Children and Young People's Mental Health Training

Background

Healthcare workers often report that they feel they lack the knowledge, skills and confidence to support young people with mental health problems. This training has been developed directly in response to the views, experiences and needs of young people and staff working in acute hospital settings.

We Can Talk was developed with funding from Health Education England at Barts Health NHS Trust and works with hospitals across England in collaboration with the Common Room, Healthy Teen Minds and the Child Outcomes Research Consortium (CORC).

It has been developed by a partnership between young people and adults with lived experience of mental health difficulties, acute hospital staff and mental health professionals.

Training overview

The aims of today are to:

- Recognise the role that hospital staff are already playing in supporting children and young people's mental health
- Develop an understanding of common mental health difficulties
- Explore the different scenarios where you support children and young people who may be experiencing mental health difficulties
- Understand the experiences of children and young people
- Explore and understand how to communicate effectively with children and young people with mental health difficulties
- Explore and understand key approaches to supporting children and young people

Things to keep in mind

- Mental health can be an emotive topic. If you need to take time out please do so.
- We want to learn from experience, but please try not to use names or personal details.
- Today is focused on building on your existing skills and experience, learning together, sharing practice, ideas and experiences.
- Sometimes, the best way to learn is to share and reflect on examples where things haven't gone so well. Please be respectful if people do share examples.
- Don't worry if you're not sure the correct terminology to use about mental health. It's better to say something than stay quiet.
- It's important to explore, discuss and debate, but try to challenge the idea not the person.

Understanding: Your Role

How do you support and care for children and young people who present to hospital in general?

- When we ask children and young people who come to hospital for their mental health what made their experience a good one – they write the same list you have just written…
- They tell us that a good experience is receiving care as usual
- We don't have to be mental health experts, we just need to show the care and compassion that we give to all patients.
- But we know from talking to hospital staff that it feels different.

Understanding: Your Role

Supporting children and young people with mental health difficulties in your role or service

What are the skills needed?

a) A person who knows how to engage with children and young people, helps them feel safe and cared for, involves them in decisions about their care and encourages them to want to stay.

b) Someone who has never worked with children or young people, doesn't engage them or show interest in their care and might only have experience of working with adults with chronic mental illness in forensic settings.

In child and adolescent inpatient mental health hospitals much of the direct care is provided by Healthcare Support Assistants (HCAs), without formal mental health training, who know how to engage and communicate with children and young people

Understanding: RMNs

- RMNs are Registered Nurses in Mental Health
- Most RMNs work with adults and as a result they might not have received much or any undergraduate or post-graduate training on children and young people's mental health
- There are currently huge vacancies for RMNs within the Child and Adolescent Mental Health Service (CAMHS) system resulting in most RMNs with any experience of working with children and young people being 'snapped up' by these services
- As a result, agency RMNs with little or no experience are routinely used to 'special' or 'one-to-one' in hospital resulting in poor experiences of care reported by children, young people and hospital staff
- Only those with environment/service specific training in restraint, that includes managing challenging children and young people, should restrain (DHSC, 2017) including agency staff (DHSC, 2014)

Understanding mental wellbeing, mental health and mental health difficulties

Understanding: **Mental health**

- Maintaining a good level of physical health does not mean we never get unwell.
- Having a good level of mental health is not about having the ‘best life ever” but being able to get through the lows and experience the highs.
- **Mental health is something we can all relate to because we all experience our own mental health.**

“Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”

World Health Organization (WHO)

“Mental health is defined as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.”

World Health Organization (WHO)

Mental Health Overview

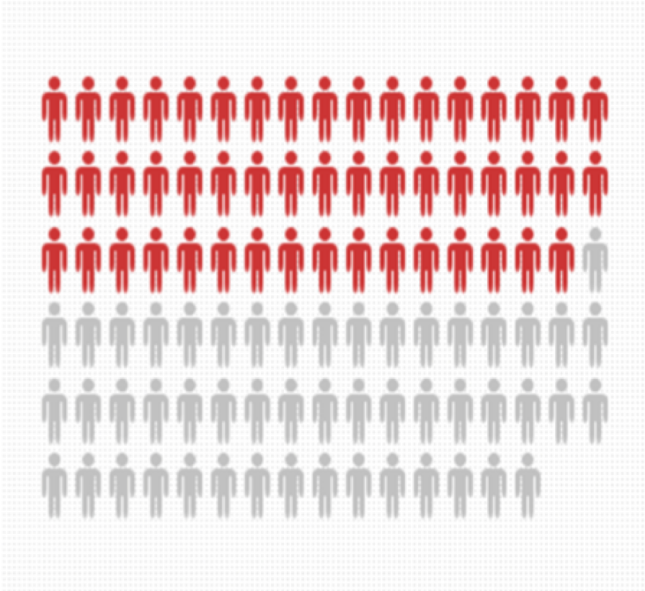
“83% of people will experience a mental health problem in their lifetime”

(American Psychological Association, 2016)

