Nursing Responses and Interventions for Episodes of Adolescent Distress in an Acute Child and Adolescent Mental Health Inpatient Unit: An Interpretive Descriptive Study

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Statement of Originality

The thesis contains no material which has been accepted for the award of any other degree or diploma in any university or other tertiary institution and, to the best of my knowledge and belief, contains no material previously published or written by another person, except where due reference has been made in the text. I give consent to the final version of my thesis being made available worldwide when deposited in the University's Digital Repository, subject to the provisions of the Copyright Act 1968.

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Date:

Stephen Spencer

DEDICATION

Despite the many hours away from family working on this study, I would not change a thing. It has been a journey of personal and professional growth. However none of it could have been possible without the love, support, and understanding of my wonderful wife Emma, and daughters Ailish, Hannah and Bethany. I dedicate this work to them, knowing they have lived this journey as much as I have.

I would also like to dedicate this thesis to one particular young person I have nursed whose struggles became too much. At times when I felt like ‘throwing in the towel’ it was the memories of time spent with them during their struggle that provided the fuel for me to keep going, so that others in their position may prosper from this work. May the light finally shine on them.

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I would also like to thank my editor Jill Valdar, who I am sure secretly wishes I had listened to my high school English teachers. Her knowledge of the English language and the written word is amazing. Who would have thought a comma has so many rules? Thanks for the lessons Jill.

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Synopsis

Adolescents who experience acute mental health problems are often admitted to acute child and adolescent mental health inpatient units for care and treatment. Nurses, at times, are required to respond to episodes of distress that adolescents experience during the admission period. Nurses engage with young people who exhibit maladaptive and often high-risk behaviours that require appropriate interventions to help alleviate their distress. The majority of research conducted on child and adolescent mental health has focussed on quantitative methodologies examining the demographic and diagnostic characteristics of young people, treatment outcome measures, or the rate of coercive interventions such as seclusion, physical restraint, and *prn* medication.

There are numerous contextual factors that influence nursing practice. This study aimed to understand which nursing responses and interventions were most helpful in resolving distress for adolescents admitted to an acute child and adolescent mental health inpatient unit. An interpretive descriptive study was undertaken to explore the contextual and experiential components of providing nursing responses and interventions for episodes of adolescent distress. This approach is suited to the subtle but complex nature of the clinical setting and understanding the interactions between nurses and adolescents.

Following a review of the relevant literature, and documentation of the researcher's assumptions, two methods were used to collect data. Non-participant observations focussing on interactions between adolescents (aged 13-17) experiencing episodes of distress and nurses who responded to them were conducted. The second-stage of data collection, semi-structured interviews (n = 10) were conducted with nurses working in the inpatient unit.

Both data sets were analysed using Thorne's three-stage interpretive descriptive method. The open, axial and selective coding process produced themes and sub-themes that provided a deeper understanding of how adolescents experience episodes of distress in the acute inpatient mental health setting, and the cultural and contextual factors that not only trigger these episodes, but also on the nurses who provide care for them at these times.

Young people experienced and displayed their distress in numerous ways and nurses used a range of responses and interventions to assist them. The importance of a person-centred approach was evident and there were multiple cultural and contextual

factors that influenced both the young people's experiences during the admission, and nursing practices.

An observation model of responding to adolescent distress, and a clinical tool that integrates findings from both data sets were developed as a result of this study. These will provide the impetus for education and training, policy and organisational change, and future research in this area of mental health nursing care.

CHAPTER 1: INTRODUCTION

It is the responsibility of adults to assist adolescents to reach the developmental milestones associated with this stage of the lifespan. Adults should act as a safety net, solid and secure, so that adolescents can explore the world in preparation for their own journey into adulthood. However, this current generation of adolescents face many stresses, obstacles, and life experiences that previous generations did not have to consider.

When the stress of life impacts on an adolescent's mental health, hospitalisation may be warranted to provide care during this difficult time. It is imperative that nurses working with adolescents in this environment act as the safety net. However, there are many factors that must be considered by nurses in order to provide appropriate intervention in times of distress on the acute inpatient unit.

This chapter will outline the background to, and stimulus for the research. A brief description of the statement of the problem, and the significance and implications of the research will be offered. The research question and methodology used for this study will be defined. The chapter concludes with a glossary of key acronyms and the structure of the thesis.

1.1 RESEARCHER BACKGROUND

It is funny how we get to certain places and circumstances in life. If you met me when I was an adolescent you would never have imagined I would now be completing my third degree, especially a Doctor of Philosophy (PhD)! I know that my younger self certainly would have laughed at the prospect, so too would many adults I knew at the time.

Working many jobs in my early adulthood (and never enjoying even one day of it) I stumbled across a career in nursing. The birth of my firstborn daughter was a turning point. The first midwife we met in the delivery suite was a male 'midman'. With a young family and no direction for my future career I considered becoming a nurse. I considered myself a caring person, and health was my best subject at school, so I thought, "Why not give it a go?".

Fast-forward 12 years, I completed hospital-based training as a Trainee Enrolled Nurse (TEN) at a psychiatric rehabilitation facility, then worked as an Enrolled Nurse (EN) in a

medium-secure forensic mental health rehabilitation unit. I realised working in the area of forensic mental health was not for me, but one thing that stuck in my mind was the social and developmental histories of the men I nursed in this environment. That is where I made the decision to work with young people. With the addition of twins to the family I commenced my Nursing degree and on completion spent 12 months in a mental health New Graduate Program where I was introduced to child and adolescent mental health nursing.

During the time as an EN I became a Prevention and Management of Violence and Aggression (PMVA) trainer for the mental health service. During my New Graduate year I commenced an Honours research project and evaluated the service's PMVA training program. I wanted to know if the learning outcomes of the training program were transferrable to clinical practice. At the end of this two-year journey I realised that in teaching PMVA to my colleagues three days are spent on physical restraint and seclusion, interventions that I would estimate account for less than one per cent of my clinical practice. I asked myself, why do I spend three-quarters of the course teaching seclusion and restraint practices and little time on evidence based interventions such as therapeutic engagement, de-escalation, and other non-coercive interventions that make up the majority of my clinical practice?

These questions formed the catalyst for my PhD thesis. I wanted to know what interventions would help young people in times of mental (and possibly physical) distress. There are no seclusion rooms in the community for people to resort to when challenging behaviours present, and parents often do not have knowledge about or access to '*prn'* medication. By obtaining greater insight into the expertise of nurses and observing the experience of distress for young people, I hoped to offer greater appreciation of the nature of situations involving nurses' responses to young people in distress; some solutions to challenges might become evident and answers to the above questions might already exist. Above all, my goal as a mental health professional was to assist adults involved in the lives of young people (both personally and professionally) to support them and reduce the likelihood of extreme distress resulting in hospitalisation for mental health problems. Should hospitalisation occur, optimal care directed at the needs of adolescents and the greatest potential for their recovery seemed to be a critically desirable element for contemporary mental health nursing practice.

1.2 MENTAL HEALTH OF ADOLESCENTS: THE CURRENT SITUATION

Adolescence is a difficult period of rapid physical growth and cognitive and social development. Nationally and globally there is an increasing need for specialist care for young people with mental health problems to minimise negative impacts on them, their families and communities. The terms mental health problems, mental health disorders and psyciatric illness will be used interchangelbly throughout this thesis. Core objectives of mental health services for young people include improving their social competence, problem-solving skills, resilience, and building a sense of hope for their future (World Health Organization, 2008).

Different definitions of adolescence exist and I will use the term interchangeably with "young people" which unless otherwise stated will refer to people between the ages of 13 and 17. This age range, known as middle adolescence (Smetana, Campione-Barr, & Metzger, 2006), will be used for two reasons. First, because it is representative of the ages of the young people admitted to the acute inpatient unit where this study was conducted. Second, from a developmental perspective this is the period in which the biological influences that occur in early adolescence (10-13) diminish, and social and cultural domains, including self-identification, greater importance of peer relationships, and transition to adulthood become more dominant (Smetana et al., 2006).

1.3 STATEMENT OF THE PROBLEM

The increased incidence of mental health problems for adolescents has placed pressure on health services to provide quality care for them. In New South Wales (NSW) Australia, approximately half of all adolescents admitted to acute inpatient units for mental health care are housed in adult mental health inpatient units (Hazell, Sprague, & Sharpe, 2016). For the remainder, specialist acute child and adolescent mental health inpatient units provide the environment for adolescents to begin the recovery process: during these admissions young people may experience episodes of distress that can result in high risk, dangerous behaviours that require coercive interventions to manage them. There is a focus on reducing the use of coercive interventions, but research has concentrated on the rates of their use, rather than trying to understand how nurses can reduce their use in the clinical environment.

1.4 SIGNIFICANCE AND IMPLICATIONS OF THE STUDY

The aim of this research was to understand which nursing responses and interventions were most helpful in resolving distress for adolescents on an acute inpatient unit. A qualitative research methodology provided a framework to establish contextual and experiential factors that influence the interactions between adolescents in distress and the nurses who provide care for them. The majority of research involving adolescent mental health has been quantitative in nature and has focused on demographic, diagnostic, and outcome data. Furthermore, quantitative research concentrated on rates of coercive interventions such as seclusion, restraint and *prn* (when necessary) medication. The findings from this study have provided a qualitative perspective to an area of nursing that has been poorly researched.

1.4.1 Significance for Adolescents

The findings have provided insights into the ways in which adolescents admitted to an acute mental health inpatient unit experience distress including triggers for episodes of distress and the coping and help-seeking behaviours they exhibit. Adolescents will benefit from nurses' being educated about how their initial response influences the acceptance or rejection of interventions they might offer to adolescents.

Implementation of the clinical recommendations outlined in the discussion section of the thesis will provide opportunities for adolescents to share information about themselves in regard to triggers, early warning signs, baseline coping skills and help-seeking behaviours with nurses, parents, teachers, and other adults who provide support to them, allowing for improved insight and awareness from the adolescent's perspective, and for earlier detection and intervention in the escalation of distress from that of the adult clinician.

1.4.2 Significance for Nurses

Nursing adolescents in an acute mental health inpatient unit can be both challenging and rewarding. The mental, physical and emotional stress that comes with responding to violent, aggressive and sometimes life threatening behaviours can be overwhelming and observing adolescents take control of their mental health and being involved in the start of their recovery is fulfilling work.

With minimal evidenced-based information available to guide nurses about how to respond to adolescents experiencing distress this study provides knowledge to nurses to help identify causes of, and reasons for the escalation of distress. Furthermore,

through the use of the proposed clinical response and intervention tool nurses can provide individualised care that is salient, consistent and validating.

Through the use of the observation model and clinical tool developed from the findings of this study, nurses will be able to respond to distress earlier in the escalation cycle, thus reducing the incidence of acute distress and associated challenging behaviours (e.g. aggression, violence and self-harming and suicidal behaviours). A reduction in these rates will also positively affect nurse's attitudes and burnout levels.

1.4.3 Significance for Mental Health Services

Admissions to acute inpatient units are costly. Hospital avoidance is a key performance indicator for the Government and findings from this study and the clinical and educational recommendations might reduce the need for admission, and 28-day readmission rates for adolescent who present in crisis. The frameworks developed will provide key clinical information to nurses working on acute adolescent mental health inpatient units that could potentially reduce rates of coercive interventions such as seclusion and restraint (S&R), and *prn* medication; as well as episodes of self-harm and suicide which are key foci of the National Mental Health Strategy (Commonwealth of Australia, 2009).

While direct information regarding improvements to the physical environment were not the focus, an abundance of data suggests that the design and location of acute adolescent mental health inpatient units can greatly assist nurses to manage and respond to episodes of distress. The findings and subsequent discussion regarding therapeutic space and environment will assist Health Services to design (or re-design) inpatient units that are therapeutic and safe for young people, nurses, and others.

1.5 RESEARCH QUESTION AND METHODOLOGY

Qualitative approaches to research provide opportunities for exploration of complex clinical phenomena (Goodson & Vassar, 2011). Use of qualitative methods helps to better understand the contextual and experiential factors that influence episodes of distress. While existing evidence can provide us with information about the rates of use for coercive interventions for acute adolescent distress, and demographic and diagnostic factors that influence their use, little is known from the perspectives of the adolescents who experience them and the nurses who conduct them.

The primary research question is: *What responses and interventions do nurses believe are most helpful during episodes of distress in an acute child and adolescent mental health inpatient unit?* The study objectives are focused on providing insights into adolescent experiences of distress and nurses' expertise in helping them to alleviate or manage it. Adolescent distress, mental illness and disorder and psychosocial stress are increasing; so too are crises related admissions. Parents, teachers and the wider community are struggling to manage the problematic behaviours associated with acute distress (aggression, violence, DSH and suicidal behaviours). The burden on young people, the community, and Governments is compounding with each poorly managed episode. These qualitative methods have offered personal perspectives from the nurses and the observations provide detailed accounts of how adolescents react to help offered. It is hoped that the clinical, educational, organisational and future research recommendations will enhance clinical care and the lives of young people and their families.

1.6 THESIS STRUCTURE

This dissertation is structured in seven chapters in the following format: Introduction; background; literature review; research design (including methodology); observation findings; interview findings; and a discussion which includes recommendations, strengths, limitations and a conclusion. Researcher reflections are also provided in the background, findings and discussion chapters.

Chapter 2 BACKGROUND

2.1 INTRODUCTION

This chapter provides a background to the major developmental, contextual and clinical considerations that underpin the review of the literature and subsequent study design and methods. The chapter will describe adolescence, acute mental health nursing, acute child and adolescent inpatient units, therapeutic relationships, and responses and interventions for adolescent distress. The conclusion will connect these concepts with current policy and the need to focus research on nursing in child and adolescent mental health inpatient units.

2.2 ADOLESCENCE

2.2.1 Adolescent development

Adolescence is the period of human development between childhood and adulthood; It is considered to occur during the age from 12 to 18 years, but puberty can occur earlier and the final biological developments (such as brain development) may not be seen until around age 25 (National Institute of Mental Health, 2011). A large number of biological, psychological and social changes occur in this period. The main age-related indicators of adolescent development include achievement of biological milestones (puberty and sexual development), increased autonomy and independence, completion of educational endeavours (or commencement of vocational skills training), formulation of moral values and self-identity (including sexuality and body image), and negotiation of parental, peer, and intimate relationships (American Psychological Association, 2002; headspace, 2013; Morris & Steinberg, 2001; Smetana et al., 2006).

Biological, social, cognitive and emotional developmental changes associated with maturation, and the cultural and contextual realities of the lives of the current generation of adolescents, can influence their mental health and wellbeing. Changes associated with puberty can impact on physical appearance and affect the emotional, cognitive and social domains. Young people often experience internal conflict in attempting to fit in with their group and to express their individuality. Physical health problems (e.g. obesity, acne), disordered eating and body image issues can impact on other areas of a young person's life (American Psychological Association, 2002; Arnett, 1999; Morris & Steinberg, 2001).

Neurodevelopment is influenced during adolescence by intrinsic factors and life experience. A large amount of reorganisation of neurons and myelination occurs. (Bennett, n.d.) suggests that this biological process helps adolescents move from a state of "awkwardness to awareness". Maturation of the pre-frontal cortex begins during adolescence. Cognitively, adolescents begin to think in more abstract and logical ways: for example they develop a better understanding of the relationships between cause and effect, consider short and long term consequences, and improved understanding of hypothetical situations (Steinberg, 2016). This change from concrete thinking improves their ability to problem-solve, reason, reflect, and plan (American Psychological Association, 2002). Despite these improvements to rational thinking, young people still display reckless or risky behaviours, and require input and guidance from adults. (Bennett, n.d.) suggests that children and adolescents of this generation (Generation [Gen] Z – late 1990s to current) are "prematurely mature (developmental compression) and are exposed to more, experience more, and experiment more at a younger age than previous generations". He argues that media and marketing result in exposure to adult themes and impact on sexuality and self-esteem. (McQueen, 2007) comments on risk taking behaviours of Gen Z members, suggesting that their risk-averse nature, supported by parents and the wider community, reinforces the idea that any risk taking borders on negligence. There is also an argument that, due to overprotection from parents (often referred to as 'helicopter parenting') and constant media input, they are less empathetic than were previous generations and exhibit an increasing prevalence of narcissistic tendencies (Elmore, 2010).

In addition to cognitive growth, learning to identify and label emotional states and developing coping and resilience are key skills that adolescents must master. Improving emotional intelligence (EI), the ability to manage and deal with stress and respond to and understand the emotional states of others, is an important developmental task. It assists young people with social skills and the establishment and maintenance of relationships (American Psychological Association, 2002). Research findings indicate that young people who are able to maintain close, supportive relationships develop higher levels of EI, especially the ability to identify and self-regulate their emotions (Ciarrochi, Chan, & Bajgar, 2001); furthermore, other emotional developmental tasks include the ongoing formation of self-identity, namely developing a positive self-concept (how one views one's own individual attributes) and self-esteem (the way in which young people like or approve of themselves) (American Psychological Association, 2002). This period of development is often a time when

formation and questioning of identity results in internal conflict as young people discover ‘who they are’ (Bennett, n.d.).

The formation of core beliefs, values and ethical behaviour is the cornerstone of moral development and influences social behaviours (American Psychological Association, 2002; Morris & Steinberg, 2001; Smetana et al., 2006). Changes to social activities include increased time away from parents and more time with peers, which provides opportunities to improve independence, practise social skills, develop a sense of identity, and negotiate emotional challenges. The introduction of intimate relationships usually occurs during this time (Morris & Steinberg, 2001). Relationships with family, community members and organisations (neighbours, school, churches, sporting groups etc.) and media all influence adolescent development (Amato, 2005; Melman, Little, & Alkin-Little, 2007; Morris & Steinberg, 2001; Smetana et al., 2006).

2.2.2 Adolescent distress

Psychological distress is a term often applied to a variety of symptoms consistent with general anxiety, depression, personality traits and behavioural disturbances that impact on a person’s level of functioning, and ability to form and maintain relationships (Drapeau, Marchand, & Beaulieu-Prévost, 2012); however, two different concepts of psychological distress have been defined. Firstly, the stress-distress model suggests that it manifests as a result of exposure to a stressful event. Those who support this concept argue that once the stressor is eliminated or one is able to cope with the stress then distress abates, but this conceptual view of distress does not factor in times when distress is evident for an individual where no stressor is present. Another way of conceptualising distress is from the psychiatric viewpoint, where distress occurs as a result of pathological processes that impact on a person’s emotional, cognitive, social, and global level of functioning (Drapeau et al., 2012).

Making an objective assessment of a young person’s level of distress is a complex task. There are numerous somatic, cognitive, emotional and behavioural domains in which each young person can display distress: for example, somatic indicators include sweating, tremor, nausea and headaches, while verbalisation of emotions and cognitive distortions like over-generalisations, catastrophic thinking and comments describing automatic negative thoughts are also indicators of distress. Behavioural cues include (but are not limited to) biting fingernails, restlessness, pacing, avoidance, poor eye contact, and self-harming behaviours.

2.2.3 The impact of technology and other social factors on adolescent development: Current contextual realities.

The ways in which adolescents socialise have changed dramatically in the past 30 years. Advances in technology (Internet, mobile phones and electronic devices) and the changes to the environmental context (nature) of the lives of this generation of young people influence their development. (Greenfield, 2004) captured the essence of these changes in her book, *Tomorrow's People:* " As the real world becomes more dominated by *[information technology]* IT…and changes the ways we use space…could have clear practical advantages in an overcrowded or ecologically compromised planet" (p.12). While IT brings great advantages, these advances in technology have diminished the time young people are engaging face-to-face, and thus they are missing important social development skills. (Rosen, 2012) provides insights into how the use of technology has impacted on behaviour, with associations made between this use and many psychiatric illnesses and disorders. For example, he argues that anxiety can be provoked by a lack of access to mobile phones (fear of missing out - FOMO anxiety); also argues that young people exhibit narcissistic tendencies when dealing with conflict through social media and instant messaging. (Elmore, 2010) supports Rosen's views by emphasising the changes technology and social media have made to relationships among the current generation of young people (Generation Z, aka iY), arguing that "trying to resolve conflict or breaking up on a screen is lazy…socially isolated and lethargic" (p.21). He suggests that these current trends in communication diminish quality relationships and the emotional support they can provide. Elmore argues that young people who socialise with others predominantly through social media and technological means miss the opportunity to learn social skills integral to establishing and maintaining lasting conventional relationships.

An overemphasis on providing a safe and secure environment and protecting young people from experiencing failure has also impacted on their developmental tasks. (Elmore, 2010) argues the overprotective parental approach exhibited by their Baby Boomer parents does not prepare them for the realities of adulthood. (Louv, 2005) takes this concept a step further by discussing how adolescents have disconnected from nature: that they spend more time in a virtual world, and that parents, teachers and society (laws, media etc.) have blocked experiences in the natural environment that provide developmental opportunities.

Creating the balance between providing opportunities for developmental experience and protecting the young is an ongoing concern for parents and other adults with whom

they come in contact. Modern day risks such as access to recreational drug use, sexually transmitted illnesses (STIs), alcohol binge drinking and Internet based vulnerabilities (sexting) are contextual realities (Ahern & Mechling, 2013). These authors discuss how sexting has created risks and consequences such as “earlier sexual behaviour, promiscuity (unwanted pregnancy), harassment and cyberbullying, arrest and incarceration, depression and even suicide” (p. 23).

2.2.4 Mental health problems during adolescence

Psychiatric disorders affect physical, social, and educational development in adolescents during a critical period, and can impact on the individual across the lifespan. International prevalence rates for these disorders have been estimated at between 12% and 29% (Guvenir, Varol Tas, & Ozbek, 2009). The World Health Organization (WHO) predicts that neuropsychiatric disorders among adolescents by 2020 will be one of the five most common reasons for morbidity, mortality and disability (Edelsohn & Gomez, 2006). On an international scale there is an ever-increasing need for specialist mental health care, with 20% of this population experiencing a mental health problem each year -- depression being the most prevalent problem and suicide a leading cause of mortality (Baker-Henningham et al., 2011; Purcell et al., 2011).

Mental health problems that may require admission to acute mental health inpatient units include depression, anxiety disorders, conduct disorders, internalising and externalising problems, trauma, suicide and deliberate self-harm (DSH), first episode psychosis, bipolar disorder and psychosocial stressors (e.g bullying and parental conflict). Research findings indicate that such people have severe and complex needs, two-thirds having both internalising (depression, anxiety) and externalising (violence, aggression, delinquency, substance use) problems, poorer social and educational functioning, lower socio-economic backgrounds, and higher rates of parental mental health issues and family dysfunction (Tonge, Hughes, Pullen, Beaufoy, & Gold, 2008).

2.2.5 Internalising and externalising behaviours

Internalising behaviours are typically associated with an inhibited style of coping, and are ‘inward’ in nature. Typical internalising behaviours include social withdrawal and isolation, loneliness, depression and anxiety; however, some emotional or behavioral disorders manifest themselves outwardly. Externalising behaviors represent an acting-out style, which includes aggressive, impulsive, coercive, and noncompliant behaviours (Yen et al., 2010). These coping behaviours affect the health outcomes of young people and are a concern for others.

Two main internalising problems diagnosed for adolescents are depression and anxiety and research indicates rates up to 20% and 17% respectively (Peter & Roberts, 2010). Research results indicate that depression during adolescence is twice as common for females as for males (McGuinness, Dyer, & Wade, 2012): the vulnerability-stress hypothesis may be the cause of these differences. Also of clinical importance is the relationship between internalising problems and self-harm, suicidal ideation, attempt and completion, with approximately 50% of adolescents who complete suicide having a diagnosis of depression (Brent et al., 1993; Fisher et al., 2012).

Externalising problems consistent with behaviours associated with conduct disorders, such as delinquency and deviant behaviours including aggression, property destruction, theft, truancy and absconding from home are more likely to be associated with males. The rates of diagnosis for conduct disorder for the genders are estimated at 6-16% for males and 2-9% for females (Farrington, 2004). Substance use is another externalising problem closely linked to mental health problems.

2.2.6 High risk behaviours: Suicide, deliberate self-harm (DSH), and aggression

Suicide is defined as the act of intentionally taking one's own life (Lifeline Australia, 2011). The causes of suicide and deliberate self-harm (DSH) are complex and multifactorial, and are a major reason for admission to adolescent mental health units. The rate of suicide has risen in Australia by 60% since the 1950s and it is now one of the leading causes of mortality (Lynskey, Degenhardt, & Hall, 2000). Psychiatric disorders (e.g. depression, bipolar disorder), substance use, personality vulnerabilities, antisocial behaviours and hopelessness secondary to psychosocial stressors account for many of the risk factors for young people in relation to suicide (Gould, Greenberg, Vetling, & Shaffer, 2006; Marttunen et al., 1998; Portzky, Audenaert, & van Heeringen, 2005; Smyth & MacLachlan, 2004). Australian statistics show that annually 2,200 people complete suicide, from 65, 000 attempts (Australian Bureau of Statistics, 2014). Those aged 15-24 years account for a quarter of these statistics, which are higher than motor vehicle accidents and homicide combined (Lifeline Australia, 2011). The most recent data outlining prevalence and methods of suicide completion for young people are presented in the table below (Australian Bureau of Statistics, 2014) (Table 1).

Mechanism of suicide	Males no.	Females no.	Total no.
Poisonings	9	9	18
Hanging	179	113	292
Drowning and submersion	0	0	0
Firearms	13	2	15
Contact with sharp object	4	0	3
Falls	7	2	10
Other	22	16	38
Total	**231**	**143**	**374**

Table 1: Suicide, Number of deaths in children aged 5-17 years by mechanism and sex, Australia, 2009-2013.

Deliberate self-harm (DSH) is defined as the deliberate destruction or alteration of one's body where no suicidal intent is present, and is a maladaptive coping strategy for managing distress (van Goethem, Mulders, Muris, Arntz, & Egger, 2012). (Robinson, McCutcheon, Browne, & Witt, 2016) defined self-harm as "a range of behaviours (including self-poisoning and self-injury) through which an individual directly causes harm to her or himself, irrespective of the type of motive or the degree of suicidal intent" (p. 9). For young women in Australia it represents the major cause of morbidity and hospitalisation (The Royal Australian and New Zealand College of Psychiatrists, 2009). In the past decade presentations to hospital for DSH have increased by 50% and 28% for females and males respectively (Lifeline Australia, 2011). Girls aged 15-17 years and males 18-24 years are most at risk, with the incidence of DSH behaviours of self-poisoning and cutting accounting for 79% and 15% of all hospitalisations respectively (Lifeline Australia, 2011). A recent article in the *Newcastle Herald* newspaper in New South Wales (NSW) provided statistics on the incidence of DSH for females (10-19 years) living in the region, with a 65% increase in hospital admissions required in the previous financial year (Wingate-Pearse & Gleeson, 2014).

Factors considered to increase the risk of DSH behaviours include mental illness, childhood trauma, neglect and abuse (physical, emotional and sexual), familial traits, poor education and substance use. Indigenous Australians, and those living in remote areas are twice as likely to engage in DSH behaviours (Lifeline Australia, 2011). Other reasons include self-loathing and punishment, and a form of distraction and self-regulation from negative emotions (Gutridge, 2010). Cultural and social factors also may contribute: peer pressure, media coverage (news, advertising, movies, books, song lyrics), and poor role modelling behaviours by celebrity idols, referred to by

(Wilkinson, 2011) as social contagion factors. She argues that the Internet (via social media, twitter, blogs) presents the opportunity for adolescents to express themselves and connect with like-minded peers and provides support and acceptance. The cultural and contextual factors outlined above have been supported by recent research reporting reasons why adolescents self-harm (Robinson et al., 2016)

During the admission period, externally-directed aggression may be exhibited instead of DSH (internal) as a way of coping (Bjorkdahl, Heilig, Palmstierna, & Hansebo, 2007). The causes of inpatient aggression have been documented in the literature (Duxbury & Whittington, 2005), and the most recent systemic model identifies environmental, intrapersonal (client) factors, the clinician, and the healthcare system as contributing factors (Cutliffe & Riahi, 2013). Client-specific causes of aggression include age, gender, psychiatric diagnosis and trauma history. (Yen et al., 2010) found that adolescents with externalising behaviours were more likely to be perpetrators of aggression, while victims of aggression were more likely to have internalising problems.

2.2.7 Psychological trauma

Children who experience episodes of disrupted attachment, violence, neglect or psychological abuse have been reported to have difficulty self-regulating on an emotional level, and poor cognitive stability (Cook et al., 2005; Peltonen, Ellonen, Larsen, & Helweg-Larsen, 2010). Adolescents who have experienced trauma during developmental progression will have deficits in areas such as self-identity, impulse control and emotional modulation, may display aggression against themselves and others, and have problems with trust and social interactions resulting in isolation (van der Kolk, 2005). Long-term, complex trauma can lead to manifestations of altered states of consciousness including dissociation, depersonalisation and amnesia (Cook et al., 2005). (Ackerman, Newton, McPherson, & Jones, 1998) conducted a study that examined the prevalence of mental health diagnoses amongst 364 abused children with findings indicating higher prevalence rates of mental illnesses, including anxiety disorders, PTSD, oppositional defiance disorder (ODD) and attention-deficit hyperactivity disorder (ADHD).

Young people with a history of trauma (physical, sexual and psychological abuse and neglect) experience biological processes that maintain states of hyperarousal resulting in fight and flight responses. These hormonal and emotion charged events override

their ability to engage in cognitive processes and impede problem-solving abilities (Paterson, McIntosh, Wilkinson, McComish, & Smith, 2013).

2.2.8 Psychosocial stressors: Bullying, parental conflict, and life stress

Adolescence is a time of increased stress and is associated with psychosocial stressors such as family upheaval, conflict and bullying. Historically, the adolescent stage of development has been described as a period of "storm and stress" (Arnett, 1999, p. 317), with much of the blame directed at puberty, hormones and biological factors (Morris & Steinberg, 2001). Other research has included social, environmental, cultural and technological factors that influence overall development. Two areas receiving a lot of attention are social factors, such as interpersonal relationships between adolescents and their peers, parents and the wider community, and the influence of technology and media (Amato, 2005; Barber & Durkin, 2002; Falci & McNeely, 2009; Giles & Maltby, 2004): for example, parental separation and divorce with its associated stressors including changes of schools, maternal or paternal absence, financial difficulties, possible changes to peer groups, introduction of new siblings and parent figures all impact development and mental health (Storksen, Roysamb, Moum, & Tambs, 2005). Research findings show that adolescent females from single parent families are more likely to be sexually active, use substances and have higher rates of depression than those from two-parent families; even in blended family situations (Burke, McIntosh, & Gridley, 2009).

Bullying is characterised by repeated aggressive or violent actions by one person against another where a power differential exists and has been shown to be associated with poorer mental health, with victims experiencing higher rates of depression, anxiety disorders, and psychosis (Arseneault, Bowes, & Shakoor, 2010; Hawker & Boulton, 2000). In addition to these psychiatric illnesses (which can require a period of hospitalisation), adolescent victims also have reduced self-esteem, poorer social skills and an increase in internalising (DSH) and externalising (violence and aggression, antisocial) behaviours (Arseneault et al., 2010).

Cyber bullying is defined as "electronic bullying through cell-phone texting, email, instant messages, chat rooms or website postings of harmful words or photographs of an individual" (Kowalski & Limber, 2007, p. 22). Previous generations who were bullied at school were able to retreat to the safety of their neighborhoods, homes and bedrooms, but the current generation is constantly connected in the virtual environment

and so is easily targeted by ongoing and relentless bullying.

2.2.9 Psychosis

The onset of psychotic disorders including schizophrenia and bipolar disorder occurs most frequently during late adolescence to early adulthood, and due to the severity of symptoms initial treatment requires a period of hospitalisation. Recent statistics show that approximately 40% of people who experience a psychotic episode, do so in their teenage years (Australian Government, 2011; Hamilton-Wilson, Hobbs, & Archie, 2005) suggested that treatment should be implemented promptly to minimise the negative outcomes associated with untreated psychosis.

These disorders affect functioning and impact on quality of life. Adolescent onset psychosis is difficult to diagnose and is more likely to present with an affective component, higher levels of behavioural disturbance, be more pathologically severe, and be associated with a concurrent substance use issue (Ballageer, Malla, Manchanda, Takhar, & Haricharan, 2005). (Hodgman, 2006) discussed the difficulties associated with diagnosing and treating adolescent psychotic episodes because of the length of time taken for symptoms to manifest. Early detection and intervention can negate an acute episode, thus reducing the impact on social and cognitive development (Hamilton-Wilson et al., 2005; Hodgman, 2006).

2.2.10 Stigma

The attitudes of family members, peers, and teachers may be the source of stigma directed at adolescents with mental health problems because of unwarranted assumptions, (accusations of manipulative behaviour), distrust, avoidance, pity, and gossip (Moses, 2010b). Stigmatising attitudes of peers often result in friendship loss and social exclusion: teachers are known to under-estimate (academically) and avoid these young people (Jorm, Kitchener, Sawyer, Scales, & Cvetkovski, 2010; Moses, 2010b).

Health professionals may also display stigmatising attitudes and behaviours. Despite their ability to recognise symptoms of mental disorders, (Nordt, Rôssler, & Lauber, 2006) showed that health professionals socially distanced themselves from those diagnosed with major depressive disorder (MDD) and schizophrenia to the same degree as the general public. Stigmatising attitudes can also be self-directed, with young people internalising community attitudes they encounter which can affect self-

esteem, social activities, and overall level of functioning (Kranke, Floersch, Kranke, & Munson, 2011; Major & O'Brien, 2005).

2.3 ACUTE MENTAL HEALTH NURSING (MHN): CONTEXT AND EXPERIENCES

2.3.1 Context

Researchers have determined that acute mental health nursing in inpatient units has changed dramatically over the past few decades (Fourie, McDonald, Connor, & Bartlett, 2005). There has been a shift in focus from institutionalisation to community treatment, downsizing and closure of acute beds, consequently increasing risks associated with aggression and violence and associated burnout, and these factors impact on mental health nurses (Cleary, 2004; Fourie et al., 2005; Muskett, 2013).

Training and education can influence nurses' therapeutic approaches and the therapeutic milieu. Historically, mental health nursing education was delivered in a hospital-based program where the student nurse was employed by the hospital. The program consisted of an experiential and theoretical schedule, and graduates were permitted to work only in the field of psychiatry (Happell, 2007). By the mid-80s mental health nursing education shifted from hospital-based programs to the tertiary sector, with mental health nursing amalgamated into the general nursing program, thus allowing graduates to work in all areas of nursing. Some nurses who graduated from hospital-based programs completed a conversion program to gain general nursing qualifications. The mental health nurse workforce in Australia is currently a mix of nurses with only hospital-based training (including Enrolled Nurses), and university educated nurses (Health Workforce Australia, 2013). It has been argued that the current generalist undergraduate approach to education of nurses does not prepare nurses with the specialist therapeutic or counselling skills required in mental health (Happell, 2007). Certainly having various paths to a career in mental health nursing means that there is no uniform basis in their approach, and they may lack a unifying treatment philosophy. In contrast clinical psychologists have a firm grounding in psychological therapies such as Cognitive Behaviour Therapy (CBT).

Mental health nursing in contemporary acute inpatient units can be a highly rewarding profession but it can also be frustrating, stressful, and dangerous. A number of authors

have commented on the attractiveness of the work (Deacon, Warne, & McAndrew, 2006; McAllister & Moyle, 2008), stresses involved, and peer relationships within acute mental health nursing (Bjorkdahl, Hansebo, & Palmstierna, 2010; Bjorkdahl et al., 2007; Cleary, Hunt, Horsfall, & Deacon, 2011; Johansson, Skarsater, & Danielson, 2006). (Deacon et al., 2006) conducted an ethnographic study in two acute psychiatric units in England where they interviewed nurses about the realities of their practice: Participants commented on the concept of closeness and chaos, the central themes highlighted were the close social and emotional bonds between nurses and clients, and also with colleagues. Some participants spoke of their clients with affection and many enjoyed recounting stories about the individual characteristics of clients they had previously cared for, leading to the conclusion that "a major attraction of acute nursing then is the ongoing comfort of spatial, interactional and professional closeness to patients and colleagues" (p. 754).

2.3.2 Experiences: The realities of mental health nursing

While the results from the (Deacon et al., 2006) study provides a positive view of acute mental health nursing, other studies paint a different picture. The stressful and oftentimes dangerous realities of acute mental health nursing also have been reported. (Ward, 2011) maintains that this has a direct effect on the retention and recruitment of mental health nurses in acute inpatient units. She conducted a critical qualitative interview study based on a feminist methodology aimed at exploring the lived experience of female mental health nurses working in acute units. Questions posed to the participants included topics such as workplace culture, stress management, and professional wellbeing. Thematic analysis uncovered some results consistent with the positive aspects highlighted by (Deacon et al., 2006) in regard to therapeutic relationships and caring for clients, but other results indicated that these participants found the work to be stressful due to organisational and client-related factors. Specific factors identified included "increased violence, patient acuity, and changing drug- and alcohol- related problems within society… impacting on their workplace" (Ward, 2011, p. 11)

(Currid, 2008) conducted a phenomenological study in which he interviewed eight mental health nurses about the lived experience of acute inpatient nursing. Results support Ward's (2011) findings when participants suggested that "heavy workloads and violent and aggressive behaviours of clients" (p. 880) contributed to workplace related stress impacting job satisfaction. (Happell & Koehn, 2011) examined the impact of nurses (n=123) job satisfaction and burnout levels on the use of seclusion. Results

showed that nurses who were emotionally exhausted, dissatisfied in their work and burnt-out were more likely to use seclusion as an intervention than those who were not ($p < 0.03$).

2.3.3 The roles of nurses working in acute mental health units

The role and functions of nurses working in acute mental health are varied: time spent with clients may be less than that spent on administrative, educational, or supervision duties. Research findings suggest that only 40% of nurses' clinical work time is related to direct client engagement (Wilson, 2009). A qualitative exploratory study conducted by (Fourie et al., 2005) examined the nurses' role in three New Zealand (NZ) acute mental health units. Nurses reported a discrepancy between their perceptions of what their role should be and their actual practice. In particular they believed that they had limited time to interact with clients because of having to deal with the demands of documentation, ward review meetings, organising transfers, supervising students, and managing crisis situations.

Crisis emerged as a theme in the study by (Cleary, Hunt, Horsfall, & Deacon, 2012) in which nurse participants commented on the unpredictable and chaotic nature of the inpatient unit, and that they were constantly managing conflicting demands between meeting the needs of clients, managing ward milieu, and attending to the ever-increasing administrative commitments. In addition, nurses often deal with moments of crisis in the unit, but factors may also contribute to the attractiveness of acute mental health nursing (Deacon et al., 2006). (Deacon & Fairhurst, 2008) suggested that nurses become proficient in multi-tasking to meet the requirements of client care, and organisational responsibilities.

The optimism-pessimism continuum theme reported by (Cleary, Hunt, Horsfall, et al., 2012) reflects the anomalies associated with mental health nursing where a sense of achievement, reward and hope is often experienced along with frustration, increased workloads, stress and safety concerns. The results of this study identify the challenges of establishing working relationships that contribute to improving outcomes of crisis events, aid recovery, and reduce the duration of the hospitalisation period.

2.3.4 Attitudes of mental health nurses

Nurses have a range of views and attitudes about people with mental health problems, which are affected by societal, clinical, educational, and experiential factors and vary between settings. Attitudes and willingness to provide care differs between nurses

working in Emergency Departments (ED) and mental health settings where people may engage in DSH behaviours (Mackay & Barrowclough, 2005).

A study conducted by (Linden & Kavanagh, 2012) used two psychometric tools to measure nurses attitudes: the Community Attitudes Toward Mental Illness (CAMI) and the Social Interaction Scale (SIS) among students (n = 66) and qualified nurses (n = 121) who were working with people diagnosed with schizophrenia. Attitudes differed between qualified inpatient and community nurses: inpatient nurses held a more negative attitude, were more socially restrictive than their community counterparts, and viewed such people as dangerous and sought to avoid them ($p < 0.05$). (Chambers et al., 2010) used the CAMI tool to measure attitudes of nurses (n = 810) working in mental health units from five European countries. While there were some similarities, the authors suggested that differences found could be the result of "wider social, cultural, and organisational circumstances of nursing practice" (p. 350). They occurred from a cultural perspective, with Portuguese ($p < 0.001$) nurses having a significantly more positive attitude than nurses from other countries (Lithuania, Ireland, Finland, and Italy), while negative attitudes were associated with age, education, and qualification levels.

(Munro & Baker, 2007) analysed responses from 140 nurses who completed the 33-item Attitude Toward Acute Mental Health (ATAMH) self-report tool which indicated a generally positive attitude toward their clients, and profession, in nurses working in acute mental health units, but some items showed evidence of divided opinion: some agreed that clients who are emotionally disturbed are too difficult to help. Nurses' attitudes can impact on the overall unit culture and make a difference in the type of care they provide.

2.3.5 Contextual factors influencing contemporary mental health nursing practice

Different models of care guide the therapeutic approaches of nurses working with people in acute inpatient units. The medical model is by default the predominant model however nurses may employ person-centred and recovery-based approaches to guide their practice. In a study by (McAllister & Moyle, 2008) nurses were interviewed about the models of care that guide their practice and reported using problem-focused care principles, and concentrated on meeting the needs of their clients. Models of care are important because they may influence therapeutic approaches; for example a nurse working in a culture influenced by a coercive model will approach a client quite

differently from one who is working in an evidence-based or person-centred approach.

Recovery and Trauma-Informed Care (TIC) are both guided by person-centred principles. The recovery model is underpinned by the principles of autonomy and empowerment. Clinicians assist clients to understand and manage their condition with the focus on reducing hospitalisation (Kaplan & Racussen, 2012). Underlying TIC is the sobering fact that 85% of all public mental health service users have a history of trauma (Chandler, 2008). Recovery models are examples of a change in focus from treating clients to empowering them to participate in decision-making about the care they receive (Chandler, 2008; Cleary, Horsfall, O'Hara-Aarons, & Hunt, 2013; Paterson et al., 2013).

There is a shift from coercive and controlling forms of care delivery to more person-centred care such as TIC, which focuses on providing choice, autonomy, opportunities for collaboration and recognition of the strengths of consumers (Chandler, 2008; Chiovitti, 2008). Nurses embracing TIC should acknowledge the effects of post-traumatic stress disorder (PTSD), and that clients are coping with their life experiences as well as they can. Chandler conducted a qualitative descriptive study to explore the introduction of the TIC model in a 20-bed psychiatric unit in the USA. Interviews provided insights into the cultural changes required to shift control from staff to consumers. Participants commented on the struggles faced in discontinuing traditional methods of care, not because they were resistant to change but because historical and cultural factors were difficult to shift. TIC principles have been a guiding force in the reduction of coercive interventions like seclusion and restraint (S&R). Some researchers suggest that nurses can actively block advances in TIC, retaining traditional methods of care (and control) (Happell & Koehn, 2011). The results of Chandler's (2008) study suggested that staff initially had difficulty in handing over control to clients, but eventually shifted from coercive care to a person-centred approach. Happell and Koehn (2010) argued that some nurses cannot embrace TIC principles and that "individual nurses contribute to and sustain a culture that supports the continued practice of seclusion in spite of strategies and interventions designed to reduce its incidence" (p. 1228).

2.3.6 Exposure to violence and aggression

As previously discussed, adolescents who experience acute episodes of distress may display externalising behaviours such as violence, aggression and absconding during their admission. These behaviours impact on the nurses who care for them. Exposure

to violence and aggression in acute inpatient units has been widely reported, and previous research has determined that 20-85% of nurses are exposed to these behaviours (Happell & Koehn, 2011; Rippon, 2000). This exposure impacts on job satisfaction, burnout, psychological wellbeing, and at times can result in physical injury (Happell & Koehn, 2011; Needham et al., 2005; Rippon, 2000).

The Zero Tolerance policy was implemented to manage aggression and violence and has been commented on by (Stone, Walsh, Treloar, & Spencer, 2013) who suggested that “when routinely and inflexibly applied it can work against positive engagement” (p. 200), and “a rigid interpretation may compound the problems by attributing blame to patients” (p. 200). It could be argued that adopting a Zero Tolerance approach could escalate an episode of client distress. (Whittington, 2000) argued that this issue is too complex to be governed by such a policy, that other factors relate to the occurrence of aggressive and violent acts, and that staff experience levels significantly impacting on their tolerance levels ($p < 0.01$).

Anecdotal evidence reported in the media suggests that the Zero Tolerance policies are not effective. The *Mercury* newspaper in Tasmania, Australia spoke with nurses working at a local hospital who reported that incidents of violence and aggression were rampant despite implementation of the Zero Tolerance policy (Smith, 2014). They refuted claims made by hospital executives suggesting statistics had declined, arguing that changes to the reporting system had resulted in the reduced number of reports.

2.3.7 Training programs designed to manage violence and aggression

Training programs designed to educate nurses to safely manage inpatient violence and aggression and to support the Zero Tolerance policy have been implemented worldwide. The effectiveness of these training programs is inconclusive due to the variety of content delivered, study limitations (e.g. lack of control groups, small sample sizes), and the vast number of outcome variables examined (Spencer, Stone, & McMillan, 2011)

Despite the contemporary focus on reducing coercive interventions (predominantly seclusion and restraint), the content of such training programs is dominated by physical skills techniques, with minimal content focused on the non-coercive interventions such as engagement, de-escalation and sensory modulation. The time spent learning physical restraint skills is disproportionate to clinical face-to-face time nurses spend

with their clients. These coercive interventions make up only a small percentage of this time, while non-coercive interventions including engagement, problem solving, and de-escalation are the dominant therapeutic duties of nurses (Farrell, Shafiei, & Salmon, 2010; Wright, 1999).

The contextual, cultural, and experiential realities of MHN highlight both positive and negative aspects of the role of providing care for clients in acute inpatient units. Many factors influence the nurse's willingness, ability and effectiveness in assisting clients in distress.

2.4 ACUTE CHILD AND ADOLESCENT MENTAL HEALTH INPATIENT UNITS: CONTEXT AND CULTURE

The closure of large psychiatric hospitals throughout Australia in the 1970s and 80s and a shift in focus towards community-based care has seen a decrease in the number of acute mental health beds and length of stay (LOS) (Bastiampillai et al., 2010; Whiteford & Buckingham, 2005). Furthermore, the move to connect acute mental health units to general hospitals (known as mainstreaming) to provide better access to care for people requiring hospitalisation for mental health problems has shaped the contemporary picture that is acute inpatient care (Happell, 2007). The decreased availability of acute beds has not only shortened LOS but has excluded all but the most seriously mentally unwell from admission. (Deacon et al., 2006) argued that "thresholds for admission are high" (p. 752), and that current acute inpatient units are environments that contain the most mentally unwell and disturbed in a concentrated fashion. The shortened LOS has led some commentators to suggest that acute inpatient units are unsafe, do not provide any therapeutic benefits, and are stressful environments for both clients and staff (Beckett et al., 2013). (Kaplan & Racussen, 2012) suggested that hospitalisation introduces difficulties into the recovery process, including problematic ward dynamics, exposure to aggression and violence, and a disconnection from primary support networks.

The majority of research has focused on acute adult mental health inpatient units. Adolescents are often admitted to acute adult inpatient units with recent statistics indicating that more adolescents, approximately 1200 in 2013 according to (Hazell et al., 2016), are admitted to these units than specific child and adolescent units in New

South Wales (NSW). The number of admissions for young people under the age of 18 increased from 759 in 2002 to 2723 in 2013 (258% increase).

Acute adolescent mental health nursing practices are specialised skills used to provide a safe, nurturing and supportive environment for this vulnerable, complex, and challenging group of patients. (Delaney, 2007) suggested that the main goal for nurses is “to create a therapeutic ward milieu that fosters improved mental and physical health outcomes based on five key concepts: safety, support, structure, involvement and validation” (p.8). Ward dynamics, peer conflicts, nurse-patient relationships, involuntary admissions and episodes of crisis during the admission period can be barriers to achieving such conditions.

Evidence is equivocal when it comes to the effectiveness of an inpatient unit as a shelter and the nature of the influence of peers on the hospitalised young person. Some studies indicate that an admission can result in a ‘disconnection’ from important social supports including, family, peers, and schools (Kaplan & Racussen, 2012). Even the young people admitted to acute inpatient units are divided on this matter. (Biering & Valgerour, 2011) interviewed 14 adolescents, 2-3 months post-discharge from an Icelandic child and adolescent psychiatric inpatient unit. The researchers used a hermeneutic methodology to interpret the data and found that adolescents perceived the inpatient unit as both a secure place that provided shelter from the harsh world and a place where trust could be developed between themselves, the staff and their peers. “Trusting relationships the adolescents developed among themselves were also manifested through mutual expression and sharing of painful experiences” (p. 6). In contrast, some participants in the study agreed with Kaplan and Racussen’s (2012) views, suggesting that the unit acted as a barrier to the outside world, was deemed to be negative, and returning to the real world was made more difficult on discharge (Biering & Valgerour, 2011).

Adolescents in the qualitative study conducted by (Biering & Valgerour, 2011) also indicated improved client satisfaction levels about care received when nurses were respectful, and treated them as individuals. In (Moses, 2010a) study, participants concurred through a different perspective, describing harmful or frightening experiences of nurse-patient interactions: episodes of care where they perceived the nurse as mean, disrespectful, and invading their personal space: ‘‘A few of them would, like, they would, like, yell at certain kids, like, like, other teens and stuff, and, you know, like, for something that wasn’t necessary. Like, they didn’t have the patience…’’ (p. 131).

2.4.1 Environment

The physical layout, design and upkeep of an acute inpatient unit should be considered in regard to improving outcomes for young people. (Lemma, 2010) conducted a grounded theory study to analyse data from interviews with 18 youth and caseworkers in a community based program in inner city London: a new initiative to provide case management for disadvantaged youth with traumatic childhood histories, mental health, substance use and homelessness problems. An important finding concerned the views of eight of them about the physical environment; its quality provided the vulnerable youth with a safe way of building trust through attachment to the physical space before moving on to the emotionally risky relationship with the caseworker. She argued that more formal care providers such as health services should consider the physical environment for young people during the recovery process, because:

> "The social, emotional and physical connection to place is important . . . as attachment to place can help stabilise memory and create an anchor for the self . . . especially important when working with young people with a history of disrupted attachments" (p. 423).

Many adolescent mental health inpatient units do not have the same positive physical and environmental attributes as those described above and the restrictive nature of a locked (or semi-secure) inpatient unit, with its associated policies and procedures enforced by staff (mainly nurses), and the external factors that influence them (e.g. involuntary detainment, budgetary constraints) all add to the complex environment that impacts on the health outcomes of young people who receive care during hospitalisation (Sheahan, 2014).

2.4.2 Rules and "norms"

The restrictive environment of an acute inpatient unit reduces levels of control and autonomy that are an important part of adolescent development. External variables such as involuntary admissions and ward policies, procedure, routines, programs, design and milieu all impact on the experience of hospitalisation. (Thibeault, Trudeau, d'Entremont, & Brown, 2010) conducted a phenomenological study on an acute adult inpatient unit focussing on understanding the experience of a hospital admission for six clients. It was described as:

> "A rule-bound, controlling, and sometimes oppressive milieu while highlighting…the dialectical, and often paradoxical experiences of fear and

affirmation, alienation and connection, and abandonment and healing" (p216).

(D. S. Hall, 2004) commented on these cultural factors by stating,

> "Acute units have a significant history and culture with social control practices firmly rooted in shared norms, values, philosophies, and rules…relocation away from large institutions has barely influenced the culture of inpatient services" (p. 540).

As reported previously, many young people are admitted to acute adult mental health inpatient units, which are not developmentally appropriate. However, care is not always optimal in mental health units, as a recent report on an adolescent hospital in the UK attests. The Care Quality Commission inspectors reported that seclusion and intramuscular injections were regularly used as threats by staff, and found that a young person who had banged his head in seclusion was left lying on the floor for 15 minutes vomiting (Boffey, 2014). Media and Government reports in Australia also comment on the high rates of seclusion use, with claims made that clients' basic human rights are not being upheld (National Mental Health Magarey, 2013; National Mental Health Commission, 2014). This suggests that on occasion health professionals' behaviour might overstep professional responsibilities and constitute an abuse of power that may have damaging effects for young people.

2.5 THERAPEUTIC RELATIONSHIPS IN THE CONTEXT OF CHILD AND ADOLESCENT MENTAL HEALTH NURSING

Therapeutic relationships form the foundations of all mental health nursing care and are a major factor in the promotion of wellbeing and recovery from illness (Walsh, Stevenson, Cutliffe, & Zinck, 2008). Relationships are built over time through the process of initial and ongoing interpersonal engagement. The initial engagement, described by (Forchuk et al., 2006) as the orientation phase of the relationship, utilises interpersonal communication skills including active listening, empathy, reflective questioning, and paraphrasing. The goal for this stage is to get to know the client, build trust and establish an alliance. When a relationship is built and the orientation phase has progressed, nurses and clients move to the second stage, working together to achieve health outcomes. This provides opportunities to set care-planning goals, establish expectations of care, and designate responsibilities.

Research findings from the perspectives of nurses and clients suggest that the required skills and attitudes include (but are not limited to) demonstrating compassion, empathy, active listening skills, willingness to help, respect, use of verbal and non-verbal communication, being non-judgemental, attentive, and having a kind heart (Bjorkdahl et al., 2010; Borge & Fagermoen, 2008; Cleary et al., 2013; Coatsworth-Puspoky, Forchuk, & Ward-Griffin, 2006; Dziopa & Ahern, 2009; Vatne & Hoem, 2008). The ability of a nurse to weave these skills into their daily tasks in the challenging environment of acute mental health inpatient units as described by (Deacon et al., 2006) is an advanced clinical skill. (Santangelo, 2015) argues that the interactions embedded in therapeutic relationships are driven by nurses' clinical experience, education and philosophical understandings of nursing practice. He suggests that nurses and clients co-construct care and that nurse's use their privileged position to support the client, emotionally and functionally.

Clients believe therapeutic relationships are established when nurses make themselves available, are consistent, and use listening and problem solving skills underpinned with respectful interactions (Dziopa & Ahern, 2009). Conversely clients felt that the relationship became strained when nurses did not use these skills or used them at inappropriate times. (Coatsworth-Puspoky et al., 2006) reported findings of their study where they interviewed 14 clients about their experiences of nurse-patient relationships. Thematic analysis identified two types of relationships: bright and dark. Bright relationships were perceived by participants to be with good nurses who displayed caring, problem-solving qualities, and who instilled a sense of hope; dark relationships contained elements of avoidance, mistrust, and "did more harm than good" (p. 350).

(Geanellos, 2002) in a qualitative study that examined the relationships between young people and nurses in the context of improved health outcomes, indicated that the nature of therapeutic relationships from both nurse and client perspectives were "relational, mutual and familial" (p.177). The author also noted that trust and connectedness between the clients and the nurses was achieved by "spending time together and sharing of themselves" (p.177). This therapeutic use of self, and sense of connectedness improved the nurses' ability to provide support and care during times of crisis.

(Cleary et al., 2011) stated that the therapeutic use of self is a major factor in reducing the levels of violence and aggression in acute inpatient units, but that little research has been conducted in this area, with the focus of research on the nursing

interventions aimed at managing inpatient violence and aggression. Considering the context of the acute inpatient unit, and the behaviours exhibited in times of distress, the therapeutic relationship between nurses and clients is often challenged and strained (Cleary & Edwards, 1999). Young people with a history of trauma will find difficulties establishing and maintaining relationships and often resort to aggressive, avoidant, and disruptive behaviours (Vatne & Hoem, 2008)

Deliberate self-harm (DSH), frequently seen in distressed adolescents, can affect the nurse-client relationship. Establishing trusting relationships built on open, respectful communication and non-judgement can assist the nurse to engage with a young person who is self-harming (Wilkinson, 2011). It is predominantly nurses who control the environment and put limits on behaviour by implementing searches, removing potentially dangerous objects and having clients under close observation: these measures can put a strain on therapeutic relationships.

