


ORIGINAL RESEARCH ARTICLE

Understanding the nature of mental health nursing within CAMHS PICU: 1. Identifying nursing interventions that contribute to the recovery journey of young people

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Child and adolescent mental health services psychiatric intensive care units (CAMHS PICU) are a small, specialised, but important component of the portfolio of child and adolescent mental health service delivery in the UK. There has been no published research in relation to nursing care provision within CAMHS PICU and little or nothing is known about nursing identity and intervention within these settings. This research study investigated the nature of mental health nursing in a CAMHS PICU setting, to propose a conceptual model of CAMHS PICU mental health nursing. A qualitative conceptual text analysis from an externally facilitated psychodynamic work discussion group over a period of six months was undertaken using a theoretically informed inductive content analysis method. This, the first of a two part paper, investigates the context of CAMHS PICU and the nursing interventions developed within it. Findings indicate that CAMHS PICU nursing contains elements that are unique from either general adolescent mental health inpatient settings and adult PICU settings. 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 against a back drop of chronic adversity, complex trauma and learning difficulties, manifests as a series of irresolvable tensions within the clinical environment. Interventions are required that explicitly engage with young people's dependency and the inherently dialectic nature of adolescent development. Part 2 of this research explores nursing staff experience of their work and of the clinical environment, and their support needs.

Key words: PICU, CAMHS, adolescent, mental health nursing, identity, intervention

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Introduction

State of research on CAMHS PICU

Child and adolescent mental health services psychiatric intensive care units (CAMHS PICU) are a small and highly specialised component of the portfolio of child and adolescent mental health service delivery in the UK. Although numbers of specific units are small (the NHS England (2014) Tier 4 CAMHS review identified 92 beds) they play an important part in the recovery journey of a significant cohort of young people in any 12-month period due to the model of care being based on time-limited admission, resulting in high patient turnover. The relative success of a PICU admission can be pivotal in deciding whether a young person's trajectory is toward a return to community care or towards longer-term restrictive or secure mental health care (Foster 2018). In addition, a shortage of CAMHS PICU beds has been recognised by NHS England with a commitment to increase the number of CAMHS PICU services available (NAPICU 2015). Despite these factors, there has been no published research in relation to nursing care provision within CAMHS PICU services to date. The numbers of children and adolescents needing to be admitted into PICU and high dependency services appears to be increasing (NAPICU 2015), suggesting that it is an important area worthy of research investigation.

The limited published evidence and guidelines available highlight that CAMHS PICU appear to provide for a more complex and diverse patient group than their adult counterparts (NAPICU 2015; NHS England 2016). This seems to be because of the patchy nature of community and crisis services for young people and the paucity of appropriate therapeutic placements for young people with multiple diagnoses or complex conditions, including those with underlying developmental difficulties (Jasti et al. 2011). This means that the adoption of the traditional emergency medicine/acute symptom stabilisation model of an adult PICU is unlikely to be fit for purpose to meet the needs of the young people admitted to CAMHS PICU settings, without significant adaptations being made. However, this assumption has not been tested through research.

Similarly, although the challenges faced by mental health nurses working with adolescents have been identified as unique (Musto & Schreiber 2012), it has been asserted that

the lack of research into nursing philosophies and ideologies in adolescent mental health settings means that the contribution of nurses to the wider multidisciplinary team care provision is poorly defined and understood (Rasmussen 2012; Musto & Schreiber 2012). Rasmussen (2012) argued that because much of adolescent mental health nursing is tacit and of limited visibility to those looking at it from the outside, mental health nurses need to be enabled to articulate their own identity, within the particular context in which they operate.

The body of research evidence in relation to adult PICU is much better established (Gwinner & Ward 2013). However, several studies have concluded that there remains no evidence regarding the efficacy of treatment approaches in PICU environments and there is an absence of clearly articulated principles and practices of nursing care in these environments (Bowers 2012; Gwinner & Ward 2013; McAllister & McCrae 2017).

PICU environments are largely organised around the provision of short-term care within a highly contained environment for those experiencing acute psychiatric distress who are usually a risk to themselves or others (Bowers 2012; NHS England 2016). The environment and high levels of violence and aggression present are often managed through relatively high staffing levels, of which the dominant workforce is unqualified nursing assistants, working alongside registered mental health nurses. An environment in which multidisciplinary care and treatment can be delivered safely is created through high levels of physical, relational and procedural security, for which nursing staff (qualified and unqualified) often carry the burden of responsibility (McAllister & McCrae 2017). Despite the lack of coherency or underpinning ideology identified, there is little evidence to suggest that quality of patient care is compromised, as compared to other inpatient settings (Lemmey et al. 2013). There is a limited but notable amount of evidence to suggest that treatment outcomes are positive for patients who are in acute psychiatric distress (Gwinner & Ward 2013), but an absence of understanding of the mechanisms that bring about change (Hayes et al. 2017). Hence the situation warrants a critical examination of what it is that nursing teams are doing to achieve these outcomes. How can it be amplified, generalised and maintained? And what are the specific demands of caring for adolescents in PICU contexts?

Nursing approaches to treatment and care

The research evidence from adult PICU settings implies that well elaborated paradigms for a nursing approach to recovery may be instrumental in helping staff surmount the highly demanding nature of the environment and have the potential to significantly improve clinical outcomes (Gwinner & Ward 2013). Intensive staff–patient interaction and the use of using multiple sophisticated interventions have been observed (Crowhurst & Bowers 2002) but the nature of these has not been accurately characterised, analysed or tested. A recent study investigating the therapeutic role of nurses within adult PICU found that a lack of clarity over the meaning of therapeutic engagement/intervention remains, impacting upon the ability of nurses to deliver it even when patients and nurses hold it as a central component of care (McAllister & McCrae 2017).

Managing the tension between regulating the environment to ensure safety and interpersonal interventions which support and promote recovery for patients, is well documented in adult-orientated literature that has attempted to capture something of the nursing task (Salzmann-Erikson et al. 2008, 2011; Björkdahl et al. 2010; Ward & Gwinner 2015). Studies that have sought to identify nursing practice in adult PICU settings, and also more generic child and adolescent mental health settings, have both found communication, education, observation and risk management to be core domains of required knowledge and skill (Rasmussen 2012; Ward & Gwinner 2015). However, studies of this kind have yet to be undertaken in a CAMHS PICU setting.

In the absence of elaborated paradigms or clearly defined principles and practices, it has been argued that the nursing task and approach tends to be significantly influenced by organisational and physical structures which are often conflicting (Gwinner & Ward 2013), and which can reduce the primary function of the PICU to the suppression of aggressive and violent behaviour (Dix 2016). Whereas it has been hypothesised that the optimum conditions for mental health recovery are supported by an integrative position in which both therapeutic care and control are held in the mind of the nursing team (Björkdahl et al. 2010; Salzmann-Erikson et al. 2011; Dix 2016).

