A rapid appraisal of the needs of nursing staff delivering care to children and young people with mental health needs, learning disabilities and/or autism

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Executive summary

The problem: Many children and young people (CYP) with mental health (MH) needs, learning disabilities (LD) and autism are receiving care in non-specialist settings where nursing staff do not have the knowledge and skills to address their needs.

Study aim: To document the needs of nursing staff delivering care to CYP with MH needs, learning disabilities and/or autism in acute care settings, as well as their perceptions of any training programmes or interventions implemented to address these needs.

Study design: We interviewed 21 healthcare workers (nursing staff and healthcare assistants) around the UK and conducted a focus group with the RCPCH Mental Health in Children and Young People's Physical Health Services Advisory Group.

Main Findings

Challenges reported by staff:

- Staff reported seeing large numbers of patients with anxiety, eating disorders and self-harm. Providing one to one care for patients at risk of self-harm or harming others with limited resources was extremely challenging, especially if restraint was needed.
- Staff mentioned having limited confidence to have conversations with CYP with MH needs – they worried about saying the 'wrong' thing.
- Staff were concerned that MH patients created an unsafe environment for others on the ward. However, there were often no other appropriate areas for CYP with MH needs.
- Patients who needed to be referred to specialist mental health units were often waiting for a bed in non-specialist acute wards, delaying their MH treatment.
- Staff reported limited access to CAMHS and available out of hours MH support.

Support received by staff:

- Current training/support accessed by staff included the 'We Can Talk' self-led training, annual study days with talks from MH professionals and the integration of MH nurse or support workers into acute wards so they could help support nursing staff and patients.
- Current tools used by staff included information folders, risk assessment matrices, and validated questionnaires.
- Nurses would also value the opportunity to debrief and reflect on difficult situations or incidents, however this practice was not currently embedded in most hospitals.

Future training should:

- Be mandatory, with opportunities clearly communicated to staff and increased places.
- Be included in pre-registration and contain placements in mental health settings.
- Include knowledge of common MH difficulties, in addition to common challenges such as reducing the anxiety of CYP and parents, communicating with CYP with LD and autism and managing mealtimes with CYP with eating disorders.
- Mainly be face to face (e.g., for role play), but include online learning options.
- Be holistic, applicable to local settings, including real cases to ensure relevance.

Aim of the study

The aim of the study was to document the needs of nursing staff and healthcare assistants (HCAs) delivering care to children and young people (CYP) with MH needs, learning disabilities (LD) and/or autism in acute care settings, as well as their perceptions of any training programmes or interventions implemented to address these needs.

Research questions

The study was guided by the following questions:

1. What are the main challenges faced by nurses and HCAs delivering care to CYP with MH needs, LD and/or autism?
2. What are the main needs of nursing staff and HCAs without specialist training who are delivering care to CYP with MH needs, LD and autism in acute care settings?
3. What type of support do nursing staff and HCAs receive? What are their perceptions of this support?
4. Have any training programmes been implemented to train staff? What are staff perceptions of these programmes?

Methods

Design

This study was designed as a qualitative rapid appraisal, with telephone interviews and focus groups discussions as the main sources of data (Johnson and Vindrola-Padros 2017; Vindrola-Padros 2020a). This study design is recommended to collect and analyse data in a targeted manner, under limited timeframes, in order to 'diagnose' a situation or capture a 'snapshot' (Green and Thorogood 2013). This method of data collection and analysis is iterative and triangulation of different sources of data ensures data validation (Beebe, 1995).

Data Collection

Interviews

In-depth, semi-structured interviews were conducted with nursing staff over telephone, Microsoft Teams or Zoom from 9 to 29 November 2021. Interviews were conducted by three researchers working in parallel, using a topic guide, which was created based on the research questions guiding the study. The interviews captured the main needs of nursing staff and HCAs, the main characteristics of their patients, what type of support they receive, and their perceptions of training programmes. Demographic information, including gender, ethnicity, role, years of experience, healthcare setting and location of work, was also collected (see Table 1). Interviews were audio recorded and interview notes were taken. These notes were then re-configured into RREAL sheets, which help organise and summarise data in real-time based on key topics of interest. Organising data in this way also enhances the team's engagement with the data, in preparation for analysis.

