Mental health hospital and inpatient processes

There are legal processes around placing people in hospital which involve psychiatrists and other professionals going through an assessment process which aligns to the Mental Health Act.

There are pros and cons to admission that also need to be considered and this includes a requirement to consider the least restrictive option available, family views and consent and individual presentation.

Sometimes the clinical view is that a person may be better supported in the community, particularly if the hospital environment may not be able to have a sufficient impact on their difficulties. There is a recognition that some young people with autism and learning disabilities, for example, do not respond well to hospital environments.

The NHS is promoting the 'hospital at home' idea or 'home treatment', where intensive support is offered at home to prevent admission to hospital (or following discharge). These are new approaches to services which are being developed and may mean that discussions about NOT admitting someone to a mental health provision become part of the discussion.

Appendix

Useful resources and reference points:

Overview | Looked-after children and young people | Guidance | NICE

Addressing Trauma and Adversity | Mental Health Resources | YoungMinds

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Understanding and Working with Oxfordshire Child and Adolescent Mental Health Service (CAMHS)

Introduction

Following a recommendation from a serious case review relating to Child R which was published by Oxfordshire Safeguarding Children's Board in December 2021,this document has been put together in order to represent some of the key words and phrases used with Child and Adolescent Service (CAMHS) and provide a point of reference. However, definitions and explanations are not always used in the same way, or may not even be 'fixed' and so discussion and clarification between professionals is encouraged. For example, a mental health practitioner may be understood to be saying that there is no mental health problem when what they really mean is that they do not have a specific intervention that they can offer that could make the kind of difference that other (non mental health) professionals hope might be possible.

It is important to note that there are treatment guidance documents (such as NICE guidelines) and best practice papers (e.g. Young Minds resources) which can be referred to. Some resources are at the end of this document.

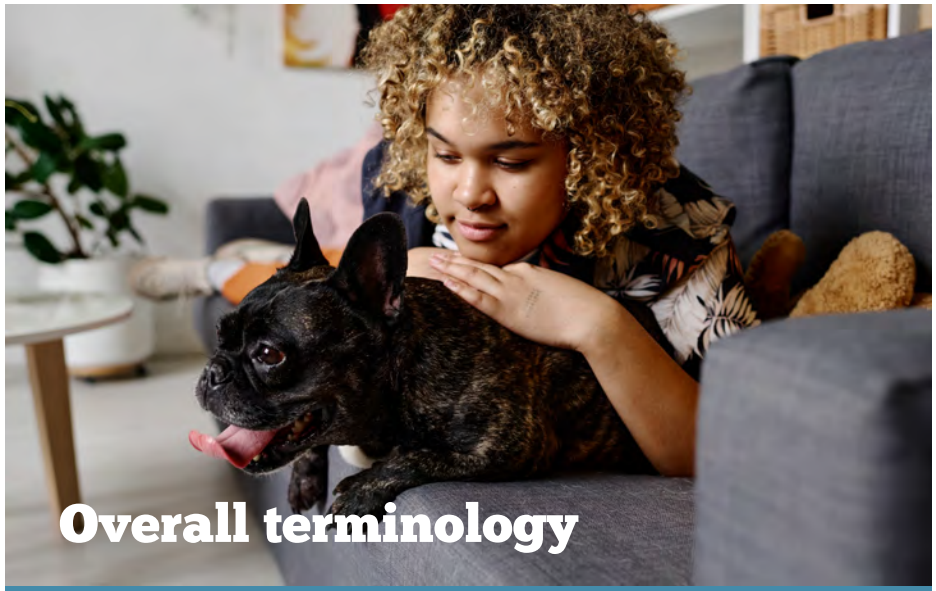
This document has been put together with the help of staff within Oxford Health and Oxfordshire County Council Social Care. We have considered that issues that were raised in the serious case review as well as current feedback.