Aims and objectives

Considering the findings of this literature review, the qualitative study reported on here aimed to address the question ‘What is the nature of mental health nursing in a CAMHS PICU setting?’ and to propose a conceptual model of CAMHS PICU mental health nursing.

We explore the nursing task within an adolescent PICU and identify nursing interventions and their contribution to young people’s recovery. A second paper will report on

the impact of the nursing task on identity, the support needs of the nursing team and a proposed model of mental health nursing for CAMHS PICU settings (Foster & Smedley 2019).

Design

A qualitative conceptual analysis of the notes from a weekly externally facilitated work discussion group was undertaken from a period of six months. The method of content analysis elaborated by Elo & Kyngäs (2007) was adopted, using a theoretically informed but inductive approach.

Content analysis has been shown to be a relevant and effective qualitative research methodology in the field of nursing, as a systematic means of describing phenomena and establishing relational links between concepts. Inductive methods of content analysis in which data is analysed through a theoretical lens to support understanding and meaning-making are particularly indicated to build up a conceptual system or enhance understanding when there is insufficient pre-existing knowledge of the issue (Elo & Kyngäs 2007; Reavey et al. 2017). The study was conducted in one 10-bed mixed gender CAMHS PICU in the North of England.

Data collection

The study collected data from the nursing team (registered mental health nurses and non-registered health care assistants) through the implementation of a weekly, externally facilitated reflective work discussion group (Jackson 2008).

The group was facilitated by an adolescent psychotherapist and mental health nurse and was open to all those members of the nursing team who were not required on the ward at that time to meet the minimum clinical observation levels. The focus of discussion was set by each meeting’s participants. The facilitator’s focus was to support shared thinking and development of collective understanding of the young people and dynamics within the ward, and to facilitate participant-led articulation of the skills, interventions and underlying principles of approach used by the nursing team. Notes of the content of discussion from each group were made by the facilitator, shared and checked with the nursing team.

Sample

The unit of analysis was defined as the set of notes from one work discussion group. There were 26 units of analysis spanning a six-month period. No data sampling method was employed as all units of analysis within the given period needed to be read as a complete data set, to capture as much detail as possible about the nature of nursing in the specific context being investigated. The unit of coding was specified as all emerging concepts or themes within

the given text of each unit of analysis. The idea of a ‘conceptual cluster’ was adopted, in which related words cluster around a broader term or idea (Berg 2002). This meant the units of coding could be individual words, a short word string or a whole sentence or phrase that captured a particular idea.

Data analysis

The coding process. This was performed in a stepwise fashion. To understand the data as a coherent whole, all units of analysis were read and re-read as a complete data set with the key research question in mind. Within the study, ‘Nature’ was operationally defined as pertaining to: tasks, actions, role, knowledge, skills, theory and practice, professional values, beliefs and philosophy. An open coding process was undertaken, in which codes within each unit of analysis were identified and marked in the margins of the text, using the framework recommended by Strauss (1987). Coding continued until no new codes appeared within the data set (saturation). The frequency of repeating codes across the data set was also recorded (Elo & Kyngäs 2007). Codes were then grouped and tabulated on one coding sheet, retaining information regarding the location of codes within the raw data.

Categorisation. Higher order concept categories, categories and subcategories, under which to group concept codes from across all units of analysis, were generated. These were defined by combining related topics and content areas. From this, main theme headings under which these concept categories fell were named. The relatedness of individual codes across different categories were then identified and mapped within the tables. Once the codes were organised under final concept categories and main theme headings, the raw data was used to identify illustrative examples.

Abstraction. Psychoanalytic, attachment and developmental theories were applied to the categorisation and abstraction process, to generate a conceptual model of mental health nursing within the specific setting from the outcomes of the content analysis. The choice of theoretical lens reflects the fact that the care of adolescents always needs to be rooted in an understanding of development and that mental health nursing and support work is fundamentally psychodynamic in nature, in that it is within the quality of the therapeutic nurse–patient relationships that change occurs (Gallop & O’Brien 2003). This means that the nursing and support work team come to have a uniquely detailed sense of the young people on the ward, based on what it feels like to be in their company, in a range of different contexts across the 24-hour cycle of care. This knowledge is often tacit or embodied rather than articu-

lated through language. As a result, it has been argued that the work involved in nursing and other roles involving nurturing and maintaining the well-being of patients tends to involve physical and emotional elements that are hard to define and invisible to others; ‘noticed only when it is not provided at the expected level or quality’ (Brush & Vasupuram 2006, p. 181). Psychodynamic theory has a language for interpersonal and relational processes that can be used to help name and make use of this unique knowledge to illuminate and understand the work of the nursing team in detail (Gallop & O’Brien 2003).

Internal verification and reporting. A transparent record of each step of the coding and categorisation process was kept using tables and schematics (Elo & Kyngäs 2007). A co-researcher with knowledge of the clinical context from which data was drawn, but who was independent of the work discussion group and the coding process, was identified to establish relative trustworthiness of the codes and categories and ensure they remained grounded in the data from which they were drawn. This was done by systematically working backwards from the theme headings, categories and codes into the raw data. Presentation and reporting of results were undertaken in accordance with the recommendations for reporting content analysis data made by Elo et al. (2014) and O’Brien et al. (2014).

Ethical approval

The University Ethics Committee (HSCR14/19) and the Research Governance Committee of the participating healthcare organisation (non-NHS) granted ethical approval. All those who chose to participate provided informed consent. Participants were informed of their rights in respect of voluntariness, information access and that data would be stored securely and anonymously in accordance with data protection regulations. There was no identifying patient material included in the study. Material regarding clinical issues discussed within the work discussion group were recorded as part of the group process in aggregated themes, with staff and patient identifiers removed.

Results

A total of 150 distinct codes were identified within the data, set across seven main theme headings of: (1) presenting difficulties; (2) complexity within the clinical environment; (3) tensions; (4) nursing interventions; (5) frustrations; (6) staff experience; (7) learning and development.

Figures 1–2 provide a summary of the analysis results. The themes of Frustrations, Staff experience and Learning & development are presented in Foster & Smedley (2019).