Understanding: Identification

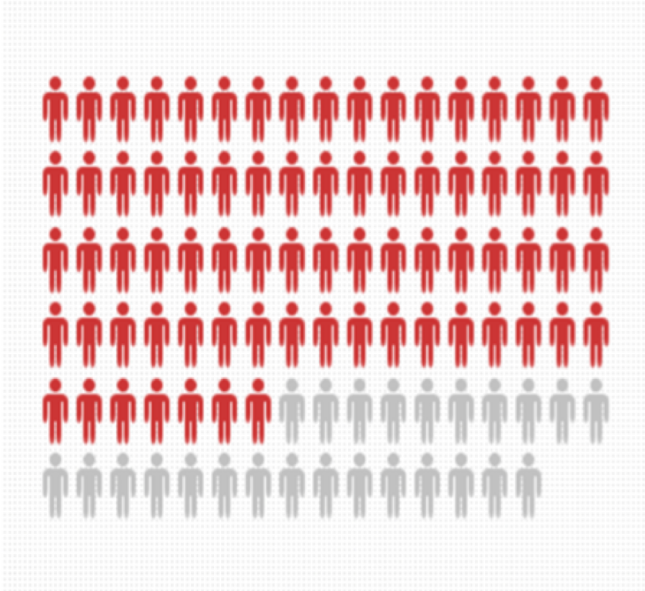
At Age 14

50% OF LIFETIME MENTAL ILLNESS (EXCLUDING DEMENTIA) STARTS BY AGE 14



By Mid Twenties

75% OF LIFETIME MENTAL ILLNESS (EXCLUDING DEMENTIA) STARTS BY MID TWENTIES



Understanding: **Identification**

50% of chronic mental illness in adults starts before the age of 14 and 75% before the age of 25 (Link).

Early identification in mental health has the same benefits of early identification in physical health.

It can:

- Prevent illness
- Lead to better outcomes
- Allow for more treatment options
- Cost less to health services

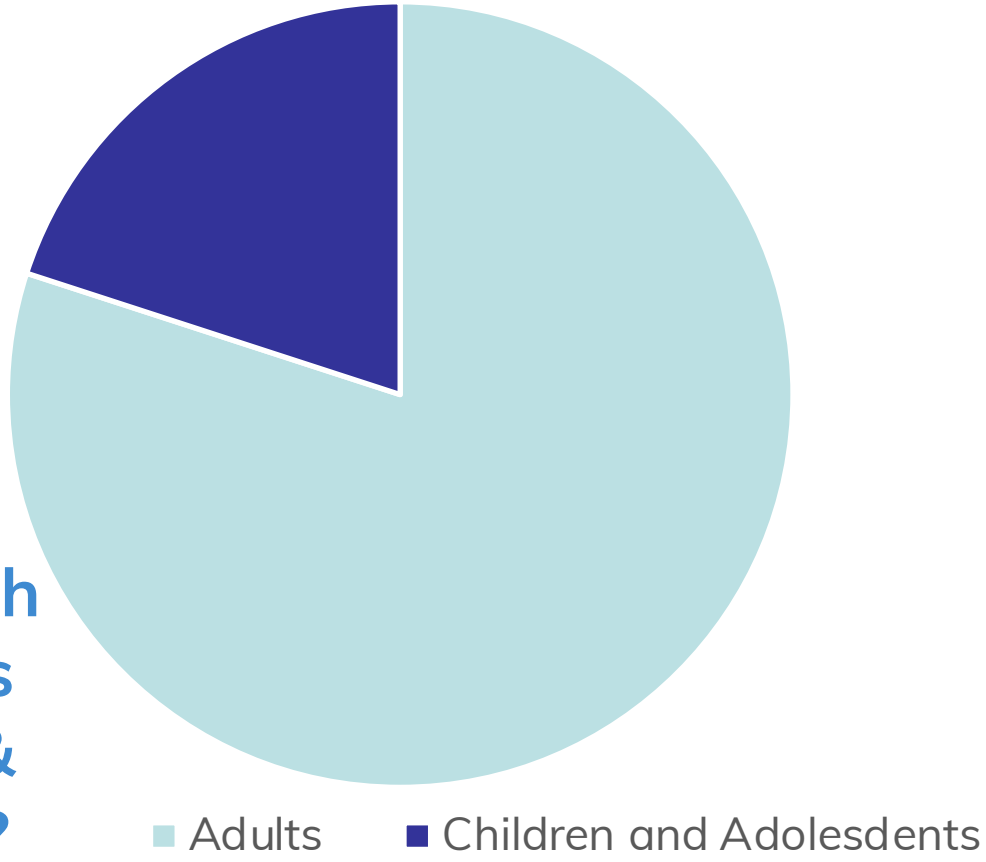
Spending on early intervention services for children and young people dropped by 49% (£3.7 billion to £1.9 billion) between 2010/11 and 2017/18. (The Children's Society, 2019).

Understanding: **Funding**

Child and adolescent versus adult population in England in 2017/2018

20% of the population

What percentage of specialist mental health funding goes on children & adolescents?



