NAPICU CAMHS Symposium
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CAMHS Inpatient Care Provision: Learning from Clinical-Focused Research - A Call for Developmentally Focused Models Of Care.

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national association of psychiatric intensive care units

Agenda:

- State of the evidence-base
- Whistlestop tour of developmental differences that need to be incorporated in service development delivery and models of care provision and workforce development
- Learning from one set of studies about how this manifests in practice

State of evidence

- New Review of PICU literature (Salzmann, 2023)
  - 47 published papers in last 5 years on adult PICU

- CYP/CAMHS PICU
  - 5 in the same period
  - 4 of those were mine!

- CAMHS inpatient admission (of all kinds):
  - Before 2020 = 7: 2 descriptive and 5 qualitative

  - Since 2020, doing a bit better: 15+
    - Methods: Descriptive, single case studies; quality improvement projects, a small number of qualitative studies
    - Topics: Disordered eating care, measuring outcomes, managing self-injurious actions and transition

Why does this matter?

- **Globally, general adolescent inpatient mental health units are the most used component of acute adolescent mental health services.**
  - Their stated purpose is to contain risk, acute distress responses and stabilize psychiatric symptoms
  - We don't have a good understanding of how it works?
  - No adequate/valid tools to assess inpatient CAMHS experience and outcomes.
  - Outcome measures we don't measure what we know is important to CYP & Families
    - Prioritising young people's moral, relational, and emotional experiences on CAMHS inpatient units is imperative, "as to be treated with dignity and fairness is a matter of life and death"
- **Work can be a source of moral distress for staff**
  - Foster, 2021; Mathews & Williamson, 2016; Musto & Schreiber 2012; Rasmussen et al., 2012.
  - Three-fold task of adolescent care:
    - to treat and manage the young person's presenting mental health condition
    - supporting normal adolescent development
    - Manage loss of dislocation and re-traumatisation that inpatient care brings

What do we know?

- Compared to adult hospital settings, child and adolescent service serve a more complex and heterogenous patient population.
- Acute psychiatric distress in young people much more likely to sit outside of easy diagnosis and be sat on top of learning disability/SEND, neurodevelopmental differences and multiple ACES /trauma, failed previous treatment attempts (NHSE, 2018)
- Hospital admission as a teenager is highly deleterious to ordinary development (Hannigan et al., 2019)
- Lengths of stay tend to be longer, and discharge can be delayed by limited community placement options.
- The care required spans several developmental stages and requires attending to attachment and dependency needs – but is not included in core mental health workforce training or models of care
- Evidence on effective treatment approaches in child and adolescent inpatient services remains limited
- Young people are nearly always in mixed gender environments
    - particular fear-power, ganging and adolescent sexuality dynamics
- Adolescence is a cultural & developmental context, that will not be ignored no matter how hard you try
- In the UK 18 yrs is the legal transition point between young people's and adult services, but it is not the natural developmental transition point
    - Recognition that adolescent stage of development does not end until 25
    - Lots of problems being stored up for care after transition to adult services

Developmental Differences

Neurobiological Differences

- Primed for prioritising decisions on basis of short-term benefits over long term
  - Need for scaffolding
- Decision-making outcomes are more heavily swayed by peer influence and need to maintain status (safety/survival) than anything else
  - Direct implications for preventing, de-escalating and managing challenging behaviour
- Biologically primed for rapid changing states of mind and mood
  - in order to be able to tolerate and adapt to changes
- Time of developmentally ordinary emotional dysregulation
  - and only emerging coping capacities
- Dissonance between physical stature and neurological development

(Lancet Commission on Adolescent Health: Patten et al., 2016)

The adolescent body – understanding incident prevalence, therapeutic management and its impact

- Use of the body for solving psychic conflicts is developmentally ordinary in adolescence (Waddell, 2018)
- Self-regulation strategies in young people/young adults are usually more 'physical', less verbal or internal, in nature. (Delaney & Hardy, 2008)
  - Dilemma: need freedom to move and closer supervision
- Emotional regulation strategies are still in development, so challenges remain, even when psychiatric disturbance is stabilised
  - needs support and attendance
- Non-verbal communication/projective identification primary means of expressing complex emotionality
  - Giving you a taste of how it feels