If trust is a major ingredient in the formation of a therapeutic relationship, especially for clients who self-harm, then research conducted by (Edwards & Hewitt, 2011) raises an interesting (and ethically challenging) argument in a discussion paper on harm minimisation practices in an inpatient unit at the St George Hospital in Salford, England. They reported that clinicians provided sterile cutting implements and sat with (supervised) clients during times of distress while they self-harmed. The ethical implications of that practice were discussed, linking it to therapeutic relationships; if trust is important, the authors argued that preventive measures (close observations, searches) reinforce the idea that clients who self-harm on the unit cannot be trusted.

Participants (n = 82) in a qualitative study conducted by (Moses, 2010a) believed that interactions with staff were helpful in regard to support, caring, coping and skill building, 45% of them suggesting that staff interactions were the most helpful aspect of inpatient care, and that the most important relational attributes the nurse could exhibit were a genuine approach, making a real connection, and giving of him or herself.

Consideration of the developmental factors associated with adolescence is important when establishing therapeutic relationships. (Roaten, 2011) argued that treating an adolescent as a “mini-adult” (p. 299) is counterproductive, while (Lemma, 2010) suggested that taking trauma into account is imperative because it impedes the adolescent’s ability to form and maintain relationships, especially in regard to trust.

(Elmore, 2010) observed that contemporary adolescents spend too little time with

adults compared with previous generations, because of decreased parental supervision (availability), single parent families, and the social withdrawal of the young into the cyber world affecting interpersonal communication skills. This developmental deficit impacts on nurses' ability to connect and build therapeutic relationships. The author suggested that adults (nurses) should find a balance between two key concepts -- responsiveness and demanding; responsiveness comprising support, patience, and attentiveness, and while upholding high standards of behaviour demanding the young person improve their personal accountability and responsibility.

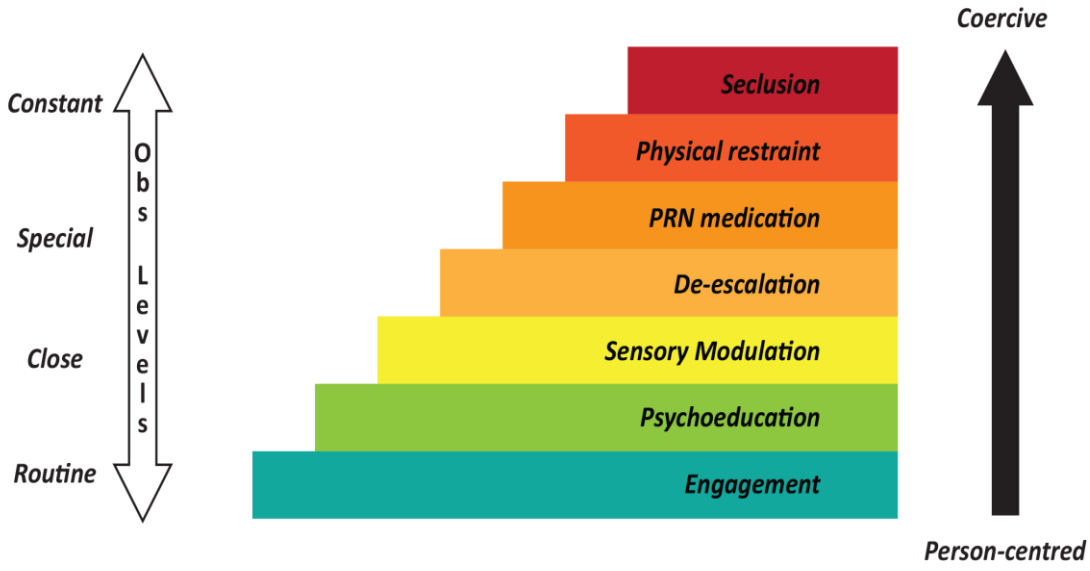
A nurse should consider many factors in regard to establishing and maintaining a therapeutic relationship in the context of acute inpatient care. Trauma, attitudes, DSH, and aggression all impact on the fragile nature of relationships between a nurse and a young person: these are important and can contribute to the decisions nurses make about the interventions they choose.

2.6 RESPONSES AND INTERVENTIONS FOR ADOLESCENT INPATIENT DISTRESS

One of the biggest challenges for clinicians is the ability to engage with, respond to and intervene appropriately for the young people when they are experiencing distress. To reduce the trauma associated with an acute admission, nurses should consider the personal histories of their clients and embrace the principles of TIC to reduce coercive practices. There is a need for clinicians to respond quickly and effectively to immediate often life-threatening or dangerous situations in the inpatient unit.

Nurses use a range of responses and interventions to minimise the levels of distress for young people during the admission period. These may be divided into coercive and person-centred (non-coercive) categories. Seclusion, restraint and *pro re nata* (prn) (when necessary) medication fall into the coercive category (Bjorkdahl et al., 2007), while engagement, psycho-education, sensory modulation, and de-escalation can be considered person-centred strategies (Huckshorn, Stromberg, & Lebel, 2004). The interventions chosen by the nurse as discussed below should take into consideration the perceived level of distress and be guided by the principle of least restrictive care (NSW Government, 2007). An illustration representing nursing interventions from least restrictive to coercive has been developed by the author (Figure 1). Informal levels of observations complement the interventions used by nurses.

Figure 1: Diagram representing continuum of nursing interventions consistent with the NSW Mental Health Act (2007) principle of least restrictive care.



* Note: De-escalation is the tipping point between person-centred and coercive interventions. Examples of person-centred de-escalation strategies include empathy, negotiation and problem solving while examples of coercive de-escalation strategies include limit-setting and action/consequence statements (e.g. 'if you don't stop kicking the door you may be physically restrained). Additionally, *prn* medication can also be administered in either a person-cantered (collaborative) or coercive manner. The arrow on the left represents the different types of levels of observation that complement the interventions as they become more coercive.

2.6.1 Seclusion and restraint

Contemporary Australian mental health standards require that care be provided in the least restrictive environment; seclusion and restraint should therefore be interventions of last resort (Happell & Koehn, 2011). They can cause re-traumatisation, be counter-therapeutic, impinge on a young person's basic human right to freedom of movement (World Health Organization, 2008), and are viewed as a punitive way of managing problematic and aggressive behaviours (Hammer, Springer, Beck , Menditto, & Coleman, 2011; Mohr & Nunno, 2011). Violence and aggression can impact on everyone in the inpatient setting, including clients, staff and visitors. Findings from a study in child and adolescent mental health units report that 23-85% of young people (n = 243) exhibited these behaviours during an admission (Barton, Rey, Simpson, & Denshire, 2001).

Seclusion is defined as the "supervised confinement of a patient alone in a locked room, which the patient cannot leave of their own accord, at any time and for any duration and for any purpose" (Prinsen & van Delden, 2009, p. 69). In response to violent and

aggressive behaviour exhibited by clients and where there is a risk of harm to others, nurses often utilise the high-end, restrictive interventions of seclusion and restraint (S&R). Seclusion and restraint impact on a person's basic human right of free movement and are used only as a last resort, and for the shortest possible duration. Ethical and clinical considerations guide nurses' decision making when choosing to use these coercive practices to manage violence and aggression. Less coercive interventions such as engagement and de-escalation should always be utilised used where possible (NSW Government, 2007).

Consumer and carer-led bodies see use of S&R in mental health inpatient settings as "avoidable, preventable, non-therapeutic, …caus[ing] emotional damage to consumers, impedes trust… creates a climate of fear, is used at unacceptable levels and is a human rights issue" (Cleary, Hunt, & Walter, 2012, p. 459). Physical restraint practices are known to cause re-traumatisation for those who have been victims of child sexual assault (Delaney, 2001), with studies on physical restraint practices reporting high rates (26-29%) of use in child and adolescent mental health units (De Hert, Dirix, Demunter, & Correll, 2011).

2.6.2 *PRN* (when necessary) medication

Medications are frequently used during times of crisis to manage the symptoms of mental disorder, acute agitation, and for patients exhibiting aggressive and violent behaviours. This discussion will concentrate on *prn* medication management as an intervention and will exclude routine medication regimes a client may receive during hospitalisation.

PRN medication should be considered as an intervention only when other non-pharmacological interventions have failed. Some argue that nurses rely on *prn* medication as a first up approach to managing distress (Mullen & Drinkwater, 2011). A previous study reported that when *prn* medication is not available for nurses to administer, there are no changes in the incidence of aggression (Thapa et al., 2003). Whilst *prn* medication may be seen as effective in reducing the levels of anxiety, agitation, aggression or any other such behaviour, it does not provide to young people the skills or coping mechanisms to re-establish emotional regulation or gain self-control (Petti, Stigler, Gardner-Haycox, & Dumlao, 2003).

2.6.3 De-escalation

De-escalation uses both verbal and non-verbal communication skills and other psychosocial techniques designed to reduce violent or aggressive behaviour. With staff-patient interactions being the major cause of inpatient aggression it is important for nurses to develop effective de-escalation skills; however both clients and staff believe these clinical skills are substandard (Duxbury & Whittington, 2005). One reason is that the majority of aggression minimisation training course content focuses on the physical skills training for the coercive interventions of seclusion and restraint. The impetus for reduction of seclusion and restraint practices has highlighted the need for the de-escalation components of aggression minimisation training to be evidence based (Leather & Zarola, 2006).

(Price & Baker, 2012) conducted a thematic synthesis of qualitative studies focusing on de-escalation techniques in an attempt to establish best-practice guidelines. From the 11 studies included in the synthesis, themes relating to staff skills and the de-escalation process itself were extracted from the data. The authors identified the characteristics of effective de-escalators as clinicians who are honest, open, non-judgemental and show genuine care toward their clients. Along with these qualities, empathy and remaining calm in times of crisis engender trust and enhance the clients' ability to regain self-control. A soft tone of voice and awareness of congruent body language are essential, with active listening skills (such as paraphrasing and reflective questioning) providing an opportunity for the client to feel validated and heard (Delaney & Johnson, 2006; Virkki, 2008).

In addition to the qualities of an effective de-escalator, the timing, type and strategies for de-escalation are vital. Early intervention is paramount when de-escalating an aggressive or agitated client. The nurse, taking into account the symptoms, psychopathology and observed behaviour of the client, requires clinical decision-making skills. Researchers suggest that de-escalation skills are intuitive, creative, flexible and individualised to each clients needs (Carlsson, Dahlberg, & Drew, 2000; Price & Baker, 2012).

2.6.4 Sensory modulation

With reduced LOS for young people admitted to acute inpatient units, it is important for nurses to assist them to develop coping skills to build resilience and reduce readmission. Seclusion, restraint and *prn* medication are not interventions that are transferable to the home environment. The focus for nurses should be to utilise

interpersonal approaches like de-escalation, engagement and psychoeducation. In addition sensory-based interventions have therapeutic benefits (Chalmers, Harrison, Mollison, Molloy, & Gray, 2012). These authors used a multi-factorial approach on an acute inpatient unit in Australia, making changes to the ward design (including a new sensory room), implementation of client safety plans, and staff education. The study focused on how sensory-based interventions significantly reduced levels of client ($n = 109$) and clinician-rated distress following use of the sensory room on the unit ($p < 0.0005$).

2.6.5 Other responses used by nurses to manage adolescent distress

Formal interventions such as those discussed above are not solely used to assist the young person during times of distress. Strategies and responses such as managing the ward milieu, observation levels, therapeutic touch, relaxation techniques (e.g. mindfulness, deep breathing exercises), and humour are also used. Managing ward milieu and maintaining levels of observation are strategies used by nurses to assess and reduce risks associated with distress (e.g. DSH, aggression). Education about mindfulness based strategies such as deep breathing prior to a distressing moment will enhance self-efficacy for regulating emotions, and can be suggested during times of distress. Therapeutic touch can be considered as part of a supportive, caring response, and humour (when used well) can disrupt patterned behaviour. These responses and strategies can be considered as preventive or supportive.

Different levels of observations are often used in response to observed distress. Routine observations (e.g. every 30 minutes) as surveillance strategies to manage risks associated with distress but when the level of risk increases more frequent observations (every 10-15 minutes) or special (1:1 nursing) may be implemented. While these are formal levels of observations and decided upon by multi-disciplinary team (MDT) members, they are also sometimes incorporated informally with a distressed adolescent: a nurse caring for a young person who is self-harming by scratching with a fingernail (seen as low severity of harm) can utilise 10 minute observations in an attempt to allow self-regulation while still assessing the situation. If the behaviour increased the level of risk (e.g. attempting to ligate with a piece of clothing), the nurse would intervene and utilise special 1:1 nursing until risk (and distress) levels reduced. Some authors suggest that increased levels of observations are ineffective and reinforce a custodial type of care. Clients who are “specialled” feel confined, experience more distress, and suggest that the care is disempowering (Cox,

Hayter, & Ruane, 2010). Results from a study by (Bowers, Brennan, Flood, Lipang, & Oladapo, 2006) where they examined the relationship between self-harm and levels of observations indicate that intermittent observations did reduce the incidence of DSH, whereas special observation (1:1) did not.

Managing the milieu on a unit is an important factor in reducing stressors that can affect the cognitive, emotional, and behavioural domains of the hospitalised adolescent. (Delaney, 2006c) suggested that interventions should identify and work on the domain in which stress manifests, using behavioural interventions such as promoting self-efficacy, reinforcement techniques, and interrupting patterned behaviour; promoting self-efficacy could include setting manageable goals and encouraging participation in ward programs. Reinforcement of positive behaviour and providing cues to young people to interrupt ingrained negative behaviours are examples of the latter. Problem solving, cognitive restructuring and linking mood, thought and behaviour are strategies that assist management of distressing thoughts such as guilt, suicidal ideation and DSH. The author advised that restructuring and linking strategies include spending time to recount a difficult social situation. The nurse and adolescent would then work together to explore thoughts and feelings associated with the event, reflect on and challenge any negative cognition, and develop new ways of coping in the future. (Delaney, 2006a) cited the use of empathy as a useful approach. Nurses who show empathy are able to validate their feelings, promote a feeling of connectedness, and even improve the adolescents' views of adults, adding that in addition to becoming aware of different affective states, nurses can assist the adolescent to identify sensory-based self-management tools, soothing practices and distraction techniques that assist in reducing distress. Using verbal responses such as humour provides nurses with a way of alleviating distress. This response may fall into the category, that Delaney describes as interrupting patterned behaviour. While there is some evidence to suggest this is an effective strategy (Lemma, 2010; Price & Baker, 2012), further in-depth research about its use is required.

The use of therapeutic touch is largely missing from the literature, especially regarding its use and effectiveness. Nurses are reluctant to use it as an intervention (Gleeson & Higgins, 2009), but the reasons why have not been thoroughly investigated (Dziopa & Ahern, 2009). With the majority of young people admitted to acute inpatient units having a history of trauma, therapeutic touch could be seen as both detrimental and helpful. Some adolescents may experience PTSD trigger type responses, while others

at least may feel comforted, and at best learn to trust adults again (Bjorkdahl et al., 2010; Price & Baker, 2012).

Responses and interventions used by nurses to assist adolescents during times of distress during an admission requires further investigation, especially in regard to the specific contextual environment that is an acute adolescent mental health inpatient unit.

2.6.6 Personal perspective

My perceptions regarding therapeutic touch are considered in the context of an episode of adolescent distress in my recent experience. One of my motivations for conducting this study relates to an episode of care that involved therapeutic touch. I was a 36-year-old male nurse working on the acute inpatient unit and I observed a 17 year-old female client repeatedly pacing up and down the unit. I attempted to talk to the young person but she walked right past me, continuing with her pacing. I decided to walk with her and initially just walked alongside. Over time I was able to engage with her and after about thirty minutes asked if she would like to sit down and continue our conversation. We sat at the dining table in the common area of the unit where she spoke to me about her thoughts and feelings associated with self-esteem triggered by eating dinner. She was teary and advised me she had never spoken to anyone about this.

The following shift I again observed her to be pacing the unit and walked toward her and put my hands up and tried to direct her to sit down with me again as I suspected she had similar thoughts and feelings as she had the previous evening. As I put my arm up she continued to walk toward me, put her arms around me and placed her head on my shoulder and started sobbing. I froze! As she held on to me I looked around to see my fellow nurses and some of the other young people on the ward looking at us. I asked her to let go of me, which she did, and we sat at the table again and I used verbal strategies to provide support and comfort.

On the drive home that night I couldn't get the interaction out of my head. I felt like I had let her down. My choice to not hug her and pat her back (which is what I would do on reflection) was based on fear and the perceptions of others (colleagues and other young people). A number of questions went through my head on the drive home that night:

- Why was I reluctant to use therapeutic touch as an intervention but I use physical restraint (another form of touch) when required?
- I teach clinicians within the Health Service and at a state-wide level how to physically restrain people, so why have I never discussed therapeutic touch during the hundreds of hours I have delivered this training?
- If I were a female nurse would it have been different?
- If the young person had been a male would it have been different?
- Did my colleagues perceive the encounter as evidence of an inappropriate relationship?
- If I was a nurse working in a medical or surgical ward and not working with a mental health client would it have been different?
- If the young person initiated the touch (implied consent) why did I choose not to reciprocate?
- Was it the way she touched me, would I have done something differently had she grabbed my hand?

I went to work the following day and apologised to the young person for not responding to her in the way she needed at the time. She had trusted me the previous evening by talking to me about her innermost thoughts and feelings and I told her I felt as though I had let her down.

She said to me at the time, “I thought I did something wrong”, referring to my response (freezing). I have changed my clinical practice in regard to therapeutic touch as a result of this incident and it has guided some of my observations and questioning for this study. Happily, on the day of her discharge the young person was in the foyer of the unit with her mother and she asked me if she could hug me goodbye. I hugged her goodbye and have never seen or heard of her since; I hope she is doing well. She will never know how much she has influenced my nursing practice.

2.7 CONCLUSION

While the background section has provided information on both adult and C&A mental health, the literature review in the next chapter will focus solely on adolescent mental health, as a subspecialty area of nursing practice due to the differences in the developmental (social, emotional, cognitive) and legal (e.g. consent) factors for adolescents. Statewide policies support this differentiation by aiming to provide care for

young people in non-adult facilities. The New South Wales (NSW) Mental Health Strategy outlines provision of care for young people, suggesting that care be age appropriate with Child and Adolescent Mental Health Services (CAMHS) separated from adult services for developmental reasons (New South Wales Health, 2008). The (NSW Health, 2011) policy *Children and Adolescents with Mental Health Problems Requiring Inpatient Care* (PD2011_016) stipulates that the most appropriate care for young people over 12 years of age should take place in a specialist C&A inpatient unit. Specific guidelines are provided in the policy for young people admitted to acute adult inpatient units when no specialist C&A beds are available. These documents support the notion that young people have their own distinct characteristics, which require specialised care.

Young people admitted to acute inpatient units experience distress for many reasons. Nurses should use therapeutically beneficial responses and interventions to help alleviate this distress. The literature review will focus on nurses and adolescents and the acute inpatient environment where they interact. Consideration of the underlying cultural and contextual factors that influence contemporary nursing practice in this setting will be discussed, and a justification for the proposed research will be provided.

Chapter 3 LITERATURE REVIEW

This chapter will outline the search strategy employed to identify the relevant literature that guided the design and focus of this study. A review of the included literature is provided to complement the background information discussed in Chapter two.

Guided by the work of (Whittemore & Knafl, 2005), this integrative review is designed to identify, analyse, evaluate and compare research conducted about responses and interventions for adolescents admitted to acute child and adolescent mental health inpatient units. An integrative review conducted by (Blair, Kable, Courtney-Pratt, & Doran, 2016) who examined nurses' recognition and responses to unsafe practice used Whittemore and Knafl's (2005) framework, which provided an exemplar to guide the researcher in this work. Search strategies were clearly documented along with data evaluation processes and analysis. The included literature is then presented with conclusions about the relevant literature provided.

3.1 LITERATURE REVIEW PURPOSE STATEMENT

The purpose of this literature review is to understand the types of responses and interventions used to manage adolescent distress in acute child and adolescent mental health inpatient units, and the contextual factors that influence those responses.

3.2 SEARCH ENGINES/DATABASES

The search was conducted using a structured process (Kable, Pich, & Maslin-Prothero, 2012) and the following limits, criteria, and search terms were used to search the CINAHL, Mosby's Index, PsychInfo, and Medline databases.

3.3 SEARCH LIMITS

The following limits were applied to the searches:

- Date range – 2004-2014.
- English language
- Human research

3.4 INCLUSION AND EXCLUSION CRITERIA

Inclusion criteria:

- Primary research papers
- Dissertations
- Adolescent mental health papers
- Articles about attitudes/discrimination (all health professionals)
- Articles about the effects of culture on nursing practices
- Interventions (e.g. seclusion, restraint, and *prn*) used during acute mental health episodes

Exclusion criteria:

- Articles that report adult data or are set in other contexts
- Community mental health settings
- Accident and emergency settings
- Paediatrics settings
- Developmental disability articles
- Discussion papers, expert opinion papers, literature reviews, and policy documents.

3.5 SEARCH TERMS

The following search terms were used:

Adolescen*, mental health, psychiatry* inpatient*, nurs*, therapeutic relationship, nurse-patient perspective. Trauma-informed care, custodial, authoritative, stigma, discriminat*, attitud*, distress, crisis, intervention, strategy, respons*, prn, seclusion, restrain*, psycho-education, engage*, de-escalation, sensory modulation, touch, humo* (humour), limit-setting, silence, observation, ward dynamics, milieu.

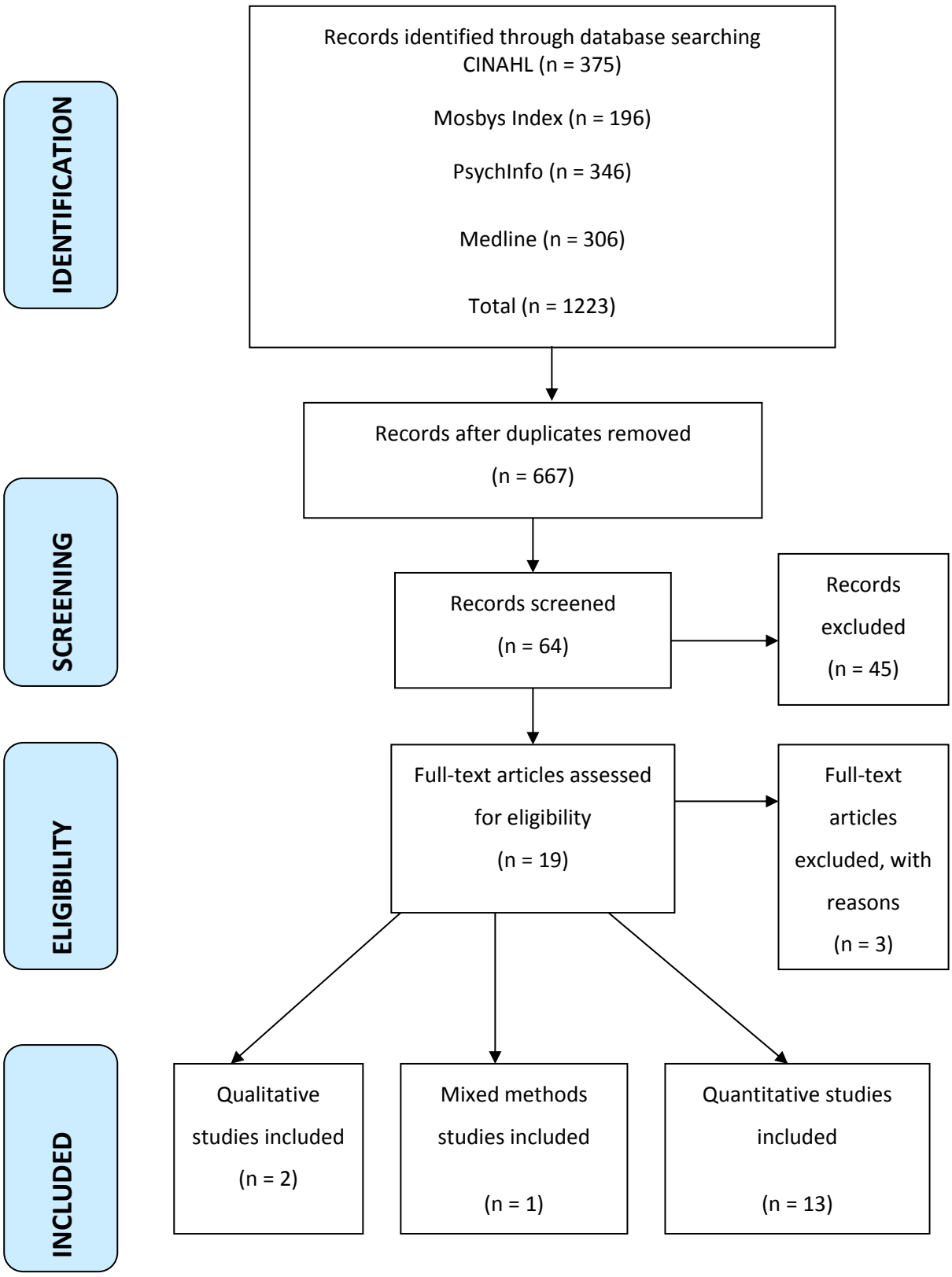
Results for the database searches are outlined in Appendix 2.

3.6 SEARCH PROCESS

Identified articles were checked to determine those that were relevant by reading the abstracts (or full papers as required). After the initial CINAHL database search was completed and during searches in subsequent databases, duplicate articles were excluded. Identified papers were screened in accordance with the inclusion and exclusion criteria. Eligible papers were entered into an Endnote reference management database and summarised Appendix 3: Literature Summary Table.

Seventeen papers were identified during the search process that met the inclusion criteria and a subsequent manual search of reference lists of those articles identified two two more relevant papers. A total of 19 papers were then critically appraised for eligibility eligibility using the McMaster's Qualitative and Quantitative Critical Review Forms and Guidelines (Law et al., 1998a, 1998b; Letts et al., 2007a, 2007b). Following the appraisal appraisal process 16 papers were selected for the critical review. Excluded papers were were not deleted from the summary to indicate the result of the critical appraisal process. Two of the included papers were qualitative studies and one used a mixed methods approach, while the remainder were quantitative studies (n = 13) (Moher, Liberati, Tetzlaff, & Altman, 2009; Shamseer et al., 2014). A PRISMA diagram was used to used to illustrate the search process and results (see Figure 2: PRISMA flowchart outlining search strategy and results.

Figure 2: PRISMA flowchart outlining search strategy and results.



(Moher et al., 2009; Shamseer et al., 2014)

3.7 LITERATURE REVIEW

An acute child and adolescent inpatient unit is often a hectic and dynamic environment where nurses provide care for clients with complex mental health problems. Most research conducted on this topic has used quantitative study designs, profiling young people admitted to acute inpatient units, predicting risks of aggression and violence, or factors influencing the incidence of coercive interventions such as *prn* medication, seclusion, and restraint. These interventions were used to manage aggressive or violent behaviours so research has focused on the outcomes of these interventions, with few studies exploring the interactions and relationships between nurses and adolescents. Quantitative studies can miss the subtleties of the complex phenomenon of inpatient settings, including the cultural and contextual factors. The perspectives of the recipients of care, and the expertise of nurses working with young people in distress are also infrequently reported in the literature. Studies included in this review were conducted in developed countries such as Australia (n = 5), United States of America (U.S.A.)(n = 4), New Zealand (NZ) (n = 2), Canada (n = 1), France (n = 1), and Finland (n = 1).

3.7.1 Young people in acute inpatient mental health units: aggression, violence, deliberate self-harm, and interventions

Few adolescents require an admission to an acute mental health inpatient unit for observation and assessment, treatment of specific psychiatric illnesses and disorders, or crisis intervention for psychosocial problems. Their demographic and clinical profiles have been the focus of studies to ascertain their risk of aggression, violence, and deliberate self-harm (DSH) (Berntsen et al., 2011; Bridgett, Valentino, & Hayden, 2012; Gullick, McDermott, Stone, & Gibbon, 2005; van Kessel, Milne, Hunt, & Reed, 2012). Frequently used coercive interventions aimed at managing these types of behaviours such as *prn* medication, seclusion, and restraint have dominated the literature (Azeem, Aujla, Rammerth, Binsfield, & Jones, 2011; Dean, Duke, George, & Scott, 2007; Dean, McDermott, & Marshall, 2006; Pogge, Pappalardo, Buccolo, & Harvey, 2013; Siponen, Valimaki, & Kaltiala-Heino, 2012; Tompsett, Domoff, & Boxer, 2011; Winterfeld et al., 2009)

Research examining less restrictive interventions is scarce, with only one study included in this review investigating non-coercive interventions and their impact on treatment outcomes. (Bobier, Dowell, & Swadi, 2009) conducted a quality improvement

project in an eight-bed unit for people aged 16-18 in New Zealand (NZ). Prospective data for admission and discharge were obtained using the 13-item clinician rated Health of the Nation Outcome Scale for Children and Adolescents (HoNOSCA) symptom severity tool. The HoNOSCA is a reliable and valid tool for measuring global functioning, with the additional benefit of identifying function and impairment in behavioural, social, and symptomatic domains. In addition nurses recorded episodes of care that identified formal interventions as outlined by the Youth Inpatient Unit (YIU) Intervention Inventory tool. The research team developed this tool with collaborative input from members of the multi-disciplinary team (MDT). The YIU Intervention Inventory allowed nurses to quantify frequently used formal interventions, such as illness education, relaxation, exercise, and problem-solving skills training. Forty-six adolescents admitted for acute treatment over a 12-month period were included in the study, with participants categorised into one of three diagnostic groups, mood disorders, mixed disorders (post-traumatic stress disorder and adjustment disorders), and psychotic disorders. Almost half of the sample was diagnosed with a mood disorder (n = 22, 48%), but those diagnosed with psychotic disorders had a longer length of stay (LOS), and scored higher on the HoNOSCA rating on admission, indicating a poorer global level of functioning. The frequency of interventions was highest for stress management and problem solving for the mixed diagnosis group. While this study provides insights into the profile of young people admitted to this unit, and improvements in health outcomes, it is not generalisable due to its small sample size, limited age range of the participants, and the tool used to measure interventions falls short of quantifying informal nursing strategies such as listening, providing support, and encouragement.

Young people in inpatient units sometimes exhibit violent and aggressive behaviours. (van Kessel et al., 2012) sought to identify risk factors for inpatient aggression and violence. The researchers conducted a retrospective clinical audit of 303 continuous admissions over a two-year period on a 25-bed C&A inpatient unit in NZ, with the sample including children and adolescents up to age 18. Demographic and clinical data were obtained along with incident rates of violence. Data relating to the characteristics (type, severity, and victim), antecedents, and consequences of these incidents were reported. Measuring the rates of violent incidents, describing their characteristics, and ascertaining clinical and demographic variables for participants who did, and did not engage in violent behaviour on the unit were the three main aims of the study. Findings indicated that there were violent incidents involving 57 young people (21.7%), with staff the most common victims; positive symptoms, agitation, and limit-setting by staff were

the main antecedents; seclusion (n=137), restraint (n=123), *prn* medication administration (n=106), and de-escalation (n=77) were the most frequent interventions; and being Maori, involuntarily admission, and an increased LOS were risk factors for aggression and violence. The authors argue that while these risk factors are indicative of inpatient violence, there were many factors that may also have contributed but were not examined.

Some of the factors that were not covered by (van Kessel et al., 2012) were discussed by (Bridgett et al., 2012) who suggested that adolescents who display aggressive behaviours on an inpatient unit do so with a level of control. The authors argue that some adolescents are more likely to engage in instrumental aggression (planned and premeditated) that is driven by a need for secondary gain, as opposed to children who are more likely to be reactive and impulsive. They also suggest that this instrumental aggression is directed toward staff members who set limits and enforce ward rules.

Results from the American study by (Bridgett et al., 2012) indicate that young people (n = 52) have difficulty remaining in control of their behaviour when fearful. Their data showed that a higher level of fear is associated with increased use of restraint ($p < 0.001$), and seclusion ($p < 0.05$). If a fearful young person became distressed and was offered no support or reassurance, the escalating level of distress could result in aggressive and violent behaviour. Furthermore, findings from the Australian study by (Gullick et al., 2005) may offer some hope in regard to managing adolescent inpatient aggression without the need for coercive intervention. Comparisons between secluded and non-secluded children and adolescents (n = 70) admitted to an acute inpatient unit were measured for a number of factors including demographic data, symptom severity, parental mental health, and family functioning. Their data showed that 86% of 199 seclusion events occurred for children aged 13 years and under suggesting that the adolescent sample were more likely to respond to less coercive interventions such as engagement, negotiation, distraction techniques, problem solving, and de-escalation.

Deliberate self-harm is another risky behaviour that nurses should consider when working with young people on an inpatient unit. (Berntsen et al., 2011) conducted a review of medical records and an incident reporting database to describe the incidence of DSH, aggression, and seclusion events. Data were collected over a two-year period with 475 incidents reported for six to 16 year olds (n = 294) admitted to an eight-bed Australian inpatient unit. Of the 475 incidents, 292 (61%) were aggressive acts, while 29% (n = 139) were for DSH. Almost two-thirds (61%) of the 294 were female, and 34 (12%) harmed themselves during the admission, with females accounting for 62% of

aggressive and 82% of DSH incidents. Diagnostic characteristics of those adolescents involved in the incidents identified depression (52%), conduct disorder (35%), and posttraumatic stress disorder (PTSD) as the most common.

While these quantitative studies have provided some insights into young people who exhibit violent and aggressive behaviours they have limitations such as retrospective study designs, under-reporting, poor generalisability (single site) and modest sample sizes. The antecedents discussed in the study by (van Kessel et al., 2012) are derived from data supplied only from the clinicians' perspectives.

3.7.2 Child and adolescent mental health nurses

Child and adolescent (C&A) mental health nursing is a sub-specialty of mental health nursing. Nurses should consider (and incorporate into their practice) the biological, social, cultural and developmental factors that are unique to those clients, as outlined in Chapter two. Although these factors are evident in the clinical setting, nurses may struggle to define their role. (Rasmussen, Henderson, & Muir-Cochrane, 2012) attempted to identify the theoretical and operational framework of the CAMHS inpatient nurses' role. A six-phase thematic method was used to analyse the data obtained from focus groups (n=7) involving all members of the multidisciplinary team (MDT)(n = 19). The focus group findings identified eight themes: knowledge transfer, theoretical framework, nursing practice, team context, contextual perspective, risk and safety, the learning environment, and professional issues. Nursing practice and risk and safety themes identified by the authors are important to consider when providing support to young people in distress. Creative methods of engaging with them are required, and strong interpersonal communication skills are essential for the CAMHS inpatient nurse. Interventions are required to manage the risk and safety of not only each individual young person but also the group. The ability to manage ward milieu and provide a therapeutic environment is vital.

Providing inpatient mental health nursing care for adolescents can be a perplexing experience because of the pace and subtle nature of the cues of distress. Responses from participants in the American study by (Greene, 2004) who used a phenomenological approach to explore the lived experiences of MHN (n=12) who work with suicidal adolescents in the inpatient setting, suggested that intuition, instinct, and sensing when things were not right with the ward milieu were key skills in maintaining safety. Four sub-themes emerged from the data in regard to safety: assessment, interventions, milieu, and delegation. Participants said that providing a safe

environment for young people included understanding the influence of milieu on the overall “atmosphere” of the unit, being attentive, supportive and offering expertise, and observing and assessing subtle changes in a young person’s presentation.

Attitudes towards young people will influence a nurse’s practice and may impact on the decision making process for the type of intervention chosen when assisting a young person in distress. One participant in Greene’s (2004) study suggested that a nurse who exhibits a judgemental attitude would destroy any chance of being able to assist them in the moment, as well as in future situations. So strong was the notion that a non-judgemental attitude was imperative that study participants did not offer any other type of attitude as being useful for working with suicidal adolescents.

Nurses’ attitudes, which collectively impact on institutional culture, may also influence the health outcomes for young people. (Berntsen et al., 2011) reported average rates of nurse involvement in aggression/DSH (n = 36) and seclusion (n = 24) on the unit. Analysis of these data indicated that two nurses had significantly different rates of seclusion than the other 17 nurses involved in the study. One of these was involved in 70 incidents of aggression/DSH and 52 seclusion events ($p < 0.05$) within a three-year period, while another nurse was involved in only six incidents of aggression/DSH or seclusion for the same period. The authors argued that staff training might account for this variation, but that nurses’ attitudes might also be involved.

Nurses’ attitudes can be influenced by their exposure to dangerous and stressful situations. Participants (n = 33) in the study by (Dean, Gibbon, McDermott, Davidson, & Scott, 2010) reported feeling “angry and intolerant” when describing how exposure to aggression and violence impacted their professional duties (p. 20). These negative clinical experiences affected nurses’ ability to concentrate, make decisions, and maintain therapeutic relationships. Participants also suggested that aggression was “part of the job”, but clarified this by arguing that the rates were “unacceptable” (p.19). This exposure to aggressive episodes was the reason why at least one-third of them had considered resigning from the unit.

Providing therapeutic care for young people in distress on an acute inpatient unit is an important role for the mental health nurse. Identifying safe nursing practices and maintaining a non-judgemental and caring attitude can improve the nurse’s ability to provide that support, but nurses should be cognisant of how exposure to stressful situations can impact their attitudes, nursing practice, and the young people’s health outcomes.

3.7.3 Therapeutic relationships

Therapeutic relationships are established through repeated engagement and can be influenced by a number of factors. Nursing participants in Greene's (2004) study suggested that interventions were selected not only in the context of the therapeutic relationship, but also on the strength of that relationship: for example, the initial stage of the relationship is aimed at building trust and it may be more difficult at this stage to suggest less coercive interventions than if the relationship was well established. The nurse participants argued that building a connection with young people is the cornerstone of therapeutic interactions, and that communication is the vehicle for this connection.

(Rasmussen et al., 2012) suggested that nurses establish therapeutic relationships through effective communication and that this task is the essence of CAMHS nursing and also that nurses should have an in-depth understanding and awareness of the developmental intricacies of nurse-adolescent relationships. Young people need nurses who are able to connect with them and build trusting therapeutic relationships, especially in times of distress but many variables can affect the nurse's ability to provide this support.

3.7.4 Culture within acute child and adolescent mental health services

Culture defines and influences the relationships between nurses and young people in the inpatient environment. Other factors such as time constraints, attitudes, and other clinical and administrative duties can also influence this culture. When considering distress, the cultural components that influence both the nurse (e.g. training, education, morale, personal beliefs, and unit norms) and adolescents (e.g. attitudes, peer influence, media, technology) can affect the type of intervention chosen by the nurse, the level of acceptance the young person exhibits toward the therapeutic attempt, and the outcome of these interactions. The concept of culture in acute adolescent mental health care in previous studies has predominantly focussed on its influence on coercive intervention outcomes (Azeem et al., 2011; Bonnell, Alatishe, & Hofner, 2014).

International efforts to reduce coercive practices in the field of mental health have been driven by person-centred approaches to care. The trauma-informed care (TIC) model of practice has been implemented for working with clients who have a history of trauma and abuse. (Azeem et al., 2011) evaluated the effectiveness of implementing the six-core strategies of TIC to reduce rates of S&R in an acute adolescent inpatient unit in

the U.S.A. The first strategy in the model is a change in organisational culture through strong leadership to reduce coercive interventions, the likelihood of retraumatisation, and staff injuries, while improving staff morale and health outcomes. Staff training and education, improved communication (hospital executive and staff meetings, debriefing), and goal setting were implemented. While culture is only one component of the six core strategies, and the time period of the study was too short to show long-term cultural change. Azeem, Aujila et al. (2011) found a reduction in seclusion and restraint rates. Seclusion and restraint was used for 79 of the 458 (17.2%) eight to 17 year old patients admitted to the inpatient unit in the three-year study period. In the first six months of the study there were 93 incidents (73 seclusion, 20 restraints), and in the last six months 31 incidents were reported, a three-fold reduction in incidents (6 seclusions, 25 restraints).

3.7.5 Mental health nursing interventions

The impact of coercive interventions on health outcomes has been the major focus of research in acute C&A mental health inpatient care. Many of the studies included in this review focus on how interventions such as seclusion, restraint, and *prn* medication impact both young people and nurses. Some studies examine how interventions effect rates of S&R (Azeem et al., 2011; Bonnell et al., 2014), and the frequency of *prn* use (Dean et al., 2006; Winterfeld et al., 2009), while others concentrate on the clinical profiles of the young people whose behaviours are most likely to incur coercive interventions (Berntsen et al., 2011; Bridgett et al., 2012; Gullick et al., 2005; Pogge et al., 2013; Tompsett et al., 2011; van Kessel et al., 2012).

As discussed previously, (Bobier et al., 2009) examined commonly used non-coercive interventions in an adolescent inpatient unit. They argued that little is known about what is considered evidenced-based practice (EBP) for working with young people in the inpatient unit. Their results focussed on how interventions affected overall levels of functioning and symptom severity for the whole admission period.

Conflicting results have emerged from studies on S&R for the adolescent population. Studies with large samples like those by (Berntsen et al., 2011) (n = 457 incidents) and (Siponen et al., 2012) (n=531 incidents) have shown females are more likely to be subject to S&R, while (Bonnell et al., 2014) (n=85 patients), (Gullick et al., 2005) (n=70 patients), and (Bridgett et al., 2012) (n=52 patients) with smaller study samples showed no significant gender differences. A younger age has been associated with increased

S&R use in many studies (Bridgett et al., 2012; Gullick et al., 2005; Pogge et al., 2013), but one study showed no significant differences for age (Siponen et al., 2012).

An increased length of stay (LOS) was shown to be associated with S&R use, with researchers arguing that young people who exhibit violent and aggression behaviours are hospitalised longer, which provides more chances of being secluded, or restrained (Pogge et al., 2013; Tompsett et al., 2011; van Kessel et al., 2012). Clinical indicators of increased risk of S&R include diagnostic variables; with psychotic, mood and conduct disorders shown to increase the risks of S&R interventions (Berntsen et al., 2011). Poorer performance on clinical outcome measures indicates an increased risk of exposure to S&R (Bridgett et al., 2012; Gullick et al., 2005; Pogge et al., 2013; van Kessel et al., 2012). Results from the study by (Tompsett et al., 2011) show that a previous history of aggression against adults, and previous admission to a psychiatric facility increases the likelihood of a young person being restrained.

Researchers, clinicians, and consumers argue that the use of S&R is counter-therapeutic, and harmful (Van Kessel, Milne et al., 2012) but Pogge, Pappalardo et al. (2013) suggested that it has some therapeutic benefit. They found that 29% of 2411 participants were involved in at least one S&R episode during the admission period, and the majority of participants required only one, indicating some level of therapeutic effect. The authors did not comment on the ethical implications but suggested that further investigations would be required to substantiate this result. However, they did not report the perspectives of the recipients of S&R associated with these episodes.

As necessary (*prn*) medication is also used by nurses to manage distress, primarily violence, aggression, and DSH behaviours. Dean, McDermott et al. (2006) reviewed medical charts retrospectively to identify its use for children and adolescents in the inpatient environment because there is a lack of data in this area to inform best practice. They compared demographic and clinical variables of those who did and did not require *prn* medication during the hospitalisation period, and reported that it is a widely used intervention. Almost three-quarters of the total sample (n=122) were prescribed *prn* medication (1-6 agents). Of the 87 young people who received *prn* medication, the mean number of administrations was eight, while 10% received it than 10 times. There was no relationship between demographic variables and clinical factors such as history of abuse, and suicidal and DSH behaviours: however diagnostic factors were significant for pervasive developmental delay, attention-deficit-hyperactivity disorder (ADHD), and comorbid diagnoses associated with increased *prn* medication use ($p < 0.001$). As the data were collected from retrospective chart audits,

reporting bias may have influenced the results in regard to indications of use. The researchers were not able to observe or ask the clinicians the reasons for administering *prn* medication and they noted that nurses' documentation of the clinical indications was poor. Agitation (38.7%) and aggression (14.5%) were the two most frequently recorded indicators and early evening was the most common time, with 62% of doses given between 1400 and 2200 hours.

Winterfeld, Le Heuzey et al. (2009) also investigated the use of *prn* medication because whilst it is a common intervention in C&A inpatient units, guidelines on the appropriate use and clinical effectiveness are lacking. The results did not indicate that demographic factors were associated with a risk for *prn* medication administration, and further support the results of Dean, McDermott et al. (2006), with evening (bedtime) being the most common time of day for administration. Winterfeld, Le Heuzey et al. (2009) provide further evidence regarding the indications for the use of *prn* medication to support the results of Dean, McDermott et al. (2006). They showed that anxiety (67%) and disruptive behaviours (22%) were the most frequently documented reasons for *prn* medication use on child and adolescent units.

Only one study reported on the outcomes associated with using constant observations (most restrictive) in the adolescent inpatient environment (Bonnell, Alatishe et al., 2014). They also examined the effects of culture change (staff restructuring, education and training) on reportable incidents. Comparisons between the before and after groups showed a significant difference in the median number of hours of constant observations from 580.3 down to 372.5 ($p = 0.02$). While this research is valuable in indicating that cultural change can reduce intrusive interventions, a number of factors should be considered. Constant observations are a formal strategy ordered by the medical officer, or MDT in response to increases in a young person's level of risk (to self or others). No studies have examined the nurse's informal use of increased levels of observation in moments of distress in this environment, and how this may affect the young person's ability to self-regulate or gain control of the situation. The study by Bonnell, Alatishe et al. (2014) had a number of limitations deserving of consideration. The study took place in a small seven-bed unit, affecting the generalisability of the results. Secondly, while there was a reported decrease in two reportable incidents (security involvement and constant observations), chemical sedation (*prn* medication) was not reported and might have affected these results had it been included.

De-escalation, a key skill of the C&A MHN (especially when considering the focus on reducing coercive interventions) was discussed and reported in only one study in this

review: van Kessell, Milne et al. (2012), who attempted to better understand inpatient violence in a New Zealand C&A unit, found that de-escalation (32%) was the fourth most used intervention for managing inpatient violence. Ranked above were seclusion (57%), physical restraint (51%), and *prn* medication administration (44%).

3.8 JUSTIFICATION FOR THE PROPOSED STUDY

Ten of the 16 studies included in this review contain data on S&R use. These are by far the most common interventions studied for this population. These quantitative studies were designed to show how factors like culture, staff training, leadership, and specific therapeutic programs were designed to reduce rates of S&R, but none of them has obtained data directly from the young people who experienced this form of intervention. Additionally, S&R should be used as a last resort for managing violence, aggression, and in some cases DSH behaviours (NSW Government, 2007). Over half of the studies in this review focus on the end result, and interventions that make up only a small part of a CAMHS inpatient nurses clinical interventions. Tompsett, Domoff et al. (2011) used a prospective research design to examine the individual and contextual predictors of restraint for young people in regard to aggressive behaviour. The authors noted that one limitation of that study is the neglect of consideration of emotional dysregulation of the young person, a possible precursor to aggressive behaviour.

Also missing from the literature is what Bobier, Dowell et al. (2012) described as the informal interventions that nurses use when working with young people in distress: responses (e.g. silence, humour) and strategies (e.g. limit-setting, role modelling, therapeutic touch) that can, at times be used to support young people in distress well before it escalates and requires coercive intervention. No studies have explored how the nurses implement these responses and interventions in their clinical practice, how young people accept and respond to them, and if they are viewed as therapeutically beneficial from the young person's perspective. Observational studies are also not available. Qualitative study designs that include an observation component, and interviews to explore these assumptions could provide further understanding of how to help young people in distress on the inpatient unit before it escalates out of control.

The clinical effectiveness and therapeutic benefit of *prn* medication for this population has not been determined (Winterfeld, Le Heuzey et al. 2009; Dean, Duke et al., 2007). While the results reported by Dean, McDermott et al. (2006) and Winterfeld, Le Heuzey et al. (2009) provide valuable insights into the medication management of distress for

the child and adolescent population within the inpatient environment, observational and qualitative studies may be able to provide a deeper insight regarding the environmental, clinical, and cultural factors that influence the nurse's decision to give *prn* medication. These interventions do not assist young people (and their primary care givers) to develop their coping skills to manage in times of distress.

Previous research has been critically reviewed in this literature review chapter and was used to guide the design and conduct of the study. The following chapter outlines the research design, overarching methodology, data collection methods and analysis approaches for the study.

Chapter 4 RESEARCH DESIGN

The literature review influenced my choice of topic and methodology, explored the relevant body of knowledge underpinning my research, and provided the basis for designing a study about adolescent distress in hospital. In this chapter I outline my methodology, research question, study setting, methods, researcher assumptions, trustworthiness in qualitative research and ethical considerations.

4.1 METHODOLOGY

Qualitative researchers aim to create meaning based on the experiential, circumstantial and situational perspectives of their participants (Hesse-Biber & Leavy, 2011). It is a creative, intellectual process that generates knowledge and takes into consideration the different phases of the research process, the impact the researcher has on the process, and the eventual conceptualisation of the findings (Hesse-Biber & Leavy, 2011). Yin (2011) suggests there are five features of qualitative research, namely extracting meaning from people's everyday lives, understanding people's perspectives, describing the context related to the area of enquiry, contribution to existing knowledge about human behaviour, and using multiple sources to gather data.

Emanating from the social sciences, qualitative research allows the researcher an opportunity to understand the lived experience of the participants and take into account the social, contextual and cultural factors that influence their experiences. Findings generated from qualitative research depict patterns, comparisons, and relationships that are derived from the researchers' subjective interpretations and judgements. These findings are then presented to in an interpretive manner to provide insights into the area of enquiry (Hesse-Biber & Leavy, 2011).

Methodology includes the theoretical principles that guide a study, and how the knowledge is generated from data sets collected. The procedural design and steps utilised to conduct research (including how data are analysed) are known as methods (Roberts, 2009). An interpretive descriptive approach assists the nurse researcher to generate knowledge of patterns and themes relating to individuals, and groups of patients, to enhance practice development (Thorne, 2008).

This qualitative study was conducted using Thorne's (2008) interpretive descriptive methodology. Thorne's interpretive descriptive methodology is well suited to a complex

clinical problem and aims to uncover what is, and what is not, known about the phenomena. Designing a study using an interpretive descriptive methodology allows the researcher to draw on clinical experience and generate questions that guide data collection methods. Data collection and analysis helps the researcher combine established knowledge and clinical experience to gain a deeper understanding of the clinical phenomena (Thorne, 2008).

> "Interpretive description ideally ought to have application potential, in the sense that a clinician would find the sense in them [findings] and they would provide a backdrop for assessment, planning and interventional strategies, in keeping with recognised nursing standards of evidence, logic and ethics" (p. 7).

Thorne (2008) suggests that deconstructing a clinical problem and examining prior knowledge can generate new insights that lead to the "application of evidence to practice" (p. 35). Exploring and examining different aspects of human health experiences can provide researchers a contextual understanding that can be applied to clinical practice.

Studies that have used Thorne's (2008) interpretive descriptive methodology in healthcare have contributed to clinical practice improvements. (Lantry, 2013) developed a model of care for patients who experience persistent abdominal pain. The model moved away from the previous clinical (medical) practices of seeing the episode as a specific acute moment for the patient, but rather a biopsychosocial approach that focuses on the patient's life course. Archibald, Caine, Ali, Hartling, and Scott (2015) analysed the responses of 21 parents whose children suffered with asthma. They found that parents' levels of education about the illness impacted on their perspective of whether asthma was an acute or chronic illness, which influenced the way in which they care for their children and how they would seek medical care. The authors developed a hierarchical model to assess parental asthma education needs.

Key to the interpretive descriptive approach is designing a study that is a small-scale investigation of a clinical problem to capture relevant perspectives of the participants to generate clinical insights. Different data collection methods such as interviews and participant observations, and data analysis methods can provide a meaningful representation of the human health experience to improve practice. The use of different data collection methods helps to negate disadvantages of reliance on one point of view. An overreliance on interview data can impact the researcher's understanding of the contextual factors that influence a phenomenon, therefore observations assist to

provide the basis for contextual understanding to complement interview data (Thorne, Kirkham, & O'Flynn-Magee, 2004).

Qualitative research methodologies are preferred for studies that aim to understand human experience (Hesse-Biber & Leavy, 2011) and thus using a qualitative research approach was critical to this study, which examined responses and interventions nurses use to help adolescents manage episodes of distress in acute mental health inpatient units.

4.2 RESEARCH QUESTION

What responses and interventions do adolescents and nurses believe are most helpful during times of distress on an acute mental health inpatient unit?

This study was designed to determine the following objectives:

1) What aspects of culture, environment and peer influences affect nurses' responses and interventions?
2) How do nurses respond and what interventions do they use in the event of young people being in distress?
3) Which responses and interventions do nurses perceive to be most helpful/therapeutic?
4) What are the most appropriate and helpful responses?
5) Are young people with mental health problems and nurses working together in times of client distress?
6) Do adolescents believe that clinical interventions such as de-escalation, *prn* medication, restraint and seclusion are helpful?
7) What skills, knowledge and personal/professional qualities and abilities do adolescents perceive in nurses who are (a) helpful and (b) not helpful in times of distress?

4.3 SETTING: ACUTE CHILD AND ADOLESCENT MENTAL HEALTH INPATIENT UNIT

The observation component of this study took place in a 12-bed acute child and adolescent (C&A) mental health inpatient unit providing care for young people aged

five to eighteen. The unit is part of a large regional hospital that services a community of 850,000 people over an area of 130, 000 square kilometres. A multidisciplinary team (MDT) comprising medical, allied health, and nursing staff provide care for these young people.

I describe the context of the unit in some detail because it is a crucial moderator of therapeutic intent and the extent to which individual nurses can contribute to what is known as a "productive ward" (Wilson, 2009). The acute mental health inpatient unit is intended to provide young people experiencing mental health problems a space to start the recovery process. In addition, the restrictive nature of this unit is designed to manage young people who display high-risk behaviours and cannot be managed in the community.

The unit is a tertiary referral centre. Direct admissions to the unit are organised through external referral systems by community mental health clinicians, local General Practitioners (GPs), and Non-Government Organisations (NGOs). Crisis admissions occur when a young person presents to the Emergency Department (ED) for a mental health assessment, which is completed by either the Paediatric Consultation Liaison team (during business hours), or an on-call psychiatric registrar after hours.

The unit is situated at the most western point of the main building and is accessed from the entry to the maternity ward. A long corridor leads to two glass main entry doors that are electronically controlled. Immediately inside the glass doors is the foyer. The foyer leads to internal electronic controlled doors and into the unit and, once inside, young people cannot leave without staff members activating the doors. On the left of the foyer is a clinic room where young people are first admitted, physical and vital sign assessments conducted, and wound care is provided. An emergency trolley and medical equipment are located in this room.

The unit is arranged on two levels. The top level contains 12 bedrooms (with ensuites), the common areas (lounge and dining rooms), kitchen, medication and utility rooms, two consultation rooms, school room, sensory room, seclusion room, Nurse Unit Manager's (NUM) office, laundry, storeroom, and nurse's station. There is also a paved, enclosed courtyard with a locked door that leads back to the entry corridor. The lounge area is divided from the unit hallway by a half-wall, which allows the nurses to observe young people from the nurse's station. The nurses' station is situated in the middle of the unit with the lounge immediately in front, rooms one to six, and rooms 11 and 12 (larger rooms for family stays) on the left and rooms 7 to 10 on the right. When

entering the nurses' station from the foyer, immediately to the right is a staircase that leads to the lower level which contains the allied health, medical and unit management offices, staff toilets, and kitchen/staffroom (that also serves as conference room).

