

# Working within child and adolescent mental health inpatient services

A PRACTITIONER'S HANDBOOK BY ANGELA SERGEANT

Edited by Dr Chris Barrett



National Workforce Programme  
Child and Adolescent Mental Health

National CAMHS Support Service



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This handbook was commissioned by the National CAMHS Workforce Lead. It has been developed with the assistance of the Quality Network for Inpatient CAMHS (QNIC) membership and is endorsed by the project's executive committee.

This resource is accredited by the Royal College of Nursing Accreditation Unit as at August 2009.

The content was collated from relevant text and best practice guidelines. It draws upon existing literature and presents some clinical scenarios and discussion questions to aid your learning. The reference list at the end identifies the sources of evidence cited within the handbook. In addition, a few specific reading materials are listed at the end of each chapter as suggested further reading. Reference to all these documents should further advance the knowledge of individuals providing care within CAMHS inpatient units.

Learning outcomes are provided at the beginning of each chapter of this workbook. They have been mapped to the following core functions/indicators;

- Skills for Health; Core Functions-Child and Adolescent Mental Health Services Tiers 3 & 4 (Specialist Targeted)
- Health and Social Care
- Mental Health
- Children's Services
- Children's Care, Learning, and Development (CCLD)
- National Indicators for Local Authorities and Local Authority Partnerships (Annex 2)

These can be found at:

[www.skillsforhealth.org.uk](http://www.skillsforhealth.org.uk)

[www.cwdcouncil.org.uk](http://www.cwdcouncil.org.uk)

[www.communities.gov.uk](http://www.communities.gov.uk)

# Introduction





## Who is this handbook designed for?

This handbook is designed to provide practitioners, working in generic Tier 4 Child and Adolescent Mental Health Services (CAMHS), with an overview of the key issues related to working within inpatient settings. Nevertheless, the workbook may be of interest to many individuals, currently working in any of the CAMHS Tiers 1-4 in a variety of locations and fulfilling different care roles (Table 2) or to staff working in Adult Mental Health services that admit young people under the age of 18. Many practitioners have specific and transferable skills that support these roles within the specialist CAMHS field.

However, this handbook identifies the unique skills and qualities that are required to work in inpatient care. It is designed to help teams currently working in Tier 4 inpatient CAMHS. Obviously the workforce skills required within inpatient treatment in the future are likely to be very different. The impact of proposed change on Tier 4, including the impact of shorter inpatient stay time, will require service providers to review the skill set. QNIC (Quality Network for Inpatient CAMHS 2009) reports a huge variation in the current length of stay of inpatient units, with an average being 3-4 months. Kurtz (2009) highlights the development of intensive community teams which will alter the focus of inpatient treatment, with increasing emphasis on symptom stabilisation and minimum necessary change before rapid discharge of the client. Collaborative workforce planning is important in preparing a specialist workforce supporting this change and requires co-ordinated financing, commissioning and delivery of appropriate training and education. Elements of this handbook will require updating as the service provision alters over time.

This handbook is particularly useful for staff members who are entering a Tier 4 inpatient setting for the first time, regardless of professional discipline. Additionally it could support ongoing development of individuals to produce a knowledgeable and skillful practitioner in CAMHS. There are fine examples of existing training manuals such as the excellent "New-to-CAMHS Teaching Package: Heads Up Scotland" (NES 2007) and relevant texts such as "Inpatient Child Psychiatry: Modern Practice, Research and the Future" (Jacobs and Green, 1998). Each chapter has a recommended reading list to direct the reader to key relevant material.

The main educational aim of the handbook is to provide you with a basic foundation of knowledge that can be enhanced by further training, reading and experience gained in clinical practice. Ideally this learning experience should be completed within the first year of inpatient service and could support an induction or preceptorship programme. Depending on your professional background and length of your experience in CAMHS some sections of the handbook may be completed quickly. It is advised however that you use this opportunity to link your theory to practice and allow 'thinking time' to reflect on your involvement as you move through the text. Table 1 on the next page offers a guide for using the handbook over approximately a year's studying and reflecting on practice.

TASK	MONTH 1/2	MONTH 3/4	MONTH 5/6	MONTH 7/8	MONTH 9/10	MONTH 11/12
With your mentor identify the first chapter to read, depending on your gaps in knowledge. Complete chapter and read a minimum of two books from suggested reading list. Use supervision sessions to discuss cases and develop a learning plan.						
Identify a priority chapter for the next 2 months to enhance development of your knowledge and competence. Ensure opportunities for clinical interventions that meet your development plan.						
As you are now halfway through the handbook, you will be able to choose the most appropriate chapter for learning needs. Take time to reflect on the knowledge you have gained and its application to practice.						
Complete your next chosen chapter. A target aim should be to use your advanced knowledge in applying theory to practice and becoming an established member of the inpatient team.						
As you work through the final chapter reflect on the knowledge you have gained and how this had advanced your practice. Discuss clinical scenarios with colleagues and encourage forums for discussion.						
Spend the last two months revisiting any chapters that you wish to revisit. Consolidate your learning within the clinical setting and at the end of this preceptorship period identify your learning needs for year ahead.						

**Table 1: Suggested user guidance for handbook.**

You may choose to develop learning objectives with your supervisor which could be added to your portfolio, as evidence of continued professional development. There is no expectation that you must work through the handbook chapter by chapter. You could consult components of the book as and when appropriate to your personal learning. It may be used to facilitate discussion and reflective practice during clinical supervision. In addition, use of the handbook to generate discussion within small groups may facilitate critical analysis of the care dynamics and clinical scenarios to enhance professional learning in the care team.

It is hoped that by utilising this handbook you will address the core skills and competencies required to work within a CAMHS team and that, regardless of your professional group or qualifications, you will develop knowledge which will improve clinical care. Ultimately the author hopes that sharing this body of specialist knowledge and learning experience will increase confidence of individual team members and overall recruitment and retention within inpatient CAMHS.

Competencies are descriptors of the performance criteria, knowledge and understanding that are required to undertake work activity. They describe what CAMHS staff members need to do and to know in order to carry out this activity, regardless of who performs it. The CAMHS worker should be able to demonstrate that she/he is competent to deliver the following range of functions;

- Effective communication and engagement with children, young people and their families and carers
- Ability to perform assessment of the physical, intellectual, linguistic, emotional and social context of the young person, based on knowledge of agreed developmental norms of the individual child
- Safeguarding and promoting the welfare of the child

- Care co-ordination
- Promoting health and well being
- Ability to support transitions
- Demonstrate multi-agency working
- Communicating information with young people and their families and relevant agencies
- Contribute to professional development and learning

*Adapted from: The Skills for Health; Core Functions: Child and Adolescent Mental Health Service (Skills for Health, 2007)*

The client group which is the focus of the handbook is children and adolescents. This group will be referred to using the umbrella term of “**young people**”. Specifically, the terms child and children will be used only in relation to those under the age of twelve. The reader may recognise that this handbook is primarily focused on adolescents, as this age group represent over 90% of the current inpatient bed numbers. Where the content relates specifically to children, whose needs are very special and distinct, this is indicated. There are elements of the handbook which would support learning within ‘Child’ centred inpatient units. These units have their own specific expert advisory groups such as the Child Psychiatry Specialist Inpatient group which may be able to provide further guidance.

**Table 2: The variety of locations and care roles in CAMHS Tiers 1-4**

**TIER 1** At this level CAMHS are provided by practitioners who are not mental health specialists working in universal services. They include GPs, health visitors, school nurses, teachers, social workers, youth justice workers and voluntary agencies. Practitioners offer general advice and treatment for less severe problems, contribute towards mental health promotion, identify problems early in their development, and refer to more specialist services.

**TIER 2** Practitioners at this level tend to be CAMHS specialists working in community and primary care settings in a uni-disciplinary way (although many will work also as part of Tier 3 services). For example, this could include primary mental health workers, psychologists and counsellors working in GP practices, paediatric clinics, schools and youth services. Practitioners offer consultation to families and other practitioners, outreach to identify severe or complex needs which require more specialist interventions and assessment (which may lead to treatment at a different Tier), and training to practitioners in Tier 1.

**TIER 3** This is usually a multi-disciplinary team or service working in a community mental health clinic or child psychiatry outpatient service, providing a specialised service for children and young people with more severe, complex and persistent disorders. Team members are likely to include child and adolescent psychiatrists, social workers, clinical psychologists, community psychiatric nurses, child psychotherapists, occupational therapists, art, music and drama therapists.

**TIER 4** These are essential tertiary level services for children and young people with the most serious problems. This could include day units, highly specialised outpatient teams and inpatient units, secure forensic adolescent units and eating disorders units. Practitioners are team members of specialist neuro-psychiatric teams, and other specialist teams (ie for children who have been sexually abused). The teams usually serve more than one district or region.

*Adapted from Health Advisory Service (1995) Together We Stand. Child and Adolescent Mental Health Services. London: Health Advisory Service.*

## The scope of the handbook

This handbook outlines some of the key themes which expert advisory groups (MDT Professionals workshop members (Appendix 1) and the National CAMHS Nurse Consultant Forum) employed in CAMHS inpatient settings have identified as important for effective working in this challenging environment. In addition, it takes into account the views of young people managed within inpatient care.

It is not designed to replace the need for specific training in children and young people's mental health. It does not cover treatment modalities such as Cognitive Behaviour Therapy (CBT), Dialectical Behaviour Therapy (DBT), Family Therapy or specific diagnostic problems. Information on these topics is already available within higher education curricula, specific training courses and within the specialist academic literature.

## Background drivers

There have been numerous reviews in the last few years that have noted the national changes in CAMHS and its impact on workforce development. The Department for Education and Skills' paper, *Every Child Matters* (DfES 2005) strongly supported the proposition that everyone working with children, young people and families should have a common set of skills and knowledge. Consequently they provided a basic description of areas that could be developed through training, learning and/or experience. The CAMHS Review (DCSF/DH 2008) upheld this recommendation and emphasised the need for CAMHS staff to enhance their specialist skills with a more comprehensive understanding of child development, mental health and psychological well-being.

The 2008 CAMHS review highlighted that the staff with the least experience of mental health issues are often the ones who spend the majority of time with the most vulnerable children. This is especially the case in Tier 4 units, which frequently have a heavy reliance on bank and/or agency staff, or a high proportion of Health Care Support workers within their workforce.

Kurtz's (2007) review of Tier 4 CAMHS in the nine regions of England reported on the type, amount and quality of provision and on commissioning arrangements within each region. The findings suggest an implicit notion that the admission criteria in CAMHS inpatient units may often be based upon the perceived capability of the staff working within that setting and their related skill set. The report raised concerns regarding the lack of staff supervision and access to specialist in-house training during challenging periods. It was apparent that poor staff development, competence and confidence to deal with complex cases had a negative impact upon the retention of staff.

There have been a number of influential documents/papers recommending the development of core skills and competencies across disciplines, such as *New Ways of Working*, (DH 2007a), the *Creating Capable Teams Approach* (DH 2007b) and the *Knowledge and Skills Framework* (DH 2004). In addition, a central feature outlined in the *NSF for Children* (DH 2004a) was the need to modernise and strengthen the workforce. With the establishment of home treatment teams and early intervention services in Child and Adolescent services, it is clear that the type of work carried out by Tier 4 CAMHS nowadays is much more complex and challenging than ever before.

The National CAMHS Workforce Programme supported by the National CAMHS Workforce Subgroup commissioned a project in 2007 exploring *New Ways of Working in CAMHS*. The project concluded that, in view of the aging healthcare workforce there was a need to concentrate on staff development to ensure that the future CAMHS workforce has the appropriate mix of skills and competencies to meet the needs of the population it serves. It recommended that in addition to generic skills, CAMHS workers should be trained, supervised and supported to be capable of delivering a full range of specialist interventions, based upon the best available evidence.

The erosion of skilled CAMHS workers is not a new phenomenon. As far back as the National Inpatient Child and Adolescent Psychiatry Study (NICAPS, 2001) it was clear that there has been a gradual decrease in specialist skills. This report highlighted that this had a profound effect on the quality of the service that was provided. Within CAMHS, nurses are the largest single professional group and make up a quarter of the workforce (Audit Commission, 1999) which highlights just how important it is to recruit and retain skilled, competent and confident nurses within Tier 4 services. A major contributory factor to skills loss in CAMHS was the demise of the English National Board (ENB) 603-Specialist Child and Adolescent nursing course in the 1990s.

Children, young people, and their families and carers, expect nurses to be safe and accountable practitioners. However, as McDougall (2006) highlights there is a lack of pre-registration education and training programmes which adequately address child and adolescent mental health issues. Nationally there are very few post-basic and postgraduate multilevel training programmes for nurses and other CAMHS professionals. Within CAMHS the ENB 603 course was considered the national benchmark for specialist training for nursing staff and was used as an indicator for career progression. Currently there is no equivalent course and there is variation in the content and academic outcomes within similar courses offered by Universities in the UK.

Senior healthcare managers, responsible for Tier 4 units, are acutely aware that recruitment and retention is an ongoing problem. There are increased opportunities for promotion and greater flexibility in the community services and a gradual drift of staff members away from inpatient services. This may leave the care of young people, the most complex and challenging client group, being managed by the most inexperienced staff. The Quality Network for Inpatient CAMHS (QNIC, 2007), noting an impact on both staff morale and effectiveness and service users and their carers, expressed concern about the over reliance of agency staff and the impact on patient and staff safety.

In addition, this report (QNIC, 2007) highlighted that, whilst provision and ability to attend training had improved somewhat, access to training was still an issue. There appeared to be many potential barriers, notably a lack of training budget and/or a lack of staff cover to enable CAMHS staff members to attend training sessions. The report notes that the individuals who could benefit most from undertaking training sessions, tended to be those that were the most difficult to release from ward duties i.e. unqualified and qualified nursing staff. On a more positive note, the report confirmed that CAMHS Inpatient units usually adhered to specific mandatory training for all staff and a locally delivered, annual training plan. This usually consisted of professional development training courses which were focused on specific diagnoses or therapies, for example Dialectical Behaviour Therapy.

Hall (2009) highlights in the foreword of *The Evidence Base to Guide Development of Tier 4 CAMHS* (Kurtz, 2009) that, until recently, Tier 4 specialist CAMHS usually equated to psychiatric inpatient provision, which may have day hospitals attached. However, the service is becoming increasingly comprehensive with multi-agency services; in-reach, outreach, intensive interventions and crisis community initiatives. Nationally there are a number of innovative services which are timely and flexible. However, there are still CAMHS units that are operating in isolation from community services or are unable to provide a seamless service across the care pathway.

There is a range of complex factors that affect the composition and resources of Tier 3 CAMHS and referrals to inpatient treatment are often determined by what can be managed by the community service. The diverse commissioning arrangements may result in the Tier 3 & 4 services being funded by differing organisations, compounding the interface problems. This continues to require the attention of service providers and commissioners to offer better outcomes for people accessing CAMHS services. Green *et al* (2008) recently recommended that in order to optimise effectiveness, inpatient services need to change along with the development of new forms of community services. This textbook relates to the reality of current CAMHS provision but aspires to support the development of the future CAMHS workforce by encouraging the skills of learning, reflection and application of theory to practice.

## Overall learning outcomes

On successful completion of this handbook, coupled with your work within inpatient CAMHS, you should be able to:

- Assume a vital role within the Multi-Disciplinary Team providing high quality care
- Ensure that the care you provide is underpinned by a robust, theoretical knowledge base
- Apply your knowledge of the theoretical approaches to working with children and young people to understand the complexities of inpatient treatment
- Develop the core competencies of a CAMHS worker required in this specialist inpatient service delivery

In addition to these **overall learning outcomes** for the workbook, **specific learning outcomes** are identified at the beginning of each chapter. The workbook content provides a choice of proven learning and teaching approaches in the presentation of factual and theoretical information, clinical scenarios and reflective discussion points to meet your personal learning needs. To enhance the practical application of the topics you have studied and to support your clinical competence you would be expected to participate in supervision, reflective practice and group discussions.

## Group discussion format

**Discussion points** are identified in each chapter of the workbook. You may choose to reflect on these alone or discuss them with another colleague. However, group discussions may be particularly beneficial both to you as an individual and in building the inpatient team. The following “what, when, where, why and how” questions may assist structured reflection on a situation or an incident relevant to each chapter.

- What is the specific issue?
- When and where did it occur?
- Why did it arise?
- Who was involved?
- Why were they involved?
- What similar situations have you been involved in or witnessed before?
- What would need to happen to bring about a successful outcome?
- What worked well in this situation that you could apply to other scenarios?
- Why did it work well?
- What would be the best possible outcome?
- What would be the worst possible outcome?
- What is your responsibility in this situation?
- What is within your power to resolve?
- What are the next steps for moving forward on this issue?
- What other resources may be useful?
- How should this issue be documented or reported?
- What effect has the experience of this group discussion had on your knowledge, learning and attitude?

## Useful websites:

[www.dfes.gov.uk](http://www.dfes.gov.uk)

[www.youngminds.org.uk](http://www.youngminds.org.uk)

[www.nice.org.uk](http://www.nice.org.uk)

[www.rcpsych.ac.uk](http://www.rcpsych.ac.uk)

[www.dh.gov.uk](http://www.dh.gov.uk)

[www.everychildmatters.gov.uk](http://www.everychildmatters.gov.uk)

[www.11million.org.uk](http://www.11million.org.uk)

[www.dca.gov.uk/legal-policy/mental-capacity/guidance.htm](http://www.dca.gov.uk/legal-policy/mental-capacity/guidance.htm)

[www.socialcare.csip.org.uk](http://www.socialcare.csip.org.uk)

[www.newwaysofworking.org.uk](http://www.newwaysofworking.org.uk)

[www.healthcarecommission.org.uk](http://www.healthcarecommission.org.uk)

[www.wales.gov.uk](http://www.wales.gov.uk)

## Foreword

Inpatient care is complex and demanding and has historically suffered from a dearth of guidance on how the service should adapt given the context of developing services particularly within the community. Indeed, a growing body of evidence is emerging that highlights a service that is struggling to meet the expectations of those people who use the service or practitioners who work in it.

The publication of this Training Pack comes at a particularly significant time, responding positively to recent publications which identified a lack of education and training provision specifically designed to address the particular needs of inpatient practitioners.

This publication signals the beginning of a process and is a significant first step in a development programme for inpatient mental health care in equipping staff with the necessary skills, knowledge and competencies to meet the needs of young people. It provides an opportunity for education and training to operate collaboratively and effectively in a whole systems model of service provision and aims to make current education, training and development opportunities more relevant and grounded within inpatient care, available to practitioners and targeted at all professional groups.

The aim of this training pack is to respond to the specific training, education and development needs of those working with young people in inpatient settings. It provides a forum to enable practitioners to work collaboratively and therapeutically with young people using the emerging evidence-based interventions.

Informed by the expert opinions and views of young people, carers, practitioners and higher education staff as well as commissioners of both training and services, this training pack recognises and builds upon the significant amount of innovative practice examples that are currently taking place around the country in terms of staff development.

Finally, this Training Pack has clear relevance outside of adolescent inpatient care. The knowledge and skills identified and discussed may well be just as relevant for mental health professionals working with young people placed on adult mental health wards recognising recent policy guidance. It will also be a relevant resource to support those promoting the emotional and psychological well being of children and young people in a range of residential care setting including children's homes, residential schools and secure establishments.

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# Child/adolescent and family development





**LEARNING OUTCOMES  
RELEVANT TO  
CHILD/ADOLESCENT  
AND FAMILY  
DEVELOPMENT**



On successful completion of this chapter, coupled with your work within inpatient CAMHS, you should be able to:

- Demonstrate an awareness of the family lifecycle
- Describe physical, sexual, psychoanalytical, psychosocial and moral development to adolescence
- Recognise the specific terminology used by some developmental theorists (Freud, Erikson, Piaget, Kohlberg and Vygotsky)
- Enhance your understanding of infancy, childhood and adolescence
- Discuss the concepts of attachment and friendship
- Demonstrate an understanding of attachment theory and influences that impact on emotional and behavioural development
- Appraise the professional's role in working with children and young people with attachment disorder

CAMHS Core Functions	Health & Social Care	Children's care learning & development	Children's services (Revised)	Quality Network for inpatient CAMHS (QNIC)	National Indicators
2	32	301, 303, 402, 403	3R, 4R	12, 14	58

## The family lifecycle

An understanding of the family lifecycle and developmental models are useful for professionals to consider when meeting the young person and their family. Disruption to the family cycle, at the crucial stages in child and adolescent development, may cause increased dependency. This may not be age-appropriate and may require a revision of the family tasks and relationships and re-establishment of phases of dependence/independence.

The emotional and intellectual stages that members of a family pass through, from childhood to retirement years, are known as the **family lifecycle**. In each stage of this normal cycle challenges may emerge. For example, coping with bereavement, divorce and remarriage may challenge family members to develop new skills and different ways of managing emotional turmoil. Developing strengths in these areas may assist the individual and the family to work through the changes but not everyone passes through these stages smoothly. Certain situations, such as severe illness, financial problems or the death of a loved one may affect how well the stage is tolerated.

When children reach adolescence they begin to separate emotionally from their families and this independence is an important stage of the **family lifecycle**. The family situation and the adolescent-parent relationship play a key role in enabling a smooth transition into adulthood. The principle aim for the adolescent is to become financially independent from parents and to be socially and physically self sufficient.

Steinberg (1998) provides an opinion that one of the most important developmental tasks in adolescence is the process of achieving a stable, positive adult identity whilst giving up parental dependence. The preparation for departure of an adolescent from the family home may coincide with the development of intimate relationships and possibly expansion of the family with the arrival of grandchildren, inside or outside of marriage or enduring relationships.

When families are joined through marriage there is a period of adjustment when the couples have to reshape their joint goals and each individual has to be flexible and accommodating to the needs of their partner. The ultimate goal at this stage is to achieve interdependence, a balance of sharing goals but maintaining space for individual interests and activities. The decision to have children is one that affects individual development, the marital relationship and identity of the family.

Introducing a child into any relationship may result in a major change in parental roles. The need for compromise and commitment is paramount as the family enters this stage of the cycle. The situation may become more strained when a turbulent period coincides with parents reaching crucial stages in their respective careers or having to spend more time caring for their own aging parents.

Divorce and extramarital affairs may occur as a significant life event and older children have more skills to help them adjust to changes and stress as they may have their own network of friends to support them (Bigner, 1998; Steinmetz, 1999)

The stage after children leave home may be a great adventure and parents may experience a sense of freedom. However, some women find this a difficult period and their depressive feelings may emerge producing an 'empty nest syndrome'. Parental quality of life may be dependent on an enduring level of physical ability and well being. Retirement may be a fulfilling and happy time, including the experience of becoming a grandparent which may bring great joy without the responsibility of child rearing.

Some useful models of family lifecycle are based on the traditional nuclear family. One example is Carter and McGoldrick's (1989) model (Table 2).