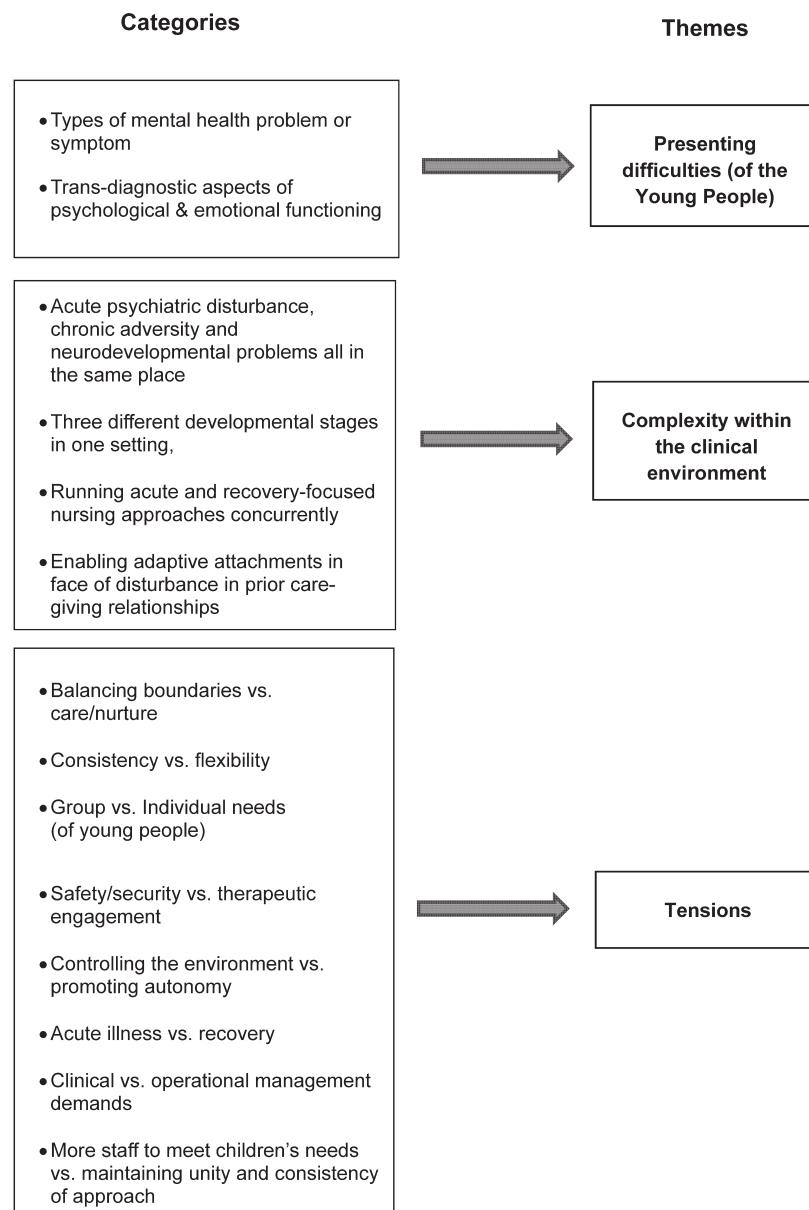


Fig. 1. Summary of the Presenting Difficulties, Complexity and Tensions themes.

Presenting difficulties

This theme comprised two categories: presenting problems brought to the group for discussion that can be described as symptoms of a mental health disorder. Secondly, broader aspects of the young people's psychological and emotional functioning that were not tied to any specific mental health diagnosis, but which were nevertheless characteristic of their psychological distress.

The types of mental health problem or symptom identified (in order of frequency of discussion) were: (1) anxiety symptoms; (2) neurodevelopmental/social communication difficulties; (3) complex post-traumatic stress and the

impact of multiple adverse childhood experiences (often relational in nature); and (4) psychotic symptoms.

Trans-diagnostic aspects of psychological and emotional functioning included: (1) unconscious defences especially splitting (of own states of mind and of staff) and attempts to control the environment, to mitigate feelings of powerlessness and anxiety; (2) self-doubt/disgust/criticism and shame dressed up as boisterousness, disinhibition or omnipotence; (3) expressions of self-loathing or null self-worth; (4) disturbance of adolescent identity or sexuality expression including ganging dynamics; (5) envy, sensitivity to injustice and to being treated unfairly; (6) loss of, or failure to ever achieve, pleasure from social

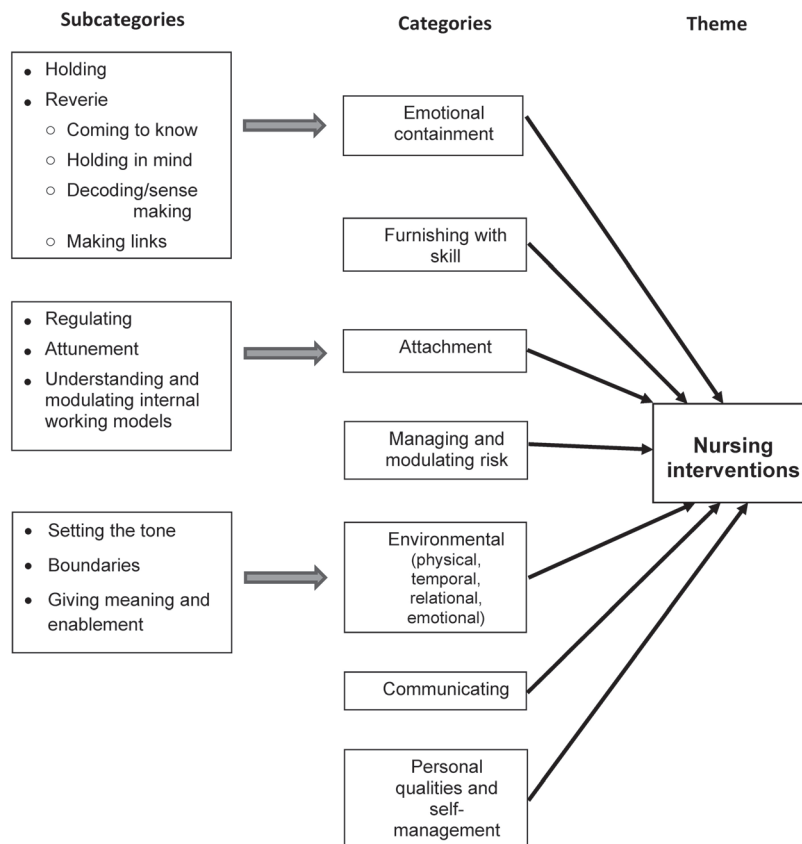


Fig. 2. Summary of the Nursing Interventions theme.

activity, presenting as withdrawn or ‘cut-off’; and (7) violence, sometimes reflecting anger or aggressive and destructive impulses but often also reported as a communication of fear, anxiety, or a request for help.

Complexity

Four domains of complexity were repeatedly identified.

The diversity and co-morbidity of the young people’s presenting difficulties meant that staff were providing for young people with acute psychiatric disturbance, the longer-term impact of chronic adversity and underlying neurodevelopmental/learning problems, in the same (highly contained) place. However, the care strategies indicated for each of these difficulties are often contrasting.

The impact of delays in discharge care pathways for young people no longer needing a PICU environment meant that the team were required to run two different nursing approaches concurrently: a more reactive, acute illness-focused approach alongside a more pre-emptive, planned, recovery-focused approach for young people awaiting discharge. The latter being at continual risk of being impinged upon by the unpredictability of the needs of the young people whose difficulties were acute.