This document contains:

(1) a summary of key terms used in relation to mental health and consideration of how to describe the presentations of behaviour by children and

(2) if considering a trauma informed framework what could be recommended or can be offered by services

It is important to note that professional and societal use of the words to describe 'mental health' vary. There are different approaches recommended to what words are used and there is no consistent 'rule'. The first consideration is around 'diagnosis'.



Overall terminology

A 'mental health' diagnosis

Diagnosis is a specific term used to describe and categorize a mental health difficulty. It is a clear and established collection or pattern of symptoms which have been present for a specific amount of time and have clear impact on wellbeing and functioning.

People with mental health difficulties/problems

A broad definition. Emphasises and acknowledges that the person is a person first, not a psychiatric diagnosis, and that many people experience mental distress and this may be a 'problem', not necessarily an illness or diagnosis. May be used when the level of mental health difficulty may not be able to be labelled as a diagnosis.

People with experience of mental and emotional distress

An even broader definition than above that aims to be as inclusive as possible, and focuses on the experience itself rather than using the concept of 'problem' as a label.

Key terms and how to describe the issues experienced by and the behaviour of the children that we work with

Despite a range of words and phrases we can use it is hard to describe other people's difficulties and behaviours as different people interpret things in different ways. Some of the terms below are often used.

If you would like more general information about CAMHS, we recommend looking at the CAMHS website which outlines some of the services available and has a jargon buster.

[All about CAMHS | Oxford Health CAMHS Oxford Health CAMHS]

Symptoms	Used to describe one or many observable aspects of a mental health difficulty or diagnosis. E.g. low mood, poor sleep, self harm.
Difficulties/ Problems	Used to describe impact of symptoms and may mean impact or severity is not at diagnostic level.
Low/moderate/ high	Used to try and describe level of severity or impact. These terms are problematic as they can mean different things to different people.
Trauma	In general use people use this as a term to describe both an event and the impact of the event. There is a wide range of use to this term. Trauma is also now used by many people to indicate that someone has had unpleasant experiences and that the difficulties that they have are likely a difficult reaction to these experiences (see developmental trauma also). Within CAMHS, single trauma is often used to indicate that there is one difficult event, multiple when there are more. These experiences may result in a diagnosis of PTSD (post traumatic stress disorder) if someone is re-experiencing the trauma (e.g. flashbacks etc). Complex PTSD is a diagnosis which means that someone re-experiences their trauma but also has other difficulties with emotions and interpersonal relationships.
Developmental Trauma	This is used to outline that someone has experienced a few/a range of traumatic or difficult experiences which will have an impact on them. This term is sometimes used to mean that someone's development may have been impacted upon by a range of difficulties experienced whilst growing up. Examples that are often considered here are prolonged neglect or physical abuse.
Attachment	Used in a number of ways to describe someone's relationship or even relationship style with another person. There are more formal ways of speaking about attachment in psychological therapies but these are not always used or followed. This term can be overused! Its use should be carefully considered as there are clear criteria which are used to diagnose attachment 'disorders'. It may be useful to speak about 'relationship difficulties' instead.
Evidence Based Treatments	These are treatments or interventions that have been 'tested out' via research and are usually the ones which are offered to people in CAMHS. They are usually talked about when someone has a diagnosable mental health difficulty. These treatments are delivered by a range of mental health professionals and include (but are not limited to) CBT, Family therapy or psychotherapy.
Formulation	This word is used to summarise how someone's difficulties are conceptualised and understood. A combination of psychological theory and facts/information about someone are brought together to give an explanation of what might be causing or contributing to their problems, as well as thinking about what could be changed. A good formulation may help us predict or understand how someone may respond to situations or experiences in the future.
Behaviour /'Behavioural'	Should be used to describe the actions that people do, but commonly (mis)used to imply that people are behaving in a way deliberately (by choice/with intention) or that the difficulties that they present with do not have any cognitive or 'internal' reasoning which fits a 'diagnosis'. This is a controversial term which merits discussion if used. It may be useful to see behaviour as a symptom of distress and recognise that it may be linked to early trauma or ways of reacting that have been learnt over time. Some difficulties with behaviour may of course be linked to how parents or significant others react or deal with the behaviour.
Acute distress	Describes the behaviour or 'presentation' of someone in current difficulty. This may include lots of expressed emotion and/or worrying and concerning actions which are not usually expected of the young person.