STAGE	TASKS
1. Family of origin experiences	Maintaining relationships with parents, siblings and peers Completing school
2. Leaving home	Differentiation of self from family of origin and developing adult-to-adult relationship with parents Developing intimate peer relationships Beginning a career
3. Pre-marriage stage	Selecting partners Developing a relationship Deciding to marry
4. Childless couple age	Developing a way to live together based on reality rather than mutual projection Realigning relationships with families of origin and peers to include spouses
5. Family with young children	Adjusting marital system to make space for children Adopting parenting roles Realigning relationships with families of origin to include parenting and grand-parenting roles
6. Family with adolescents	Adjusting parent-child relationships to allow adolescents more autonomy Adjusting marital relationships to focus on mid-life marital and career issues Taking on responsibility of caring for families of origin
7. Launching children	Negotiating adult-to-adult relationships with children Adjusting to live as a couple again Adjusting to include in-laws and grandchildren within the family circle Dealing with disabilities and death in the family of origin
8. Later life	Coping with physiological decline Adjusting to the children taking a more central role in family maintenance Making room for the wisdom and experience of the elderly Dealing with the loss of spouse and peers Preparation for death, life review and integration

**Table 3: Carter and McGoldrick's model of family lifecycle (cited in Carr, 1999)**

## Models of development

It is important when working within CAMHS to have an understanding of the theories underpinning child and adolescent **development**. The term 'development' refers to the process by which an organism (human or animal) grows and changes through its life span. In humans dramatic growth occurs in infancy and childhood and during these first eighteen years of life profound changes occur in physical, cognitive and social status. A few major developmental theories are presented in this chapter, although by no means all of them. Use of the recommended reading list, presented at the end of this chapter, will further your understanding of the concepts and models of development. A good place to begin your learning on child/adolescent and family development is to explore stages of normal physical and sexual development (Table 4) before moving onto theories of cognitive, psychosocial and moral development.

AGE	PHYSICAL DEVELOPMENT	SEXUAL DEVELOPMENT
0-3 years	<ul style="list-style-type: none"> <li>Needs to be touched and held physically</li> <li>Triple weight between birth and aged 3</li> <li>Double height between birth and age 3</li> <li>Learn to crawl and walk</li> <li>Develop large motor skills such as jumping, running</li> <li>Begin to control bodily functions through toilet training</li> <li>Begin to take clothes on and off</li> <li>Develop 75 % of brain capacity</li> </ul>	<ul style="list-style-type: none"> <li>Rub and touch genitals</li> <li>Can experience orgasm from masturbation</li> <li>By age of two know own gender</li> <li>Aware of differences in male/female genitalia and how males/females urinate</li> </ul>
3-9 years	<ul style="list-style-type: none"> <li>Experience slower rate of growth than in infancy</li> <li>Reach at least 50% of their adult height and about 20% of their adult weight by 6yrs</li> <li>Increase in strength</li> <li>Loose baby teeth and grow adult teeth which may appear too big for their face</li> <li>Develop small and large motor activity skills</li> <li>Develop lung capacity and ability to breathe more deeply</li> <li>Continue significant brain development</li> <li>Develop less fat and grow more muscles than in earlier years</li> </ul>	<ul style="list-style-type: none"> <li>Practice urinating in different positions</li> <li>Highly affectionate and enjoy hugging peers and adults</li> <li>May imitate adult social and sexual behaviours</li> <li>May play 'doctors and nurses' looking at each others genitalia and showing theirs</li> <li>Sex play happens due to curiosity</li> <li>May become more modest about dressing and bathing</li> </ul>
9-12 years	<ul style="list-style-type: none"> <li>Experience growth spurt with significant muscle growth and weight gain</li> <li>Production of: <ul style="list-style-type: none"> <li><i>testosterone in males</i>; voice deepens, sperm is produced, scrotum darkens</li> <li><i>oestrogen/progesterone in females</i>; breasts develop, vaginal lubrication increases, ovulation and menstrual cycle begin</li> </ul> </li> <li>Skin becomes oily; spots may develop</li> <li>Sweating increases and body odour may occur</li> <li>Hair grows on pubis and under arms and in males on chest and face</li> <li>Body proportions change(shoulders broaden in males, hips widen in females)</li> </ul>	<ul style="list-style-type: none"> <li>Puberty occurs</li> <li>Secondary sexual characteristics develop for both boys and girls as early as 10yrs</li> <li>More self conscious about bodies</li> <li>Masturbation increases</li> <li>Same-gender sexual behaviour is common</li> <li>Some group dating may occur</li> <li>Sexual experimentation may begin to occur</li> <li>Understand jokes of a sexual nature</li> <li>Value privacy highly</li> </ul>
12-18years	<ul style="list-style-type: none"> <li>Complete puberty</li> <li>Reach adult height, especially females, males can continue to grow into early twenties</li> <li>Males start to shave</li> <li>Growth and development need a lot of energy so may need a lot of sleep</li> </ul>	<ul style="list-style-type: none"> <li>Interest in romantic and sexual relationships</li> <li>Strong attachments to partners</li> <li>Sexual intercourse</li> <li>Very preoccupied with appearance</li> <li>Fall in and out of 'love'</li> </ul>

**Table 4: Normal physical & sexual developmental stages (adapted from Kaplan 1991)**

Key developmental theorists such as Freud, Erikson, Piaget, Kohlberg and Vygotsky provide theoretical frameworks to inform cognitive, moral and psychosocial issues of development. It is essential that all team members working within inpatient Tier 4 CAMHS recognise the specific terminology inherent in these theories. You will use this specific theoretical knowledge to enhance your understanding of young people within inpatient care. This section provides an introduction to the major contributions made by these selected theorists. Use of the recommended reading list, presented at the end of this chapter, will further your understanding of child and adolescent development theory and its application to your role in CAMHS.

## Freud's psychoanalytic child development theory

Sigmund Freud (1856 -1939) formulated a staged theory of human development and positioned three levels of awareness. He stressed the importance of childhood events and experiences upon adult interactions. According to Freud (1962) moral behaviour is controlled by the superego, which compromises the conscience and ego-ideal. The conscience is that part of our personality which punishes us for wrong doing and is the source of guilt. The ego-ideal rewards behaviour which is in accordance with our basic moral values. It is the source of our feelings and pride.

According to Freud's psychoanalytic theory of personality, the Id is the personality component made up of unconscious psychic energy that works to satisfy basic urges, needs, and desires. The Id operates based on the pleasure principle, which demands immediate gratification of needs ([www.about.com/psychology.com](http://www.about.com/psychology.com)).

Freud's belief was that personality is mostly established by the age of five and these early experiences shape personality development. They continue to influence behaviour throughout life. He proposed specific, identifiable psychosexual stages; oral, anal, phallic, latency and genital, which are discussed below. During these stages the pleasure seeking energies of the Id become focused on certain erogenous areas. This psychosexual energy or libido is the driving force behind behaviour. Freud argued that if these stages are not successfully completed a 'fixation' can occur and the individual remains stuck in this stage until this conflict is resolved.

### The Psychosexual Stages: oral, anal, phallic, latency and genital

#### The Oral Stage

The **oral stage** begins at birth and lasts approximately one to one and a half years. The baby's oral cavity (mouth) is well developed at birth. The infant gains pleasure through sucking and later biting and is preoccupied with nursing and the pleasure of sucking and accepting things into the mouth. If the child is frustrated by not being fed on demand or overly stimulated, the child may become fixated. Its personality may become characterized by pessimism, envy, suspicion and sarcasm or, in the case over the overindulged child, optimistic, gullible, and full of admiration for others around him. An adolescent who is fixated in the oral stage may seek out oral stimulation through smoking or drinking.

## The Anal Stage

At about eighteen months of age, the child enters the anal stage which may last one to two years. With the advent of toilet training comes the child's obsession with the erogenous zone of the anus and with the retention or expulsion of the faeces. The libido- (A term used to describe the energy created by the survival and sexual instincts) becomes attached to the anal cavity from that age, until approximately three years of age. During this stage the child gains pleasure from expelling waste products and gratification from withholding them. The child may experience conflict between the parent's demands and his/her desires and physical capabilities in one of two ways. The child may put up a fight or simply refuses to use the toilet. If the parents are too lenient and the child manages to derive pleasure and success from this retention it will be likely to have character traits such as miserliness, neatness precise and a passive-aggressive nature.

## The Phallic Stage

The phallic stage occurs during the age of three to six years and is the setting for the greatest, most crucial sexual conflict in Freud's model of development. In Freud's view, as the young male becomes more interested in his genitals he may experience sexual feelings towards his mother and a desire to possess her sexually. However, the son may have desires to get rid of his father, who may be viewed as a rival for maternal affections. Freud labelled this the Oedipus complex (the Electra complex in women). It involves the young person's unconscious desire to possess the opposite-sexed parent and to eliminate the same-sexed one. The young male may feel aggression and envy towards his father, and he fears that his father may discover his desires and castrate him. He resolves this dilemma by identifying with his father and repressing his feelings towards his mother deep in his unconscious.

Fixation at the phallic stage develops a phallic character, which is reckless, resolute, self-assured, excessively vain and proud. Failure to resolve this conflict may cause a person to be afraid or incapable of close love. Freud postulated that fixation in the phallic stage may be a root cause of homosexuality.

## The Latency Stage

Generally, from about six until puberty the phallic stage resolves and a period of latency occurs. This is not a psychosexual stage of development but, rather, a period in which the sexual drive lies dormant. The sexes appear to segregate and boys tend to play with boys and girls with girls during this stage. At puberty the genitals once again become a central focus of libidinal energy.

## The Genital Stage

The emergence of puberty, with its accompanying hormonal disturbance, focuses the young person's energies again on his/her genitals. Interest turns to heterosexual relationships. The less energy the child has left invested in unresolved psychosexual developments, the greater his capacity may be to develop normal relationships with the opposite sex. Continued fixation, particularly in the phallic stage, may cause development marked by further repression and defensive behaviour.

## Erikson's theory of psychosocial development

One of the most influential psychosocial development theories arose from the work of Erik Erikson (1902 -1994). Within his work on personality and identity formation he explains the psychosocial stage of development (Erikson, 1963). According to Erikson, the **ego identity** is constantly changing due to new experiences and daily interaction with others and at each stage of social development the individual faces a personal dilemma. The way in which each dilemma is resolved is dependent upon the social context and influences the way in which individuals describe themselves. Erikson believed that a sense of competence in one stage would enable the individual to become competent in other life stages. However Moshman (1998b) highlighted that Erikson proposed that formal operations may be a necessary, though not sufficient, condition for the construction of identity.

Erikson's stages of psychosocial development are articulated by **eight stages**, from **infancy** to late **adulthood**. In each stage the young person and adult confronts, and hopefully masters, new challenges. Each stage builds on the successful completion of earlier stages. The challenges of stages not successfully completed may be expected to reappear as **problems** in the **future**.

### Psychosocial Stage 1 – Trust vs. Mistrust

The first stage occurs between birth and one year of life. The infant learns that either the world is fundamentally good and can be trusted or is fundamentally bad and may not be relied upon to meet its needs. Because an infant is utterly dependent, the development of trust is based upon the dependability of caregivers. If parents are responsive to these needs, in a predictable and sensitive way, the infant develops a sense of trust. In the long term, this underpins a capacity to have hope in the face of adversity and to trust, as adults, that difficult challenges can be resolved. Unsuccessful completion of this stage can result in an inability to trust, and therefore a sense of fear that the world is threatening. It may result in anxiety, heightened insecurities, and an over feeling of mistrust in the world around them.

### Psychosocial Stage 2 – Autonomy vs. Shame and Doubt

Between the ages of one and three, children begin to assert their independence for example, by walking away from their mother, picking which toy to play with, and making choices about what they like to wear or eat. During this period children become aware of their separateness and strive to establish a sense of personal worth and impose their will on the world. If children in this stage are encouraged and supported in their increased independence, they become more confident and secure in their own ability to survive in the world. They learn to assert their own desires and frequently say "No"! There is a gradual move away from rebelling against boundaries and routines begin to become internalised such as bedtimes and mealtimes. Like Freud, Erikson believed that toilet training was a vital part of this process as to learn control over one's body functions leads to a feeling of control. If parents are unable to be patient with a wilful child, if the child is overly controlled or not given the opportunity to assert themselves, they may begin to develop a sense of self-doubt, inadequacy and shame. As adults they may criticise themselves excessively and lack confidence in their abilities. It may lead some individuals to repeat their efforts at unsuccessful problem solving if they have difficulty coping with the shame of not succeeding.

### Psychosocial Stage 3 – Initiative vs. Guilt

Around age three and continuing to age six, children assert themselves more frequently. They develop their sense of autonomy in the pre-school years and turn their attention to a wider social spectrum. The internalization of certain adult values, perhaps of their parents and teachers, begins to produce feelings of guilt for doing wrong. The child begins to plan activities, make up games, and initiate activities with others. If given this opportunity, children develop a sense of initiative, and feel secure in their ability to lead others and make decisions. However, if a child is punished for expressing his or her own desires or plans he/she may develop an excessive sense of guilt, which may lead to a fear and lack of assertiveness. If the child feels like a nuisance to others and it may remain as a “follower”, lacking in self-initiative. Children who resolve this dilemma of initiative versus guilt act with a sense of purpose and vision as adults.

### Psychosocial Stage 4 – Industry vs. Inferiority

During the middle years of childhood, from age six to puberty, children begin to develop a sense of pride in their accomplishments. Having established a sense of trust, autonomy and initiative children need to develop skills and engage in meaningful work. The development of a sense of industry allows them to initiate projects, see them through to completion and feel good about what they have achieved. During this time, teachers play an increased role in the child's development. If children are encouraged and reinforced for their initiative, they begin to feel industrious and feel confident in their ability to achieve goals. If their initiative is not encouraged, or is restricted by parents or a teacher, then the child may begin to feel inferior. There may be self-doubt about ability and therefore the child may not reach his/her potential. If children are constantly compared with others and always come second they may develop a sense of inferiority and in adulthood lack the motivation to achieve.

### Psychosocial Stage 5 – Identity vs. Confusion

During adolescence, the transition from childhood to adulthood is most important. Children become more independent and begin to look at the future in terms of career and relationships. During this period, they explore possibilities and begin to form their own identity based upon the outcome of their explorations. Adolescents may try different behaviours and values from those accepted in their family of origin. They may experiment with sex, alcohol or drugs, different music tastes or new hobbies. The young adolescent may face a dilemma about following a peer group and risking the sacrifice of their own individuality, aspirations and goals. Whilst trying to define themselves as separate from their parents and to develop unique views of their own most adolescents still adopt many of their parents' values and behaviours. It is important for parents and schools not to control friendship formation whilst still offering a sense of security and boundaries. Adolescents who do not develop a sense of identity may develop role confusion and a sense of aimlessness and drift in society.

### Psychosocial Stage 6 – Intimacy vs. Isolation

The major psychosocial dilemma for people who have left adolescence is whether or not to develop an intimate relationship or to move to an isolated position. During this stage individuals explore relationships leading toward longer term commitments with someone other than a family member. Adolescents who do not develop intimacy and commitment may experience isolation, loneliness and, sometimes, depression. According to Erikson, there may be gender

differences in intimacy development in that women may define their identity as someone's wife or someone's mother. Consequently their identity may be determined by the men with whom they have relationships. Those who are successful at this step will develop relationships that are committed and secure and may lead to comfortable relationships and a sense of commitment, safety, and care within these relationships.

### Psychosocial Stage 7 – Generativity vs. Stagnation

Having established one's values and a close relationship with another person, the adult during middle adulthood now wants to pass on what he or she has learned through productive work, settling down within a relationship, beginning a family and nurturing the next generation. Those who fail to attain this skill often feel unproductive, stagnant and uninvolved in the world. In this stage individuals may "give back" to society by becoming involved in community activities and organizations and may experience a sense of contributing to the world.

### Psychosocial Stage 8 – Integrity vs. Despair

This phase occurs during old age when a person looks back on his or her life. The individual who has achieved integrity at the end of life may be satisfied with what has been achieved and may be ready to face death. However, if he/she is in despair or realises that loving relationships have not been achieved or personal goals met, they may feel that life has been wasted and may experience many regrets. The individual may be left with feelings of bitterness and despair, often leading to depression and hopelessness. Successfully completing this phase means looking back with few regrets and a general feeling of satisfaction. These individuals will attain wisdom, even when confronting death.

## Discussion point 1

- From your reading so far on developmental theorists, identify which you would consider to be the most useful to your current practice. Reflect on why this theory has particular meaning for you.
- Reflect on situations in your clinical experience in which the psycho-social development of your clients appears, in retrospect, to reflect a pattern described above. Are you able to link this to your knowledge of their life cycles?
- Identify two young people, with whom you are currently working, who appear to be at different developmental stages. Compare and contrast how they appear to relate to their peers and different members of the care team.



## Moral and cognitive development by Piaget, Kohlberg and Vygotsky

Moral reasoning refers to how individuals reason, or judge whether an action is right or wrong and decide on a course of behaviour. Cognitive development refers to the successive levels of intellectual adaptation, from birth to adulthood (Lehalle, cited in Jackson & Goosens, 2008). The analysis of Moral and Cognitive development remains strongly influenced by the work of Piaget, Kohlberg, and more latterly Vygotsky.

### Jean Piaget (1896-1980)

Piaget is probably the most influential developmental psychologist of the twentieth century (Gauvain & Cole, 1997). According to the classic version of Piaget's theory, cognitive development progresses through four stages which, although repeatedly debated, continue today to inform understanding of the social and intellectual development of children.

Piaget's theory surrounding the **Sensory Motor** stage is centred on the basis of 'schema'. This is a mental representation or idea about what things are and how we deal with them. Piaget deduced that the first schemas of an infant are to do with movement. He believed that much of a baby's behaviour is triggered by certain stimuli, in that they are reflexive. A few weeks after birth, the baby begins to understand some of the information it is receiving through the sensory system. It learns to use some muscles and limbs for movement. These developments are known as 'action schemas'. The sensory motor stage occurs from birth to two years of age. Infants investigate their world using their senses of sight, hearing etc and motor activity. They develop object permanence, which is the understanding that people and objects do not disappear just because they are out of sight. A recognition of how one thing can cause or affect another begins to develop and simple ideas about time and space. This important ability, to build up mental pictures of objects around them, arises from the knowledge that they have developed on what can be done with an object. Large amounts of time are spent regarding surrounding objects and the baby explores these to see what can be done with them. At around the age of eight or nine months, infants become more interested in an object for the object's own sake.

The **Pre-Operations** stage occurs between two and seven years of age. In this stage the child's thought processes are developing although they are not considered to be 'logical thought' exhibited in the adult. Now the child can use one thing to represent another for example a piece of wood may symbolise a boat. The vocabulary of a child expands and develops during this stage, as they change from babies and toddlers into 'little people'. Pre-operational children are usually 'ego-centric', meaning that they are only able to consider things from their own point of view, and imagine that everyone shares this view, because it is the only one possible. Language allows the child to have a direct experience although communication can still be difficult.

Piaget (1964) differentiated two discrete operational stages; the **Concrete Operations**, and the **Formal Operations** stage.

The **Concrete Operations** stage occurs from seven to about eleven years of age. As children progress through the stage of concrete operations their thought process becomes operational as characterised by more rational, mature and adult thinking. This process may continue well into the teenage years and the formal operations stage normally occurs in adolescence.

Piaget proposes that the main developments of the concrete operational stage are that thinking becomes more flexible and children begin to understand the issue of reversibility (i.e. that objects once displaced can be put back to their original position). The child starts to succeed at conversational tasks such as quantity and number and has the ability to develop logical thought about an object, if they are able to manipulate it. A second major development at this stage is the child's ability to classify and order, which the pre-operational child found difficult. Despite these changes in cognitive abilities, some limitations in the concrete operational child's thinking remain. In particular, children at this stage have difficulty dealing with abstract ideas, because they continue to be reliant on the immediate environment. The child cannot therefore speculate abstractly or use deductive logic until they move into the formal operational stage at around eleven years old.

The **Formal Operational** stage begins around the age of eleven and is fully achieved by the age of sixteen, bringing with it the capacity for abstraction. This permits adolescents to reason beyond a world of concrete reality to a world of possibilities and to operate logically on symbols and information that do not necessarily refer to objects and events in the real world. By the age of eleven children can reason hypothetically and they no longer require the concrete presence of things in the real world. These abilities allow the child to control ideas in their mind and speculate about the possible. Additionally, this stage involves a higher degree of equilibrium than is achieved in the concrete operational stage.

In adolescents, moving through the formal operational stage, the structures of development become the abstract, logically organized system of adult intelligence. When faced with a complex problem, the adolescent speculates about all possible solutions before trying them out in the real world. At this age there is a sudden shift in cognitive development whereby the child begins to understand the significance of events that took place earlier in his/her life.

There have been numerous reviews of Piaget's theory and using this basis for further research and debate and interestingly Keating (2004) and Moshman (1998a) did not find a significant relationship between formal stage and identity status.

### **Lawrence Kohlberg (1927-1987)**

Following Piaget's cognitive developmental approach to moral development in the 1960's was Kohlberg's moral reasoning theory. This was based upon research and interviews with groups of young children which described the ability of these children to consider presented dilemmas. From his research, mainly based on interviews with adolescents, Kohlberg described a three-level, six stage sequence of moral development (Kohlberg, 1969).

#### **Level 1: Pre-conventional Morality**

The pre-conventional level of moral reasoning is especially common in children, although adults may exhibit this level of reasoning. The child is responsive to cultural rules and labels of good and bad, right or wrong and may judge the morality of an action by its direct consequences. The pre-conventional level consists of the first and second stages of moral development and is solely concerned with the self in an ego-centric manner.

**Level 1 Stage 1** (Obedience and Punishment). This is the earliest stage of moral development. Children view rules as fixed and absolute and may focus on the direct consequences of their actions on themselves. In this stage the child will avoid breaking rules because it may lead to punishment.

**Level 1 Stage 2** (Individualism and Exchange). In this stage children account for individual points of view and judge actions accordingly. There is a sense of fairness although often actions may be motivated by an attitude of: "what's in it for me?". The child's reasoning shows a degree of interest in the needs of others, but only to a point where it might further its own interests. Reciprocity is a matter of "you scratch my back and I'll scratch yours" not one of loyalty, gratitude or justice.

### Level 2: Conventional Morality

At the conventional morality level conformity is the most important factor. The conventional level of moral reasoning is typical of **adolescents** and adults. The individual conforms to the expectations of others, including general social order. Those who reason in a conventional way judge the morality of their actions by comparing them to society's views and expectations

**Level 2 Stage 3** (Interpersonal relationships and conformity driven). In this stage there is an emphasis on living up to the expectations of others, being "nice" having learned that there is inherent value in doing so, and consideration of how others influence personal views. Individuals are receptive to approval or disapproval from others as it reflects society's accordance with the perceived role. The desire to maintain rules and authority exists only to further support these social roles. There is much conformity to stereotypical images of what is "natural behaviour".

**Level 2 Stage 4** (Maintaining law and order). In this stage young people begin to recognise the important of laws, authority, fixed rules and social order in maintaining a functioning society. They begin to consider society as a whole when making judgments. Right behaviour is accepted to consist of showing respect for authority, doing one's duty and maintaining social order. Moral reasoning moves beyond the need for individual approval to an acceptance that society's needs must transcend individual ones.