At any one time the patient group could be made up of young people in three different developmental stages (early, mid and late adolescence), each requiring a different approach (Waddell 2002); including strategies to manage potential safeguarding risks.

The task of enabling and regulating adaptive attachment relationships (required by all young people not yet self-sufficient, to meet their basic care needs) was described as complex in the face of frequent disturbance in relationships with their primary attachment figures, often compounded by significant geographical separation.

Tensions

Eight key tensions faced by the nursing team, emerged from the analysis: (1) boundaries versus care/nurturing; (2) consistency versus flexibility; (3) whole group versus individual needs; (4) safety/security versus therapeutic engagement; (5) controlling the environment versus promoting young people’s autonomy; (6) acute illness versus recovery; (7) numbers of staff on shift (increased resource to meet needs versus maintaining unity and consistency of approach); and (8) clinical versus operational management demands.

Clinical versus operational demands were reported by

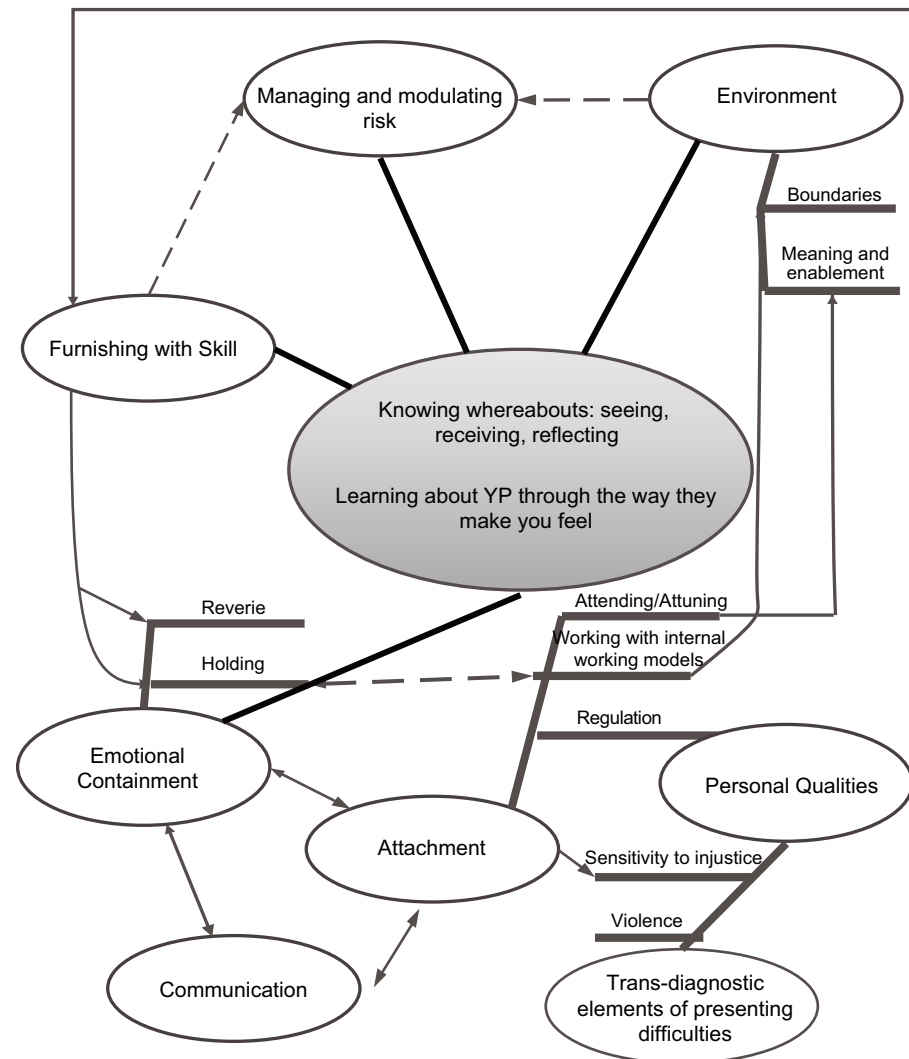


Fig. 3. Conceptual relationship between content analysis categories of the Nursing Interventions theme.

shift coordinators as upward pressure from frontline nursing staff versus downward pressure from the organisation to comply with adult focused policies and procedure that were often perceived as ill-fitting for their setting.

Analysis of the repetition of these tensions within the data indicated that they required continued attendance and active management by the nursing team with no final point of resolution and all eight tensions were active at once. The nursing team described working continuously to find and sustain an optimal position between the two poles of each dialectic, operating within an ongoing state of tension. The findings of this study suggest that these tensions are the crucible in which the nursing interventions specific to CAMHS PICU are forged.

Nursing interventions

A total of 75 nursing intervention codes were identified, constituting seven key categories of practice (Fig. 2): (1)

emotional containment; (2) communication; (3) attachment; (4) personal qualities and self-management; (5) furnishing with skill; (6) environmental; and (8) managing and modulating risk.

The results for this theme heading are most clearly presented in a linear manner, organised by category. However, it is important to recognise the conceptual links and points of overlap between many of the categories, as nursing interventions are complex and not made up of discrete parcels delivered in a step-wise fashion. A schematic map illustrating the points of connection between the categories of nursing intervention is provided in Figure 3.

41% (n = 31) of the codes describing nursing interventions fell under the categories of Emotional Containment and Attachment. These categories describe different dimensions of the same phenomenon; the therapeutic relationship. Codes within Emotional Containment describe internal

cognitive and emotional skills used by the nursing team to understand and respond to the young people's communications in ways that seek to assuage distress and promote growth and recovery. Codes within the Attachment category describe ways in which the staff used their relationship with the young people to create moments of change.

Emotional containment

This is a term coined to describe the interaction processes that occur firstly between the infant and their primary carers (Bion 1962) and then as the child moves into adolescence, between them and the adults who people the systems and organisations in which they live and learn (Waddell 2002). It is the capacity of the carer to be attuned and responsive; accepting of all aspects of the child, communicated through the way in which the child is handled and held within the carer's gaze (Winnicott 1971, pp. 111–118; Bowlby 1988) and the intersubjective space between carer and child (Schore & Schore 2014). These processes govern both the child's experience of anxiety and development of their cognitive, emotional and interpersonal functioning, resilience and understanding of themselves (Reisenberg-Malcom 2001).

The internal working models for understanding ourselves and the world around us, developed from the experience of being known, and the learning within our important relationships have a significant impact upon mental health and wellbeing across the course of life (Schore & Schore 2014). So it follows that the transformational quality of the processes described have an equally important potential to contribute to recovery from mental distress and the role of mental health nursing practice (Adshead 2002).

The intervention codes within this category have been organised into subcategories based on the different components that are known to characterise 'good enough' emotional containment: (1) holding; and (2) reverie.