Focus group

A focus group discussion was conducted on Microsoft Teams with a group of 13 multi-professional leaders from various professional bodies such as the Royal College of Paediatrics and Child Health, Royal College of Psychiatry, Royal College of Nursing, and British Psychological Society. It is believed that a focus group of this size renders diverse information (Onwuegbuzie et al., 2009). This was an opportunity to investigate the needs of clinical teams working to provide care for CYP with MH, LD or autism in a structured way.

Sample and recruitment
A purposive sample of 21 healthcare professionals with experience of delivering care to CYP with MH needs, LD or autism in the context of acute care were interviewed (see Table 1 for the sample characteristics). The original recruitment strategy sought to create a sample that could represent different areas of the country, levels of seniority, areas of the hospital, gender, and ethnicity. An initial message with information about the study and researcher contact details was sent out by Health Education England (HEE). Staff members who showed interest in participating in the study contacted one of the researchers via email. Participant information sheets and consent forms were sent to potential participants, and interviews were arranged.

Data analysis
Following rapid qualitative data analysis approaches (Vindrola-Padros 2020b), RREAL sheets were reviewed by the research team to identify recurrent topics across study participants. A list of key findings was generated and interview notes and recordings were reviewed to create detailed descriptions of these findings and identify illustrative quotes.

Ethical review and governance

The study was classified as a service evaluation by the HRA decision tool. The study was implemented following an informed consent process, with written consent for the interviews and verbal consent for the focus group. The research team anonymised all of the notes generated during the interviews and the focus group. All notes were stored on a secure UCL server. All members of the team have undergone IG and GDPR training.

Table 1. Sample characteristics

Professional role	**Healthcare setting**	**Years of experience (current role/nursing)**
Paediatric Transition Coordinator/ Nurse	Acute wards, outpatients, community	1 year/ 19 years
Mental health nurse specialist	Children's Hospital	1 year
Matron	Surgery wards, hospital	4 years
Clinical nurse specialist	Transition services	33 years
Lead practice educator	Tertiary Paediatrics	5 years
Clinical skills facilitator	Children's hospital	6 years/ 23 years
Paediatric mental health liaison	Children's ward	1 year
Practice development nurse	A&E	8 years/ 25 years
Deputy director of nursing	Community Mental Health Trust	7 months/ 30 years
Children's ward manager	Children's ward	18 months
Clinical matron for CYP	Children's ward, acute hospital	1 year/ 23 years
Advanced clinical practitioner	Children's emergency department	8 years/ 17 years
Senior nurse CAMHS lead	Acute NHS Trust Children's hospital	1 year/ 25 years
Matron	Children's hospital	8 years/ 24 years
Healthcare Assistant (Band 2)	Paediatric acute ward (Paediatric oncology)	3 years
Chief Nurse	Non-clinical support for paediatric teams	1 year/ 27 years
Paediatric safety lead	Acute hospital, children's ward	5 years/ 27 years
Community modern matron- CAMHS	Community Mental Health Services	8 months/ 21 years
Lead nurse for children's services	Acute Trust, District General Hospital	10 years/ 28 years
Team lead family therapist	Acute Trust, District General Hospital	8 years/ 36 years
General Paediatric Nurse	Torbay General Hospital	15 years

Findings

Main challenges faced by staff and support needs

The main challenges identified by staff could be organised in four main categories:

1. Challenges produced by **communication difficulties**

Study participants reported challenges when caring for CYP with LD and autism, particularly in cases when patients were non-verbal. These communication difficulties complicated the assessment of symptoms and led staff to talk only to parents, excluding CYP from conversations.

In the case of CYP with MH needs, study participants often lacked the confidence to discuss 'sensitive topics' and worried that they might be doing 'more harm'. As a consequence, some participants indicated that this limited the information that could be obtained from CYP during assessments and discussions about MH and wellbeing.

> "*A lot of the young people that I work with are non-vocal and so, you know, need someone with them to act as an advocate* (paediatric nurse)".
>
> "*A child just sometimes wants you to say: 'what's up, why are you doing that?' [...] sometimes we don't ask that question because we don't know what to do with the answer*" (ward manager).