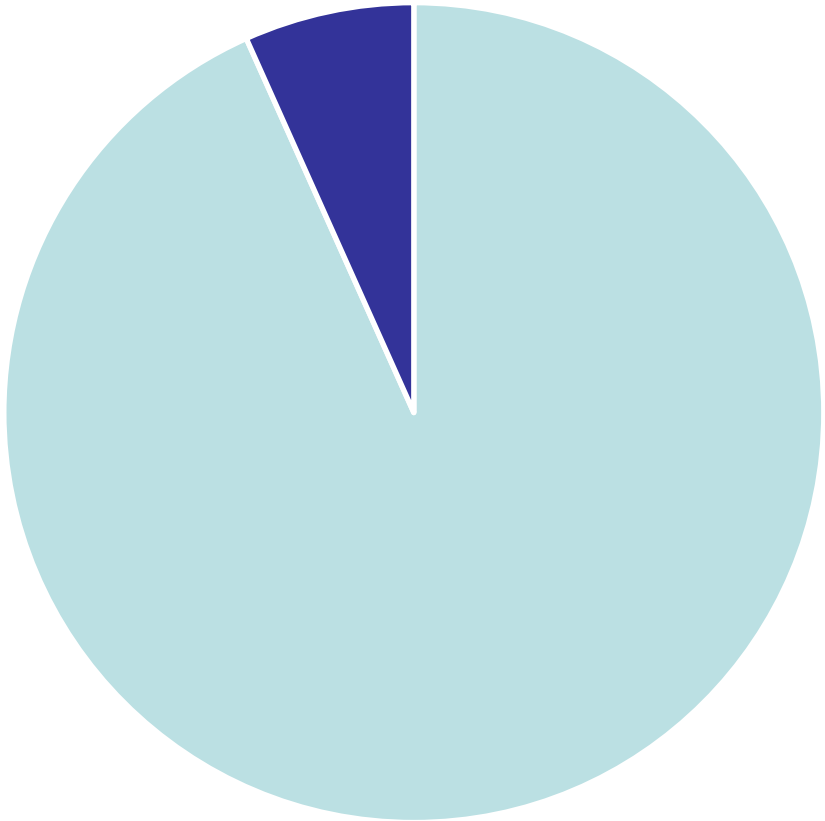
Children's Commissioner for England, 2018

Understanding: **Funding**

Money spent by local NHS areas on specialist mental health in 2017/2018

20% of the population

6.7% of the funding



Children's Commissioner for England, 2018

Understanding: **Funding**

In 2015/2016 services were funded so around **one in four** children with a diagnosable mental health disorder **had access** to specialist treatment.

NHS England's plan by 2020/2021 is for this funding to increase so that **one in three** children with a diagnosable mental health disorder can access treatment. (NHS Long Term Plan, 2019)

NHS England and local Clinical Commissioning Groups (CCGs) all together spent £1 billion on children and young people's services in 2017-18 (around 1% of their total budget). (National Audit Office, 2018)

NHS England cannot be certain all the additional funding announced in 2016 was spent as intended, and does not have strong levers to ensure that CCGs increase spending in line with their intentions. (Children's Commissioner for England, 2018)

Defining: Depression

When we get “stuck” feeling down

Defining: Depression

Depressive Symptoms	
▪ Continuous low mood or sadness	▪ Lack of energy
▪ Avoiding contact with friends	▪ Poor self care / self image
▪ No motivation or interest in things	▪ Low sex drive
▪ Loss of pleasure	▪ More/less sleep
▪ Having thoughts of harming yourself or suicide	▪ Changes in diet
▪ Feeling tearful	▪ Unexplained physical symptoms (aches, pains)

Defining: Depression

- Many people use the word ‘depression’ or ‘depressed’ to describe their mood when they’re not talking about a ‘clinical depression’
- It is normal for everyone to experience periods of sadness or low mood following trauma or other negative life events
- Symptoms tick lists can give us some ideas but understanding the impact of their mood on the child or young person is key

Defining: **Anxiety**

When our worries get in the way of our life

Defining: Anxiety

Types of Anxiety
Separation anxiety
Generalised anxiety disorder
Social anxiety
Specific phobias
Panic disorder
Obsessive Compulsive Disorder (OCD)

Defining: Anxiety

Anxiety Symptoms	
▪ Nausea	▪ Feeling worried
▪ Shaky/Dizzy	▪ Upset / tearfulness
▪ Rapid heart rate	▪ Irritable
▪ Breathless	▪ Avoiding situations
▪ Butterflies in the stomach	▪ Tension
▪ Poor concentration	• Distress about normal tasks

Defining: Anxiety

- It is normal for all of us to experience different types of anxiety during our everyday lives
- There are benefits to experiencing a normal range of anxieties (exam preparation, road safety, etc)
- There is huge overlap between the physical and emotional symptoms of anxiety (and all mental health problems)
- There is also a huge overlap of symptoms between different mental health conditions, making it tricky to identify exactly what is going on
- Symptom checklists can give clues to explore further but recognising the interference in someone's life and their level of distress versus other children and young people you interact with is key in early identification