Holding. This subcategory is described as the whole routine of ordinary care provided through the day and night (Winnicott 1960). In good-enough circumstances it provides an experience of being both physically and emotionally held, in a way that anxiety is assuaged sufficiently to facilitate mental and physical maturation.

Interventions under this subcategory were:

- Being the only place that can hold the young person's distress at that time.
- Containing the young person's worst fears regarding their own capabilities – meeting them at their darkest.

These codes particularly related to the early phases of admission in which young people were often in a very chaotic and dysregulated state. It included being able to

keep young people safe from their own destructive impulses

- Helping young people bear their pain, fears, hopelessness, loss, frustration, guilt and shame.

Participants described acting as literal containers for feelings that were acted out and directed at nursing staff, until they could help the young people develop skills to manage the feelings for themselves.

- Exploiting the practical to enact the symbolic.

Multiple examples were identified of staff using seemingly every day aspects of care to speak to aspects of young people's more fundamental underlying needs that 'as yet have no words' (Alvarez 1999).

The act of knowing a young person's whereabouts, including specifically knowing the hiding places of individual young people, was repeatedly highlighted as an important tool for conferring a sense of security, value and positive regard for young people, not just for ensuring physical safety. This appeared to be particularly important in an environment where the use of touch, more ordinarily associated with provision of a 'holding environment', was not readily available to the nursing team outside of carefully prescribed processes for the physical management of violence and aggression. One way this was enacted in practice was through performance of general observation duties. This task was understood to be about far more than physical safety: staff described differentiating their approach to entering each young person's space in accordance with their knowledge of individual preferences and vulnerabilities related to prior relational trauma, sensory sensitivities and current mental state. This included changing their footsteps on approach, knock, means of entry, proximity to, and process of, verbally or visually connecting with the young person.

Reverie. This describes the carer's receptiveness to all aspects of the child's communications (verbal and non-verbal), including those that feel hostile, and their ability to make them understandable, without being overwhelmed by them (Waddell 2002). In the short term this helps soothe anxiety, and in the longer term supports the development of the child's own ability to hold and process their feelings and experiences. This concept can be divided into three ideas: (1) coming to know; (2) holding in mind; and (3) decoding.

Coming to know was described as a 'gathering up the pieces' from individual interactions to develop detailed 'whole-team' knowledge and understanding of young people, from the experience of being with them. 'Learning about young people through the way they make you feel' was identified in 11 out of the 26 units of analysis (43%).

This process of projective identification is our most

primitive means of communication. In infancy, the innate ability to stir up feelings in our carers through non-verbal processes enables us to communicate and get rid of unbearable states of being, and have our needs met. So essential is it to our survival that although it is increasingly replaced by language as we get older, it is never completely dispensed with and is often returned to during times stress. Adolescence is a developmental period in which there is a return to reliance on this communication mechanism, due to the mismatch between the intensity of the emotions young people experience and their not yet fully developed language (Briggs 2009). Its success is dependent upon adults being receptive to receiving and thinking about what they are being invited to feel.

The code of 'Holding your nerve' described the related process of trying to bear the destructive, hostile and provocative parts of young people, without being permanently hurt or overwhelmed by them, or without being pushed into critical or punitive reactions.

Holding in mind was described in three different ways, linking directly to the 'trans-diagnostic presenting difficulties' subcategory and utilised in 'management and modulation of risk':

- Keeping in mind the needs of young people whose difficulties were of a more internalised nature, who could easily be forgotten in a very noisy and distress-filled environment. Examples included: persisting with making interpersonal approaches to children whose history of emotional neglect and deprivation had resulted in them presenting as shutdown and withdrawn; remembering the prior trauma acted upon young people whose behaviour appeared to be intentionally provocative of dismissive or neglectful responses from adults; and keeping symptoms in mind when they can't be seen (e.g. psychotic thinking, delusional beliefs in young people who were guarded).
- Using this knowledge pre-emptively at times when young people weren't able to actively seek engagement or help from staff.
- Holding up a receptive and accepting mirror to all parts of young person. For young people in split or fragmented states of mind, remembering the good in the face of the bad and vice versa. This was described as reflecting back a more integrated/compassionate version of self as times when young people are self-berating and not forgetting latent risks at times when they presented with an idealised 'all-good' version of self.

Codes in the subcategory of Decoding describe the work undertaken by staff to try and understand the underlying meaning and function of what they see rather than responding to it at face value. Decoding was characterised by hearing the feeling/request without reacting to *how* it

has been communicated, for example, de-escalating threats of violence by naming and responding to underlying fears or needs. 'It's not what it looks like' described decoding the idiosyncrasies of each young person's pattern of emotional expression. For example, that one young person's expressions of boredom in fact denoted agitation and emotional dysregulation, whereas for another, giddiness and elation signified unbearable feelings of sadness.

'It's not what it seems' labelled a process of extracting meaning and coherence from concrete or seemingly bizarre expressions. For example, coming to understand that a young person's report of being in a sexual relationship with a well-known film action hero represented a means of managing emerging feelings of desire towards a peer, which in turn activated anxieties for the young person that she may be vulnerable to unwanted sexual approaches from that peer.

Communication

Codes within this category described mechanisms for achieving the interventions above and for using the knowledge gained in the process of emotional containment to promote recovery:

- Communicating understanding of what is really going on under the face-value behaviours to the young person: putting words to the behaviour
- Communicating knowledge and understanding of young person to themselves and to others (e.g. family, MDT, staff in future placements); this included holding and sharing information about the small details of patient's needs and preferences ('their little ways')
- Providing narrative on progress as an intervention to counter feelings of hopelessness expressed by young people.

Attachment

Attachment is the evolutionary mechanism by which we socially and physiologically connect with others to regulate our internal feeling states through the arousal/relaxation cycle (Schore & Schore 2010). It is also the process through which children's experience-dependent developing brains receive (or not) the stimulus that drives them to develop their own capacities to regulate emotions and manage their arousal levels independently. In time this develops into the capacity to think about one's own mind and the mental experiences of others (Adshead 2002).

Attachment-based interventions were described in the data as working to provide meaningful relationships for young people that carried the helpful characteristics of attachment, in lieu of the carers and family members from whom they were separated, but that could also be clearly distinguished from their primary carer relationships (neither competing with or repeating unhelpful elements).

This category comprised of three subcategories: (1) regulating; (2) attunement; and (3) understanding internal working models

Regulating. This involved acting to helping young people calm down, get back in control. This was exemplified by considered intentional use of physical and emotional proximity of staff to young people to down-regulate or soothe distressing emotions, or to up-regulate positive emotions. This was done by giving clear prompts and direction to take young people through a guided process that supported them calming down in accordance with assessment of mental state.