4.3.1.1 Staffing and ward program:

There are three medical teams based on geographical regions aligned with the community mental health teams. Each of these comprises a Consultant Psychiatrist and Psychiatric Registrar; and the remainder of the multi-disciplinary team (MDT) is made up of a clinical psychologist, social worker, pharmacist, speech pathologist, dietician, schoolteacher, teacher's aide, and nurses. A Nurse Manager (NM) oversees the MDT members, and the NUM leads the nursing staff. In the afternoon, a senior nursing team member is allocated as Nurse in-Charge (NIC).

Nurses staff the ward 24 hours a day and there are four shifts. The morning shift (A shift) starts at 7:00am and finishes at 3:30pm with four nurses and the NUM on duty. The mid-afternoon shift (E shift, one nurse) starts at 12:30pm and finishes at 9:00pm. The afternoon shift starts at 2:30pm and finishes at 11:00pm (four nurses), and the night shift (three nurses) from 10:45pm to 7:15am. Bedtime was 9pm for the young people on the unit. Between the hours of 7:00am and 9:00pm nurses provided care and treatment to young people based around activities of daily living (ADLs), assisted the allied health and education staff to run ward programs, and accompanied medical staff with their clinical interviews with the young people (and families).

Nurses receive a clinical handover at the commencement of each shift, which provides clinical information regarding the clients on the ward, and potential risk factors (for clients and others). Nurses on the morning shift also provide a safety briefing handover to the other members of the MDT at 8:40am in the schoolroom prior to those staff members entering the client areas. At the commencement of each shift nurses are allocated to care for two to three clients by the NUM or NIC. They are also assigned tasks for the shift such as medications (two nurses), general observations (vital signs), and meal support therapy (on another ward). The nurses' station has a whiteboard allocating these roles, and each young person's name and room number will correspond with the name of the nurse they have been allocated for the shift. Two nurses also are allocated as care co-ordinators for each young person on the ward, allowing the nurse to work closely with the young person and their family during the admission, complete relevant paperwork including community mental health referrals, and maintain continuity of care for clients.

4.4 METHODS

Qualitative research methods were used to complement the overarching methodology and included procedural principles and activities such as observing the behaviours of a small number of participants in a predetermined setting. The use of various methods of data collection provided a broad scope to capture as much relevant data as possible, and an analysis, which promotes description that lead to meaningful interpretation (Thorne, 2008).

The following research plan is in accordance with the ethical approval granted by both the Hunter New England (13/07/17/4.05) and University of Newcastle (H-2014-0030) Human Research Ethics Committees (HREC) (Appendix 10).

Please note: Following expert review the research methodology was changed from an ethnographic study to Thorne's (2008) interpretive descriptive approach and data analysis methods as it was more suited to the clinical phenomena being examined. Consequently the Consent forms and Information statements (Appendices 4, 5, 6, 7 and 8) contain the term ethnography.

4.4.1 Sampling approach

Purposive sampling was used as the method for selecting the study participants. Thorne (2008) stated that these key informants had to be specific members of the culture who can provide insights into what is happening, be willing to engage with the researcher, and have a vested interest in understanding the phenomena being studied.

Nurses were to be recruited by those means, but the criterion method of purposive sampling was to be used for young people included in any field of observation: it allows identification of participants with specific characteristics that meet predetermined criteria important to the aims of the study (Patton, 1990). The method was chosen based on the ethical and legal (consent) parameters considered as part of the overall research design. Young people aged 13-18, with parental consent (where possible) were able to participate in the observational component of the study.

The exact number of participants required at the outset was difficult to ascertain: Atkinson and Hammersley (2007) suggested that selecting a single setting or group, and keeping the study small scale can provide enough data to gain an understanding

of the phenomena, while Thorne (2008) argued that “five to eight participants might be sufficient for a homogenous group” (p. 95).

4.4.2 Proposed sampling for semi-structured interviews with adolescents

Ethical approval was granted to interview young people who had been discharged from the inpatient unit and were receiving community CAMHS follow-up. Inclusion criteria also included being aged between 16 and 18 years, and parental consent. The age range was based on the ethical considerations of consent: while the age of consent to medical treatment in NSW is 14 years, parental consent can apply to treatment up to 16 years (Bowles, 2014); the researcher excluded young people under 16 years of age from the interview section because of the nature of the clinical problem being examined (i.e. distress).

Participants and parents/carers were informed about the study by the Community CAMHS case manager involved in their treatment, and hard copies of Information Statements were available in the community CAMHS offices’ waiting rooms. Interviews were to take place at one of the three community CAMHS buildings after a scheduled appointment with the case managers. The researcher was to liaise with the CAMHS clinicians before the interviews with an anticipated five or six adolescents to ascertain their current mental state, and reschedule if there were any concerns.

Unfortunately, the interviews could not be conducted and some research objectives were not answered. Feedback from some community CAMHS clinicians was that some young people wanted to be involved but parents/carers thought it was not in their best interest; and during the recruitment period a number who fitted the inclusion criteria were readmitted to the unit and so were unable to participate. Study design may have been impacted, as the researcher was dependent on a third party recruitment method (CAMHS clinician), which slowed the process. Most critically, during the recruitment period a young person in the target group suicided. It was not appropriate to continue recruitment because other potential participants knew the deceased and the decision was made that interviewing them was potentially distressing.

4.4.3 Participant recruitment

Participants were recruited from two groups: The observational phase of the data collection process involved two groups: nurses working in an acute mental health inpatient unit, and adolescents aged 13-18 years receiving care provided by these

nurses. Initially it was not the actual numbers of participants that guided the decisions on sampling but rather the time required to observe enough interactional episodes between nurses and young people in times of distress. The maximum number of nurses and young people in the field at any one time was anticipated to be five, and 12 respectively.

Once observational data had been collected and analysed nurses were recruited for the semi-structured interviews. Participation was voluntary and nurses were advised beforehand that they could withdraw from the study at any time. Nurses were interviewed at a time suitable to them at the inpatient unit (or hospital site), and up to 10 nurses were sought because it was hoped that would provide sufficient data. Further recruitment could be conducted if the data were insufficient.

4.4.3.1 Adolescent recruitment

A poster (Appendix 12) was displayed in the foyer of the Unit to advise young people and their families/carers about the observations to be conducted. An Information Statement (Appendix 5) inviting participation in the observation phase was placed on the Unit counter. In addition, the researcher was able to remind nurses during handover between shifts.

Parental/guardian consent was required because of the age range of the young people (13-18). Nurses on shift, whether or not they participated in the study, would advise the researcher of any patients being cared for, who showed an interest in participating and who had parental assent and the researcher would meet them and make sure they, and the parents, had been through the procedure and answer any questions, and direct them to the supervisor contact to seek further information if required. Consent was confirmed on receipt of the consent form with signatures of both a parent and the adolescent (Appendix 7) reiterating that participation was voluntary and that they could withdraw from the study at any time.

4.4.3.2 Nurse Recruitment

For both phases of the study the NUM emailed an electronic copy of the Information Statement (Appendix 4) to nurses working in the Unit. In addition, hardcopies were placed on the Handover clipboard and in the lunchroom for casual nurses not on the staff email list. Nurses were required to sign a consent form (Appendix 6 and 8) for both the observation and interview components of the study.

Permanent nurses (n=21) and regular casual nurses (n~ 7) working on the acute inpatient unit were invited to participate in the interview stage of the study. Permanent staff received an email from the NUM with the Information statement and consent form inviting them to participate, and a hard copy was placed on the Handover clipboard and in the staff lunchroom for casual nurses who might not be on the email list. Ten nurses returned completed consent forms (Appendix 8) to the researcher in person indicating they wished to participate in the interviews.

4.4.4 Data Collection Methods

4.4.4.1 Literature Review

A review of secondary data provides an opportunity to understand what is already known about the area of inquiry, and allows the researcher to hone the research questions, design the study, explore preconceived assumptions, and identify research gaps. Reviewing secondary data should start with an expansive perspective on the topic and funnel down, as more is understood (Whittemore & Knafl, 2005). The process of review of secondary data, such as the literature review that precedes data collection, allows not only definition of the exact research questions but also an opportunity to group bodies of knowledge (Thorne, 2008). The study design was informed by the deficits in the literature concerning recognising and responding to adolescent distress and informal interventions nurses use for adolescents in distress. In addition, there is limited information in the literature regarding adolescents' responses to nurses attempting to assist them during episodes of distress.

4.4.4.2 Observations

The philosophical underpinnings that guided the data collection and analysis process are described and then the specific details of the methods used. Observation data collection methods were used to answer research objectives 2, 4 and 5. From a methodological standpoint, observation data collection methods for qualitative studies provide an opportunity for the research team to prospectively extract data in the naturalistic environment. This observation activity provides stimulus for direct and pertinent questions in a semi-structured way to elicit deeper understanding.

The task of the qualitative researcher is to observe participants in their own space rather than a controlled setting: in which the people under investigation interact on a daily basis (Thorne, 2008). The researcher (overtly or covertly) observes participants to record what happens, what is said, and collects documents that provide insights about the clinical problem being explored. The researcher then uses the observation data to

critically analyse what is recorded, and reflect on the process and content of data collection in an effort to answer a specific area of clinical inquiry (Thorne, 2008).

Non-participant observations were used in this study for clinical and ethically relevant reasons, particularly pertaining to consent. The focus was the responses and interventions used to alleviate and manage distress for a purposively recruited sample of adolescents admitted to the inpatient environment, and the nurses who provide care for them. Non-participant observations were selected instead of participant. It would be counter-therapeutic to engage and question patient or nurse during times of distress, or act in the dual role of nurse and researcher if participant observations were used. Non-participant observations limited potential for the researcher to influence these interactions. While this may be seen as a limitation of the study design, the researcher had experience in this setting, and an understanding of the clinical reasoning in these situations.

During observational periods, a number of methods were used to distinguish the researcher from clinicians on the unit. A poster (Appendix 12) displayed in the unit advised patients, staff members and visitors what was taking place. The researcher wore a University of Newcastle polo shirt to distinguish himself from other staff, and from his normal clinical duties. Observational data collection occurred during the researcher's annual leave time, enabling separation of the roles. Fifty hours of observations were required to collect sufficient data. An observation template (Appendix 11) was used to ensure that data collected were consistent with the objectives of the study. The observation template was developed in collaboration with supervisors based on the CIT framework (L. Anderson & Wilson, 1997). In addition to the major headings outlined in the framework (Situation, Action, Outcome), the researcher and supervisors added contextual (time, date, shift, occupancy at time of observation etc.) and environmental components (people, activities, and objects) as potential data items.

No evidence based objective criteria exist for measuring different levels of distress (mild, moderate and acute). Definitions for this study were guided by the researcher's objective judgment based on years of clinical observation. Lastly, to enhance the reflexivity of the research process, a personal reflective component was incorporated into the template, allowing the researcher to consider how he would have engaged with the young person in the same situation, and an opportunity to identify and separate his

clinical beliefs and judgments from what was observed, so that the data analysis process was not influenced.

A Smartpen was used to document the observations, enabling recording of audio notes to complement written notes. The observation template provided a framework to maintain consistency in documenting each individual episode of distress. Data recorded with the Smartpen were uploaded electronically and transcribed into a Microsoft Word document, which was stored in the NVivo 10 software program for data management purposes. Observational field notes and reflective entries were documented in a study journal and reviewed during the data analysis process.

4.4.4.3 Semi-structured Interviews

The next stage of data collection focused on semi-structured interviews and gaining answers to research objectives 1, 2, 3, 4 and 5. The questions were derived from the CIT framework (SAO) (L. Anderson & Wilson, 1997). Subordinate questions were posed to gain further data and insights into this complex clinical practice. Analysis of the data guided development of subordinate interview questions under each of the CIT framework headings (SAO), affording opportunities to validate, qualify or provide further insight into the researcher's interpretation of the data. The research supervisors reviewed these questions, and a copy of the semi-structured interview questions approved by the HNE HREC is provided in Appendix 9.

Nurses who consented to participate in the study were interviewed in an office adjacent to the acute inpatient unit. Nurses were asked to confirm that they had read the information statement, given an opportunity to ask questions, and confirm they signed the consent form prior to the interview. Ten interviews with nurses were conducted between October 16th, 2014 and January 6th, 2015 on the inpatient unit in a quiet office (to ensure privacy and confidentiality). Interviews commenced either prior to, or following a rostered shift at a time convenient for participants. Duration of interviews ranged from approximately 15 to 60 minutes; more than four hours of data were recorded with a digital recording device and uploaded to the researcher's password protected computer. Field notes were kept during each interview and a reflection about the interview in the researcher's reflective journal once the participant left.

The audio recordings were uploaded to the researcher's computer and sent to an external transcriber. The transcripts were returned as a written verbatim record of the interviews. The researcher checked the transcripts for accuracy by listening to the recordings and reading the transcripts. The researcher then invited participants to

member check the printed transcript. Four of the 10 participants agreed and completed member checking and returned the printed documents to the researcher signed and dated. No participants questioned the accuracy of the transcripts and they confirmed the trustworthiness of the documents. Prior to data analysis, nurse participants were allocated a code (N1-N10) to ensure confidentiality and protect their privacy.

4.4.5 Data analysis approach:

Thorne's (2007) three-stage interpretive descriptive method was used to analyse the observation data. These stages focus on allowing the researcher to use a consistent, iterative process by breaking down and sorting the data, and to combine personal experience, clinical orientation, and assumptions to establish insights from the data.

Concurrent data analysis and collection were conducted throughout both the observation and interview phases of the study, for methodological reasons and time efficiency. The interpretive descriptive method of data analysis provides:

> "A grounding for the conceptual linkages that become apparent when one attempts to locate the particular within the general, the state within the process, and the subjectivity of experience within the commonly understood and objectively recognised conventions that contemporary health care contexts represent" (Thorne et al., 2004, p. 3).

The principles of interpretive description allowed the researcher to examine a clinically complex problem and identify behavioural patterns that provided an opportunity for meaningful analysis for the purposes of improving practice development (Thorne, Kirkham et al., 2004).

Thorne (2008) also argued it is easy to produce a superficial account of the data and that there are difficulties in constructing an in-depth analysis. She suggested that a quality analysis process draws on relationships and associations between data that will conclude in "aha" moments for the reader from what the researcher says about a particular topic, rather than just a descriptive account (p. 141). Thorne offered strategic techniques that will assist the researcher to produce quality analysis for discussion; preliminary coding, coding alternatives like memo taking for outliers and specific components of data that require further consideration, constant comparative analysis methods, and researcher documentation of analytic thinking during the analysis process.

Strategies to enhance the depth of the findings through the data analysis process as described by Thorne were used. During analysis of the interview data the researcher listened to the audio recordings and reviewed reflective journal notes to enhance understanding of the context and meaning. For example, tone of voice, emotive language and field notes documenting the participant's body language were considered at certain stages of data analysis to provide a deeper understanding.

An additional consideration offered by Thorne (2008) for data analysis was borrowing techniques of proven qualitative approaches. Consequently, the researcher's reflective journal and audio notes from the observation period were used as part of the data analysis process. Analysis of data obtained from observations of clinical interactions between nurses and young people and the insights provided in semi-structured interviews continually included consideration of any influencing contextual, cultural, and experiential factors.

The NVivo 10 (QSR International, 2010) qualitative software was used to organise recorded and transcribed interview data. Qualitative software programs do not analyse the data, but they do provide a mechanism for the researcher to manage, theorise, and ask questions of the data entered into them (Bazeley, 2013). Thorne (2008) suggested that while these programs have useful features the researcher must be cognisant of how these can inhibit "reasoning, intelligence, and inductive thinking" (p. 144) that is the hallmark of quality interpretive descriptive analysis. NVivo 10 (QSR International, 2010) software provided a methodical approach to data storage that allowed ease of access to read, reflect, and explore relationships and contrasts between the data resulting in categorised codes and thematic patterns. To produce meaningful and conceptually grounded research findings the interpretive descriptive data analysis method requires "thorough iterative listening, observing, writing, thinking, listening, writing, thinking" (Thorne, 2008, p.162) processed to recognise patterns, relationships, and outliers.

4.4.5.1 Stage 1: Non-participant observations

Open coding:

The initial stage of Thorne's (2008) data analysis process, open coding concentrates on becoming familiar with the data, examining the whole, then loosely "fracturing" (p.145) it without assigning early coding labels. Thorne (2008) argues that when using an interpretive descriptive method general themes and concepts are generated, rather than specific "finely-tuned" (p. 145) words and expressions to describe the objective

data. She warns against “excessive precision” (p.145) in the first coding stage because it may hinder depth of understanding as the analytic process evolves.

Transcribing the raw observation notes was the first step for the researcher becoming familiar with the data as a collective unit. Each critical incident (19 in total) was typed out in the critical incident format: Situation, Action, Outcome (SAO), and additional observation template notes were also transcribed. During this time I loosely took notes about themes and concepts as they arose. Once this process was completed a second pass was conducted for each critical incident. Fracturing of notable units of data occurred, and these were separated out and given a number of loosely associated headings to consider for the next stage of analysis.

Axial coding:

This stage of the analysis process allowed the researcher to categorise the initial coding themes into a more amalgamated framework by grouping together similar components of data extracted from the open coding process. Thorne (2008) suggests that by categorising the data it “creates the mechanism through which interactions among them can be worked out by identifying such properties… and the contexts within which they are typically embedded” (p. 145).

Each individual critical incident observation consisted of fragmented open coding units and these were printed and cut out. The researcher then grouped similar themed units together, and four general themes emerged during this stage of analysis. Further analysis of these data, in consultation with my research supervisors allowed for refinement of the axial coding themes.

Selective coding:

Selective coding is an expansion of the axial coding themes and allows the researcher to identify sub-categories, and build on the conceptual framework that emerged from the classifications identified in stage two of the analytic process. The process by which the researcher achieved this was to construct a summary table (Appendix 14) of each individual critical episode and enter information regarding the major themes identified in the axial coding process. Using the summary table as a guide the researcher examined and considered the relationships between the five themes identified from the axial coding process. This was supported by reviewing each individual critical incident simultaneously which helped to maintain a holistic overview while working with the segmented axial coded units of data. Sub-categories were established as the selective coding process evolved.

Following Thorne's (2008) three-stage interpretive descriptive method of data analysis the researcher was able to check, test, compare, and contrast both sections and whole components of the data to identify differences, similarities, relationships, and patterns to gain an understanding of the complex nature of the interactions between nurses and young people in distress in the acute inpatient mental health environment.

4.4.5.2 Stage 2: Semi-structured interviews

Interview data were also analysed using Thorne's (2008) three-stage interpretive descriptive method that allowed the researcher to use a consistent, iterative process to identify themes that best described the complex clinical phenomena being studied. This process also allowed the researcher to consider personal clinical experience and assumptions.

Open coding

After checking the accuracy of the transcribed interviews (n=10) I reread the full interviews. I made notes in my research journal about loosely associated themes and keywords. Each interview was then reread and data were separated into smaller units by copying and pasting them into a word document. For each of the smaller components of data, keywords and phrases were assigned to identify different themes within that section. Guided by Thorne's (2008) key principles of the open coding process, I was careful not to overly separate the data or limit the number of keywords.

Axial coding

I constructed a table (Appendix 16) with three columns. The first contained all of the assigned themes, keywords, and phrases allocated to the open coding segments of data. Once the list of keywords and themes was completed in column one, I reviewed each smaller segment of data and "pasted" it into the most appropriate keyword row. The participant identifier (e.g. N1, N2, N3 etc.) was assigned to assist with identification of the data source. The open code segments were at times further separated to filter down the data into the most accurate keyword theme. It was important to continue to review the individual interview transcripts as this provided context to the smaller segments of data. Once all data from the open coding process were allocated to keywords in the table, keywords that were not allocated any data were removed, leaving the final table. The axial coding table was then printed and divided into individual components with the theme, data segment, and associated nurse identifiers.

To continue the axial coding process a review of the data themes and keywords was conducted and similar ones were grouped together. Expert review of the axial coding

segments was then conducted. Two of my supervisors (expert peer reviewers) checked the process I had used to this point of data analysis and challenged my thematic coding. Through this process we were able to reassign more accurate themes to the grouped data. This had two advantages, the number of outliers was vastly reduced (n=5) and the grouped themes seemed to relate better to one another and link to the research questions. Additional analysis was conducted with my research supervisors (who were qualitative experts) resulting in further refinement of the axial coding themes.

4.4.5.3 Selective coding

Selective coding data analysis involved reviewing, comparing, and drawing conclusions from each of the data segments within the axial coding themes. In addition, comparing and aligning the relationships between the axial coding data themes also derived deductions.

Through the selective coding process sub-themes were identified providing a deeper understanding of the themes outlined in the axial coding process. Once the selective coding process was completed I reviewed the axial coding themes and, with expert peer review, was able to further refine the axial coding themes. This process allowed me to simplify the thematic coding and produce themes that more closely represented the clinical phenomena being studied.

4.5 RESEARCHER ASSUMPTIONS

A list of researcher assumptions is provided based on clinical experiences in child and adolescent mental health, and from reviewing relevant literature:

1. Responses to perceived distress in young people form a continuum from a custodial/authoritative/position of power and control at one end to a person-centred/collaborative/working partnership at the other.
2. Young people may not respond appropriately to nursing interventions for a number of reasons, including pre-determined frameworks from adults, cases based on life story (eg. past trauma); self-loathing (not worthy of care); hopelessness and helplessness associated with depressive/anxiety symptoms.
3. Nurses with a previously established therapeutic relationship with a young person will be more able to alleviate distress.

4. When in distress, young people will seek out a nurse with whom they have a previously established therapeutic relationship.
5. Nurses who work from a person-centred approach will be more willing to establish therapeutic relationships with young people in their care (to build a foundation to use when responding to distress).
6. Some nurses will most often use coercive interventions (primarily *prn* medication) irrespective of assessed level of distress. This will be based on skill and confidence levels, and attitude towards young people. These nurses are most likely to work from the custodial approach, whereas nurses operating from a person-centred approach will negotiate, problem-solve, and work towards assisting the young person, respond based on an assessment of level of distress, and will suggest congruent interventions, strategies, and responses.
7. Ward dynamics, peer interactions, and ward routines will influence nurses' abilities to assist: nurses will need to take into account ward dynamics, peer interactions, and ward routines in their interventions.
8. Favorable staff-patient ratios in this study site mean that nurses will observe and be able to respond to most episodes of distress in young people.
9. Young people will share concerns/feelings/thoughts with peers before they seek help from nurses. Nurses are likely to view this unfavorably.
10. The five main reasons/contributors to young people becoming distressed on the unit will be:
    a) Manifestations of or worsening of symptoms.
    b) Ward rules, routines, and the restrictive nature of the unit.
    c) Fears/concerns about being discharged.
    d) Staff-patient interactions.
    e) Reliving traumatic experiences.

Assumptions have the potential to bias the study design, and collection and analysis of data. The researcher provided his assumptions prior to the design, collection and analysis process being conducted to minimise the potential for bias. Researcher assumptions will be revisited again in the discussion chapter and Appendix 16.

4.6 TRUSTWORTHINESS AND ENSURING RIGOUR IN THE CONDUCT OF THE STUDY

Four areas comprise the foundations of trustworthiness in qualitative research, namely credibility, transferability, dependability, and confirmability. Quantitative researchers aim to ensure that tests and measures used in a study are designed to do exactly as they intend, also known as internal validity. From a qualitative perspective internal validity is referred to as credibility and is seen as a key factor in ensuring trustworthiness (Shenton, 2004).

This study employed strategies such as using a well-established methodology, a practitioner as researcher who has an understanding of the complexities of the setting culture and context, and informed participants' experiences. Cross checking methods employed to compare and contrast the data sets (observations, interviews, and secondary data), close supervision of the student by expert researchers, ongoing peer review, and member checks throughout the study period also added to the research rigour. Another important factor is that of reflective commentary which is part of the final discussion (Shenton, 2004).

4.6.1.1 Credibility

Trustworthiness is what qualitative researchers strive for when designing, conducting, and writing up studies. As qualitative studies are considered naturalistic in nature, trustworthiness is how researchers using these methodologies incorporate the concepts of validity and reliability that their quantitative counterparts argue for (Shenton, 2004). Reviewing salient literature, observation notes, interview data, and reflective commentary of the researcher further enhanced this process. The findings presented in the final discussion include a reflective commentary of the researcher, this is especially important for describing the choices made when designing the study, and when reporting how themes and patterns emerged (Shenton, 2004).

The importance of adopting appropriate and previously tested research methods for the study design assists the researcher to enhance credibility (Shenton, 2004). A detailed description of the phenomena, setting, and participants is provided in the findings chapter to demonstrate credibility. This process offers readers the opportunity to understand the context and situation from which data are interpreted (Barton, 2008; Shenton, 2004). The researcher has clinical experience and was an insider with a prior understanding of the setting, participants, and process and routines of the unit. This

experience added to the familiarity of the culture and can be considered as “prolonged engagement”, an important aspect of credibility (Shenton, 2004, p. 65).

The researcher received ongoing close supervision throughout the study period, which enabled the experienced researchers in the supervision team to discuss and direct the student, act as a sounding board, and challenge the student’s biases: especially important because of the insider status already discussed. In addition, expert peer review and input about data analysis processes and themes, presenting initial findings to clinical and academic colleagues, and conference presentations provided opportunities for important feedback.

4.6.1.2 Dependability

Dependability is the factor associated with the quantitative concept of reliability whereby the researcher provides an account of the research process and reporting so that readers are satisfied that if the study were recreated; similar results would be achieved (Shenton, 2004). To achieve dependability the researcher documented the research process through reflective commentary and journaling. Decisions regarding the research processes were documented and are presented in the Audit Trail (Appendix 13). These narrative descriptions are accompanied by a diagrammatic flowchart outlining the processes and components of rigour during the design and conduct the study.

4.6.1.3 Transferability

Quantitative researchers opt for external validity and representative study samples and adequate power, so that study results can be applied to larger populations than that of the participant sample. Due to the small number of participants in qualitative studies researchers, do not aim for transferability of results.

Some authors (Firestone, 1993; Lincoln & Guba, 1985) suggest that practitioners who review results from qualitative study can assess whether the setting, situation, and results could apply to the context in which they practice. This study is reliant on a concise description of the contextual factors of the phenomena including details of the setting, participants, and interactions observed. This is achieved by:

> “providing a thick description of the phenomena…to allow readers to have a proper understanding of it…enabling them to compare instances…with those that they have seen emerge in their situations” (p. 70).

The researcher provided a detailed description of the study setting and context to assist readers to make sound judgements about the potential transferability of the findings to other settings and contexts.

4.6.1.4 Confirmability

Confirmability (or objectivity to the quantitative researcher), utilises cross checking data methods, discussion of assumptions, and the step-by-step description of methods employed, to ensure that results are a representation of the experience of the participants and cultural dynamics and not just what the researcher assumes. Member checking also enhanced confirmability, as interview participants were offered the opportunity to review interview data after transcription. Four of the interview participants confirmed the accuracy of the transcribed interview data. In addition a list of researcher's assumptions was provided, and an audit trail is provided (Appendix 13) which documents the research processes and methods used to ensure rigour during this study.

4.7 ETHICAL CONSIDERATIONS

Scientific enquiry requires planning and adherence to ethical practices of research to protect participants. Historically research on human participants has not always been conducted in an ethical manner (Sierra, 2011). Principles of ethical research involving human participants are established by the National Statement on Ethical Conduct in Human Research (NHMRC, 2007), and these guided the planning, design, and conduct of this study. The purpose of the National Statement is to offer guidance to researchers with a framework to conduct ethically sound research. There are four values and principles outlined by the National Statement that should underpin all research in Australia involving humans.

4.7.1.1 Research merit and integrity

Relates to the research project overall with a focus that all research aims should add value to mankind. In addition, the researcher must act with integrity and the 'right spirit' throughout the process. Continual commitment to maintaining integrity throughout the research process was at the forefront of the researcher's methods and actions. In addition, an audit trail (Appendix 13) outlines and describes the processes made throughout the conduct of the study. Furthermore, no complaints were received by the

research supervisors in regard to the way in which the researcher conducted himself during the study.

4.7.1.2 Justice

Refers to the considerations regarding the burden and fairness of participant involvement in research. There were no identifiable burdens on the young people who participated in the study. Interviews with nurses were conducted prior to or following a rostered shift to minimise the time burden of participation in interviews. Adolescent and nurse participants were advised that there was no financial benefit to participating in the study; parents, adolescents, and nurses were advised by way of the Information Statements that there might be no personal benefit to them from participating in the study but findings from previous studies argued that participants appreciate being involved in the research process for numerous reasons, including empowerment, ability to help others in similar situations, and adding to evidence based practice and education (Hutchinson, Wilson, & Wilson, 1994; Tingen, Burnett, Murchison, & Zhu, 2009).

4.7.1.3 Beneficence

Refers to the risks and benefits of participating in the research, for individuals and the wider community. A sub-set of a vulnerable population within our community, young people experiencing a mental illness was one of the specific groups of participants, and the National Statement provided direction in the planning, design and conduct of the research (NHMRC, 2007). Additional sources were used to supplement the National Statement to further understand the ethical considerations relating to participation of young people with mental health problems (Hoop, Smyth, & Roberts, 2008; Koelch & Fegert, 2010).

Potential risks were identified and strategies to minimise these were planned for each of the stages and participant groups of the research. For the observation stage, nurse participants were at risk of being reported for any illegal or unethical practice I may have observed. There were no risks identified for adolescents during this stage of the research as they were observed in a 'treatment as usual' situation.

Risks identified for nurse participants in the semi-structured interviews were any emotional or psychological trauma associated with recalling an episode of care when providing care for adolescents on the inpatient unit. Strategies such as informing the nurses of the Employee Assistance Program (EAP) and Clinical Supervision were

provided to nurses before the interview commenced; participants were also advised they could terminate the interview at any time.

4.7.1.4 Respect

Respect for participants involved in research is paramount to ethical research and considerations such as autonomy, consent, and privacy/confidentiality are covered by this principle. A number of particular ethical considerations were considered in designing and completing the ethics application for the study. The nature of study setting, an adolescent mental health inpatient unit where young, vulnerable people experience mental health problems, warrants careful consideration of possible issues. Consent procedures and principles were carefully thought out, as was the upholding of privacy and confidentiality for both nurses and clients who participated. Specific details in regard to ethical considerations and procedural adherence are provided below.

Consent

Information Statements (Appendices 4 and 5) were provided to potential participants in both the nurse and adolescent groups. The Nurse Unit Manager (NUM) emailed an electronic copy of the Information Statement and Consent form to nurses. Hard copies of these documents were placed on the Handover clipboard and in the lunchroom for casual staff not on the email list.

Hard copies of the young person Information Statement were available to parents and adolescents at the front counter of the Unit. Allocated nurses would also advise parents and young people about the study. The inclusion criteria for adolescent participants in the observation phase of the study were 13 -18 years of age, so parental consent was sought. Consent forms were provided to parents and young people once they approached the researcher, or the allocated nurse who would advise the researcher, about their interest in participating in the study.

There were times where a previous therapeutic relationship was already established between the researcher and some of the adolescent participants in the observation phase. In addition professional and collegiate relationships existed between the researcher and the nurse participants. It was imperative that participant consent was freely given and the design and methods for recruitment did not involve any coercive implications. Both nurse and adolescent participants were informed by way of the Information Statement that their work or care relationship with the Health Service would not be affected by being involved in the research, or not. Furthermore, participants were informed that they were free to withdraw from the study at any time.

Privacy and confidentiality

All study participant privacy and confidentiality has been maintained throughout the course of this research. I employed to transcribe the nurse interview data a professional transcriber who is affiliated with the University and has previous experience in working with confidential data. To ensure data were de-identified pseudonyms were used for all adolescent and nurse participants allocated a code for both data sets. Master copies of both the recorded audio and written transcriptions of data, which contains confidential and private information, are stored securely at the School of Nursing and Midwifery, University of Newcastle and will be destroyed after five years from completion of the study. I have ensured when reporting the findings of the study that privacy and confidentiality has been maintained and no participant can be identified in reporting of data and resultant publications.

4.7.1.5 Human research ethics committee and facility approval

The Clinical Director of the LHD Mental Health Services provided permission for me to conduct the research in the inpatient setting and with the adolescents and nurses who receive and provide care in the Unit. I conducted this research project in accordance with both the National Statement principles and values that acted as a guide, and the requirements as set out by the HRECs who approved this study. There were no complaints or breaches of ethical behaviour and I focused on conducting research that protected the rights of the young people and nursing colleagues who consented to be involved.

Chapter 5 FINDINGS: STAGE 1

This chapter sets out the findings of the first stage of the study. Non-participant observations were conducted to examine the interactions between adolescents experiencing distress and the child and adolescent mental health nurses who provided responses and interventions in the acute C&A MH inpatient unit, which was the setting for the study.

5.1 OBSERVATION FINDINGS

Observations on the interactions between adolescents in distress and nurses were coded following Thorne's (2008) three-stage coding approach; five themes were identified from the observation data.

Open coding

Transcribing the raw observation notes was the first step to me becoming familiar with the data as a collective unit. Each critical incident (19 in total) was typed out in the critical incident format: Situation, Action, Outcome (SAO), and additional observation template notes were also transcribed. During this time I loosely took notes about themes and concepts as they arose. Once this process was completed a second pass was conducted for each critical incident. Fracturing of notable units of data occurred, and that these were separated out and given a number of loosely associated headings to consider for the next stage of analysis. For example, in the first critical incident (observation 1) three sections of the data were divided under headings such as workloads, routines and clinical duties; communication; and medical procedures.

Axial coding

Each individual critical incident observation consisted of fragmented open coding units and these were printed and cut out. The researcher then grouped similar themed units together, and four general themes emerged during this stage of analysis. The themes identified were clinical context, triggers, coping/help-seeking, and interventions. After expert peer review (research supervisors) of these data and categories, the themes were expanded out into six themes. The axial coding themes at this stage were clinical context, triggers, coping and help-seeking actions, interventions, management of distress, and outcomes.

Further analysis of these data, in consultation with my research supervisors allowed for refinement of the axial coding themes. The final axial coding themes were: 1) Triggers and the context in which they occurred; 2) Expression of distress: Adolescent coping and help-seeking actions; 3) Engagement: responses and interventions for working with distress; 4) Adolescent reactions and nurses' clinical decision making to manage distress; and 5) Outcomes: Escalation or resolution of distress.

Selective coding

The researcher progressed the analytical process from axial to selective coding by constructing a summary table (Appendix 14) of each individual critical episode. Information was entered regarding the major themes identified in the axial coding process. Using the summary table as a guide the researcher examined and considered the relationships between the five themes identified from the axial coding process. This was supported by reviewing each individual critical incident simultaneously which helped to maintain a holistic overview while working with the segmented axial coded units of data.

Sub-categories were established as the selective coding process evolved. When the relationship between clinical context and triggers was explored, three main clinical context themes were identified: treatment, ward routine, and social or relational factors. Within each of these selective themes further sub-categories were recognised. Treatment factors could be grouped into either medical procedures or treating team reviews. Ward routine factors provided five sub-groups, namely: ward programs/handover; activities of daily living (ADLs); unstructured or free time; medication rounds; and mealtimes. Social and relational factors produced three sub-categories and were separated into peer, parental, and staff domains.

Coping and help-seeking axial coding themes were explored further and were separated into internalising and externalising behaviours with sub-groups identified to provide further depth of understanding. Young people who exhibited internalising type behaviours as a way of coping with distress or attempting to gain help from the nurses used self-soothing techniques, isolation and withdrawal behaviours, avoidance, and deliberate self-harm (DSH) or verbalisation of suicidal ideation. Other times young people used externalising behaviours such as defiance, antagonism, aggression, absconding, and violence to cope or elicit help.

The clinical context included the young people, staff, and visitors who interacted in the acute adolescent inpatient unit. Triggers that impacted on young people's distress levels were identified and categorised into Individual, Treatment, Ward routine, and Relational factors. Following a triggering event within the clinical context young people would attempt to draw on intrinsic coping strategies or use help-seeking actions (HSA) to elicit assistance. When nurses noticed these they would provide interventions and assist the young person to manage the distress (with exception of three incidents). In regard to the outcomes of the responses and interventions, all episodes of distress were resolved. However, this was achieved in different ways. Young people reacted positively to some attempts to provide assistance and work collaboratively until the distress was alleviated, while at other times the nurse's response and intervention resulted in escalating their distress. At this point some nurses would adjust their response and provide alternate interventions, while others would disengage leaving the young person to cope alone.

5.1.1 Triggers and the context in which they occurred

Factors identified as triggers that caused distress for young people on the unit were embedded in a clinical context of some description. These two themes were inextricably linked:

5.1.1.1 Individual clinical factors:

For five of the observations the young person's individual characteristics were a contributing factor in the trigger of distress**.** Young people spoke directly about previous traumatic experiences of physical abuse. There also were times when young people expressed perceived abandonment by parents indicating attachment problems. Young people also revealed that they were scared or had pre-existing anxiety issues.

Observation 12 involving Jane provides an example of previous trauma and attachment issues, triggering a distressing event. Jane was speaking with her mother on the phone and her distress levels quickly escalated. She was telling her mother about a time where her father had physically assaulted her. This was followed by accusations towards the mother about not helping her at the time of the assault, and leaving her in a "mental hospital".

The adolescent participants' anxiety was a contributing trigger of episodes of distress. Alice was anxious about her pending discharge from hospital and was trying to tell her mother this on the phone. She said to her mother, "I get all stressed out". After the call Alice went to her room in some distress. The nurse in-charge and Alice's allocated

nurse had a conversation about the distressing event and the allocated nurse said, “She told her mother that if the doctors try to discharge her she will tell them she will suicide”.

5.1.1.2 Treatment factors:

***Diagnostic/medical procedure**:* Two recorded episodes relating to medical procedures for diagnostic reasons (blood collection) were triggered more by the amount, or lack, of information provided and the communication style of the nurse rather than the procedure itself. The two incidents relating to this theme involved the same nurse and young person. At the time of observation the unit was busy and nurses were rotating through the allied health/medical team handover in the schoolroom, one nurse was assisting a young person to gain access to personal items (toiletries) from her locker. Some of the young people on the unit were attending to Activities of Daily Living (ADLs) (showers etc), and five were sitting in the common area. The nurse walked out of the nurse’s station and instructed (in a loud voice so as to be heard over the commotion of the unit) the young person to, *“Sarah (pseudonym), come to the clinic and get bloods done”.*

The four other young people sitting in the lounge area responded to the nurse’s voice by stopping what they were doing (conversing/watching TV) and looked first at the nurse, then at Sarah. Her affect and facial features changed instantly. As an observer I was unsure whether this was in response to the actual procedure, the nurse’s communication style, or the focus from peers. Sarah responded and the ensuing interaction took place:

> **Sarah:** *“I’m not getting injected with anything”.*
> **Nurse:** *“No, we want something from you”.*
> **Sarah:** *“I’m not having it done”.*
> **Nurse:** *“Please come over here (into corridor) so that we can discuss this without yelling across the room”.*
> **Sarah** gets up and walks into corridor to speak with nurse.
> **Nurse** attempts to negotiate, explain reason for needing blood test – *“to help with your diagnosis”.*

Sarah and the nurse enter the clinic and after approximately 2-3 minutes they both leave the clinic. Sarah returned to the lounge area and a peer asks if the procedure took place. She indicated it did not. While Sarah walked to the lounge area the nurse walked to the nurses’ station; there was no communication between them.

The nurse involved in this interaction was not Sarah's allocated nurse. As the observation took place early in the day this could possibly have been their first interaction. When the pathology staff members arrive the receptionist usually asks the closest nurse to facilitate this duty; the nurse may have had competing clinical duties at this time. This could be the reason for the nurse focussing on the task of "getting bloods" rather than a thoughtful interaction where more information and consideration of privacy and confidentiality was afforded to the young person.

About two hours later Sarah and the nurse interacted again in the context of the blood collection procedure. Sarah spoke to the observer and her peers stating, *"I am waiting on cream to numb my arm to get blood taken".* It was agreed that Sarah would have blood taken if anaesthetic cream was used. The observer noticed that Sarah still seemed apprehensive about the procedure. This was evident as she asked other peers if they had blood taken. Despite staff (nurses and allied health) standing in the vicinity, they offered no reassurance.

At this time five young people and five staff members were leaving the unit via the internal entry doors (leading to the foyer) to attend an off-ward activity. Sitting alone on the lounge Sarah was waiting for the medical procedure. The nurse from the first interaction walked up to her and said:

> Nurse: "*OK, get up, we are going to the Starlight room".*
>
> Sarah: *"What about my cream and blood test?"*
>
> Nurse: *"We can organise that on return – let's go and enjoy ourselves".*

Sarah appeared perplexed (frowned) about what was happening in regard to her care. She followed the nurse's instructions and got up to attend the off-ward activity.

Medical/treating team reviews: Distress arising from treating team reviews with young people and/or their parents' triggered two critical incidents involving the same young person. Nurses were involved in the reviews along with other members of the treating team; however, only the nurses managed the resultant distress. Parents and other staff did not provide any input managing the distress on the unit during these events.

[Reflection] Nurses accompany the young people during medical reviews. These reviews average approximately 20-45 minutes; however nurses are able to provide information to the team based on hours of time spent with the young person. As is evident from this observation, despite the medical staff members being involved in the review, they (and parents) seldom assist nurses to manage any distress that arises during these assessments.

On these two occasions where the treating team review with either the young person (and/or family) was the trigger, the researcher was not involved in the clinical reviews and is unaware of the discussions that took place. The distress was evident in the young person when they returned to the unit's common area.

> Observation 3: Jane was observed to walk into lounge area from corridor… sat on lounge… knees up (hugging), grabbed personal blanket...no eye contact (head down)…many people in area looked over at her.

Medical team reviews are conducted on the unit at the end of the corridor in one of the two consultation rooms. For young people to re-engage in ward activities after these reviews, or to attempt to isolate in their room following a review, they must walk past the nurses' station and lounge room. In the first episode Jane entered the common area and sat on the lounge and used non-verbal cues to seek help from the nurses. These included frowning, attempting to make eye contact with others, foot shaking, wrapping herself in a blanket, and banging her hand on the arm of the lounge. In the second episode Jane attempted to use both verbal and non-verbal cues to both nurses and peers, however when this was unsuccessful she attempted to gain access to her room.

> Observation 18: Jane verbalised to peers anxiety/stress relating to the fact that her parents were currently meeting with the treating team…discussed ongoing estrangement from parents, verbalising concerns as to what parents and treating team were discussing, "about my future". Another young person asked, "Why don't you go down there and find out?" She replied, "I don't want to see my parents". Jane stopped talking to peers, sat quietly on lounge (observed to be ruminating)…foot shaking increased, affect changed (scowl/ furrowed brow)…There were no nurses present in the immediate area…parents

> walked down corridor and left unit after meeting…she turned to see parents leave unit… sat for further 1-2 minutes in lounge area. The nurse involved in family meeting followed doctors and allied health staff into nurses' station… Jane stood up and went to her room: approximately 1-2 minutes later, she was screaming and crying.

5.1.1.3 Ward routine factors:

Ward program/handover: Three critical incidents were recorded at times allocated for ward programs and handover (medical and allied health staff). During handover, nurses involved go to the other end of the unit in the schoolroom. It was also morning tea break for nurses. Of the four nurses on a morning shift, only two were available in the clinical area (where the young people were). At this time of the day young people are attending to their ADLs such as showers, make-up, breakfast etc. Some are in their rooms, others in the common area waiting for the ward programs to commence, or requesting access to their lockers (for supervised items). These times were characterised by reduced staffing levels and therefore insufficient supervision.

> Observation 2: Three young people sitting in lounge room (no nursing staff present, or in immediate vicinity)…waiting for morning "catch-up" meeting (commencement of ward program for the day)…nursing staff currently rotating through allied health/medical team handover – in schoolroom at other end of ward.
>
> Three young people discussing a television programme that they watched the previous evening…related to adult themes (drugs, violence, weapons, prostitution etc). One who was involved in the conversation was reading a magazine about guns/hunting: at time of observation he was looking at a page with advertisements for hunting knives … Jane (cuddling blanket) said she became mildly upset/distressed when watching this programme last evening; the scenes involving nudity/prostitution, made her "angry" about how the programme depicted females in this way… Jane had arms crossed, scowl on face, tone/volume of voice rose, and was using emotive language ("It was disgusting").

Activities of daily living: Young people are woken at approximately 7:30am each morning to attend breakfast, and have their general observation (vital signs) recorded.

There is a 30-minute restriction of young people to their room/bathrooms after breakfast and nurses are providing handover to the other staff members. Supervision is decreased due to nurses' multiple clinical duties. On one occasion Jane attempted to use verbal cues to indicate her distress through discussion with peers; and the nurse was present and observed the distress, intervening with distraction techniques congruent with the context of ADLs (attending to laundry). This helped the nurse to isolate her from peers and work one-on-one.

Unstructured activity/ free time: This was the time when most incidents occurred. During free time when young people engage more with each other, there appeared to be less supervision at these times by nurses, and visiting/family contact is also increased. The daily ward program ends at approximately 3:30pm and visiting hours start at 3:00pm. Young people with leave privileges have time off the unit with family. Nurses continue to accompany medical staff members in family/young people reviews (until 4:30pm), maintain supervision, provide activities, conduct 1:1 psycho-education sessions, administer medications, and assist with all ADLs in an effort to promote sleep hygiene in readiness for bed at 9:30pm.

[Reflection] During observations on the afternoon shift it was evident that some nurses were aware of the sensory impact on ward milieu/agitation levels of the young people. Some nurses turned down the lights and volume on the TV at similar times (8:30pm – after medications/supper), while others seemed to not consider this necessary.

Medication round: Nurses were conducting the evening medication round (two nurses are required for this clinical duty). At this time of the day supper has just finished, visitors have left, and young people have free time. Nurses help young people settle prior to the 9:30pm bedtime. During the medication round a nurse observed Alice exhibiting both non-verbal cues (psychomotor agitation), and language that showed increasing distress. The nurse ceased the medication round and intervened, first using distraction techniques which Alice declined. The nurse then used limit-setting communication to manage Alice's verbal distress (derogatory comments). Two other nurses recommenced the medication round and gave Alice her routine medication. The limit-setting intervention allowed Alice to self-regulate her distress (and associated

behaviour) and the distress reduced after a short time and she re-engaged with peers/activities. The nurse with her sat in silence for some time before disengaging.

Mealtime: On one occasion an episode of aggression/violence started during dinnertime. While this event originated from the context of ward routine (mealtime), it was attributed more to ward dynamics and milieu.

5.1.1.4 Social and relational factors:

Ward dynamics, milieu, and peer conflict: was directly and indirectly involved in many of the episodes observed. Peer conflict and the associated milieu of the unit was directly involved in two events, while on three occasions it was indirectly related. The directly related episodes originated between two young people who attended the same school and had a 'conflictual' relationship and nurses now had to manage this relationship within the clinical environment.

> Observation 14: Hannah had been admitted to the unit while Alice was out on leave with family… Alice returned from leave, walked into common area…ignored peers/staff…started shaking foot/scratching arm (DSH) with fingernails... approached nurse and reported she was upset. *"You obviously don't care about me, want me to get better, if you let Hannah in here".*

On a number of occasions nurses had to manage a young person's distress originating from peer interactions, or try and manage a young person's distress where they were situated amongst the group. On one occasion two young people colluded in a premeditated episode of aggression and subsequently violent behaviours.

Parental conflict: This clinical factor and trigger was responsible for a few episodes. On one occasion Jane was distressed because of merely knowing that her family was on the unit and involved in a clinical meeting with the treating team. Other events occurred when young people talked with their parents on the telephone.

Clinical engagement: Nurses' interactions with peers were associated with a number of incidents. Factors to be highlighted here include nurses' style, language, and the communication techniques the nurses used to engage with young people. On other occasions it was the nurses unwillingness or inability (due to competing duties) to engage with young people that resulted in increased levels of distress. Clinical engagement was involved in all but two of the incidents (as part of the intervention or

responses to distress) and will be discussed in the intervention section, because they were not the triggering events.

After a triggering event was observed the young person attempted to either cope with the ensuing distress or elicit care through help-seeking actions. On two occasions nurses described this as attention-seeking action. A number of coping or help-seeking actions were used by the young people, which in turn would (for the majority of episodes) cause nurses to respond and intervene. On three occasions there was no response from the nurses. The first two times the nurses did not observe the distress, and the third time the nurses chose not to engage the young person.

> Observation 7: Alice had a telephone call to mother (teary)… nurse sitting in nurses' station doing administrative tasks, another nurse standing in corridor about 3-5 metres from Alice.
>
> Alice talking on handset passed through hole in Perspex of nurses' station (cradle stays in nurses station). Alice stating to mother that she does not want to go home yet (from hospital). *"I get all stressed out"…* tone of voice rises a little; body language and tone suggest possible frustration. Alice keeps putting her hand (palm) to forehead when she repeats her request to mother. Alice turns and makes brief eye contact with observer, rolls her eyes, and turns back to put forehead on Perspex. Phone call continues between Alice and mother for approximately two minutes…frustration remains and then phone call ends abruptly… hangs up phone and walks down the corridor to her room.
>
> Nurse sitting in nurses' station walks out and has a brief discussion with nurse who was standing in corridor. *"Her mother wants her discharged home". "She told her mother that if the doctors try to discharge her she would tell them she will suicide". "They [referring to young people] treat this place like a fun camp".* Second nurse nods and smiles (non-committal), however does not offer a comment. No action taken in regard to working with young person (no interaction) – only discussion of the event between the nurses.

Nurses used a variety of responses and interventions to assist the young people in distress; these interventions were categorised by the researcher into person-centred, intermediate, and coercive interventions or responses. My observations of nurses

highlighted two distinct approaches to distress intervention: a thoughtful or mindful approach where the nurse was present with the young person and engaged in the moment, or conversely an inattentive ("auto-pilot") approach. When nurses were mindfully engaged they were more likely to be using a collaborative framework, exhibiting higher-level communication skill, clinical reasoning to direct their interventions, and being more aware of the environment. Nurses would at times use a single response, while at others a combination was required to produce an outcome. Sometimes the outcome resolved the distress for the young person while at others the intervention appeared either not to help, or increase the level of distress.

5.1.2 Expression of distress: Adolescent coping and help-seeking actions

The coping or help-seeking actions (HSA) that young people used to alert the nurses to their distress were both verbal and non-verbal and are best categorised into externalising and internalising. Young people would use combinations of these behaviours as a primary reaction to distress and act as a clinical cue for nurses as an indication of the level of distress.

5.1.2.1 Internalising behaviours:

Sensory or self-soothing based: Young people would attempt to cope with their distress by comforting themselves with self-soothing or sensory-based strategies such as hugging or wrapping themselves in a blanket, or hugging their knees to their chest (with or without rocking). Screaming and crying was also used to self-soothe and this was observed to be both coping and help seeking in nature.

Isolation, withdrawal, and disengagement: Disengagement from social interactions was observed to be a very common coping method. Young people would appear to "go into themselves" (ruminate) and withdraw, not from the area but socially. They would disengage from peer discussions and many times employ other non-verbal cues such as foot shaking (psychomotor agitation) and the sensory-based behaviours described above. On a few occasions they would withdraw from the area and attempt to gain access to their rooms to be in a more private space. Sometimes their rooms were locked in which case the young people would ask the nurses for access, or use non-verbal means such as shaking the door handle.

Deliberate self-harm (DSH) and suicidal ideation (SI): Young people used low severity DSH behaviours as a way of either coping, and/or to alert the nurse about their

distress. Scratching their arms with fingernails and wound interference were common. These behaviours were conducted in the common areas where the likelihood of nurses noticing them was increased. While other forms of higher severity DSH behaviours such as cutting are prominent in the unit, there were no episodes observed during this phase of the study. On one occasion a young person used verbalisation of suicidal ideation ("I will kill myself") to portray their distress associated with difficulties relating to peer conflict. There were no observations of attempted suicide, although previous attempts had occurred on the unit.

5.1.2.2 Externalising behaviours:

Defiant behaviours: Defiance was used as a coping strategy for young people to manage distress in two ways. I observed one using this to challenge a nurse's communication style trying to gain more information about a medical procedure. This was done without malice and appeared to be more avoidant in nature. However, on most occasions defiance would be used as a tool to antagonise or argue with a nurse in an effort to elicit further care, or repel the assistance that was offered to them in the context of the nurse's intervention.

Aggression (inanimate objects and others), absconding, and violence: On four occasions aggression was used against inanimate objects (door slamming) to raise a response from nurses, or release distress in a physical manner. Verbal aggression towards staff (direct threat) occurred, and during the same incident young people involved used aggression toward an inanimate object in an attempt to abscond from the unit. I observed them running at the fire exit door and shoulder charging it to try and break the lock. When nurses intervened in this situation one of the young people assaulted a nurse (violence).

5.1.3 Engagement: Responses and interventions for working with distress.

Responses were defined as being the initial interaction techniques of nurses to engage with young people. They were informal in nature and included different types of interpersonal communication techniques, and clinical skills and strategies. The observed interventions were categorised into three headings: person-centred (collaborative) approach, intermediate approach, and coercive in nature. Nurses would use single interventions, or combinations of interventions, which were categorised across a continuum ranging from person-centred interventions to coercive interventions. These formal nursing interventions (Figure **5**) include psycho-education,

sensory modulation, de-escalation, *prn* medication, physical restraint, and seclusion. They are considered a tiered response to distress based on the principles of least restrictive care as defined by the *NSW Mental Health Act* (2007).

Observations of interventions showed that some nurses would use continuous “in the moment” assessments of distress levels and respond with thoughtful interventions. In one episode two nurses chose not to engage or assist the young person at all. On a number of occasions it was observed that an already established relationship was evident. The nurses would use the information gained from forming this relationship to respond on an individual basis. At other times it appeared that nurses would use the same default intervention (despite level of distress or with different clients): the same nurse offered Jane *prn* medication as a sole intervention on two occasions but there was a marked difference in the level of her distress. In the first instance (Observation 7) Jane used self-soothing techniques (hugging knees/blanket wrap) with some psychomotor agitation (foot shaking) present, but during observation 14 Jane, in addition to shaking her foot and using blanket wrap, was scratching at DSH wounds on her inner forearm.

5.1.3.1 Person-centred Responses and Interventions:

Silence: Nurses used silence in a number of ways; one sat with Rose for about five minutes in the common area as a way of being present with her, allowing them to sit and connect. While Rose was amongst her peers she was not engaged in the conversation or social activities; she appeared to be ruminating about something. The nurse did not talk until Rose appeared to notice the nurse sitting on the lounge. After a few more minutes Rose started talking about her anxieties.

Nurses used silence to bring closure to an intervention; one used a combination of person-centred and intermediate interventions (distraction techniques, limit-setting) to help alleviate distress for Jane. The nurse sat in silence for approximately 10 minutes as the distress levels reduced and eventually left the area after advising Jane to seek her out if she wanted any further assistance.

Another used silence as an effective communication strategy when engaging with Alice who was shouting. Alice raised her voice in an effort to communicate her needs; she reiterated these demands and the nurse stood silently. Eventually Alice stopped yelling, and the nurse waited approximately 10 seconds before responding. This use of silence seemed to change Alice’s focus from yelling to listening, facilitating

engagement with the nurse who then used other strategies, such as reflective questioning to alleviate the distress.

Psycho-education: Nurses provided information about the mental health problems including possible triggers, early warning signs of agitation/distress, symptom management and improved coping and resilience techniques.

During an observed episode Zoe talked with the nurse about her concerns about the impact of her recent suicidal behaviour on her relationship with family. The nurse suggested Zoe should call her family and discuss these concerns, and offered support for this phone call by a role-play scenario about what she might wish to say, and some of the responses received from family during the discussion.