2. Challenges produced by **limited knowledge on how to assess and treat CYP**

Although nurses were identified by study participants as extremely empathetic and highly skilled to perform medical tasks, they mentioned that many nurses and HCAs lacked expertise or confidence to assess and deliver care to CYP with MH needs. Some CYP present to hospital with a wide range of MH needs or they might present with physical conditions, with their MH problems identified after further exploration. According to some participants, it was difficult for nursing staff and HCAs to have an in-depth understanding of all of the MH conditions they might encounter in the Emergency Department (ED) or on the wards. Commonly reported MH problems included: psychosis, overdoses, strangulation, eating disorders, and self-harm.

Study participants reported that nurses sometimes lacked the confidence or knowledge to support young people through mealtimes, or, in more severe cases, during restraint for refeeding. There were conflicting views in relation to patient restraint, with some staff indicating that restraining a patient should not be a part of their role, whereas others recognised it might be needed in extreme cases as long as they received appropriate training. Due to a lack of staff trained in this area, participants reported cases where wards had to rely on staff from other departments or members of the security team, which was upsetting for staff and other patients on the ward.

"The overriding theme is feeling underequipped, under-skilled, lacking in knowledge to know how to support these young people" (Senior nurse).

3. Challenges produced by **limited MH specialist support** for nursing staff and HCAs

Study participants also identified a need for more joined up care between CAMHS and an acute setting, particularly when a CYP needed out of hours support. Patients who needed to be referred to Tier 4 specialist MH units were often waiting for a bed in non-specialist acute wards. This resulted in delays in their MH treatment, as the staff in acute care settings were not trained to deliver MH support to these young people. One exception to this was in Chesterfield, where CAMHS was integrated within the acute children's hospital. Care for CYP with eating disorders was delivered by a multi-disciplinary team, including paediatric nurses, CAMHS clinicians, play therapists, consultants and dieticians. The implementation of this model of care had been successful in reducing the number of CYP needing referrals to a Tier 4 bed, as the majority of their care was provided in the acute setting.

Study participants indicated that nursing staff and HCAs needed access to clinical supervision and the opportunity to debrief and reflect on difficult situations experienced on the ward to manage their wellbeing. Participants indicated that not all hospitals/wards provided weekly debriefs for staff. They also reflected on the potential benefits of weekly psycho-social meetings to discuss patient cases to provide better support. Participants welcomed better relationships, communication and support from MH services including access to CAMHS colleagues for daily support and to tailor training to real-life situations.

"I'm saying this is not to be a negative person, but all of the paediatric wards around the county and district general hospitals have no current link whatsoever with their mental health teams" (paediatric nurse).

4. Challenges produced by **the hospital environment**

The ward environment was also reported as a challenge for staff and CYP. The majority of participants worked in mixed specialty wards, which meant nurses had to care for teenagers with mental illness next to young children. Nurses reported a negative impact on the atmosphere of the ward if a CYP was experiencing MH difficulties when on the ward, and these situations raised concerns about the safety of other patients. Some CYP, especially those with LD or autism could struggle with the busy, loud nature of the hospital environment, which increased their anxiety. Participants identified the need for a safe space for these young people to be cared for. There have also been changes in the therapeutic environment due to COVID-19, as wards are bare, with toys removed due to infection control procedures, which has also impacted on patient anxiety.

"Those that present with mental health issues that are also on the spectrum with a diagnosis or, or not a diagnosis of ASD but those very strong traits, being in a noisy, bright, loud environment is actually really difficult for them to manage" (paediatric nurse).

Current training/support accessed by staff

The study participants identified training programmes they had attended or were aware of that could help address some of the knowledge needs identified above (see full list in Table 2).