### Level 3: Post-Conventional Morality (or Principled Morality)

The post-conventional level consists of stages five and six of moral development. There is a growing awareness that people hold a variety of values and opinions and those beliefs differ in society as a whole. However, members of the society should agree and uphold social contracts. Rights are a matter of personal values and opinions but the emphasis is on the legal point of view.

**Level 3 Stage 5** (Social contract and human rights). In this stage individuals are viewed as holding different opinions and values. Similarly, laws are regarded as **social contracts** rather than rigid dictums. Those which do not promote the general welfare should be changed when necessary to meet "the greatest good for the greatest number of people". This should be achieved through **majority decision**, and inevitably, **compromise**. However, some are non-relative values, for example life and liberty, and must be upheld in any society regardless of the majority opinion.

**Level 3 Stage 6** (Universal ethical principles). In this stage the correct behaviour is defined as a decision of conscience in accordance with self-chosen ethical principles. These principles are universal principles of justice. Although Kohlberg (1969) insisted that stage six existed he found it difficult to identify individuals who consistently operated at that level. He hypothesized that in all societies individuals would progress upwards through these stages in sequence. An individual would be attracted by reasoning just above their scale but would not understand reasoning more than one stage above.

Later research by Wark and Krebs (1996) categorised real life dilemmas into four types; **philosophical** dilemmas such as capital punishment, **antisocial** dilemmas such as having unprotected sex, **social dilemmas** such as pressure from family and **prosocial** dilemmas such as conflicting demands from divorced parents. Most of their thoughts were compatible with those of Kohlberg, outlined above.

### Lev Semenovich Vygotsky (1896-1934)

Vygotsky (1962, as cited in Carr, 1999) introduced a further major theory of cognitive development. Like Piaget, Vygotsky studied the relationship between learning and development and argued that cognitive development does not coincide with learning processes, rather it lags behind. It results in zones of proximal development. He viewed cognitive development as a gradual increase in knowledge, in which skills are developed and built upon. Vygotsky expressed a similar view to Piaget, in proposing that for some children it may be useful to provide additional guidance from either adults or peers in order to further their learning.

## The concept of friendship

Friendships can be a wonderful source of emotional strength for children and may assist development of self-confidence. The key lies in helping children establish high-quality friendships that provide skills in validation, intimacy, companionship and conflict resolution. Good parenting provides opportunities to socialise and to learn appropriate interactions. Childhood friendships are the training grounds for important adult relationships, including marriage. Close friendships are characterised by affection and a sense of reliable alliance and intimacy. This may include sharing personal information in the knowledge that the friend can be trusted. This social bond begins in the early years during play times, as illustrated in the following model of friendship expectations (Table 5).



<b>REWARD-COST STAGE</b> Common activities, living nearby, similar expectations	Around 7-8 years
<b>NORMATIVE STAGE</b> Shared values, rules and sanctions	Around 9-10 years
<b>EMPATHIC STAGE</b> Understanding, self-disclosure, shared interests	Around 11-12 years

**Table 5: The three stage model of friendship expectations (Bingelow & La Gaipa, 1980)**

During pre-school years arguments are inevitable and the child learns to share, take turns, co-operate with others and learn to resolve conflict. The experience of having a close friend to confide in can promote feelings of trust, acceptance and sense of being understood. On a wider scale, peer group acceptance offers children a sense of inclusion. These examples of social relationships offer the child experience in nurturing and self-worth. Kaplan (1991) highlights how younger children are often brought together by adults and may engage in parallel play alongside another child but not actually interact with them.

At school and into middle childhood play is more cooperative and a distinct "leader" is starting to emerge. By middle school years gender segregation of children's groups becomes more dominant. By the ages of 10-11 years, patterns of acceptance, friendship and psychological adjustment begin to gel. Berndt (2004) stresses that having high-quality friendships are important for children and adolescents' success in the peer social world

By early adolescence, the nature of friendship changes again. As the time spent with parents begins to decline same sex gangs and sub groups start to form and peer influence increases. Carver, Joyner & Udry (2003) note the likelihood of romantic feelings and experiences emerging during the adolescent years. They identify that sometimes these early attachments may be unreciprocated and kept quiet as the young person tries to work out the meaning of the relationship for them.

Parental influence over their teenagers may vary considerably linked to shared value systems. During this phase there may be a determined rebellion against parental values by the teenager and their choice of friends may cause alarm. From the parent's viewpoint teenagers may fall in with the 'wrong crowd' and this may be the cause of much tension and conflict. During adolescent years Goossens (1997) suggests that demands for personal autonomy increase. According to Arnett (1999) this element of family relationships, related to the autonomy of the adolescent, is one cause of family conflict.

## Discussion point 2

- How may moral reasoning or moral behaviour be encouraged in the child and adolescent in the family and within an inpatient care setting?
- Reflect on a family with whom you are currently working.
  - Have they undergone any significant life events that could have prevented them from completing the normal family lifecycle?
  - How has the family coped with life changing events such as a child moving away to university?
- Reflect on a young person with whom you are currently professionally involved.
  - Do they appear to have maintained a stable friendship group?
  - How has this impacted on their sense of confidence?
  - Can you think of ways in which their normal milestones may have been disrupted?
- Reflect on a group of young people with whom you are currently working.
  - Can you identify behaviours that you may have considered previously were part of their illness rather than normal development?
  - How has your learning in this chapter changed your perception of young people?



## The importance of attachment

An understanding of attachment theory is useful for understanding common behavioural disturbances that may occur within inpatient CAMHS settings. It offers theoretical approaches to the professional management of clinical problems that may be encountered as a result of disrupted attachments.

The human infant is fairly helpless at birth and the newborn baby has a lot to find out about the world. The concept of attachment will now be considered as this is a key area in understanding young people and their families.

In order to have a secure base from which to explore the world, be resilient to stress and have meaningful relationships with themselves and others, all infants need a primary adult who cares for them in a sensitive way and who perceives, makes sense of and responds to their needs. Attachment is an instinctive system in the brain that evolves to ensure infant safety and survival. Primary caregivers are usually the natural mothers, although they need not be. The father or another person may function as the primary caregiver provided that they sustain a central role

in the child's life, for at least the first three and preferably five years of life, during the period when a child's brain develops most rapidly.

Each attachment occurs in its own unique way. Infants vary with regard to what calms and soothes them and what they find most pleasurable. Effective primary caregivers will have responded to the cues of the infant.

Attachment theory was originally formulated by Bowlby (1969) as a way of explaining the observed responses of young children and infants to separation from their caregivers. He conceptualised attachment as a biological drive towards species survival.

Attachment is... "The propensity to make strong emotional bonds to particular individuals is a basic component of human nature"

(Bowlby, 1969)

It was initially suggested by Bowlby that attachment behaviour, triggered by the child's distress was terminated as the child was comforted, however Main (1999) concluded that there is now an acceptance that the attachment system is continually active. Early studies by Spitz (1950) and Harlow (1961) demonstrated the relationship between profound social deprivation and later pathology. Bowlby (1969) shared the psychoanalytic view that early childhood experiences have an important influence on development and behaviour later in life. He believed that attachment had an evolutionary component in that it aided survival. Also, those attachments vary in their quality in accordance with the type of attachment relationship the child has experienced.

## Characteristics of secure attachment

Secure attachment establishes the basis on which the child will form relationships with others. This includes developing a sense of security about exploring the world, becoming resilient to stress, being able to regulate emotions, making sense of life and creating meaningful relationships. Children who are securely attached do not demonstrate significant distress when they are separated from their caregivers and greet the return of the parent with positive behaviour. These children demonstrate a preference for their parents over other adults. Their parents are usually able to anticipate the needs of their child and to decipher causal relationships for crying or distress. Zilberstein (2006) argues that children with secure attachments feel that their caregivers are physically and emotionally available to them.

Relationships characterised by secure attachment demonstrate alignment and interpersonal connections. The adult aligns his/her own internal state with that of the infant or child and communicates this in non-verbal ways that the child understands. This "communication" forms a bond of trust that makes the infant feel that he/she is understood, secure and respected. Through this mutually attuned interaction the infant learns to feel safe, manage emotions and form interpersonal connections to others. In adulthood, the attachment bond and behaviour is usually directed at partners and close friends. Prior & Glaser (2006) suggest that in old age attachment behaviour goes full circle and reverts to the parents from their offspring.

The quality of the caregiver's emotional availability early in life is critical in the development of a healthy internal representation of the self, the attachment figure and the external world

(Rosenstein & Horowitz, 1996). However, no communication is perfect and there will be times when the caregiver will interpret a child's needs incorrectly. The 'repair' process, when the adult tries to reconnect, will set an example to the child of how to resolve conflict.

Platts *et al* (2002) proposes that individuals with a secure attachment style are generally viewed as trustworthy, altruistic and dependable. In contrast adults with anxious attachment styles are more likely to feel they have little control over events in their lives and find other people difficult to understand.

## Characteristics of attachment disorders

Ainsworth *et al* (1978) tested Bowlby's work empirically. According to Wilson (2001) their findings have subsequently become the most widely used method of assessing the quality of attachment. They delineated **three patterns of attachment behaviours** in the children they studied categorised as A, B, and C. Group A were labelled **insecure/avoidant** and greeted the caregiver on return with a marked avoidance of proximity and showed little distress at their subsequent departure. They could be easily consoled by a stranger. Insecure attachments are often the product of a caregiver who is emotionally unavailable or intermittently responsive. Group B were categorised as **secure**. They demonstrated a marked preference for the familiar caregiver over a stranger and showed little sign of avoidance or resistance to proximity with the caregiver. Secure attachments are suggested by Zilberstein (2006) to provide a 'secure base' with the caregiver that fosters safe exploration and learning. Group C were characterised as **insecure/resistant**. Ainsworth *et al* (1978) noted that these children displayed a noticeable resistance to interaction and contact with the caregiver on reunion. Despite initially seeking close proximity to the caregiver, they then attempted to push them away and rejected the caregiver.

A fourth pattern of attachment was later identified by Main & Solomon (1986), as Group D consisting of **disorganised** infants. These children show contradictory behaviours indicating apprehension or confusion towards the caregiver. Of all of the types of attachments, disorganised children tend to be at the highest risk for later behavioural and emotional difficulties (Zilberstein, 2006). However according to Carlson, (1998) and Green & Goldwyn, (2002) when psychopathology does emerge, in relation to this group there may be multiple risk factors underlying, rather than simply disorganised attachment.

A form of severe insecure attachment disorder is clinically recognised as **Reactive Attachment Disorder (RAD)**. This is a developmental disorder resulting from either severe abuse and/or neglect of a child (Sheperis *et al*, 2003). There are two types of RAD; inhibited and disinhibited. The inhibited type is characterised by a child's persistent failure to initiate and respond to social interactions in a developmentally appropriate manner. There may be a resistance to comfort, along with a mixed pattern of approach and avoidance behaviours. Disinhibition is the lack of discrimination or selectivity of the attachment figure. The disinhibited type is characterised by social promiscuity and the child may fail to discriminate attachment behaviours. For example, a child with RAD-disinhibited type may be overly charming; inviting strangers home with them.

## Causes of disrupted attachment

Although attachment theory makes clear that early relationships are important to development there may be factors which disrupt this attachment developing. Listed below are some of the causal factors (Table 6) and signs and symptoms (Table 7) of disrupted attachment. These have been identified by the author based on her professional experience of young people in CAMHS.

### Table 6: Major causes of disrupted attachment

- Unplanned pregnancy
- Consideration of termination
- Post natal depression/psychosis
- Physical/emotional neglect or abuse
- Separation from primary caregiver
- Parental conflict
- Maternal addiction to drugs or alcohol
- Frequent moves or placements
- Traumatic experiences
- Unresponsive baby
- Undiagnosed, painful illnesses such as ear infections/colic
- The caregiver and child not being attuned
- Poor parenting skills
- Parental difficulties with attachment

Many different signs and symptoms of attachment disorder may be demonstrated by young people and an individual may exhibit one or more types of these behaviours (Table 7).

### Table 7: Signs and symptoms of attachment disorder

- Low self-esteem
- Persistent lying in the face of the truth
- Inability to develop and maintain friendships
- Superficially charming but lacking genuine trust, intimacy and affection
- Clingy, needy and makes unreasonable demands or has a pseudo-maturity presentation
- Lack of self control, impulsiveness and lack of normal fear
- Aggression, anti-social behaviour, cruelty and violence
- Unable to self-soothe when faced with emotional turmoil and loss
- Speech and language difficulties with possible behavioural and academic problems at school
- Unhealthy interest in blood, death or fire
- "Black and White" and "All or nothing" styles of thinking
- Obsession with food; hordes, gorges, refusal to eat, hides food or has strange eating patterns
- Repetition of maltreatment and attachment disorder in their own children

According to Rutter (1997) there may be environments that foster problematic attachments and these may have multiple deficits apart from attachment difficulties, such as inappropriate disciplining by parents and the temperament of the child. Sroufe, Carlson, Levy & Egeland (1999) suggest that the early relational interactions gradually evolve into complex patterns that affect regulation of, attitudes towards and expectations of relationships.

## The role of the professional in attachment

Within the inpatient CAMHS setting there are two professional roles, to encourage normal attachment and to repair inadequate attachment. It is never too late to create positive change in a child's life. Professionals and carers can provide an important experience of connection and strength for the child's developing sense of self. According to Boris & Zeanah (1998) insecure or disorganised attachment appears to be an important risk factor in the development of psychopathology in later childhood. Therefore, it is very important for professionals to learn to identify, prevent and treat attachment problems.

It may take many months or even years before the young person may gain trust in professional involvement. Trust may only form if reliable, consistent and predictable communication is established. The professional, providing care within an inpatient CAMHS, should provide a secure base that has clear, consistent boundaries and continue to educate and teach behaviour management strategies. These strategies should assist the young person to experience increased feelings of trust and support.

With attachment theory in mind the professional must convey, often non-verbally, respect and genuineness without forming an inappropriate, intense relationship. The young person's own eagerness for a relationship with an adult may in itself feel overwhelming for the professional. It is vital that the relationship has clear boundaries to avoid feelings of rejection if professionals have to distance themselves after becoming 'over-involved'. Setting limits and boundaries is crucial to the development of self-control, sense of security and confidence in young people and to protect them from harm. The essence of the professional role is outlined below (Table 8).

**Table 8: The professional's role within inpatient CAMHS with regard to attachment**

To enable the young person to:

- Develop trust
- Develop an appropriate balance between dependency and autonomy
- Restore their self esteem
- Settle into a secure, structured and controlled environment
- Form healthy bonds within a managed environment
- Discover, through ample opportunities, that their behaviours have real consequences
- Express feelings and learn appropriate coping strategies
- Acquire skills of confidence, self control and self-protection

The following case study is presented for discussion. You may choose to individually reflect on Sarah's story or it may be useful to talk over your ideas with a colleague or within a group.



### Sarah's case scenario

The team have been requested to assess Sarah with a view to admitting her for inpatient treatment. She is a sixteen year old girl with an eighteen month history of intermittent depression and frequent self-harm. She has frequently used laxatives, binged and occasionally she has vomited up to fifteen times a day. She has cut herself frequently and has taken at least three overdoses in the last four months. She has refused psychiatric admission, up until now, but admits that her life is 'out of control'. However, recently she has, acknowledged that she is in need of more intensive care than can be offered to her in the community.

Sarah's natural father died of cancer when she was sixteen months old and her mother was depressed for some time prior to and following this event. In the following year Sarah's mother used alcohol and drugs as a way of coping with her depressive feelings and it is known that she often took Sarah out in her pushchair during the early hours to find drugs to feed her addiction. Her mother remarried when Sarah was four years old and Sarah has a half sister and brother from this relationship. In addition, there are two children from the step-father's previous marriage.

Whilst at primary and junior school Sarah began to present with behavioural problems and the GP and Social Services became involved. Sarah made allegations that her step-father had abused her and the police were involved but decided not to prosecute. She was placed on the Child Protection Register.

Sarah was often seen by the school nurse for superficial self-harm and after her transfer to Senior School the intensity and frequency of these episodes escalated. She was reviewed regularly by her social worker whom Sarah reports she could not relate to. Despite a change of worker Sarah still found it difficult to form any meaningful relationships.

Sarah was referred to community CAMHS when she was thirteen years of age. There was a promising start when she saw a psychologist for individual therapy but two months into therapy the professional went on maternity leave and Sarah felt abandoned. This resulted in her taking an overdose and she was admitted to the local Paediatric ward. She appeared to 'enjoy' this environment, however the staff found her 'difficult to manage' as she would interfere with the care of the younger children and she struck up some unhelpful alliances. These resulted in her stealing needles and implements to use for self-harm purposes.

Meanwhile the family moved home to this area and Sarah's mother and step father had two further siblings. They felt that Sarah was being too difficult to manage at home. However, the new Social Services team, currently linked to Sarah, have not been able to secure appropriate Foster placements and she is still living at home, albeit sleeping there infrequently.

The community CAMHS service became involved approximately one year ago. Sarah was prescribed Fluoxetine, 20 mgs, which has since been increased to 60mgs daily. The team has had limited success in engaging the family in family therapy sessions. Appointments are frequently cancelled and when meetings are achieved Sarah does not feel her parents listen to her point of view. Sarah has received weekly therapy from another therapist in the team (a male) who was believed to have become over involved with Sarah, to the point of giving her his mobile number and email address. On reflection the team have decided to allocate another worker to Sarah.

Despite weekly therapy, Sarah is still presenting with very impulsive and high risk behaviour patterns, but she has finally agreed that she needs further help.



## Discussion point 3

- Regarding Sarah's case scenario what do you feel would be the initial response of your team to the referral for assessment?
- On accepting the referral what concerns might the team express about admitting Sarah into inpatient CAMHS?
- What are your thoughts about the professional challenges this case presents?
- How may the cycle of inadequate attachment be broken?
- What would you need to consider if you were planning, as part of her care, to form a therapeutic alliance with Sarah?
- How, and when, would you and your team prepare Sarah for discharge from hospital?



### Further Suggested Reading

Bowlby, J. (1969) **Attachment and Loss, volume 1: attachment.** Vol. 1. London: Hogarth Press.

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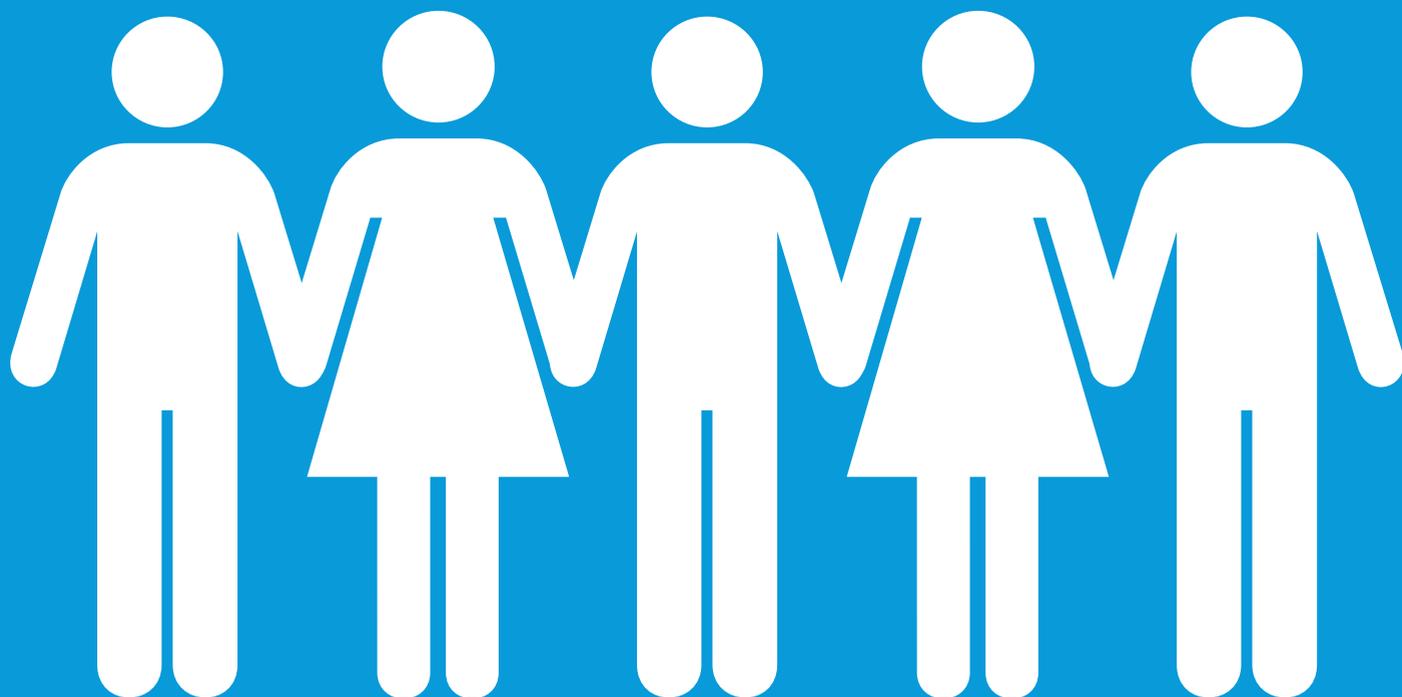
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# Staff behavioural skills for inpatient CAMHS team members





**LEARNING OUTCOMES  
RELEVANT TO STAFF  
BEHAVIOURAL SKILLS**



On successful completion of this chapter, coupled with your work within inpatient CAMHS, you should be able to:

- Critically reflect upon the nature of therapeutic relationships, with reference to examples from your own practice
- Critically evaluate the key skills required to engage positively with children, young people and families and build rapport
- Discuss the relative contribution of individual team members in creating therapeutic alliances and a therapeutic milieu in this care setting
- Identify supportive strategies to identify and prevent the unhelpful dynamics occurring within inpatient settings
- Critically evaluate your understanding of the importance of boundaries
- Discuss the concept of resilience in professional teams

CAMHS Core Functions	Health & Social Care	Children’s care learning & development	Children’s services (Revised)	Quality Network for inpatient CAMHS (QNIC)	National Indicators
1,3	31, 32, 34, 41, 44	401, 402, 403	17R, 18R, 25R	12.13, 12.14, 14.1, 14.1c	58

## The importance of creating a therapeutic alliance

Therapeutic alliance is a central process in a collaborative relationship with the young person and their families. McKlindon and Barnsteiner (1999) recognise that the therapeutic alliance is a dynamic, two-way reciprocal relationship between a caregiver, patient and, at times, the patient’s family. They emphasise that the relationship should be caring, clear, positive, professional and must have clear boundaries. It is further acknowledged that qualities that are central to the work of mental health professionals are empathy, genuineness, warmth and positive regard. However, developing a therapeutic alliance with children and adolescents may be a difficult task for even the most experienced and skilled professional. There are numerous reasons for this including lack of self-referral and non-acknowledgement of problems and/or challenging behaviour.