When Jane was extremely distressed, exhibiting DSH behaviours (hitting head and punching face) the nurses used a combination of interventions. Oral *prn* medication was given initially and whilst waiting for it to become effective the nurses guided Jane in a mindfulness-based deep breathing exercise to manage the distress. This was communicated in a caring and supportive manner with the nurse role-modelling the intervention.

Reflective questioning and problem-solving techniques: Once a nurse used problem-solving techniques to manage distress associated with anxiety (rumination). S/he included reflective questioning as part of the negotiation and a beneficial outcome was achieved as part of the problem-solving technique.

The nurse, when engaging with Alice who was discussing an unmet need also used reflective questioning but the nurse's technique did not result in that need being met and Alice withdrew and slammed the door, which resulted in the nurse using more coercive interventions: increased observation levels (informal) and oral *prn* medication (after 20 minutes of observations).

> ***Nurse:*** *"I think it is fair that we let your mum rest, I will look after you tonight and in the morning you can call her to find out what to wear – before you shower in the morning, what do you think?"*
> ***Alice****:* turns on heels and marches to room, slamming door, continuing to cry/scream*, "I want to call my mum".*

A nurse engaging with Jane about a recent social interaction used reflective questioning to provide the opportunity to consider her involvement in the matter, and

behaviour in the present moment. Jane was discussing the care provided earlier in the day by her allocated nurse.

> **Jane:** *" I get frustrated with some of the nurses, I don't care about the rules (of the unit), and the nurses should talk to us with respect".*
> **Nurse:** "*It can be hard here sometimes, for you guys and nurses. Did you try to sort out the situation with the nurse this morning?" "How did you feel at the time?"*
> **Jane:** named nurse (from the morning's care) with a condescending tone/language *"She's not a good nurse".*
> **Nurse:** *"Remember that respect goes both ways".*
> **Jane:** Seemed to become more mindful of what she was saying and stated *"[the morning nurse] is ok, we usually get along".*

Distraction techniques: Nurses would often suggest different types of activities to the young people to distract them from the focus of their distress, at times based on leisure/hobby interests, while at other times they were based on ADLs. Young people were mixed in their acceptance of this strategy; they were more likely to accept it if the nurse knew the types of activities they preferred.

Young people refused to engage in distraction techniques suggested by nurses on a few occasions where the level of distress and emotional dysregulation was too high to permit concentration. At these times the intervention was not congruent with the level of distress.

> **Nurse:** *"Would you like to play a game or do some art with me?"*
> **Jane:** *"No, I am too angry, I want to talk".*

On another occasion the same nurse was able to engage with Jane by distracting her from her distress by getting her to attend to their ADLs (laundry). The difference between these two events was Jane's level of distress, and that the nurse intervened earlier and with a more appropriate intervention for the level of distress.

Humour: There was only one critical incident where humour was used towards the end of the event when the Jane's distress levels were abating. It was evident in this situation that Jane and the nurse had developed a close therapeutic relationship because, if this had not been established, it might have seemed invalidating or insensitive. Jane had been engaging in DSH behaviours approximately 10 minutes

earlier (hitting head) and the nurse had employed other interventions but as Jane's level of distress decreased the nurse made a joke about the cleanliness of her room and suggested they clean it together tomorrow. Jane was crying with her head down, and when the nurse made the joke she lifted her head, and laughed through her tears and sobs. Jane seemed to be regaining some emotional control, but after the nurse made the joke he/she left the room, leaving Jane alone. This resulted in her becoming distressed again.

Sensory modulation: Like the use of distraction techniques, the nurses suggested sensory-based interventions to soothe distress. Once when other interventions were failed to alleviate Jane's distress, .she seemed to become more frustrated with the nurse's attempts and asked to use the sensory room at the end of the unit, and very isolated. It has a massage chair and comfort beanbag to sit on and many other sensory tools. The nurses unlocked the door to the sensory and left Jane to manage her distress; she could not, and became further distressed, requiring *prn* medication. The nurses seemed aware of the increasing distress and failure to contain it, yet still chose to leave her alone in the sensory room to self-regulate. They did not discuss or plan any further interventions (such as increased observations). Only Jane's screaming and yelling for help caused the nurses to reconsider, and offer *prn* medication.

Sensory modulation appeared to be most effective and accepted when it was offered promptly. Nurses were observed to provide personal items such as blankets and stuffed toys. The most common and effective intervention was a hot shower supported by increased levels of observations, because bathrooms are considered to be one of the most common areas of the unit for DSH behaviours to occur.

Therapeutic touch: I observed this technique used four times by nurses and it was well received by the young people. On two occasions the nurse rubbed Hannah's arm or shoulder as a way of conveying comfort and support, and was combined with encouraging, soothing words. On another occasion the nurse used therapeutic touch in the same manner as described above but the nurse put their arm around Jane's shoulder while standing alongside them (half hug). Once the nurse used therapeutic touch not to comfort or soothe but rather to ground Alice in the present moment, gain eye contact and this was accompanied with more direct communication where the use of "us" also provided a bridge between nurse and Alice:

Nurse bent over to be on same eye level with Alice, placed hands on her shoulders, smiled and said, *"let's organise some fresh towels and clothes and get you freshened up, always makes us feel better".*

5.1.3.2 Intermediate Level Responses and interventions:

As described above, nurses used interventions along the person-centred –coercive continuum. Sometimes nurses attempted to use a person-centred approach but were not able to resolve distress so chose interventions half way along the continuum. These intermediate responses include limit setting, de-escalation, and increased levels of observation.

Increased levels of observation (informal): At times because of the risk, nurses formally employed increased levels of observations that either they initiate or are ordered to implement by the MDT. The levels of observation in the unit, from least restrictive to most restrictive, are routine: (every 30 mins); close (either 10 or 15 minutely); special (1:1 line of sight in the same room); and constant (1:1 arms length). However nurses used an informal approach to increased levels of observations based on the above framework and varied the levels depending on the assessed level of distress -- a common strategy used to assess and manage distress. On eight occasions nurses used this strategy, once as a solitary intervention; on another occasion as a follow-up strategy after an episode involving physical restraint and *prn* medication because of high level of risk to others. Three times it was used in conjunction with person-centred strategies and three times with *prn* medication.

When used in isolation, the nurse in charge (NIC) ordered maintenance of a closer level of observation on Alice who had isolated herself in her room while upset. No exact time interval was discussed and the nurse was advised not to engage Alice, to "limit secondary gain".

When used in isolation, the nurse in charge (NIC) ordered maintenance of a closer level of observation on Alice who had isolated herself in her room while upset. No exact time interval was discussed and the nurse was advised not to engage Alice, to "limit secondary gain".

Two attempts to abscond from the unit by trying to break down the fire door at the far end of the unit were de-escalated by negotiation and requirement of examples of expected behaviour ("please stop kicking at the door"), but resulted in directed aggression against the nurses. Hannah required *prn* medication and physical restraint

to minimise the level of distress and associated risk, then the nurses disengaged, ceased physical restraint, and used special levels of observation (1:1 line of sight) to continue to monitor Hannah's level of risk. As her behaviour improved and the distress level decreased, the nurses moved on to close observation levels.

Close observations on three occasions of risks associated with DSH and suicidal behaviour involved once when Jane was self-harming (punching herself in the head) and the nurse was advised to maintain close observations and not stop Jane because "she knows her limits".

On two occasions, showering (identified high risk area/time) used as a sensory modulation, soothing technique was suggested, supported by increased levels of observations (close). The observations were infrequent, five to ten minutes apart. For one the nurse checked regularly on Jane because of an incident of attempted self-strangulation (using an item of clothing) in the bathroom the previous day.

Close levels of observation were used in combination with both person-centred and coercive interventions on three occasions in a tiered response moving along the continuum using *prn* medication as a coercive approach. Twice levels of observations were used simultaneously with *prn* medication to continue to monitor and assess the level of distress. On one occasion Jane asked to use the sensory room and the nurses left her alone despite evident high level of distress; it continued to escalate and the nurses gave her *prn* medication and again left her alone in the sensory room with close observations the only other level of support. During *prn* administration (either oral or intramuscular) a time delay occurs between administration and efficacy but nurses did not choose to increase the levels of observations for these three episodes, choosing on all occasions to implement close observations. In the last observation described above Jane had a much higher level of distress, yet the nurses did not stay with her during the time prior to or after *prn* administration.

Limit-setting and de-escalation: was used by nurses on three occasions in different contexts. I once observed a nurse using limit-setting as one of numerous strategies, giving Jane routine medications, offering to play games/do art as part of distraction techniques, and asked reflective questions, and used limit-setting in the context of social intelligence. The nurse asked Jane to be mindful of her language when talking about another nurse who was not present.

Limit-setting strategies were employed by another nurse to manage Jane's increasing distress and also its effect on others. In this observation Jane was venting her distress in about family relationships, previous life events, and her treatment while in hospital. She was allowed to vent for a brief period but then was advised to stop verbalising her feelings as her distress levels elevated.

> **Jane** verbalised past trauma, raising voice: *"It is better to not say anything, when I told people about what happened to me I thought I would get help, now I am here (mental health unit), homeless, and missing out on my childhood".*
>
> **Nurse:** *"I think this is going around in circles, it is upsetting you, and others, I will ask you to let it go".* (Two young people had left the common area during conversation).

Nurses used de-escalation in one episode of violent and aggressive behaviour when two young people attempted to abscond from the unit. Nurses used de-escalation communication techniques such as problem-solving, negotiations, active listening, limit-setting, and acknowledging feelings in an attempt to prevent a seclusion and restraint episode, however this was unsuccessful because the young people involved were not receptive to the negotiations and requests. While nurses used a team response to manage this high-risk situation, only one of the nurses was observed to be talking during the de-escalation process. The nurses appeared to work as a team and their language and stance showed a unified front.

5.1.3.3 Coercive responses and interventions:

Communication styles: On two occasions the nurse used a controlling style. On both occasions the clinical context related to the requirements for a medical procedure and the nurses did not provide any information about it, did not seek to gain consent. In tone and volume of voice there was a fine line between instructive communication, and a demand to comply with treatment. Conversely, when nurses were working collaboratively with young people the tone and volume of conversations was soothing and supportive:

> **Observation 6:** Young person reported concerns about recent suicidal behaviour, physical health ramifications of suicide attempt, and impact on family (especially sibling).

> **Nurse:** "*Sometimes you get anxious about things, so I can support you when you make the call, or we could practice what you would say before you ring" (role play).*

Prn medication: was a widely used intervention in six episodes where it was administered to young people in distress. On one occasion it was the only intervention used: Alice became upset because of peer conflict. She talked about her displeasure in having a peer admitted to the unit (past conflict in the community), and she also started to scratch self-harm wounds on her inner forearm. The nurses did not offer any alternative interventions or strategies and gave the *prn* medication and walked away, withdrawing to the nurse's station.

Prn medication was used in conjunction with physical restraint and an increased level of observation, as previously described. On four other occasions it was used as part of a combination of strategies across the intervention continuum. For each of these four observations the nurses gave oral *prn* medication to help alleviate distress but did not stay with them while the medication became effective (approximately 15-40 minutes).

Seclusion and restraint: One episode of seclusion and restraint was observed and was precipitated by violent and aggressive behaviours displayed by two young people attempting to abscond. Lilly physically assaulted a nurse who tried to intervene as part of a team response. Hannah was combative and argumentative and two nurses used a standing secure hold to control her arms and decrease the severity of harm to others. The nurses held Hannah for approximately five minutes while they negotiated oral *prn* medication administration, and outlined the expected behaviour required before they released the physical restraint. During this episode four nurses were required to manage the situation, leaving one nurse to provide care and support to the other 10 young people on the unit.

5.1.4 Adolescent reactions and nurses' clinical decision making to manage distress

5.1.4.1 Adolescent reactions to the nurse's response and intervention

The responses and interventions described above were observed during interactions between young people experiencing distress and the nurses who assisted them. There were times when young people appeared to readily accept the offer of assistance from the nurse, while at other times clear rejection of the help occurred. Young people would

display behaviours such as listening, making eye contact, follow instructions, or answering questions that indicated they accepted the responses and interventions.

> **Observation 10:** Jane was speaking with another young person about some peer conflict on the unit. She was becoming increasingly loud and her distress levels were escalating. The nurse appeared to observe this and engaged Jane providing her with a distraction intervention (washing laundry) which Jane readily accepted. She walked off with the nurse conversing and making eye contact, her distress level abating.

On other occasions young people would display internalising and externalising behaviours consistent with the coping and help-seeking themes described above. These included arguing, walking away and ignoring instructions and slamming doors, which indicated they were rejecting the help offered.

In observation 3 the nurse used responses that could be categorised as coercive on two occasions and was also dismissive of the perspective of the young person whose reaction was to become argumentative, defiant (break rules) and attempt to isolate in her room. The nurse offered *prn* medication, engagement and de-escalation interventions. The level of distress was observed to escalate and be unresolved for approximately 40 minutes, which coincided with the time frame for the *prn* medication to take effect. Conversely, Observation 11 provided an instance where a nurse used person-centred responses along with engagement (person-centred) and increased observation levels (intermediate) as interventions, which were accepted. This was evident by the way she made eye contact with the nurse, and later (10 minutes) socialised with peers and nursing staff.

5.1.4.2 Nurse's critical thinking and managing distress

When adolescents' reactions to the response or intervention were to reject them, some nurses would use these clinical cues to assess their effectiveness. If the level of distressed increased some nurses would use a cyclical response strategy until their care was accepted and then offered an intervention to manage the distress.

> **Observation 8:** Jane became distressed due to parental conflict. The nurse identified the distress through her verbal (indirect) and non-verbal help-seeking behaviours. The nurse responded to Jane's in a person-centred manner, smiling and engaging with her; she was offered routine medications and distraction techniques as interventions. Jane rejected these stating she was too

angry to talk. The nurse recognised Jane's rejection and readjusted a response by asking her what she would like to talk about. Jane initially entered into a superficial conversation then after a period of time she started talking about her concerns. The nurse responded to this with empathy and understanding and used reflective questioning to help Jane to continue to talk about her distressing thoughts. During the conversation the nurse also had to employ limit setting as a de-escalation tactic. Despite the use of this intermediate intervention Jane's reaction was one of acceptance, and the outcome resulted in alleviation of her distress.

The reactions of the adolescents allow the nurses an opportunity to assess whether the responses they used were accepted or not. These reactions provide clinical information for the nurse's decision-making process about the effect of their initial response. Some nurses would adjust accordingly and offer different responses and interventions if distress escalated, or was not alleviated.

5.1.5 Outcomes: Escalation or resolution of distress

Outcomes need to be considered in a number of ways, and in the context for which they occur. The primary goal for nurses should be to provide support to the young person to manage their own distress and improve their coping and resilience skills. Nurses also need to identify the coping or help-seeking actions the young people display and conduct ongoing mindful assessments of the young person's reactions to the nurse's responses and interventions. This provides key clinical information to the nurse about the way their assistance has impacted on the young person's level of distress.

In regard to identifying coping and help-seeking actions nurses missed two episodes of distress and the young people were left to manage this alone. For the remainder of the episodes nurses identified behaviours that alerted them the young person was experiencing distress, but on some occasions it was not the first set of behaviours that were noticed and the young people would then display more overt behaviour to be recognised (which was consistent with increasing distress).

There were incidents where nurses would recognise the counterproductive impact of their responses and interventions. They would consider the outcome of their initial attempt to provide assistance and offer alternative responses and interventions to help alleviate distress. Overall, thirty interventions were used in various combinations in the 19 critical incidents of distress observed. For three incidents no interventions were

offered: two because nurses did not witness the incidents, and one where the nurses chose not to engage the young person. For all three of the episodes where nurses did not provide interventions for the distress, the young people were able to manage this themselves. For the remaining 16 observations nurses used responses and interventions either as a single method or in combination, all of which can be placed along the person-centred-coercive continuum. Analysis of the observations in regard to outcomes will consider the intervention or combination of interventions used and how this impacted on the young person's level of distress.

5.1.5.1 Person-centred interventions:

There were three critical incidents where person-centred interventions were the only type of response offered by the nurse in helping the young person to manage their distress. For the first of these incidents the nurse received a handover where the previous allocated nurse on the morning shift advised they did not spend much time with the young person given competing duties. The nurse coming onto the afternoon shift went out and sat with the young person in silence. It was observed that the young person although sitting amongst her peers was not engaged in the conversation and appeared to be ruminating. The young person engaged with the nurse who was sitting there silently (presence) and divulged her concerns about family relationships in the context of her recent suicide attempt. The nurse used further person-centred interventions such as reflective questioning, psycho-education, problem-solving strategies, and therapeutic touch to assist the young person. Following the intervention by the nurse the young person's demeanour changed (started smiling), and she joined in on the conversation with her peers.

Another incident occurred when Jane was asking her peers if they saw another young person verbally abuse her earlier in the day. They indicated they had not, and Jane explained. A nurse entered the lounge room at an opportune time and became aware of the conversation and the possibility of Jane's distress escalating (increase in hand gesturing, volume of speech and inflected tone observed during the initial conversation). The nurse appeared to briefly assess the situation then asked Jane to come to "check your washing". The nurse used distraction techniques based on the ADLs, effectively changing the focus of Jane's attention and ceasing the escalation of distress. Jane walked with the nurse to the laundry smiling and talking as she went.

Jane was observed to be sitting in the lounge room on another occasion and the allocated nurse was talking with another nurse in the corridor around the corner from the lounge room (out of sight of Jane). When the nurses entered the lounge room they

observed Jane crying. The nurse walked over and sat alongside Jane on the couch and hugged her and started stroking her hair. Jane stated, " I don't want to talk to my family". The nurse advised Jane that the unit social worker would contact her family. The nurse continued to hug and stroke Jane's hair and as Jane's distress decreased the nurse asked, " Are you OK now?" and when Jane nodded the nurse disengaged and returned to the nurses' station.

5.1.5.2 Intermediate interventions:

Alice was sitting in the dining room with some of her peers when two ambulance officers escorted Hannah to the unit via the external corridor, which was visible from where Alice was sitting. Alice had previously had some peer conflict with Hannah outside the unit. Alice immediately got up from the table, pushing her chair back, and stated, "If Hannah comes here I will kill her, or myself – I need Seroquel." Alice then stormed to her room slamming the door. At this point the NIC heard the commotion and entered the unit from the foyer via the internal entry doors. The NIC spoke with Alice in her room for a brief period then returned to the nurse's station and instructed the allocated nurse to "keep a closer eye on Alice, but limit secondary gain" – just observe more closely". The allocated nurse appeared to accept these instructions and was observed to check on Alice at irregular time intervals (every 3-5 minutes) for the next 15-20 minutes. The increased observations ceased when Alice returned to the common area of the unit and asked the NIC for a tissue. The NIC offered words of reassurance at this time, "Hannah may not even come here, let's cross that bridge if and when the time comes".

5.1.5.3 Coercive interventions:

For two critical incidents the nurse used an authoritarian communication style to engage with a young person. The way in which the nurse engaged with the young person, and the request for a medical procedure was the triggering event. The nurse continued to use demands and instruct despite observing the change in the young person's presentation. In both instances the nurse provided minimal information about the treatment plans and instead attempted to manage the young person. The lack of information provided, the tone and delivery of the interaction, the response to the nurse by the young person, and the dismissive nature of the nurse's approach all resonated with a coercive care approach.

Observation 4: **Nurse** - "*OK, get up, we are going to the Starlight room".*

Sarah: *"What about my cream and blood test?"*

The outcome of these interactions showed a breakdown in communication and the young person disengaged with the nurse. These events appeared not to be resolved other than in the passing of time.

Jane entered the lounge room from the corridor after being involved in a meeting with the doctor and her allocated nurse. She was visibly upset, sat on the lounge, did not make eye contact or speak with her peers. Jane hugged her knees to her chest and wrapped herself in a blanket. The allocated nurse went to the nurses' station, grabbed the medication chart and asked another nurse to assist with *prn* medication. The nurse returned and gave Jane some tablets and Jane accepted and swallowed these with minimal information and engagement by the nurse.

> **Nurse:** *"Here is your medication, slow release – it will help".*

This seemed to indicate that Jane and the nurse had a working therapeutic relationship based on trust. However the nurse questioned this trust during the intervention.

> **Nurse:** *"Drink some more".*
>
> **Jane:** *"Why, I am not thirsty?"*
>
> **Nurse:** *"So I know you swallowed it".* (Jane refused to drink more, handed back cup).

[Reflection] It was difficult to ascertain from a researcher's perspective the level of assessment the nurse conducted to choose prn medication as the first line intervention. However, the researcher's assessment observed that the nurse did not engage with Jane and discuss any alternative interventions such as sensory-modulation. For example, the researcher noticed Jane used the blanket and knee hugging in an attempt to minimise her distress and soothe herself. I thought the nurse could have considered accompanying Jane to the sensory room to provide support and use sensory-based interventions and distraction techniques to manage the distress.

Another incident where the nurse used *prn* medication, as a single intervention was very similar to the one described above for Jane. Alice returned from leave with her parents to see that Hannah had been admitted to the unit. She entered the lounge area, sat away from staff and peers and did not engage or give eye contact to anyone. She immediately started to pick at her healing DSH wounds and scratch intact skin with

her fingernail. Alice then got up and approached a nurse and stated: *"You obviously don't care about me,* [if you] *want me to get better, if you let Hannah in here".*

Prn medication was administered to Alice with minimal interaction from the nurses. Then they left Alice alone in the dining room and after five minutes she again went and sat in the lounge room, away from her peers.

5.1.5.4 Combinations of interventions:

Person-centred and intermediate:

A nurse used a combination of person-centred (distraction techniques, reflective questioning) and intermediate (limit-setting) interventions to assist with Jane's distress. She became upset during a conversation with her peers about her family relationships. The nurse intervened and offered to spend time with Jane and participate in a number of possible activities (eg. art, board games), which she declined saying she was *"too angry to draw"*, but indicated she wanted to talk. She started to discuss her dissatisfaction with her care and a recent interaction with another nurse who was not on the unit using derogatory language, about the nurse. The nurse sitting with Jane used limit-setting techniques to limit Jane's comments and redirect her to the present moment:

> **Jane:** *" I get frustrated with some of the nurses, I don't care about the rules (of the unit), and the nurses should talk to us with respect"*
>
> **Nurse:** *"It can be hard here sometimes, for you guys and nurses. Did you try to sort out the situation with the nurse this morning?" "How did you feel at the time?"*
>
> **Jane***: "She's not a good nurse".*
>
> **Nurse:** *"Please don't talk about nurses when they are not here, remember that respect goes both ways".*
>
> **Jane** seemed to become more mindful of what she was saying and stated, *"She [the morning nurse] is ok, we usually get along".*

The same combination of interventions was used to assist Jane when distressed: she became upset after a phone call to her mother. The nurse used limit setting with Jane when her conversation with her mother increased her distress to a point where she was not able to manage it herself (screaming):

> Nurse came out of nurses' station and got down on the floor (kneeling), made eye contact with Jane and advised, *"I am happy for you to still talk with your mum, but you need to keep your voice down".*

Jane terminated the phone call and went to her room and started to self-harm (hitting herself in head/face). The nurse implemented increased levels of observations (line of sight) and person-centred interventions (therapeutic touch, humour, and sensory modulation) to assist Jane to settle.

On two occasions nurses used increased levels of observations (intermediate intervention) when they suggested the young people take a shower (sensory modulation) to assist with managing distress. They checked at irregular times while they were in their room attending to showers, a strategy used in response to risks associated with recent self-strangulation attempts.

Intermediate and Coercive Interventions:

A team response managed an episode of aggression and violence when two young people colluded in attempting to break out by kicking the rear fire doors. De-escalation techniques were used to negotiate a change in absconding/exit-seeking behaviour of Lily, and Hannah. Lily became aggressive and required physical restraint by two nurses (standing secure hold). Lily continued to be combative and was escorted to the seclusion room. She was able to break free of the physical restraint for a brief time and assaulted a nurse (punch to head). She was subsequently secluded.

Two nurses physically restrained Hannah (standing secure hold), while de-escalation attempts continued. Hannah was persuaded to accept *prn* medication, and when her distress decreased the physical restraint was ceased. Hannah returned to the common area of the unit and attempted to involve other clients in her cause (absconding/riot against nurses), so increased levels of observation were implemented and a presence maintained until the *prn* became effective and Hannah's distress (and associated behaviours) changed.

Full range of interventions:

On three occasions nurses used all categories of interventions as highlighted by this analysis (person-centred to coercive). Person-centred approaches such as sensory modulation, silence, reflective questioning, therapeutic touch, and psycho-education were used as a first order response, complemented by intermediate interventions such as limit-setting and increased levels of observations. On all occasions *prn* medication

(restrictive) was used. The combination of all three-intervention categories is evident in the incident involving Alice, who became upset when the nurse did not permit a phone call to her mother, but explained that her mother called and advised she was unable to talk tonight because she was ill. Immediately upset, Alice demanded to speak with her mother, screaming at the nurse, who used silence to gain Alice's attention then used a reflective question and reassurance to negotiate with Alice to call her mother tomorrow. Further distressed, Alice stormed to her room, slamming the door. The nurses continued to assess her distress, giving her time in her room to settle, by initiating increased levels of observations. When it appeared that Alice was not able to self-regulate the nurses initiated *prn* medication.

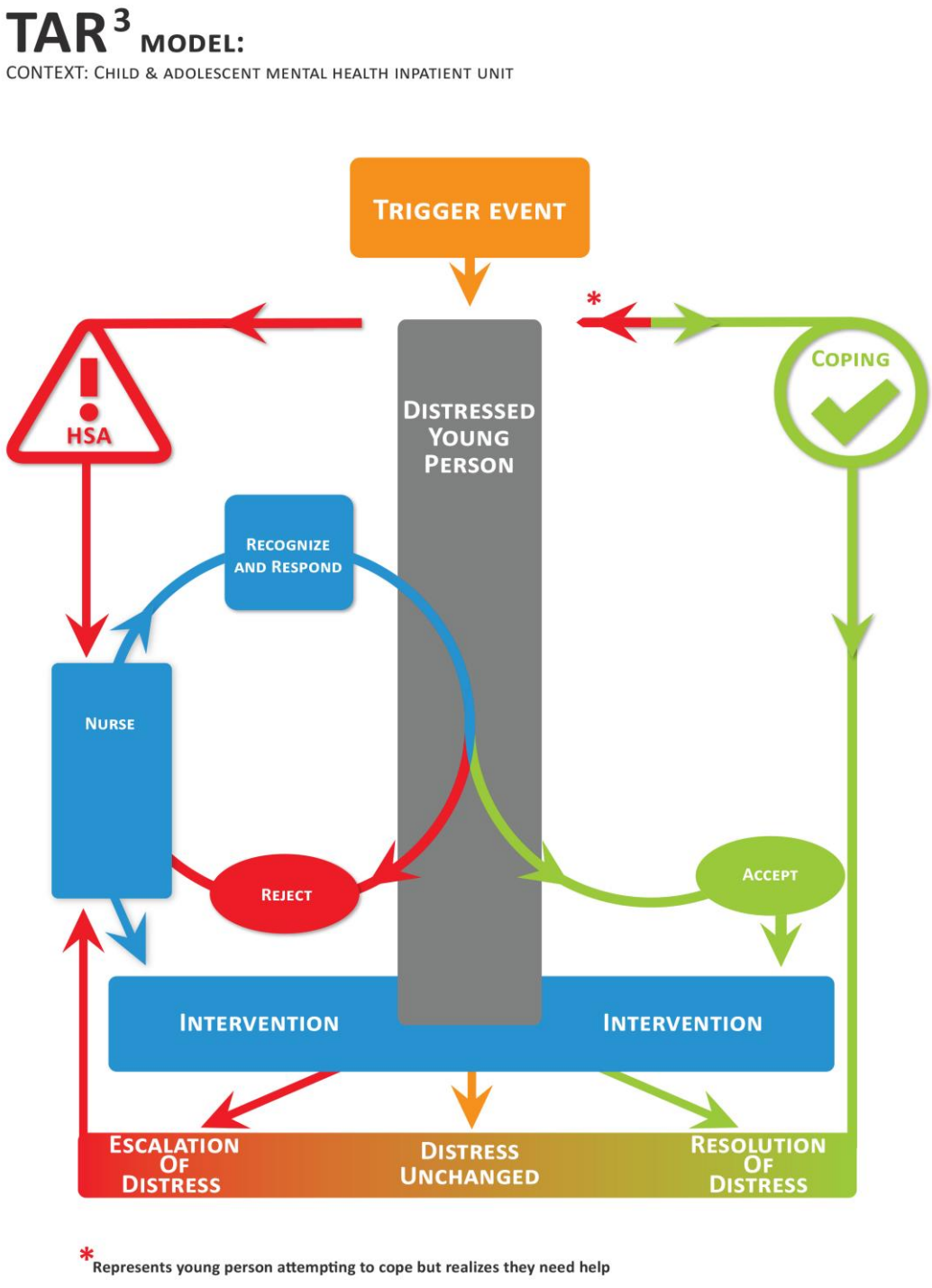
[Reflection] It appeared that young people and nurses worked collaboratively, not just because of the type of intervention offered by the nurse but as much by other factors such as the intent, thoughtfulness, and congruence. For example, prn medication was given at times with no refusal or questioning by the young person, while at other times they refused to engage in distraction techniques because of their high level of distress.

Analysis of the observational data and the associated themes produced and how they translate to the context of clinical practice has generated a model that outlines the process and effectiveness of nurses' responses to adolescent distress.

5.1.6 TAR^3 Model

The TAR^3 Model (Figure 3) provides a diagrammatical representation of the findings from the observational data that can provide a framework for nurses to respond to adolescents experiencing distress. Trigger, Action, Response, Reaction, and Resolution are the themes that are incorporated in the model.

Figure 3: TAR[3] Model



Chapter 6 FINDINGS: STAGE 2

This chapter sets out the findings of the second stage of the study. Semi-structured interviews were conducted to gain insights from nurses about responding to adolescent distress in the acute C&A MH inpatient unit, which was the setting for the study.

6.1 INTERVIEWS WITH NURSES

Interviews with nurses were coded following Thorne's (2008) three-stage coding approach. Analysis methods using this framework and the subsequent themes are presented.

Open coding

Once transcripts were checked for accuracy I then reviewed each interview comprehensively and assigned loosely associated keywords to sections of the data. This fracturing of the data separated items to consider for the next stage of analysis. Notes were also documented in my journal during this stage of data analysis.

Axial coding

Initially I constructed a table (Appendix 16) with three columns and started the open coding process. The first contained all of the assigned themes, keywords, and phrases allocated to the open coding segments of data. Once the list of keywords and themes was completed in column one, I reviewed each smaller segment of data and "pasted" it into the most appropriate keyword row. The participant identifier (e.g. N1, N2, N3 etc.) was assigned to assist with identification of the source of the data. The open code segments were at times further separated to filter down the data into the most accurate keyword theme. It was important to continue to review the individual interview transcripts as this provided context to the smaller segments of data. Once all data from the open coding process were allocated to keywords in the table, keywords that were not allocated any data were removed, leaving the final table.

To continue the axial coding process a review of the data themes and keywords was conducted and similar ones were grouped together. I was able to construct seven groups: aggression, therapeutic relationships, adolescents, mental health nursing, interventions, outcomes, and outliers. This initial analysis left a number of components of data in the outlier group that did not seem to fit.

Expert review of the axial coding segments was then conducted. An expert peer reviewer checked the process I had used to this point of data analysis and challenged my thematic coding. Through this process we were able to reassign more accurate themes to the grouped data. This had two advantages, the number of outliers was vastly reduced (n = 5) and the grouped themes seemed to relate better to one another and link to the research questions. The resultant axial coding themes were environment, nurse safety, peer relationships, “unsure what to do”, culture, unhelpful interventions, helpful interventions, working together, therapeutic relationships and knowing. The outliers were then reviewed and explored against the themes already allocated, and the research questions. Four of the outliers were discarded, as they added no value to the data analysis or to answering the research question. The remaining outlier was allocated to the helpful intervention theme.

Additional analysis was conducted with my research supervisors (who were qualitative experts) resulting in further refinement of the axial coding themes. Axial coding themes were divided into three groups. Themes were grouped together under the banner of 1) Promoting engagement: Salient responses as they were interrelated: Therapeutic relationships; Informed and productive responses and interventions; Uninformed and non-productive responses and interventions; Working together: Safety of young people and nurses. 2) Culture and Peer relationships, and 3) Environment.

Selective coding

Through the selective coding process sub-themes were identified providing a deeper understanding of the themes outlined in the axial coding process. For example the axial coding theme “Working together: Safety of nurses and young people” provided insights into general reasons for nurses and young people not working together (e.g. poor self-esteem); however more distinct sub-themes identified were DSH, Aggression and violence, professional safety, physical safety, and emotional impact on nurses.

Once the selective coding process was completed I reviewed the axial coding themes and, with expert peer review, was able to further refine the axial coding themes. This process allowed me to simplify the thematic coding and produce themes that more closely represented the clinical phenomena being studied, and resonated with the qualitative approach used. These themes also were representative of the clinical environment and the language used by clinicians.

Detailed below is a list of the sub-themes identified for each of the final axial coding themes:

1) Promoting engagement: Responses and interventions used to manage adolescent distress.

- Responses and interventions used to manage adolescent distress and resultant outcomes: Escalation or resolution.
- Therapeutic Relationships: "knowing" your patient
- Being present
- Aligning interventions with the assessed level of distress
- Person-centred approach
- Commitment to the safety of young people

2) Challenges associated with Engaging Adolescents in Distress:

- Clinical Experience: "Just don't know what to do".
- Significant deliberate self-harm (DSH)
- Aggression and violence
- The unit environment: Physical design and layout
- Milieu management and adolescent peer relationships
- Unit procedures and routines
- Safety of nurses: Professional and physical
- Emotional impact on nurses

3) Culture:

- Safety in the work environment
- "We are all so different"
- Unit management, and teamwork
- Influence of unit culture on clinical decision-making
- Environment: Climate and atmosphere

6.2 PROMOTING ENGAGEMENT: RESPONSES AND INTERVENTIONS TO MANAGE ADOLESCENT DISTRESS

Nurse participants described providing responses and interventions to adolescents in times of moderate to acute distress. Unlike the observational stage, where analysis of the data allowed for the researcher to describe the earlier signs of distress (mild), nurses reported on situations only where distress was apparent.

6.2.1 Responses and interventions used to manage adolescent distress and resultant outcomes: Escalation or resolution.

Consistent with the findings of the observational data from stage one of this study, nurse interviewees reported using a range of responses and interventions when working with young people in distress.

6.2.1.1 Nurses' initial responses

Responses are not considered as interventions (as outlined in Figure 1: Diagram representing continuum of nursing interventions consistent with the NSW Mental Health Act (2007) principle of least restrictive care.) because they are types of approaches and interpersonal communication styles nurses rely on, to engage with young people when they recognise they are distressed.

6.2.1.2 Nurse interventions

Nurse's descriptions of the interventions they used ranged from person-centred approaches to controlling approaches. The initial interventions described are presented in these two categories (and on some occasions subsequent interventions are also described), and the associated outcomes of these approaches are presented.

6.2.1.3 Person-centred approaches and outcomes

Nurse participants described using verbal and non-verbal de-escalation techniques that were complemented by other interventions such as sensory modulation, *prn* medication, seclusion and physical restraint, if these were ineffective singly.

Key phrases used by nurses to describe de-escalation included negotiation, reflective questioning, talk-down, grounding, validation, and reassurance. Verbal de-escalation was reported many times as the primary focus of the nurse's intervention but would often be accompanied other interventions.

> N2: *The doctors had said he could go out on leave with staff but obviously at that point in time he was too distressed to be able to go on leave. So we have negotiated the fact that if he could help us, help calm him down, that we would be able to go out for a walk if he stayed calm for half an hour.*

N3: *We tried to talk to her… trying to de-escalate her…brink her back to the moment… distract her… just grounding things, 'you know me'. I'm here to look after you'.*

N6: *Trying to verbally de-escalate him, just reflect it back to him, try and reassure that he was in a safe place and our priority was his safety.*

N7: *Trying to break through those [external doors to unit] but they are stronger… we just managed to talk her down and talk her into coming back onto the ward. I sort of just said, 'look, you know this has happened before. You know we will call the police and they will come and get you and bring you back. Try to work with us here 'cos we all want you to get out. We know you want to get out so how about you just come inside and we can talk about it'. Although she was pretty angry still but she did come inside.*

N9: *I took on the de-escalation role. I would go in, talk to her, remove myself, go in and talk to her, remove myself. Every five minutes maybe, giving her a little bit of space. Still trying to negotiate.*

The outcomes of these person-centred interventions varied. For two of the five interventions (N2 and N7) the nurses were able to use the verbal de-escalation interventions to achieve resolution of the distress. The young people accepted the interventions offered. The verbal de-escalation (assurance and comforting words) offered by N3 did not alleviate the young person's distress and *prn* medication (IMI) was subsequently used. N6 was able to use verbal de-escalation to negotiate with the young person experiencing acute psychotic phenomena to take oral *prn* medication; while N9, despite numerous attempts to use person-centred de-escalation techniques was unable to alleviate the distress for the young person and police intervention (physical restraint) was required, before it was possible to administer *prn* medication, which eventually alleviated the distress.

When engaging with a young person in distress a nurse provided an example where verbal de-escalation was ineffective in alleviating the distress and changed their response and used silence resulting in resolution of the adolescent's distress.

N1: *I realised I was doing all of the talking and it was actually distressing the patient having me ask questions… I could see she was tensing up, her eye contact was limited with me and I was pretty much losing my rapport with her*

and I just thought you know, when I'm upset I don't like people constantly talking to me.

A number of person-centred interpersonal communication approaches were commented on by N2 who used acknowledging feelings, asking permission, and providing an explanation to de-escalate a potentially aggressive or violent situation.

N2: *I asked him, 'do you want me to stay here for a while?'* (Seeking permission).

N2: *You were kicking at the door and hitting at the door and that frightens people… he turned to me and said to me, 'I'm not going to hurt you'. I said, 'I know, but you're still making a lot of noise and it's frightening when people are hitting and kicking things'.* (Providing an explanation).

N2: *Kind of acknowledged his feelings as well because he was quite distressed that he was locked away in a unit. It was true; he was locked away in a unit. So I guess kind of reinforcing that yeah, it does kinda suck that he is locked away and can't just leave whenever he wants to.*

The nurse also described providing the young person with the behaviour required from him. The nurse outlined the expected behaviour (stop kicking the door and regain self-control) and followed this up with the benefits for him of choosing this option: using escorted leave and going for a walk. The young person accepted the nurse's approach, which resulted in resolution of the distress.

Validating feelings and providing reassurance were other interpersonal communication styles and approaches nurses used to manage distress. Participants used these approaches during all phases of the distress cycle: escalation, crisis moment, and following the distressing event.

N1: *Her crying and in between I'd just say, 'it's OK. You're gonna be OK. Just reassuring and then when she did speak, I was just validating what she was saying… I was just listening to her and repeating back to her what she said.*

N2: *Validating what he was saying. Just reflected back and validated, that must be really hard that you are stuck here. Not trying to put words in his mouth but just kind of validating some of the emotions he was having.*

N3: *Yes towards the end I sat in silence. I could see she was very distressed in the beginning. I just sat and talked her through…'you're alright, you're safe.'*

N4: *Bring her back to reality and that she was safe and there wasn't anyone in the room. Like she'd go, 'he's here, he's here'… Just trying to reassure her she was safe.*

N9: *We just did regular 'obs'* [observations] *after somebody has an IM* [Intra-Muscular] *injection… I didn't talk to her about it. I didn't try to engage at all at this point apart from I sort of stroked her hair for a little bit and said, "it's OK'. You're gonna get a little sleepy now and you can just sleep it off'… She looked so exhausted.*

Each of the episodes of distress described above were resolved however; acknowledging feelings was used as a verbal de-escalation intervention in combination with other interventions, rather than as a single intervention.

Nurses described occasions when they provided interventions that were ineffective in reducing or managing the level of distress. In some instances the distress levels escalated resulting in the young people resorting to DSH behaviours to cope. For example, in an episode where a nurse was using levels of observation, reassurance, and grounding strategies for a young person in distress the following escalating behaviour occurred:

N4: *Starting to really scream and then she started to really escalate and started banging her head on the brick wall in her room.*

The nurse explained that head banging was the "next big thing" in regard to self-harm on the unit suggesting this was because the interventions and procedures put in place to reduce the availability of razors and other sharp implements had resulted in the increase in head banging behaviours.

Assertive communication strategies were also commented on by N8. The nurse had found a young person who was attempting to self-strangulate with an iPod cord in the bathroom. The nurse used assertiveness to provide direction.

N8: *I just said, 'you know what? We're not gonna stay, I need to get help. We need to check you out but I'm not going to leave you down here. So you're going to have to come with me because I don't want to have to push my duress alarm or call out and alert the whole ward. So can you stand up?*

While this approach worked and the young person followed the nurse to a room closer to the nurse's station, another nurse in a separate incident used this approach and was unsuccessful. In the first instance (N8) the assertive and directive nature of the approach from the nurse was accepted: while in the second (N9 below) the young person rejected it.

> N9: *I went back in without security and said, 'you've really got to hand over the pencil now. I'm not doing this; it's not a negotiation. I need you to hand over the pencil to me and we're going to work through this in a different way.'*

Once a nurse provided details of an attempt to use limit setting to manage the ward milieu and increasing distress that was resulting in verbal aggression. The patient, and their visiting friends, did not accept the limit-setting intervention.

> N1: *We'd only gotten to asking her friends to leave and that caused a group sort of attack on us nursing staff where racial slur was used... they attacked another nurse that was with myself and said…'What are you even doing here? You don't belong in this country you black bitch!'*

Once the visitors had left the unit the young person's distress escalated, which resulted in the young person verbally abusing the nurse.

A similar incident was reported about an attempt to negotiate with a group of young people, which resulted in escalation of distress and verbal abuse of the staff. The nurse was attempting to get a group who were exhibiting defiant and abusive behaviour to come back inside the unit because it was late in the evening.

> N7: *Trying to get them to come inside so we could shut the courtyard. Trying to remind them about their responsibilities I guess to behave in an appropriate manner on the unit…and trying to get them to calm down and come inside.*
>
> Interviewer: *And what were their replies?*
>
> N7: *[laughs] Bad swear words!*

In addition to the above responses, nurses used the environment to manage risk. One participant suggested that those who have been assessed as high risk, or are well known to staff and frequently distressed, be accommodated in rooms closest to the nurse's station. This close proximity allowed nurses to observe for early warning signs of distress and intervene promptly. In addition to strategically placing at risk young

people in certain areas of the ward nurses also used different levels of observation to manage risks, and provide support. Increased levels of observations were used in both formal and informal ways. One nurse spoke of how a young person who had been on 15-minute close observations the previous night but had ceased that day had attempted to self-strangulate in a bathroom later that evening. The nurse used special observations (constant line of sight) to stay after the DSH event, until she fell asleep, when the nurse initiated 10-minute close observation overnight.

Nurses provided information about their use of increased levels of observations. For example N1 reported, *"I usually tell them, 'Ok I'll give you your space, but I will be checking on you every couple of minutes'".* Nurses used close observations (informally) to manage the ward milieu. In an incident reported by N7, a group of young people were displaying defiant and unco-operative behaviour and stayed out in the courtyard late in the evening despite staff requests to come back in to the unit. Rather than escalate the situation by continually repeating the request, the nurses retreated to the dining area and observed the young people, providing the time and space for them to manage their own distress; once it had resolved the young people came inside as requested.

> N7: *They came in later… because they just weren't listening to us. So we just watched them and they came in a bit later on and none of them actually had any medication.*

Nurses commented on psycho-educational interventions they used such as instructions on deep breathing techniques to manage adolescent distress, reported as a way of engaging and intervening in the patterns of behaviour displayed as the distress increased. One nurse provided a good example when working with one who was hitting the door. This intervention, combined with other verbal de-escalation techniques and therapeutic touch, assisted the nurse to resolve their distress.

> N2: Making sure he was in control of the situation… focussing on little things like breathing… getting him to stop hitting.

Therapeutic touch was widely commented on by participants as an intervention for providing comfort and reassurance. Nurses were descriptive in the ways in which they offered this strategy but some participants also commented on the precautions nurses should take in using therapeutic touch.

N2: *I had my hand on his shoulder… I guess it's difficult. You really need to assess the situation with your therapeutic touch because if you don't know the patient very well or you don't have a very good rapport, some people can take* [interpret] *that… like it's inappropriate.*

N1: Holding her hand until she was ready to talk or putting my arm around her until she was ready… I consoled her by putting my arm around her, holding her hand and when she stated to speak, that' s when I realised I can start asking, 'what can I get you now?'

Nurse participants perceived interventions such as sensory modulation, and in some circumstances *prn* medication as helpful. In the examples provided below, the nurses used sensory modulation combined with other interventions to assist the young people to resolve their distress. Sensory modulation was commented on by a number of nurses with listening to music, and the use of weighted blankets most commonly reported on:

N1: *I also find the iPod is very, very effective.*

N2: *We did manage to get him up and into his room and we used the weighted blanket… I think the day before when he was a little bit upset about something we put the weighted blanket on him; I guess he liked the comfort, the secure kind of feeling of that.*

Nurse participants commented on *prn* medication as both a helpful and unhelpful intervention. From a helpful perspective, nurses believed that *prn* medication was most beneficial when the level of distress was so high that less restrictive interventions would be ineffective, and inappropriate.

N9: *I started to stress… all I kept thinking was now it's gone past the oral medication…. With an injectable drug… I wasn't prepared to go straight to that but I was thinking if she is going to keep doing this [self-harm]… she needed prn of some sort.*

In this example the nurse was able to align the interventions to the assessed level of distress and consider less restrictive interventions in the first instance, but the distress level escalated and physical restraint and IMI sedation were administered.

In contrast to the above situation, one participant spoke of an incident when *prn* medication was offered and declined. This collaborative approach assisted the nurse to

use other interventions such as de-escalation, negotiation, and being present to provide support. The *prn* medication intervention was rejected but the less restrictive intervention was accepted.

Distraction techniques as an intervention were commented on by two of the participants as not being helpful; it was not that distraction techniques themselves were ineffective, but rather the unit resources and opportunities to use distraction techniques that were individually preferred were not available.

> N1: *It's hard at times when one of our distraction techniques is things like going for a walk and obviously the level of risk associated with absconding,* [it] *isn't possible* [to go for a walk]*… we don't even have a punching bag on the ward. How many times when you're young and impulsive and you're angry have you ever wanted to lash out at things… yet we have nothing here… a healthy outlet to lash out with.*

> N1: *We do have a fair few options here on the ward but unless it's the option they're focussed on at the time, they don't use it.*

> N9: *When I came onto the shift and she was a bit agitated… I was trying to think of ways to distract her. So we sat down and said, 'what can we do to help?' and it was, nothing, nothing'.*

6.2.1.4 Controlling approaches and outcomes

Use of the principles of Zero Tolerance to verbally de-escalate and encourage expected behaviour was unsuccessful. Two nurses spoke of Zero Tolerance responses to aggressive and challenging behaviour, and. one suggested this was because nurses had dealt with numerous incidents and this had started to affect the stress levels.

> N6: *Staff are just stressed and taking a sort of Zero Tolerance approach.*

One nurse, who was attempting to manage the challenging behaviours of a patient, and her visiting friends, offered an example where a Zero Tolerance approach was unsuccessful.

> N1: *I reminded that particular patient and the other friends with her that there is a Zero Tolerance policy to verbal and physical abuse. And I was basically told to 'go fuck myself'.*

Nurse participants gave examples of interventions such as *prn* medication and more restrictive measures such as IMI sedation, restraint, and seclusion. In many of the episodes they reported attempts to use less restrictive interventions but were unsuccessful, or where the behaviours displayed were too risky for the less restrictive. These were deemed to be unhelpful because of the reactions, or the nurse's assessment that the distress was not alleviated by its use.

For example, one spoke of when oral *prn* medication was administered felt and produced a paradoxical effect. The agitation levels escalated from the effects of the *prn* medication, and nurses had to use other interventions to manage the distress.

> N8: *She didn't need IMI or… restraint or anything like that. But I think the Lorazepam actually amped her up a bit… we gave her the prn and instead of settling her, it seemed to fire her up more.*

Nurse participants 6 and 10 suggested that a culture existed in the unit of using *prn* medication as a primary intervention without considering less restrictive alternatives; Nurse 10 felt that this is a missed opportunity to enhance patients' coping skills and their ability to cope in the future:

> N10: *So it's actually really important not to drug them to the eyeballs 'cos they're never going to experience distress. They're never going to know how to deal with it… I'm for medication when it's needed but I see it given much, much, much, much, much, much too much.*

The nurse argued that this approach actually hinders the development of the young person's coping and resilience, and in some cases minimised coping skills that were already established.

> N10: *I think most of the time we never give them the opportunity. We are so reactive and so quick to do everything… we don't give them a chance to work through their emotions to actually find some measure of control or work out what they need.*

> N10: *We actually send them home with less than they probably came in with… they probably pick up negative ways of responding and I don't think we send them home with any skills to deal with life. I think it's non-existent what we do for them in terms of helping them take control over their distressing moments*

and thought and actions… I think it's hugely detrimental. It puts back their ability to take control over their lives.

Nurse participants provided examples of administration of intramuscular injections (IMIs), for sedation purposes, combined at times with other restrictive interventions like physical restraint and seclusion. One offered two examples: the first instance, one of absconding from the unit and attempting to run in front of traffic on the hospital grounds. While the restraint interventions assisted to maintain safety in the context of suicidal behaviour, there was further risk of injury due to poor restraint practices. The physical restraint intervention did not alleviate the distress and subsequently an IMI was administered:

> N3: *The casual nurse was trying to hold her… they were all trying to restrain her but not with PMVA* [physical restraint training procedure]*. Three people but they were struggling to hold her… Because they weren't doing proper walking restraint, once she got to the door there was a step and they couldn't get her to come up the step… that would have put a lot of strain on her shoulders and wouldn't have been very secure. It would have felt like she was being manhandled really.*

In the second example the same nurse described two female clients who were experiencing psychotic symptoms and displaying violent and aggressive behaviour. One was placed in seclusion, which only escalated her level of distress. Once an IMI was administered to the second one, the first was escorted from the seclusion room to their bedroom and also given an IMI.

One spoke of a young person refusing oral *prn* medication, and the ensuing escalation of distress:

> N4: *The girl continued to cry and we tried to offer her PRN medication orally. She wouldn't take it… started banging her head more persistently…. She just escalated and escalated and just kept banging her head… really hard. We ended up getting security: we ended up giving her IMI… then when she was being held down to have her IMI she kept trying to keep her face in the mattress trying to suffocate herself. We had to try and keep her head up so she wouldn't suffocate.*

In another incident three young people were fighting. Two female clients had targeted a male patient and a physical fight ensued. The full range of restrictive interventions (IMI

sedation, physical restraint, and seclusion) was used to manage the high levels of distress. The reactions of the young people showed how ineffective these interventions were: their distress was not resolved. There were too few nurses to manage the violence, and the male client and one of the female clients were physically restrained. The other female was able to physically assault the male because she had a 'free shot' because she was not restrained. The initially restrained female client was escorted to seclusion and continued to escalate.

> N5: *You could hear her hitting walls, hitting doors, punching. There were lots of loud noises coming from seclusion, screaming, still swearing… still directed towards the male patient even though he was out of sight*.

Security staff stayed with the adolescent male in the courtyard area, which was locked to prevent the second female client from approaching him. The nursing staff worked with the second female who was walking around the unit, offering her oral *prn* medication because her behaviour was continuing to escalate, placing staff at risk.

> N5: *She was still frustrated that her friend had been placed in seclusion. She was argumentative towards staff… It was then directed by the nurse in-charge to get prn in the form of IMIs… security were needed and she was held… she had the IMI.*

With one of the female clients in seclusion, and the other receiving an IMI, the male client started to escalate in the courtyard. The decision was made to physically escort him to his bedroom and administer an IMI to manage his aggression towards the staff. This intervention had an effect on the female client who was in seclusion.

> N5: *So we actually had to walk him past the seclusion (room) and when we did that, the girl in seclusion escalated… the next direction was that the patient in seclusion also required IMI just because of the level of agitation. Screaming, 'I'm gonna fuckin' kill him'… there was real concern for the male patient.*

The young people in this scenario rejected all interventions offered by the nurses and their distress levels only resolved after the *prn* medication (IMI) became effective. All other interventions used resulted in their distress levels staying the same, or escalating.

After attempting to assist a young person in distress using distraction techniques one nurse later found the her isolating in her room self-harming with a pencil (superficially

scratching her arms). The nurse asserted that all further interventions (of which there were many), were refused to the point where the superficial self-harm escalated to suicidal behaviour as the levels of distress increased, and resulted in police intervention, physical restraint, and IMI sedation.

Controlling and authoritarian approaches were commented on by nurses and were perceived as unhelpful: a nurse reported security was called to provide assistance in a Code Black (Psychiatric Emergency) situation, as the nursing team could not manage the escalating distress, and alluded to using the security team to show authority require to compliance surrender of an implement of self-harm. This approach was unsuccessful and further escalated the situation to the point where police were used to retrieve the potential weapon.

> N9: *Basically I said, 'look we've called security; they're going to be here soon. I don't want to go down this path. I'd really like if you could hand it over without their help. They came in with a bit more firm approach than the nurse in-charge and I were trying to do… she turned around and said, 'if you try to take this pencil off me. If you take one more step towards me, I'm going to kill myself with it'.*

6.2.2 Therapeutic relationships: "Knowing your patient".

Nurse participants commented about therapeutic relationships on numerous occasions. In general terms they spoke of the importance of building a therapeutic relationship and how this made it easier to work with young people in distress. Six of the ten nurses interviewed argued that having an established therapeutic relationship made it easier to provide assistance. Some suggested that reading assessment notes to gain background information then spending time with, and taking an interest in the young person helped to establish the relationship.

> N1: *Love getting to know the young people on the ward and getting to know their talents and what they offer.*

> N10: *Establishing some kind of bond and building on that each time is beneficial to my practice. I would prefer kids I've had before… it makes it easier for them because they don't have to keep telling their story over and over again.*

Nurse participants commonly reported on "knowing your patient" and gave many specific examples where this concept guided their responses and interventions.

"Knowing" preferences for interventions and previous assessments of their reactions to responses often assisted the nurses to provide individualised, person-centred care.

Having a prior therapeutic relationship and knowing their clients assisted them to understand the individual's triggers and early warning signs of distress.

> N9: *She's a patient who doesn't have a very good family… kind of thing going on at home… mum very rarely comes to visit her and ignores phone calls. So I usually go into a shift with a bit of TLC* [tender loving care] *approach with her… going in gentle and give her that attention that she needs and she's craving.*

> N10: *I remember looking in the lounge room thinking they're all pretty quiet just sitting doing their own thing. Which is probably not the most conducive environment for her. She needs distraction to cope with her own feelings.*

Early warning signs were commented on by nurse participants which provided detailed examples where knowing a patient assisted them to provide an appropriate intervention. The most common early warning sign was social withdrawal and isolation.

> N1: *I look for things like breathing 'cos when you're anxious and upset you breathe harder and faster. If they are regulating their emotions they would be breathing slower, their pupils won't be fixed or large, they won't be banging their heads.*

> N4: *She sneaks off to her room and gets distressed… hearing her starting to ramp up crying like hysterical panting and crying. She slinks off... she'll go down to the end of the corridor.*

> N7: *She becomes isolative and irritable and snappy with staff.*

> N10: *She would start pacing… present loud and manic… very friendly over the top and quite giggly.*

> N1: *She would get quite distressed and isolate herself in her room and do some significant self-harm.*

When nurses responded to young people where no therapeutic relationship had previously been established, they were able to use their clinical experience in working with other clients to identify early warning signs to guide their practice. One participant

spoke of a time where social withdrawal prompted observation of a patient who had gone to the bathroom and tied iPod headphone cords around their neck.