An important part of the process identified within the content analysis was ‘Coming alongside obliquely to find and hold a middle ground’. This was exemplified by a strategy used with a young person who experienced significant discomfort and distress when people tried to engage him in social encounters. His discomfort led to him isolating himself and simultaneously expressing beliefs about being treated less well than other young people, due to perceiving (correctly) that staff were spending less time with him. The young person’s care plan was altered to ensure members of staff sat side-by-side with him whilst he played computer games (preferred leisure activity), occasionally commenting on the game rather than to him, so that he could experience being with others, without having to make direct eye contact or speak.

Staff described intervening in established ways of coping that served to escalate the young people’s arousal rather than promote relaxation, to break negative self-reinforcing cycles. This included ‘managing unconscious defence mechanisms’ that young people employ to manage distress in the short term, but which in the longer term serve to maintain the problem.

An example of this was an intervention with a young man for whom high levels of arousal would lead to misidentification of staff as perpetrators of harm, prompting violence towards staff, followed by denial of any memory of his actions (related to difficulties tolerating guilt) and a subsequent increased risk of perceiving staff as intending him further harm (due to fear of retaliation). Physiological indicators of anxiety (increased respiration, pallor change) were used to alert the young person as early as possible in the arousal cycle to changes in his affect, and to trigger staff to give him extended personal space whilst also giving continuous verbal direction to support him in self-managing his arousal levels. In the relaxation phase of the cycle, opportunities were used to provide reflective feedback on what staff had observed during the period in which the young person reported memory loss, to promote the linking together of the split-off aspects of himself.

Attunement. This category describes the process of looking, noticing (non-verbal cues), taking in what is seen, and responding accordingly. Interventions under this category included amplified communications of interest in and curiosity about the young person, to try to pique interest in their own internal experience and the social world around them. For young people with neurodevelopmental difficulties and/or impact of profound deprivation this was described as trying to bring deadened internal worlds to life. For young people with previous frightening experiences of adults, this was for trying to stir pleasure rather than anxiety in social encounters. Whereas, for young people experiencing acute psychotic symptoms who were trapped in a frightening internal world, the focus was on helping them find a way of ‘looking out’ and making connections with the external world. In all interventions of this kind, knowing and playing to a young person’s strengths and interests was seen as key.

Understanding internal working models. Internal representations or working models of individual’s most important attachment relationships, are often reactivated by being in hospital, as hospital admission and the process of separation from family members constitutes a source of threat (Adshead 2002). Interventions in this subcategory were based on noticing recurrent themes in encounters with staff, as representative of important relationships young people have with others outside of the hospital setting. Then, working to moderate these patterns of interaction through relational experiences.

Unlike more direct strategies typically used in psychological therapy, challenging unhelpful relational assumptions (e.g. men hurt you, women are weak, others can’t bear me) was not undertaken by naming or challenging them. Instead, staff described consistently seeking to conduct themselves in ways that side-stepped young people’s invitations to confirm their worst fears, to offer an alternative experience. Similarly, knowledge of family issues and past events in a young person’s life story were used to understand triggers in the ‘here and now’ that symbolised underlying precipitants of their difficulties.

Personal qualities and self-management

Throughout the data a set of personal qualities, reported by team members as integral to successful nursing intervention, were repeatedly articulated. These were identified as direct interventions in themselves for particular aspects of presenting difficulties (e.g. young person sensitivity to injustice and management of violence). They were also identified as essential prerequisites to effective emotional containment and attachment interventions. The qualities were: (1) consideration (defined as thinking before doing); (2) tenacity and persistence (being able to sustain emotional and physical effort, including being able to

tolerate indifference to, or active rejection of their attempts to help); (3) patience and tolerance; (4) conducting oneself in a way that upholds the principles of fairness; (5) acting to preserve young people's dignity (helping them save face); and (6) mediating one's own response (verbal, proximal, behavioural, affectual) according to the young person's arousal levels. Examples of this were being able to keep fear responses under control in the face of physical threat and aggression and withdrawing engagement in response to non-verbal cues that indicated the young person needed less stimulus, when their natural instinct was to try and help more.

Furnishing with skill

This category describes the ways in which staff supported young people to learn emotional and relationship management skills. It highlighted that staff supported learning through showing, doing-with and with high levels of repetition; providing scaffolding to support a step-wise move over time from staff to self-regulation of distress. The skills most commonly identified were: (1) skills for coping (distress-tolerance, distraction, problem solving); (2) emotion identification; (3) interpersonal relationship role-modelling; (4) how to make reparation (including not just how to say sorry, but managing the feelings that go with it, e.g. guilt, vulnerability, shame and humiliation); and (5) helping young people with misperception.

In acute states of mental distress, or in the case of young people who have not had good-enough experiences of their perception and feelings being reflected back to them, there is a tendency for a phenomenon that has been coined 'psychic equivalence' (Fonagy 2003), in which the young person's perception and external reality are felt to be identical (how it seems is how it is). Examples were recorded in the text of the ways in which staff worked to help young people notice the differences between what they think they saw/heard and what was actually happening, and how their underlying beliefs, worries and feelings could have affected their perception.

Environmental (relational, physical and temporal)

This category comprised three subcategories: (1) setting the tone; (2) meaning and enablement; and (3) boundaries.

Setting the tone. Staff recognised that PICU for many young people was a 'last-chance saloon', their last chance to find a way towards recovery before a decision to place them in a much longer-term restrictive environment may be reached. Contributing to creating an environment in which young people can come back from the brink, was valued as an important component of their role: described as always working to give young people a second (third or fourth) chance, laying out a map of ways in which they

could put mistakes right, or giving multiple opportunities to change one's mind.

Ensuring reliability and clarity were repeatedly identified as mechanisms for setting a helpful tone within the environment. This was achieved by working to create predictability in individual and team responses, in the structure of the day, and within individual young people's care, through care planning. Young people were helped to know what to expect and how to navigate the ward, through setting out expectations and rules in advance, and by giving information in simple terms and manageable chunks.

Meaning and enablement. This category relates to structuring the passage of time through interventions that give the day shape. Examples include supporting and motivating young people to get up and engage with education and the therapeutic day, supporting mealtimes, enabling meaningful leisure activity and a sense of achievement in a very restricted space.

This process incorporated actions aimed at promoting young people's autonomy and choice in a restrictive environment. Examples of interventions of this kind were: joint care planning; taking advance instruction from young people about how they would like to be managed during times of distress/violence; activity planning; advocacy in meetings; taking a position of giving all requests reasonable consideration re: feasibility, before saying 'no'; and partnering 'no' with explanations.

Enabling interventions also included working to buffer young people against the stress of the many points of transition in their care that could activate anxiety, not just the obvious transition associated with discharge. These included being nursed on different parts of ward, on different observation levels, developmental transitions (including birthdays), mealtimes, medication changes, access off the ward and visits (from outside to inside the ward, being with and then without family).