One of the most salient factors affecting the therapeutic alliance and motivation for treatment is the fact that children and adolescents do not usually self-refer for treatment. Young people are usually brought along by worried parents who have the support of concerned professionals from

CAMHS community teams. Diguseppe *et al* (1996) suggest that this non-self-referral process makes the establishment of a therapeutic alliance more difficult and can obstruct the therapist and client seeking to reach shared decision-making and agreement on the goals of treatment. The young person may not even acknowledge the existence of problems and are often not motivated to change. Professionals in inpatient settings often hear the young person expressing the feeling that 'if all the adults around them left them alone they would be fine!' This view may be very apparent to the professionals, even at the initial contact meeting. It may be a challenging experience to obtain any information from a silent, unresponsive and "sulky" teenager.

Despite the difficulties facing professionals in establishing common ground all is not lost. Successful engagement with a young person can be achieved. According to Shirk & Saiz (1992) children and adolescents are more likely to form a positive therapeutic alliance if they have a schema for positive attachments with others. This means they can evaluate their own emotions and behaviour, generate internal attributions for behaviour and hold a belief that their efforts can result in positive outcomes. These authors highlight that younger children may have developmental limitations in understanding the concept of needing treatment and therefore age appropriate communication is crucial. O'Hara (2003) notes that some families from ethnic backgrounds do not possess a vocabulary equivalent to standard English and may be misunderstood as 'uncommunicative'. Information may be poorly understood and it is important to have access to interpreter services and written information available in different languages. Tribe (1999) suggests that interpreters can bridge the gap of cultural understanding between service providers and service users.

When forming a therapeutic alliance it is important to consider developmental factors. Younger children are often more willing to adopt the goals suggested by the professional, whereas adolescents are less receptive to having ideas imposed upon them by adults argue Diguseppe *et al* (1996). Adolescents often choose their own way to formulate goals and work out how they are going to achieve them. They are more likely to be more rebellious and oppositional to change than the younger age group. These challenges may make adolescents the most treatment resistant group in psychiatry. It is helpful to provide them with choices and offer suggestions in the third person, for example; "some young people find it helpful to..." This is a method of depersonalising the discussion. A successful therapeutic relationship requires not only specialist communication and interpersonal skills but the ability to build rapport and trust with the patient.

As part of the process of working with young people within the inpatient setting, Hollyoake and Fitzgobbon (2002) highlight the multi-faceted nature of the relationship with issues such as mothering, attachment, containment, working with family processes, and the necessity to nurture and understand. These issues are frequently experienced as being more problematic in CAMHS, than within adult mental health settings, due to the developmental aspects of childhood. Therefore, staff members need to be more flexible than in other forms of psychiatry. Clinicians must be aware of the challenging behaviours with which adolescents may present and their specific developmental needs. It may be a complex and challenging task maintaining a therapeutic alliance with a young person and the CAMHS team has to be skilled in using negotiation and compromise strategies whilst being effective in maintaining limits and boundaries.

The essential characteristics and elements of a therapeutic relationship, summarised in Table 9, have been identified by many other authors (Rogers 1973, Halek 1997, Murray & Huelskoetter 1991, Dexter & Wash, 1995).

**Table 9: Identified factors in a therapeutic alliance**

- Trust
- Commitment
- Unconditional positive regard
- Genuineness
- Honesty
- Support
- Responsiveness
- Consistency
- Confidentiality
- Non-judgemental attitude

Jackson & Stevenson (2000) interviewed staff members and patients about nursing interventions and their findings demonstrated that patients expected nurses to be accessible to them, anticipate their needs and relate to them both as a friend and a professional. Drury (2005) commented that adolescents need to be shown respect and to be given opportunities to discuss their views in a way that is appropriately role-modelled by parents and other adults. Young people may be very challenging of other individuals and astutely know 'which buttons to press', thus disempowering team members. Key skills are required to establish a rapport with adolescents who are experiencing mental health problems, such as creativity, honesty, respect and openness. Staff members need to have enthusiasm, energy, a good sense of humour and the ability to persevere in the face of adversity.

According to Green (2006) '**therapeutic alliance**' has been cited as the most important determinant of treatment success. The term therapeutic or 'working' alliance has been defined as;

A relatively non-neurotic, rational relationship between patient and analyst which makes it possible for the patient to do work purposefully in the analytic situation

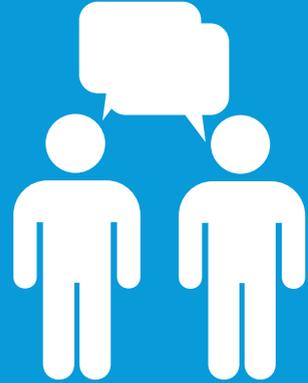
Greenson (1967, p. 46; cited in (Thurston, 2003)

Although originally a Freudian term the requirement, within a therapeutic alliance, for a conscious collaboration over treatment goals is emphasised in various treatment modalities, such as cognitive and behavioural therapies and humanistic and psychodynamic approaches. Thurston (2003) notes that whilst humane values and attributes are necessary in promoting engagement with patients and their families, they are not in themselves sufficient to produce a therapeutic alliance.

Green and Burke (1998) argue that the intensity of the admission to an inpatient unit may be a causal factor of a rift. It may amplify the difference between the alliance with parents and the alliance with the child. They highlight that the essential part of the early therapeutic engagement is developing a trusting relationship with all parties. During inpatient CAMHS treatment the nurses within the professional team are those who are most likely to fulfil certain roles; providing therapy, supporting daily living tasks, advocacy and co-ordination of care. However, as Hougaard (1994) highlights, there is a need for balance in the therapeutic alliance, between patient empowerment and professional dependency, as young people may often become overly dependant on certain individuals in the team.

## Discussion point 1

- Have you ever felt 'caught in the middle' of family communication issues? If so how has this been resolved?
- In your experience so far, what have been the most difficult challenges to forming a therapeutic alliance?
- Reflect on a family with whom you are currently working. Has it been problematic maintaining a therapeutic alliance? If so, why do you think this is occurring?
- Can you recall working with a family where the relationship has been transformed from a difficult relationship to a positive one? What factors do you think caused this change?



## Creating a therapeutic milieu

**Milieu** is derived from the French word for environment. The term **therapeutic milieu** refers to a health-promoting environment for patients. It is the environment itself that is used as an instrument for treatment. Milieu therapy can be used with children and has been in existence since the late 1800s, when moral treatment and therapeutic communities were the key approaches in the treatment of choice for psychiatric problems/disorders. In the 1920s August Aichorn, Bruno Bettelheim, Fritz Redl and David Wineman were among the early pioneers in using milieu therapy to treat "impulse-ridden and ego-impaired" children in residential and school settings. Their work demonstrated that it can be a powerful therapeutic tool whereby individual dynamics and the social system are integrated in a planned and meaningful way to manage and change behaviour and relationships.

Milieu therapy requires a planned treatment environment in which everyday events and interactions are remedial. The purpose is to enhance social skills and build confidence in the young people. This is an important prerequisite of the care process in order to promote health. All too often an admission into a Tier 4 unit is seen as the 'last resort'. Therefore it is crucial that the young person is given an opportunity to be exposed to and relate to others in a constructive way that is seen as beneficial to themselves and wider society.

The essential difference between inpatient and outpatient care is the controlled milieu in which it operates. It creates a safe environment that is rich with social opportunities and is nurtured by immediate feedback from caring staff. The milieu is not static and it has to remain flexible. It features normalizing and developmental perspectives that use common structures intended to be familiar to all children, such as daily routines, consistent rules and activities. The therapy is planned so that it is constantly supporting, guiding and reinforcing the young person's ability to learn life skills, such as problem solving and coping skills. At the same time it offers a safe place

for these skills to be practiced and integrated into the young person's repertoire of positive, normal life strategies.

One of the primary goals of milieu therapy is to teach young people "how to fit in" socially and emotionally. They need to learn new skills that help them to better understand themselves and their relationships. In an inpatient CAMHS setting this may be represented by 'going to school' or attending occupational therapy groups during the day and residential focused groups in the evenings. In addition, the structure of mealtimes, attendance to daily living skills such as tidying bedrooms and celebratory activities such as marking birthdays or leaving events are important. Opportunities to experience co-operative and collaborative activities are of benefit to domineering, overbearing and controlling patients and alternatively taking on a leadership role is useful for non-assertive, dependant young people. Testing authority in a safe environment is a developmental task that the child or adolescent may not have been able to practice in the home environment for a variety of reasons. According to Kurtz (2009) removal from social difficulties in the external environment and exposure to the inpatient milieu can produce rapid gains in functioning (socialisation and academic achievement) and self-esteem.

Although milieu therapy was originally implemented in long-term care settings its concepts are now applied in short-term inpatient settings (Boyd & Nihart, 1998). According to Peplau (1988) the milieu has both structured and unstructured components, which include diverse interactions between patients and staff. However, as all aspects of the environment are 'manipulated' to contribute to the patient's recovery it is not surprising that in the South African study by Muller & Poggenpoel (1996) the themes of custodial care, lack of intimacy, stereotyping rule enforcement as well as issues related to friendliness and caring emerged. There is a need for focus comparative and evaluative studies to provide an evidence base on the effectiveness and outcomes of milieu therapy in CAMHS.

The nursing team play a predominant role in the management of the therapeutic milieu within inpatient CAMHS. Registered Mental Health Nurses (RMNs) form the majority of the nursing team. In more recent years there has been a move to a more varied skill mix such as including Registered Children's Nurses (RCNs). There is an increasing recognition of the importance of the physical health and well being of the young people receiving care. Cotton (1993) emphasised qualities that staff members should uphold, including respect, empathy, energy, resilience, intellectual curiosity, self-reflection, self-awareness, co-operation and playfulness.

It is crucial that there is a clear understanding of power, control, authority and their relationship to the milieu. The Nurse in Charge of each shift often has to make decisions weighing up the needs of each individual against the collective needs of the inpatient group, especially out of normal working hours. He/she makes judgements and decisions, often considering risk-taking behaviours within several clinical crises in rapid succession.

The milieu needs to be effective and functioning regardless of patient and staff turnover and in crisis situations or periods when the atmosphere is very challenging. It needs to survive if there are disagreements or 'splitting' amongst the team members. The senior staff members need to function as the 'culture carriers' and instil, into less experienced individuals, enthusiasm, optimism and hope. They draw on experiential knowledge that the unit has been 'chaotic' and the team has 'pulled together' before and the atmosphere can be improved. A capacity to tolerate anxiety, contain distress and have a good sense of humour can enable the team to

withstand difficult periods and individuals to remain objective and dynamic. Green & Burke (1998) comment that milieu treatment is a labour intensive activity and an attempt to operate it with too few staff may lead to stress, burnout and institutional decay. They identify a range of tasks, which typically could be undertaken within a therapeutic milieu in inpatient CAMHS.

**Table 10: Typical tasks undertaken, by team members, within a therapeutic milieu**

- Ensuring basic care of children, including safety, nutrition, comfort and cleanliness
- Maintenance of space and time organisation of the unit, through activity schedules and programmes
- Maintenance of the physical organisation and tidiness of the environment.
- Performing structured nursing and psychiatric assessments of the individual child
- Providing individual counselling relationships with specific children
- Maintenance of healthy group dynamics amongst patients, through active early interventions and group work
- Delivering specific psychological treatments such as CBT or anxiety management
- Delivering and monitoring medications
- Taking part in team meetings, case conferences and presenting assessments
- Managing interactions with families at visiting times, including informal but intense communications from distraught or angry parents

## Therapeutic milieu and attachment

Within an inpatient CAMHS setting young people may develop powerful attachments to the unit and staff. The concept of **attachment** was discussed in Chapter 1. It is an important team task to manage attachment and to encourage the development of age appropriate skills in young people. Team members should avoid reinforcing dependent relationships. They are unhelpful for both parties and increase the likelihood of an escalation of difficulties as discharge approaches. **Transference** or **counter-transference** may occur. Transference is a phenomenon in psychoanalysis characterised by unconscious redirection of feelings for one person to another. It is the redirection of feelings and desires and especially of those unconsciously retained from childhood. Counter-transference is defined as the redirection of a therapist's feelings towards a client, or more generally as a therapeutic emotional entanglement with a client. When transference feelings are not an important part of the therapeutic relationship, there can obviously be no counter-transference.

Professionals may be aware of tensions and rivalries between patients with whom they work closely. There may be jealousy related attachment and to how much time is spent with each individual by the same Consultant or Primary Nurse. Staff members who have experienced this phenomenon may report that particular young people are 'watching them closely' or rejecting of attempts to meet. These behaviours may result if the young person considers that they have had less time with, or attention from, professionals than other patients. Young people within inpatient units may demonstrate their feeling with a range of unacceptable behaviour. Learning to deal with aggression, envy, verbal or physical attacks and conflict is challenging for the team and patients. Adolescent sub-groups may develop and at times may contain individuals who encourage rebellion against the team. At the other end of the spectrum there

are young people who attempt to seduce staff or overstep stated boundaries. The unit must act as a “safe container” for patients and staff and the environment itself may act towards enabling recovery (DH, 2001).

## Therapeutic milieu and provision of Tier 4 services

There are some Tier 4 units that struggle to meet the needs of young people. These units may have a poor physical environment, a lack of resources and an absence of a therapeutic milieu. According to Thurston (2003) this may contribute to an atmosphere of tension, boredom and menace. There may be difficulty in recruiting and retaining staff or an over-reliance on bank or agency staff. This is seen as undermining the ‘secure base’ required to establish a therapeutic culture in inpatient settings.

Shorter stay, combined with the establishment of home treatment teams and Tier 4 in-reach/out-reach workers, has led to a transformation in the culture of inpatient services. Longer term psychodynamic services are being replaced by more short-term, acute psychiatric care provision. More recently Kurtz (2009) highlighted that with a reduction in the length of stay, the therapeutic milieu, as it is historically understood, is on the decline. Kurtz described inpatient care as returning to more acute hospital practice, with the emphasis on mood stabilisation and minimal change before discharge of the client.

It appears evident that in the past, in some inpatient CAMHS units, there may have been an over-reliance on a narrow therapeutic ideology, with very similar treatment packages for all patients (Corrigall & Mitchell, 2002). These authors acknowledge the concerns, highlighted by commissioners, about long lengths of inpatient stay, citing bureaucratic inefficiencies and professional desire for ‘therapeutic perfectionism’ as influencing factors.

Therapeutic **perfectionism** applies when a unit aims to resolve all of the presenting problems before deciding that the young person is ready for discharge. This will extend inpatient stay times. Therefore the task ahead, for each Tier 4 service, is to decide their core business and to create a complementary therapeutic milieu and interfacing systems. Green (1992, 1993) described this as a ‘Janus-faced’ position. It requires inpatient teams to maintain the internal milieu of a ward and to be aware of their position when interacting with wider systems, including families and other agencies.



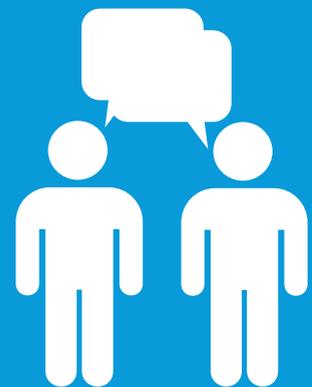
### Izzy's case scenario

A 17 year old girl was admitted for inpatient treatment four months ago. Izzy had a 9 month history of depression and multiple suicide attempts. She has shared information that she had been subjected to a sexual assault. A police investigation into the matter is underway. Whilst on the unit Izzy has been very selective regarding which members of staff she would communicate with. Izzy has begun individual work and the family has just engaged in family therapy. However, her mother, who has a history of depression, has often left the sessions in an angry state. She has become hostile and abusive towards the nursing staff if they do not allow her to spend time alone with her daughter after each session. Izzy has reported that she has a very close relationship with her mother and appears to have tried to emulate this relationship with her primary nurse.

During one particular shift, when her primary nurse was on duty, Izzy became very agitated and started punching the wall. She put her hands around another young person's throat. She explained that she believed that her primary nurse was spending too much time with a fellow inpatient. When another member of staff intervened she ran off. She was heard telling other young people that the staff could not be trusted and she tried to entice another inpatient to attack staff. She demanded to see her 'Consultant' and wanted immediate discharge. She stated that no-one was listening to her and said that "I can't see the point of staying any longer". When she was advised that it was not possible to comply with her demands she called her mother insisting that she be taken home. Her mother contacted the unit and also demanded to speak to the Consultant. She said that she felt that her daughter's distress was not being managed effectively by the team.

## Discussion point 2

- Reflect on a recent event, influenced by a planned treatment environment, that you found very challenging to deal with. What dynamics were occurring in the unit at that time?
- Are there certain staff members that you feel are skilled in creating a safe, containing milieu? If so, what qualities do those individuals bring to the unit?
- Recall a young person whom you felt became overly dependant on a team member or on the unit.
  - What type of behaviour did they display?
  - What effect did this have on the team?
  - What responses were apparent in other patients?
- How does your team balance the need for an optimum length of stay for the individual and the maintenance of a therapeutic milieu?
- How may families and other carers be supported to understand the concept of therapeutic milieu?



## Boundaries in therapeutic relationships

A simple and pragmatic definition of a **boundary** is the ability to know where you end and where another person begins. Professional boundaries are imperative to ensure that the relationship between the professional and young person remains therapeutic. The purpose of boundaries is to ensure that practice standards are adhered to, so that the patient and professional are protected. This is of paramount importance when working within an inpatient CAMHS environment.

The concept of boundaries and therapeutic relationships has been widely discussed in the nursing literature. Scanlon (2006) suggests that it is the nurse's responsibility, when working within CAMHS with young people experiencing mental illness, to have an awareness of their role in the therapeutic relationship and the management of professional boundaries.

Working alongside young people for so many hours at a time and in such an intense environment may cause over-familiarity or encourage team members to 'let their guard down'. This may be evidenced by unprofessional and dangerous activities. They may discuss unit issues or other staff members in a public area where they may be overheard by patients. If a loss of vigilance is noted there may be a subtle erosion of professional boundaries. Young people can be very seductive or persuasive in extracting personal information. It is crucial that staff members do not allow those in their care to access their telephone number, home address or email address or other personal contact details. Young people may be very keen to listen in

on formal and informal conversations between team members. It is important to be aware of the potential for the patient to misconstrue or misuse seemingly innocuous information, for example about social activities. In addition, individuals within the inpatient team must be discrete and maintain the privacy of their colleagues.

The adolescent needs to know boundaries and rules exist regarding their behaviour and the rules for negotiation. They prefer certainty and stability, even though they may protest against it. Noller (2005) stated that, within rules and boundaries, there is a need for room to negotiate and experiment. The challenge is to find a balance between an informal, friendly approach and a professional stance. In theory aspects of these stances may overlap but clear boundaries are essential. Conveying a simple, clear sense of order will allow the young people to feel they can trust and depend on staff, which will evoke feelings of respect and trustworthiness. Individual staff members must be confident, when setting a limit or boundary, that they will be able to carry out any agreed consequence. The consequence results directly from the action or non-action of the patient that has been deemed non-therapeutic and unacceptable.

If the young person does not comply with a negotiated plan or stated boundary, team members will be left in a very precarious position. It may mean that the staff have to tolerate a degree of challenging behaviour until more staff arrive or choose to ignore certain behaviours until it is safe to tackle the issue, even if this is some time later. Staff members may feel completely powerless and this experience may seriously undermine their authority and limit their ability to contain future difficult scenarios. To avoid this difficulty it is advisable to state a consequence in an agreed treatment plan that will be feasible to implement in many different future situations. In the real world of CAMHS provision the team may be depleted and individuals may be vulnerable to manipulation or inexperienced.

The impact that the inpatient team may have on the lives of adolescents is not to be underestimated. Young people are constantly watching how adults interact and behave. By doing this they learn how to interact with others and develop a view of themselves and the world around them. Therefore, it is crucial that staff members are self-aware and that they act consciously as appropriate role models. The need to create and maintain boundaries is central to effective working relationships with young people.

## Communication issues

Effective communication and engagement with children, young people and their families is a central theme within the Skills for Health's (2007) Core Functions for CAMHS staff. This document emphasises the need for respectful and professional relationships that engage families and follow best practice principles on confidentiality and information sharing. Good communication involves listening, understanding and responding to what is being communicated by demonstrating understanding, respect and honesty (DfES, 2003). Self-disclosure by the clinician may be a useful tool in communicating but reflection on the reason for sharing information is a prerequisite. Self-disclosure about personal life, beliefs or worries may only add to the concerns of the inpatient adolescent. The following practical guidance from the RCN (Table 11) is useful with respect to communication.

**Table 11: The Royal College of Nursing's Practice Principles for working with young people (RCN, 2008)**

- Make sure the young person is fully informed and involved – explaining your role and expectations regarding frequency of contact and role in relation to other team members.
- Use appropriate forms of communication – providing written information that is age appropriate or using web resources.
- Personalise any interaction with the young person – a degree of self disclosure for example interests in sport/music may facilitate communication.
- Take time to listen and emphasise with the young person – use active listening and open questioning.
- Demonstrate trust and honesty – be genuine and honest about the care you are providing.
- Set boundaries to care – explain to context of your role and professional boundaries and limits of confidentiality.
- Make sure the environment is appropriate for the young person – make sure first impressions are positive such as putting teen magazines in waiting area.

## Supporting adolescents in Tier 4 units

Adolescence can be a time of great turmoil so there is a need for teams working in Tier 4 inpatient units to be able to accurately assess the difference between normal and abnormal adolescent behaviour. Normal behaviour for this age group may include mood swings, argumentativeness and “talking back”. Abnormal behaviour, which may indicate psychiatric illness, may be exhibited as sustained mood swings or heightened anxiety. Adolescents may want to be treated like adults and they are no longer children. However, they still require support, guidance and boundaries for healthy development. Individuals derive a sense of safety from testing boundaries in adolescence and seeing those boundaries remain in place. They are more likely to trust actions rather than words. Adolescents are astute and critical and aware of the identifying characteristics of their age group. They report that there is nothing worse than an adult attempting to be an adolescent and they are very astute at identifying a lack of sincerity or acceptance. Adolescence is a time when separation from parents commences as a normal developmental process and it precedes the independence of adulthood.

These characteristics of adolescents direct the way in which inpatient CAMHS teams need to support individuals and the client group as a whole. There is a need to ensure that **language** used in communicating with adolescents is age appropriate. It is essential to check comprehension if the young person is looking blank. Rephrasing the question may require creativity in order to communicate effectively. It is unwise to adopt an unprofessional style of speech, such as swearing or to try to be ‘trendy’. This may be quoted later and may be embarrassing and/or breach codes of professional conduct. Conversely, it is vital to avoid professional jargon or assume knowledge, even if the young person appears fairly sophisticated or uses some medical terminology. They may not know the difference between a Consultant Psychiatrist and Consultant Psychologist or the clinical meaning of boundary, attachment or consequence. Effective inter-team communication skills are important as young people may ask a number of staff members the same question in an attempt to find a ‘weak link’ in the chain.