Psychosocial Developmental considerations

Maturational gains in the ability to see from multiple perspectives and consider needs of others are new and fragile

- they are lost in moments of high arousal and distress

Issues of perceived equity, justice and fairness are of prime concern

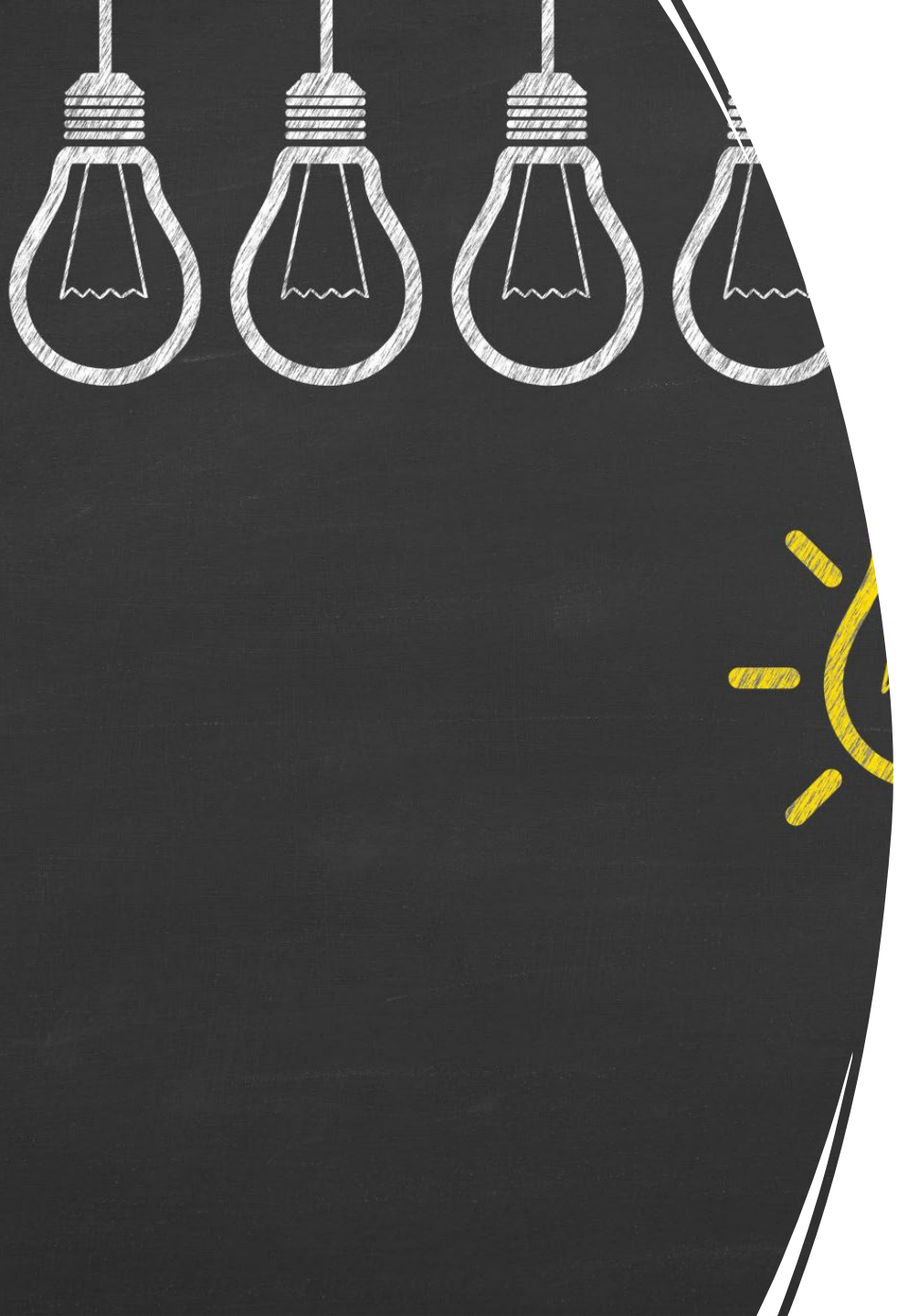
- Sensitivity to injustice is major trigger for incident