> N8: *She disappeared… right down the end* [of the unit]*. New admission; she'd only been in for two days… Maybe only one night. So I just went for a walk down there and then looked through the window and I couldn't see her so I went into the bathroom…she was in the bathroom.*

Nurses provided details about the difference in knowing a patient compared with working with someone where a relationship has not been established.

> N1: *It makes it very difficult in a situation when you don't know somebody…it can be quite distressing when you keep offering them things 'cos you're trying to help…get to know them in 25 seconds of trying to calm them down. You know what works and what doesn't with knowing a patient… like another patient upstairs at the moment when she gets distressed I wouldn't have thought to get her, her journal 'cos she enjoys writing short stories; that's her escape…I would never have guessed that.*

Another nurse who spoke of a time working with a potentially aggressive patient supported those views.

> N2: *I'd still try to approach him but I don't think I could have worked as well with him because I wouldn't have known what to say or what worked well with him… like the weighted blanket…therapeutic touch and things like that. I wouldn't have felt comfortable approaching him and being able to put my hand on his shoulder.*

Nurses stressed the importance of a therapeutic relationships and "knowing your patient", but conceded there were times when no early warning signs or distinguishable triggers could be identified. One nurse mentioned one client they worked with would, *"look fine on the outside but be very different on the inside",* and another nurse spoke of a client who would go from "fine to not fine" very quickly without any discernable triggers or early warning signs apparent.

Nurse participants offered specific responses for different types of triggers for distress for individual clients and spoke of psychosocial issues (e.g. accommodation problems), domestic violence, trauma, flashbacks, hallucinations, parent-child conflict and interactional styles. In regard to interactional style, one nurse stated that one of their

clients would often become upset and distressed if “people keep coming at her with all these questions”.

Participants discussed the importance of therapeutic relationships when distress levels were high, and self-harm and aggressive behaviours were evident. Knowing their patients guided interventions and responses in high-risk situations to keep safe themselves and their client’s.

> N10: *I took a look at her… I’ve seen lots of kids with things around their necks; she wasn’t even purple and she was talking to me. She wasn’t a risk to anybody else… it didn’t warrant restraint…It didn’t warrant a speedy removal of it from around her neck. That was a clinical judgement looking at her and talking to her.*
>
> N9: *She was already so agitated and that’s her coping mechanism and probably her biggest coping mechanism is to go straight to that [referring to DSH].*

Nurse 2 suggested that a positive outcome can enhance the therapeutic relationship and assist in times of distress in the future.

> N2: *I guess it built on our therapeutic relationship because I was able to help him through that without any instances of seclusion or ‘anything negative’ happening. It was positive for me and him in terms of that, we could work through that the next time (if there was one).*

When discussing an acutely psychotic client experiencing paranoid thoughts, a nurse suggested that in the absence of an established therapeutic relationship, an effective handover and reviewing progress notes provided enough information to “know” the young person and help to alleviate the distress associated with psychotic symptoms.

6.2.3 Being present:

Nurses acknowledged the importance of being present with adolescents experiencing distress and suggested that it improves the therapeutic relationship.

> N9: *…it’s taught me to sit with them and be with them.*

N10: *I think a lot of kids are here because they don't feel connected to anyone in the world… so if somebody in their moment of distress can connect with them; even just sitting with them.*

N10: *Look, you hear attention-seeking behaviour all the time. If they're seeking attention by their behaviour it's because they need some help… so. If all you do is sit with them then you've acknowledged their distress… sometimes that's all they need.*

When nurses were consciously present with the young person the interventions offered were thoughtful and often accepted, providing choice and empowerment in a difficult time.

N2: *Then I just asked him as well, "do you want me to stay or would you like me to leave you alone?" I just gave him the option, "I'm happy to stay here. We don't have to talk or anything but I'm happy to stay here while you calm down". So he was in bed with the weighted blanket on. And he said, "Oh can you stay?" He just wanted to sit in silence… about 10 minutes later he said. "You can leave now".*

N1: *I just went quiet for a while and I just sat with her and after a certain amount* [of time] *I consoled her by putting my arm around her, holding her hand and when she started to speak, that's when I realised I can start asking, 'what can I get you now?' It was like she needed to get through that distress herself in her mind but obviously have somebody there to help to keep… I dunno just to know that you've got someone there to feel safe. I asked her if there was anybody she wanted to give a call to? Would she like her phone for music?... it worked out that eventually I had just given her space and was able to help her through that.*

Nurse participants commented on using silence and grounding by verbal commands as a way of letting young people know they were present with them.

N3: *So I stayed with her and just kept grounding her saying, 'It's me. I'm here. I'm not going to go'.*

N8: *Even if nothing changes it will end. So often my role is just to sit there, to watch them, to make sure that they're safe and let them ride out the distress.*

N6: *You don't have to fill every space with words. Sometimes they just need someone to sit with them and be with them and not talking with them.*

N1: *I just went quiet for a while and I just sat with her… a good twenty minutes at least.*

6.2.4 Aligning interventions with the assessed level of distress:

Commenting about the importance of assessing the level of distress and choosing an appropriate intervention to address it, many nurses mentioned taking a moment to assess the situation and consider all factors before choosing how to respond, as N10 talked about a young person who wrapped a rubber band around her neck. The nurse made a decision based on the level of perceived risk associated with the distress to engage and give support to the young person, as opposed to a more restrictive approach like physical restraint to remove the rubber band. This difficult situation was compounded by the fact that other members of the nursing team wanted to call a code black and use restraint.

N10: *I wanted her to respond to me verbally, and she did, and she looked at me and was breathing, and a good colour. I said how about we try and sort it out before we jump straight to doing something like that. They wanted to* [activate their] *duress* [alarms]*, to have the team come to restrain her and take the rubber band off her neck forcibly… she wasn't threatening anybody.*

Another nurse reported using assessment skills to choose increased levels of observations to maintain safety related to a high-risk situation.

N9: *I sort of took a step back. I could see she wasn't trying to hurt herself too badly… I recognised that she wasn't doing too much at that point, [I] went out of the room for a minute and stood at the door.*

N1 outlined the clinical decision making process they use in times where they are working with young people exhibiting self-harm behaviours, like those described above by N9 and N10.

N1: *If they start head banging, scratching themselves, looking for items to use to wrap around their neck and obviously at this point if it was escalating further, and they weren't sort of helping me help them with any interventions* [referring to non-coercive/non-pharmacological interventions]*, I would be offering oral*

medication… if they became a higher threat to themselves… or others, I'd be pulling my cord [duress alarm].

While these examples demonstrate the process whereby nurses assess and select the appropriate intervention, it is important to highlight that other nurses who also used this process make mention of the fact that more controlling interventions are also considered to be the appropriate response at times. One participant (N8) described an episode attempted self-strangulation when a similar clinical decision-making process of assessment was used to choose the intervention (increased level of observations and engagement, but observed that at times this approach would be insufficient and more controlling interventions are appropriate.

N8: *Where* [the] *priority is safety… providing care means restraining the person or giving them medication. Doing whatever you need to prevent any further harm.*

Another participant supported the approach described by N8 above, and they called a Code Black response for an incident of violence that resulted in a restraint, IMI sedation, and seclusion interventions for three of the young people.

N5: *There was threatening words used and physical fists raised in the air at each other. So I pulled my duress alarm.*

In contrast to the above examples, where nurses assessed the level of distress (and associated risks) and offered responses and interventions that were person-centred, congruent and appropriate, some nurses spoke of times where this does not occur: one talked about *prn* medication being the only intervention offered by some nurses to young people in distress.

N6: *There's a cultural… tendency to go for prn far too early or too soon, as the first option rather than down the track…I think for some staff, prn medication is the first line of defence, and certainly patients would report that as well I'm sure. You hear it said that all they do is offer medication.*

6.2.5 Person-centred approach

A person-centred approach was evident in many of the responses provided by participants. The language used to describe the empathy and compassion that underpinned their interventions reflected this approach.

N9: *So I kind of would go in and give her warm towels and things like that… tuck her into bed… let her pick her favourite movie.*

One participant's response was detailed and epitomised the person-centred approach, being present and matching the response and intervention to the assessed level of distress

N10: *So I crawled under the table with her and I just sat with her…I didn't sit too close and I didn't make eye contact. I just sat next to her and just waited a minute or so. And just started talking to her about what was going on and stated the obvious that I could see that something was obviously bothering her and that she felt the need to have a rubber band around her neck… I just sat there really quietly. I didn't rush her. That didn't bother her. It was a case of just taking my cues from her and she was OK with me being there. So I thought OK, I'll sit and I can continue to try and engage her…she was all right with that. And then when I started talking I didn't rush her. It was just about her having time to deal with whatever had caused her to want to put a rubber band around her neck. I just started talking to her about general things… school, and just general conversation, just to try and like 'bring her anxieties down', and not focus on what was going on. Just sitting as though we were having a conversation. She wasn't trying to do anything else to herself. She wasn't hiding it and she wasn't trying to remove it; she was pretty neutral…then when I could tell she was more relaxed and just talking to me about general things then I just kind of brought up about the rubber band and just made my questions a bit more specific and asked if she wanted to talk to me about whatever it was that had distressed her. And then she started telling me things about her family and the things that had been upsetting her at home which were obviously what had precipitated what she was doing. And she said she wanted to end her life and that's why she put the rubber band around her neck. I just talked to her about the likelihood of that happening being very small in the environment she was in… that there were other ways that we could help her with her distress rather than her hurting herself and feeling out of control. I said there's other ways you can feel more in control of what's going in with your life and your emotions at the moment. And so we just talked about some options… she didn't agree to any of it and she didn't disagree. And then she was just talking to me about general stuff. I said, 'look how about we just sit here and talk to you. How about we take the rubber band off. We just said 'do you want to take it off or do you want me to take it*

off?' She just took it off and handed it to me. And I didn't make a big fuss about it or I didn't mention it again because it was in my hands. And then we just talked about life and how she was feeling and general stuff. Just a mixture; It wasn't like a big discussion about poor her and her life and all the rest. It was just general life stuff … how she wasn't happy about being where she was, wasn't happy about her family.

The nurse later commented that other staff wanted to call a Code Black to physically restrain her to remove the rubber band.

6.2.6 Commitment to the safety of young people:

Another recognisable aspect of the nurse's reports of working with adolescents in distress was the persistence and tenacity required for this type of clinical care in the inpatient environment. Despite the challenges that will be described in the next section of this analysis, nurses displayed a profound commitment to supporting adolescents and maintaining their safety. This was most evident in the response from a participant who described the incident working with the young person who was threatening suicide and DSH with the sharp pencil that required police intervention:

> N9: *She said, 'no, I'm going to die tonight.' I actually said, 'not on my shift. You're not doing this tonight. And you're not going to do this while you are in hospital… We're going to actually try to help you'. And her response was something along the lines of, 'you're not helping me: I'm going to die tonight'… From start of shift, probably two hours…actually the police… no it would have been more. I think the police got there just before dinnertime… it was actually about three hours of me engaging with her.*

In describing an episode of care where a young person was attempting to self-strangulate, N8 suggested that at times controlling interventions are required and appropriate, to maintain safety for young people whose actions associated with acute distress put them at risk.

> N8: *Where* [the] *priority is safety… providing care means restraining the person or giving them medication. Doing whatever you need* [to do] *to prevent any further harm.*

6.3 CHALLENGES ASSOCIATED WITH ENGAGING ADOLESCENTS IN DISTRESS

6.3.1 Clinical experience: "Just don't know what to do"

This theme provides numerous examples of the uncertainty of the nurses, young people, and society as a whole when it comes to managing distress. From a social and cultural (community) perspective one nurse emphasised the challenges families, schools, and the wider community have in managing distress and the associated acute risks; and suggested that admitting young people to the unit is viewed as a solution to managing distress, "people just don't know what to do with them. So they come here" (N7).

Some of the nurse participants argued that the nurses themselves were confused and unsure at times what to do or how to respond.

> N9: *I was standing there sort of thinking… what do I say? What do I say?*

> N10: *Sometimes I even question what I do 'cos I think what I do or want to do is so different to what's done by other nurses… And then I question is my way the right way?*

What was clear from some of the responses was that at times even they felt "out of their depth" (N9), and were unsure of how to help. In describing an episode of care where on becoming aware of someone about to self-harm, she discussed her internal response and thought processes at the time, "Oh my God! I don't know what to do here!" (N1). She went on to qualify that she used therapeutic touch as an intervention and the response flinching; she said that at the time she did not realise the young person was in a dissociative state and on reflection admitted to not knowing at that time what dissociation was.

Nurses discussed a lack of clinical experience as being a factor. One reflected on his or her own inexperience in working with someone who was actively inflicting significant self-harm wounds with a razor (pencil sharpener blade):

> N1: With no prior mental health experience…that was visually quite distressing at first to see. I honestly had no idea how to help her at all really.

Another nurse also discussed the limited clinical experience of the nurse in-charge (NIC) of a shift where a serious DSH incident occurred:

> N9: The nurse in-charge…it was her first in charge shift…as soon as I told her she was kind of like, *"Oh! What are we gonna do?"*

The NIC was very supportive and attempted to work with the team on duty to manage the incident. However, the outcome resulted in a need to involve hospital management, security personnel, and police.

Admitting confusion about her understanding of how to assist during violent and aggressive behaviours, the nurse described other people's conflicting opinions of others about consequences, while recognising a punitive approach is not beneficial:

> N4: *We're in a ward where there seems to be no consequences for* [the] *actions of the kids…I know that they can't be punitive but there needs to be a better way of dealing with the occurrences that happen on this ward. I don't know what it is.*

Not knowing what to do was also described concerning the patient's perspective. One nurse argued that in times of acute distress, young people are sometimes unable to process, let alone verbalise, the cause of it.

> N1: *I think when young people are upset they've got so much going on in their head that they don't understand you know, why would I try and tell somebody when they don't understand what they're trying to say themselves.*

One participant described trying to assist a young male client who was experiencing psychotic symptoms (paranoid delusions), and was aggressive, antagonistic, and verbally threatening. The nurse was very detailed in outlining the interventions used, and the rationales for them, but felt less effective assisting young people with other mental health problems such as depression and eating disorders:

> N6: *In bed crying, you can't get them out of bed, can't get them to engage in anything and got no will to do anything. That one I find harder than dealing with the other one* [referring to the aggressive male patient*]…in instances where you've got the aggressive guy you sorta can't back out the door and just leave it alone.*

Nurses directly mentioned that young people were not working with them in times of distress and this was most prevalent at the times when they were aggressive or deliberately self-harming. Only one nurse mentioned this concept in general terms and

reflected that sometimes it felt as if it is “patient versus nurses” and that some were unable to accept the care for reasons such as a poor sense of self-worth:

> N1: *Cos some [young] people don’t want our help…some don’t and a lot do. More do than don’t…. I think that comes with a lot of low self-esteem and having poor support in their life. Not knowing how to accept help as well.*

The nurse further qualified this by relating it directly the subject of her discussion with the researcher as part of the situation, action, and outcome format of the interview.

> N1: *This particular patient was one that didn’t like to have help because I believe she didn’t know how to receive help.*

6.3.2 Significant deliberate self-harm

DSH behaviours were a barrier to working collaboratively with young people. Often nurses talked about the difficulty in removing implements capable of inflicting self-harm and to suggest alternate methods of coping that would be accepted by them. One described trying to use distraction techniques or *prn* medication with someone who was threatening DSH (holding sharpened pencil to abdomen to stab herself), employing negotiation, assertive communication and problem-solving skills. The incident escalated and alternate strategies were rejected.

Seconded by another nurse, N1 described an incident of responding to a young person inflicting serious self-harm wounds with a razor from a pencil sharpener, and the conflicting priorities of being unable to, provide medical care and wound management.

> N1: *As well as trying to soothe her, it’s also trying to get the item away from her to try and reduce further self-harm… I need to get bandages on these and need to clean them up but the level of distress is too high.*

Nurse 8 spoke of responding to an attempted self-strangulation with an iPod earphone cord, and receiving no cooperation:

> N8: *‘If you let go, you’ll keep your iPod cords… If you don’t I’ll cut them’. She wasn’t going to die. She wasn’t hanging…Worse case scenario she would’ve passed out and then would have come loose anyway because she was using her hands to hold them tight…then I jammed my fingers in between them and after a few minutes she let go.*

Once the iPod cord was removed she was receptive to the nurse's instructions and followed her to a bedroom closer to the nurse's station so she could call for assistance without alerting other clients on the ward.

6.3.3 Aggression and violence

Aggressive and violent behaviours were reported as barriers to working together with young people: being exposed to verbal aggression (including threats), antagonistic and defiant behaviours, and aggression against inanimate objects. Verbal aggression was a frequent response when physical restraint and *prn* medication interventions were used.

> N5: *She was secured* [physically restrained] *probably twice and then after that she said, "Fine, I'll stay in my room…just piss off and leave me alone".*

About an episode of care, one participant described in detail the verbal abuse and threats of violence they received from a patient experiencing psychotic symptoms:

> N6: *He was in the courtyard…very agitated and very aggressive, very provocative toward staff in terms of trying to instigate a fight. Just derogatory comments to me and other staff… calling me, "you're a f'n gay prick! You f'n 'cunt'! I'll smash ya like a flea": Verbal threats right in my face, trying to get a reaction out of me.*

If aggression escalates from verbal abuse to violent behaviour then these difficulties are compounded.

Aggression against objects was often reported, such as banging doors, kicking and pushing over chairs, and damaging property:

> N7: What happened was somebody smashed a window in the courtyard and it escalated about three or four other kids…just destroying property… saying they want to get out… a big gaping hole in the courtyard… nobody went out… just destructive.

6.3.4 The unit environment: Physical design and layout:

The physical design and layout of the acute inpatient unit were described in three different ways: the milieu, and procedures and routines, suggesting that it was poorly designed and hindered attempts to manage distress, as expressed emotively by N6:

The physical environment is crap! (laugh). For a building that's allegedly purpose built… it's woeful. I'd love to sit down with whoever designed it and go through the design elements and hear the rationale for it because it's crap!

And again:

N6: If there's conflict between anyone (if you put 12 kids in one room you're gonna get differences of opinion and conflict) especially when you've got unwell kids. There's nowhere else for them to go so they've got nothin' to do but conflict with each other.

About the restrictive nature of the unit in general terms, insights into working with someone who was kicking at the internal entry doors (electronically locked) yelling out to carers who were on the other side of the door in the foyer area. The young person was begging…"don't leave me in here…take me out" (N2).

Finding space to work was difficult, because of limited space, the numbers of people for the size of the area, and restrictions to areas due to property damage -- most notably for the courtyard area.

N8: If someone's distressed and you want to go and have a chat, I find quite often you end up doing it in a bedroom or maybe in the courtyard if you're lucky and it's open! Quite often it's closed because it's damaged… there's risks in terms of broken pavers or broken windows.

And again:

N9: The courtyard was closed at that point due to needing to be fixed…some of the doors. She'd identified that was something that would help her and we weren't able to provide that at the time.

N1: I myself get cabin fever, especially in an air conditioned environment you can't even open a window to get fresh air, let alone sunshine which is required for getting your regular melatonin to regulate your sleep… it just seems like a very artificial environment.

N1: She has been a regular person to come through here… I was asking her what we could do better here when she's upset. She expressed that one of the biggest things that upset her… such a small area with people that are unwell and upset and she's got her own problems. 'There's people screaming, people

banging, there's people spitting or lashing out…it actually makes me worse sometimes being in here'.

6.3.5 Milieu management and adolescent peer relationships

Nurses had mixed views about the appropriateness of adolescents establishing peer relationships. One participant suggested that at times peer relationships were positive and argued that young people would prefer to confide in one another.

> N1: *I often find when young people share their problems with each other and start forming relationships, it can be very therapeutic but on one hand I can find it restricts what they're willing to share with us… I would like my friends…I'm comfortable with. We're the same age. I've only met you* [a few] *times.*

Just as nurses and young people were often not working together in distress, so too sometimes peer relationships are conflictual:

> N5: It was out in the courtyard with several patients when an argument broke out between two of the patients…one of the patients was male…and the two girls were against him teasing him about it [rejection from another girl regarding dating]… he flared up pretty quickly which then escalated.
>
> The nurse went on to discuss the reactions to, and outcomes of this episode. The two females required physical restraint (one was also escorted to seclusion), both received IMI sedation; so too did the male. Security assistance was required and there was potential for all clients, nurses, and security personnel to be physically injured, along with the stress of verbal aggression and direct threats. Afterwards nurses on duty discussed possible management of potential risks of retaliation or further aggression and violence and contacted the male client's parents, requesting they take him on overnight leave because of concerns for his safety. The parents declined, and nurses had to manage the risks overnight.

Some nurses were more specific when discussing environmental effect. Describing the above episode, one nurse said:

> *N5: The environment made it difficult… we had officially one seclusion area but three patients that needed containing for their own safety and for the safety of other patients… having to utilise the courtyard for a second safe area but then having a third patient… on the ward who was sort of aggressive.*

Participants also commented on the difficulties in maintaining privacy for patients:

> *N2: Everyone was gawking at him…already self-conscious of everyone watching him…having all the people walk past.*

> *N9: The nurse in-charge, me, and two security guards at this point… some of the kids were sorta looking in the room.*

The milieu factor most commented on was managing the "contagion effect" for other young people in the environment, that a young person in distress and displaying loud, aggressive, or disruptive behaviour would trigger distress in other clients, and that at times there were not enough resources (staff) to manage both the young person, and supervise others.

> *N2: It's like an overflow effect and if someone's really distressed then the noise and screaming…the crying, or angry… things definitely affect a lot of people especially the anxious ones. They often become distressed and also need… people to be there for them during those situations.*

> *N3: It's very distressing on other patients and I think it's well known that once someone is distressed, it causes a domino effect and that often happens.*

> *N9: I don't even know how to describe it. Things just escalate very quickly… we have kids with violent histories…you find that when one person sets off then another one… like a domino effect.*

Working with a young person whose distress was escalating, N9 attempted to use distraction techniques as an intervention and prior knowledge of the patient to pre-empt the ensuing distress:

> *N9: I had to settle her quite quickly…there were other patients escalating, and she's a type of patient that when people are distressed around her or there's a lot of noise, she immediately builds up… it just frustrates her…no tolerance for other people being upset.*

Having insufficient staff to manage the number of people in distress because of the contagion effect made supervision of the whole inpatient group difficult when a team response was required to the initial distress.

N5: It really was quite a stressful situation and staff felt stretched. Obviously that had a flow on effect with other co-patients and they were in levels of distress… some of them were seeking out, 'can you give me prn; I'm not coping'.

N8: I think towards the end, one of the other patients became quite distressed because of the disruption to the ward… you had to get help from other nursing staff, 'cos I had two that were not doing great'.

During a lengthy intervention for a young person displaying suicidal behaviour, one nurse said another nurse had to take the remaining young people down to the schoolroom (other end of unit) away from the noise.

N9: Being kept in the schoolroom, kind of wondering why, what's going on? Didn't want to heighten everyone else's distress… of course they were all curious. They got quite frustrated down there… one of my patients needed some prn medication to settle.

The nurse who described the positive aspects of peer relationships concurred with colleagues describing an interaction between peers on the unit that was distressing and counter-therapeutic for one of the young people involved.

N1: *She was utilising all these distraction techniques and a friend of hers sat down and just came out with all this negative, derogatory things about other people on the unit, and her day, and her family. Upon observing the other patient I found was getting quite distressed and quite angry about this, 'cos it's nearly like you're dealing with your own problems and taking on somebody else's too.*

One nurse discussed how an unsettled milieu could be a trigger for distress: describing an incident where he or she was mindful of the young person's poor capacity to manage emotions.

N9: *She doesn't have the ability to deal with those emotions or be able to handle the noise around her. It just frustrates her…no tolerance for other people being upset. So I was already quite concerned about that, which is why I immediately tried to give her something to do and distract her from it.*

6.3.6 Unit procedures and routines

Nurse participants spoke of organisational factors in regard to personnel. Staff shortages and not being able to access a doctor (psychiatric registrar) were mentioned as impacting on their ability.

Ward routines were discussed with emphasis on the differences between free time and when the young people were engaged in structured ward activities: one suggesting engagement in ward activities throughout the day distracts them, and once the evening arrives they are tired, have minimal stimulation, and thus time to ruminate.

> *N1: At that time of the afternoon where you know, they've had a big day and they're just starting to wind down and they've got a lot of thoughts. When there's a set structure and routine on the ward kids are aware of what's happening… but come afternoon there's no set activities as such.*

Other nurses supported the views of N1:

> *N6: I think it was just after or prior to morning teatime… that's why there were other kids around. They weren't engaged in another active program… they were on a break.*

> *N8: If we're lucky, there'll be a group (of young people) settling down for some TV… this time of year when the sun's still out, maybe a bit of time on the courtyard. But it's also that time of the day that you might notice that someone's disappeared into their room… It tends to be that time of the day when it's time to settle down that you find people starting to get a bit more distressed.*

> *N10: Straight after morning fruit break… the kids had come out of from school… just kind of hanging around… but it was like a non-scheduled time on the program.*

Nurses commented on clinical tasks, duties, models of care, and policy processes that impacted on their ability to engage, and ward rules by N1 in the context of policy, and unspoken rules.

> *N1: We had a patient who had some friends come and visit and myself and another nurse had noticed that one of her friends had passed on some sharp contraband to the patient… and part of our rules here is you ask them to leave and search the patient.*

N1: Working here for a while now, I guess I think that's just been an unspoken rule. I've never actually seen anything written down anywhere that says that's a rule… it depends who's on I guess at the time.

The nurse was discussing components of clinical practice driven by policy, Zero Tolerance and age of unsupervised visitors (16+), but went on to the ward "rules" governing telephone calls for young people. Nurses suggested different nursing models of care and competing clinical duties impacted on their ability to manage distress, and provide adequate supervision.

Nurses are allocated to care for two to three young people per shift depending on acuity, bed occupancy, and staffing levels. The allocated nurse provides primary care for each young person and would usually be the first to respond in times of distress. One participant spoke of a nurse allocated to patients who required assistance who was also acting as nurse in-charge for the shift:

N1: He was caught up with another patient and he was also the allocated nurse in-charge… it was difficult for him to keep a 'radar' on his patients. I think that was a risk factor in itself. I don't think it is suitable to have nurse in-charge as allocated nurse… especially for high risk [patients].

Nurse 6 provided a different perspective on this clinical problem:

N6: I probably allocated him to myself because he had been aggressive on the unit prior to then.

N5: I'm not doing my job to my allocation of patients but these things… I guess prioritising what needed to be done. It felt like just completely neglecting them but just not having the potential to leave the current situation to go and check in with them.

N10: *It's mainly time… because nurses don't have the time,* [they] *are too busy.*

Patient allocation can provide ethical and moral obstacles for nurses. Nurse 10 suggested that it is difficult at times to watch a client with whom they have a strong therapeutic relationship work with a nurse who does not know that young person as well. They intimated that there seems to be an "ownership" of patients through the use of allocation, which stifles any prospect of teamwork in managing a young person's distress:

N10: *My biggest problem is when it's not my patient and I'm not in-charge…it's very difficult to watch what happens to the kids. A few times someone else has got 'em and I know that other nurse hasn't developed a bond… I would like to intervene… sit with them but it isn't my place because it isn't my patient.*

One participant viewed an aspect of patient allocation in a positive manner in that they redirected a young person who was distressing other patients by discussing her own problems to go and speak with her allocated nurse.

N1: I suggested that the person who was distressing the other patient, maybe have a chat to her allocated nurse… and that it's important that everybody here is dealing with their own things. It's just important to share it with your nurse… we've got access to means to be able to help.

Nurses mentioned competing clinical duties as a barrier to assisting young people in distress; N10 stated, "There's minimal time on the morning shift to actually even spend time with them". During this shift a nurse is allocated up to three clients. In addition to providing direct care the nurse is required to liaise with allied health/medical staff, and with families, provide supervision for the milieu, assist in ward programs and complete documentation.

One nurse had to leave a person in mild distress to go and do other clinical duties, and when they returned the patient's distress had escalated from self-harm to suicidal behaviour and more restrictive interventions (physical restraint and IMI sedation) were required..

N9: I had to go and get another patient some prn medication… I checked on her just before I went. Looked at her, she looked relatively calm. I thought OK, I'll be five minutes and I'll come back and see how she's doing...When I had to go off for medications there was that little bit of me that was concerned leaving her.

6.3.7 Safety of nurses: Professional and physical

Nurses provided insights into the dangerous nature of working with young people in an acute inpatient unit. One argued that the physical layout of the unit provided obstacles for intervening. Nurses do not engage with a young person who is aggressive or violent on their own: this intervention requires a team response. However, if the young person is not aggressive but rather teary, sad, and isolative the nurse would be expected to

engage and provide assistance, but the nurse the nurse reported that many of the bedrooms where young people go to be alone, are not visible to other members of staff (due to ward design). This makes it difficult to intervene:

> N6: *Looking at a personal safety point of view, the only way to do that is going onto a client's bedroom, which really I'm reluctant to do for…allegation reasons. To get someone one-on-one in a quiet space that is observable by others so if there were allegations, other people can say, "nah, I could see what happened". It is really difficult to do because there's not many places to go.*

. Nurses reported times they were exposed to aggression and violence. Many offered examples of when they were put at risk when attempting to provide interventions to manage distress. Exposure to verbal threats of violence, aggression towards objects, physical assault, and being exposed to weapons were mentioned. One nurse described an episode of care in which he or she found a young person in a bathroom in a dissociative state who was inflicting significant self-injury with a razor blade. The nurse shared his or her internal conflict: on one hand he or she spoke of wanting to provide assistance due to the concern associated with the severity of harm, but there was also a personal safety factor and concern that attempts to intervene would place him or herself at significant risk. The nurse spoke of the process of "testing the waters": stepping closer to gauge the young person's reaction, assessing the level of orientation or consciousness (dissociation), and knowing the patient is someone who is not very receptive to care in order to decide whether or not to intervene.

> N1: *I guess I test the waters and because this particular patient was one that didn't like to have help because I believe she didn't know how to receive help…she was at this nearly dissociative state. I stepped into the bathroom…she threatened me with the razor, I knew right… you don't approach.*

He or she went on to qualify there were times when this process was used and they were able to provide interventions, which were accepted by young people.

> N1: *Some patients I'd feel quite comfortable with that. I wouldn't be worried about them coming at me with it* [referring to a razor].

Aggression toward objects was often mentioned. One nurse spoke of a time when using de-escalation skills to reduce the level of distress of one who was standing at the locked unit entry doors kicking at them in an attempt to abscond. The nurse reported, "I

didn't feel safe with him one-on-one". When colleagues supported the nurse forming a team response to the aggression the young person escalated. The nurse then explained the process used to resolve the situation:

> N2: I said to him, *"you're making a lot of noise at the moment…everyone's a little bit frightened for me because I'm sitting with you. So that's why they're gonna stay".*

Participants made several comments suggesting that physical safety was an ongoing concern, one nurse participant said:

> N4: *"I'm more concerned about my safety at the moment. I know this is a job and that we're here to look after young people but I'm really much more aware now of going home safely just after the environment I've been working in over the last six months."*

Similarly another nurse stated, "Let's go with any day of the week really!" (N8). This nurse was also referring to the level of risk nurses can be exposed to. More specifically another nurse spoke of a time when nurses were attempting to assist a young person in distress who was verbally threatening them; "She'd keep screaming…I think staff, including myself, felt threatened by her" (N5).

As described above, the unit's design also impacted nurses' assessment of their own safety. There were times when they were unable to assist a young person because of the threat.

> N10: *I didn't want to speak to her on my own… it's not safe to talk to her on my own… whether she'd be a danger to myself… I needed another staff member.*

> N9: *I was not going any closer than sort of the end of the door inside the room… a few metres away… because I was concerned … I think it was more for myself in a way.*

6.3.8 Emotional impact on nurses

The emotional impact of working with young people in distress was the most widely commented on aspect in regard to nurses' safety. Seven of the ten nurses interviewed provided detailed examples of how this work affected their emotional health, describing their emotional responses as variously, being guilty, distress, hopelessness, anxiety,

feeling overwhelmed, traumatised, and being teary when faced with a situation in which they intervened with young people in distress.

Nurse 9 mentioned it can be distressing to witness the depth of hopelessness that a young person experiences, and how selling hope to them at these times can be difficult. In addition, the nurse highlighted the transient nature of nursing in an acute inpatient unit and not knowing whether the care provided helps the young person in the longer term. Maintaining and portraying a sense of hope in this context can be emotionally taxing:

> N6: *I kinda hope somewhere down the track in the future when they get a bit of capacity to reflect they might think back to that time and say, "That was a really tough time in my life but I got through it and that person helped me".*

This nurse also talked about the distress he or she felt when caring for a young person with an eating disorder who was using the naso-gastric (NG) tube to ligate and attempt suicide.

> N6: *I can remember sitting in a room with an eating disorder patient… who sorta had no will to live and was trying to strangle herself with the NG tube and that was really distressing to see that and work with it.*

Nurses' emotional distress was also commented on by N1 who recalled a time when she witnessed a colleague's hurt following a racial taunt by a group of young people on the unit.

> N1: *They attacked another nurse that was with myself… her* [patient] *exact words were, "What are you even doing here? You don't belong in this country you black bitch!" And therefore that caused the nurse, of course, distress.*

Traumatised and angry were the ways one participant (N3) described the emotional state of their colleague afterwards. Another participant echoed the views of N3:

> N4: *I'm burnt out… I know I'm burnt out at the moment and I shouldn't be I am only a new nurse to mental health but it's such an anxiety provoking… pretty horrific place to work a lot of the time with little support.*

Anxiety was mentioned by N10 who said it can affect their ability to intervene with young people, and may even influence the types of interventions they will choose. The nurse described trying to assist a young person who was attempting to strangle herself

and they also had to manage the anxiety of fellow nurses who wanted the nurse to use *prn* medication as an initial intervention for the young person's distress. The nurse suggested this was more about their colleague's anxiety, than the young person's level of distress:

> N10: *I was on with a couple of nurses I could tell were a bit anxious about what was going on and they wanted to have an intervention straight away. They were looking anxious… their body language… walking around pacing… hands on their alarms… That was two nurses and there was another nurse that I had worked with before who was OK… quite calm and happy to try and sort it out… As soon as you get a nervy, anxious nurse… it tips the whole sense of, 'we can get through this', … it just flips into something that's more dangerous and risky. So I'm always aware of the staff that are around me.*

A nurse described an incident during which they were attempting to provide assistance to someone self-harming with a pencil which he had been given by the nurse to do some drawing but eventually used this as an implement of DSH. The nurse described feelings of guilt, anxiety, concern, panic, and emotional exhaustion.

> N9: *She made eye contact with me while she was doing it… watching for my reaction. Inside I was concerned… feeling guilty because I gave her the pencil… It was quite traumatic for staff… I was actually a bit teary because it was really hard to watch someone actually actively trying to take their life in front of me….the staff were quite exhausted and I was emotionally drained. I wanted to cry, I wanted to scream. I was just so frustrated. Not with the patient, but just with the draining… watching somebody try and do that, for me, was not something I expected to see… you know these kids are so young and to watch such a young kid try to do this was not something that I ever wanted to see.*

Many of the participants spoke of the numerous administrative and clinical duties required following incidents that were described as emotionally, mentally, and physically taxing, indicating that nurses do not get a chance to process or debrief, and that they struggle emotionally at times because of the incessant nature of needing to provide care to young people on the unit who are in distress.

> N3: *I think that's why some people struggle on the unit…it is one stress after another. You haven't got over one incident or stress. It hasn't come back to*

normal; hasn't come back to homeostasis. It keeps climbing and climbing until it comes out in physical sickness… or something like that.

N5: *We sort of went about starting observations… they all had IMIs.*

N1: *After the episode… I had taken her into the treatment room and dressed her wounds.*

6.4 CULTURE

Nurses described culture in terms of the general 'climate' and 'atmosphere' of the Unit. They described different approaches to helping young people in distress; and variable support offered by Unit management, and each other.

6.4.1 Safety in the work environment

Nurses described the hectic and dangerous nature of the inpatient unit that was their workplace.

N4: *My main objective is to get myself, and the rest of the team of nurses home safely; coming home the way we left in the morning.*

N5: *Exhausted… and just completely stretched. Just the classic scenario where I haven't done the best of my ability because of what has occurred and how stretched we've been.*

One nurse, discussing the nature of the milieu, suggested that the young people were traumatised by their admission, and the care they received:

N10: *I see unnecessary trauma to kids that we've inflicted on them…we've let kids down… we've done damage, we've traumatised kids... It's very difficult for me to sit back and watch… trauma happening at our own hands. That's probably what distresses me the most when I go home. What drives me to come back every day is when I have had an opportunity to do something and I've made a difference.*

The nurse in this instance not only commented on the dangerous workplace environment for themselves, but how this and some of approaches used to manage distress resulted in harming young people.

6.4.2 "We are all so different"

Nurses provided examples where the various approaches used by staff could be confusing. They suggested different approaches and rationales for the use of certain interventions. In addition, one nurse commented on how these different approaches impact on young people.

> N10: *I take my hat off to the kids that come in here; they've got to deal with us! We are all so different how we do it. We all respond to distress in different ways… it's really unfair for us to expect these kids to be able to respond appropriately. They've got to try and work us all out and never know who's going to do what to them. They come from environments like that, and that shouldn't be what we give them here. It shouldn't be that way.*

At times, these different approaches resulted in conflict amongst the nursing team about the most appropriate intervention:

> N6: *The other nurse just wanted to call security… I didn't… I was more interested in dealing with the situation. I guess there was some real conflict between the two of us, in how we approached it. Taking the course* [of action] *that was gonna cause the least amount of problems and distress to him, it would have been, in my opinion, more distressing to have security come down and restrain him… potential for injury to someone; either him or staff.*

> N1: *A lot of people here have mixed feelings: if they self-harm you don't go near them. Whereas I'm probably more of a nurturing person… I don't like to see anybody in distress feel like they have to battle through it alone.*

One participant spoke of a time where he or she had to choose an approach and interventions to work with the young person in distress as well as having to manage the other nurses on the team. The nurse identified another colleague who had a similar approach, and asked the nurses who were reactive and anxious to attend to another task- to check on the other clients and remove them from the situation. This allowed the nurse to concentrate on responding to the young person using a person-centred approach.

Comments indicated that the nurses' employment status could be a factor in assisting young people in distress on an inpatient unit. One participant (N3) suggested that a casual nurse who was working on shift might not have had access to the service

aggression minimisation training, and this might limit their ability to identify escalating distress, or manage it effectively.

Participants also commented about the differences in opinion about roles and functions of acute inpatient nurses, in managing distress amongst the nursing team, highlighting the uncertainty about times when nurses were not sure what to do:

> N8: *I think nurses see their role differently… I don't see myself as a therapist. I am not trained in that. I see my job as keeping you safe and helping you to manage your own distress. But if someone's in distress and they can't get themselves out of it, I can't get them out… I don't know if I want to, because they have to learn that the distress is going to end.*

6.4.3 Unit management, and teamwork:

Discussing the concept of teamwork amongst the nurses resulted in varying perspectives. Some nurses spoke about the camaraderie forged while working in the acute inpatient environment.

> N4: *I love my fellow nurses; that's why I come* [to work].

> N10: *I was lucky I had a nurse that I knew would support me.*

While other nurse's spoke of poor teamwork, and conflict between nurses.

> N6: *Yeah there was at the time…* (long pause), *there was a bit of conflict going on because of the vast number of instances we've had.*

> N10: *It's difficult because if the team was working properly… before interventions happened there should be a discussion amongst the staff that are there, but it doesn't happen.*

When describing the episode where three patients were aggressive and violent toward each other and nurses had to use physical restraint, a nurse participant reinforced the sentiments of N10 expressed above. The nurse spoke about an instance when a colleague did not provide assistance during the physical restraint, thus putting another colleague in immediate danger.

There were times when other staff members worked with nurses to provide interventions for young people in distress. Hospital security personnel assist Unit staff

when they respond to a Code Black psychiatric emergency. One nurse provided an example of when these staff did not work cohesively:

> N4*: I had a security guard comment over a patient, 'this is ridiculous. We shouldn't be in this restraint for this long'. I asked him to leave the restraint because he was really inappropriate… like it was a bad situation; he just made it worse… I mean what could we do? The kid was out of control, hurting herself… she needed more medication and we had to wait for it.*

There were positive and negative comments about managerial support. One participant commented on the contrast between managerial approaches on this unit, compared with another acute adolescent inpatient unit where they had worked previously.

> N3: *The thing that stood out in my mind is, we had management walking up and down, looking in the room, which was very distracting for me. I found that very distracting; looking in and demanding that [the young person's] nurse be in there and not me. Despite the fact that* [the allocated nurse] *was distressed... When I was on a different unit… it was always handled. That is what has shocked me since I've been working here because our* [former] *boss… she would come to work and say, "you guys done a great job keeping everybody safe. Would you like to talk about it now? We'll make time for a formal debrief."*

> N3: *On an afternoon shift it feels like we're hung out to dry really… I said to the person in charge, "ring the PECC* [Psychiatric Emergency Care Centre] *manager'… This is a situation where we need them. I think she rang and told them, but they weren't willing to* [come]*… I've often as a nurse in charge rung them and they say, "what do you want me to do?"*

In contrast, two participants spoke about the positive support offered by management in regard to episodes where they had been involved in providing care for a young person in distress.

> N4: [Manager's name] *did follow it up with me. I think because it occurred over a patient and they asked me what I wanted to happen.*

> N9: *Before the police got there, we had the Nurse Manager of the hospital come down. We had someone from the surgical team come down.*

6.4.4 Influence of unit culture on clinical decision-making

Many participants provided examples of the unit culture and the influences of their peers impacting on the way in which they responded to young people in distress. A culture of 'ownership' over the young people who the nurses are allocated to, was evident in the unit.

> N10: *My biggest problem is, when it's not my patient and I'm not in-charge…it's very difficult to watch what happens to the kids. A few times someone else has got 'em and I know that other nurse hasn't developed a bond… I would like to intervene… sit with them, but it isn't my place because it isn't my patient.*

Nurse participants 6 and 10 suggested that a culture of using *prn* medication as a primary intervention without considering less restrictive interventions existed on the unit. Nurse 10 suggested that this practice is a missed opportunity to develop the young person's coping skills and their ability to cope in the future:

> N10: *So it's actually really important not to drug them to the eyeballs 'cos they're never going to experience distress. They're never going to know how to deal with it… I'm for medication when it's needed, but I see it given much, much, much, much, much, much too much.*

> N6: *There's a cultural… tendency to go for PRN far too early or too soon as the first option rather than down the track…I think for some staff, PRN medication is the first line of defence, and certainly patients would report that as well, I'm sure. You hear it said that all they do is offer medication.*

> N10: *A lot of people* [nurses] *expect a quick resolution to distressful situations… there's a sense of shoving things down quickly for the safety of, not only the staff but the other patients and the child themselves… If they're allowed to work through the things they take little baby steps forward, but as soon as you get a staff member on, that practises that old way that's really reactive, it's like they take 10 steps backwards and the next time they're in trauma they can't cope.*

> N10: *I wanted her to respond to me verbally and she did, and she looked at me and was breathing and a good colour. I said, "how about we try and sort it out before we jump straight to doing something like that". They wanted to duress, to have the team come to restrain her and take the rubber band off her neck forcibly… she wasn't threatening anybody.*

N10: *I was on with a couple of nurses, I could tell were a bit anxious about what was going on and they wanted to have an intervention straight away. They were looking anxious… their body language… walking around pacing… hands on their alarms… That was two nurses and there was another nurse that I had worked with before, who was OK… quite calm and happy to try and sort it out… As soon as you get a nervy, anxious nurse… it tips the whole sense of, 'we can get through this', … it just flips into something that's more dangerous and risky. So I'm always aware of the staff that are around me.*

These descriptions suggest that nurses who felt unsafe and anxious in the workplace were influenced by these feelings when making clinical decisions.

Nurse participant 6 described having to minimise the type of restrictive interventions used for a young person experiencing psychotic symptoms, and to negotiate with him to take oral *prn* medication:

N6: *One of the other female staff ('cos we've had a number of incidences of aggressive clients and some pretty serious incidents of self-harm and stuff on the unit) had a pretty low tolerance for it and was just wanting to pull the cord and go code black, get security down, basically IMI him. We were trying to get prn medication (oral) into him but again there was paranoia around the medication… The female staff member was, 'what are we buggering around with this for? Just IMI him!'*

6.4.5 Environment: Climate and atmosphere

The impact of unit culture on clinical decision-making and teamwork, as described above, promotes a 'climate' and 'atmosphere' in the unit that is not conducive to helping young people further develop coping skills, recovery, or a therapeutic space. The environment and the overall dynamics of the unit based on these principles, adds to the difficulties of responding to adolescents in distress. The ward 'climate' is affected by the conflict between nurses who practice according to a person-centred framework and those who use a controlling and restrictive approach. The result of such conflict diminishes teamwork for nurses. It also causes confusion for young people who have to consider variable approaches from each nurse caring for them.

Nurse's responses when they recognise adolescents in distress are absolutely critical to their successful engagement and subsequent clinical decision-making in this environment. The data presented in this chapter clearly identify many episodes where

nurses who were quick to adopt controlling and restrictive interventions encountered resistance and a poor reaction from young people in distress. Nurses who were validating, empathic and used a person-centred approach to establish and maintain therapeutic interactions often elicited positive reactions (acceptance) from young people and would work collaboratively to help them resolve their distress. The existing unit culture was not always supportive in achieving therapeutic outcomes for young people in distress.

6.4.6 Conclusion

In this chapter I have discussed in depth the major themes: Promoting engagement; Responses and interventions for managing adolescent distress; Challenges associated with engaging adolescents in distress; and Culture. Further content and understanding was provided by the sub-themes derived from analysis of data from nurses about their interactions with adolescents in distress on an inpatient unit. The next chapter places these findings in the context of other data and literature, evaluates the achievement of the study aims, identifies study limitations; and makes recommendations for clinical practice, education and further research.

Chapter 7 Discussion

This chapter will discuss the key elements of the findings and revisit the research questions and researcher assumptions. In addition, methods employed to maintain trustworthiness and rigour, and the study strengths and limitations will be described. Recommendations for practice, organisational change, and education and research will be provided. The chapter will conclude with a summary of how the research project has changed clinical practice in the unit at the centre of the study.

7.1 INTRODUCTION:

For adolescents, the mental health inpatient environment can be a place of respite and recovery, a shield from the stresses of everyday life. An admission to an acute mental health inpatient unit offers an opportunity to enhance the recovery process in a therapeutic environment. According to (SANE Australia, 2014) recovery from mental illness is defined as “a process by which people regain hope and move forward with their lives with or without the symptoms of mental illness” (p.5).

Conversely, it can be chaotic and dangerous, and disconnect young people from their community support networks (Beckett et al., 2013; Kaplan & Racussen, 2012; Muir-Cochrane, Oster, Grotto, Gerace, & Jones, 2013). Based on the principles of least restrictive care (NSW Government, 2007), an admission to an acute inpatient unit should be the last option, and by definition the adolescents admitted to acute inpatient units are likely to be the most complex mentally ill, or disordered group of adolescents with mental health problems. This is an important point in terms of determining the appropriateness of any ‘nursing response’ to such a level of complexity.

Three conceptual frameworks will guide this discussion: 1) the Recovery Model, 2) Protective Empowerment (Chiovitti, 2011), and 3) the principle of least restrictive care in accordance with the *NSW Mental Health Act* (NSW Government, 2007). The Recovery Model framework will be used to guide the discussion because of the centrality of person-centredness in the interpretation of my findings. Principles of the Recovery Model include personal recovery and well-being for the individual, delivering evidence based practices that are supported by strong therapeutic relationships, and partnership (MIND, 2012). The goal of an admission to an acute inpatient unit for an adolescent is to provide a safe environment for stabilisation, and to commence the

recovery process. Nurses must develop awareness of, and adopt a recovery-focused model of care with the adolescent (and family) at the centre.

Protective Empowerment is an opposing concept that can guide nurse's responses and interventions when assisting adolescents experiencing distress. The empowerment end of the continuum supports the principles of recovery and aims to facilitate autonomy, personal decision-making and partnership. At the other extreme, protective principles are more controlling and restrictive, potentially more directive or coercive in nature, and are aimed at minimising risk and ensuring safety (Chiovitti, 2011). Lastly, the principle of least restrictive care is used to outline the continuum of nursing interventions (Figure 1) involving options from person-centred to controlling/restrictive interventions.

The Australian College of Mental Health Nurses (ACMHN) recently released their Core Values for specialist mental health nursing practice (Australian College of Mental Health Nurses, 2016). Nurses working in a specialist area such as child and adolescent mental health inpatient units need to align their thinking and practices to accord with these values and the principles of recovery, and as (Santangelo, 2015) describes, offer:

> *"Care that is collaborative, co-constructed with the consumer and their family, and as a consequence, committed to a recovery approach that results from the special way in which nurses view, relate and respond to an individual's needs" (p. 194).*

Contemporary values and principles should guide nursing responses and interventions for adolescents experiencing distress, to aid their recovery by empowering them to further develop resilience and skill in recognising and adopting strategies that work for them in distressing situations. However, a nurse's ability to provide safe and effective care can be influenced by contextual factors associated with the setting, and the prevailing culture within the unit. Nurses should consider how these issues affect their responses and interventions for young people in distress.

7.2 ACHIEVEMENT OF STUDY OBJECTIVES

The primary research question and all but one of the research objectives outlined in the research design section were achieved. Objectives 6 and 7 were unable to be

answered due to difficulties recruiting young people for interviews. This study limitation will be discussed further in this chapter. The following discussion will integrate the findings in relation to the research question and provide insights into each of the study objectives.

7.3 RESEARCHER ASSUMPTIONS REVISITED

Assumptions made by the researcher prior to the commencement of the literature review and data collection were documented. These assumptions were provided to enhance the trustworthiness of the study by reducing researcher bias. Prior to discussing the research question and objectives a review of the researcher assumptions was considered (Appendix 17).

7.4 THESIS STATEMENT:

My thesis statement summarises my findings and I will expand on this further in the chapter:

> The complexity of clients admitted to acute child and adolescent mental health inpatient units presents major challenges for nurses. Nurses have to build therapeutic relationships with adolescents, and are first responders to distress that may escalate into dangerous behaviour, including deliberate self-harm, suicide attempts and aggression. A range of interventions, used either singularly or in combination, was observed and described by nursing participants to be effective in alleviating this distress. However, the response by the nurse during the initial interaction that precedes a chosen intervention is the most crucial factor. Maintaining a person-centred nursing presence to select the best initial response in an effort to engage with the young person is paramount. This ‘connection’ established with the adolescent, allows the nurse to guide solution-based interventions, a feature of therapeutic care that enhances stabilisation and starts the recovery process.
>
> In addition to the person-centred approach of the nurse, the physical environment and unit culture influences the young person’s capacity to feel safe and secure. A therapeutic environment and community empowers young people to be active agents in their recovery.

7.5 NURSING RESPONSES AND INTERVENTIONS USED TO MANAGE ADOLESCENT DISTRESS

The following discussion presents a synthesis of the findings in both data sets. This enabled greater ease of interpretation of the data. These were complex clinical situations for the participants. Nurses' responses and interventions to adolescent distress demonstrated the levels of complexity in the situations they were facing. Consideration of the observational data, semi-structured interview data and relevant complementary literature will identify new insights and enhance knowledge of this clinical practice. Personal reflections are also documented in this chapter.

To understand how nurses responded to adolescent distress on the acute inpatient unit the following question guided the study:

> *What responses and interventions do nurses perceive are most helpful during episodes of adolescent distress on an acute mental health inpatient unit?*

Other subordinate questions aligned with the research objectives discussed in this section include:

- *What are the most appropriate and helpful responses?*
- *What interventions appear to be the most helpful/therapeutic?*
- *Are young people with mental health problems and nurses working together effectively in times of client distress?*
- *How does the setting influence nursing practice?*

Interpretation of the types and outcomes of responses and interventions nurses used to help adolescents experiencing distress will be presented. I will then reconceptualise interpretations of the major findings that underpinned the way in which nurses delivered or provided these responses and interventions: Current models of care will be used as a basis for comparison.

7.5.1 Types of nurse responses: Person-centred versus controlling/ restrictive.

It is important for nurses to understand how their initial response to adolescent distress can impact on their willingness to accept care. The TAR^3 Model (Figure **3**) demonstrates that the nurse's initial response causes a reaction from the adolescent

indicating whether the young person accepted or rejected the offered care. When adolescents rejected the nurse's initial response it would often result in an escalation of distress.

Nurses whose initial response and subsequent interventions were person-centred were observed to engage the young person experiencing distress in a collaborative manner and focus on finding solutions to alleviate their distress. They would often use reflective questioning, or silence and remain with the young person in an effort to allow more time to gain information about how to proceed and support the young person. In addition, these nurses would often offer a range of options to the young person and create opportunities for the adolescents to make their own decisions about their care.

Nurses who used person-centred initial responses, such as empathy and acknowledgement of feelings, reported seeing reactions from the young person such that they were willing to consider the intervention that would be offered next. Validation is a key interpersonal communication skill that assists people who are emotionally sensitive and in distress. Marsha Linehan, who developed Dialectical Behaviour Therapy outlines six levels of validation: Being present, Accurate reflection, Guessing what others might be feeling, Understanding behaviour in terms of history and biology, Normalising emotions, and Radical genuineness (Hall, 2012).

The mental and emotional aspects associated with nursing adolescents experiencing acute distress can be challenging. Despite difficult clinical situations these nurses were able to maintain a presence with an adolescent, provide reassurance and let them know they are not alone during the episode of distress. Sharing thoughts through reflection and showing awareness of the young person's emotional state acknowledges the young person's difficulties. The nurse assists them to become more aware of their use of language about different emotions. Normalising behaviours and understanding what is driving them are ways in which nurses externalise the behaviour and not take it personally, especially in regard to aggressive behaviours such as swearing. Distressed adolescents require consistent genuine interactions and nursing behaviours to feel secure. Incorporating Linehan's principles of validation into their practice provides the child and adolescent mental health nurse the capacity to support and care for young people who experience distress on the inpatient unit.

Conversely, nurses who practiced from a more controlling and authoritarian approach were observed to respond to distress in the first instance by being directive, instructing the young people in a way that did not show a willingness to partner with them in

decision-making. These nurses were observed to spend less time engaging with the young person and would initiate interventions that were more restrictive.

Nurses who used a controlling or authoritarian type of initial response, and did not consider and/or practise the collaborative principles of recovery (such as empowerment, partnership and autonomy), elicited reactions from adolescents that were rejecting in nature. These reactions increased the likelihood of the young person's distress escalating, and thus the possibility of controlling interventions. Nursing attitudes and practices associated with control promote a culture where patient needs and input are not considered, and non-person-centred interventions are accepted as the norm (J. E. Hall, 2004). Some nurses were able to recognise through critical thinking that the reaction from the young person was one of rejection and adjusted their response until a working relationships was established. The overarching culture of the unit can influence the nurse's responses and interventions. This will be discussed further in relation to the impact of culture on nurse's clinical decision-making, their ability to work together, and the overall 'atmosphere' of the unit.

