RiSC

An evidence synthesis of risk identification, assessment and management for young people using tier 4 inpatient child and adolescent mental health services (CAMHS)

Young people's consultation

YoungMinds

April 2013

What we did

Over the course of a week we held five separate recorded conversations with young people who had been previously been in CAMHs inpatient settings to ask them about their perceptions of risk. The young people were extremely insightful and had a number of interesting points and common ideas about a variety of risks to young people existing in both CAMHs in patient settings as well as on adult wards.
The conversations with young people were recorded and partially transcribed so that the ideas, quotes and themes could be used to stimulate debate amongst members of the project team and stakeholder group.
The young people were asked five specific questions:

- What do you think the risks to children and young people in inpatient settings are?
- How do you think those risks are assessed?
- What do you think is done about those risks?
- Do you think there are a different set of risks for young people who are inpatients in adult wards?
- What risks do you think the research team should focus on in its in depth review?

What the young people said

What do you think the risks to children and young people in inpatient settings are?

The young people talked about a wide range of risks and some risks were seen to be more obvious whilst others were more obscure. The young people we spoke to felt that all of the risks should be taken seriously and that just because a risk might be less obvious it didn't make it any less important, in fact quite the reverse. Risk was seen as a very broad term covering lots of areas including; physical harm to one's self, or from others as well as the risk of emotional harm resulting from social isolation, negative peer pressure and the lack of quality education, young people becoming 'institutionalised' and poor planning on discharge.
"I think that they can be volatile places, several people all in together and the atmosphere can be quite fraught there is a risk of violence from other patients."
"...Injury from being restrained."
"...Risk to emotional wellbeing of seeing and experiencing really distressing scenes."
"People who have been in units for years some risk of getting institutionalised and not being able to cope when getting out."
"...Missing out on education you can't get qualifications. There was a school attached to the unit I was in but it wasn't good enough. The quality wasn't good enough."
"Facebook is not allowed and where that's the main form of communication the risk of becoming detached and isolated increases."

“From my experience the risks are becoming identified as someone who is “ill” so you use your normal identity in friendships groups, families, and professionals. You begin to see yourself as “ill” and don’t know where you fit outside of that category.”
“It isolates the family as well: They are seen as not suitable to look after their child. It has an impact on the emotional wellbeing of family.”
“Hospital was a safe place and so it was hard to go home.”
“My life was fragmented.”
“The risk of you to yourself and the other one will be the cliques that form in an inpatient setting aren’t healthy and unhealthy habits are picked up and are taken on from the hospital.”
“You go into prison and you are good at cannabis and go to prison and you come out with a PhD in Cocaine. Self-harm, eating, medication abuse. CAMHS units expose you to things that you are not ready for that are not part of your life and you are not ready for.”
“The obvious one is the risk to yourself of self-harming, but there are risks that are thought about less; the emotional needs of people, being around other people who are not in a good place can be emotionally damaging.”
“Falling behind with education or work: The impact of this was this I was missing out on a lot of school work – I was behind with work and with friendships and I was not fitting in with people.”
“It’s not sensible to send people out from an inpatient unit into a highly stressful situation again without the slow integration.”

How do you think those risks are assessed?

This question also generated some really common answers in that the young people we spoke to felt that some risks, like self-harm, were assessed thoroughly, though not necessarily positively, whilst others such as the lack of educational continuity was ignored.

“There was a lot of care taken over things and it was gone over and evaluated in meeting. There are some things are more difficult to assess. It’s much harder assess the emotional impact that being restrained has on someone.”
“Education wasn’t part of the priority at all. It might not be a priority at the time but you won’t be in there forever.”
“People don’t really acknowledge that it becomes an identity until you are recovering.”
“The risk of being out of a friendship group was not noticed or acknowledged and friendship groups were not nurtured.”
“Assessing risk should be about having individual conversations with young people that are inclusive and done with the young person. It needs to be informal. Risk needs to be seen as a very personal thing and is not a black and white issue.”
“I think the risks of self-harm and suicide are thought about extensively with the whole team in ward rounds and risk assessments will be done before people leave. The other types of risks are not being thought of at all. I can’t remember ever being asked about education at all. In terms of relationships on the ward but it was not necessarily done in a sensitive way. Also, risk assessment procedures aren’t followed through because of people’s workloads. Emotional and educational risks are not taken into account.”

What do you think is done about those risks?

As with the young people’s perceptions of assessment, what was being done to mitigate the risks that were identified was split between the ‘obvious’ risks and the

'less obvious'. The young people were aware of some actions being taken but felt there were significant gaps that need to be addressed. The young people also highlighted practice in relation to the assessment of physical risks which the young people felt were very unhelpful, in particular around restraint and threats to send young people to an adult ward. The young people talked about planning for discharge in response to this question but again highlighted this as inconsistent and often poor.