Table 2. Training identified by study participants

Training received or under consideration	Description/staff comments
Placements in mental health and learning disability environments.	During nursing training.
Degree-level CAMHS course for caring for CYP.	Participant provides/arranges training and supporting other members of staff. Tries to send at least one staff member per year.
Plans for staff to access university modules on mental health (20 credits).	County-wide initiative.
'We can talk' self-led training.	Receives a lot of positive feedback. Although one participant found it difficult to assess if it was appropriate to spend the amount required on this.
CAMHS short courses or bespoke training.	In talks around developing internal short courses.
Actively working to improve signposting using materials developed by charities such as BEATS and Young Minds.	Delivered by mental health nurse who works with colleagues in acute settings.
Annual ward study days with speaker from different mental health services.	Participant provides/arranges training and support for other members of staff.
RCPCH curriculum (physical and mental health).	Royal College of Paediatrics and Child Health, core competencies
HEE Framework for self-harm.	Considered good competency framework suitable for any frontline professional.
CYP mental health (e-learning, simulation, masterclasses).	London-wide; available to all paediatric staff in London.
Mental health core competencies included the Paediatric training programme.	Not as many as there should be.

Current support and tools

Useful support strategies mentioned by study participants included:

- Weekly MDT psycho-social meetings to encourage the sharing of different perspectives and different ways of thinking.
- Teams of psychologists and psychiatrists that can offer case consultation, discussion and reflection to support learning which helps to boost nurses' confidence.

- Initiatives to integrate mental health nurses or support workers into acute wards so they can help support nursing staff and patients.
- Care passports when transitioning patients from paediatric to adult services, which are a helpful method of quickly communicating medical history and needs of the individual.
- Cupid mission plans, which are shorter care cards containing brief overviews of patients presenting at A&E.
- Mental health information folders, containing risk assessment matrices and key components of the Mental Health Act.
- Validated questionnaires on mental health disorders such as anxiety and self-harm are also being utilised and are providing staff with a guide to follow while having conversations with CYP about their mental health concerns.

Preferences for future training

Topics

Study participants indicated that nursing staff and HCAs would welcome training on:

1. Common mental health conditions, as staff knowledge and understanding of MH is not uniform. This increase in awareness would help reduce the fear of the 'unknown' of MH, reported by several participants.
2. In-depth training on how to communicate with CYP with mental health needs. Staff struggle to communicate with patients whose conditions often relate to underpinning trauma, that staff must be sensitive to. Having better ability to communicate and interact with patients, would increase their confidence to initiate and guide conversations, which is a primary form of support.
3. Training on informed consent would also aid in the development of more complex communication skills. Categorically, tools and skills specific to managing mealtimes for CYP with eating disorders and general skills in reducing anxiety in patients and parents, were identified as highly necessary.

> *"A lot of it is not, actually, may not necessarily be the real content of the training, it's actually about giving the nursing staff the confidence to have the conversations to support, to actually just sit and chat"* (Senior nurse).

Format

An ideal training programme was described as exciting, interesting, based on lived experiences, practical and supported by management. There was general consensus that training should be mandatory, as currently staff seek their own training in most hospitals. Some participants mentioned that training should be included at the stage of pre-registration and combined with placements in mental health settings to give pre-registered nurses better hands-on experience.

Face to face training was preferred over online training as emphasis was placed on practice-based exercises, role-playing and simulation training. Participants emphasised that the

reflective learning that occurs after the simulation should be expanded, as this is where staff can develop skills on what worked well and what needs to be improved. One suggestion was to develop interprofessional training based on shadowing MH colleagues or conducting peer-observations of those who have received prior MH training, such as outreach MH services. This would make the training more applicable to local settings, more practice-based and, hence, more relevant.

> *"Lived experiences from the CYP...if they can say this is what would have made a difference, hearing it from them, that for me is a very strong message...this will give me something, a skill, to take away*" (CNS).

Limitations of this study

The findings included in this report should be interpreted in relation to the limitations of the study. The study was designed as a rapid appraisal carried out over six weeks, so the interviews and focus group discussions will be limited in their scope and depth. Furthermore, even though the initial recruitment strategy was designed to be inclusive and cover a wide range of geographical locations, levels of seniority and ethnicities, we were limited to the study participants who replied to HEE's invitation to take part in the study. The views reflected in this report are not representative of the experiences of all nursing staff and HCAs delivering care to CYP in the UK. The study focused on capturing perceptions of delivering care, but practices of delivering care were not documented.

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