Defining: **Bipolar Disorder**

Swings between extremes of depression and mania

Defining: Bipolar Disorder

Mania / Manic Symptoms	
▪ Incredibly happy or ‘high’ in mood	▪ Difficulty in concentration
▪ Rapid speech	▪ Inflated ideas about self and abilities
▪ Increased talkativeness	▪ Not looking after yourself
▪ Racing thoughts	▪ Lack of sleep
▪ Restlessness	▪ Overspending or other reckless behaviours

Defining: **Bipolar disorder**

- Increasingly the word 'bipolar' is used in everyday language to describe ups and downs, mood swings or emotional dysregulation
- Bipolar and mental illness in general is often portrayed negatively in the media and/or associated incorrectly with violence (Time to Change, 2014)
- Unlike mood swings, manic and depressive symptoms can remain 'stuck' for several days/weeks and don't necessarily need to follow an 'up or down' pattern
- 1% to 2% lifetime prevalence for bipolar disorder versus 20% lifetime prevalence for depression (Bipolar UK, Mental Health Foundation)

Defining: Psychosis

An altered state of how we think, feel, see and act

Defining: Psychosis

Psychotic Symptoms	
▪ Seeing or hearing things that aren't there	▪ Thought control (both ways)
▪ False beliefs incompatible with society or culture	▪ Broadcasting their thoughts
▪ Ideas of grandeur	▪ Mindreading (both ways)
▪ Feel they are being persecuted	▪ Incoherent speech

Defining: Psychosis

- Each person has a unique experience and combination of symptoms

- More than three quarters of men and two thirds of women experiencing their first episode before the age of 35 (Link)

When asking questions about psychosis it is also important to consider:

1) Normal childhood development (i.e. having an imaginary friend or understanding your 'internal voice', which can be more difficult for children with social/communication problems)
2) Faith/religion (i.e. hearing the voices of a god)
3) The effects of alcohol/drugs
4) Other illness or physical complaints (head trauma, UTIs, tropical diseases etc)

Supporting: Psychosis

When we speak to young people who have experienced psychosis they tell us it's most help for staff to:

- Acknowledge the experience, connect with emotions
- Don't pretend you're experiencing their reality
- Validate their distress without colluding or backing up their abnormal experiences
- Don't assume they won't be able to make any decisions about their care
- Young people say they remember people who made them feel safe or who were nice, even when they can't remember what the person said or did.

Defining: **Medically unexplained symptoms**

Physical symptoms we don't understand

Defining: **Medically unexplained symptoms**

- Our physical health responding to our mental and emotional health is **NORMAL**. Our brain is part of our body.
- We accept certain physical symptoms as ‘real’ (e.g. sweaty hands and upset stomach linked to anxiety) but other more extreme physical symptoms are often subject to disbelief and stigma.
- Don’t forget – history of misdiagnosing issues as mental health problems when there are physical causes (e.g. epilepsy as a ‘moral condition’)(Link).
- Medically unexplained symptoms present a challenge to services as most physical and mental health systems are set-up to work separately often resulting in lengthy periods in either service until an alternative approach is sought

Supporting: **Medically unexplained symptoms**

- Remember that there is still a huge amount of stigma about mental health and so many people would prefer to have a physical health problem rather than a mental health one.
- Positive communication about the role of mental health professionals in supporting physical health symptoms can make a big difference in how care is received
- Be open minded about physical or emotional cause but don't always assume these symptoms relate to trauma. During childhood, adolescence and young adulthood our brains are still developing and making connections.
- There is a lot we don't know about how our bodies and our minds interact.

Defining: **Eating Disorders**

- We all have a **relationship** with food.
- Some of us or more or less aware of that relationship depending on our personalities, interests and dietary needs, but we all have a relationship with food.
- Most of us will also have experience of supporting someone who was in a dysfunctional relationship with another person (e.g. abusive or negative partner/spouse/boyfriend/girlfriend)
- We recognise that they are unlikely to be able to act on our advice to "just leave them" but we can play a supportive part in their journey.
- The same is true of a young person with an eating disorder. We might not be able to direct the change we want to see but we can play a supportive role on their journey.

Defining: **Eating Disorders**

Dysfunctional relationship with food

Defining: Eating Disorders

Diet versus Disorder (Restrictive Eating Disorders)	
▪ Denial of diet	▪ Change in food rules
▪ Denial of hunger and craving	▪ Covering up weight loss
▪ Increased interest in food	▪ Claims of needing to eat less
▪ Eating slowly	▪ Avoiding eating with others
▪ Ritualised and compulsive behaviours	▪ Socially isolated and low in mood
▪ New or increased exercise routine	▪ Biological changes (periods stop)

Defining: Eating Disorders

- Eating disorders are not just about weight loss. People can maintain a normal weight and still have an eating disorder (e.g. bulimia nervosa).