Emotional Dysregulation	Can be used in a number of ways to refer to someone not 'controlling' their emotions and showing clear signs of anger / upset / low mood. It can also be used to say that people are quick to change emotions or react strongly in certain situations. Distress shown can be higher than 'usual' or expected
Personality disorder	Within mental health services, diagnosis of personality disorder can be debated. Within CAMHS personality disorder should not be diagnosed or referred to as a problem as generally it is acknowledged that our personalities are in development into adulthood. Research suggests that some young people with characteristics that could be 'personality disordered' can recover into adulthood in some circumstances. The words 'traits of' or 'emerging personality disorder' are sometimes used to say that someone has difficulties that need to be noted/treated/thought about more.
Attention seeking	Many practitioners are aware that it makes more sense to think about using the phrase 'attention needing'. This is because we recognised that all behaviour is a signal the child is giving to the external world about their needs. Attention needing implies a response is required and thinking about the young person and the child will help shape what the appropriate response should be. We have seen that often important behaviours are dismissed as attention seeking and so key preventative interventions aren't taken up.

Treatments/interventions within CAMHS – things to consider

- Treatments and interventions recommended can vary depending on (1) how the problem is understood and (2) what may work for the young person (and the evidence base) and (3) their choice.
- There is probably always a second (or third!) opinion but this is not usually something to get into debating too much as within CAMHS most cases are discussed within the team to get another clinical opinion.
- Some treatments follow clear practice guidelines (e.g. CBT, family therapy, medication) or some can be more flexible in how they are offered/used or applied (e.g. 'informed' work can suggest this).
- Treatments are only effective if young people and their families support them. Someone may attend a meeting with CAMHS but still not 'do the work'. Sometimes their environment prevents them from 'doing the work'. We know that the support network around a young person can have a big influence on how they get on with treatment.
- Sometimes the context needs to change before treatment can sensibly be offered: this follows ideas of 'staging' or how to support someone engaging or being motivated. Sometimes the home situation can be disruptive and interfere with the young persons ability to focus or make changes.
- Sometimes CAMHS may form an opinion that an intervention or treatment will not work. These types of decisions will have been based upon the evidence for different treatments, clinical experience of the practitioner and will have been discussed with involvement from the multi-disciplinary team. CAMHS will always try to work with all involved to find a suitable alternative.
- It is important to note that nuerodiversity (autism) or learning difficulties/disabilities may mean that people can't access individual therapy in the same way and may need support from professionals but offered through the people who have a pre-existing relationship with the young person or with a parent
- Young people's motivation and preparedness needs considering: we know that the young person needs to be curious about having support or therapy from CAMHS if it is going to be successful. Preparation for this is important.
- If someone is not able to engage within therapy they may still benefit from being offered some support – this can be a 'care-cordination' role which can help with the plans around someone; and perhaps meet with them from time to time to see how things are.
- If there is a problem with engagement it would be important to get a shared multiagency plan which works towards dealing with the issues – this may draw on the relationships or interventions that already exist.

When should we be worried about a young person's mental health?

This is a difficult question to answer as everyone is different and each 'difficulty' may result in unique changes.

If you feel that something is not right – don't ignore it – check out the facts and gather information and seek support/advice

It is generally felt that any marked changes in how someone presents is important to notice - such as clear changes in mood (extremely high or low), anxieties, irritability, sleeping and eating patterns. An increase in avoiding things or withdrawing from previously enjoyed activities or people can also be a sign that things are not going so well.