"There is training on how they restrain you and I'm sure they are gone over but training is hard because the reality is different."

"If someone becomes very volatile and violent they were told they were discharged or were sent to an adult unit."

"They do try and plan for leaving and it is staggered. They have to talk to you about what happens next but it feels rushed and to pressured because of the strain on money. It was more about getting people 'well enough' but that's not really making enough progress."

"The risk of isolation was not addressed at all, nothing was done."

"Family wise we had family therapy which could have been a space to address but there wasn't a space for them to go which was just for them. Though I might have taken this badly at the time and might not have understood their needs and the risk to them."

"The action can be very tick box based and a lot of the time things aren't explained well enough to the young people and not enough is done about it. Sometimes even if there is a care plan the young person might not know about it of feel like they were given the opportunity to take part in it."

"Having discussions with nursing staff and meetings with the doctor about physical safety; the typical risks being managed; windows are closed, sharp things are taken away. There was a discussion around college work which was focussed on do you need to drop out not how could you carry on."

"We have to be seen to be giving you an education because you are under 16 but it was lip service and not of a high quality at all."

Are there a different set of risks for young people who are inpatients in adult wards?

All of the young people we spoke to felt that there were some different risks associated with being in on an adult ward but they were described as similar but exaggerated. The young people felt it was more likely you would be physically or emotionally damaged because there is far less support available. Therefore the risks escalate and this means and increased likelihood of readmission.

"Yes I do, young people are more vulnerable and will be treated like an adult when you are not. Nurses even say that they are not nice places. You will be put in a room, medicated and left to it."

"It was scarier and I didn't fell as safe. The behaviour from the other patients was more extreme and so you could see it more. The behaviour from other patients and the staff from the adult teams were not as able to engage me or willing to look after me."

"When you are under 18 you don't necessarily have an idea of what your rights are and might have come straight from the family into hospital and this presents new risks. Discharge is a particular problem as people are sent out without enough support. How are the friendships managed, people might become institutionalised and want to get back in."

"Yes I think there are. There is more risk of self-harm and suicide because there is less supervision. There is far less emotional support; if you are quiet people leave

you alone. There is no education, no contact with peer group inside of less of a change to get a peer group. It was also really, really scary."

What risks do you think the research team should focus on in it's in depth review?

There were a range of ideas that the young people felt the research team should focus on but there was certainly an interest in the emotional consequences of having your life 'fragmented'. They young people certainly perceived the practice of the CAMHS workers on the wards as aimed far more at the assessment and mitigation immediate risks to the physical harm of young people. This was seen as coming from a lack of research in this area.

"Restraint; it's done in the same way as the police, it's done in an aggressive way and it's used as a deterrent."
"Institutionalisation: People like the routine of being in a unit; it's safe."
"They should be looking at the identity issue; you become to see yourself as not well and not normal or part of normal society and friendship groups. It's easier to hang on to that identity. The more you are in institution that says you have to be ill the more the increase in risks. Detaching from that label is the most difficult thing."
"The idea that risk assessing people high risk makes it more likely that they will be at risk – it's a self-fulfilling prophesy!"
"I think it should be the emotional and educational risks as they are less thought about but do need thinking about. Those are the things that allow the people to get back to a normal life."

Conclusion

Though we spoke to a relatively small number of young people there were some clear themes that emerged from all of the conversations and those themes came out of the direct experiences the young people. They told us that there were a number of risks that were not adequately being assessed or addressed and that this might be because of a lack of resources or training. All of the types of risks that we discussed were seen as equally important and the assessment of risk was highlighted as an area that needed to be carefully considered as a poorly done risk assessment could feel extremely punitive and could therefore have a negative effect on the individual's emotional wellbeing. Most of the young people talked extensively about the risk of emotional harm caused through exposure to distressing experiences as well as negative peer group influences. The young people also mentioned the risk of having their social lives put on hold indefinitely and the lack of opportunity to get any high quality educational provision. One young person used the term 'fragmented' to describe how what had happened to their life felt and the result of this fragmentation was their self-identification as 'ill'. This new identity was seen as damaging as it prevented recovery and made it more difficult for the young people to move back into a 'normal' life off the ward. The young people said that they were put on wards to get better but that in many cases there were reasons why being placed in an inpatient setting was in fact detrimental to them. However they also recognised that leaving too early was equally damaging. The risks are present in the immediacy of the inpatient setting but the failure to address those risks has severe implications on both the young people and services as not addressing them leads to increased emotional distress as well as the increased likelihood of a readmission.