- Anorexia nervosa has the highest mortality rate compared to other mental health illness (three times higher) (NICE, 2004)

- Many eating disorders services are not set-up to manage compulsive overeating or binge eating disorders with these conditions in children often being seen as a public health, 'healthy eating', problem.

Understanding: Mental illness

- Mental illness is not a tick box exercise (although often mental health services are fixated on tick boxes!)
- Mental heath is still a young field, with few answers about what works / doesn't work or what causes people to become unwell
- Supporting the individual and responding to how they are feeling and acting is essential to providing high quality care.
- There is a myth about violence and mental health. People with mental health problems are **FIVE** times more likely to be a **victim** of assault (rising to **TEN** times more likely for women with mental health problems) (Mind, 2013).
- We hear from talking to hospital staff, however, that they remember these incidents more because they felt out of their depth in managing the situation (e.g. versus the child who kicks out when having a canular).

Understanding: Mental illness

All people with the same diagnosis will appear, act, feel and respond differently to you.

It might be helpful to consider the following when there is a question of the presence of mental illness:

- Impact on every day functioning
- Rapid deterioration (in any area)
- Disengagement
- Significant change in behaviour
- Risk to self/others
- Bizarre behaviours/beliefs/statements

Understanding behaviour and communication

Understanding: **Behaviour**

Understanding: **Behaviour**

- Regardless of which mental health difficulty a young person is experiencing, they have core needs like all patients; their behaviour is not just a product of their mental health issue

- **Behaviour is a form of communication** – we need to try and understand what they are trying to express

- Young people are individuals – 10 young people with the same mental health difficulty will all have different underlying feelings, worries, wants. This is why it is important to understand and respond to underlying feelings, core needs, rather than the visible behaviours (or assumptions about behaviour)

- All children and young people have the same core needs - which is exactly what healthcare workers are skilled and experienced at supporting. **You don't have to be an expert in mental health to help.**

Understanding: Self Harm

Are these the only types of self harm?

- Cutting
- Burning / scalding
- Head banging
- Breaking bones
- Punching body
- Inserting/swallowing objects/poisons
- Throwing self against something

Understanding: Self Harm

What about?

- Smoking
- Tattooing
- Risk Taking Behaviours
- Body Piercing
- Eating Disorders
- Alcohol use
- Drug Use

Defining: Self Harm

- We all do things that are harmful in some way. There is a difference between ”things that are harmful” and self harm.
- Intention is more important than the act or “amount”/severity of visible harm. Seek to clarify self harm versus suicidal act.
- The children and young people most at risk to themselves may be those who describe their mood in the least risky way.
- Challenge the use of the word “deliberate” or dismissive terms like “superficial” or “attention seeking”.
- Young people may self harm as a way to “seek attention” or to “seek care” or “seek support” from professionals / parents / carers because they aren’t able to access it via any other route.
- There are all sorts of reasons why young people self harm (e.g. to feel something, to cope with difficult feelings, for a sense of control).

Understanding: Experience

Why do children and young people come to hospital in mental health crisis?

- Hospital isn't the first choice for young people experiencing mental health difficulties.
- They need professional care to stay safe, just like those attending with physical needs.
- When forced to seek medical care, they do so with feelings of shame and unworthiness.

Understanding: Experience

Hearing children and young people's voices

"I will not go up there anymore, mainly because I feel like such a time waster, and I hate all the questions they ask you … I just want to get back home, hide under the duvet and die of shame … I've ended up with numerous infections however from not getting wounds treated."

"I can understand their frustration at having to stitch someone up knowing that there is a possibility of them returning the next day with a new injury or after re-opening the stitches … They are only human and have bad days just like anyone else."

Understanding: Experience

Positive and negative experience of mental health support in acute hospitals

Staff attitudes/behaviours have more impact on young people's experience and are more important than a lack of knowledge around mental health.

Negative experiences mean young people are less able to cope when they leave hospital and encourages young people to abscond when attending due to their mental health.

CAMHS don't always get this right either, and the same goes for non-healthcare organisations such as schools struggling to support young people in mental health difficulty.

Understanding: Experience

Hearing children and young people's voices

"The last time I had a blood transfusion the consultant said that I was wasting blood that was meant for patients after they'd had operations or accident victims. He asked whether I was proud of what I'd done…"

"…they have concentrated on medically patching me up and getting me out. Never have I been asked any questions regarding whether this is the first time I have self-harmed or if I was to do it again or how I intend to deal with it."

Understanding: Experience

Positive and negative experience of mental health support in acute hospitals

Children and young people have a better experience if involved in decision making and if staff explain the reasons for/the goals of assessment

They like being given a chance to talk about their problems

Children and young people who self harm say that it is a better experience when they can talk through what led up to the event.

The most positive encounters are where young people receive 'treatment as usual': non-discriminatory care, delivered with kindness and empathy, not just focusing on the physical aspects (if applicable).