Omnipotence and omniscience is the natural defence against vulnerability, which is felt like a threat to survival

- Asking and accepting help is a threat – 'coming alongside' is key to success

Powerlessness and uncertainty = shame and humiliation

- = rage/aggression
- = withdrawal/downing tools



How is this translated in current policy, service specifications and models of care

- **Macro level** - It isn't really…
  - Models of provision organised around diagnostic categories
  - Specifications take an adult acute model and adapt from there
  - There is now a competency/skills framework for working in child and adolescent inpatient settings
    - Not yet a strategy about how to bring these competencies and skills into life in all settings

- **Micro Level** – we know there are all sorts of innovations, and adaptations to produce good outcomes
  - They need shining a light on

Adolescence and young adulthood is a time of huge opportunity – getting it right counts for all of society

- Nothing is set in stone
- Everything is biologically and developmentally primed for growth
- Every small success gets set down as part of the fabric of future resilience, problem solving and coping capacities
- Opportunity not just to improve presenting mental health needs, but to provide a working relationship that enables growth and development

What can we learn from some primary research studies that have been done into approaches for children needing intensive care (wherever the setting)?

7 Studies over ten years :

2 paediatric medical wards and 1 CAMHS PICU site

- Foster C. (2021) Caring for adolescents with acute and complex mental health need in hospital settings: A developmental, object-relations approach to conceptualising and enabling nursing task, identity and intervention. PhD Thesis: University of Salford. http://usir.salford.ac.uk/id/eprint/59326

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- Fisher, G., & Foster, C. (2016). Examining the needs of paediatric nurses caring for children and young people presenting with self-harm/suicidal behaviour on general paediatric wards: Findings from a small-scale study. *Child Care in Practice*, 1-14. https://doi.org/10.1080/13575279.2015.1118013 http://usir.salford.ac.uk/id/eprint/36844

- Foster C (2009) Adolescents in Acute Mental Distress on In-patient Pediatric Settings: Some reflections from a paediatric liaison practitioner. *Journal of Child & Adolescent Psychiatric Nursing,* 22(**1**), 16-22. http://usir.salford.ac.uk/id/eprint/31777

Trans-Diagnostic/adolescent aspects of Psychological & emotional functioning require the most intervention (Foster & Smedley, 2019a)

Role of anxiety and uncertainty in client presentation

- self doubt, disgust, criticism, shame, anxiety: dressed up as boisterousness and disinhibition,

Self-loathing or attribution of null worth to self

Disturbance of adolescent identity or sexuality expression

Attempts to control the environment, to:

- manage anxiety
- mitigate feelings of powerlessness

Envy, Sensitivity to injustice being treated unfairly

Fear, anxiety and requests for help expressed through violence and hostility

Adolescent group/ganging dynamic

Working Context

(Foster, 2009, Foster, 2018, Foster, 2021)

- Higher societal/legal expectations re: preservation of life
- Working practices privilege ‘doing’ over ‘thinking’
- Conflicting foci of work - multiple jobs in 1 setting
- Low autonomy in decision-making and pathways that directly affect their work
- Shared sense of incarceration, hardship and scrutiny in the system with CYP
- Restriction is pro-safety but anti-development – re-traumatising, activates adolescent defences and transdiagnostic difficulties

Produces unresolvable tensions that staff have to occupy (Foster & Smedley 2019a)

1. Balancing boundaries vs. care & nurturing
2. Consistency vs. flexibility
3. Group vs. individual needs
4. Safety/security vs. therapeutic engagement
5. Controlling the environment vs. promoting autonomy
6. Acute illness vs. adolescents in recovery
7. Clinical vs. operational management demands
8. Increasing numbers of staff on shift: more resources to meet children's needs vs. harder to maintain unity and consistency of approach

Caritas as the method of intervention (Foster 2021)