7.5.2 Interventions: Nursing practices

Interventions employed by mental health nurses to engage with, and provide care for, young people experiencing distress (and associated behaviours) can be represented on a person-centred-coercive continuum, as described by the nursing intervention continuum (Figure 1). Findings from both phases of this study suggest that nurses use different interventions combined with different levels of observation (routine, close, special and constant) consistent with the assessed level of distress. The NSW Health restraint and seclusion policy (NSW Health, 2012a) dictates that a young person should be under constant observation during an episode where physical restraint and seclusion is used to manage dangerous behaviours associated with high levels of distress such as violence, aggression, and significant deliberate self-harm. However, in addition to these formal practices, nurses would make assessments of a young person's distress level and would change the timing of their observations to complement their responses and interventions in accordance with the assessed level of distress. This would assist the nurse to make clinical judgments and assess over time how their responses and interventions affected the young person's level of distress.

When assisting young people experiencing distress on the acute inpatient unit nurses used numerous interventions. They often used combinations of interventions, however

at other times a single intervention was sufficient. All interventions used or described by nurse participants in this study were ultimately effective in reducing distress. Factors related to the clinical setting, broader systematic influences and the overarching unit culture also impacted on the nurse's ability to respond to adolescents experiencing distress.

7.5.2.1 Engagement and psycho-education:

Engagement constitutes a purposeful interaction whereby the nurse uses communication strategies and a nursing presence to engage with a young person. (Finfgeld-Connett, 2009) suggests that engagement must be "authentic" (p. 533) and that nurses aim to make a person-to-person connection with the client. This allows the nurse to tailor the interaction in an effort to distract them from their escalating distress, and offer interventions for self-regulation. Psycho-education follows engagement and allowed the nurses in this study to impart information, ideas, and instructions to assist the young person to alleviate their distress. Psycho-education is aimed at providing specific information to improve health outcomes and can include diagnostic, symptomatic, treatment related education so people are able to understand their illness better. Additional information may include details about prognosis, and relapse prevention (Australian Psychological Society, 2010). Psycho-education is a recovery-focused intervention that requires active involvement from the young person. Recovery-based principles such as goal attainment, improving life satisfaction, learning and enhancing global functioning underpin psycho-educational interventions (Griffiths, 2006). It is imperative that a collaborative approach to psycho-education is maintained: this is achieved through collaborative engagement with the young person.

Nurses in this study provided information to adolescents about individualised early warning signs, coping behaviours, problematic or maladaptive behaviours, mindfulness exercises (deep breathing), and distraction and soothing techniques as psycho-educational interventions. These interactions also provided opportunities for young people to build on their understanding of their disorders in the longer-term, enhancing recovery. (Griffiths, 2006) suggests that the qualities of the clinician leading the psycho-education intervention have an impact on information uptake. He states that a clinician should, "…hold the belief that those with mental illness can learn and absorb information, and that they can have the potential to live more productive lives… communicate hope and the belief in the potential to grow and change" (p. 23).

7.5.2.2 Sensory modulation:

Nurses often suggested specific self-soothing techniques and sensory modulation tools and strategies especially where the nurse 'knew' the young person's preferences. Sensory modulation is used as an intervention to help "regulate the degree, intensity and nature of responses to sensory input" (Chalmers et al., 2012, p. 35), to reduce agitation and prevent aggression. The use of sensory-based tools and safe, low-stimulus environments help young people to reduce their distress. (Chalmers et al., 2012) suggest that the best way to know and use individualised sensory-based strategies is through the completion of "personal safety plans" (p.36).

Individualised 'calming plans' were introduced during the study period to identify a young person's baseline adaptive coping behaviours and strategies. Many of the responses young people could choose from on the calming plan are associated with sensory modulation techniques. Showering as a sensory intervention was a common suggestion made by nurses during the observational component of the study. Nurses commented on therapeutic touch and weighted blankets in the interview phase of the study as a key sensory modulation strategy for those adolescent's whom they knew had responded well to these in the past, or who were accepting of these strategies. Trauma-informed sensory modulation tools and strategies include the use of weighted blankets and therapeutic touch, and these options were commonly observed or commented on during the study period. In particular weighted blankets and therapeutic touch have been shown to reduce levels of agitation and distress (Champagne & Stromberg, 2004). Despite the evidence-based indications for therapeutic touch nurses are reported to be reluctant to employ this as an intervention (Gleeson & Higgins, 2009). However nurses in this study provided examples of how and when they used therapeutic touch, many of them suggesting that this intervention is appropriate when a strong therapeutic relationship had been established.

One of the difficulties in using some of the sensory-based strategies in the acute inpatient unit is the availability of the tools. For example, listening to music is a common sensory-based strategy however young people are unable to access their mobile phones on the unit where their individual music preferences are often stored. The unit purchased a number of iPods to counteract this problem but young people may be reluctant to use them due to the choice of music.

Sensory modulation offers an alternative approach to affective and behavioural regulation that psychotropic medication and psychological therapies are unable to match. Psychotropic medications and their use and effectiveness, can vary from

individual to individual (Warner, Koomar, Lary, & Cook, 2013). Psychological therapies are effective only if young people have the required cognitive ability and are regulated at the time. Verbal de-escalation strategies rely on 'top-down' cognitive engagement with adolescents (Warner et al., 2013). During times of acute or moderate distress the young person's ability to think is diminished, reducing the ability to use these psychological approaches. However, affective dysregulation is the domain of the emotional centres of the brain (Sutton, Wilson, Van Kessell, & Vanderpyl, 2013). Sensory modulation strategies aim to establish regulation of the affective and behavioural domains by minimising the impact of neurobiological hyper-arousal (Warner et al., 2013). These strategies help young people in distress, especially those with a history of trauma, to regulate their behaviour and are used in conjunction with psychological approaches once the young person's arousal state has decreased (Warner et al., 2013).

The unit's sensory room was infrequently used because of its location away from the nurses' station and common areas. This impacted on the young people and nurses' willingness to use it as an option. Nurses were often observed not providing supervision or encouraging its use and spent little time educating young people about the tools or benefits of sensory modulation. In contrast (Chalmers et al., 2012) reported use of the sensory room was supervised by staff and set up with the individual sensory preferences of the young person based on the safety plan.

7.5.2.3 De-escalation:

De-escalation, as an intervention, is the tipping point between person-centred and more controlling and restrictive interventions, and the use of de-escalation was observed and commented on by nurses in this study. Aggression minimisation training programs that incorporate de-escalation skills training have been shown to reduce the use of more controlling interventions such as seclusion and restraint (Calabro, Mackey, & Williams, 2002; Cowin et al., 2003; Laker, Gray, & Flach, 2009). Person-centred approaches when employing de-escalation strategies include negotiation, problem solving, empathy, and active listening (Martin, Keieg, Esposito, Stubbe, & Cardona, 2008; Price & Baker, 2012). However, communicating direct instructions, limit setting and outlining expected behaviours as a de-escalation strategy are more controlling in nature (Finfgeld-Connett, 2009; Maguire, Daffern, & Martin, 2014).

A model of therapeutic and non-therapeutic responses to patient aggression was developed by (Finfgeld-Connett, 2009) who conducted a meta-synthesis on the nursing management of inpatient aggression. She suggests that aggression escalates initially

when needs are unmet and as the distress increases their ability to communicate diminishes. Furthermore, she suggests that “signals” displayed by the patient are “confusing” (p. 532) and the nurse must know the individual’s patterns of escalating behaviour. Findings from the interview component of this study support the work by (Finfgeld-Connett, 2009) where nurses argued for the importance of knowing your patient. Furthermore, observation findings from this study also signify that coping and help-seeking actions are key clinical indicators or early warning signs of escalating distress.

Responding to young people experiencing distress requires specialised skills and knowledge. (Finfgeld-Connett, 2009) suggests there are two styles of therapeutic responses to patient aggression, intuitive and emergent. Intuitive responses are embedded in key interpersonal communication skills of the nurse and their ability to effortlessly weave the salient and appropriate intervention into the interaction. The other response, the emergent type, is grounded in the nurse’s critical thinking and knowledge where nurses assess and respond in a calculated way based on previous clinical experiences and education. The findings of this study draw on both styles of therapeutic responses offered by (Finfgeld-Connett, 2009), whereby nurses who “know” the young people they are working with, will use intuitive responses. In contrast, nurses who are providing responses and interventions during times of distress for an adolescent they have not worked with before, use the emergent style. Nurses at this time will use previous clinical experience, and diagnostic and developmental assessment information about the young person in lieu of ‘knowing’ them.

7.5.2.4 *PRN* medication:

The use of *prn* medication as an intervention for behavioural control and symptom reduction is widely used in mental health inpatient settings. Results from a number of studies have argued that the use of *prn* medication for children and adolescents is used excessively, often not indicated, or a less restrictive intervention is not considered (Dean et al., 2006; Dean, McDermott, & Scott, 2009; Thapa et al., 2003; Winterfeld et al., 2009). In contrast, (Petti et al., 2003) surveyed children and adolescents (n = 42) who were the recipients of *prn* medication. Results from their study show that young people believed that *prn* medication was the right intervention at the time in 50% of cases. However, 30% of the sample indicated that other alternatives were not offered.

Inconsistencies in regard to the use of *prn* medication, like those reported in previous studies (Dean et al., 2006; Dean et al., 2009; Winterfeld et al., 2009) were observed and commented on in this study. At times it was used by nurses according to the

assessed levels of distress displayed by the young person. That is, *prn* medication was used in times of acute or moderate levels of distress as either part of a combination of interventions, or singularly. However at other times it was used for mild distress as a first line intervention. It appeared that nurses who used *prn* medication in this manner did not conduct appropriate assessments to ascertain the level of distress, and used it as an intervention without consideration of less restrictive options.

There were times where nurses gave *prn* medication after collaborating with the young person (person-centred approach), while at other times it was a controlling intervention. Oral *prn* medication was the only type of administration method used by nurses during the observation phase of the study. However, the interview participants spoke of both oral and intra-muscular injection (IMI) administrations of *prn* medication possibly because the researcher was able only to observe episodes of distress that ranged from mild to acute, while interview participants spoke mainly about times working with adolescents where distress levels were moderate or acute in nature. A comparison and examination between the two data sets indicated that some nurses' use *prn* medication as a frontline intervention, while others use it based on the assessed level of distress. Interview data provided examples of this clinical issue when two participants (N6 & N10) spoke of a time where they had to argue with colleagues to minimise the use of *prn* medication.

There were some contrasts between what the nurses did after administering *prn* medication for the two data collection methods. It was observed at times that nurses would administer medication to young people and directly following this, walk away from them. On one occasion this withdrawal of the nursing presence was the key catalyst for escalating distress. Both oral and IMI medication require time between the administration point and when it becomes effective, it was surprising that nurses were observed to walk away from young people immediately following administration. In contrast nurse participants spoke often of staying with adolescents for who they administered *prn* medication, irrespective of administration route. (Duxbury et al., 2010) conducted an observational study and reported that nurses were poor at monitoring the effectiveness for the medication they administered to clients. The authors also indicated that the provision of information regarding the medications they were giving, and the attainment of consent was also very low. In one of the observations for this study the nurse did not collaborate with the young person, provided minimal information about the medication (desired effect or indication for use), and relied on

implied consent. The observation was consistent with the findings reported by (Duxbury et al., 2010).

7.5.2.5 Seclusion and Physical restraint:

Calls to have seclusion and restraint practices eliminated from mental health settings have been the focus of consumer groups, governments, and health services (National Mental Health Commission, 2014). The restrictive practice of physical restraint is most commonly used as a nursing intervention to manage aggressive and other problematic behaviours (including DSH), however it is known to be traumatising for young people, especially those with a history of physical and sexual abuse (Day, 2002). It seems counterintuitive that nurses would use interventions in the inpatient unit that are shown to be harmful, traumatic, non-effective, and non-transferable to the home environment. Nurses use physical interventions (restraint) to manage violent behaviour exhibited by young people and this use of force does not teach young people to manage aggressive or violent behaviour (Dean et al., 2007).

Using physical restraint as an intervention to manage aggression and violence poses ethical and moral conflicts for nurses. When considering the concept of protective empowerment offered by (Chiovitti, 2011) nurses are faced with the dilemma of assisting the young person to regain control of their behaviour without the use of coercive interventions such as seclusion and restraint, while at the same time protecting them (and others) from serious harm. (Bonner, Lowe, Rawcliffe, & Wellman, 2002) argue that the nurse's anxiety and the unit environment influences their decision to use restrictive interventions, as opposed to other empowering options. Interview participants in this study spoke openly about managing their anxieties (and those of their colleagues), working in stressful and difficult situations, and the poor design of the unit, all of which has the potential to increase the use of physical restraint.

Only one episode of distress involving physical restraint was observed in this study. This incident occurred when two young people required physical restraint for displaying absconding and aggressive behaviours. While physical restraint was used to manage these behaviours for each of the young people, in conjunction with de-escalation techniques, two different reactions occurred. One young person became combative and assaulted a nurse, while the other was somewhat accepting of the ensuing *prn* medication and de-escalation interventions. Incidents where nurses are injured as a result of restraint use increases the likelihood of its use if anxiety levels are not managed when they are exposed to similar clinical experiences. Injuries to staff increase the chances of burnout and recruitment and retention problems (Hsu, Chen,

Yu, & Lou, 2010; Jenkins & Elliott, 2004; Winstanley & Whittington, 2002). Despite the chances of physical injury and psychological trauma for nurses involved in the use of restraint, many of them see it as part of their job (Bigwood & Crowe, 2008), for providing a safe environment for clients and others.

Training packages to enhance the safety and effectiveness of physical restraint and seclusion practices, in conjunction with policies and procedures, allow nurses to conduct a co-ordinated response to violent and aggressive behaviours. Patient injury and traumatisation still occur irrespective of the efficacy of training programs designed to minimise them (Delaney, 2006a). Despite clear policies and procedures, and annual mandatory training for nurses in the health service where this study took place, nurse interview participants spoke of times where incorrect physical restraint techniques, practices, and procedures were implemented.

Seclusion is the most coercive intervention nurses can use and should only be used when acute distress manifests in behaviours that are violent or where aggression has the potential to place others at immediate risk of harm. Overarching state-wide and local health service policies guide the procedures for the use of seclusion on the Unit. For the one episode of seclusion that was observed in this study the young person assaulted a nurse during the physical restraint (escorting) of the young person to the seclusion room. When the young person was secluded she initially became further distressed; however over time she became calmer and was subsequently let out of seclusion. Nurse interview participants commented on episodes of care where they used seclusion to manage violent behaviours and also suggested that young people did not react well to this intervention, with escalation of distress evident. In many instances, young people see the use of seclusion as unnecessary and forceful (Steckley & Kendrick, 2007). Their perspectives on the use of seclusion provide some reason for why the young people in this study responded poorly to having to spend time in seclusion. Their reaction to being secluded, an escalation of distress, is consistent with other studies that have explored this clinical intervention.

Milieu management and times when more than one young person is exhibiting aggressive behaviours are a concern for nurses. In the above observation, and as described by one of the nurse interview participants, there were times where more than one person required seclusion to manage violent and aggressive behaviours. This poses an interesting consideration. In the observation outlined above what would have occurred if the young person who was not secluded did not accept the *prn* medication and continued to exhibit combative and violent behaviours? In addition, for the episode

of distress that N5 recalled, where three young people became involved in a verbal and physical altercation, one of the young people was secluded due to the level of violent behaviour, however both of the other young people also displayed the same set of behaviours but were not. These young people were managed using physical restraint, increased observation and *prn* medication (IMI). If this were the case, one must ask why the young person who was escorted to seclusion was not treated with the same interventions described the least restrictive interventions in the Mental Health Act (NSW Government, 2007). Counterarguments can also be made. Reduced staffing resources (staff to patient ratios) may influence clinical decisions however; lengthy physical restraints can place young people at risk of injury, re-traumatisation, and death.

7.6 CULTURE AND CONTEXT

A number of factors associated with culture, environment and peer relationships impacted on the nurse's ability to respond to and provide interventions for distressed adolescents. The following subordinate research question provided the impetus to understand the contextual and cultural factors that influenced the nurse's ability to respond to adolescent distress:

- *What aspects of culture, environment, and peer influence affect nurses' responses and interventions?*

7.6.1 Unit culture:

The collective unit culture, and the individual nurse's beliefs and values (which influences attitudes) can influence how they respond to adolescents experiencing distress. From a recovery perspective the acute mental health inpatient unit provides the opportunity for adolescents to take time out and stabilise their lives in order to re-enter the community and continue the recovery process. Nurses working in this environment must prepare themselves against the complexities and harshness of the work and maintain a sense of hope. They must then share this with the young people for whom they provide care. This is most crucial during episodes of distress. Maintaining and promoting a sense of hope was evident from the comments offered by nurse interview participants. A number of them spoke directly about the importance of instilling a sense of hope for the young person. Nurses also spoke of the hopelessness

displayed by many of the adolescents for whom they provide care. Verbal responses, extreme behaviours associated with acute distress and recurring episodes were indicators of hopelessness and helplessness. Promoting hope to clients is achieved through building strong therapeutic relationships, caring for people holistically and maintaining a nursing presence (Turner & Stokes, 2006). Nurses in this study also suggested that the constant challenges of the work (and environment) impacted on their abilities to maintain their own sense of hope, let alone promote this for young people.

Nurse's attitudes and clinical experiences can interrupt the nurse's ability to adopt systematic nursing processes. Nurses commented on unit culture about how nurses were, "all so different". They suggested that adolescents would be confused at times because responses and interventions were not consistent or systematised. They argued that sometimes responses were more likely to be personal preference of the nurse instead of what the young person needed at the time. Two of the participants spoke of having to manage their colleague's behaviours as well as the dangerous behaviours displayed by the adolescents with whom they were engaging. On both occasions their colleagues wanted to opt for restrictive interventions instead of the person-centred approach the primary nurse was attempting to use.

It is difficult to ascertain whether nurses' attitudes guided the approaches described above, or if competence and confidence to manage such difficult and dangerous situations was a contributing factor. However, there is evidence from the observational data that suggests that both of these are influencing factors. During the observation period two nurses witnessed a young person's distress levels escalate when she was unable to call her mother (who had requested no contact), as she was unwell. The nurses chose not to respond or provide interventions other than routine observation levels. The nurse's tone indicated judgment of the young person's behaviours and influenced the other nurse's lack of response. Given the non-participant nature of the observations, it is impossible to ascertain the reasons for any decision by a second nurse to not provide assistance. Limiting secondary gain was the rationale given by the nurse for not responding. From a neurodevelopmental perspective, adolescents are egocentric (Sturman & Moghaddam, 2011) and it is important for nurses to understand that developmental factors influence their behaviour. They are likely to be demanding and not consider others feelings (or position), such as the reaction the young person gave the nurse in this situation. This example provides an opportunity for nurses to

consider developmental factors that may influence their responses and interventions instead of relying on personal values and beliefs to guide their practice.

In addition to nurse's attitudes and beliefs, other factors associated with culture influence nurse's responses to distress. The nurse's preparedness, confidence and competence to respond to adolescent behaviours associated with distress in instances where immediate safety (nurse and adolescent) is involved is also important. Nurse participants spoke of not knowing what to do in certain situations given their inexperience and knowledge and skill deficits in regard to different types of adolescent presentations (diagnoses). Nurses also indicated that poor morale and teamwork amongst the group, and a lack of support from unit management were contributing factors. Research findings indicate that health outcomes improve when nurses feel supported (Cleary, Horsfall, O'Hara-Aarons, & Hunt, 2012). Additionally, positive work cultures and establishing affirming work environments occurs through the teamwork between nurses who work 'on the floor'. Consistent with the findings from the study by (Cleary, Horsfall, et al., 2012), a number of nurses interviewed in this study commented on the lack of support and acknowledgement of the difficulties associated with working in acute inpatient units, especially in regard to their own safety.

During an incident involving three young people, where a verbal and physical altercation occurred, one nurse participant spoke of not being able to respond because their colleague did not follow the 'Code Black' emergency response protocol and walked away leaving them to manage the situation alone until other staff arrived. These factors can contribute to a nurse's level of confidence and competence in regard to responding to an adolescent in distress. In contrast to the above arguments, some nurses were observed to show a willingness to engage with adolescents who were experiencing distress and exhibiting problematic behaviours such as DSH and aggression. This willingness was supported by the person-centred approach of the nurse toward the young person. These nurses espoused collaboration and empowerment and focused on assisting the young person to draw on their strengths and baseline coping by providing a solutions-oriented approach to the distress. Unit and nursing culture, and confidence and competence, impact on the nurse's willingness to engage with adolescents experiencing distress.

7.6.1.1 Safety of mental health nurses

For nurses to respond and provide interventions for adolescents experiencing distress they need to feel safe. Like the principles underpinning 'first aid' (DRABCD), the ability to maintain safety for the initial responder is crucial in providing further assistance.

Nurses on the unit are designated with the responsibility of providing the 'psychological first aid' for the adolescents who experience distress. However, both observational and interview data provided examples of safety risks for nurses. Observations involving adolescents who displayed violent, verbally abusive, and aggressive behaviours impacted on the physical and emotional wellbeing of the nurses. Nurses interviewed spoke of professional safety in regard to the risks associated with young people making false accusations against them.

The stress nurses' experience when responding to adolescents in an inpatient environment that is unsafe affects their ability to provide mindful interventions. Some argue that a nurse's ability to respond in a caring manner is influenced by the stress they are experiencing at the time, and on their overall level of satisfaction with their work (Lützén, Blom, Ewalds-Kvist, & Winch, 2010). Many of the nurses interviewed described different emotional responses to working with young people in distress. While some of the participants' spoke of positive feelings, many also indicated the emotional exhaustion and burnout that comes with this type of clinical work. Nurses described feeling anxious, frustrated, fearful, and angry. In addition, nurses also said they felt physically unsafe on the unit due to the levels of violence and aggression. Nurses who work in unsafe and stressful environments are more likely to experience burnout and have poorer mental and physical health themselves (Peterson et al., 2008). Burnout and stress can affect nurses attitudes toward clients, the overall culture of the unit, and the way they respond to them (Bowers, Nijman, Simpson, & Jones, 2011). Therefore, the emotional and physical safety concerns nurses have, directly impacts their ability to engage with a young person, remain present, and thus provide responses and interventions that are considered and congruent with the level of distress.

When comparing the two data sets (observational and interview data) it is apparent that changes and differences occurred within individual nurses as a result of culture and safety issues as described in this analysis. Nurse four (N4) was observed to be involved in three critical incident observations. On the first occasion they received a handover for their allocated client and were advised that due to competing duties the previous shift, the allocated nurse had not been able to spend adequate time with the young person. The nurse giving handover advised N4 that there was some disengagement from peers and staff and that the young person had been observed to be ruminating or preoccupied throughout the day.

It was observed by the researcher that N4 used silence, presence, validation and reflective questioning to provide help to the young person in distress. These person-centred approaches were evident in the nurse's responses and interventions. In the context of the interview data analysis' major theme Therapeutic Relationships, and the associated sub-theme "Knowing your patient" and "Being", N4 commented during the interview that the principles of these themes are imperative when working with young people in distress.

However, during another observation, N4 seemed to show a different attitude and approach to a young person compared with the previous episode. The nurse was standing in the common area of the unit when a young person was talking with their mother on the phone. The young person became upset and was overheard to be verbalising concerns regarding their discharge. The young person's distress levels continued to escalate with the young person hanging up the phone and going to their room, and slamming the door. The nurse in-charge (NIC) of the shift came out of the office and spoke with N4 and neither the NIC nor N4 went and engaged with the distressed young person.

The differences in attitude and overall approach in these two incidents by N4 may be due to the stress and the emotional impacts described by nurses in the interview data, or cultural factors associated with different personnel from shift-to-shift. The nurse (N4) also described an incident where they were involved in providing care for a young person who was self-harming by banging their head against a concrete wall, and attempting to self-strangulate (using hands).

7.6.1.2 Knowing roles and function:

Expert mental health nursing care, in particular the knowledge and skills required in a specialist area such as child and adolescent mental health nursing, requires nurses to provide care that is holistic by drawing on the principles embedded in nursing theories. Additionally, nurses must also incorporate into their practice the informal, dynamic use of psychotherapeutic principles (DBT, CBT etc.) and deliver these with consideration of developmental factors. Child and adolescent mental health nurses are required to assimilate psychological interventions and therapies while providing direct clinical care, with consideration of the developmental needs of the adolescent (Delaney, 2006b, 2007). Understanding the different roles and functions of an acute child and adolescent mental health nurse is imperative in responding to episodes of adolescent distress (Rasmussen et al., 2012).

Nurse participants spoke of how they were “all so different” in their approaches, levels of expertise, and philosophies about their roles in regard to responding to adolescent distress. These factors, different approaches displayed by the nurses (controlling/person-centred), poor understanding of roles, and a lack of clinical expertise in dealing with acute episodes of distress impact on the consistency and effectiveness of the responses nurses provide.

Roles and functions were further complicated when some of the nurse participants spoke of being unsure what to do or how to help the young people in distress. One nurse commented they were, “out of their depth” when responding to a young person who was self-harming. Others spoke of being inexperienced or not having the adequate clinical skills to respond to distress, especially those episodes where the young person’s behaviours became increasingly risky (DSH and aggression).

Nurse participants also commented on the difficulties in working with young people who are diagnosed with different mental health problems. An understanding of the symptoms of adolescent mental health problems can assist the nurse to guide their responses and interventions, however it is as important to match them to the level of distress. One nurse provided an example to illustrate this point, describing a time where they were using a person-centred response (reassurance of safety) and de-escalation to negotiate with a young male who was experiencing psychotic symptoms (paranoia) to take oral *prn* medication. The nurse later commented on how this scenario was easier than dealing with a young person who was depressed, suicidal, and had lost hope. However, in both instances the nurse was able to provide details on how they responded and provided interventions based on the level of distress rather than the specific diagnosis. In the scenario with the young psychotic male client de-escalation and *prn* medication were used due to the high levels of distress (and associated risk of aggression), while they described how silence, a nursing presence and engagement was used to provide comfort for the depressed client.

A model of nursing roles and functions in relation to interventions (B. Anderson & McMillan, 2015) provides direction for acute child and adolescent mental health nurses. The authors outline two primary roles of a nurse: care giver and facilitator. They argue that nursing functions, when in the role of caregiver, are to assess and monitor clients, and maintain an environment conducive to recovery. While in the role of care facilitator nurses act as communicators, researchers, and educators to plan, organise, counsel, evaluate, and promote recovery. Findings from contemporary research regarding the role of the acute child and adolescent inpatient nurse conducted by (Rasmussen et al.,

2012) support the observations and comments offered above. In regard to knowledge and skill, the authors argue that collegiate support is required for inexperienced nurses to develop the skills and knowledge to work in such a specialised environment. Additionally, they comment on the importance of teamwork among the nursing group and between them and other members of the MDT. (Rasmussen et al., 2012) also support the findings of this study when they comment on the importance of the nurse's role in maintaining a therapeutic milieu, and managing risk and safety.

Nurses who participated in the study by (Fourie et al., 2005) commented on the importance of nurses working with one another and other members of the MDT to maintain safety and manage risks on inpatient units. Additionally, they commented on the challenges for nurses to accomplish this in the face of other clinical practice tasks such as medication administration, therapeutic engagement, responding to challenging behaviours, and administrative responsibilities. There were numerous times during the observation period where nurses were prioritising multiple tasks and roles. The nursing teams consisted of four to five nurses on any particular shift and were often spread across the unit attending to different duties (both direct face-to-face clinical and administrative/procedural). These competing duties often left some of the adolescents unsupervised and resulted in episodes of distress that may have been avoided with earlier intervention. This occurred during both morning and afternoon shifts. Despite additional Allied Health and Medical staff during the day the supervision of the young people and the responses to distress were left to the nursing staff. There appeared to be minimal communication between the other members of the MDT and the nursing staff.

The unit culture whereby nurses were solely responsible for managing distress was a common practice at the time of the observation component of the study. However, a Unit 'Code Black' (psychiatric emergency) procedure was written during the study period and this practice has changed. Based on the local health district (LHD) policy that outlines the roles of all staff members in the response to psychiatric emergencies, the nursing, allied health, medical and administration staff now works cohesively to manage these types of clinical situations. The LHD aggression minimisation procedure complements this clinical practice and the aggression minimisation training program that guides this procedure provides a framework for clinicians of all experience levels to work collaboratively, with clearly defined roles, to manage violence and aggression on the inpatient unit (Spencer et al., 2011).

7.6.2 The ward environment ("therapeutic space") with an emphasis on safety, security, empowerment:

The inpatient unit should be a therapeutic space designed to provide safety and security for adolescents experiencing acute mental health problems. Previous studies reported that the physical design and 'climate' of an inpatient unit influences client behaviours, nurse's attitudes toward their work and the use of coercive interventions (Van Wijk, Traut, & Julie, 2014). Despite the evidence that suggests that staff-patient interactions play a key role in episodes of distress that result in aggression and other problematic behaviours (Cutliffe & Riahi, 2013; Nijman, a Campo, Revelli, & Merckelbach, 1999), ward designs and other environmental factors also impact on the experience of being an inpatient. The ward design and layout, routines, and organisational "rules" contribute to the difficulties experienced by both adolescents and nurses. Episodes of adolescent distress were both observed and discussed in the context of the complexities of the ward environment.

The *Safewards* model developed by (Bowers, 2014) provides guiding principles that reduce conflict between those in the inpatient environment and the coercive interventions that are used to manage the behaviours associated with the conflict. Bowers argues that patient modifiers, staff modifiers and originating domains (those related to the physical environment that is the acute inpatient unit) result in flashpoints for conflict and subsequent containment measures. He suggests that reducing episodes of conflict and the need for controlling interventions can be influenced at every level and that a culture of nurses choosing not to use controlling and restrictive interventions can be attained.

The staff modifiers provided by (Bowers, 2014) can help to create a therapeutic space for young people. Managing staff anxieties and frustrations, enhancing the nurse's understanding of the functional nature of conflict behaviour, promoting teamwork and having a moral commitment to reducing controlling and restrictive practices can provide a culture within the unit that helps young people to feel safe and secure.

Adolescent distress was observed on numerous occasions where the triggering event was related to the deficiencies of the unit design. In general terms the observation of the inpatient unit revealed a physical space that was poorly designed, and looked worn. There was insufficient seating, graffiti and scratch marks were prominent, and a number of objects were broken or not working (e.g. patient lockers, water bubblers). Furthermore, the environment was 'sterile'; apart from a few metres of shrubbery in the

courtyard, there were no other natural elements to the unit. These environmental limitations can impact on a young person's ability to cope with distress. Research findings indicate that a connection to the natural environment assists people to cope with distress and build resilience (Ingulli & Lindbloom, 2013; Louv, 2005). (Hassell, 2014) discussed the future direction of designing acute mental health inpatient units suggesting that while research supports the need for units to be therapeutic there are still difficulties in creating a space where treatment is the main aim. They suggest that evidence-based designs (EBD) incorporate findings from research, reflection and critique of previously built units, and consumer involvement.

Ward routines and "rules" also added to the list of triggers. For example, the concurrent timing of morning handover and nursing breaks (morning tea) impacted on the nurses' ability to provide adequate supervision for the young people. On a number of occasions nurses missed episodes of distress that escalated during this time, or early warning signs of distress were not noticed, and nurses intervened later in the cycle of distress. The ward program provided opportunities for adolescents to be engaged and work on their recovery. However, it was observed that many of the young people were reluctant to engage in the ward programs and spent their time sitting in the common areas socialising. Nurses would be required to maintain supervision of these disengaged adolescents as well as contribute to the ward program activities, be present at medical reviews, and numerous other clinical duties. At these times the disengaged adolescents were often left unsupervised. Free time between ward program activities also impacted on adolescent distress. During free time the young people would congregate together and often peer dynamics would trigger episodes of distress. The unit design also played a part in this. The locked unit has minimal space for separating adolescents in conflict and this proved to be a challenge for nurses.

Other routine factors such as medication rounds, mealtimes, and medical reviews were also other factors that triggered adolescent distress. Mealtimes for young people occurred concurrently with nurses' meal breaks and would often result in reduced numbers of nurses for supervision. Compounding this problem was the location of the dining area situated in the middle of the unit, and the tables are often used for other purposes such as arts/crafts, completing paperwork, playing board games, and other ward program activities. No specifically designated dining area is available for the young people.

Nurses who responded to adolescents experiencing distress were observed to try and manage distress but they encountered barriers that were the result of the poor design

and layout of the unit. Nurses were observed to try and provide privacy for the young people with difficulty. At times nurses would have to speak quietly to the young person when discussing private and confidential information. At other times, nurses were unable to maintain this confidentiality because of the close proximity of others. When adolescents became verbally abusive toward staff or other young people or when they exhibited aggression toward inanimate objects (kicking chairs, slamming doors) this would be seen and heard by all on the unit due to the confines of the design. Additionally, when young people engaged in self-harming behaviours the other adolescents on the unit would know this was occurring, and like aggression would trigger distress for others and start a contagion effect.

Ward layout and design also presented difficulties for nurses to manage problematic behaviours such as DSH, aggression, and violence. Young people were observed to use isolation and withdrawal as a way of coping with distress. Adolescents would isolate themselves in their rooms, and it was in these private moments that they would often engage in self-harming behaviours. Bedrooms are spread across the whole unit and few are visible from the common areas and nurses' station. Furthermore, the layout of many of the bedrooms does not allow for direct observation of young people through the Perspex panels in the doors. The safety of the young people on the unit was a concern for nurses in both phases of the study. Nurses used increased levels of observations to monitor safety risks. Nurses were seen to be most wary of risks when the young person isolated in their room. This was mainly due to the poorly designed rooms where adolescents could hide and not be visible to nurses who were conducting routine observations. In addition, previous risky behaviours also increased the nurse's observation levels. The scenario where the nurse suggested Jane use a shower as a soothing strategy to reduce distress is a prime example. Jane had previously attempted to strangle herself in her bathroom a few days before. When Jane accepted the nurse's suggestion of a shower the nurse checked on Jane numerous times during the time she showered.

Many of the nurses spoke about safety concerns including suicide attempts, DSH, and violence and aggression. Nurses gave examples where adolescents were at risk either from their own actions, or those of other young people. A number of participants suggested how difficult it is to work with young people and provide responses for distress when they are exhibiting significant DSH (with implements) or aggressive behaviours. (Dean, McDermott, Davidson, & Scott, 2010) interviewed both clinical and non-clinical staff working on an acute child and adolescent mental health inpatient unit

(n=32) with findings indicating that aggression displayed by young people impaired the therapeutic capacity of staff, increased the likelihood of absenteeism, and impacted on retention of experienced staff. These factors have influenced the culture of the unit where this study took place, and from an organisational perspective, recruitment and retention problems have been constant. These recruitment and retention problems have impacted on staff experience levels, rostering and staff to patient ratios, which add to the overall safety issues on the unit.

Episodes of low-level DSH were observed during the study period, while nurses commented on more acute DSH behaviours that were potentially life threatening. Self-harm behaviours, while maladaptive, are reported to be highly effective in reducing distress from a biological perspective (Groschwitz & Plener, 2012; Niedtfeld et al., 2010) and at times young people rejected the alternative adaptive coping strategies nurses offered. One nurse commented on the difficulties in providing interventions for young people exhibiting self-harming behaviours, suggesting young people are not likely to accept distraction or sensory-based interventions while they have access to implements of DSH.

Contemporary research by (Warne & McAndrew, 2014) involved interviews with seven young people aged between 13-17 years. The researchers conducted an interpretive phenomenological analysis methodology to analyse the subjective accounts of young people who self-harm. Young people in the study suggested that self-harm was a way of alleviating stress associated with interpersonal and intrapersonal difficulties, coping with stress, peer influences, and as a way of communicating help-seeking. The subjective experiences of the young people in the study by (Warne & McAndrew, 2014) are supported by the observational findings of this study. Young people were observed to use self-harm to alleviate distress and as a way of conveying this to nurses in their attempts to seek help. Observational and interview data from this study also highlight another comparison to the study by Warne and McAndrew (2014). The young people in that study commented on the fear of being judged as attention seeking. Nurse interview participants from this study spoke about attention seeking, however one nurse (N10) described attention seeking in the context of help seeking. This attitude was consistent with the thematic codes attributed to the observational themes, as described in the TAR^3 Model (Figure **3**). Interestingly, for young people and nurses to comment on this highlights the stigma associated with DSH. Consider responding to someone who hurt him or herself accidently by cutting their finger with a kitchen knife while cooking. Medical attention would be the first response of the caregiver. However,

when a young person cuts themselves in the context of relief from emotional pain then seeking medical attention is perceived as ‘attention-seeking’. It is for this reason; the term “help-seeking actions” for the thematic code described above was chosen, to reduce negative perceptions.

Managing the ward milieu and peer conflict, which often led to episodes of distress, was further compounded by the poor unit design. Nurses were observed to try and engage a young person and respond to early warning signs of distress while the young person was situated in a group. On other occasions the nurse had to draw the young person out of the group and respond to them on a one-on-one basis. Maintaining privacy and confidentiality, preventing the contagion effect, and managing the ward milieu were not the only environmental challenges for nurses when responding to distressed adolescents. Nurses were also observed to try and adapt the interventions they used because of environmental factors, which would limit their options. For example, many times the nurses would offer distraction and soothing techniques such as art or exercise activities only to be restricted by insufficient resources and designated areas.

Managing the ward milieu was commented on by many of the nurses: Contagion effect, peer conflict, and problematic behaviours such as aggression and DSH were challenges compounded by the poor design and influences of the daily routine. Nurses suggested that overcoming these difficulties and managing the ward milieu was paramount in minimising the episodes of distress, as well as responding and intervening in a timely and appropriate manner. Developmentally, peer social interactions and a feeling of belonging are crucial. Nurses working with adolescents in an acute inpatient unit are often faced with nursing young people individually, and in a group. Managing the milieu because of this can be difficult at times. Episodes of distress and associated problematic behaviours such as aggression, self-harm and defiance can be influenced by peer contagion, making it difficult for nurses to manage the milieu (Dishion & Tipsord, 2011). Furthermore, creating a therapeutic milieu that allows nurses and young people to work together is vital. Nurses in this study often spoke of an, “us and them” situation when referring to the working relationships between adolescents and nurses. (Delaney & Johnson, 2006) suggest that nurses need to create a safe therapeutic space based on positive culture to prevent this problem. (Mahoney, Palyo, Napier, & Giordano, 2009) argue that contemporary inpatient units should be designed as a therapeutic environment that considers client needs to enhance healing. Additionally, they argue that it is the processes and the

overall system that prioritises a person-centred approach, along with clinicians who focus on holistic care that optimises health outcomes.

7.6.3 Peer relationships

Adolescence is a period of growth in numerous developmental domains. The increased autonomy and independence, importance of peer relationships, and the commencement of intimate relationships are examples of the social changes adolescents' experience. The social ecology model developed by (Bronfenbrenner, 1994) outlines the dynamic nature of an adolescent's social world. With the adolescent at the centre, the complex web of social supports and influences can impact on developmental tasks.

In the inpatient unit, social influences are present and can be triggers for episodes of acute distress. The observation phase of the study provided examples where social interactions with peers, family, and unit staff triggered these episodes. Many of the episodes of distress observed were either triggered initially by a social interaction, or escalated because of it. For nurses this requires them to not only understand the social factors that trigger distress, but also consider their own communication style when responding to distressed adolescents. As previously discussed, the way in which the nurse initially responds to the adolescent can influence the young person's willingness to accept care and work collaboratively with the nurse, and also the outcome.

Factors relating to peer relationships were evident during the observational stage of the study. At times peer conflict would be a major contributor to episodes of distress. However, on many occasions young people would congregate and support one another during these times. At no time during the observational period did a young person approach a nurse and directly ask for help. However, this was common among the peer group. Adolescents were often seen to discuss concerns, anxieties, past histories, and their life stories with one another, but rarely with nurses. This sharing with one another seemed to connect the young people and provide a sense of belonging. This connection seemed to bring the adolescents together to the point where the nurse would have to 'nurse the group', or connect with the young person by drawing them away from it. In contrast to what was observed, when adolescents would discuss their care and life stories with one another, nurse participants viewed this as detrimental to young people.

Strong collegiate relationships between nurses, and other members of the MDT, are an important factor that contributes to providing quality inpatient care. During the

observation period, teamwork was observed between nurses themselves and with other members of the MDT. However, on some occasions nurses were left to deal with adolescent distress and the other members of the MDT did not provide assistance. Whether this was a personal decision or as a result of the lack of guiding procedures was not able to be ascertained due to the non-participant nature of the observations. Teamwork and professional conflict arose during interviews with nurses. Some of the nurses suggested that the different styles and philosophies (person-centred vs coercive) would often bring about conflict that would impact on their ability to respond and intervene. Interview participants spoke of times where other members of the MDT, and other nurses did not support them.

Comparing and determining the relationships between the themes provided insights into answering the research questions. When nurses are aware of their role, and feel safe, they are able to engage mindfully with young people to build therapeutic relationships and draw on critical thinking skills to match the intervention with the observed level of distress. The style and approach of the nurse during the initial response to the adolescent's distress has a major impact on the outcome and whether the young person will work collaboratively with the nurse. In many instances (especially low level distress) the initial approach was more important than the subsequent intervention. Providing effective and person-centred responses and interventions to adolescents in distress, and making a difference for young people is an example of the attraction of acute mental health nursing as described by (Deacon et al., 2006).

7.7 THE PREFERRED APPROACH FOR RESPONDING TO ADOLESCENT DISTRESS:

To enhance the helpfulness of the nursing responses and interventions discussed above, nurses can use the following framework in their clinical practice when providing care for young people in distress. Insights gained from answers to the research question, and the study objectives, provide a best-practice framework for nurses to respond to adolescents experiencing distress. A person-centred approach complemented with sound clinical decision-making that incorporates the individual, environmental and cultural influences can enhance outcomes for young people, and reduce coercive interventions.

To minimise the chances of adverse events and risky, maladaptive coping behaviours such as DSH, suicidal behaviour, or violence and aggression, nurses must consider the contextual situation and identify and 'know' individual triggers and early warning signs (baseline coping and help-seeking behaviours) for the young person for whom they are caring for. Early intervention in the cycle of distress, and selecting the intervention to suit the assessed level of distress (based on the understanding of the clinical cues associated with warning signs) will reduce the need for the use of restrictive interventions such as seclusion, and physical restraint. Given the range of experience, confidence, and competence of nurses working in this context at any time, there is a particular need for optimal use of mindful nursing care.

Adolescents who experienced episodes of distress were not observed to ask for help. Rather they would use their own baseline coping strategies or display help-seeking action in an attempt to alert the nurse to their distress. The literature on adolescent help-seeking behaviour indicates that individual factors that promote effective help-seeking actions include motivation, awareness of the need for help, and past experiences of asking for help (Barker, 2008). Based on the lack of observed positive verbal help-seeking actions of the adolescents in this study it could be argued that they were either not aware of their need for help, or had previously experienced negative outcomes in the past. Consequently, it is critical for nurses to develop the clinical skills for recognising and responding to distress.

When nurses recognise adolescents experiencing an episode of distress it is imperative that a person-centred approach guided by the principle of least restrictive care is succeeded by an initial response that enhances collaboration and acceptance from the young person. The initial response influences the young person's acceptance or rejection of the help offered by the nurse.

A safe therapeutic environment is essential for young people who are admitted to acute child and adolescent mental health inpatient units. If provided, a therapeutic environment and safe, secure interactions with nurses will allow young people to further develop their coping and resilience skills, increase their level of self-control, and reduce episodes of escalated behaviour both in the unit and in the community following discharge.

7.7.1 Knowing your patient:

Responding to and providing interventions for distressed adolescents was perceived to be easier when nurses had background information about the young person, or a previous therapeutic relationship. During the observation component of the study nurses were observed to receive handover of each adolescent on the unit and were then allocated to specific young people as their primary care nurse. Following handover some nurses were observed to spend time reading the medical files of the young people they were allocated to, prior to engaging or introducing themselves. In contrast other nurses decided to proceed straight onto the unit and missed the opportunity to gain relevant and important information about the young people. Nurse interview participants commented on the importance of spending time reviewing the clinical notes and one stated that nurses who do not, "should be "slapped". One nurse provided details of a time working with an acutely psychotic young person, and how the handover and progress notes provided information that assisted them in the de-escalation process. The nurse suggested without this pertinent information more controlling interventions and a different clinical outcome would probably have occurred (indicating S&R and IMI sedation).

The first priority for acute mental health nurses working with adolescents in the inpatient unit is to establish a therapeutic relationship. Nurses should aim to recognise individual needs across numerous domains (physical, emotional, psychological, developmental, cultural), while simultaneously "getting to know" the young person and how they make sense of their world, illness, and the environment they find themselves in (Carter, Bray, Dickinson, Edwards, & Ford, 2014). The first stage of getting to "know your patient" commences during the shift-to-shift handover. Secondly, the young person's medical file provides further personal assessment and observation information that helps the nurse to better understand the young person's life, including psychosocial stressors, mental health diagnoses, physical health problems, family structure and dynamics, global functioning, and previous treatments.

Following a review of the young person's medical file a nurse should then engage with and "get to know' their client. Identification of individual baseline coping behaviours, maladaptive behaviours, early warning signs of distress (help-seeking actions), and triggers for distress should be explored with the young person. Identifying early warning signs of distress can provide the nurse with the ability to intervene early in the cycle of distress. Much of the research on early warning signs and relapse prevention has focused on those with a diagnosis of schizophrenia (Koichi & Miyamoto, 2009;

Meaden, Hacker, & Spencer, 2013). (Walker & Kelly, 2011) also focused on early warning signs for adolescents hospitalised with psychotic symptoms. The use of a journal to record the journey of their admission provided the adolescent and clinicians an opportunity to identify early warning signs and reduce the chances of relapse. However, the literature is limited about the identification of early warning signs of distress, irrespective of diagnosis.

Expanding on general comments made by nurses in this study regarding the enjoyment they get from spending time getting to know the adolescents they provided care for, nurses were also very specific and detailed in recounting their understanding of the triggers and early warning signs for some of the young people they had nursed on numerous occasions. The time spent "getting to know" the young person provided clinical information that assisted the nurses to recognise and respond effectively to distress. In contrast nurses commented on how difficult it was to recognise these factors and respond to distress for adolescents with whom they had not established the same level of understanding.

While the observation component of this study focused on times of distress, some nurses were observed to prioritise clinical face-to-face time with young people in a range of activities. Nurses would spend time with young people, by assisting them with ADLs, completing clinical paperwork (e.g. care planning documents), playing games, engaging in craft/art activities, and going for walks on the hospital grounds. These interactions appeared to have two main aims, spending time getting to know the young person as an individual, and engaging the young person in purposeful activities as part of the ward program routine. It was during this time that nurses would build an understanding of the young person's values, beliefs, personal triggers, and early warning signs of distress that they would use later when responding to distress. The systematic collection of this information was sporadic and while nurses would build their own understanding of particular adolescents this was often not transferable to other team members. Collation of information, or the 'wisdom' they learn through engagement with each young person is not currently shared between staff. There is no repository of specific individual information relating to each young person about the ways in which they express distress, their baseline coping strategies or what responses and interventions have been helpful in previous episodes of distress.

The principles of a Child-centred Care (CCC), a form of person-centred care (PCC), and the nursing approach that stems from this philosophical viewpoint, recognises the importance of young people being active agents in the care they receive (Carter et al.,

2014). Building a partnership that allows the young person to fully participate in their care provides opportunities for enhancing key developmental tasks associated with independence. When young people are able to exercise these rights, it provides occasions for validation, empowerment and autonomy.

7.7.2 Being present:

Due to the often dangerous and risky behaviours associated with acute adolescent distress, nurses must maintain an awareness of the complex dynamics occurring within the ward environment and recognise and respond to episodes of distress. Furthermore, by being present in the moment of distress the nurse is more likely to observe reactions from the young person in regard to their responses and interventions by conducting ongoing assessments of the adolescent's level of distress.

During the observation phase of the study there was an episode of distress for Jane where the nurse did not collaborate with Jane in regard to the intervention used to assist with her distress. The nurse appeared to choose *prn* medication as a frontline intervention. The nurse did not take time to assess and evaluate Jane's level of distress. Jane was upset following a medical review and she attempted to use sensory-based coping strategies. If the nurse engaged with her in the moment, sensory modulation interventions may have been an alternative intervention (and transferable to the home environment on discharge). After administering *prn* medication the nurse walked away from Jane and her distress continued to escalate. The nurse had to reengage with Jane for 30-40 minutes until the *prn* medication became effective and her distress subsided.

In contrast another nurse was observed to sit in silence with Rose who had disengaged from her peers and was ruminating about the impact of her suicidal behaviour on family relationships. This approach provided time for Rose to notice and connect with the nurse who then made comments that indicated they "knew" Rose well. The nurse then used body language, tone of voice, and validating comments that enhanced the interaction and allowed Rose and the nurse to work together to de-escalate her distress. The nurse observed in this interaction with Rose, also provided insights during an interview about how being present with a young person in times of distress is advantageous.

Nurse participants also commented on the importance of maintaining a presence following periods of acute distress. Even when coercive interventions were used. Nurses used presence to reconnect to the young person and provide reassurance,

support, and a sense of safety. Coercive interventions have the capacity to impact on the therapeutic relationships nurses build with adolescents, and the use of presence following these events seemed to be a strategy that nurses used to rebuild trust and maintain the therapeutic relationship.

Presence is described as a state of mindfulness, and nursing presence therefore is the clinical practice of being in the here and now with a client, working in collaboration, and an awareness of the clinical cues that promote quality decision-making (Boeck, 2014). Nurses who exhibit a therapeutic presence provide opportunities for improved outcomes for young people. Nursing presence is considered a key feature of establishing therapeutic relationships and conveys caring, compassion, and empathy (Boeck, 2014). Being present with an adolescent in distress provides opportunities to create trust and a connection that will enhance the therapeutic relationship. (Papastavrou, Esfstathiou, & Charalambous, 2011) suggest that a nursing presence personifies caring to the patient through the use of interpersonal sensitivity, expert clinical practice, and the reciprocal nature of the nurse-patient relationship. Nurses who provide personalised responses in this way provide validation for the young person during their episode of distress.

Maintaining a sense of presence with a young person in distress relies on the nurse to consider the different domains associated with “being present”; namely the physical (positioning or touch) and psychological (cognitive and emotional). Presence also allows nurses to create the space needed for clients to engage with their suffering and better understand their experiences (Zyblock, 2010). Despite the evidence that suggests being present with a young person is therapeutic, Boeck (2014) argues that as workloads and demands on nurses increase the opportunities to be present with clients is diminishing. She argues that these factors can contribute to nurses providing care that is of a “rote fashion, with little or no therapeutic interaction” (p. 3).

7.7.3 Ongoing assessment and clinical judgement:

Quality nursing assessments and observation skills are critical to recognising the early warning signs and behaviours associated with escalating distress, and categorisation of these to the different levels of distress (mild, moderate, acute). Nurses must conduct an initial assessment of a young person’s level of distress, and ongoing assessments of the adolescent’s reaction to the nurse’s responses and interventions. These assessments provide key information for the nurse to consider when making clinical judgements about responses and interventions required at any point in time.

Clinical decision-making is at the forefront of choosing the most appropriate response or intervention when working with adolescents in distress. Collecting subjective and objective information in the moment, drawing on clinical experience, and using historical client information will guide the nurse. Choosing the appropriate response to a young person's assessed level of distress in the complex environment of an acute inpatient unit, which is often chaotic (Deacon et al., 2006) requires the nurse to be thoughtful and emotionally aware. (Croskerry, 2009) demonstrated the complexities and difficulties of clinical decision making suggesting there are "over 40 cognitive and affective biases… that may impact clinical reasoning".

Many nurses in this study were observed to respond to a young person's distress with timely and considered interventions. Some nurses appeared to be mindfully engaged with the young person in the moment and responded to the complex dynamics at play, using responses and interventions that matched the level of distress. However, on a few occasions nurses seemed to respond with the same individual response, irrespective of the level of distress. These interventions seemed to be the "default" interventions used by the nurse as if working on "auto-pilot", and *prn* medication was the most frequently used intervention for this category. The automated and mindful responses observed in this study mimic the concept outlined in Croskerry's (2009) model of diagnostic reasoning. She suggests that nurses vacillate between repetitive, easily recognised clinical situations that require minimal conscious reasoning and draw on these experiences to guide interventions. Conversely, when faced with a more complex or new clinical presentation nurses are required to engage in a slower and more thoughtful clinical reasoning process. This outlines the importance of mindful and ongoing observation and assessment of the adolescent's level of distress in an effort to maintain flexibility in matching the appropriate response or intervention at any point in time.

Both the observational and interview data provided insights on how nurses used continual assessments and clinical judgements to guide decision-making processes for responding to adolescent in distress. Interview data were checked against the TAR^3 Model to see if observations of nursing responses and their perceptions of these were consistent. For each of the interviews (n=10) the data aligned with the observational data themes. Contextual clinical triggers, coping or help-seeking actions exhibited by young people, and their reactions to nursing interventions all provide opportunities for nurses to monitor for escalating distress, and assess the outcomes of interventions they used.

Along with the general approach (person-centred/coercive) of the nurse, selecting the response and intervention to suit the assessed level of distress was a key factor in how the adolescents reacted. During the observational stage of the study nurses were seen at times to provide interventions like *prn* medication for levels of distress that may have been receptive to less restrictive interventions like sensory modulation and distraction. Conversely, there were times where nurses responded to young people with interventions such as reflective questioning and silence, which were ineffective, resulting in an escalation of distress.

7.8 THE TAR^3 MODEL AND A PROPOSED CLINICAL RESPONSE AND INTERVENTION TOOL

The two data sets were integrated by comparing the interview data against the TAR^3 themes (Appendix 16). Data from each of the 10 interviews were similar to the TAR^3 themes, thus providing evidence and confirming the interpretation of the data. Additional details were extrapolated from the interview data, which enhanced the application of the findings to clinical practice. Most notably when the interview data themes *Therapeutic Relationships: knowing your patient* and *Aligning interventions with the assessed level of distress* are amalgamated with the TAR^3 model. Researcher journaling and expert peer review of the thematic analysis and interpretation provided confirmation of the combined interpretation of the two data sets.

Building coping and resilience skills are developmental tasks for adolescents. This domain of self-mastery occurs when young people experience episodes of distress and are able to manage these on their own (or with the assistance of others) in a positive and adaptive way. Each time this happens the young person builds a ‘coping and resilience block’. When the level of distress exceeds the young person’s ability to cope using adaptive coping strategies then maladaptive (or problematic) behaviours are used (see Figure 4: **Diagram** representing different levels of distress and the type of coping strategies used to manage distress by the young person

Figure 4: Diagram representing different levels of distress and the type of coping strategies used to manage distress by the young person

It is important to know the adaptive and maladaptive behaviours that each young person uses to manage distress. Drawing on the concepts incorporated in Cognitive Behaviour Therapy (CBT), young people have actions, behaviours and habits that are a result of conscious or sub-conscious reactions to thoughts and feelings they experience as they live their lives.

The TAR[3] observation model and the key findings of Promoting Engagement generated from the interview data were amalgamated to develop the *Auteenome* clinical response and intervention tool (Figure **5**: *Auteenome* response and intervention tool). The term *Auteenome* was chosen to highlight the concepts of autonomy, teen, and me (individual). An *Auteenome* response and intervention plan is developed by the young person with the assistance of an adult to provide an opportunity for 'voice and

choice'. During my time as a child and adolescent mental health nurse many young people have described to me that they feel parents and other adults in their life see them as a 'mental health problem'. While parents have often said to me they struggle to trust young people with autonomy and freedom to explore the world due to their concerns for high-risk behaviours such as DSH and suicide. The *Auteenome* tool is designed to promote communication between the young person, using their voice (and non-verbal cues), and the adults who support them.

Obtaining specific data about a young person's adaptive and maladaptive coping and help-seeking behaviours, triggers for distress and the interventions that assist them are key to developing individual response and intervention plans. Additionally, expressions of distress for each level (calm, mild, moderate, acute) are evaluated to assist the responder to assess the level of distress at any point in time, and measure whether the response and intervention offered has caused an escalation of distress, or helped to resolve it.