Understanding: Experience

Hearing children and young people's voices

"I allowed a student nurse to observe and she was really kind and asked me why I self-harm because she said she didn't really understand it, and it was really nice … to be able to actually help someone learn about it."

"He… took great pains to suture very neatly – when I commented on this he said "I don't want it to leave any scars" to which I replied that I am covered in them. He said "not on my watch"."

"The nurse consultant who assessed me was very easy to talk to. She explained everything clearly in a non-threatening way. It felt like a friendly chat. She was great!"

Understanding: Experience

Summary

Whilst there may be many perceived challenges to supporting children and young people with mental health difficulties, it is the small things that make the biggest difference:

- Care
- Compassion
- Empathy
- Validation
- Reassurance
- Time to talk

All things that healthcare workers are highly skilled and experienced in doing.

Understanding: Experience

Summary

Whilst there may be many perceived ch
children and young people with
the small things that ma

- Care
-
-

All healthcare workers are highly skilled and expe ed in doing.

Remember children and young people don't want someone perfect and scripted so embrace any awkwardness!

Communication

Support: Communication

Key areas of good communication: Validation

- Let them know they're in the right place and that you're glad they came to hospital for help
- Talk to them about and acknowledge their distress and mental health difficulty, don't avoid the elephant in the room
- Remind them that you care and want to help keep them safe (this might feel obvious because you're in a caring profession but remember young people often feel they're wasting your time by attending hospital due to their mental health)
- Try to understand and meet their core needs as a patient

Support: Communication

Key areas of good communication: Risk

- Risk exists regardless of whether we ask about it or not.
- Asking about suicide does not cause harm, in fact, it may help (Link)
- Talking about risk lets young people know you are worried about them and want to help them feel safe and supported.
- Ask them about what you might see or notice if they start to feel worse or become more distressed (all young people show this in different ways e.g. some may become more withdrawn meaning it is hard for staff to notice).
- Talk to the young person and agree with them how they can let you know if they are starting to feel more distressed and what might help.

Support: Communication

Key areas of good communication: Choice

- Involving young people in making choices and decisions about their care and support can transform their experience of care

- There is always choice. Often ‘what’ needs to happen is not a choice but ‘how’ it happens is. (e.g. we need to inform your parent/carers but you can be there with me or I can have that discussion separately)

- We can give choice around how we communicate – using writing, drawing or other approaches – be flexible.

- Choice around managing risk? Can you negotiate the best way for them to let you know they need support? (Call bell, standing at the nurses station, sitting in the chair versus bed, etc,)

Support: Communication

Summary of key messages and further resources

- Communication is highly valued by young people. Conversations make them feel heard, seen and valued. This alone can dramatically change their experience.

- **Saying something is better than saying nothing**

- Intention is more important than getting it perfect

- Approaching these conversations with **the right attitude is more important** to children and young people than the right expertise.

- The **wecantalk.online** website has a download of 'Top Tips' on how to communicate with young people about their mental health and **Mefirst.org.uk** has a host of resources to support communication with CYP in healthcare

Support

Support: Practical

Distraction and relaxation

- Paper and pens are valuable tools!
- Listen to music
- Board games, cards
- Breathing exercises (YouTube!)
- Progressive muscle relaxation
- Mindfulness (Mindful Eating)
- Consider strategies specific to your clinical team or environment

Support: Mental Health

Risk and Protective Factors

Support: Mental Health

Risk factors

Too many to list but some specific factors you may encounter

- Learning disabilities
- Physical illness
- Poverty
- Low self-esteem
- Chronic health problems

What others do you encounter?

Support: Mental Health

Protective factors

- Supportive relationships
- Pathways to raise problems
- Good communication and problem solving skills
- Faith or spirituality
- Ability to reflect
- Sense of community
- Good housing
- Opportunities for valued social roles
- Strong self identity

Support: Mental Health

Protective factors

Relationships are the most important factor in young people's experience in hospital.

As with all patients, their time and contact with you can make a significant impact.

It's the small things that make the biggest difference to someone's experience.