Staff members function as **role models**. Adolescents are in a much better position to learn appropriate social skills and behaviours when observing or being part of professionally managed communication and interactions. They need to observe others modelling positive behaviours. Fostering open dialogue and listening to adolescents may allow them to explore their own values and beliefs in a less judgemental way. They may respond well to boundaries that are clearly communicated, concise and held firm.

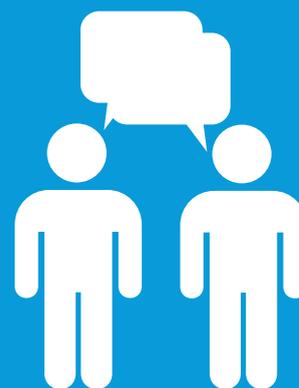
The team hold a shared body of **expert knowledge** on the process of child and adolescent development. This informs age-appropriate interactions and recognition that adolescents are not all at the same developmental trajectory. Due to their varied life experiences patients may react very differently to the same situation. In order to build a trusting relationship the team must identify tasks that are relevant to capabilities and developmental stage of the individual adolescent.

Creation within the unit of a **supportive environment** in which adolescents may have authentic interactions may be effective in improving dysfunctional behaviour and social skills. Modelling of coping strategies and positive behaviour are likely to have a profound effect on a dysfunctional individual. Inpatient treatment may be the first opportunity some individuals have experienced in their lives to interact safely with their peers without fear or prejudice.

Finally, it is crucial that the aim of the team is **consistency of approach** but unfortunately this is not always achievable in the real world of staff shortages and operational policy changes. Ideally consistency in application of treatment and therapeutic approaches will instil a feeling of stability and routine in the unit. Coping successfully with challenging experiences may assist team members to cope with stress and similar situations in the future. These learning experiences may be strengthened by reflective practice. Consistency in the team may be heightened by the inclusion of resilient individuals. These individuals tend to be good communicators, more empathic and have good coping strategies. Resilience is an excellent quality in inpatient teams alongside humour and optimism. Resilient individuals may 'rally' others into looking more positively at challenging situations, such as those which arise in caring for the disturbed adolescent.

## Discussion point 3

- Can you recall a time when you feel that you or your colleagues blurred professional boundaries? If so, how did that situation arise?
- What effective communication strategies have you observed being used with a child or family, by experienced clinical staff members, when communication has been difficult or strained?
- Reflect on the communication needs of young people across the age range with which you work. What communication techniques do you need to adopt to work effectively?
- What reactions in the inpatient group may indicate that a boundary is clear and established?
- What factors may affect variations in resilience in the team delivering inpatient CAMHS?



### Suggested further reading

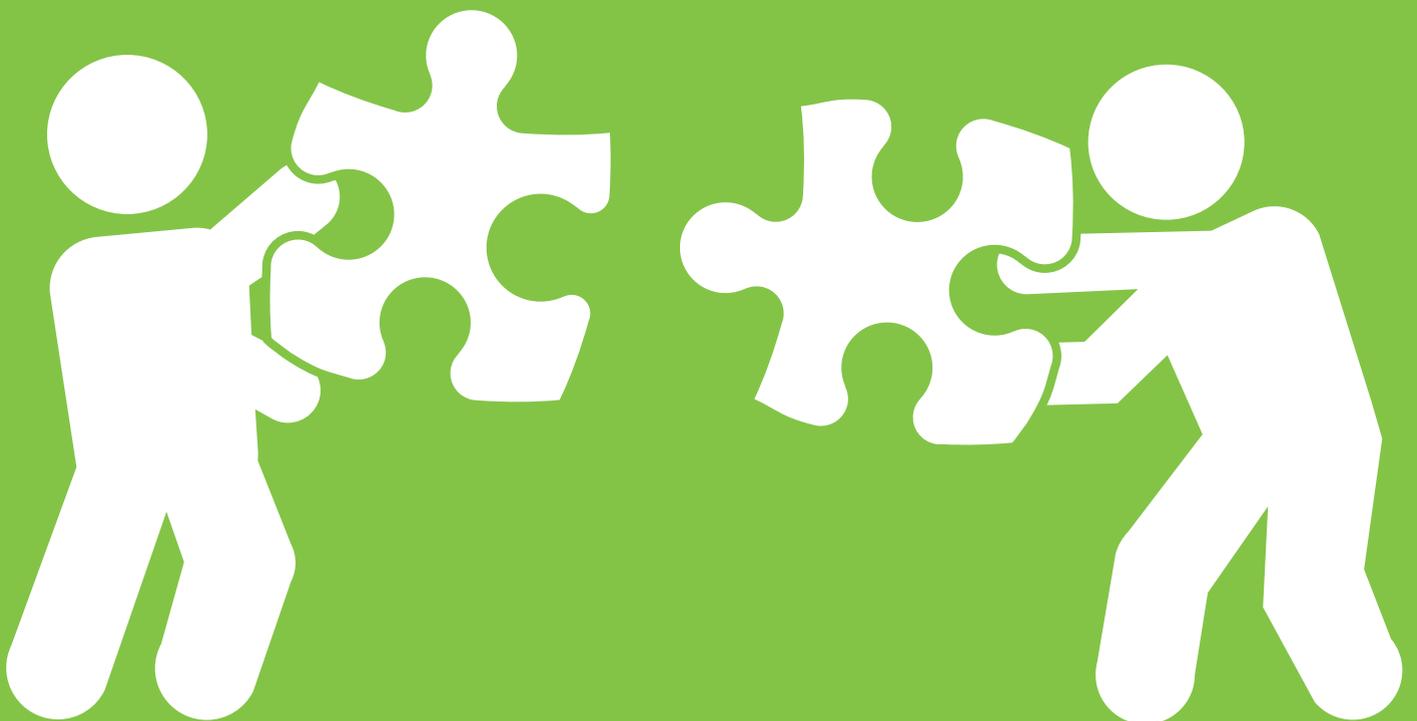
Green, B., & Jacobs, B. (1998) **Inpatient Child Psychiatry: Modern practice, research and the future**. Routledge: London.

Royal College of Nursing (2008) **Adolescence: boundaries and connections**. An RCN guide. RCN London.

Skills for Health (2007) **Core Functions: Child and adolescent mental health services, Tier 3 & 4**. National Workforce Programme & Care Services Improvement Partnership.



# Self care of professionals & team work





## LEARNING OUTCOMES RELEVANT TO SELF CARE OF PROFESSIONALS AND TEAMWORK



On successful completion of this chapter, coupled with your work within inpatient CAMHS, you should be able to:

- Critically analyse the staff dynamics that occur in inpatient settings
- Appropriately engage in professional and academic communication, within a multi-disciplinary team, maintaining client confidentiality
- Identify and critically discuss professional issues regarding information sharing
- Demonstrate an understanding of reflective practice, supervision and staff support in relation to professional self-care
- Identify systems which should be in place to enable effective work in Tier 4 CAMHS
- Critically evaluate the role of clinical supervision in supporting learning and reflection in practice

CAMHS Core Functions	Health & Social Care	Children's care learning & development	Children's services (Revised)	Quality Network for inpatient CAMHS (QNIC)	National Indicators
9				10, 10.2, 14, 23, 36.3	58

## Staff dynamics within an inpatient setting

Adshead (1998) suggests that within the dynamics of inpatient treatment it is likely that early patterns of relationship and attachment will be reactivated. As a result there is considerable pressure on staff members to unconsciously react to these relational patterns because of the processes of **splitting** and **projective identification**. In 1946, Melanie Klein introduced these terms and used them in the following way. Splitting referred to the separation of the things the child loves (good, gratifying objects) and the things the child hates (bad, frustrating objects). Projective Identification referred to the hatred against parts of the self as directed towards the child's mother. These relational patterns need to be understood, through supervision or reflective sessions, to enable individuals to practice a more positive response. Young people may have been subjected to negative responses in earlier years. If the inpatient team operates an ethos that is overly controlling and oppressive, it is likely that young people may adopt an oppositional stance. They may 'act out' by withdrawing or becoming overly hostile.

The following principles were developed by Tom Main, who pioneered the development of understanding group processes in residential settings during his thirty years, as Medical Director

at the Cassell Hospital, from 1946. The Cassell Hospital, which is based in Surrey, is a therapeutic community that offers residential treatment to adolescents, families and adults with major psychological difficulties who require care in a long term setting. Main's work illustrated the importance of the dynamics between staff and patients, highlighting how divisions arose in the staff team, as doctors and nurses experienced patients from a very different perspective. Main observed that some patients aroused a strong desire in staff members to work beyond the usual limits of the service. These 'special patients' would, in turn, would make the staff member feel 'special'. As a consequence differences of opinion arose within the team between members of the 'out-group', who were not so involved with the patient, and those in the 'in-group', those who were possibly too involved. A 'polarised view' emerged in which the 'out-group' staff members often felt resentful or envious of the 'in-group' who were closer to the patient. Consequently they felt unable to be open about their views of the patient. Main highlighted the importance of staff members being able to voice when they felt that patients had evoked powerful and antagonistic feelings, so that this could be reflected on within the team.

Children and adolescents may become very adept at 'splitting' parents or inpatient teams. They form a view, of one parent being 'softer' or 'firmer' than the other, and subsequently may attempt to recreate this dynamic within inpatient treatment. Splitting within the team can be prevented by setting clear and firm boundaries, which create trust and security within the therapeutic relationship. Gardiner (2002) purports that within mental health settings a dynamic of 'good/bad' staff members may occur, and that it is even more likely to occur in child and adolescent treatment teams.

Patients can appear to 'reward' lenient staff members, for example by making them feel appreciated. This may increase a sense of impotent rage among the remaining team members as may feel that some patients are 'getting away' with non-acceptable behaviour. This is when the team are most likely to be fragmented and decisions are made that may feel punitive and unjust. Counter-transference responses are elicited in the recipient (professional) by the other's (patient's) unconscious transference communications. These responses should be monitored and discussed during supervision sessions. Dolan & Coid (1995) suggest that therapeutic exploration leads to a better understanding of deviant and unhealthy behaviour, thus resulting in altered interpersonal behaviour and improved psychological functioning.

In contrast to the behaviour of young people who attempt to split teams, team members may have favourite patients. The result of having 'special' or 'favourite' patients can be a deterrent to successful therapeutic relationships (Holyoake 1999). Young people seem to evoke the need amongst the inpatient team to protect, guide and to take responsibility. Indeed, it is often the case that in a 'clinical handover' situation, individuals may be faced with a feeling that 'their' patient has caused difficulties on the previous shift and feel an overwhelming sense of responsibility.

It is important within inpatient CAMHS to create an atmosphere of trust and in which staff members feel free to challenge each other and talk openly about their differing emotional responses to patients. They need time and space to reflect on the various opinions of their colleagues. Marsden (2001) believes that if members of the team are able to expose some of their own feelings, it becomes possible to explore projections of both patients and staff, so that "splitting" can be identified and reintegration is possible for both parties.

### Michael's Case Scenario

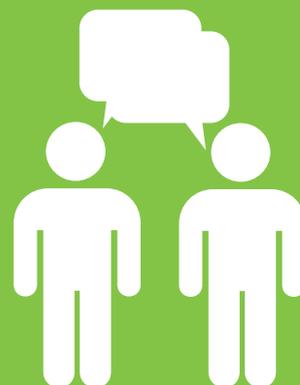
Michael is a thirteen year old boy, suffering from severe Obsessional Compulsive Disorder (OCD). He was extremely distressed at being separated from his mother on admission and staff members had to intervene to separate them. Once the admission was underway Michael needed intensive physical and psychological support. His obsessions were overwhelming. A daily plan of care, aimed at addressing his OCD, was devised by the psychology staff in conjunction with the core team in CAMHS.

Some staff members found it difficult to implement this plan due to Michael's continued distress and his attempts to involve staff in his rituals. These individuals, if they became involved, were at risk of being perceived as 'soft' by other team members. These adverse group dynamics were heightened when Michael showed a definite preference for particular staff members. In addition, other professionals felt frustrated because Michael's obsessions constantly changed and he developed new rituals. Within the multi-disciplinary team there were tensions surrounding the best care approach to take with Michael. Concern was expressed that his mother was not working collaboratively with the team.

Improvement in Michael's progress was extremely slow. The team were divided as to the value of inpatient treatment and some individuals were advocating that Michael should be discharged back to community CAMHS.

## Discussion Point 1

- What are the behavioural characteristics of a young person with potential to create "splitting" within your team?
- How does your unit allow opportunities for ventilation of feelings about staff dynamic issues? What is the most suitable venue for this to occur?
- How may positive staff dynamics be fostered by team leaders or managers?
- What practical interventions may be effective in preventing the formation of 'in-groups' and 'out-groups'.
- Discuss what impact Michael's illness may have on the team and why he may cause further tension within the Multi-Disciplinary Team.
- Consider why some staff may have difficulties setting boundaries for Michael.
- How would you establish a 'therapeutic alliance' with Michael?



## Systems of support in Tier 4 CAMHS

There are several systems that should be in place to enable effective work in Tier 4 CAMHS. These include generic staff support, post-incident debriefing, clinical supervision and development and creation of a positive learning environment.

### Generic staff support

Working with adolescents can be one of the most rewarding as well as one of the most challenging environments in mental health care. The task of containing powerful emotions is a challenging one and working with young people who are resistant and/or hostile may be exhausting. As a result it is crucial that professional individuals and teams working with young people and their families are provided with ongoing support, training, education and supervision. It cannot be overemphasised that individuals need 'time to breathe', to be able to reflect on practice and to offer each other support. The team needs time and a supportive environment to be 'visionary' about the needs of the service. Within inpatient settings nursing is the most disadvantaged professional group due to pressures to continue to deliver the service and meet the demands of providing 24hr cover. It is ironic that this is the team that probably requires the most 'time out'. It is essential that nurses, along with others in the multi-disciplinary team, remain effective, self-aware, confident in their own contribution to care, communicate effectively and able to differentiate their feelings and responses towards inpatients and colleagues.

In the face of possible hostility and rejection, that occurs from in the inpatient group, staff resilience is a crucial quality. As identified in Chapter 2, resilience involves being able to adapt to change or recover from challenging life difficulties. It is the ability to be able to function as well as before, or with the benefit of 'hindsight'. Resilient individuals use experience in a positive way and they are able to withstand the challenges faced working within an inpatient setting. They may act as role models for young people in how to effectively adapt, cope or 'bounce back' from difficulties. Pro-active support from senior managers in CAMHS, in terms of enabling learning and "time-out" may increase team resilience.

### Post-incident debriefing

Staff may experience a wide range of stressors related to working in inpatient settings particularly after the occurrence of critical incidents. Each health and social care organisation has a duty of care under both common and statute law, which includes the need to take reasonable care of the health and safety of the workforce. There may be a number of organisational systems in place to support staff, such as Clinical Supervision, Debriefing meetings and Critical Incident Stress Debriefing (CISM, 2007). The latter is a formal, structured intervention carried out by a trained support team. Individual Crisis Counselling may be provided by Occupational Health Services or Psychological Services.

It is helpful to bring together staff members soon after an incident occurs. It is vital that debriefing should be timely when it has involved violence. It is very important to conduct the meeting in the spirit of a 'blame free' culture. Staff members should be enabled to separate the 'technical' and 'emotional' side of events to establish the details of the incident and how they may be feeling after the event. Involving managers in the factual debriefing emphasises that incidents of violence are taken seriously. One outcome may be to highlight lessons that

can be learnt from the incident. Individuals may need ongoing counselling or support in order to cope more effectively and to recognise potential stress triggers for the future. Most NHS Trusts have a specific team available to support debriefing and to ensure confidential counselling is available. This is provided by in-house counsellors, occupational health departments or independent external bodies. As part of the debriefing process it is important for the team to discuss their response to the perpetrator. The police should be requested to assist if there is a continued risk of violence which the team does not feel able to contain. If necessary an alternative placement may need to be found for one or more of the young people involved in the incident.

## Clinical supervision & staff development

**Clinical supervision** presents a crucial opportunity for professional support and learning to explore the valuable elements of clinical practice. It is excellent practice to encourage reflection within supervision to support learning processes. Clinical supervision allows the practitioner to reflect on their interactions and examine everyday situations in a supportive manner. **Reflective practice** should be a fundamental part of the working lives for CAMHS inpatient staff members to help prevent burnout and professional complacency.

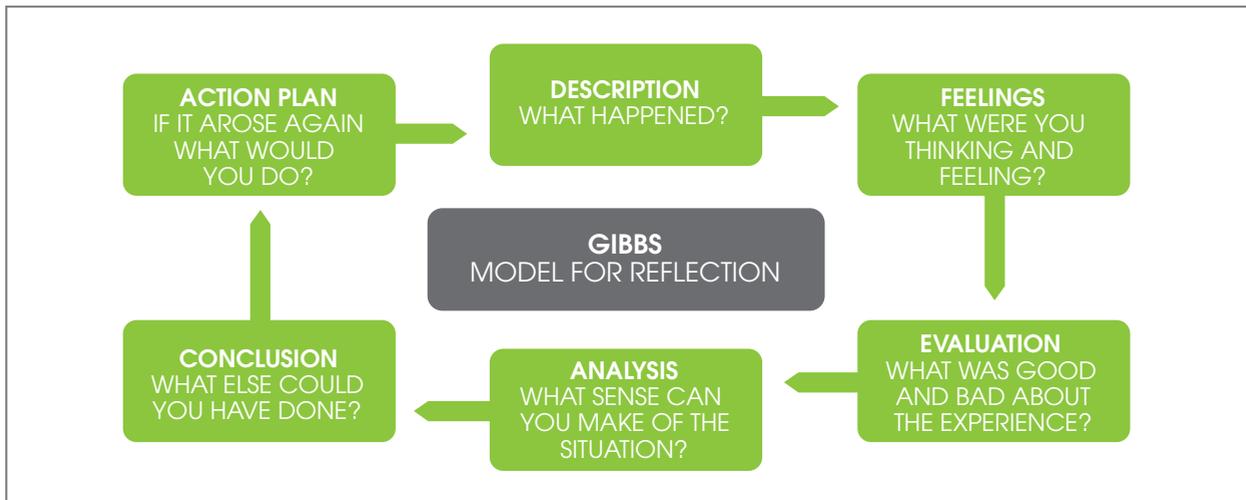
The Department of Health (1993) document 'A Vision for the Future' defines clinical supervision as;

"a formal process of professional support and learning, which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance consumer protection and the safety of care in clinical situations... central to the process of learning and to the expansion of the scope of practice... encouraging self assessment and analytical and reflective skills".

Cited in: RCN (2003) *Clinical Supervision in the workplace* (p2)

Clinical supervision and reflective practice present crucial learning opportunities for professionals to explore the valuable elements of practice and to promote professional development, for example through learning action plans. Supervision may be delivered on a one-to-one basis and its nature may be clinical, managerial and/or educational. As emphasised throughout this Chapter finding time to explore problems, difficulties and feelings encountered within inpatient CAMHS work is crucially important. Supervision is one mechanism which may be used and a group supervision format may facilitate the inpatient team to reflect and to discuss pertinent issues. Supervision may enable the professional to become more self-assured and grow in confidence and to broaden his/her thinking through problem solving.

There are various reflective models and frameworks described in the nursing literature including Gibbs (1998), Johns (2004) and Rolfe *et al* (2001). They usually describe cyclical or linear processes with feedback loops, which facilitate learning and practice. The Reflective Cycle developed by Gibbs is presented overleaf.



### The Reflective Cycle – Gibbs (1998)

The clinical or educational supervisor may use a model, such as that suggested by Gibbs (1998), to enable the supervisee to reflect on a specific clinical scenario and explore solutions in a more proactive way, rather than focusing on why the problem has happened, or is happening. Johns (2004) believes that practitioners already have an idea of what is good practice. Johns' model of structured reflection enables reflection on practice and may form the basis of good clinical supervision.

## Creating a positive learning environment

The drain of staff from inpatient CAMHS to community settings is an important workforce issue that is familiar to CAMHS service providers and commissioners (NICAPS, 1999). One traditionally held view is that individuals spend a couple of years to 'get the basics' in CAMHS before moving onto better opportunities in CAMHS community settings. It is fair to say that inpatient units have struggled to evidence that they provide a supportive professional learning environment. However, this perception is changing and should continue to alter. In recent years inpatient CAMHS has demonstrated an eagerness to develop national benchmarks in standards of care and compliance with these standards. With the development of a Quality Network for Inpatient CAMHS (QNIC) inpatient units have embraced the opportunity to open their doors to external review and to learn from feedback and advice. They have been able to prove evidence of considerable improvements year on year in their annual reports.

The workplace learning environment is crucial to maintain a dynamic service that is not only an attractive career opportunity but has the ability to retain clinical expertise. As stated in the introduction to this handbook, the National CAMHS Review Final Report (2008) offered key recommendations regarding training and development for the people who work with young people. These seek to ensure that there is an improved basic knowledge of child development, mental health and psychological well-being across the Children's workforce. If the culture, within CAMHS inpatient setting, continues to encourage gaining and sharing knowledge, this may lift morale, improve clinical care and positively benefit staff retention. The ultimate goal

would be to boost service delivery, improve standards of patient care and enhance the reputation of the unit, which would benefit staff members and reassure patients and their families.

One approach to creating a positive learning environment is the development of a dynamic learning culture. Key principles to achieving this are outlined in South Central SHA's magazine for healthcare educators; *NHS Education and reproduced below in Table 12.*

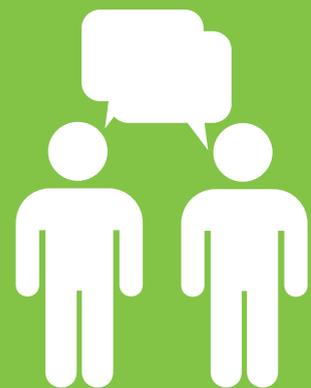
**Table 12: Key principles that apply to developing a dynamic learning culture (NESC, 2009)**

- Allow trainers and trainees time for reflection and study activities
- Encourage experienced educators to share the benefits of supporting learners with others in the team
- Develop buddy systems for new staff and be supportive of new staff
- Participate in induction programmes
- Develop education materials
- Share good practice
- Develop an 'education notice board'
- Develop inter-professional learning activities

Strong leadership and management are required to develop a culture of learning in practice and ensure that staff members and teams are provided with appropriate and timely learning opportunities. Training should be linked to appraisals and service requirements. Good role modelling, within clinical practice areas, may reinforce good standards of care and assist in developing an atmosphere of enquiry and learning.

## Discussion point 2

- Recall a time in recent months when you observed conflict, within the multi-disciplinary team. What triggered this and how was it resolved?
- Reflect on an issue raised in a staff support group that, in retrospect, enabled you to think differently about your work. How did it modify your behaviour towards a specific child, young person or family?
- How may the roles of educators, managers and clinical supervisors support reflective practice and the creation of a positive learning environment?
- How may you and your team enable the expansion of the scope of your practice as described in "A Vision for the Future" (1993)?