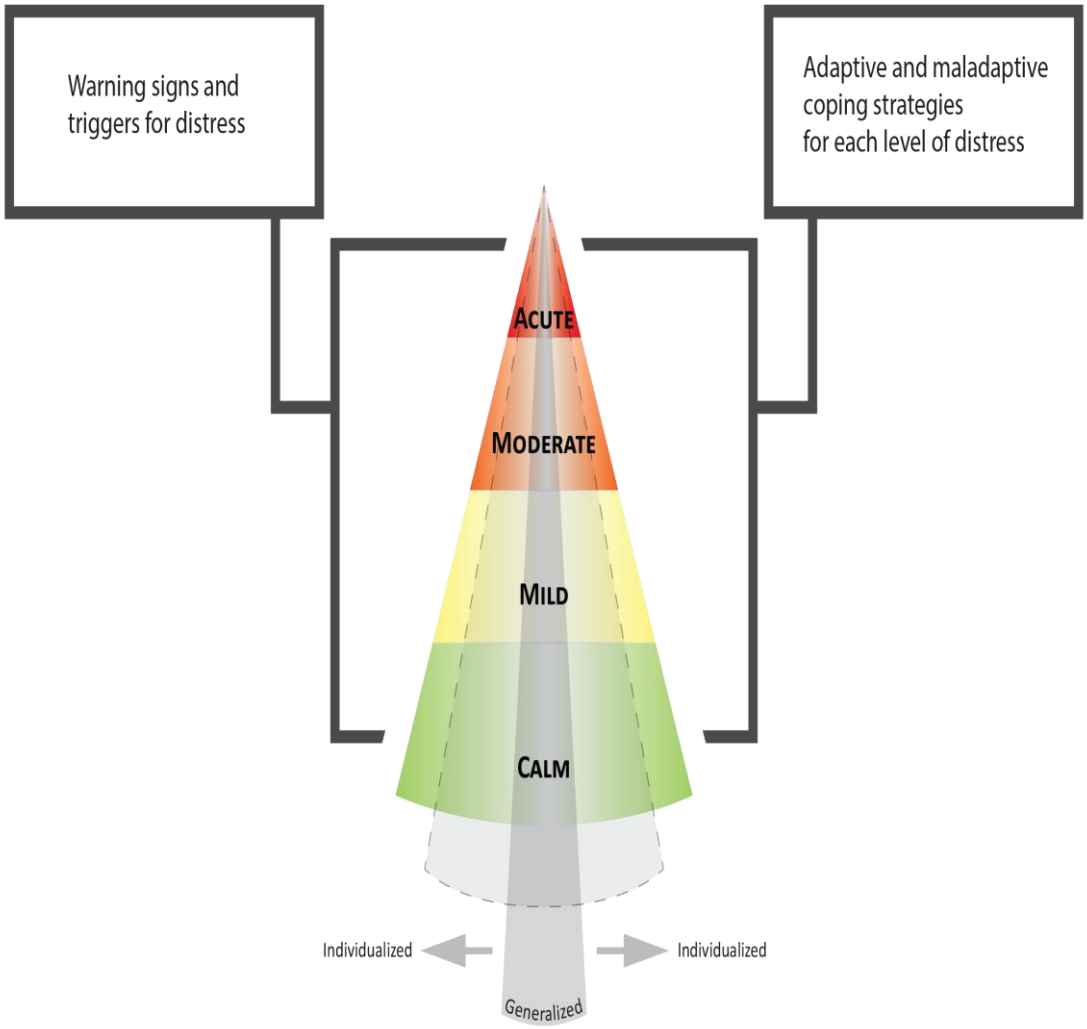
The TAR^3 Model (Figure **3**) shows that certain actions and cues are present in each of the different levels of distress and become more pronounced as the young person's distress escalates. For example, a young person might avoid, dismiss or oppose the nurse trying to provide assistance when they are mildly distressed. As the level of distress rises to moderate the young person may be verbally abusive, threatening and aggressive toward an object (e.g. kicking a chair towards a nurse). In the final stage, acute distress, the young person may be violent (e.g. punching) toward the nurse. Maladaptive coping strategies for moderate and acute distress include aggression, violence, risky and reckless behaviours, substance misuse, and significant self-harm and suicidal behaviours. As the young person's distress tolerance increases and concomitantly their coping and resilience capabilities develop, the most dangerous behaviours are less likely to occur.

Nursing observations and assessments are conducted to gain an understanding of the triggers, early warning signs, and adaptive and maladaptive coping strategies of the young person. There are a number of assessment tools (calming plans) that can provide the nurse with a framework to gain the information required (Stromberg & LeBel, 2003).

To use this tool nurses should engage with young people to complete a calming plan, and then populate each section of the *Auteenome* response and intervention tool (Figure **5**) categorise the early warning signs (expressions of distress), triggers and

maladaptive (problematic) behaviours of the young person. In addition responses and interventions that have been helpful in previous episodes of distress for each level can be used to guide nurses to recognise, assess and respond to escalating distress as early as possible.

Figure 5: *Auteenome* response and intervention tool



Stages One and Two (green and yellow) indicate equilibrium (calm) and mild levels of distress respectively, but are also representative of the neo-cortex (the cognitive brain) associated with decision making, critical thinking (e.g. action/consequence). Stage Three (amber) indicates moderate distress and can be likened to the emotional brain (reactivity, passion, volatility). Lastly, Stage Four (red) indicates acute distress (primitive brain), which overrides cognitive functioning. Each time an adolescent is able to re-establish equilibrium after experiencing higher levels of distress they build resilience and self-mastery skills such as emotion regulation and behavioural control.

The tool has been designed to align with the TAR^3 Model so nurses can recognise and respond to episodes of distress to assist young people in an individualised manner, by "knowing their patient". However, without specific information the nurse can use past clinical experience and ongoing assessment information to modify responses and interventions based on the observed level of distress.

As distress escalates for young people their ability to think critically and make decisions diminishes. The emotional high-jacking that occurs as a result of increased levels of distress requires the nurse to respond and intervene to maintain safety in the first instance, and re-establish equilibrium in the second. As the young person's distress declines their ability to think (and make decisions) improves. It is imperative that nurses continually assess and monitor distress levels and ensure interventions are dynamic; so they can provide opportunities for the young person to regain control and improve self-mastery. Maintaining a nursing presence allows the nurse to be mindful of the subtle changes in behaviour that may occur with escalating or de-escalating distress and allow for flexibility in their interventions. Furthermore, "knowing the patient" allows nurses to recognise the subtle changes specific to that adolescent, and provide interventions that are individualised and have been successful previously, or that are preferred by the young person.

While knowing your patient is advantageous in this instance it is not imperative. Nurses can use previous clinical experience to guide their responses and interventions, while they attempt to connect with the adolescent and gain the information required to establish an individualised approach. Consideration of the above principles may assist new and inexperienced nurses to use this tool to engage with adolescents who are experiencing situations involving escalating distress. This clinical issue was raised by some of the nurse interview participants when they felt "out of their depth" and lacking experience.

The potential harm associated with controlling interventions such as *prn* medication use, physical restraint and seclusion discussed previously, highlight the importance of nurses using person-centred interventions such as sensory modulation, psycho-education, de-escalation and engagement. To enhance the use of these interventions nurses must be aware of the contextual triggers and early warning signs that will allow them to intervene earlier, and match the intervention with the assessed level of distress.

7.9 SUPPORTING AND ADDING TO EXISTING KNOWLEDGE OF CHILD & ADOLESCENT MENTAL HEALTH CARE:

Contemporary research into child and adolescent mental health distress, as outlined in the literature review in Chapter Three is dominated by quantitative studies that focus on coercive interventions such as seclusion, physical restraint, and *prn* medication. Twelve of the studies measured patient, staff, organisational, and familial factors that influence the use of these coercive interventions. One study used a mixed methods approach to ascertain the impact on staff in regard to exposure to aggression on an inpatient unit. There are two qualitative studies that have contributed to this body of knowledge that explored the role of the CAMHS nurse (Rasmussen et al., 2012), and the lived experiences of nurses who work with suicidal adolescents (Greene, 2004). This study has added to the evidence base and supported some of the findings of previous research.

Previous research on S&R use has examined organisational changes to improve culture in an effort to reduce the use of these interventions (Azeem et al., 2011; Bonnell et al., 2014). Other studies have explored patient characteristics such as psychopathology (Bridgett et al., 2012; Gullick et al., 2005; van Kessel et al., 2012), familial factors (Gullick et al., 2005), and clinical practices such as training and the introduction of individual patient management plans (Bonnell et al., 2014; Dean et al., 2007; Tompsett et al., 2011) on the use of S&R. Three studies provided quantitative evidence regarding the antecedents and precursors to aggression (van Kessel et al., 2012) and S&R use (Pogge et al., 2013; Tompsett et al., 2011). The findings from this study add qualitative evidence to these phenomena and provide further understanding of the contextual, experiential, and cultural influences that impact on escalating distress and subsequent aggressive behaviours in inpatient units by young people. These insights provide opportunities for nurses to recognise the initial early warning signs and help-seeking actions displayed by adolescents that will assist with earlier intervention, thus reducing the need for the use of coercive interventions.

(Dean, McDermott, et al., 2010) used a mixed methodology to explore nurses' exposure to aggression and violence. While these authors examined the rates of exposure, this study can provide details of the contextual and cultural influences of adolescent aggression in the inpatient unit. In addition, increased understanding of these factors, and the environmental and interactional factors that emerged that can influence adolescent aggression provides opportunities for nurses to minimise these behaviours. For example, the observational findings indicated that young people would

display subtle coping or help-seeking actions (HSA) to elicit care. However, when this was ignored, missed, or responded to, in an incongruent manner by the nurses, the adolescent's behaviours would escalate. Furthermore, information about clinical and contextual triggers that impact on adolescent distress gives nurses a chance to minimise episodes of distress, especially when they know the individual triggers for the young people with whom they have established therapeutic relationships.

(Bobier et al., 2009) provided evidence of the types of formal interventions nurses' use in reducing symptom severity for adolescents aged 16-18 years. Rather than concentrating on overall symptom reduction like (Bobier et al., 2009) this study examined episodes of distress irrespective of diagnoses, and offers descriptions of the interactional responses nurses use to engage with a young person prior to implementing an intervention. This study provided insights into how nurses weave these interventions into their daily practice when working with adolescents in the moment of distress. The findings indicate that a person-centred initial response increases the likelihood of the adolescent accepting the interventions offered, and thus improving outcomes through collaboration.

Two studies examined the use of *prn* medication as an intervention in child and adolescent inpatient units (Dean et al., 2006; Winterfeld et al., 2009), and one study provided evidence of the use of intra-muscular injections (IMI) (sedation) rates (Siponen et al., 2012). These quantitative studies provided evidence for the prevalence of the use of these coercive interventions but did not provide any details about the complex nature of intervening with highly distressed adolescents who display aggressive, violent, or self-harming behaviours. (Berntsen et al., 2011) conducted a study where they examined trends in the prevalence of DSH and aggressive behaviours and rates of seclusion. The authors reported that one nurse was involved in 70 episodes of seclusion and 52 episodes of aggression suggesting that cultural and interactional factors may influence the use of coercive interventions. They suggested that research be conducted that examines individual nurse-patient interactions. This study was able to use observational data to analyse these interactions. Analysis of the observational data produced the TAR^3 Model (Figure **3**) that can assist with early intervention and an understanding of the reactions from adolescents in regard to responses and interventions offered. Analysis of interview data can enhance the insights of the observational data and improve outcomes for adolescents by incorporating the *Auteenome* tool (Figure **5**) to match the response to the level of distress and use individualised information to provide person-centred care. This study

was able to also provide descriptions of the types of interventions nurses used prior to resorting to coercive interventions, and contextual information around the use of these interventions. Similarly, these insights can also be used when attempting to understand the use of other coercive interventions such as physical restraint and seclusion.

Exposure to aggression impacts on the physical, emotional and professional safety of nurses (Dean, McDermott, et al., 2010). This study also contributes to this body of knowledge. Interview data highlighted the importance of the nurses feeling safe physically, emotionally, and professionally when responding to episodes of adolescent distress. When nurses are fearful, emotionally exhausted or feel professionally vulnerable, their ability to respond and provide interventions for distressed adolescents is diminished.

The qualitative study conducted by (Rasmussen et al., 2012) which examined the role of the CAMHS nurse also highlighted the importance of nurses feeling safe in their work. They argued that if nurses are able to be proactive in a safe environment then they are more capable of enhancing learning to improve clinical skills and build confidence to undertake their role. Nurses in this study commented that teamwork and support form unit management are also contributing factors. However, nurses suggested that at times acute child and adolescent inpatient nurses are confused about their role because of the numerous duties they are required to perform, and the differences in nursing experience and philosophical perspectives.

Rasmussen, Henderson at al. (2012) also indicated that nurses should be able to interact and build therapeutic relationships with adolescents, and conduct developmentally appropriate observations and assessments to guide their practice. This study provides descriptions of how nurses engage and get to know the young people as individuals, and the nursing presence required to achieve these relationships. This study also provides descriptions of how nurses incorporate the types responses and interventions they use when caring for distressed adolescents in a manner that Rasmussen, Henderson et al. (2012) calls ‘walking therapy”. That is, how nurses weave responses and interventions into their practice in a dynamic, informal, and collaborative manner with the young person.

Observational and interview findings from this study also contribute to the work conducted by Rasmussen, Henderson et al. (2012) who reported on risk and safety for young people as a theme. They suggested that a nurse’s role is to maintain safety and minimise risk for adolescents. Nurses from this study also indicated that this was

important. Nurses were observed to use informal levels of observations to manage these risks and provide safety. In addition nurses' descriptions of managing peer conflict, the milieu of the unit, and understanding the early warning signs of escalating distress provided insights into how nurses can achieve safety for adolescent inpatients.

The observational component of this study provides further evidence of the types of interventions nurses use for distressed adolescents on the inpatient unit. Participants from the study by Rasmussen et al. (2012) suggested that crisis management is a large proportion of a nurse's work and they described the types of interventions they used, and commented on the importance of therapeutic relationships in administering these interventions. The observations from this study provides a deeper understanding of the effectiveness of the nurses responses and interventions in reducing adolescent distress, and how adolescents react to the assistance offered. These insights provide opportunity for nurses to conduct ongoing assessments of their responses and interventions in an effort to gain collaboration from the young person, minimise distress, and promote the development of key self-mastery skills such as coping and resilience.

(Greene, 2004) conducted a qualitative study that explored nurses' lived experiences of working with adolescents who self-harm. This study provided both observational and interview data that contributes to this body of evidence. (Greene, 2004) reported on the therapeutic use of self as a valuable tool for nurses. She suggested that this use of self provides nurses with the awareness to recognise subtle changes in a young person's presentation. Observational findings from this study indicate that understanding contextual triggers and adolescent coping and help-seeking actions can also assist in recognising escalating distress. These factors will then contribute to earlier intervention, a reduction in coercive interventions, and reduced risks to young people (DSH and suicidal behaviour). Furthermore, this study provides descriptions of how nurses use a nursing presence to 'be' with the young people in times of distress, which is the practical application of the therapeutic use of self.

Participants in the study by (Greene, 2004) commented on interventions they used in nursing suicidal adolescents but do so in general terms. They suggest that nurses support the young person's coping but argue that research into the contextual factors that influence interventions is required. They also commented on the anxiety that nurses experience when choosing the appropriate interventions for nursing these young people because of the lack of evidence in regard to which interventions are best practice. This study provides cultural and contextual factors that influence the types of

responses and interventions nurses adopt for working with distressed adolescents. In addition, analysis of the observational data produced the TAR^3 Model (Figure **3**) that highlights the factors that contribute to the effectiveness of the responses and interventions nurses used, by way of ongoing assessment of the adolescent's reaction, and the changes to the level of distress.

Findings from both this study and that of (Greene, 2004) highlight the importance of building positive therapeutic relationships with adolescents. Participants suggested that sincerity and a non-judgemental approach were paramount to achieve this (Greene, 2004). The current study provides descriptions of cultural influences that impact on the therapeutic relationship and the responses to distress such as nurse's attitudes and willingness to provide care. Furthermore, study participants argued that "knowing your patient" and "being with" allows the nurse to understand the young person's individual triggers, help-seeking behaviours and increases the likelihood of working in a person-centred, collaborative manner with the adolescent.

(Greene, 2004) also provides commentary on how limit-setting and increased observation are used as interventions. The observational component of this study provides descriptions of how these interventions are used, and the adolescent's reactions to them. These intermediate interventions are important because if they are conducted with a person-centred approach, then the likelihood of escalating distress and subsequent use of coercive interventions can be minimised.

When asked why nurses continue to work with suicidal adolescents the participants in the study by (Greene, 2004) suggested that it is rewarding work helping kids, while nurses in this study suggested that providing a sense of hope was important. Nurses also suggested it was to support and work alongside their colleagues. Participants in both studies did however comment on the emotional toll for nurses working with these complex young people who exhibit high-risk behaviours.

This study has been able to support the results and findings of previous studies into the area of acute child and adolescent mental health inpatient nursing, and the interventions used for this population. It has added new knowledge and insights in regard to the cultural, contextual and experiential factors that influence nursing practice for responding to, and providing interventions for distressed adolescents in this environment.

7.10 METHODOLOGICAL CONSIDERATIONS:

Thorne's (2008) interpretive descriptive approach was used to explore the research questions posed in this study. It provided me with the means to profoundly understand the context and experiences of adolescent distress and the nurses who provide care to them in the acute inpatient unit. Thorne's (2008) interpretive descriptive data analysis methods process allowed for a standardised, consistent approach for both interview and observation data sets. The coding methods, and the subsequent interpretation, provided the overarching framework to develop an understanding of both adolescent and nurses' perspectives.

A number of factors influenced my choice of Thorne's philosophical framework, methodology and approach to data analysis and interpretation. First, the interpretive descriptive methods are well suited to the complex clinical research questions in this study. Thorne's data analysis methods aim to represent the meanings and subjective experiences of participants while also considering the "social and cultural forces that may have shaped that perspective" (Thorne, 2008, p. 49). (Thorne, 2008) suggests that the interpretive descriptive methods "mimic the interpretive mental attitude…of the applied health clinical reasoning process" (p. 51), and should generate new knowledge that can be applied to improve clinical care. Additionally, given the complex nature of the acute inpatient environment, and participants embedded within it, Thorne's interpretive descriptive methods allowed me to consider similarities and differences between the data sets while maintaining consistency. Testing relationships within each individual data set, and then looking for those that were evident in both, allowed for greater insight into interpretations of clinicians' understanding of how young people experience distress, and how nurses respond to them on the acute inpatient unit.

7.11 TRUSTWORTHINESS: CREDIBILITY, CONFIRMABILITY, DEPENDABILITY AND TRANSFERABILITY

Understanding how nurses respond to young people in times of distress was the aim this study. Methods and strategies employed by the researcher to ensure the internal validity of this study are presented below.

7.11.1.1 Credibility

Credibility was achieved in the design, conduct and reporting of this study through the use of a proven research approach and methods of data collection and analysis. A

qualitative approach supported by Thorne's (2008) interpretive descriptive methodology provided the framework for credible research through the use of both non-participant observations and semi-structured interviews. Thorne's (2008) interpretive descriptive data analysis methods further enhanced this aspect of trustworthiness. Furthermore, the researcher had a pre-established understanding of the setting, and informants within the environment, to enhance the period of engagement.

Proven and established sampling methods and ethical considerations such as obtaining consent to participate, and the right to withdraw from the study also enhanced the trustworthiness.

Another strategy used to enhance credibility was the comparison of both types of data collected to identify consistency between data sets. Cross checking methods employed to compare and contrast the data sets (observations, interviews, and secondary data), close supervision of the student by expert researchers, ongoing peer review of data analysis, and member checks throughout the study period also added to the research rigour. Furthermore, the addition of reflective commentary pieces in both the reporting of the findings, and in the discussion chapter, provided opportunities to enhance trustworthiness.

7.11.1.2 Dependability

To achieve dependability the researcher documented the research process through reflective commentary and journaling. Decisions regarding the research processes were documented and are presented in the Audit Trail (Appendix 13). The processes and strategies used are documented in a table and accompanied by a diagrammatic flowchart.

7.11.1.3 Transferability

This study relied on the researcher providing a concise description of the cultural and contextual factors associated with the phenomena including details of the setting, participants, and interactions observed. The detailed description of the study setting and context can assist readers to judge the potential transferability of the findings to other settings and contexts.

7.11.1.4 Confirmability

Confirmability was established through strategies such as cross checking data, discussion of assumptions, and the step-by-step description of methods employed to

conduct the research. Member checking by a number of the interview participants was also completed to confirm the accuracy of the transcripts. In addition, a list of researcher's assumptions was provided and discussed in the context of the findings, and an audit trail is also provided (Appendix 13) documenting the research processes, and methods used to ensure rigour during this study. Where appropriate, the use of direct quotes to represent the participants' voices was also used to promote confirmability of the interpretation of these data.

7.12 STUDY STRENGTHS AND LIMITATIONS:

The researcher's extensive prior knowledge of the environment and prior relationships with some of the young people who participated, strengthened his ability to meaningfully interpret situations. Nurses were also well known to the researcher; and as an 'insider', this allowed for deeper analysis of observed nursing practices and comments made about providing responses and interventions for adolescents in distress. On reflection, both nurses and young people who participated in the study appeared eager to do so. This eagerness was especially prominent during the interview component of the study where nurses openly spoke of difficult clinical experiences and were willing to 'put themselves out there' to offer their insights. In addition to having an understanding of the participants of the study the researcher also had practiced in the inpatient unit and understood the environmental designs and other systemic and contextual factors that influence nurses providing responses and interventions. The prolonged engagement in the setting enabled the researcher to align the conduct and analysis of the project with the overarching methodological approach. However, the research findings may not be transferable to settings that are not comparable to this study setting.

I was unable to address and answer the following subordinate research questions due to difficulty recruiting adolescent participants for interviews:

- *What skills, knowledge and personal/professional qualities and abilities do adolescents perceive in nurses who are (a) helpful and (b) not helpful in times of distress?*
- Do adolescents believe that clinical interventions such as de-escalation, *prn* medication, restraint and seclusion are helpful?

Only adolescents who received the assistance of nurses in times of distress can answer this question. In addition, obtaining the views of young people at the time of the distress, or while being provided treatment in an acute inpatient unit is unlikely to be an ethical or practical option. To overcome this study limitation, I proposed to interview adolescents aged 16-18 years of age who had been discharged from the acute inpatient unit and received community outpatient care within the same service. Community case managers who oversaw the community treatment of these adolescents provided an information statement to eligible young people (and their parents/carers). Parental consent was an inclusion criterion for this stage of recruitment. Feedback from these case managers to the researcher was that while some of the young people showed an interest in participating the parents felt that they were not ready to discuss episodes of distress associated with their hospitalisation. The limited age range of the adolescent participants also played a role in poor recruitment outcomes as it greatly reduced the number of possible participants. In addition, a number of eligible participants were readmitted to the acute inpatient unit and a sentinel event (completed suicide) occurred during the data collection period. After consultation with my research supervisors it was decided that further recruitment efforts would not continue and that nurses would be the only interview participants. Future research should aim to gain the adolescent's perspectives on these research questions and the clinical phenomena that was the focus of this research.

Another limitation of the study was the low representation of male clients. Only one male client consented to participating in the observation component of the study, however there were no observed occasions of this young person experiencing distress. This may have been a result of the observation period occurring at the end of his hospitalisation period, or his not experiencing observable distress during the observation times. Further research should aim to include more male clients to compare the findings of this study. However, there were a number of nurses who spoke about providing care to young males in distress during the interviews.

Finally, design and recruitment strategies did not concentrate on identifying participants of Aboriginal or Torres Strait Islander (ATSI) heritage. It is unknown whether people from this cultural group are represented in this study. The findings and recommendations for practice therefore cannot be directly generalised to these young people. Further research could focus on understanding if the findings from this study are consistent for young people who identify as ATSI. Such research would provide

impetus to further “Close the Gap”, a key initiative of the Health Department (NSW Health, 2012b)

7.13 IMPLICATIONS

Practice

Understanding the concepts embedded in both the TAR^3 Model (Figure **3**) and the *Auteenome* tool (Figure **5**) can assist nurses to assess the level of distress and match their response and intervention for adolescent distress in a congruent manner. Furthermore, ongoing assessment of the reaction provided by the young person to the response and intervention will provide clinical cues to ascertain if distress is escalating, or being alleviated.

Engaging with young people when they are at equilibrium (calm) and completing an assessment (calming plan) that identifies individual triggers and baseline coping and help-seeking behaviours (adaptive and maladaptive) for each of the designated levels of distress (mild, moderate, acute) is the first stage in developing an *Auteenome* response and intervention plan (Appendix 18). In addition to the subjective information gained from the young person, observational data is also added from other sources including the clinician’s own observations, and from others who ‘know’ the young person (family, teachers, and friends). Information is then transferred to the tool to provide detailed explanations of the patterns of behaviour the young person would exhibit for each of the levels of distress. Essentially the information provides guidance about what the young person would say (indicating thoughts and feelings) and do at each level so that the nurse can identify and assess the levels of distress. At the moderate and acute levels nurses might observe the maladaptive, risky behaviours such as aggression, absconding and DSH.

To enhance the congruence of the response and intervention, nurses can use the information to assess the level of distress and then use any of the individual, adaptive coping strategies identified in the initial assessment to provide person-centred assistance in times of distress. Identifying distress in the early stages of escalation (mild level) allows the nurse to intervene early, which increases the likelihood of the young person using an adaptive coping strategy to manage the distress. This early involvement by the nurse could reduce the need for more coercive interventions.

The goal of the tool is to provide key information (obtained from the young person) to help the nurse recognise distress and provide an individualised response to alleviate the levels of distress. Nurses can use the coping and help-seeking action information for each category (equilibrium, mild, moderate, and acute) to ascertain if the initial response and intervention escalated or decreased the young person's level of distress.

Findings from this study could be used to enhance the clinical care provided to adolescents in the acute mental health inpatient unit for the LHD where this study took place. This study provides key clinical understandings of the context, associated triggers, and early warning signs for adolescent distress. Understanding the coping and help-seeking actions that indicate escalating distress will assist nurses to respond earlier in the episode of distress. By providing nurses with information about how their initial response can impact on the acceptance (or rejection) of care, can guide them in more effective ways of working collaboratively with adolescents in times of distress. All of these factors allow for opportunities to reduce the use of coercive interventions such as seclusion and restraint. Other findings in this study will allow opportunities for nurses to understand how culture, attitudes, peer relationships and the physical environment can impact on adolescent distress.

Organisational

From an organisational perspective, the findings from this study will assist the LHD CAMHS Executive to understand the cultural and contextual factors that may guide their current commitment to changing the model of care and redesign of the inpatient unit to one that is evidenced-based, and that reflects the needs of adolescents in the region. For example, moving the sensory room to a more suitable location on the unit and improving the layout of bedrooms to improve observation practices could be considered.

Individualised safety planning, based on the *Auteenome* tool (Appendix 18), can be used as part of the inpatient care and discharge planning which will assist the LHD to work toward establishing a consistent improvement to key performance indicators such as the reduction of seclusion and restraint, and 28-day readmission rates. Individualised plans can be used to provide improved clinical care in the inpatient unit, and offered to parents and other adults who engage with adolescents in the community to provide an evidenced-based approach to responding and intervening with adolescents that are experiencing distress.

Research

Further research into this phenomenon should focus on the limitations of this study including obtaining the voices of the young people who are recipients of responses and interventions from nurses in the acute inpatient unit. Previous research where the voices of young people have been instrumental in gaining this important perspective could guide such studies (Warne & McAndrew, 2014). In addition, a research project aimed at evaluating the effectiveness of the application of the *Auteenome* tool (Appendix 18) to reduce critical incidents for young people will provide validation of the tool in reducing adverse events associated with acute episodes of distress.

The focus of further research should also aim to assess the effectiveness of sensory modulation interventions. For example, a mixed methods research methodology could provide data on the use of sensory tools, and their impact on reducing coercive interventions (*prn* medication and S&R). Qualitative data collected from the voices of young people about the most common and effective sensory modulation tools can guide resource allocation and environmental design for acute child and adolescent inpatient units.

Education

Formal education and skills training on how to provide evidenced-based responses and interventions that are collaborative and reduce the likelihood of coercive measures should be implemented. Furthermore, using the evidence from this study to provide essential education to nurses already working in other specialist child and adolescent mental health inpatient settings and other adults who provide care for adolescents (such as parents, youth workers and teachers) will provide opportunity to improve essential mental health support for young people.

7.14 CONCLUSION:

This research has provided valuable insights into how adolescents' experience distress during their hospitalisation in an acute mental health inpatient unit. Information provided by nurses about how they respond and deliver interventions for adolescents during times of distress provides opportunities for improved practice, education, and further research.

Understanding the individual behaviours of distressed young people provides nurses with the clinical information to respond early to escalating distress. A person-centred

approach during the initial response enhances the adolescent's acceptance of the assistance offered. It is essential that the culture and context of care delivery focuses on providing a safe environment that supports young people to develop their coping skills, and overall resilience.

[Reflection] The process of conducting this research has been influential in changing my nursing practice. Choosing a research topic so closely linked to my clinical work has given me valuable insights. For example, completing the literature review changed the way I responded and provided interventions for young people exhibiting low-level, non-suicidal self-harm. I feel as though my clinical practice influenced my research and in turn my research has returned favour and improved my clinical practice. After all, this is the goal of all research and clinical practice, to establish an evidence-base that makes a real difference to young people.

I have been fortunate during the time I was conducting the study to have some career advancement also. Most recently I have attained the role of Clinical Nurse Consultant for the inpatient unit within this service. I hope this opportunity allows me to further my clinical practice and provides further prospects for clinical research. In addition to the role described above, I see my future in this field developing tools to enhance the responses and interventions for young people in distress. Providing the information obtained in this study to other clinicians and adults who care for adolescents to reduce the episodes of distress, and the associated risky behaviours (such as suicide attempts, self-harm, and aggression and violence) will be the focus of future work for me.

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Appendix 1: Glossary

Commonly used acronyms used in this study.

Acronym	**Definition**
CAMHS	Child and Adolescent Mental Health Service
MHN	Mental health nurse
LOS	Length of stay
S&R	Seclusion and restraint
CBT	Cognitive Behaviour Therapy
DBT	Dialectic Behaviour Therapy
EI	Emotional Intelligence
HoNOSCA	Health of a Nation Outcome Score Child and Adolescent
prn	*Pro re nata* (when necessary)
IMI	Intramuscular injection
LHD	Local Health District
ED	Emergency Department
NGO	Non-Government Organisation
GP	General Practitioner
PTSD	Post-Traumatic Stress Disorder
ODD	Oppositional Defiant Disorder
ADHD	Attention-Deficit Hyperactivity Disorder
DSH	Deliberate Self-harm
MDD	Major Depressive Disorder

EN	Enrolled Nurse
TEN	Trainee Enrolled Nurse
RN	Registered Nurse
NIC	Nurse In-charge
TIC	Trauma-informed Care
ADLs	Activities of daily living
NSW	New South Wales
UK	United Kingdom
U.S.A	Unites States of America
NZ	New Zealand
C&A	Child and Adolescent
MDT	Multi-disciplinary Team
EBP	Evidence-based practice
EBD	Evidence-based design
PMVA	Prevention and Management of Violence and Aggression (training program)
HREC	Human Research Ethics Committee
NUM	Nurse Unit Manager
NM	Nurse Manager
CIT	Critical Incident Technique
SAO	Situation, action, outcome
ACMHN	Australian College of Mental Health Nurses

HSA	Help-seeking actions
ATSI	Aboriginal or Torres Straight Islander

Appendix 2: Search results table

Search Results

Search Engine	Search (S) terms	# Retrieved: (numbers in brackets used in combined searches)	# Met inclusion criteria	Table 2 article ID#
CINAHL	S1 Adolescen*	(157 871)		
CINAHL	S2 Mental health	(22 654)		
CINAHL	S3 Psychiatr*	(16 714)		
CINAHL	S4 Inpatient*	(20 597)		
CINAHL	S5 Nurs*	(64 430)		
CINAHL	S6 S1, S2, S3, S4, & S5	28	4	1,2,3,4
CINAHL	S7 Therapeutic relationship*	(529)		
CINAHL	S8 Nurse-patient perspective	(4)	1	5
CINAHL	S9 S1, S2, S3, S4, S7	2		
CINAHL	S10 S1, S2, S3, S4, S8	0		

CINAHL	S11 Trauma-informed care	(18)		
CINAHL	S12 S1, S2, S3, S4, S11	1	1	6
CINAHL	S13 Custodial	(103)		
CINAHL	S14 Authoritat*	(3 261)		
CINAHL	S15 S2, S3, S13	9		
CINAHL	S16 Stigma	(4 102)		
CINAHL	S17 Discriminat*	(8 957)		
CINAHL	S18 Attitud*	(77 501)		
CINAHL	S19 S2, S3, S5, S16, S17	7		
CINAHL	S20 S1, S2, S3, S4, S5, S18	5		
CINAHL	S21 Distress	(10 806)		
CINAHL	S22 S1, S2, S3, S4, S21	6		
CINAHL	S23 S1, S2, S4, S21	9		

CINAHL	S24 Crisis*	(2 234)		
CINAHL	S25 S1, S2, S3, S4, S24	9		
CINAHL	S26 S1, S2, S4, S24	10		
CINAHL	S27 Intervention*	(88 538)		
CINAHL	S28 S1, S2, S3, S4, S5, S27	7	1	7
CINAHL	S29 Strategy	(41 343)		
CINAHL	S30 S1, S2, S3, S4, S5, S29	7	0	
CINAHL	S31 Respons*	(77 586)		
CINAHL	S32 S1, S2, S3, S5, S31	17		
CINAHL	S33 PRN	(108)		
CINAHL	S34 S1, S2, S3, S33	2	1	8
CINAHL	S35 Seclusion	(202)		
CINAHL	S36 S1, S4, S35	14	3	9, 10, 11
CINAHL	S37 Restrain*	(1 731)		

CINAHL	S38 S1, S2, S4, S37	9		
CINAHL	S39 Psychoeducation	(878)		
CINAHL	S40 S1, S2, S3, S4, S39	2		
CINAHL	S41 Engage*	(11 608)		
CINAHL	S42 S1, S2, S4, S5, S41	3		
CINAHL	S43 De-escalation	(70)		
CINAHL	S44 S2, S3, S43	6		
CINAHL	S45 Sensory modulation	(48)		
CINAHL	S46 S1, S45	6		
CINAHL	S47 Touch	(1 576)		
CINAHL	S48 S2, S5, S47	9		
CINAHL	S49 Humo*	(793)		
CINAHL	S50 S2, S5, S49	3		
CINAHL	S51 Limit-setting	(37)		

CINAHL	S52 S2, S5, S51	2		
CINAHL	S53 Silence	(323)		
CINAHL	S54 S2, S5, S53	5		
CINAHL	S55 Observation*	(30 631)		
CINAHL	S56 S2, S4, S5, S55	43		
CINAHL	S57 S2, S4, S55	75		
CINAHL	S58 Ward dynamics	4		
CINAHL	S59 Milieu	(1 430)		
CINAHL	S60 S2, S4, S59	11		
CINAHL	S61 Ethnograph*	(3 643)		
CINAHL	S62 S1, S2, S61	24		
CINAHL	S63 S2, S3, S4, S61	16		
CINAHL	S64 Culture	(37 469)		
CINAHL	S64 S1, S2, S4,S5, S64	1		

CINAHL	S65 S2, S5,S8, S64	0		
CINAHL	S66 S2, S4, S5, S64	23		
Mosby Index (MI)	S1 Adolescen*	(165 892)		
MI	S2 Mental health	(59 468)		
MI	S3 Psychiatr*	(236 204)		
MI	S4 Inpatient	(15 951)		
MI	S5 Nurs*	(142 467)		
MI	S6: - S1, S2, S3, S4, S5	17	1	12
MI	S7 Therapeutic relationship	(3554)		
MI	S8 Nurse-patient perspctives	322		
MI	S9:- S1, S2, S3, S4, S7	0		
MI	S10:- S1, S2, S3, S4, S8	0		
MI	S11:- Trauma informed care	(1502)		

MI	S12:- S1, S2, S3, S4, S11	0		
MI	S13:- Custodial	(177)		
MI	S14 Authoritat*	(602)		
MI	S15: S2, S3, S13	21		
MI	S16: S2, S3, S14	23		
MI	S17 Stigma	(1755)		
MI	S18 Discriminat*	(25 242)		
MI	S19 Attitudes	(23 273)		
MI	S20:- S2, S3, S5, S17, S18	3		
MI	S21:- S2, S3, S4, S5, S19	3		
MI	S22:- Distress	(7 697)		
MI	S23:- S1, S2, S3,S4, S22	1		
MI	S24 Crisis	(5 987)		
MI	S25: S1, S2, S3, S4, S24	5		
MI	S26:- S1, S2, S4, S24	5		
MI	S27 Intervention	(112 618)		
MI	S28:- S1, S2, S3,	3		

	S4, S5, S27			
MI	S29 Respons*	(272 642)		
MI	S30: S1, S2, S3, S4, S5, S29	3		
MI	S31 Strateg*	(101 889)		
MI	S32:- S1, S2, S3, S4, S5, S31	5		
MI	S33 PRN	10		
MI	S34 Seclusion	(249)		
MI	S35:- S1, S4, S34	17	3	13,14,15
MI	S36 Restrain*	(176)		
MI	S37:- S1, S2, S4, S36	0		
MI	S38: S2, S36	5		
MI	S39 Psychoeducation	(1 392)		
MI	S40: S1, S2, S3, S4, S39	1		
MI	S41 Engage*	(22 653)		
MI	S42: S1, S2, S4, S5, S40	1		
MI	S43 De-escalation	(184)		
MI	S44: S2, S3, S43	4		
MI	S45 Sensory	(1722)		

	modulation			
MI	S46: S2, S45	9		
MI	S47 Touch			
MI	S48: S2, S5, S47	4		
MI	S49 Humo*	(9 368)		
MI	S50: S2, S5, S49	15		
MI	S51: limit setting	(1 052)		
MI	S52: S2, S5, S51	3		
MI	S53 Silence	(734)		
MI	S54: S2, S5, S53	13		
MI	S55 Observations	(14 812)		
MI	S56: S2, S4, S5, S55	2		
MI	S57 Ward dynamics	(541)		
MI	S58: S1, S2, S4, S57	0		
MI	S59 Milieu	(1 365)		
MI	S60: S2, S4, S59	5		
MI	S61 Ethnograph*	(3 157)		
MI	S62: S2, S4, S61	1		
MI	S63: Culture	(7 399)		
MI	S64: S2, S63	(614)		

MI	S64: S5, S64	(139)		
MI	S65: S1, S64	17		
Psych Info (PI)	S1 Adolescen*	(78 266)		
PI	S2 Mental health	(23 185)		
PI	S3 Psychiatr*	(78 496)		
PI	S4 Inpatient	(9 093)		
PI	S5 Nurs*	(37 151)		
PI	S6: S1, S2, S3, S4, S5	8		
PI	S7 Therapeutic relatonships	(553)		
PI	S8 Nurse and patient and perspective	(241)		
PI	S9: S1, S2, S3, S4, S7	0		
PI	S10: S1, S2, S8	0		
PI	S11: Trauma informed care	(42)		
PI	S12: S4 S11	6		

PI	S13 Custodial	3		
PI	S14 Authoritat*	16		
PI	S15 Stigma	(8 524)		
PI	S16 Discriminat*	(28 817)		
PI	S17 Attitud*	(127 513)		
PI	S18: S2, S5, S15	35		
PI	S19: S2, S5, S16, S17	10		
PI	S20 Distress	(23 749)		
PI	S21: S1, S2, S3, S4, S20	3		
PI	S22 Crisis	(10 344)		
PI	S23: S1, S2, S4, S22	25		
PI	S24 Intervention	(2 169)		
PI	S25: S2, S5, S24	0		
PI	S26: S1, S2, S24	8		
PI	S27 Strateg*	(2 552)		
PI	S28: S2, S5, S27	0		
PI	S29 Respons*	(5 573)		
PI	S30: S2, S5, S30	2		
PI	S31 PRN	(172)		

PI	S32: S2, S3, S31	7		
PI	S33 Seclusion	(486)		
PI	S34: S1, S33	58	1	16
PI	S35 Restrain*	(3 867)		
PI	S36: S1, S2, S4, S35	4		
PI	S37 Psychoeduaction	(1 564)		
PI	S38: S1, S2, S4, S37	1		
PI	S39 Engage*	(61 821)		
PI	S40: S1, S2, S4, S39	2		
PI	S41 De-escalation	(114)		
PI	S42: S2, S4, S41	1		
PI	S43 Touch	(4 042)		
PI	S44: S2, S5, S43	9		
PI	S45 Humo*	(9 142)		
PI	S46: S2, S5, S45	9		
PI	S47 Limit setting	(181)		
PI	S48: S2, S5, S47	3		
PI	S49 Silence	(2 182)		
PI	S50: S2, S5, S49	8		

PI	S51 Observation*	(22 643)		
PI	S52: S1, S2, S4, S51	52		
PI	S53 Ward dynamics	1		
PI	S54 Milieu	(1 801)		
PI	S55: S2, S4, S54	39	1	17
PI	S56 Ethnograph*	(12 492)		
PI	S57: S2, S3, S4, S56	12		
PI	S58 Culture	(48 849)		
PI	S1, S2, S5, S58	24		
Medline	S1 Adolescen*	(404 780)		
Medline	S2 Mental health	(35 241)		
Medline	S3 Psychiatr*	(62 492)		
Medline	S4 Inpatient*	(24 895)		
Medline	S5 Nurs*	(76 402)		
Medline	S6: S1, S2, S3, S4, & S5	40		
Medline	S7 Therapeutic relationship*	(655)		
Medline	S8 Nurse-patient perspective	0		
Medline	S9: S1, S2, S3, S4,	1		

	S5, S7			
Medline	S10: S1, S2, S3, S4, S8	0		
Medline	S11 Trauma-informed care	17		
Medline	S12: S1, S2, S3, S11	1		
Medline	S13 Custodial	(180)		
Medline	S14 Authoritative	1		
Medline	S15: S2, S5, S13	8		
Medline	S16 Stigma	(9 119)		
Medline	S17 Discriinat*	(44 984)		
Medline	S18 Attitude	(57 746)		
Medline	S19: S2, S3, S5, S16, S17	1		
Medline	S20: S1, S2, S3, S4, S5, S18	11		
Medline	S21 Distress	(24 406)		
Medline	S22: S1, S2, S3, S4, S21	5		
Medline	S23 Crisis	(6 751)		
Medline	S24: S1, S2, S3, S4, S23	13		
Medline	S25 Intervention	(142 882)		

Medline	S26: S1, S2, S3,S4, S5, S25	5		
Medline	S27 Strategy	(87 096)		
Medline	S28: S1, S2, S3, S4, S5, S27	0		
Medline	S29 respons*	(506 099)		
Medline	S30: S1, S2, S3, S5, S29	29		
Medline	S31 PRN	(306)		
Medline	S32: S1, S2, S3, S31	5		
Medline	S33 Seclusion	(261)		
Medline	S34: S1, S4, S33	34		
Medline	S35 Restrain*	(5 443)		
Medline	S35: S1, S2, S4, S35	12		
Medline	S36 Psychoeducation	(544)		
Medline	S37: S1, S2, S3, S4, S36	1		
Medline	S38 Engage*	(31 967)		
Medline	S39: S1, S2, S4, S5, S38	1		
Medline	S40 De-escalation	(267)		

Medline	S41: S2, S3, S40	8		
Medline	S42 Sensory modulation	(55)		
Medline	S43: S1, S42	9		
Medline	S44 Touch	(6 276)		
Medline	S45: S2, S5, S44	10		
Medline	S46 Humo*	(6 735)		
Medline	S47: S2, S5, S46	1		
Medline	S48 Limit-setting	(63)		
Medline	S49: S5, S48	10		
Medline	S50 Silence	(1 895)		
Medline	S51: S2, S5, S50	2		
Medline	S52 Observation*	(117 453)		
Medline	S53: S1, S2, S3, S4, S52	10		
Medline	S54 Ward dynamics	0		
Medline	S55 Milieu	(4 301)		
Medline	S56: S2, S4, S55	20		
Medline	S57 Ethnograph*	(2 607)		
Medline	S58: S1, S2, S57	29		
Medline	S59 Culture	(93 089)		

Medline	S60: S1, S2, S3, S4, S5, S59	1		
Medline	S61: S2, S4, S5, S59	21		

Manual hand search of reference lists for retrieved articles:

Bonnell et al. (2014) = 1 18

Bridgett et al. (2012) = 1 19

Appendix 3: Literature review summary table

	Author (year) / country	Study design	Sample size, child and adolescent age range, and sites.	Comments/ key findings	Limitations	Quality appraisal: Include/ exclude
1	Rasmussen, P., Henderson, A.A.N., & Muir-Cochrane, E. (2012). An analysis of the work of Child and Adolescent Mental Health nurses in an inpatient unit in Australia. *Journal of Psychiatric and Mental Health Nursing, 19*(4), 374-377. Australia.	Qualitative: Interpretive methodology – social constructivist theoretical framework. Document analysis led to focus group questions with aim to identify themes for semi-structured interview questions (not reported in findings).	Adolescent MH inpatient unit (singe site). Focus groups (x7) = 19 participants Age range not reported.	Initial findings provide interpretation and description of Child and Adolescent (C&A) mental health nursing (MHN) role. Developmental (nursing practice, learning environment) and contextual (teamwork, risk & safety, professional issues) frameworks	Study reporting only initial findings of focus groups, no semi-structured interview data available. Description of participants provided but no description of inpatient unit (e.g. number of beds) – environmental/ contextual factors.	Include

2	Bobier, C., Dowell, J., & Swadi, H. (2009). An examination of frequent nursing interventions and outcomes in an adolescent psychiatric inpatient unit. *International Journal of Mental Health Nursing, 18*, 301-309. New Zealand	Quantitative: Quality assurance project – cross-sectional study. Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA: 13-item symptom measurement tool), and Youth Inpatient Unit (YIU) Intervention Inventory measures examined.	Christchurch Youth Inpatient Unit – single site. N=46 treatment admissions. Adolescent participant age range = 16-18.	No differences in admission HoNOSCA total scores between patients with mixed disorders and patients with psychosis (P= 0.123), or mood disorders (P = 0.201). Patients diagnosed with mixed disorders received stress management (and problem-solving interventions more frequently than those diagnosed with mood (p=0.006) or psychotic disorders (p=0.026) Positive associations were shown when all disorders were analysed together for medication education, with a reduction of the HoNOSCA total score (r = 0.347, P = 0.019), and symptom score (r = 0.303, P = 0.043)	Intervention tool only categorises formal interventions and does not include informal interventions that nurses have difficulty quantifying (e.g. listening, encouragement) Small sample size Patient age range (16-18 years) – decreases generalisability.	Include

3	Greene, P.E. (2004). The lived experience of psychiatric –mental health nurses who work with suicidal adolescents in inpatient psychiatric settings. Texas Women's University. U.S.A	Qualitative: Phenomenology – Collaizi's (1978) procedural steps. Nursing theories used in data analysis: Peplau, Orlando, Travelbee, Benner	Purposeful sampling – (snowballing) N=12. No specific site.	Themes generated from data: • Self • Safety • Therapeutic relationships • Why stay? • Professional development • Multidisciplinary team (MDT) • Patient factors	Phenomenolog-ical studies are not generalisable, however rigour, authenticity, and trustworthiness discussed.	Include
4	Dean, A.J., McDermott, B.M., & Marshall, R. T. (2006). *PRN* sedation-patterns of prescribing and administration in a child and adolescent mental health inpatient service. *European Child and*	Retrospective chart reviews. Descriptive/exploratory statistics	N=122 Single site metropolitan 12-bed acute child and adolescent inpatient unit. Age range:	• Approximately 75% of patients (sic) received *prn* (1-6 agents). • Number of doses/patient range = 1-54 (mean 8, median 3) • Indications for use not well documented.	Retrospective chart reviews – data only available by what is documented (including bias) Limited access to staff or time in environment	Include

	Adolescent Psychiatry, 15(5), 277-281. Brisbane, Qld, Australia.		2-17 (average 12.8 years).	• Agitation 38%, aggression 14.5% - mostly 2-10pm (peak 8pm). • Clinical factors, history of abuse, self-harm, suicidal behaviour did not influence *prn* use.	– does not consider interactional/ contextual factors.	
5	Varol Tas, F., Guvenir, T., & Cevrim, E. (2010). Patients' and their parents' satisfaction levels in a child and adolescent mental health unit. *Journal of Psychiatric and Mental Health Nursing, 17*, 769-774. Turkey	Retrospective survey – questionnaire. Descriptive statistics. 5-Point Likert scale for 27 items by adolescent pts.	N=39 (7-drop-outs) Single site adolescent inpatient unit – Turkey). Adolescent participant age range: 11-18.	Unit assessed to be "helpful" by young people and parents. Clinician rated scores for individual psychopathology (37% 'much better', 58.7% 'partly better) and family functioning (10.9% 'much better', 63% 'partly better'). Patient satisfaction levels highest for admission process, availability and helpfulness of staff, and socio-cultural outings.	Small sample size – poor generalisability Patient (sic) mental state not examined at time of collection No description of tools used by clinicians to measure psychopathology or family functioning.	Exclude Insufficient details of tools used to measure symptom severity. Findings report overall satisfaction with admission period, not intervention based as per

						proposed study.
6	Azeem, M.W., Aujla, A., Rammerth, M., Binsfield, G., & Jones, R.B. (2011). Effectiveness of six core strategies based on trauma informed care in reducing seclusions and restraint at a child and adolescent psychiatric hospital. *Journal of Child and Adolescent Psychiatric Nursing, 24*, 11-15. U.S.A	Retrospective study – descriptive statistics. Demographic and clinical variables, seclusion and restraint (S&R) database – medical records/"standard form" Six core strategies: • Leadership toward organisational change • Use of data to inform practice • Workforce development • Use of S&R reduction tools • Improved consumer roles • Debriefing techniques	N= 458 (276 females/182 males) 9-bed male unit, 9-bed female unit, 8-bed child unit – single site. Adolescent participant age range: Male and female unit = 13-18; child unit 6-12)	17.2% patients required S&R (n=79 – 44 female, 35 male). 278 episodes of S&R (139 seclusion/119 restraints). 3.5 episodes/patient mean (range (1-28). 1st 6 months 93 episodes (73 seclusions, 20 restraints) Last 6 months 31 episodes (6 seclusions, 25 restraints). Higher rates of seclusion and restraint for patients diagnosed with disruptive behaviour or mood disorders. Direct correlation with an increased length of stay (LOS) and S&R incidents	There was no data available to report on per 10,000 bed days (reduces impact). Possible bias due to concurrent Dialectical Behaviour Therapy (DBT_ program implemented on units). Retrospective data, possible documentation bias. Short duration of baseline data before implementation	Include

				(3+ = 84 days, <3 =64 days).	of strategies.	
7	Bonnell, W., Alatishe, Y.A., & Hofner, A. (2014). The effects of a changing culture on a child and adolescent psychiatric inpatient unit. *Journal of the Canadian Academy of Child & Adolescent Psychiatry, 23*(1), 65-69. Canada	Before and After study - comparative statistical analysis. Implementation of external reviewers recommendations including staff restructuring, debriefing sessions, and staff training of collaborative-problem solving (CPS) program. Outcome measures: • Demographic data • Reportable incidents • Constant observations • Sick leave • Seclusion use • Security response • LOS	Before n= 85 After n= 39 7-bed C&A inpatient unit. Adolescent participation age range: Not defined however mean patient age before group = 14.3 (SD=2.5), and mean age of after group = 15 (SD=2.4).	No significant differences for: • Gender (p=0.432) or age (p=0.205) • Reportable incidents (p=0.054) • Sick leave (p= 0.103) • Seclusion (p=0.104, 95%CI) • Security (p=0.191) • LOS (p=0.745) Significant differences: • Proportion of patient diagnoses (p=0.036) (before group = adjustment, anxiety, psychotic/ after = personality disorder) • Constant observations (p=0.002), median number of hours of	Overlapping of intervention and retrospective analysis. Too short a time period to assess change (before 2008/9 – after 2010). Small Unit (7-bed), affects power of study results. Decreased incidents, security involvement, and observation results may have been affected by chemical sedation	Include

				observation before = 580.3 (SD=225.3), after 372.4 (SD=126.9). • Chemical sedation intervention not measured/reported, however there are results for seclusion rates but no physical restraints during study period?	intervention – not reported.	
8	Winterfeld, U., Le Heuzey, M., Acquaviva, E., Mouren, M., Brion, F., & Bourdon, O. (2009). The use of *prn* medication in a child and adolescent mental health inpatient service in France. *International Journal of Psychiatry in Clinical Practice, 13*, 252, 258.	Prospective survey - analysis of *prn* prescription and administration over 4 months. Outcome measures: • Demographic • LOS • *PRN* use administration • Medications (agents used)	N= 187 Two acute C&A units (24 inpatient beds) and a partial hospitalisation facility (9 beds). Age range not reported, however *prn* group mean age = 13.0 (SD +/-2.4),	*PRN* admin: Significant differences between groups (with *prn*, without *prn*): • Gender (male p=<0.0001) • Age (p=<0.001) • LOS (35 vs 12 days, p=0.0001) • Distribution of clinical diagnosis differed significantly between groups	Single site study – affect generalisability Patient (sic) diagnoses were taken from admission assessment no assessment specific for study purposes.	Include

	Paris, France.		and without *prn* group = 9.7 (SD +/- 3.1).	2.9 (+/- 2.9; range 1-15) doses/patient average Oral *prn* 94%, 5% IM Evening most used (peak 2300hrs) Symptoms associated with *prn* administration: Anxiety 67%, disruptive behaviour 22%, insomnia 8%. "Other" diagnosis most *prn* administration group (34%) (Personality disorder, narcolepsy, Conversion Disorder, and Tourette's Disorder).		
9	Gullick, K., McDermott, B., Stone, P., & Gibbon, P. (2005). Seclusion of children and adolescents: Psychopathological	Case-control and descriptive statistics analysis. Outcome measure: • Demographic data	Secluded n=70 Non-Secluded n= 78	199 seclusion events (n=70 patients): - Children and adolescents >13years made up 86% of all seclusion	Dataset does not include all factors to develop predictive model as per aim of study. Authors	Include

and family factors. *International Journal of Mental Health Nursing, 14*, 37-43. Australia	• Seclusion events database • Child behaviour checklist (CBCL) • General Health Questionnaire (GHQ) • General Functioning Scale of the Family Assessment Device (GFS-FAD) • Life Events Scale (LES) • Youth Self Report (YSR)	Outpatient n=84 Adolescent participant age range not specified – "child and adolescent facility"	events. - Almost two-thirds (65.7%) of secluded group were male. - Of 70 secluded patients 31 (44%) secluded only once (range 1-13) Significant differences between secluded group and non-secluded/ outpatient groups: - Younger age (p=<0.001) - CBCL total scores (p=<0.001) - FAD scores (p=<0.01) Precursors to seclusion: - Risk to others (75%) - Violence toward staff (29%) - Risk self (28%) - Property damage (12%) - Actual DSH (2.5%)	suggest need for: Demographic data Measure for parenting styles Family modelling and impulse control measures Peer interaction Prior anti-social acts