Boundaries. These were intrinsically linked with Attachment. Implementing boundaries has been identified as essential for creating safety in environments where there are high levels of unregulated feelings (Adshead 2002).

Effective use of boundaries was characterised by: implementing strategies for safety in a proactive, planned, neutral way, and avoiding reactive consequences where possible as these were understood to be prone to interpretation as punishment by young people; applying rules and boundaries in an intentional and judicious manner, using general principles that could be adapted to individual needs; accommodating knowledge of a young person's attachment patterns and internal working models into setting and implementing boundaries (understanding how they would be perceived by particular young people and

adapting accordingly); and considering timing of implementation of boundaries commensurate with the young person's mental state.

Although the nursing team often carried the lion's share of responsibility for implementing boundaries (as a function of the 24-hour cycle of care), the data also reflected that boundary setting was a process supported by the wider multidisciplinary team.

Managing and modulating risk

The identified strategies for managing and reducing individual and whole group risks on the ward, relied upon application of detailed knowledge of young people, developed through the previous relationship-focused interventions:

- Identifying early warning signs and triggers that at first glance seem imperceptible (based on detailed observation)
- Knowing young people's whereabouts; noticing absence and knowing their likely whereabouts
- De-escalating aggression through counterintuitive responses based on knowledge of individual young people
- Reacting/adapting to crisis; understanding that safety takes precedence in the hierarchy
- Pre-empting, avoiding and contingency planning for individual and group flashpoints
- Continuous risk assessment, using detailed observation of young people and their environment, particularly their rooms; recognising change of any magnitude as potentially significant
- Application of team knowledge of safe management of violence.

Themes and categories up until this point have described the clinical context of the nursing team's work and the interventions developed to enable young people within it. To some extent, the nursing intervention codes describe the work of the team 'at its best'. Foster & Smedley (2019) presents findings regarding the organisational factors identified by participants that impact upon the team's perception of their ability to provide care at the level to which they aspire, the impact of the clinical work itself upon staff sense of self, and their ability to keep going with the interventions that characterise the team 'at its best'.

Discussion

This study provides a rich account of the nature of nursing task and intervention in the previously unexamined practice area of CAMHS PICU nursing.

Interventions have been shown to be 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 against a back drop of chronic adversity, complex trauma and learning difficulties. As the nursing task is fundamentally relational and developmental in nature interventions are required that explicitly engage with young people's dependency and the inherently dialectic nature of adolescent development.

It has been observed that the systems and cultures present in healthcare institutions fail to reward the contribution that sensitive and affectively attuned caregiving can make to patients (Schuengel et al. 2010). It has also been observed that mental health nurses often have to use extensive summarising practices to manage the amount of detail involved in their work when communicating with others, undermining their ability to give sophisticated accounts of their expertise to other members of the multidisciplinary team (Deacon & Cleary 2012).

This report is therefore unapologetic in its detailed account of what has been learnt about nursing intervention through the course of the study, contributing to a process of supporting mental health nurses to more clearly articulate their own identity and expertise.

Similarities and differences with adult PICU nursing and other forms of CAMHS inpatient nursing

The concept of tension is central to understanding the nature of nursing identity and the interventions employed by the team within the CAMHS PICU. This parallels findings in adult PICU literature (Salzmann-Erikson et al. 2008; Björkdahl et al. 2010).

A key difference, however, is that studies in adult PICU identify managing the tensions within the environment as the nursing intervention; whereas this study contends that tensions arising in CAMHS PICU are an ever-present manifestation of the fundamental care needs of the patient group from which a range of specific nursing interventions are given birth.

The fundamental tension identified in adult-focused studies can be characterised as: maintaining security and creating stability, through control, surveillance and structuring of the environment, versus initiating therapeutic relationships to give intensive assistance and to soothe the distress (Salzmann-Erikson et al. 2008, 2011; Björkdahl et al. 2010; Ward & Gwinner 2015). This study has also borne out the presence of this tension within in the CAMHS PICU environment. However, it is one amongst eight co-occurring dialectics that have to be continuously occupied by the nursing team.

The broader range of tensions that have to be managed are in part accounted for by the nature of presenting difficulties identified within this study. The findings mirror previous work highlighting that multiple diagnoses, co-morbid neurodevelopmental problems and experiences

of fragmented/unsuccessful care and abuse, are the norm within CAMHS PICU (NAPICU 2015; NHS England 2016).

We argue that ‘tensions’ as the producer of nursing interventions reflects how CAMHS PICU nursing is itself located on the boundary of two nursing specialisms: PICU nursing and CAMHS nursing. Comparison of the findings of this study with a study exploring adult PICU nursing (Ward & Gwinner 2015) and a study of CAMHS open inpatient nursing (Rasmussen 2012), shows that communication, teaching skills, observation and managing risk are common to all three settings. However, the range of additional interventions, described within the categories of ‘emotional containment’, ‘attachment’ and ‘personal qualities’ are distinct from those reported in either adult PICU or the CAMHS inpatient nursing studies.

Ward & Gwinner (2015) characterised the aim of adult PICU nursing interventions as creating a trustworthy environment so adults can *tell* their story. This study found that the emotional and cognitive development needs of adolescents means that extensive ‘emotional containment’ nursing interventions are required to create relational conditions in which young people can *show* their story to adults who are prepared *feel* something of the story not just see it, so that they can translate it into words or helpful actions and give it back in a form that the young person can understand. This process of ‘reverie’ requires staff to withstand and make sense of a high level of intrusion, violence and disinhibition as a primary means by which the young people communicate pain and vulnerability. These are characteristics that appear to set them apart from more general CAMHS inpatient settings.

In Rasmussen’s (2012) study of CAMHS inpatient nursing intervention, advocacy was described as making a case for young people who staff felt needed to move on, due to their behaviours and risks being too difficult to manage. In contrast, in the ‘last-chance saloon’ context of CAMHS PICU, advocacy was conceptualised as ‘sticking with’, not giving up on young people no matter the degree of risk, in the knowledge that there is nowhere else for them to be ‘moved on’ to. This was followed by convincing other care-providers of young people’s positive capacities, and the emotional and developmental gains made, in order to advocate for them moving out of PICU.

The concept of child/patient-led care may also be constructed or enacted differently within CAMHS PICU. Although the care systems in place on the unit did seek to involve children in their care in a variety of ways, the high level of control, boundaries, scrutiny and legal and physical restriction to which the young people are subjected, places significant constraints upon the opportunities for promoting the participatory and emancipatory characteristics usually associated with the term ‘child-led’ (Winkworth & McArthur 2006). However, there was evi-

dence in several categories (Attachment, Boundaries, and Personal requirements) of staff being led by young people within the frame of their individual interpersonal encounters and approach to relationship building. This parallels the way in which Bowlby (1988) observed ‘good-enough’ mothers allowing themselves to be led by their infants as a means of enabling them to develop reciprocal communication, empathy and social adaptability. The ability of a carer to create a relational setting in which the child experiences themselves as potent in the face of material powerlessness has been identified as essential to the development of sense of selfhood in children (Winnicott 1971; Lebau 2009), the ultimate aim of participatory and child-led approaches. In the innately paternalistic and patriarchal context of the CAMHS PICU (LeFrancois 2013) child-led nursing approaches might therefore be said to reside within the use of ‘maternal’ functions within the small details of the ‘to and fro’ of interpersonal encounters. This provides relational spaces for young people that mitigate the impact of the unit’s safety-focused restrictions on the young person’s sense of personal power and agency, which nurses are also responsible for executing.