### Suggested further reading

Department of Health (1993) **A vision for the future**. Report of the Chief Nursing Officer. DH London.

Department of Health (2003a) **Delivering Race Equality: a framework for action**. Mental health Services Consultation Document. London. HMSO.

National Institute for Mental Health England (2003) **Inside Out: improving mental health experiences for black and minority ethnic communities in England**. London. NIHME.

Noller, P. (2005) **Communication with parents and other family members: The implications of family process for young people's wellbeing**. In: A. Williams, and Thurslow, C (Eds.) (2005) *Talking adolescence: Perspectives on communication in the teenage years* (3rd ed.) New York: Peter Lang.

Young Minds (2005) **Minority Voices: research into what young people from black and minority backgrounds – and the staff who work with them- say about mental health services**. London: Young Minds.

# Risk management





## LEARNING OUTCOMES RELEVANT TO RISK MANAGEMENT



On successful completion of this chapter, coupled with your work within inpatient CAMHS, you should be able to:

- Identify the key principles of risk assessment and management
- Critically evaluate the key areas of a risk assessment in inpatient CAMHS
- Discuss a schematic model and approach to risk-taking which could be adopted by the inpatient team
- Identify potential problems related to risk management within inpatient settings
- Discuss the principles of therapeutic engagement as part of the formal observation procedure

CAMHS Core Functions	Health & Social Care	Children's care learning & development	Children's services (Revised)	Quality Network for inpatient CAMHS (QNIC)	National Indicators
1,3	31, 32, 34, 41, 44	401, 402, 403	17R, 18R, 25R	22.1, 22.1a, 45.4	58

## Risk assessment and management

Risk and potential harm are a natural part of daily life and may be the unexpected or unwanted outcome to any everyday action. Risk may be interpreted in different ways by individuals. A typical dictionary definition of risk is 'the possibility of meeting danger or harm'. "Pure risk" is the likelihood (possibility) of a harmful outcome (danger or harm) (Hampshire Partnership NHS Foundation Trust, 2007) has two elementary variables; outcome(s) which may be good or bad and likelihood (s), which may be high or low. There is uncertainty about all or some of these and the likelihoods relate only to a period of time.

### Risk assessment

It may be possible to avoid the risk by taking appropriate actions and employing various control methods that may limit any potential negative consequences of risk. However, there are often multiple causes to an adverse event. The document *Rethinking risk to others in mental health services* (RCPsych, 2008) offers the following definition of risk assessment;

Risk assessment relates to a current situation and is not in itself a predictor of a particular event. It is integral to practice as the basis of proper risk management. A critical function is to stratify people into a group (low, medium or high risk), which will help dictate the appropriate risk management strategy

(RCPsych, 2008 p. 24)

Risk assessment requires the collection of information about the various potential outcomes and the likelihoods, identifying different **risk options** and making a **risk decision**. Essentially, assessment is undertaken to identify appropriate risk management measures i.e. those which minimise harm and increase the likelihood of benefits for the person being assessed and other people. Risk options are informed by the professional and experiential knowledge of the inpatient CAMHS team. Within an inpatient setting the impact on children, adolescents and the care team must be considered. The developmental aspects of young people, discussed in Chapter 1, must feature as part of the risk assessment. For example, a dangerous risk decision would be to place a seventeen year old disturbed, physically well-developed adolescent to be managed alongside smaller, less well developed twelve year olds without some safeguards in place.

Risk assessment is an assessment of a current situation, not itself a predictor of a particular event. As a minimum, risk assessment tools used in CAMHS must identify and assess specific factors (Table 13).

**Table 13: Factors that must be identified by a CAMHS risk assessment tool**

- Risk to the young person
- A young person's perspective on risk
- Risk to others
- History of risk behaviours/incidents
- Known triggers for behaviours
- Risks to property/buildings/objects
- A young person's compliance with treatment
- Protective Factors
- A young person's willingness to contribute to the assessment, planning and implementation of their care

The Royal College of Psychiatrists (2008) recommends a tiered approach to **risk assessment**, rather than use of a standardised risk assessment tool. They emphasise that clinical judgement should be an essential adjunct to using this approach (Table 14).

**Table 14: A tiered approach to risk assessment (RCP, 2008)**

- A full mental state examination aimed at eliciting factors which increase the risk of violence
- An examination of the young person's history
- If risk is identified, a more structured risk assessment process using an agreed assessment tool
- A record of any concerns raised by relatives/carers or significant others

## Risk management

This is the intervention to control the implementation of the risk decision. Risk has a constant presence in inpatient treatment which must be managed by timely establishment of risk management policies and processes. Decisions about risk management involve improving the service user's quality of life plans for recovery, while remaining aware of the safety needs of the service user, their carer and the public (Mersey Care NHS Trust, 2005).

Appleby (2007) stated in the open remarks of the *Best practice in Managing Risk* document;

Safety is at the centre of all good health care... Patient autonomy has to be considered alongside public safety and a good therapeutic relationship must include both sympathetic support and objective assessment of risk.

(Appleby, 2007)

This document goes on to highlight that a consistent approach to risk and its management will enable better communication and will contribute to improved care and any risk framework should relate to three main areas of risk; violence (including antisocial and offending behaviour), self-harm/suicide, and self neglect.

The discussion paper; *Patient safety & Clinical Risk* (BMA, 2002) describes a number of steps that should be taken regarding the clinical risk management process; identification, analysis, treatment and evaluation. Throughout this process they suggest a number of factors to consider which are listed in Table 15.

**Table 15: Factors for consideration in the clinical risk management process (BMA, 2002)**

- Review of incident reports of adverse events or near misses
- Review of clinical care records
- Direct observation of clinical care
- Review of complaints
- Collection of routine data on clinical performance
- Proactive identification of risks
- Consideration of potential probability, and potential impact, of harm
- Consideration of risk control (e.g. ligature points, restrictive window/door openings)
- Acceptance of risk (e.g. back-up systems, contingency plans)
- Avoidance of risk (e.g. PEAT inspections of potential hazards, individualised treatment plans)
- Reduction or minimisation of risk (e.g. clinical risk management plans)
- Establishment of a 'low blame' culture
- Availability of constructive advice and guidance on how to manage similar situations

The recent publication *Best Practice in Managing Risk Principles: evidence for best practice in the assessment and management of risk to self and others* (DH 2007c) presents some fundamental ideas on effective risk management. **Positive risk management** should be part of a carefully constructed plan and conducted in the spirit of collaboration. It requires an organisational strategy as well as efforts by the individual practitioner and recognition of the importance

of clinical governance policies, procedures and processes. The report states that good management can prevent and/or reduce harm in most cases. It highlights that knowledge and understanding of mental health legislation are important components of good risk management.

A CAMHS **risk management plan** should include a summary of all risks identified, formulations of the situations in which identified risks may occur and actions to be taken by practitioners and young people in response to crisis situations. In terms of risk management all units need to have in place a set of policies and procedures related to the management of risk, for example; locked door policy, rapid tranquilisation or absent without leave (AWOL).

The national policy document, *Patient and Public Involvement in the New NHS* (DH, 2003c) emphasises the importance of service users' views being integral to NHS development and delivery of care. This is in keeping with the *Best Practice in Managing Risk* (DH, 2007c) document which concurs that service users should be integral to risk management plans.

### Risk taking

This is an essential component of CAMHS inpatient practice and it is an informed process. The need arises in clinical work for decisions about measures to reduce risk and interventions to reduce or eliminate risk. This involves carefully weighing up the harms and benefits. The CAMHS inpatient team members need to be fully aware of the principles of risk assessment and management in order to avoid death of individuals, complaints and litigation against themselves and their organisation. Risk taking involves working with uncertainty and the professional needs to consider all risk factors. It will be important to assess their relevance and value in the clinical decision making process. A decision regarding risk, based on clinical judgement, consideration of relevant information and the best available evidence may be the best decision that can be made under the circumstances. Central to the decision making process for risk taking with young people, is the developmental process. Professionals will need to consider the appropriate level of autonomy and independence of the young person, alongside their ability to make an informed decision.

The decisions regarding risk should include the young person's presentation within the therapeutic milieu and how their actions may be influenced by others.

Decisions made in advance will enable the young person to feel more involved and empowered during times of crisis. These decisions must be disseminated across the team so that there is a consistent response and staff members are not 'reacting' in a way that inflames the situation. The "sea of faces" watching to see how the team manage crisis situations may be very judgemental. Young people need to feel confident that they are not being placed at unnecessary risk from violent individuals in the inpatient environment. The management of young people who are violent and aggressive is a very stressful process for all concerned and it is vital that staff members receive the necessary support, supervision and training.

## Protective factors

Gillett (2008) highlights that protective factors may be individual bio-psychosocial issues or environmental/ socio-cultural in nature that enhance resilience and serve to reduce the likelihood of the event occurring. Therefore, understanding the interactive relationship between risk factors and protective factors and how this can be modified is the essence of risk management. A list of protective factors is presented in Table 16.

**Table 16: Individual, family, school, peer and community and cultural protective factors (Gillett 2008)**

#### Individual

- Positive/resilient/easy temperament
- Positive attachment to family
- Social competence and problem-solving skills
- Perception of social support from adults and peers

- Healthy sense of self
- Positive expectations/optimism for the future
- Above average intelligence and positive school achievement
- Skills in problem solving and conflict resolution

### **Family**

- Good relationships with parents/bonding or attachment to family
- Opportunities and reward for prosocial family involvement
- Having a secure, stable, supportive family
- More than two years between siblings

### **School**

- School motivation/positive attitude toward school
- Student bonding and connectedness (attachment to teachers, belief, commitment)
- Positive school climate
- Opportunities for success and rewards for pro-social school involvement
- High-quality schools/clear standards and rules
- High expectations of students
- Presence and involvement of caring, supportive adults

### **Peer**

- Involvement with positive peer group activities and norms
- Good relationship with peers
- Parental approval of friends

### **Community and Cultural Factors**

- Economically sustainable/stable communities
- Strong cultural identity and ethnic pride
- Positive social norms
- Opportunities and rewards for prosocial community involvement/availability of neighbourhood resources
- High community expectations and good housing
- Attachment to and networks in community
- Community/cultural norms against violence

## **Risk review**

Risk assessments must be reviewed whenever any significant change in clinical presentation is noted, before any approval of leave or in the event of any absent without leave events. All risk assessments must be carefully recorded including signature, date and time and who was involved in the process.

It is important to bear in mind that risk can change over a very short timescale so there should be a managed opportunity for re-assessment of risk. This may be a procedure, such as a multidisciplinary clinical handover, or a clinical meeting. Treatment plans and nursing care plans must include a clear statement of risk management, for example 'accompanied walks' or 'search of belongings' on return from home leave. The plan should contain contextual information such as early warning signs, trigger factors and other vulnerabilities which are particularly relevant to all young people in the unit.

### John's case scenario

John has a history of violent and aggressive episodes against staff and other young people. Recently these episodes have increased in frequency and intensity. His nursing care plan states that when an episode occurs, the nursing staff may remove him from the group to a separate intensive care area. The team may use 'control and restraint' techniques and medication, if necessary, to manage his behaviour in this safe area.

On an afternoon shift John became aggressive and physically attacked staff and furniture and he was being verbally abusive to other young people. The male Nurse In Charge (NIC) and 2 other male staff removed John to the ICA where they remained for a long period of time, in an effort to manage John's destructive behaviour. The deputy nurse asked the female Senior House Officer (SHO) to review John's medication. Rather than prescribe emergency medication, which the nursing team felt was indicated, she advised the uses of John's routine 4hrly medication.

In order to convey a sense of order and safety within the unit, the staff team, now reduced in numbers attempted to work with the remaining young people in continuing to preserve the structure of the day e.g. group activities, specific care plans.

On several occasions the deputy NIC went into the ICA to assess the situation and to organise relief for the staff members. The male NIC insisted that he and his colleagues remain in place. This ongoing situation resulted in the two senior individuals not having the opportunity to effectively discuss the running of the shift or to consider the needs of the other young people.

As the shift progressed, several crisis situations occurred, for example a student nurse finding a young person who had self harmed in need of nursing treatment and the absconding of another young person.

## Discussion point 1

- What do you consider to be the Nurse in Charge's motivational factors for keeping John in the intensive care area?
- Discuss how you would have managed this incident if you were;
  - the Nurse In Charge of the shift
  - the Deputy Nurse in Charge
  - the Senior House Officer on duty
- When may you have considered contacting any available 'on call' staff members? Discuss the rationale for your decision.
- Discuss what systems you would have put in place to manage this shift effectively.
- Identify when there may have been a need for 'de-briefing' opportunities on this shift. Suggest the key areas for discussion within the de-briefing.



## Managing challenging situations

Practitioners working in Tier 4 CAMHS continually make decisions about how to help a young person manage their potential for self-harm, suicide, self-neglect and violence. An added dimension of care, for consideration, by inpatient teams, is the element of risk between individuals. There can often be a 'domino' effect when the unit is disturbed by one individual which may trigger off further incidents. Staff members will have to skillfully manage the situation to contain incidents from becoming 'out of hand' and the unit potentially becoming unsafe for both staff and patients. Experience of crisis management is crucial in order to maintain stability and ensure containment in this environment.

In adolescent settings the developmental needs of each individual must be considered. An incident involving self harm or violence may potentially be less scary for a seventeen year old than for a twelve year old. The difference in the adolescent's sheer strength/force from another individual's strength may affect how many individuals are needed to manage a violent situation. Some form of '*Management of Aggression*' training is essential and should be included in staff induction programmes and regular refresher training. A consistent strategic and operational approach to risk and its management is essential. It is important the team manages risk situations in a consistent way. The threshold for intervening should be clearly identified and carefully co-ordinated.

There may be situations whereby some staff members will avoid intervention until the risk situation escalates out of control. This may be due to the anxiety levels of individuals. More skilled/experienced staff members may intervene with a risk plan at an earlier stage. Young people may observe and take advantage of this situation and, as a result, some shifts may be more 'disturbed' than others. The perception of the inpatients about the team's level of ability

to contain the situation often sets the tone for how the risk situation may develop within a period of work.

Most units have policies and procedures for managing incidents with clear operational systems in place to investigate any serious events. The member of staff most likely to be managing the violent incident is a nurse. Higgins and McDougall (2006) highlight the importance of the nurse's role in remaining calm and managing their own emotions. The young person will not feel safe or reassured by highly emotional, frustrated or frightened staff.

Good communication may be demonstrated by staff members using conflict resolution skills. This may be a feature of behaviour and interaction that is absent within the family systems of some young people. If a member of staff deals with a situation involving conflict in a decisive and calm manner this may prevent an issue escalating into a confrontational dispute with the potential for violence. Resolving conflict using negotiation-based components allows the individual to 'save face' and leave the situation without feeling humiliated. The need to use a variety of skills and approaches to manage disruptive situations whilst considering the needs of other young people and the support and contribution of their multi-disciplinary team colleagues is crucial (Higgins and McDougall, 2006).

### *Peter's case scenario*

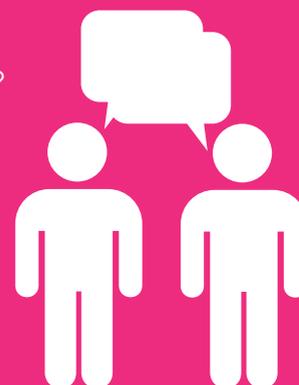
*Peter was a 15 year old boy referred with a 2 year history of impulsivity and multiple overdoses. On a few occasions he wrote suicide notes and his feelings of despair lasted several days. Peter had admitted smoking cannabis for the previous two years and he smoked this several times a week. He had tried Ecstasy and Cocaine and reported experiencing some paranoid beliefs. He had begun drinking excessively at weekends and started to self-harm, cutting himself when drunk.*

*From the beginning of admission Peter would have some settled periods then several days when he would abscond from the unit and put himself in high risk situations. On one occasion he climbed over a bridge and threatened to jump onto the motorway below. The police were called and it was possible to persuade him to come down and return to the CAMHS unit. Regular risk assessments were carried out and as a result a contract was drawn up with Peter regarding his ongoing admission to the unit. This included him contracting to take part in therapeutic activities and to seek support from nursing staff when he was distressed or angry. If he did not comply with this he was to be sent home for 24 hours and the purpose of re-admission was to be reviewed.*

*His parents were very supportive of this approach and they did arrive at short notice to carry out the plan, when Peter breached his contract. He engaged well in individual Cognitive Behaviour Therapy and Occupational Therapy groups. The family found Systemic Family Therapy very useful. He was discharged back to the local community CAMHS team with a co-ordinated reintegration plan.*

## Discussion point 2

- Discuss what your team's approach could be in the management of Peter's care.
- What do you feel are the key issues the 'contract' should contain?
- What purpose do you think the 'contract' served in managing Peter's risk?
- Consider what method of assessing risk you would use when 'sending' Peter home following a breach of his contract.
- How do you feel the multi-disciplinary team could contribute to the Peter's treatment plan?
- Discuss what methods of risk management your team may adopt for Peter.



## Managing risk issues for professionals

The NHS considers clinical risk as one of several risks facing its organisation and health and safety highlights Subotsky (2003) who offers helpful advice to professionals regarding management of potential risks in child psychiatry (Table 17).

**Table 17: Management of the potential risks in child psychiatry (Subotsky, 2003)**

- Be aware of standards, guidance and policies at national and local level
- Comply with appraisal/CPD/revalidation requirements
- Ensure good documentation and communication
- Document a full general assessment, preferably according to locally agreed template
- Assess risk to self, to others and from others
- Use these identified risks to write risk assessment and management plans
- Ensure that responsibilities of other agencies, such as social services, are clarified before closure especially in high-risk cases
- Consider guidance and training on 'appropriate boundaries'
- Take care when there is potential conflict between the interests of parents and children
- Identify if resource issues could lead to poor risk management
- Clarify the boundaries of professional responsibilities in situations of risk

- Maintain confidentiality, which may be a cause of complaints (disclosure, non-disclosure)
- Avoid being in a professionally isolated position
- Arrange personal defence cover, beyond the Trust's indemnity policy

Staff members should also ensure membership to professional bodies such as the British Medical Association, Royal College of Nursing or the British Psychological Society.

The practice principles outlined are in harmony with the National Patient Safety Agency's *Seven Steps to Patient Safety* (2004). This provides guidance on good practice and a framework to assist the development of a safety culture that learns lessons from serious incident reviews and builds on good practice. There are seven steps in the framework (Table 18):

**Table 18: Seven steps to patient safety (NPSA, 2004)**

1. Build a safety culture
2. Lead and support staff members
3. Integrate risk management activity
4. Promote reporting
5. Involve and communicate with service users and the public
6. Learn from and share safety lessons
7. Implement solutions to prevent harm

## The use of formal observations as a method of managing risk

As part of risk management within inpatient CAMHS units the use of formal observations is used widely. It is predominately related to the management of suicidal behaviour. **Suicidal** is a term used to describe people who deliberately want to kill themselves. The need to address the problem of suicide in people with mental health problems is not a recent phenomenon (Rosen, 1971, Aldridge, 1998). However, more attention has focused on this clinical issue during the last ten years. The document *Modernising Mental Health Services: Safe, Sound and Supportive* (DH, 1998) identified that suicide was the second most common cause of death in those under thirty-five years of age. Subsequent national reports *Safer Services* (DH, 1999c) and *Safety First* (DH, 2001), indicated that approximately one-quarter of those in Great Britain who had committed suicide had been in contact with mental health services in the year before their death.

The practice of **close observations** is one method of managing people 'at risk' of suicide in Tier 4 CAMHS units, which has been in use for over 25 years. This is predominately a nursing activity. The Standing Nursing and Midwifery Advisory Committee Practice Guidelines contain the following definition of close observations:

"Regarding the patient attentively, while minimising the extent to which they feel that they are under surveillance".

(SNMAC Practice Guidelines, 1999 p. 2)

Most NHS Trusts have developed policies in relation to the use of **formal observations** however there is no standard observation policy in the United Kingdom to date. There are a number of clinical terms to describe this activity such as 'specialling', 'constant observations', and 'continuous observations'. In contrast, the reasons for imposing **special observations** are consistent throughout the literature. These include the exhibition of acute symptoms, a danger to self or others, suicidal risk and absconding.

There is paucity in the literature regarding young people's experiences of the nursing intervention of "observation", in all its forms. The majority of the evidence and opinion focuses on adult mental health. Barker and Cutcliffe (1999) highlight that nurses usually have the main responsibility for caring for people at risk of suicide as they are one of the few mental health professionals working with patients over a 24 hour period. They recommend that formal/close observations should be carried out by permanent nurses on the unit which presents problems for inpatient areas that rely on bank/agency staff on a regular basis.

Some authors on this subject have raised their concerns about the mechanical implementation of constant observations which they feel leads to an erosion of the nurse-patient relationship (Bowles and Dodds, 2001, Barker, 2001). They argue that this intervention, which is commonly ordered by medical staff, puts a significant strain on nursing resources. They suggest that it may be implemented with scant regard for the impact on nursing activity, staffing levels and the nursing needs of the larger patient group. It is crucial that CAMHS Tier 4 staff have an overview of the capacity of the unit to undertake observations and the associated legal frameworks are considered, particularly if this involves the use of integral intensive care areas (ICAs).

Formal observations are a contentious issue. Barker and Cutcliffe, (1999) advocate that observation should be completely abandoned to focus solely on therapeutic engagement. Their fear is that they are requested only because organisations fear litigation and the absent doctor is assured of the physical safety of the patient. Duffy (1995), identified ambivalent core issues of 'controlling' and 'helping' and pointed out the non-therapeutic nature of care, which arose from adopting a custodial, paternalistic, medical tradition. As highlighted in *Engaging People: Observation of people with acute mental health problems* (NHS Scotland, 2002) nurses, as the only profession which has 24 hour contact with patients, are in a key position to ensure robust safety and therapeutic care. It is clearly not good practice to simply "watch or guard" patients, the report concludes and states that observation is a therapeutic engagement.

Lehane (1996) have found that the attitudes of staff members towards patients became less sympathetic when the close observation continued beyond five days and the patient felt that they had become a problem to the observer. The negative impact of close observations was also noted by Jones *et al* (2000) who found that most research subjects did not like the experience of being observed, found it intrusive and that some nurses did not talk to the patients at all during the observation period.

The literature does highlight the therapeutic benefits of formal observation of the client group such as gaining emotional support, optimism and feeling protected (Pitula and Cardell, 1996). These outcomes were enhanced when observers had a positive attitude and engaged the participants in supportive interaction. However CAMHS Tier 4 inpatient staff should be cautious about formal observation with some adolescents. Young people who have experienced

disrupted attachments may inadvertently 'like' being on close observations due to the benefits of feeling contained and having more 1-1 time with staff. In clinical practice there may also be rivalries between young people who are on close observations or a feeling of abandonment when they are withdrawn.