Understanding: CAMHS

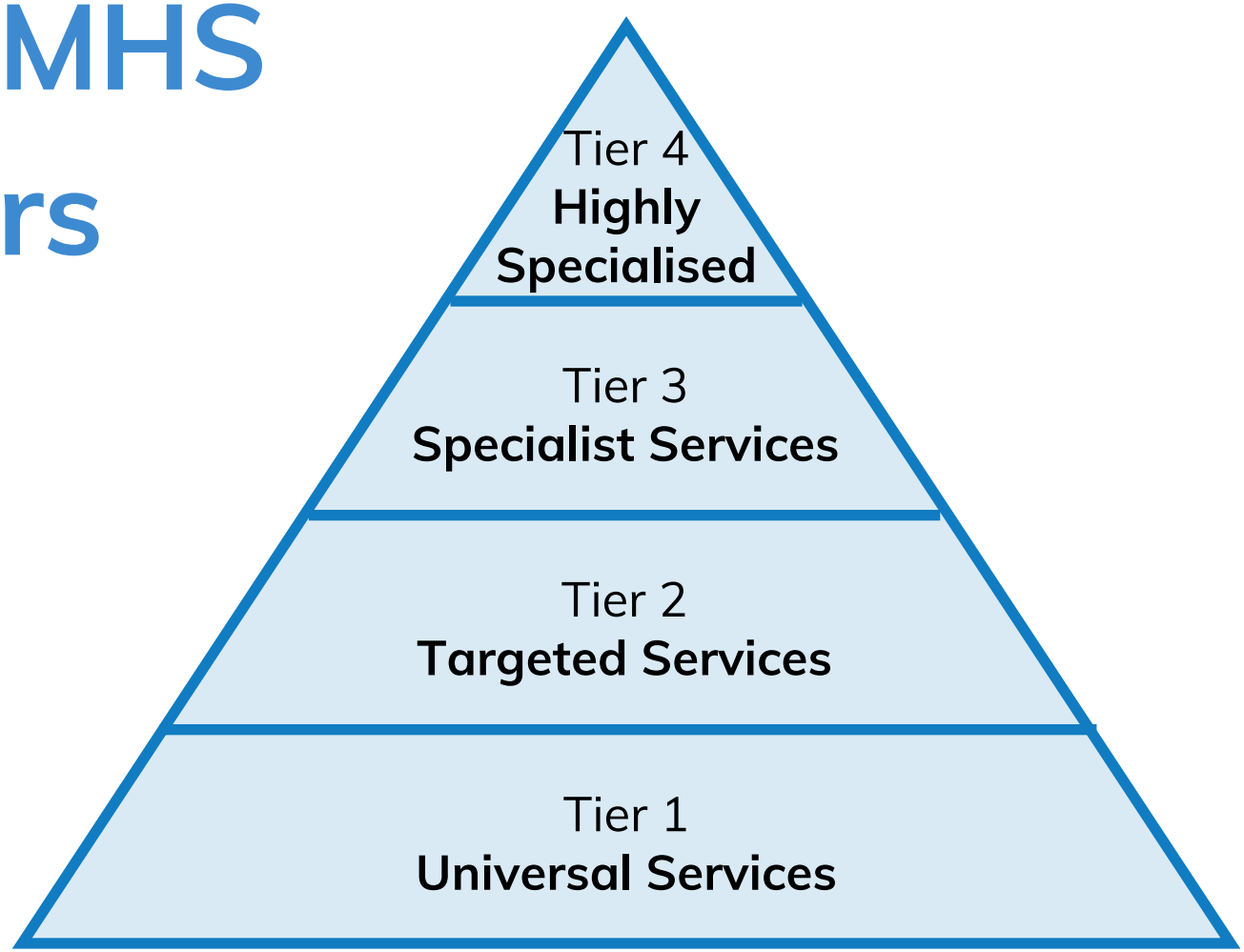
Child and Adolescent Mental Health Services (CAMHS)