The psychiatric diagnostic system usually sees problems that have been occurring for 6 months or more as meriting a diagnosis, as it is important to recognise that some people can have short-time problems which can get better without always needing specialist support.

Usually all professionals respond quickly to self-harm and attempts at suicide and separate guidance exists on this.

When a young person engages in repeated episodes of self-harm or para-suicidal behaviours, specific targeted care plans are developed as part of the therapy. Please make sure that you read the individual care plans for the young people that you are working with.

If the level of immediate concern is lower (but there is still ongoing concern) you may get advice from a professional on the CAMHS duty line, but you should note that this advice may be limited to the information presented at that time and may focus on safety planning.

If you are still worried you can:

There are often a range of professionals who may help you with the situation. It may be that the voluntary sector or early help offer may be useful to consider at this point. Some useful principles to follow are:

- Use supervision or consultation to discuss and review the case
- Ask for or arrange an extra meeting with professionals involved
- Use an escalation process in consultation with your manager

Note that regular reviews and discussions with others involved in the young person's care are opportunities to consider progress and concerns – be that TAF / CIN / CP or CPA. Multiagency working at its best means that all needs are reviewed by all involved at any review meeting.

Trauma informed thinking

Trauma informed thinking outlines that service should be:

1. **Trauma aware (be aware of the impact Trauma can have)**
2. **Trauma skilled (think about how being aware of Trauma can enhance what you do)**
3. **Trauma focused (offering specific input and therapies to treat the Trauma)**

It is important to think about which levels of these inputs may be needed. Sometime people think specialist trauma focused input is needed but a CAMHS assessment may actually suggest that people may get some help from more general input which is trauma skilled, or even be better served by general support which is trauma informed.

Case example

Billy is a 14 year old boy who has become increasing withdrawn at school in the last few months. He has got into trouble with some teachers over his behaviour. Historically there were concerns about his home situation and previous social care involvement at the CP level due to parental substance misuse and neglect of him and his brothers. One of his older brothers has been exploited and then got into trouble. There is a sense that he has witness some domestic violence and had some bullying by his older brother.

A **Trauma-informed** input would support him through providing specified time with professionals to speak about his difficulties and concerns. Regular meetings would build a relationship and may make some links with him about his past experiences and current situation and how these may be influencing how he is feeling and acting. Overall, it would help him and others see that he is feeling as he is due to what has happened to him.

A **Trauma-skilled** level of support may build on the above and consider using some more focused tasks (e.g. life story work) to help him tell his story, and may make some clearer links to particular experiences and the impact on him. It may spot things that he could do differently (e.g. increase his activities by getting back into football) and support these changes to happen.

A **Trauma-focused** input would build further and use specific therapy techniques to examine aspects of his mood and see whether there are particular thoughts that are triggering the times when he feels worse.

A note on interventions

A Trauma informed approach as outlined above means that careful consideration of needs is required. The Trauma informed approach is helpful in emphasising the layers of need and intervention. Assuming that 'therapy' is needed for an individual may be accidentally missing or reducing the other needs or also not noticing that someone may not engage with this. We need to consider what can be offered and by whom.

One of the difficult aspects of therapeutic support is that whilst services can try and engage people (get them to come to an appointment/meet someone) we can not always effectively engage people into doing the therapy. People need to be ready to do this. Services can focus on and build relationships to help trust, but it doesn't automatically mean that individuals will 'do' therapy.

Trauma informed approaches help here: we can think about what else may be useful, who else is around that can help in some way, and take a very clear needs led approach to help.

There is also good evidence that supporting people with basics such as routines, activities, building relationships is not only an important step to creating change but can sometimes be the main way of helping (and mean that other input is then not required).

Summary of abbreviations used

TAF - team around the family
CIN - child in need
CP - child protection
CPA - care programme approach
CBT - cognitive behaviour therapy