searched the term DELIBERATE SELF-HARM followed by DELIBERATE SELF HARM; they brought similar results. We searched for DELIBERATE SELF HARM on three separate days to discover whether time lapse would yield significantly different results. We also searched the terms ATTEMPTED SUICIDE and SUICIDE SELF HELP and performed a search for the phrase HOW TO COMMIT SUICIDE. In addition, we used the facilities provided by http://www.about.com – a network of websites organised by 'expert guides'.

We visited a site if the annotations under the title of its page suggested that it would provide self-help for people who self-harm. We followed links within sites with the same strategy. Where we obtained information that pointed to sources of further information we (V.P.) contacted the sources by e-mail or letter, explaining the nature of the study and requesting further information. At no time did the searcher enter discussion forums because of the ethical considerations: these forums offer help and are not aimed at health professionals. In the Findings, set out below, we have selected, from the scores of sites found, a few examples that we think illustrate the characteristics of self-harm related websites, and ones that we think may be useful resources.

Searching for published literature about self-help on the internet

Medline was searched from 1997 to March 2000. The subject terms DELIBERATE SELF HARM, SELF-INJURIOUS

https://doi.org/10.1192/pb.25.6.219 Published online by Cambridge University Press