Work with children and young people from 0-18*
*some areas up to 25

Work with families, parents, carers & other professionals

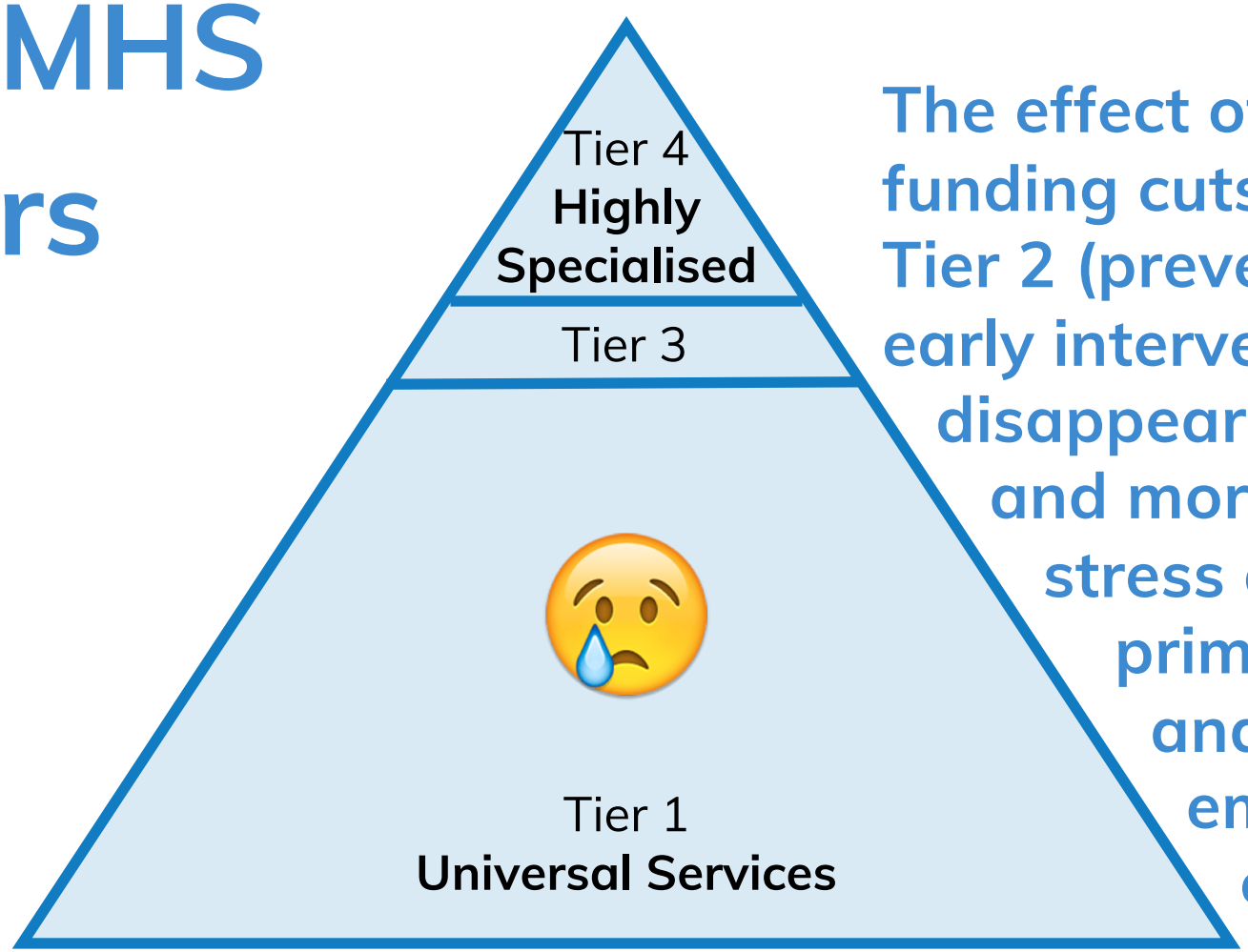
Understanding: CAMHS

CAMHS Tiers



Understanding: CAMHS

CAMHS Tiers



The effect of funding cuts is that Tier 2 (prevention, early intervention) disappears and more stress on primary and emergency care

Understanding: CAMHS

Referral Routes

- Self-Referral
- **GP**
- **School**
- Social Care Team
- A&E / Urgent Care / Paediatric or Adult Wards

Understanding: CAMHS

Referrals include:

- What is the problem?
- Why is the referral happening now?
- What does the child/carer want?
- What do you think they/you need?
- What is making the problem worse?
- What is helping manage the problem?
- What risks are involved to the young person/carer?

Understanding: CAMHS

(Better) Referrals include:

- Current situation (location / on-going physical treatment?)
- Relevant historical factors
- Timescales
- Risks
- Professional details of those involved

Understanding: CAMHS

Who are CAMHS?

- Child Psychiatrists
- Mental Health Nurses
- Family Therapists
- Child Psychotherapists
- Psychologists
- Maybe… Art/Drama/Other Therapists/Counsellors/OTs, Physio, ????
- Different professional backgrounds
- Different clinical approaches
- One size does not fit all

Support: **Online**

www.MindEd.org.uk

www.youngminds.org.uk

www.mefirst.org.uk

www.rcpsych.ac.uk

www.wecantalk.online

Support: **Online**

Follow us online (not all the way home)

Facebook.com/WeCanTalkCYPMH

Twitter **@WeCanTalkCYPMH**

#WeCanTalk

Children and Young People's Mental Health Training

Principles

The **We Can Talk** Principles are a young people and staff accessible version of the educational framework that the training is based on.

They outline the key areas that all staff should feel confident and capable in addressing with children and young people after attending the training

1) **We Can Talk** and listen about your emotional and mental health needs in a clear and non-judgmental way

2) **We Can Talk** about how we will look after your physical *and* emotional needs while in hospital

3) **We Can Talk** about how to help manage the challenges of being in hospital by using distraction and relaxation techniques

4) **We Can Talk** about your problems and we can try to find the right person to help

Principles

5) **We Can Talk** about how to keep you safe while you are staying with us in hospital

6) **We Can Talk** or we can communicate in another way that might work better for you, by writing, drawing, using signs and pictures etc. We're flexible.

7) **We Can Talk** about self harm and other big issues that might be worrying you

8) **We Can Talk** in private and will always talk with you about information that needs to be shared.

9) **We Can Talk** about difficult or awkward subjects in a way that is not as difficult or awkward as either of us thought it would be

10) **We Can Talk** to you and your parents / carers about helpful places to access additional support or information around your mental health

References

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Guidelines for self-harm National Institute for Clinical Excellence (2015)

Further quotes from the young volunteers of “The Mentality Project”, Off The Record (Bristol).

Thanks to Newham CAMHS Participation Group for their ideas and suggestions.

Project Team

For more information about **We Can Talk** please visit www.wecantalk.online, speak to your local Project Lead or e-mail the team at info@wecantalk.online.

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