Pitula and Cardell (1996) also identify the non-therapeutic aspects of observation if the observer exhibits a lack of empathy or acknowledgement, or fails to provide information about constant observation. Those being observed may experience a lack of privacy and feelings of confinement. This is an area of particular concern to teams working with young people given the developmental nature of privacy issues. The therapeutic value of practice, such as close observation, is challenged by Cutcliffe and Barker (2002). They highlight the concern that in many parts of the country observation is carried out by bank or agency staff, as it is invariably regarded as a low skill activity. The excessive use of bank and agency staff has been highlighted by the Quality Network for Inpatient CAMHS (QNIC, 2005, 2006). They cite evidence to suggest that young people feel the therapeutic milieu is negatively affected by their use. Bowles and Dodds (2001) argue that constant observations are 'counter-productive' and contribute little in the way of assessment of risk.

The *Mental Health Policy Implementation Guide-Adult Acute Inpatient Care Provision* (2002) outlines the need for observation policies and practices as a therapeutic intervention, a view supported by the United Kingdom Central Council (UKCC) who define observation as; a two-way relationship, established between a service user and a nurse, which is meaningful, grounded in trust, and therapeutic for the service user (UKCC, 2002). The clinical practice guidelines for the short term management of disturbed/violent behaviour commissioned by NICE (available at [www.nice.org.uk/CG025NICEguideline](http://www.nice.org.uk/CG025NICEguideline)) upholds observations as applicable to the management of violence and self harm.

If forms of close/formal observation are used often within the unit, it is important for the inpatient team to keep an overview of the number of constant or intermittent observations that are being implemented at any one time. They should monitor its impact on the therapeutic milieu. The decision to implement such an intervention is a factor in the overall management of risk and there should be clear timescales for review within the risk assessment plan. The reality of clinical practice is that unless key individuals prioritise the review observation levels there is the danger that young people may remain on them unnecessarily. Each inpatient unit is likely to have their own Trust's guidance on the implementation of constant observations. It is crucial that inpatient staff receive relevant training at induction to the service. They should understand the therapeutic component of this professional intervention, so that it is not just delivered in a 'mechanical' fashion or in a 'custodial' way that could actually be delivered by hiring private security companies!

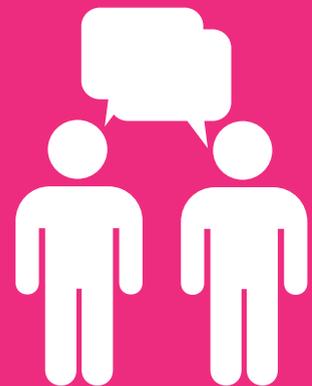


### Lucy's case scenario

Lucy is a 15 year old girl who was admitted for treatment of Anorexia Nervosa. She was managed under the specific eating disorder treatment plan but, as she started putting on weight, her low moods became more apparent. She reported sleep disturbance, poor concentration and physical exhaustion. Lucy was commenced on Mirtazapine which initially produced little response. She began cutting her arms superficially and expressing suicidal thoughts. This self-harm continued to escalate over the coming month and she took drug overdoses on weekend leave, on two occasions. She was managed in the Intensive Care Area due to her level of self-harm and she was closely observed for many weeks. The dose of Mirtazapine was increased and, in addition, Diazepam was prescribed to reduce her agitation and distress. Due to lack of response from Mirtazapine, Prozac was commenced with good effect. Her parents regularly visited her on the unit. Lucy was unable to have home leave as a result of her impulsivity and high risk behaviour. Her parents needed a great deal of support from the team to respond appropriately to Lucy's interactions when she became very hostile towards them. Lucy was very anxious at the slow reduction of close observations as this re-enacted her underlying fear of abandonment and it took careful negotiation and collaboration to reduce these without provoking a re-escalation of self destructive behaviours. Staff members were able to identify, with Lucy, certain times during the day when observations could be reduced and when she felt that she still required 1:1 observations. These intervals were increased slowly as Lucy developed coping strategies and her risk behaviours started to diminish.

## Discussion point 2

- What would you consider to be the contributory factors to Lucy's reluctance to 'come off' close observations?
- If you were undertaking 1:1 observations with Lucy what do you think you would need to consider in order that your time together is 'therapeutic'?
- How would you plan the reduction of observations?
- What dynamics do you think may occur within the team in relation to Lucy's care?
- If your unit does not contain an Intensive Care Area - what systems do you have in place to manage risk behaviours such as those exhibited by Lucy?



### Suggested further reading

Clinical Negligence Scheme for Trusts at: <http://www.nhs.uk>.

CSIP (Care Services Improvement Partnership) (2007) **Best Practice in Managing Risk in Mental Health Services: Implementation Tool Kit**. CSIP: London.

Department of Health (1998) **Modernising Mental Health Services: Safe, Sound and Supportive**. DH: London.

Department of Health (2001) **Safety First – Five Year Report of the National Confidentiality Inquiry into Suicides and Homicides by People with Mental Health Problems**. Her Majesty's Stationery Office, London.

Department of Health (1999) **Working Together to Safeguard Children**. DH: London.

National Institute for Mental Health in England (NIHME) (2004b) **Mental Health Policy Implementation Guide; Developing Positive Practice to Support Safe and Therapeutic Management of Aggression and Violence in Mental Health Inpatient Settings**. NIHME: Leeds.

NHS Scotland (2002) **Engaging People: Observation of People with Acute Mental Health Problems**. Edinburgh: Scotland.

McDougall, T. (2006) **Child and Adolescent Mental Health Nursing**. Blackwell Publishing.

# The inpatient pathway





## LEARNING OUTCOMES RELEVANT TO THE INPATIENT JOURNEY



On successful completion of this chapter, coupled with your work within inpatient CAMHS, you should be able to:

- Discuss the basic principles of confidentiality and information sharing
- Recognise the specific determinants of capacity and consent to treatment
- Demonstrate an awareness of key milestones in the inpatient pathway of care
- Critically discuss the relevance of liaison, transition and CPA
- Discuss the importance of considering ethnicity and cultural issues during assessment
- Appraise each professional's contribution within the 'core team' of the young person during the inpatient treatment
- Discuss the legal aspects of admission for CAMHS inpatient treatment

CAMHS Core Functions	Health & Social Care	Children's care learning & development	Children's services (Revised)	Quality Network for inpatient CAMHS (QNIC)	National Indicators
1, 2, 4, 5, 6, 7, 8	31, 32, 34, 38, 39, 41, 44, 310, 329	301, 302, 401, 402, 403	5R, 7R, 8R, 10R, 13R, 20R, 22R, 30R	19, 19.1, 21.1, 26, 36, 38, 38.1	51

## CAMHS and the inpatient unit

The National Institute for Health Service Delivery and Organisation Programme (2008) highlighted that approximately 2,100 young people in England and Wales are admitted to specialist child and adolescent units each year (Worrall *et al* 2004). According to Gowers and Rowlands (2005) the shortage of specialised beds results in young people being admitted to paediatric or general psychiatric wards. The main presenting illnesses, according to O'Herlihy *et al*, (2007), are mood disorders (~17%), psychotic disorders (~17%) and eating disorders (25%). Whilst the number of individuals being admitted is relatively small Goodman (2005) recognises that the impact of these conditions on the young person may be prolonged and severe and the admissions have high resource implications. Approximately 10% of current Tier 4 inpatient services are specifically for treatment of children below the age of 12 years.

As stated earlier in the handbook a number of Tier 4 specialist CAMHS are multi-faceted with multi-agency services that provide alternatives to hospital admission. These services may be described as 'wrap around' and have emerged in the last few years. Other services are still

developing such as therapeutic fostering, establishment of home treatment teams, and early intervention services in the community for young people with first episode psychosis (McGorry *et al* 2002). Alternatives to inpatient treatment may allow some young people, who would have been admitted in the past, to remain out of hospital. How these services will compare to inpatient treatment is not known and this will need to be evaluated in forthcoming years. Indeed, as Kurtz (2009) highlights, as yet there is not a sufficient evidence base to decide which model is best for which group of young people.

Referrals for inpatient treatment fall into three categories according to Maskey (1998). The 'enquiry', whereby the referrer is uncertain about the suitability of the case for inpatient treatment or if the unit would be able to meet the young person's needs. The actual 'referral', whereby the referrer is confident about the suitability of the case and anticipates that the unit will be able to meet the young person's needs. The 'emergency' referral is more often a crisis, whereby the request for urgent inpatient admission is made but, as Maskey (1998) notes, is a rare occurrence for example in suicidal depression or acute onset psychosis.

Young people who are admitted to CAMHS inpatient care or other mental health services have complex needs, often with co-morbidity. Inpatient treatment is generally offered when outpatient care has been unsuccessful or when the difficulties are so severe that the family are unable to manage at home or cope at a particular time. Admission **must** operate within a pathway of care, involving the local community teams. It is **essential** to avoid a protracted length of stay and the development of dependency on inpatient treatment, or loss of contact by the young person with their family and community. It is the role of inpatient services to explore alternatives to admission and assess the suitability of an individual for inpatient treatment. The young person's strengths and the protective factors within the family environment must be considered. It is important to balance the need for admission against the disruption to school attendance and the individual's social and local environment. Green and Jones (1998) identify an unwanted effect of inpatient treatment as loss in relation to local professional involvement. Local agencies may take admission as a cue to withdrawing completely from involvement with the case. These problems may be ameliorated by good communication between the inpatient service and local agencies.

## Admission for treatment

### Initial Assessment Meeting

**Assessment** can be defined as a systematic process of gathering a range of information relating to the young person. This information will assist in identifying their strengths and needs and inform action planning. It may provide a baseline of information against which the young person's future development can be measured and any improved outcome measures attributable to the inpatient treatment interventions. Most inpatient services have a referral process whereby new referrals are discussed, and members of the team are allocated appropriately to arrange the young person's **initial assessment meeting**. This meeting may take the form of a consultation or 'choice meeting'. The aim is to put the young person and their family in control of their treatment options. It will entail giving information that allows them to ask the professionals the right questions about their health and proposed treatment. Then, with the clinician, they can choose a course of action that is right for them.

The consultation meeting gives an opportunity for the young person and their family to meet two or three representatives of the inpatient team. It offers them an opportunity to discuss the reasons that admission is being considered, their expectations of the admission and the likely treatment plan. The professional is able to gauge the degree of consensus about the need for admission and discuss alternatives. Professional assessment skills are crucial and this consultation opportunity should be supportive, investigative and diagnostic to enable informed decision-making. As appropriate this meeting may include other agencies, already involved with the family, so that a systemic approach may be adopted.

Each individual in the team has their own method of information gathering and communication style but the initial assessment usually involves the collection of specific information (Table 19) that should be collected in a methodical manner.

**Table 19: Information to be identified in the initial assessment meeting**

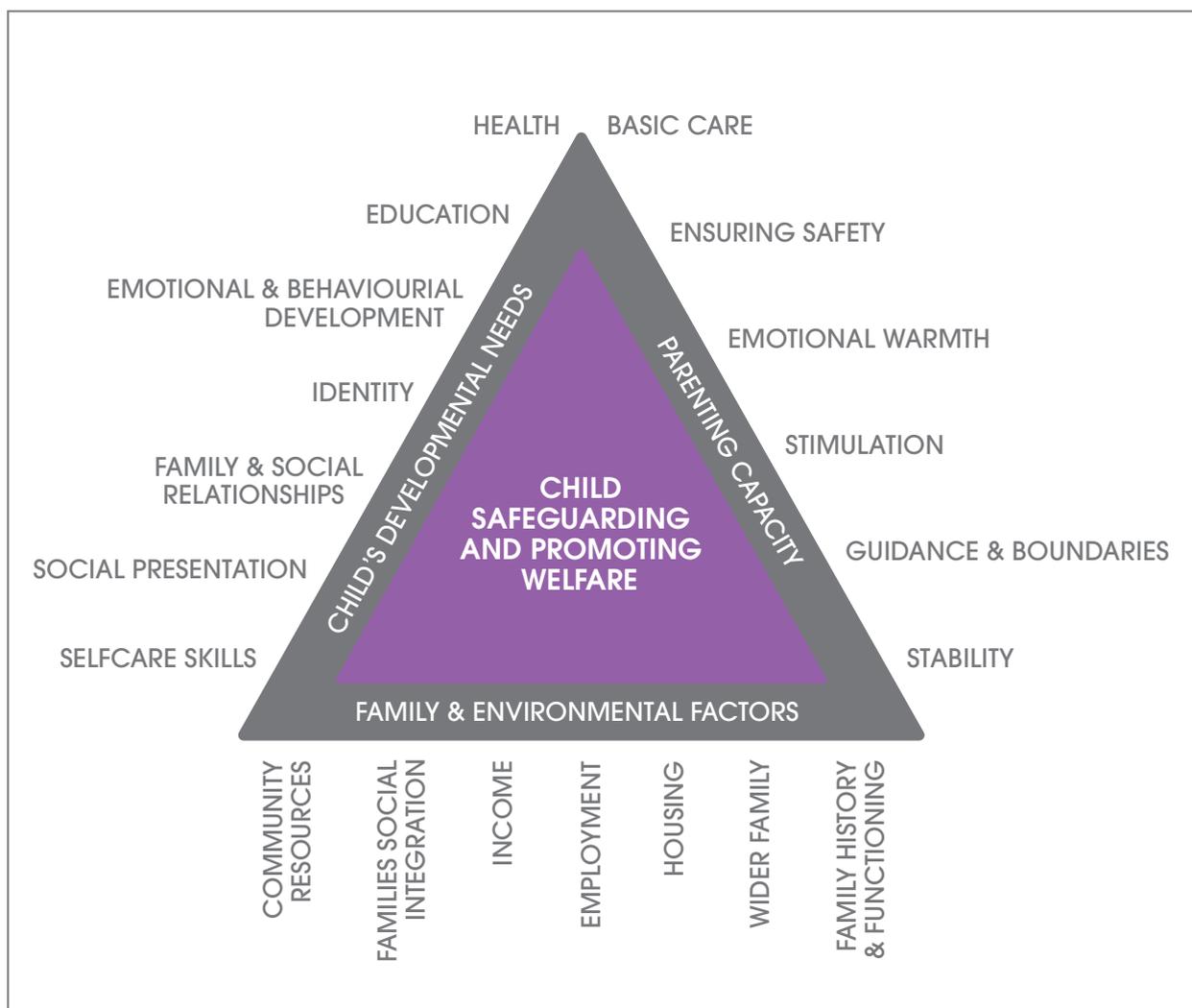
- The expectations and understanding of the young person and his/her family members about
  - the assessment meeting
  - the possibility of admission to an inpatient unit
  - the potential outcomes of admission
  - consent issues
- The history of the young person's presenting complaint
  - Onset and duration
  - Treatment to date
- The history of the young person
  - Developmental History
  - Family History
  - Significant Life Events
- Identified Risk Factors
- Ethnicity and cultural and religious issues
- Examination of "Individual Mental (and physical) State"
- Formulation of problems
- Types of treatment plans and therapeutic approaches

Assessment information may be obtained from a wide range of sources, such as the referral team's background information, contact with other agencies and possibly knowledge of the wider family. Some young people may have been subject to the Common Assessment Framework (CAF) (2005) prior to admission and this information should be sought. It will help confirm data gathered by your own assessments and should prevent duplication of effort and information. The data may contradict your own assessment findings and may act as a useful "check" mechanism. It may prompt you to ask more questions and seek further information. However, it is important not to rely purely on information from other sources. It may be misleading as, in many instances, it is out-of-date and non-contextual. Your assessment must reflect the current status of the individual.

The Common Assessment Framework is featured below and the aim of this is to;

- Reduce the number of assessments that a child undergoes
- Break down professional boundaries
- Improve information sharing

**Table 20: Common Assessment Framework (2005)**



The framework is intended to provide "a systematic way of analysing, understanding and recording what is happening to children and young people within their families and the wider context of the community in which they live".

Practitioners who undertake assessment need to be skilled, trained professionals who know how to engage and work with children, young people and their families and elicit vital information. The key engagement and assessment skills, identified in the Framework for the Assessment of Children in Need & their Families (2000), required to undertake effective assessments with children, young people and their families include:

- Working ethically and with consideration for consent and confidentiality
- Understanding behaviour
- Interviewing
- Questioning
- Observation
- Listening
- Summarising
- Accurate empathy and reflective listening
- Giving constructive feedback
- Challenging
- Working for change with children, young people and their families

This underpins the importance of the **initial assessment meeting** as an important stage in the inpatient journey. If the meeting is held within the unit it allows the family to familiarise themselves with the inpatient facilities. This may alleviate their concerns about the fabric of the building although staff members should bear in mind the potential for levels of disturbance on the unit and must be selective about which areas to visit. It is important to remember that this may be the first time that young people have been away from home and that the whole family are bound to be apprehensive. The professional should facilitate a positive discussion on the risks and benefits of inpatient treatment and provide an opportunity to discuss alternatives to such treatment. It must be emphasised that inpatient treatment is only an interim part of the care pathway.

The risks associated with admission for inpatient treatment were identified early in this chapter. A frequent concern is that admission may reinforce the image of the individual as a scapegoat or stimulate covert rejection of the young person from the family and local social networks (Green & Jones, 1998). It is common for parents to feel deskilled at some stages of the admission and it is crucial that this is not reinforced by the attitudes of team members who should not become preoccupied with 'rescuing' the young person or blaming the parents.

O'Hara (2003) highlights that the concept of **ethnicity** is complex and includes cultural, religious background and shared history. It is an important consideration on admission of a young person. Neale *et al.* (2005) suggests that the uptake of mental health services by black and south Asian young people remains low often due to prejudice and racist perceptions that are prevalent in mental health service planning and delivery. Clarke (2003) argues that as a result of this lack of involvement, young people and their families fail to access CAMHS as they feel marginalised.

### Admission Processes

When it is felt appropriate for inpatient treatment to occur consideration will need to be given as to whether this is on an informal basis. Alternatively admission may be within a legal framework, relevant to the country of the UK. In England the Mental Health Act 1983 (as amended by MHA 2007) is applied. Whichever country you are working in it will be crucial to become familiar with the legislation and to be aware that there are adaptations of English law. *The Legal Aspects of the Care and Treatment of Children and Young People with Mental Disorder (2009)* states the legal basis for admission will depend on a range of factors; the age and maturity of the young person, their capacity/competence to agree to the admission or availability of parental consent. How professionals make these decisions are discussed in Chapter 3 of that book.

When conducting the **admission process** the key areas, for careful consideration by the inpatient team member, are consent, capacity, confidentiality and information sharing. These must be discussed with the young person and his/her family members, as and when appropriate, within the admission process. There should be documented evidence that this has been achieved and any areas of concern, such as lack of understanding or consent, should be communicated immediately within the team. It is an essential component of the professional's duty to care that these actions are timely and competently addressed.

## Consent and capacity

Within the United Kingdom there are differing legal frameworks. These include The Mental Health (Care and Treatment) (Scotland) Act 2003, which came into effect in 2005 and the Mental Health Act Code (MHA, 1983 as amended by MHA 2007). The latter defines **consent** as:

The voluntary and continuing permission of a patient to be given a particular treatment, based on sufficient knowledge of the purpose, nature, likely effects and risks of that treatment, including the likelihood of its success and any alternatives to it. Permission given under unfair or undue pressure is not consent.

(MHA, 1983 23.31)

Young people (and their parents) need valid, up-to-date, accurate and well presented information on consent on admission to the inpatient unit. It should not be assumed that they are knowledgeable and informed in spite of previous contact with CAMHS and healthcare services. The level of information provided should be in keeping with their level of understanding. They must have the **capacity** to make an informed decision about consent to or refusal of treatment. Guidance on how to assess whether a young person is able to make decisions about admission to hospital and/or treatment is discussed in the *Mental Capacity Act* (MCA, 2005), which came fully into force in October 2007. The provisions of the MCA 2005 apply to all individuals aged 16 or over. An assessment of a person's capacity must be based on their ability to make a particular decision at a particular time.

For further understanding of professional issues related to capacity you are advised to read; *Mental Capacity Act 2005 (as amended) and Mental Capacity Act 2005 Code of Practice and Deprivation of liberty safeguards – Code of Practice and The Legal Aspects of the Care and Treatment of Children and Young People with Mental Disorder: A Guide for Professionals (2009)*.

During a discussion on consent the professional should provide specific information (Table 21).

**Table 21: Specific information to inform consent to inpatient treatment**

- Professional opinion on the most appropriate treatment
- What the treatment will involve for the individual and family members
- The intended benefits of treatment
- The chances of the young person getting these benefits
- Alternatives and options
- The degree of associated risk
- The potential effects of non-consent to treatment

An important difference to note, in relation to the work of CAMHS, is that the consent of the parents cannot override refusal of consent by a competent child. Children who are able to make decisions are deemed as being "Gillick competent". According to *The Legal Aspects of the Care and Treatment of Children and Young People with Mental Disorder* (2009) the Gillick competent child has attained sufficient understanding and intelligence to be able to understand fully what is involved in the proposed intervention will be regarded as competent to consent to a particular intervention, such as admission to hospital or proposed treatment (p18).

Adults, defined as people over the age of 18, are usually regarded as competent to decide their own treatment. The Family Law Reform Act 1969 gave the right to consent to treatment to anyone aged 16 to 18. Similar provision is made in Scotland by *The Age of Legal Capacity (Scotland) Act 1991*. In Northern Ireland, although separate legislation applies, the Department of Health and Social Services Northern Ireland stated that there was no reason to suppose that the House of Lords' decision would not be followed by the Northern Ireland Courts and this was upheld.

Competence varies depending on the nature of the decision and may fluctuate. It is important that competence is assessed in relation to each decision that is made. As a matter of good practice, the consent of a competent child should always be sought before providing treatment, unless any delay in doing so would put the child's life or health at risk.

According to the judgement in the Gillick case (*Gillick v West Norfolk and Wisbech Area Health Authority* (1986) A.C. 112) in order to assess the young person's level of competence it is necessary to ensure that he/she understands the treatment offered, why it is being proposed, the main benefits, risks and alternatives and consequences of no treatment. The young person needs to make an independent choice which is informed and supported and he/she should not be subjected to pressure.

*The Legal Aspects of the Care and Treatment of Young People with Mental Disorder: Guide for Professionals* (2009) offers a comprehensive guideline for all the aspects that professionals must take into account. It highlights the course of action to be taken when young people are unable to make a decision and the role of parental responsibility.

## Confidentiality and information sharing

As with people of all ages receiving care, **confidentiality** is extremely important to young people. Breaking a confidence may damage the therapeutic alliance irrevocably. Young people under the age of sixteen have the right to confidentiality. If it is judged by professionals that under the age of sixteen an individual is mature enough to consent to treatment then the content of a meeting may remain confidential (DH, 2003:). However there are exceptions to this when **information sharing** occurs, for example if the health, safety or welfare of the young person or others is deemed to be at risk.

*The Legal Aspects of the Care and Treatment of Children and Young People with Mental Disorder: Guide for Professionals* (2009) states that simply asking for information from those with parental responsibility and other carers about the young person need not involve any breach of confidentiality, provided in doing so, the individual requesting information does not reveal any personal confidential information that the parents or carers would not legitimately know anyway.