Attachment and nurture in CAMHS PICU nursing interventions

The nature of nursing interventions described in this study can be best described using attachment and object relations theory, which characterises the aspects of the primary-carer–child relationship that are understood to bring emotional and mental resilience in life. That is, either trying to use the characteristics found in good-enough attachment relationships to understand, soothe and enable, or understanding the ways in which aspects of ward setting and relationships may act as overt reminders of previous attachment disruptions. (Adshead 2002; Minne 2011).

Adshead (2002) argued that the treatment of mental health disorder is innately linked to the promotion and enablement of development, and amelioration of the impact of less than optimal experiences upon the social, emotional and interpersonal stress regulating functions of an individual’s internalised attachment representations. Whilst this is true across the life course, it is especially so during adolescence. It is increasingly recognised that care of young people in any residential setting necessarily needs to address issues of care, dependency and attachment to be most effective (NICE 2015). Adolescence is a time in which the attachment patterns and internal working models set up in infancy are tested and re-worked, drawing on the mental functions developed through the primary-carer relationships experienced in earlier developmental stages (Waddell 2002).

The length of stay in PICU for some young people, the stability it can provide for young people whose biography

has been characterised by insecurity, the way in which illness and hospital activate attachment seeking/regulating behaviours and the intensity of the difficulties for which the young people are being treated, mean that the formation of strong bonds between young people, staff and the ward itself are to be expected (NAPICU 2015).

Against this backdrop, perhaps it is not surprising that the nursing interventions that have emerged to meet the needs of young people explicitly attend to the need for attuned, responsive carers who can forge relationships that soothe and promote growth and recovery. What is noteworthy is that ostensible descriptions of CAMHS PICU or similar secure mental health service models tend not to explicitly name this aspect of treatment instead focusing much more on acute psychiatric symptom management and pragmatic approaches to conferring safety (DH 2010; NHS England 2016).

One possible reason for this is that western medical accounts of illness which are usually rooted in understanding adult populations, can stigmatise the notion of dependency as they 'presume a [prior] normal state of independence interrupted by a discrete, time-limited period of abnormality and dependence' meaning that 'appropriate care-seeking and care-giving is conceptualised as aiming to restore normality and independence.' (Adshead 2002, p. S42).

Experiential knowing and receptive looking: reconceptualising the role of observation practices

Two codes were threaded through all the nursing intervention categories (Fig. 3): (1) learning about young people through the way they make you feel; and (2) knowing the whereabouts of young people.

A significant finding of this study is the way in which the practical task of high intensity observation (five-minute observations as standard) is enacted to extend beyond the task of harm prevention, in the service of the process of emotional containment and regulation/modulation of young people's mental representations of self.

Openness to receiving, and a preoccupation with making sense of, a child's indirect communication of feelings via projective identification, is a fundamental component of 'good-enough' care giving, described as feeling oneself into the place of the infant to develop an almost magical understanding of need (Winnicott 1960). Neuropsychological studies have shown how emotional distress and dysregulated affect are rapidly communicated through unconscious body-based intersubjective communications, before words can be found for them (Schore & Schore 2014). The ability to track verbal and non-verbal moment to moment fluctuations/rhythms in young people's internal states and to continuously modify one's own behaviour and responses, in order to be in synchrony with these, has been asserted as the foundation of effective therapeutic

relationships (Schore & Schore 2010), highlighting the importance of this aspect of intervening within acute psychiatric care settings.

In the mental health nursing literature, the purpose of high intensity or close observation practices is predominantly seen as harm prevention and risk assessment (Holylake 2013). As a result, close observation nursing practices are also often critiqued. Regulation by policy of observation as a task rather than a personal encounter has been said to privilege physical safety over emotional safety, to objectify patients and depersonalise nursing care (Stevenson & Cutcliffe 2006; Holylake 2013). As a form of surveillance, observation has been criticised as seeming to signify safety, whilst actually being an institutional instrument of power used against both patients and staff (Holmes 2001). Within CAMHS PICU standards (NAPICU 2015), the interpersonal component of observation is recognised but only in so far as its contribution to developing clinical intuition that can be used to prevent harm. However, the findings of this study reveal that the practical task of observing appears to be used by the nursing team to provide an important aspect of the psychological holding environment and maternal reverie, through visual transaction (Shore & Schore 2014).

How we are gazed upon and handled by our carers confers love and acceptance (Winnicott 1971), and is the foundation of the value we come to attribute to ourselves (Lemma 2009). Winnicott conceptualised the therapeutic task involved in working with individuals in mental distress as a 'complex derivative' of the original face (primary carer) whose role it was to reflect back all that the infant/patient brings. A sense of selfhood is forged through the work of looking and of being looked upon (Lebau 2009). Fundamental to this is the idea that 'being seen' is the experience of not just being looked at, but of being taken in, recognised, and reflected back by a receptive other (Winnicott 1971), which in itself serves a containing function (Alvarez 1999). In good-enough circumstances this is the internalisation of an 'other' who sees us for all that we are and still cares for us. Whereas, in circumstances where children have developed within a hard, critical or disorganised carer-gaze, they may become identified with a harsh, ruthless or chaotic internal observer (Lemma 2009); demonstrated through the self-loathing and self-destructive impulses evident in the codes describing the difficulties of the young people within the PICU setting.

Though linked to early developmental stages, the presence of acceptant and reflective others in adolescence is so important because adolescence is characterised by a developmentally 'normal' preoccupation with self-examination in mirror-like or reflective surfaces in the pursuit of understanding one's emerging identity (Winnicott 1971). The experience of being looked upon receptively is an

invitation to engage (Alvarez 1999) and has a bodily-experienced component to it that can instil a more benign appraisal of self which also equates to a hopefulness that other people can like them too (Lemma 2009).

That is not to say that the problems with enhanced observations, identified within the published literature, are not also present within CAMHS PICU. Increasing levels of observation from five minutes to 1:1 or 2:1 were used to increase safety and relational security for young people in crisis. However, periods of enhanced observation of this kind were identified as a frustration for staff, significantly impacting upon staff appraisals of their usefulness. An issue that will be elaborated upon further in the second part of this series (Foster & Smedley 2019).

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