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- Primary interventions parallel the growth promoting elements of good enough parenting:
  - Understanding that all behaviour is information and currency for connection, growth and recovery
  - Extending oneself to the betterment of for no reward or gain (Agape)
  - Commitment to occupying continuous states of tension (nurture as the mediating force of destructive elements)
  - To get up close and feel the 'felt' difficulties, even when its disturbing (openness to projective identification)
  - To provide a receptive and accepting gaze upon all parts of the YP (so they can feel seen)
  - To balance specific 'tender' knowledge of individual YP, against general professional & clinical principles and boundaries
  - To use oneself: lending values, body, mind, heart
    - Whilst under fire, in hostile environmental, emotional and occupational circumstances
  - To limit and control one's one needs, to maintain the centrality of the original primary-carer relationship (tenderness)

Gaze & Observation: Seeing, not looking at….. (Foster, 2021)

Usual close observation practices within the adolescent were actually exploited by the staff to provide receptive and attuned care and psychological holding environment

In absence of touch use of knowing whereabouts, looking and managing proximity of self in relation to young people to help soothe and calm.

Adolescent reversion to communicating via non-verbal ways as words fail them

providing a space in which young people can show their difficulties to people who are prepared to get up close and feel something of their disturbance, without looking away, denigrating, invalidating or retaliating

We know there is a direct relationship between professional identity, sense of competence, staff wellbeing, compassion for service-users and quality of care

When it goes wrong
(Foster, 2009; Foster & Smedley 2019b)

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- The capacity for this kind of loving intervention are eroded by its very practice

- That which enables therapeutic intervention/environment and gets in its way are two sides of the same coin
  - Openness to feeling young people's felt feelings,
  - Prolonged close proximity to disturbance
  - Shared experience of hardship of the restrictive environment
  - High levels of projective Identification with neglect, maltreatment, aggression and victimisation carried by young people

- Difficulties of Naming/valuing what they are doing (feeling illegitimate)

- Without support and understanding, Produces unbearable feelings of loss, can feel depleted, overwhelmed at the mercy of the environment and the young people themselves
  - Leads to enactment of psychological defences to protect oneself (at individual and team level).

What can help (Foster 2020 & 2021)

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Intentional, developmentally focused clinical design

That recognises the specificity and additionality of caring for children, teenagers and young adults within the realities of the MH care pathway – different to adults!

Staff support: Spaces for 'Thinking about' thoughts and feelings.

Staff need the same 'faithful loving care' as the CYP they are caring for – the specific details of their work need to be seen, understood and nurtured, through:

- Time to think, and space in which thinking is possible and facilitated.
- Being enabled and encouraged to speak, feel and wonder about their experiences, safely and freely.
- Being helped to contextualise young people's difficulties, by situating them in:
  - knowledge of the young person's biography, and specific mental health conditions,
  - greater understanding of adolescent development.
- Being supported to interrogate the underlying unconscious drivers for the feelings and actions of both the young people and themselves
  - 'Why they do it? Why we do it?';
- Learning about and with each other and having a mirror held up, to help them see their work and its value.

In one setting, an adapted weekly psychoanalytic work discussion group

Over 6 months, Improved:

1) Knowledge and understanding;
2) Emotion management;
3) Personal efficacy;
4) Approach to challenging behaviours;
5) Therapeutic relationship with the young people;
6) RMN clinical leadership;
7) Professional identity;
8) Team functioning

(Foster, 2020)

Conclusions

Learning so far tells us:

- The nature of mental health interventions within CYP hospital settings is unique
- Given birth to by the manifest tensions of the primary nursing task of enabling developmental growth and reparation for young people who are experiencing acute psychiatric disturbance during a critical phase of their maturation,
- This is often against a backdrop of neurodevelopmental difference, chronic adversity and complex trauma
- Clinical distress and tasks are fundamentally relational in nature requiring explicit up-close engagement with a young people's dependency
- Meaning that the factors that enhance or impede recovery are often two sides of the same coin.
  - To maintain care quality and improve outcomes, staff needs must be attended to

Requires coalition of clinicians, young people, families, researchers and policy makers

- Development of a model which explicitly speaks to the inherent role of attachment/relational in every aspect of design and care & workforce development
- Construction of a language that draws from theory outside of biomedical, e.g. developmental, attachment and object relations theory
- Understanding of staff support needs and strategies to address these in order to sustain therapeutic task
- Better/ new research methodologies that directly impact on an influence practice

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