If a young person does not wish their parents to be involved in decisions about their care every effort should be made to fully understand the reasons for this. Before sharing information it is best practice to negotiate with them about what information may and may not be shared. If the decision is made to share information the young person should be informed. It is important that these decisions are clearly documented and communicated to the inpatient team.

The Royal College of Nursing (2008) guide; *Adolescence: Boundaries and Connections* advised that nurses will be required to disclose information in the following situations; if there is a court order (for example, if a young person is suffering from anorexia nervosa and is at risk of serious physical harm by refusing to eat or drink) or if it is required by statute (for example, if a young person is being sexually abused). The Skills for Health (2007) document *Core Functions for CAMHS staff* emphasises the need for respectful and professional relationships that engage families and follow best practice principles on confidentiality and information sharing.

Issues may arise within inpatient treatment when the team holds information that may impact on the family or planned home leave. An example is when a young person may have superficially self harmed and they are reluctant for their parents to be informed. Each CAMHS inpatient unit will need to clearly state their agreed approach to addressing confidentiality dilemmas. Similarly professionals need to inform the young person and their family what information will be relayed on a 'need to know' basis. This should be part of the **confidentiality** policy and should be made apparent from the outset.

With regard to separated or divorced parents the systems of notification of information need to be stringently clarified. One parent may be nominated or agreed to be the receiver of all contact and undertake responsibility to inform the other parent and relevant others. Alternatively both parents may wish to receive information directly from the team. This is an area of professional concern as the connections and relationships within modern families may be complex due to separation, divorce and single sex partnerships and multiple marriages. For example one or more of the parents of the divorced couple may have assumed all practical responsibility for the young person and may wish to be involved in decision-making on their behalf.

The following case discussion is presented for discussion. You may choose to individually reflect on Ellie's presentation or it may be useful to talk over your ideas with a colleague or within a group.



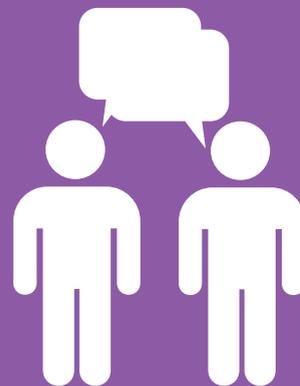
### Ellie's Case Scenario

Ellie is a sixteen year old girl, with a ten month history of depression and anxiety, who has arrived for admission with her divorced parents. Both parents have their new partners accompanying them. It is clear that there is animosity between both sets of parents and neither wanted to miss the admission process, but it is clear that Ellie is agitated by the friction.

Ellie's mother, Mrs Thompson asks if she can spend time with the admitting team in private and divulges that Ellie has taken two overdoses since the time she was seen by the Inpatient team for assessment. Both of these occurred after weekend visits to her former husband, who suffers from a depressive illness. She has not shared this information with her former husband and does not wish him to be informed. She also tells staff that Ellie is having 'second thoughts' about wanting to be in hospital and is worried that Ellie may run away if she is "forced to come in".

## Discussion point 1

- If you were part of the admitting team, how would you respond to Mrs Thompson?
- Consider how you may deal with the fact that she is having 'second thoughts' about being admitted to hospital and may abscond.
- What information would you share with Ellie's biological father?
- How do you feel the admission process should be conducted given both sets of parents wish to be involved?
- How could you demonstrate that you have considered the legal aspects of admission to hospital?



## Issues to consider during the admission

When inpatient care is offered, parents are often very relieved and may breathe a sigh of relief. To some extent all parties will get some respite from an exhaustive situation. This relief may be short-lived. Gross & Goldin (2008) identify the high expectations that are present in the early stages of admission that may give way to hostility and rivalry towards the team. The parents with feelings of inadequacy may feel hostile towards professionals who appear more successful in helping their child. The potential dynamics that occur between families and professionals must be considered as part of the admission process. On admission it is imperative that parents understand the aims of treatment and that all parties have a clear understanding of expectations of behaviour and boundaries. For example attendance at meetings and frequency of contact must be discussed. Once CAMHS inpatient treatment is required an **admission plan** needs to be agreed with the family and referring agency. Planning for discharge is an on-going process that begins on admission to the unit.

Prior to admission families should receive written information and a verbal explanation of the recommendation for inpatient treatment, the associated benefits and risks and an outline of the available, alternative treatments. Inpatient teams must have clear aims that avoid 'therapeutic perfectionism' which means; attempting to resolve all the presenting problems that are evident on admission or emerge thereafter. It is often the case that young people and their families may have long standing difficulties and treatment aims need to be realistic and achievable.

On admission staff members begin to establish a therapeutic relationship, both with the young person and with their family or carers, encouraging autonomy and a collaborative approach. This relationship and the principles of therapeutic care are discussed in Chapter 4. The young person has an allocated consultant psychiatrist who is medically responsible for him/her during inpatient care. As well as having a nominated care co-ordinator, key worker or named nurse, the young person should be allocated to a **core team** of multi-disciplinary staff. This team is responsible for co-ordinating the treatment plans and will work closely with the young person and their family. The family must be reminded what the goals of treatment will entail, even if this has been discussed in the pre-admission meeting. The time scale to achieve these goals should be clarified. All those involved should be given a clear explanation of the roles of the core team and information on lines of communication and how progress will be monitored. The core team will be the hub for communication with the family and referring teams. The multi-disciplinary team must meet regularly (probably weekly as a minimum) to discuss the progress of all inpatients. There is a separate meeting to discuss policy and operational issues.

The **key worker** focuses on communication with the young person, the family, the involved community professionals and the other members of the inpatient CAMHS team. When the key worker is off duty the young person and family should always be informed who is deputising. Families may receive additional support, in their own right, from groups such as parent support groups and advice/help lines. They may be actively involved in the treatment offered through regular review meetings, family discussion and family therapy.

Each young person should have an **individualised treatment plan** based on the patient's perceived difficulties in biological, psychological and social functioning. They should be actively involved in the development of all these functions. This may be embedded into clinical practice by their involvement in 'core team meetings' attendance at clinical reviews, collaborative care planning, written feedback from the young person prior to treatment

reviews, feedback on weekend leave etc. Paper copies of this information should be made readily available to the young person. A psycho-educational component enables the young person and their families to have a richer understanding of the evidence base for their treatment, and their prognosis.

## Discussion point 2

- Think of a young person who was recently admitted to your unit. How much information do you share with the family on the first day of admission and what key areas do you feel must be covered?
- Consider what methods you may use to 'engage' the young person and their family in the treatment plan discussions.
- In your unit are young people encouraged to be actively involved in treatment decisions? If so what systems are in place to enable this?
- Discuss how you could achieve setting realistic goals for inpatient treatment with the families that come into contact with your service.



## Discharge planning and the Care Programme Approach (CPA)

**Discharge planning** should occur even before a young person is admitted to a CAMHS inpatient unit so that transition in and out of hospital is seamless. Competent **discharge planning** by the inpatient team will involve the establishment of regular communication with the referring team, clarification of the nature of on-going involvement and exploration of the possibility of joint therapeutic interventions. The young person and their family should recognise this activity as an organised and planned part of the care pathway. Whenever possible they should be actively encouraged to be involved in the decision-making. Discharge planning requires agencies to take responsibility for providing continuity so that inpatient work is undertaken in the context of family and local professional networks. As a prelude to discharge from inpatient care a 'stepped care' model may be considered relevant whereby more nights are spent at home or in day care. By offering inpatient, day-patient or outpatient programmes more flexibly, the young person is offered a graded return to the community. This flexible arrangement allows a timely response to an emergency when it may be necessary to work more intensively. It promotes a collaborative approach with young people and their families. It allows healthcare services to tailor modalities of treatment for each individual and to be well placed to assess levels of risk and judge the necessity for the correct level of intensity of treatment.

The **Care Programme Approach (CPA)** was first introduced in 1990 and was originally developed for adult services. However, it is now a requirement for young people aged sixteen or over (DH, 2008). Some CAMHS services have adopted this approach for all of those admitted regardless of age. It has been reviewed twice since its introduction, most recently in 2008

(DH, 2008), with the recommendation that the previous two level system of 'standard' and 'enhanced' CPA be amended so that two categories will no longer apply. The term CPA will be used in this workbook to describe the process of assessing, planning, reviewing and coordinating the range of treatment, care and support that may be required by the young person and their carers. The Department of Health policy and guidance; *Refocusing the Care Programme Approach: Policy and Positive Practice Guidance* (DH, 2008) sets out a number of key principles regarding CPA, contingency and crisis plans which link to the Department of Health *Best Practice in Managing Risk Guidance* (DH 2007c) discussed in Chapter 4 of this handbook.

To ensure the momentum of working towards transition of the young person back into the community regular CPA reviews must be held at a minimum of six weekly intervals with the families and referring teams. Throughout inpatient care consideration should be given, on a weekly basis, to the patient's length of stay. Regular CPA meetings should be held at least 6 weekly with the referring teams and if delays occur to discharge they must be addressed and commissioners informed of the reasons for the prolonged stay. These delays may be in relation accommodation or transition to adult services. The final CPA meeting prior to discharge should ensure that the young person has an identified care co-ordinator to monitor their progress and provide a smooth transition back into the community. At this meeting, factors affecting prognosis and relapse prevention plans must be fully considered and documented. The young person's family is central to this discussion.

There is a risk of **relapse** following discharge from inpatient care, as the intensity of care is reduced and as the family readjust to living together again. Green *et al* (2007) found that at follow-up, a quarter of young people had not received any of the services recommended at discharge and only 10% received the full discharge package. This is of real concern and it may not be surprising that some young people relapse following discharge (Green *et al*, 2001). Relapse may be minimised if the unit operates a 'stepped-care' model and if there is negotiated, comprehensive community involvement. Inpatient services should provide a written report to the referring community CAMHS documenting a wealth of information relevant to the care of the young person. This should include findings and agreements arising from the pre-admission assessment, the initial assessment review, the initial period of inpatient care, regular meeting reports (for example; six weekly and discharge planning) and a summary statement. Discharge planning and aftercare which is based on the principles of the CPA is vital in helping to prevent relapse.

## Transition issues

The *National Service Framework (NSF) for Children and Young People* (DH, 2004a) recognises that transition should be a guided, therapeutic, educational process rather than an administrative task. Some young people report feelings of being "dumped, cut off and abandoned" as they reach the transition period (Shaw, Southwood & McDonagh, 2004 cited in RCN 2004). It is therefore important to involve young people in the decision making process and to make it clear who will be involved in their care following discharge and to state the frequency of contact.

The impact of the young person's history of attachment and current attachments to staff members, the place (e.g. psychiatric establishment, CAMHS inpatient unit) and their family is

a recurring theme in how young people perceive and manage the transition process (Kane, 2008). If this is not carefully managed it may present a huge risk to the young person's recovery and treatment. Kane (2008) suggests that whilst consideration of attachment issues may be a fundamental part of CAMHS services it is not thought to be a concept that adult mental health services relates to easily. They may be less likely to undertake a detailed developmental assessment.

Kane (2008) highlights other factors, such as contact with family, as extremely important and further states that the levels of involvement and support to the family, once in the adult mental health (AMH) system, is sporadic and variable. Some AMH systems are more proactive in taking a family systems approach whilst others may work with the young person in isolation. Preparation of the young person for transition to AMH systems includes timely interventions from the follow-up team, whilst existing services reduce their contact or frequency of therapies to dovetail with discharge planning. The community team or adult service need to be actively involved in the care planning as early as possible. Wherever possible it may be appropriate for community CAMHS team to remain involved throughout the young person's inpatient admission, to any AMH setting, therefore easing the transition pathway.

One other factor is that of developmental issues. As young people progress into healthcare services provided for adults they become the youngest in the placement. Therefore they may require a graduated move to their next care area so that they can get to know the team and become acclimatised to their new environment. A good transition plan would include several preparatory visits to the next placement prior to discharge.

The document '*A Positive Outlook*' - *A good practice toolkit to improve discharge from inpatient mental health care* (CSIP (2008) offers examples of good practice that demonstrate solutions for effective discharge practice which reduces delayed discharges and promotes individual recovery.

## Transition to adult mental health services

The need to provide separate inpatient facilities for child and adolescent mental health care was highlighted by the World Health Organisation (WHO, 2005). Children and adolescents can experience fear and intimidation if they are treated alongside adults. This view has been supported by reports from the Children's Commissioner for England, *Pushed into the Shadows* (11 MILLION 2007), *Out of the Shadow* (11 MILLION 2008) and Standard 9 of the *National Service Framework for Children, Young People and Maternity Services* (DH, 2004a).

The National Service Framework for Mental Health (NSFMH, 1999) for adults of working age requires services to develop and agree transition protocols for the transition arrangements for people moving between CAMHS and Adult Mental Health services (DH 2006). However, due to the lack of provision some young people will be admitted to adult wards as a temporary solution. If this situation arises NHS Trusts should identify wards or settings that would be better suited to meet the needs of young people. There should be agreed protocols between CAMHS and adult mental health services to safeguard a young person's safety, welfare and dignity.

The Government is committed to safeguarding and promoting the best interests of children and young people and has pledged to bring the new section (131A) of the Mental Health Act

(MHA, 1983) into force in April 2010. This amendment will ensure that all young people under the age of 18 that are admitted to adult wards, are treated in an environment in hospital which is suitable, having regard to their age (subject to their needs). This assumes that young people within inpatient settings have certain entitlements (Table 22).

**Table 22: Requirements of Age-Appropriate Environments**

- Suitable physical facilities
- Individuals with the right training, skills and knowledge to understand and address the specific needs of children and young people
- A hospital routine that allows personal, social and educational development of the young person to continue as normally as possible
- Access to educational opportunities, equal to that of their peer group, taking into consideration their mental state

Cited in; *Working Together to Provide Age-Appropriate Environments and Services for Mental Health Patients Under 18* (2009, p. 9)

In some areas, young people under the age of 18 years are admitted to adult wards due to the lack of provision of adolescent beds, with more than half of adolescent services reporting insufficient beds for the locality (QNIC, 2006-07). The Local Delivery Plan Returns (LDPR 2007-8) identified that at least 10 percent of occupied bed days, within the NHS units in England for under-18s who require inpatient treatment for mental health problems, were on adult wards. This evidence is cited in *Working Together to Provide Age-Appropriate Environments and Services for Mental Health Patients Under 18* (2009, p.9).

Within the Department of Health Consultation document *New Horizons: Towards a shared vision for mental health* (2009) a key area of focus will be finding ways to improve transition from childhood to adulthood and supporting young people at this crucial time.



### Katie's Case Scenario

Katie is a 17 year old girl who was admitted as an emergency following the 'planned suicide' of her brother. She found it difficult to settle into the unit. She believed other young people did not like her and she unsuccessfully attempted self-strangulation by tying a shoe lace around her neck and attaching it to a towel rail. She had a persistent sense of hopelessness and ideas of suicide. Attempts to decrease nursing observations resulted in an increase in Katie's self-harm incidents. During individual work she was unable to talk a great deal about her thoughts and was concerned that as her parents responded angrily to her distress she was a burden to them. She reacted angrily to any discussion about discharge and refused to re-engage with her old social networks locally. However, she absconded from the unit on four occasions and needed police assistance to return on two occasions. She made three attempts to suffocate herself with a plastic bag, cut her self sufficiently to require hospital attention and overdosed on Paracetamol. She remained on the unit for 6 months. Katie eventually agreed to become involved in her discharge planning and, due to her age, Adult Mental Health Services were involved in the CPA meetings. In the last few weeks of her admission there was a dramatic reduction in self-harm and Katie seemed less angry towards staff. However, she did remain low in mood and she reported having fleeting thoughts of ending her life.

## Discussion point 3

- At what point(s) during Katie's inpatient experience could she have been assessed for sectioning under the Mental Health Act? What rationale would you offer her parents for this intervention?
- Consider what services would need to be involved in Katie's care in order to have a safe transition from CAMHS to Adult Mental Health Services (AMH).
- Discuss how the risks associated with transfer of care may be identified and managed effectively.
- What role do you think Katie's parents should play in her treatment once she is transferred to AMH? How should their contribution be evaluated?
- What are the legal issues to consider with regard to Katie's treatment?
- What level of information should be shared between CAMHS and AMH regarding Katie's treatment and her response to it during her inpatient stay?



### Suggested further reading

**Child and Adolescent Mental Health Services: Everybody's Business.** (2001). National Assembly for Wales.

Fonagy, P., Target, M., Cotterell, D., Phillips, J., Kurtz, K. (2005) **What Works for Whom?** The Guildford Press: New York.

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O'Herlihy, A., Pugh, K., McDougall, T., Parker. (2009) **Safe and Appropriate Care for Young People on Adult Mental Health Wards.** Royal College of Psychiatrists: London.

Royal College of Nursing (2004). **Adolescent Transition Care – Guidance for Nursing Staff.** RCN. London.

[www.dh.gov.uk/en/Healthcare/nationalserviceFrameworks/MentalHealth/DH\\_4132161](http://www.dh.gov.uk/en/Healthcare/nationalserviceFrameworks/MentalHealth/DH_4132161)

## Postscript – some personal thoughts

I believe CAMHS inpatient treatment has changed for the better over the last ten years but there is still a long way to go before young people and their families receive the 'seamless care' they deserve. Inpatient services should no longer be considered in isolation from their community counterparts and the emphasis will be on a shorter length of stay, stabilisation of symptoms and minimum necessary change before discharge. This will require Tier 4 inpatient services to work much more closely with community colleagues from all relevant agencies to offer a 'wrap around' service. All over the country there are examples of responsive, flexible services that demonstrate our ability to provide integrated high quality care.

Alongside better strategic management of services CAMHS inpatient teams have been reassured and energised by the formation of QNIC. This has presented CAMHS teams with an opportunity to exchange ideas and share good practice. We need to continue to take pride in our service and share our successes with our young people and their families. In order to provide evidence of our expertise we need to be open, transparent and embrace audit, outcome measures, patient satisfaction surveys and reflective practice. Service users will expect greater user involvement such as in developments of services and to be given more 'choice' over the care they receive and where this takes place.

However, I recognise that there is a paucity of specialist CAMHS literature, particularly on 'what really works for whom' and our knowledge-base needs to be strengthened. There are good examples across the country of innovation and audit. Research needs to be undertaken to challenge, confirm or supplement existing theory and funding of evaluative and comparative studies help support and aid understanding as to what makes inpatient treatment effective.

The central tenant of *New Horizons: Towards a shared vision for Mental Health (2009)* is early intervention to promote positive mental health among infants, children and young people in order to lay sound foundations for mental health and well-being into adulthood and older age. Lord Darzi in the *NHS Next Stage Review (2008)* has emphasised high quality care for all with personalised service experiences. Service providers are encouraged to strive for excellence. I believe this applies not just for users of CAMHS but that it should be a condition for the education and training system for the CAMHS team. This is a golden opportunity to explore 'New Ways of Working', within teams and embrace the changes ahead. CAMHS inpatient care is already team based and embraces a multi-professional approach. It needs to further develop multi-agency working across service boundaries. *New Horizons: Towards a shared vision for Mental Health (2009)* offers opportunities to influence Tier 4 commissioning. We need to ensure that there is more cohesiveness and flexibility across the Tiers, within CAMHS. As service providers we may identify mechanisms for influencing Tier 4 commissioning and delivery. This is a new challenge of some magnitude in the face of the financial constraints that will affect the NHS in the next few years. It will require service providers to review their working practices and their requirement for new workforce roles. The challenge is to improve productivity and giving maximum value whilst still providing high quality care.

There are other changes ahead which confront all healthcare delivery, two examples are the implementation of the European Working Time directives for doctors and the move towards an all graduate nursing workforce. Transition to Adult Mental Health services will continue to be high on the agenda for both CAMHS and Adult Mental Health services over the next couple of years. We need to facilitate opportunities to share professional knowledge and develop the specialist skills required so that young people receive a safe and appropriate transition into adult mental health services for those with continuing needs.

I hope this handbook conveys the key aspects of working in a CAMHS inpatient setting and that you discover, as I have, that they are positive learning environments. Fantastic working relationships are forged, between committed and experienced professionals, which make the impossible seem achievable. Approaches to mental health and service delivery may change constantly but some things remain constant. For me the passion and joy of working with young people and their families in CAMHS inpatient settings continues and I feel optimistic about its future.



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## Appendix 1

TIER 4 CAMHS CLINICIANS' WORKSHOP, MONDAY, 16TH FEBRUARY, 2009.

### Attendees

NAME	UNIT	TITLE
Mr Barry Nixon	National Workforce	CAMHS lead
Mrs Carmel Carter	Alpha Hospital, Woking	Clinical Nurse Manager
Miss Tina Patience Chigumadzi	Alpha Hospital, Woking	Registered Mental Health Nurse
Ms Jane Claxton	Prudhoe hospital, NTW NHS Trust	Service Manager Tier 4 CAMHS
Mrs Mary Connellan	Clinical Co-ordinator	St Patrick's Hospital, Dublin
Olivia Dexter	Pine Cottage, Dorset HCT	Acting Clinical Manager
Mr Carl Dykes	Collingham Child and Family Centre, London	Clinical Nurse Specialist
Dr Nicoletta Gentili	Corner House, St George's, London	Consultant Psychiatrist
Dr Dan Hayes	Aquarius Unit, London	Consultant C&A Psychiatrist
Debbie Holder	St Andrew's Hospital	Social Worker
Dr Shermin Imran	McGuinness Unit, Manchester	Consultant Adolescent Psychiatrist
Mr Nick Jones	Lime Trees, North Yorkshire PCT	Nurse Consultant
Mrs Vanessa Kinsey-Thatcher	St Andrew's Hospital, Northampton	Governance facilitator
Mr Matt Maitland-Ellis	Alpha Hospital, Woking	CAMHS Consultant
Mr Tim McDougall	Cheshire and Wirral Partnership NHS Foundation	Consultant Nurse/Network Manager
Ms Catronia McPhillibin	Lecturer	Trinity College, Dublin
Dr Jane Morris	Lothian NHS Trust- CAMHS	Consultant C&A Psychiatrist
Dr Catherine Nagan	Tier 4 CAMHS Belfast	Consultant Psychiatrist
Stephen Noble	Tier 4 CAMHS Belfast	Ward Manager
Dr James Oldham	Alpha Hospital, Woking	Consultant Psychiatrist
Catherine Parker	Tier 4 CAMHS Belfast	Nurse Team Leader
Dr Rafik Refatt	Coborn Centre for Adolescent Mental health, London	Consultant C & A Psychiatrist
Miss Nicola Riley	Greater Manchester West Adolescent Services	Advanced Practitioner (Trainee)
Mr Peter Thompson	Quality Network for Inpatient CAMHS	Programme Manager
Mr Neil Strachan	CAMHS North of Scotland	Regional Network Project Manager
Ms Ruth Turnbull	2gether Foundation Trust, Gloucester	Head of Nursing CAMHS
Mr Ray Waters	Cotehele Unit, Plymouth	Consultant Nurse
Mr Simon Whibley	Stephenson House, Prudhoe Hospital, Northumberland	Acting Ward Manager
Jacqui Wilson	Tier 4 CAMHS Belfast	Ward Manager



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