10	Van Kessel, K., Milne, D., Hunt, K., & Reed, P.W. (2012). Understanding inpatient violence in a New Zealand child and adolescent psychiatric setting. *International Journal of Psychiatric and Mental Health Nursing, 21*, 320-329. New Zealand	Cross-sectional – retrospective clinical audit. • Demographic and clinical data • Rates of violence • Characteristics of incident • Antecedents to incidents • Consequences Comparison between admissions with violence (WV) and those without WoV).	N= 263 Continuous admissions over 2 year period in 25-bed C&A mental health inpatient unit. Adolescent participant age range: Children and adolescents up to 18 years.	Risk factors for aggression and violence: (multivariate modelling): • Maori ethnicity • Involuntary admission • LOS (p=0.001) “Although predictive of violence, these factors account for only a minority of all that might portend violence during an admission” (p.323). Staff most frequent victims of assault/ most severe cases. Antecedents - Positive symptoms, hostility, agitation, limit setting by staff. Consequences: seclusion, restraint, *prn* medication,	Retrospective design Under-reporting Scale used to measure injury to staff measured physical, not psychological. Young people not asked about antecedents – staff perceptions (reporting bias) Single unit-limited generalisability	Include

				de-escalation [(p=<0.05) between the severity of incident and type of consequence].		
11	Martin, A., Krieg, H., Esposito, F., Stubbe, D., & Cardona, L. (2008). Reduction of restraint and seclusion through collaborative problem-solving: A five year prospective inpatient study. *Psychiatric Services, 59*(12), 1406-1412. U.S.A	Before and after – implementation of Collaborative Problem-Solving (CPS) intervention to reduce Seclusion and restraint (S&R) rates. • Demographic and clinical data. • S&R rates/duration • Staff injuries.	N=755 15-bed acute C&A inpatient unit. Continuous admission five-year period. (2003-2007 fiscal years). Adolescent participant age range: “School aged children” (Range 3-15, median age 11).	Risk factors for S&R: Male (χ^2=2.94) African-American (χ^2=2.94). 2230 S&R incidents (559 restraints/1671 seclusion events (25/75%). Reduction in number of restraints from 263 to 7/year (a 37.6-fold reduction, slope β =–0.696). Decrease seclusion events (432 events to 133/year (a 3.2-fold reduction, β =–0.423). Staff injury – 180 (peak 2006 mid-implementation).	No test for IQ measure (unlike other studies). No *prn* use data reported No data on child injuries as result of S&R events No objective measure of adherence by staff to CPS program Several milieu changes implemented at time of program may also have impacted	Exclude Age range (3-15 years) and demographics of this sample not similar (generalisable) to proposed study. Different cultural and contextual perspective

					results: Increased family involvement in treatment Improved phone access on unit Longer visiting hours Family education and support program	
12	Wheatley, M., & Austin-Payne, H. (2009). Nursing staff knowledge and attitudes toward deliberate self-harm in adults and adolescents in an inpatient setting. *Behavioural and Cognitive Psychotherapy, 37*,	Cross-sectional – comparison between groups. Demographic data Vignette Questionnaire comprised adapted questions from: Q1-5 Attributional Style Questionnaire (ASQ)	N= 76 (27 adolescent and 49 adult mental health nurses) 12% response rate for questionnaire	Attitude: Similar scores for effectiveness of managing DSH between groups (11.54 adult vs 11.63 adolescent), however nurses caring for adolescents' scored higher for negativity and worry (p=0.06). Knowledge: no significant difference between groups	Not discussed in paper Potential for non-response bias (12% response rate).	Exclude Limitations not discussed, poor response rate possibly affecting results, and only minimal

	293-309. United Kingdom	Q6-9 Emotional Response Rating Scale Q10-11 Optimism/Pessimism Scale Q12-14 Helping Behaviour Scale Modified knowledge and attitude questionnaire (Yes/No response)	Age range of clients for adolescent mental health nurse participants not reported.	All other data does not differentiate between adult and adolescent nurses (see inclusion criteria)		findings relevant to critical review for proposed study.
13	Pogge, D.L., Pappalardo, S., Buccolo, M., & Harvey, P.D. (2013). Prevalence and precursors of the use of restraint and seclusion in a private psychiatric hospital: Comparison of child and adolescent patients.	Cross-sectional – comparison of child and adolescent groups – prospective data collection (2 year period). S&R order form. Demographic data: - Age - Gender - Socio-economic	N=2411 Continuous admission data. Age range for participants: Child unit (>12yrs) Adolescent	Almost one-third (29%, n=703) of sample experienced S&R. Predicted factors for risk of seclusion and restraint: - Young age (p=<0.001) - Increased LOS (p=<0.001) Therapeutic benefit? Majority of sample had one	Single site study (generalizability) Diverse sample mix due to geographical borders of catchment area (city/urban/rural) however this is representative of the study	Include

	Administration and Policy in Mental Health, 40, 224-231. U.S.A	status Clinical (clinician rated except LOS): - Global Assessment of Functioning (GAF) - Derogatis Psychiatric Rating Scale (DPRS) - Global Pathology Index (GPI) - Children's Psychiatric Symptom Rating Scale (CPSR) - LOS (p.227)	unit (13-17),	episode only. Adolescents had fewer events but longer duration than children. Adolescents more likely to have suicidal ideation (SI) and deliberate self-harm (DSH) behaviours, so instrumental/planned aggression as opposed to explosive child (Hot/Cold cognitions). Adolescents: Reaction to rules/restrictions of unit – not because unable to control behaviour.	population.		
14	Bridgett, D.J., Valentino, K., & Hayden, L.C. (2012). The contribution of children's temperamental fear and effortful control to restraint and	Cross-sectional – prospective data collection. Measures: • Maltreatment Classification System (MCS)	n=52 Continuous sample. Excluded – severely intellectually delayed,	Poor effortful control (EC) and high fear is associated with restraint ($p<0.001$), and seclusion ($p<0.05$). Temperament characteristics robust after accounting for clinical/demographic	Missing data (p.7). Diagnosis for young people obtained from initial assessments, not specifically	Include	

	seclusion during inpatient treatment in a psychiatric hospital. *Child Psychiatry and Human Development.* U.S.A	• Child Behaviour Checklist (CBCL) • Children's Depression Index (CDI) • Early Adolescent Temperament Questionnaire Revised (EATQ-R) • Delis-Kaplan Executive Function System (D-KEFS).	acutely psychotic pts. Adolescent participant age range: 7-17 years.	variables. Significant association with S&R in first two weeks of admission period (r=0.44, p<0.05). Total S&R associated with LOS (r= 0.83, p<0.05). Maltreatment history, after accounting for age and gender did not emerge as a predictor of either seclusion or restraint (p<0.10)	for study purposes. Modest sample size (n=52)	
15	Siponen, U., Valimaki, M., & Kaltiala-Heino, R. (2012). The use of coercive measures in adolescent psychiatric inpatient treatment: A nation wide register study. *Social Psychiatry and Psychiatric Epidemiology, 47*,	Retrospective database register audit. Descriptive statistics: • Demographic • Clinical • S&R rates/duration • Involuntary Intra-muscular (IM) sedation rates	Continuous sampling. Continuous admissions to 5 tertiary catchment areas, comprising 21 hospital districts (nation-wide	531 incidents of coercive interventions. Average prevalence of S&R use was 1.71/10 000/year for study period. S&R much more common than IM sedation. Significant variation across regions and catchments. Two of the five catchment	Despite 8-year study period there are low numbers of incidents affecting impact. Time period of study does not report changes to legislation that were introduced	Include

	1401-1408. Finland		register/data). Age range of participants: 12-17 years.	areas reported lower incidences than the national average. Risk factors for coercive measures: female (p=0.005). Equal incidence (27%) of coercive treatment for early (12-14) and middle (15-17) adolescent age groups. Treatment cultures more likely to explain variances between catchments. Qualitative studies needed to achieve an understanding of impact of culture on coercive interventions.	during this time. Insufficient data for IM/physical restraint to run detailed separate analysis.	
16	Bernsten, E., Starling, J., Durheim, E., Hainsworth, C., de Kloet, L., Chapman, L., & Hancock, K.	Descriptive statistics – retrospective database/file audits. • Incidents of Deliberate self-	N=294 adolescent patients. Continuous admissions	475 incidents – 292 (63%) aggression & 139 (29%) Deliberate self-harm (DSH). 294 patients - 61% female.	Reporting bias – Incident Information Management System (IIMS) data often	Include

(2011). Temporal trends in self-harm and aggression on a paediatric mental health ward. *Australasian Psychiatry, 19*, 64-69. Australia	harm (DSH), aggression, and seclusion. • Interventions: - Staff training - Dialectical Behaviour Therapy (DBT) and Behaviour programs - Exercise	between Jan 2006/Aug 2009. Age range of adolescent participants: 6-16 years. De-identified work schedule of nurses for one year.	84 patients involved in 475 incidents: - Average age 13yrs (SD=2) - Females accounted for 62% of aggressive and 82% of DSH incidents. - Diagnosis: depression (52%), Conduct Disorder (35%), and Post-Traumatic Stress Disorder (29%). Seclusion and aggression were highly correlated (Pearson correlation: 0.37, P <0.0001); seclusion followed 73% of aggressive events. There was a 3-fold decrease in DSH incidents, with 35% of DSH incidences requiring seclusion as a management practice. One nurse had 70 seclusions and 52 aggressive DSH incidents,	incomplete and subject to reporting bias due to individual thresholds for defining and reporting aggression Multiple interventions delivered simultaneously No objective measure of staff adherence to DBT

				while another only registered 6 aggressive and DSH incidents combined (staff influences) “A more detailed measure of individual staff-patient interactions would be useful” (p. 69).		
17	Dean, A., Duke, S.G., George, M., & Scott, J. (2007). Behavioural management leads to reduction in aggression in a child and adolescent psychiatric inpatient unit. *Journal of the American Academy of Child and Adolescent Psychiatry, 46*(6), 711- 720. Qld, Australia.	Before and after: Comparisons six-months pre and post-intervention (behavioural management program). Behavioural management program: - Staff training - Individual patient management plans - Standardised framework for behavioural management Measures:	N=151 admissions (65 pre/86 post). 10-bed C&A inpatient unit. Participant age range: 4-18.5 years.	Demographic data (Before): - Age: 13.6 years SD=3.11, 33% children, 67% adolescents). - Gender: Female 56.9% - LOS 18.4 days (SD=20.8, median 9, range 1-84) (After) - Age: 13.3 years (SD=2.90, 47% children, 53% adolescents) - Gender: Female 60.5%) - LOS 21.2 days (median 14, range 1-152,	Program not planned with research in mind. Reporting bias: retrospective clinical recording as opposed to prospective standardised tool. Number of gaps in outcome data No data on staff morale, patient	Include

		• Aggressive incidents rates • Injury rates (staff & patients) • Security involvement • Physical restraint & seclusion rates • Time-out rates • *Prn* sedation use • Staff factors (sick leave, casual pool, budget) • HoNOSCA (13-item symptom measurement tool)	SD=46.2) Significant reduction in number of general incidents ($p<0.05$), injuries ($p<0.05$), and restraint interventions ($p<0.001$). Significant improvement in HoNOSCA for both groups between admission and discharge ($p < .001$), but no differences between admissions occurring before or after implementation of the program ($p = 0.23$).	preferences, or family attitudes.	
18	Dean, A.J., Gibbon, P., McDermott, B.M., Davidson, T., & Scott, J. (2010). Exposure to aggression and the impact on staff in a child and adolescent inpatient unit. *Archives of Psychiatric Nursing,*	Mixed methods: Quantitative -incidence of exposure to aggression and General Health Questionnaire (GHQ-30) scores. Qualitative – broad content analysis of responses to two interview questions	N=33 (70% response rate). All clinical and non-clinical staff of 10-bed C&A inpatient unit. Age range = 2-17 (average	Quantitative Demographic (n=33): - Two-thirds female - Mean age 42 years - ½ nurses Rates of aggression: 85% staff at least one episode of violence and aggression,	Small study sample.	Include

	24(1), 15-26. Australia.	(recorded and transcribed)	12.8).	(91% verbal). 97% believed was “part of the job”, however 70% rated as “unacceptable level on unit” Nurses most likely to be exposed. One-third of participants considered resigning due to aggression. Qualitative: Q1) Physical, emotional, and professional domains Q2) Type, frequency, young person characteristics, context.		
19	Tompsett, C.J., Domoff, S., & Boxer, P. (2011). Prediction of restraints among youth in a psychiatric hospital:	Translational action research (prospective). To examine individual and contextual factors for risk of restraint for C&A	N= 149 Continuous sample (admissions between Jan-	Demographic: - 85 males, 61 females - Mean age 14, (SD=3)	Sensitivity of measures used - maltreatment/abuse not	Include

Application of translational action research. *Journal of Clinical Psychology, 67*(4), 368-382. U.S.A	inpatients. Clinician rated 27-item Risk Analysis Checklist for Institutionalised Youth (RACIY): - History of aggression - History of maltreatment - Family history of risk for aggression - Demographic data - Body Mass Index (BMI) - Previous hospitalisation/placement (if institution) - Intelligence functioning - Psychiatric diagnosis	June 2008). Age range of participants: 5-17 years.	Clinical: - LOS 42 days (range 2-221). - Diagnosis: Bipolar (48%), mood disorder (29.5%). Of 149 youth: - 40 (27%) restrained (224 incidents – 40 mechanical/184 physical). - 37 (93%) fewer than 15 restraints. - 221 incidents of aggression with 145 against staff, 20 toward fellow young person, 30 DSH.	factored. No *prn* or de-escalation considered to compare against restraint practices (fewer coercive measures).

Appendix 4: Information statement - nurses

Stephen Spencer
School of Nursing and Midwifery,
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Information Statement for the Research Project: Nurses.

What responses and interventions do nurses believe are most helpful during episodes of distress in an acute child and adolescent mental health inpatient unit?

Document Version [3]; dated [14/10/2013]

You are invited to participate in the research project identified above which is being conducted by Mr Stephen Spencer from the School of Nursing and Midwifery at the University of Newcastle.

The research is part of Mr Stephen Spencer's PhD studies at the University of Newcastle, supervised by Conjoint Prof Teresa Stone and Prof Margaret McMillan from the School of Nursing and Midwifery, University of Newcastle and Assoc Prof Tanya Hanstock from University of New England.

Why is the research being done?

The purpose of the research is to observe the interactions between adolescent mental health clients and nurses and conduct interviews based on themes extracted from the observation period to elicit information about what responses, engagement strategies and interventions adolescent mental health clients and nurses believe are helpful in times of crisis during an admission to a child and adolescent inpatient unit.

An ethnographic methodology will be used for this study and will involve a period of observation where the researcher will observe the interactions between nurses and adolescents in the acute inpatient unit in regard to crisis intervention. Ethnographic

research allows for understanding and discovery, observation of the group in a 'natural' setting and an opportunity for the researcher to provide explanations for the behaviours observed. Ethnography allows for understanding and "making sense" of the behaviours of the group being studied and thus drives clinical practice development.
Ethnography will be used over other forms of qualitative methods such as questionnaires as these types of methods may miss the subtleties and complexities of adolescent mental health crisis intervention. The observation component of this study will provide the impetus for direct and pertinent questions in an semi-structured way to elicit a deeper understanding of the themes extracted from the observatory period.

Who can participate in the research?

We are seeking permanent or casually employed nurses who work at the Nexus child and adolescent mental health inpatient unit, John Hunter Hospital to participate.

What choice do you have?

Participation in this research is entirely your choice. Only those people who give their informed consent will be included in the project. Whether or not you decide to participate, your decision will not affect your relationship with Hunter New England Mental Health.

What would you be asked to do?

If you agree to participate, you will be asked to attend an interview with the researcher. The interview questions will follow a situation (what was happening), action (what did you/ the client do) and outcome (what was the result) format, and will ask you to remember a time during your clinical duties where a client was in distress or upset.
You will be given an opportunity to review the written transcript of your interview. The interview transcripts and all your responses will be non-identifiable. The research team noted above will be the only people who have access to your responses.

How much time will it take?

The interview should take approximately 30-45 minutes to complete.
It is envisaged that I would take no more than 30 minutes to review the transcript of your interview, if you choose to do so.

What are the risks and benefits of participating?

The risks associated with participation in this study may include remembering episodes of care that were difficult to manage clinically. If during the course of participating in this study you have any concerns or require assistance please contact the research team on the numbers and emails provided below or utilise the Employee Assistance Program (EAP) services by contact them on (02) 4921 2822.

You may not benefit from participating in this study.

How will your privacy be protected?

You will be assigned a coded pseudonym as a way of protecting your privacy and confidentiality on all documents or electronic data collected. These will be kept securely in a locked filing cabinet and external hard drive respectively. Data will be retained for at least five years at the School of Nursing and Midwifery, University of Newcastle.

How will the information collected be used?

The information collected from the interview will be analysed and presented as part of the researcher's PhD dissertation. As part of this process the information may also be presented in scholarly journals, via presentations and to the area health service if requested.

Participants of the study will be forwarded a summary of the work submitted as part of this higher degree and may request a copy of the final dissertation by emailing a request to the research team.

What do you need to do to participate?

Please read this Information Statement and be sure its contents are clear to you before you consent to participate. If there is anything you do not understand, or you have questions, contact the researcher.

If you would like to participate in this study please fill out and sign the consent form attached and forward it to Mr Stephen Spencer via internal mail to the Nexus Child and Adolescent Mental Health Unit, John Hunter Hospital.

Complaints about this research

This project has been approved by the Hunter New England Human Research Ethics Committee, Approval No. 13/7/17/4.05.
Should you have concerns about your rights as a participant in this research, or you have a complaint about the manner in which the research is conducted, it may be given to the researcher, or, if an independent person is preferred, to the Human Research Ethics Officer, Research Ethics and Governance Unit, Hunter New England Health, John Hunter Hospital, Lookout Rd, New Lambton, NSW 2305 or via phone 02 49214950 or email, Nicole.Gerrand@hnehealth.nsw.gov.au

Further information
If you would like further information please contact Mr Stephen Spencer or the project supervisor, Dr Teresa Stone, School of Nursing and Midwifery, University of Newcastle.

Thank you for considering this invitation.
Stephen Spencer
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Professor Teresa Stone
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Margaret McMillan@newcastle.edu.au

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Appendix 5: Information statement – clients

Stephen Spencer
School of Nursing and Midwifery,
University of Newcastle,
NSW, 2308
02 49855800
c9518187@uon.edu.au

Information Statement for the Research Project: Clients.
What responses and interventions do nurses believe are most helpful during episodes of distress in an acute child and adolescent mental health inpatient unit?
Document Version [3]; dated [14/10/2013]

You are invited to participate in the research project identified above which is being conducted by Mr Stephen Spencer from the School of Nursing and Midwifery at the University of Newcastle.

The research is part of Mr Stephen Spencer's PhD studies at the University of Newcastle, supervised by Conjoint Prof Teresa Stone and Prof Margaret McMillan from the School of Nursing and Midwifery, University of Newcastle and Assoc Prof Tanya Hanstock from University of New England.

Why is the research being done?
The purpose of the research is to gain an understanding of what responses, engagement strategies and interventions adolescent mental health clients and nurses believe are helpful in times of crisis during an admission to an inpatient unit.

An ethnographic methodology will be used for this study and will involve a period of observation where the researcher will observe the interactions between nurses and adolescents in the acute inpatient unit in regard to crisis intervention. Ethnographic

research allows for understanding and discovery, observation of the group in a 'natural' setting and an opportunity for the researcher to provide explanations for the behaviours observed. Ethnography allows for understanding and "making sense" of the behaviours of the group being studied and thus drives clinical practice development.

Ethnography will be used over other forms of qualitative methods such as questionnaires as these types of methods may miss the subtleties and complexities of adolescent mental health crisis intervention because they rely on self-report. The observation component of this study will provide the impetus for direct and pertinent questions in an unstructured way to elicit a deeper understanding of the themes extracted from the observatory period.

Who can participate in the research?

We are seeking adolescent mental health clients, aged 16 years and above who have been an inpatient at the Nexus Child and Adolescent mental health unit, John Hunter Hospital and are currently receiving care from one of the community mental health services with the HNE CAMHS (Lake Macquarie, Newcastle and Hunter Valley) teams.

What choice do you have?

Participation in this research is entirely your choice. Only those young people who give their informed consent (and that of their parent/guardian) will be included in the project. Whether or not you decide to participate, your decision will not affect your relationship with Hunter New England Mental Health.

What would you be asked to do?

If you agree to participate, you will be asked to attend an interview with the researcher following one of your scheduled appointments with the community mental health team. The interview questions will follow a situation (what was happening), action (what did you/ the nurse do) and outcome (what was the result) format, and will ask you to remember a time during your admission to Nexus where you were in distress and required help from the nurses.

It should be noted that any information provided by you regarding illegal activity should not be specific as to time, date and place as this is reportable under the NSW Crime's Act.

The interview transcripts and all your responses will be non-identifiable. The research team noted above will be the only people who have access to your responses. You will also be offered an opportunity to review the transcript of your interview.

How much time will it take?

The interview should take approximately 30-45 minutes to complete. It is envisaged that it will take approximately 30 minutes to review your interview transcript, if you choose to do so.

What are the risks and benefits of participating?

The risks associated with participation in this study may include remembering a time when you received care at the Nexus inpatient unit when you were upset or managing the symptoms of your illness. If during the course of participating in this study you have concerns or require assistance contact your CAMHS case worker for support. You may not benefit from participating in this study.

How will your privacy be protected?

You will be assigned a pseudonym as a way of protecting your privacy and confidentiality on all documents or electronic data collected. These will be kept securely in a locked filing cabinet and external hard drive respectively. Data will be retained for at least five years at the School of Nursing and Midwifery, University of Newcastle.

How will the information collected be used?

The information collected from the interview will be analysed and presented as part of the researcher's PhD dissertation. As part of this process the information may also be presented in scholarly journals, via presentations and to the area health service if requested.

Participants of the study will be forwarded a summary of the work submitted as part of this higher degree and may request a copy of the final dissertation by emailing a request to the research team.

What do you need to do to participate?

Please read this Information Statement and be sure its contents are clear to you before you consent to participate. If there is anything you do not understand, or you have questions, contact the researcher.

If you would like to participate in this study please fill out and sign the consent form attached (including parent consent) and forward it to Mr Stephen Spencer, School of Nursing and Midwifery, Richardson Wing, University of Newcastle, Callaghan, NSW, 2308.

Complaints about this research

This project has been approved by the Hunter New England Human Research Ethics Committee, Approval No. 13/7/17/4.05.

Should you have concerns about your rights as a participant in this research, or you have a complaint about the manner in which the research is conducted, it may be given to the researcher, or, if an independent person is preferred, to the Human Research Ethics Officer, Research Ethics and Governance Unit, Hunter New England Health, John Hunter Hospital, Lookout Rd, New Lambton, NSW 2305 or via phone 02 49214950 or email, Nicole.Gerrand@hnehealth.nsw.gov.au

Further information

If you would like further information please contact Mr Stephen Spencer or the project supervisor, Dr Teresa Stone, School of Nursing and Midwifery, University of Newcastle.

Thank you for considering this invitation.

Stephen Spencer
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Professor Teresa Stone
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Associate Professor Tanya Hanstock
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Appendix 6: Consent form – nurse observations

Stephen Spencer
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02 49855800
c9518187@uon.edu.au

Consent Form for the Research Project: Nurses
What responses and interventions do nurses believe are most helpful during episodes of distress in an acute child and adolescent mental health inpatient unit?

Mr. Stephen Spencer, Prof. Teresa Stone, Prof Margaret MacMillan (OAM), Assoc Prof Tanya Hanstock
Document Version [2]; dated [14/10/2013]

I agree to participate in the above research project and give my consent freely.

I understand that the project will be conducted as described in the Information Statement, a copy of which I have retained.

I understand I can withdraw from the project at any time and do not have to give any reason for withdrawing.

I consent to:

Being observed by the researcher in common areas of the Nexus unit for the purpose of documenting interactions between the patients and myself.

I understand that my personal information will remain confidential to the researchers.

I have had the opportunity to have questions answered to my satisfaction.

Name: _____

Signature: _____

Date: _____

Appendix 7: Consent form – clients

Stephen Spencer
School of Nursing and Midwifery,
University of Newcastle,
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02 49855800
c9518187@uon.edu.au

Consent Form for the Research Project: Client.
What responses and interventions do nurses believe are most helpful during episodes of distress in an acute child and adolescent mental health inpatient unit?

Mr. Stephen Spencer, Prof. Teresa Stone, Prof Margaret MacMillan (OAM), Assoc Prof Tanya Hanstock
Document Version [2]; dated [14/10/2013]

I agree to participate in the above research project and give my consent freely.

I understand that the project will be conducted as described in the Information Statement, a copy of which I have retained.

I understand I can withdraw from the project at any time and do not have to give any reason for withdrawing.

I consent to:
Being observed by the researcher in common areas of the Nexus unit for the purpose of documenting interactions between myself and the nurses.

I understand that my personal information will remain confidential to the researchers. I have had the opportunity to have questions answered to my satisfaction.

Client Name: _____ Parent/Guardian Name:_____
Signature: _____ Signature: _____
Date: _____ Date: _____

Appendix 8: Consent form - nurse interviews

Stephen Spencer
School of Nursing and Midwifery,
University of Newcastle,
NSW, 2308
02 49855800
c9518187@uon.edu.au

Consent Form for the Research Project: Nurses
What responses and interventions do nurses believe are most helpful during episodes of distress in an acute child and adolescent mental health inpatient unit?

Mr. Stephen Spencer, Prof. Teresa Stone, Prof Margaret MacMillan (OAM), Assoc Prof Tanya Hanstock

Document Version [3]; dated [14/10/2013]
I agree to participate in the above research project and give my consent freely.

I understand that the project will be conducted as described in the Information Statement, a copy of which I have retained.

I understand I can withdraw from the project at any time and do not have to give any reason for withdrawing.

I consent to:
Attending and participating in an interview with the researcher.
Direct quotes from the interview being used (anonymously) as examples in reported data from this study. (No individuals will be identified in reported data).

I understand that my personal information will remain confidential to the researchers.

I have had the opportunity to have questions answered to my satisfaction.
Print Name: _____

Signature: _____

Date: _____
Contact numbers:_____

Appendix 9: Semi-structured interview questions

Semi-structured in-depth interview prompts:

The participant will be greeted and reminded of the researcher's role and the aims of the research prior to commencement. The researcher will verify the signature on the study consent form and confirm that he or she is willing to be interviewed.

Thank you for coming to the interview today. Before we commence I would like to remind you that you can withdraw at any time during this interview and let me know if any of the topics discussed are distressing for you. I also ask for your permission to record this interview.

Adolescent participants:

- Can you tell me about the experience of your admission to the Nexus unit?
- **Situation:** Can you tell me about a time that you were upset, angry or frustrated? What was happening what were your thoughts, who was there at the time?

  Action: What did the nurses do at these times to help/assist you?

  Outcome: Did this help? How did you feel, can you use this at home etc?

It is intended that the researcher will ask if there was more than one incident as described above and the situation, action, outcome template will be used to explore these.

- Do you have any suggestions on how we can improve our service to young people in the future?
- Do you have any further comments you would like to make in regard to your admission to Nexus?

Nurse's questions:

- **Situation:** Can you tell me about an experience you may have had working with a client at Nexus was in a state of crisis? What was happening, what were your thoughts, who was there at the time?

Action: What did you do? How did you engage with the client? Did you have an established therapeutic relationship (or rapport) with the client? What engagement strategies or intervention did you use to manage the crisis?

Outcome: Do you think your intervention was helpful? Was the outcome what you were expecting?

- What do you see as the interventions that are most helpful to young people at Nexus who are stressed, sad, angry, upset, frustrated, annoyed etc..?
- Do you have any suggestions on how we can improve our service to young people in the future?
- Do you have any further comments?

The participant will be thanked for participating and reminded of the opportunity to review the transcript, if he or she would like to.

Appendix 10: Ethics approval letter

18 October 2013

Professor Teresa Stone
Faculty of Health Sciences
Yamaguchi University
UBE Japan

Dear Professor Stone,

Re: What responses, engagement strategies & interventions do adolescent mental health clients & nurses believe are most helpful on an inpatient unit during a crisis: Nursing strategies in response to crisis on an adolescent inpatient unit (13/07/17/4.05)

- **HNEHREC Reference No: 13/07/17/4.05**
- **NSW HREC Reference No: HREC/13/HNE/272**

SSA Reference No: SSA/13/HNE/425

Thank you for submitting the above protocol for single ethical review. This project was first considered by the Hunter New England Human Research Ethics Committee at its meeting held on **17 July 2013.** This Human Research Ethics Committee is constituted and operates in accordance with the National Health and Medical Research Council's *National Statement on Ethical Conduct in Human Research (2007)* (National Statement) and the *CPMP/ICH Note for Guidance on Good Clinical Practice*. Further, this Committee has been accredited by the NSW Department of Health as a lead HREC under the model for single ethical and scientific review. The Committee's Terms of Reference are available from the Hunter New England Local Health District website: http://www.hnehealth.nsw.gov.au/Human_Research_Ethics.

I am pleased to advise that following acceptance under delegated authority of the requested clarifications and revised Information Statements and Consent Forms by Dr Nicole Gerrand Manager, Research Ethics & Governance, the Hunter New England Human Research Ethics Committee has granted ethical approval of the above project.

The following documentation has been reviewed and approved by the Hunter New England Human Research Ethics Committee:

- For the Information Statement for Nurses (Version 3 dated 14 October 2013);
- For the Consent Form for Nurses (Version 3 dated 14 October 2013);

- For the Information Statement for Clients (Version 3 dated 14 October 2013);
- For the Consent Form for Clients (Version 3 dated 14 October 2013); and
- For the Researcher on Premises Poster (Version 1 dated 28 June 2013)

For the protocol: **What responses, engagement strategies & interventions do adolescent mental health clients & nurses believe are most helpful on an inpatient unit during a crisis: Nursing strategies in response to crisis on an adolescent inpatient unit**

Approval has been granted for this study to take place at the following site:

- **Hunter New England Mental Health**

Approval from the Hunter New England Human Research Ethics Committee for the above protocol is given for a maximum of **3** years from the date of this letter, after which a renewal application will be required if the protocol has not been completed.

The *National Statement on Ethical Conduct in Human Research (2007),* which the Committee is obliged to adhere to, include the requirement that the committee monitors the research protocols it has approved. In order for the Committee to fulfil this function, it requires:

- A report of the progress of the above protocol be submitted at 12 monthly intervals. Your review date is **October 2014.** A proforma for the annual report will be sent two weeks prior to the due date.

- A final report must be submitted at the completion of the above protocol, that is, after data analysis has been completed and a final report compiled. A proforma for the final report will be sent two weeks prior to the due date.

    - All variations or amendments to this protocol, including amendments to the Information Sheet and Consent Form, must be forwarded to and approved by the Hunter New England Human Research Ethics Committee prior to their implementation.

    - The Principal Investigator will immediately report anything which might warrant review of ethical approval of the project in the specified format, including:

        - any serious or unexpected adverse events

            - Adverse events, however minor, must be recorded as observed by the Investigator or as volunteered by a participant in this protocol. Full details will be documented, whether or not the Investigator or his deputies considers the event to be related to the trial substance or procedure. These do not need to be reported to the Hunter New England Human Research Ethics Committee

- Serious adverse events that occur during the study or within six months of completion of the trial at your site should be reported to the Manager, Research Ethics & Governance, of the Hunter New England Human Research Ethics Committee as soon as possible and at the latest within 72 hours.

- All other safety reporting should be in accordance with the NHMRC's Safety Monitoring Position Statement – May 2009 available at http://www.nhmrc.gov.au/health_ethics/hrecs/reference/_files/090609_nhmrc_position_statement.pdf

- Serious adverse events are defined as:

  - Causing death, life threatening or serious disability.
  - Cause or prolong hospitalisation.
  - Overdoses, cancers, congenital abnormalities whether judged to be caused by the investigational agent or new procedure or not.

- Unforeseen events that might affect continued ethical acceptability of the project.

- If for some reason the above protocol does not commence (for example it does not receive funding); is suspended or discontinued, please inform Dr Nicole Gerrand, as soon as possible.

You are reminded that this letter constitutes ethical approval only. You must not commence this research project at a site until separate authorisation from the Chief Executive or delegate of that site has been obtained.

A copy of this letter must be forwarded to all site investigators for submission to the relevant Research Governance Officer.

Should you have any concerns or questions about your research, please contact Dr Gerrand as per the details at the bottom of the page. The Hunter New England Human Research Ethics Committee wishes you every success in your research.

Please quote **13/07/17/4.05** in all correspondence.

The Hunter New England Human Research Ethics Committee wishes you every success in your research.

Yours faithfully
For: Professor M Parsons
Chair
Hunter New England Human Research Ethics Committee

Appendix 11: Observation template

Date:

Time:

Shift:

Number of clients: (occupancy) # of client participants:

Number of nurses: (on shift) # of nurse participants:

---

1. Environmental notes:

- A) People – gender, staff, clients, visitors… Sociogram.
- B) Activities at time.
- C) Objects in environment

2.Situation: (Capture the moment) – context.

- A) Level of distress? Assessment
- B) Interactions/ Therapeutic relationships
- C) Cues, body language (clients/staff)
- D) Relationships – transference/ trust, boundaries
- E) Mental health (?)
- F) Ward dynamics
- G) Routines

3. Action:

- A) Responses
- B) Strategies
- C) Intervention
- D) Person-centred
- E) Custodial

4. Outcome:

- A) Win/Win – Win/Loss – Loss/Loss
- B) Custodial, negotiate, problem-solve, teachable moment
- C) Nurse/ Patient, or collaborative (see-saw of control)
- D) Pay off – (Berne)

- E) Control/ containment

5. Personal reflection:

- A) Assessment – what do I think is going on? It could be that?
- B) Counter-transference (observer)– I felt like? I would have done?

Appendix 12: Researcher on premises poster

Researcher on premises

Mr Stephen Spencer is currently conducting a study as part of his Doctorate studies with the School of Nursing and Midwifery, University of Newcastle.

The research being undertaken is a study whereby Stephen will be spending time on the unit observing the interactions between nurses and adolescent mental health clients in regard to crisis responses, strategies and interventions.

Stephen will be acting as a non-participant observer only and will not be engaging the clients or nurses about what is observed, however field notes will be recorded. Your consent is required to participate in the observation component of this research.

This study has been given ethical approval by the HNE (3/7/17/4.05) and University of Newcastle (H-2014-0030) ethics committees.

The observation period of this study will take place between the dates: _____ to _____.

If you have any questions or would like to know more about this research please contact Margaret McMillan at:

Margaret.McMillan@newcastle.edu.au or 02 43342759

Appendix 13: Research audit trail

Research question:

The primary research question developed for this study was: *What responses and interventions do nurses believe are most helpful during episodes of distress in an acute child and adolescent mental health inpatient unit?* This research question was developed by the researcher due to identified gaps in the literature, and clinical practice, for responding to adolescent distress in an acute mental health inpatient unit.

Researcher bias/Assumptions:

The researcher was employed as a Clinical Nurse Specialist (CNS) on the unit where the study was conducted and therefore the researcher had an 'insider' perspective. To minimise the potential for bias, the researcher used a reflective process to articulate assumptions prior to commencing the research process. In addition, the researcher took leave from his clinical role during stage one of data collection (non-participant observations), to ensure the rigour of the study.

Research process:

The aims of the study were to understand the types of responses and interventions nurses use to assist adolescents during times of distress in an acute mental health inpatient unit. An interpretive descriptive methodology and methods (non-participant observations and semi-structured interviews) were used to gain insights into this complex clinical practice.

Trustworthiness and rigour:

Strategies for ensuring trustworthiness for this study were based on the four criteria of rigour (Guba, 1981; Miles & Huberman, 1994; Shenton, 2004): Credibility; Dependability; Transferability and Confirmability. Conducting rigorous research, and ensuring trustworthiness, provides the opportunity for clinicians to embed evidence-based recommendations into their practice, and improve health outcomes for patients. Decisions made during the research process are presented in the diagrammatic flowchart below, which outlines the processes and components of rigour during the design and conduct of the study.

Research process components	**Criteria for ensuring rigour**	**Strategies used to demonstrate criteria for trustworthiness**
Research design	• Credibility • Dependability • Confirmability	Credibility was achieved in the research design as the researcher (major instrument of data collection) was an insider and had a number of years of clinical experience as a Clinical Nurse Specialist in the study setting. Confirmability was achieved by selecting the interpretive descriptive approach after reviewing and considering other qualitative research methodologies. Confirmability and dependability were achieved by the documentation of the audit trail, which provides details of the research design and its implementation.
Sampling methods	• Credibility	Credibility was achieved in the design of this study through the use of proven and appropriate sampling methods for each of the participant groups. Adolescents aged 13-18 years were recruited for the observational component of the study. Due to the age related inclusion criteria set for the adolescent participants, the criterion method of purposive sampling was used. The criterion method of purposive sampling allows identification of participants with specific characteristics that meet predetermined criteria important to the aims of the study (Patton, 1990).

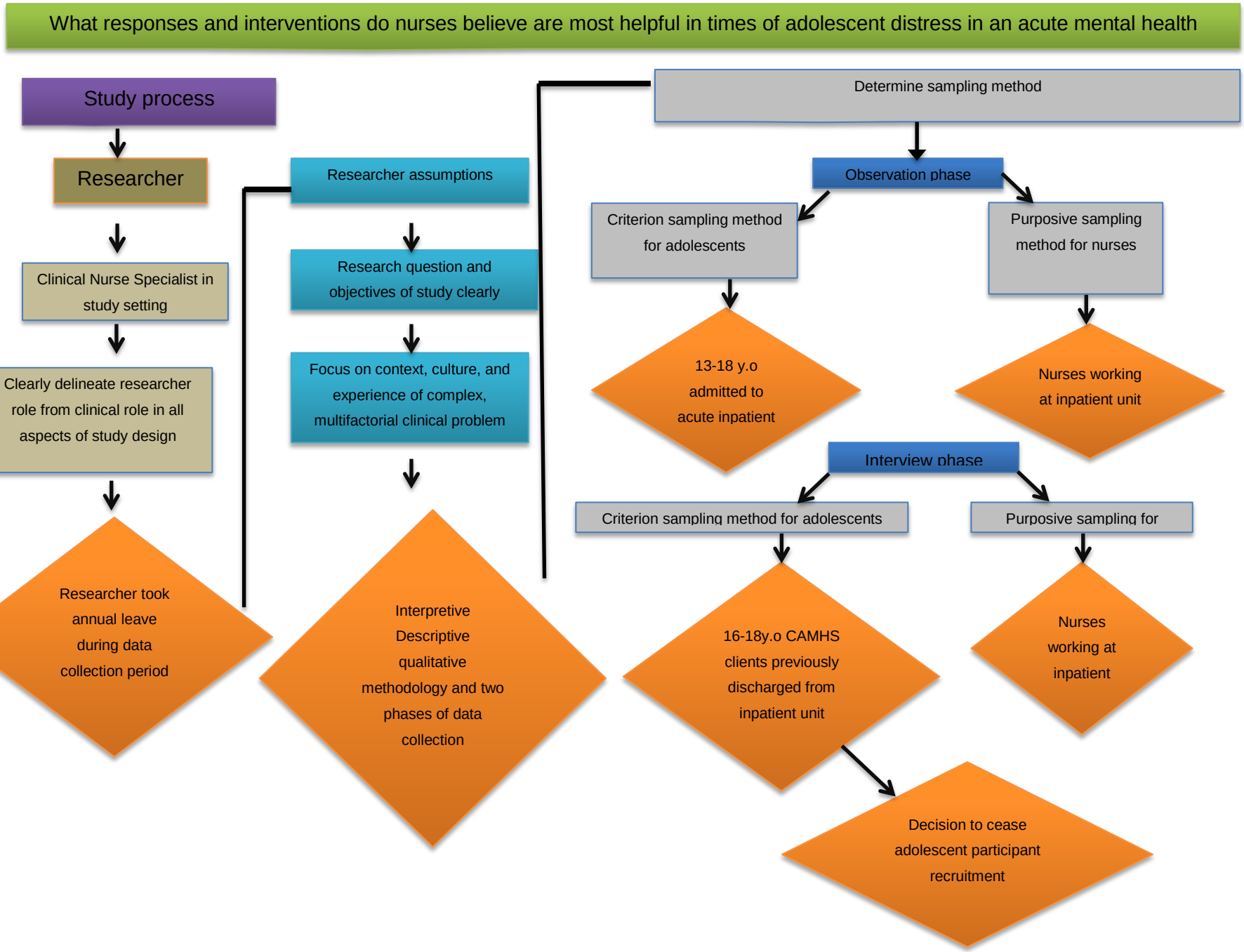
		Nurses were recruited to the study using typical purposive sampling methods. Each of these groups was selected for the study based on their experiential perspectives of the research topic. Credibility was further demonstrated as participants had the right to consent and withdraw from the study at any time, which enhanced trustworthiness. Close supervision of the student by expert researchers also added to the credibility of the study.
Data collection: Non-participant observations	• Credibility • Confirmability • Dependability	Credibility was achieved in the design and conduct of this study through the use of a proven research approach and methods of data collection. Close supervision of the student by expert researchers, and ongoing peer review of the data collection process added to the research rigour (credibility). Confirmability was achieved through the use of the Critical Incident Technique (CIT) framework adopted during the observation phase. A template (Appendix 11) based on this framework was used to maintain consistency in documentation of the observations. To achieve dependability the researcher documented field notes during the data collection

		period and maintained a reflective study journal.
Data Collection: Semi-structured interviews	• Credibility • Confirmability • Dependability	Credibility was achieved in the design and conduct of this study through the use of a proven research approach and methods of data collection. Semi-structured interview questions were developed from the analysis of the observational data and were also guided by the CIT (situation, action, outcome) method, which added to the credibility of the research. Credibility was further achieved through close supervision of the student by expert researchers, and ongoing peer review of the data collection process added to the research rigour. Credibility was achieved through the use of a professional transcriber and the researcher checking the accuracy of the transcriptions against the audio recordings. Following this process nurse participants were provided with a copy of the completed transcription for member checking. Four of the nurse participants completed member checking and confirmed the accuracy of the transcription (confirmability). To achieve dependability the researcher documented field notes during the data collection period and maintained a reflective study journal.

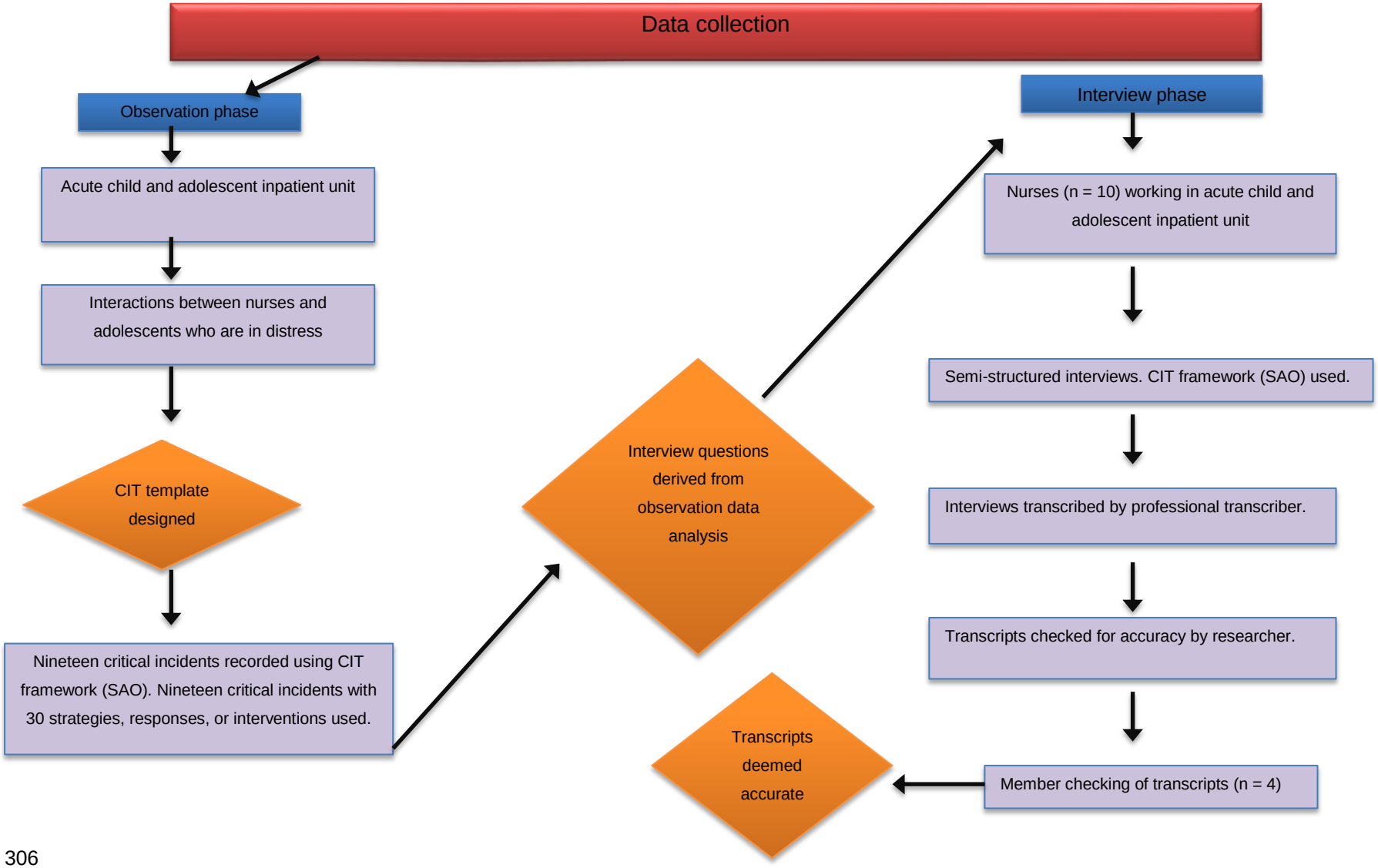
Data Analysis	• Credibility • Confirmability • Dependability	Credibility was achieved in the design, conduct and reporting of this study through the use of a proven data analysis method (interpretive descriptive). Thorne's proven interpretive descriptive data analysis methods added to the credibility of the study and were chosen because the analysis methods and processes are aligned, and well suited to, the clinical nature of the area of enquiry. As an insider the researcher had a pre-established understanding of the setting, and participants within the environment, to enhance the period of engagement, an important component of the qualitative methodology chosen. This added to the credibility of the study. Another strategy used to enhance credibility was the construction of the TAR^3 model from the observational data and subsequent comparison with the interview data (Appendix 15). Data for each of the interviews was crosschecked with the components of the TAR^3 model to help confirm the credibility and confirmability of the model. Cross checking methods were employed to compare and contrast the data sets (observations, interviews, and secondary data – journal entries/field notes). Close supervision of the student by expert researchers and ongoing peer review of the data analysis process added to the research rigour. These strategies enhanced the credibility of the study. Credibiliity and dependability were achieved through the use of reflective commentary pieces

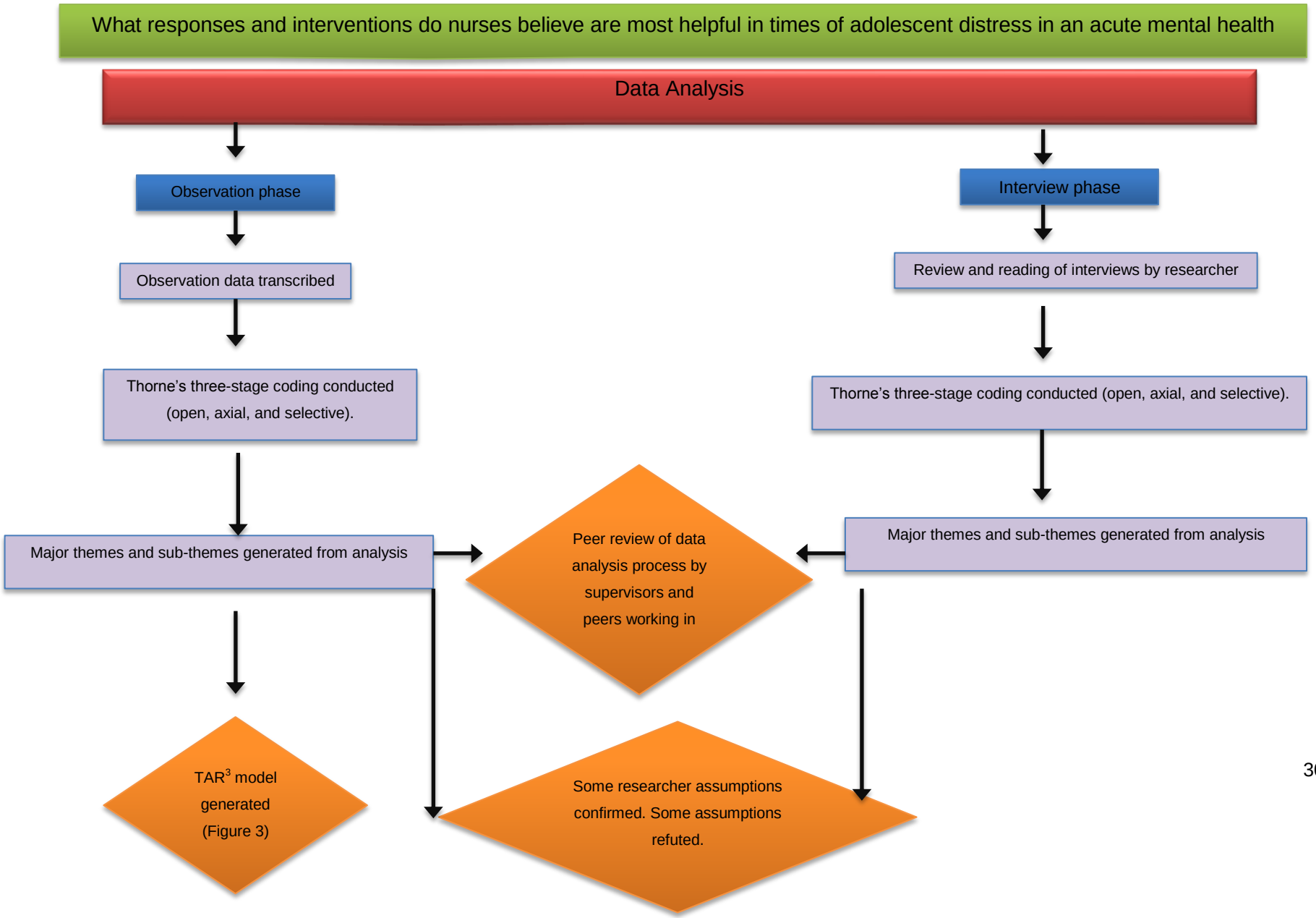
		in both the reporting of the findings, and in the discussion chapter, which provided opportunities to enhance trustworthiness. The study methodology relied on the researcher providing a concise description of the contextual factors of the phenomena including details of the setting, participants, and interactions observed. The detailed description of the study setting and context can assist readers to judge the potential transferability of the findings to other settings and contexts. A list of researcher's assumptions added to the credibility of the study. Assumptions were provided prior to data collection commencing and were revisited and discussed in the context of the findings. Where appropriate, the use of direct quotes to represent the participants' voices was also used to promote confirmability. Credibility was also achieved through the comparison of the study findings against previous research conducted in this field.

(Guba, 1981; Miles & Huberman, 1994; Shenton, 2004).


What responses and interventions do nurses believe are most helpful in times of adolescent distress in an acute mental health
Study process
Researcher
Clinical Nurse Specialist in study setting
Clearly delineate researcher role from clinical role in all aspects of study design
Researcher took annual leave during data collection period
Researcher assumptions
Research question and objectives of study clearly
Focus on context, culture, and experience of complex, multifactorial clinical problem
Interpretive Descriptive qualitative methodology and two phases of data collection
Determine sampling method
Observation phase
Criterion sampling method for adolescents
13-18 y.o admitted to acute inpatient
Purposive sampling method for nurses
Nurses working at inpatient unit
Interview phase
Criterion sampling method for adolescents
16-18y.o CAMHS clients previously discharged from inpatient unit
Purposive sampling for
Nurses working at inpatient
Decision to cease adolescent participant recruitment

What responses and interventions do nurses believe are most helpful in times of adolescent distress in an acute mental health inpatient unit?




What responses and interventions do nurses believe are most helpful in times of adolescent distress in an acute mental health
Data Analysis
Observation phase
Observation data transcribed
Thorne's three-stage coding conducted (open, axial, and selective).
Major themes and sub-themes generated from analysis
TAR3 model generated (Figure 3)
Interview phase
Review and reading of interviews by researcher
Thorne's three-stage coding conducted (open, axial, and selective).
Major themes and sub-themes generated from analysis
Peer review of data analysis process by supervisors and peers working in
Some researcher assumptions confirmed. Some assumptions refuted.

Appendix 14: Observation data TAR^3 table

Episode	Trigger	Distress level	HSA/Coping	Initial Response	Reaction	Intervention	Outcome
1	Medical procedure	Mild	Defiance, non-cooperative	Coercive (Authoritative)	Defiance, non-cooperative	Psycho-education	No change in distress level. (Medical procedure not conducted).
2	Peer interaction	Mild	Sensory modulation (SM) (blanket wrap), scowls, raised voice, verbalised anger, and used emotive language. Isolated to room.	No response, reaction, or intervention – not observed by nurses			Distress escalated (see episode 3)

Episode	Trigger	Distress level	HSA/Coping	Initial Response	Reaction	Intervention	Outcome
3	Medical review (also see episode 2).	Mod	Hugging knees, blanket wrap (SM)	1. Coercive (authoritarian), non-collaborative). 2. Dismissive 3. Coercive (authoritarian)	1. Initially accepting then defiant when nurse questioned YP medication complianceAttempt to isolate in room but locked – rule breaking (defiance) 2. Argumentative	1. *Prn* medication 2. Engagement 3. De-escalation	No reduction in level of distress until 30-40 mins post *prn* medication administration (efficacy).

Episode	Trigger	Distress level	HSA/Coping	Initial Response	Reaction	Intervention	Outcome
4	Medical procedure (see episode 1)	Mild	Verbal communication (questioning nurse)	Person-centred	Accepting	Distraction technique	Reduced distress level, immediate change in facial features and tone of voice.
5	Ward program/ free time	Mild	Ruminating. Picking at DSH wounds, attempt to be noticed by nurses by walking in their vicinity	No response to distress – unnoticed by nurses.	Isolated to room, slammed door.	No intervention	Reduced distress over time (time limited self-management of distress/coping)

Episode	Trigger	Distress level	HSA/Coping	Initial Response	Reaction	Intervention	Outcome
6	Unstructured free time	Mild	Social withdrawal from peers, ruminating	Person-centred 1. Engagement (introduction as allocated nurse for shift) 2. Acknowledged YP	1. Ignored nurse 2. Accepted, collaboration	1. Silence 2. Psycho-education, reflective questioning,	Minimised distress – YP reengaged with peers and ward activities .
7	Parental conflict	Mild	Raised voice, verbalising frustration, rolls eyes, hand on forehead. Verbalising suicidal intent. Isolative behaviour (to room)	No response from nurses (willingness/attitude – "fun camp" comment).	Nil	No intervention	Reduced distress over time (time limited self-management of distress/coping)

Episode	Trigger	Distress level	HSA/Coping	Initial Response	Reaction	Intervention	Outcome
8	Peer interaction, ward milieu	Mod	Self-soothing SM (hugging knees), shaky foot (vigorous). Raised voice and emotive language, hitting inanimate object (lounge)	Person-centred: 1. Smile and eye contact – acknowledgement.	1. Engaged with nurse – accepted initial response 2. Rejected initial intervention – "too angry" (not congruent with level of distress) 3. Acceptance of second interventions attempts	1. Distraction technique - art 2. Engagement, psycho-education and de-escalation (limit-setting, expected behaviour).	Decreased distress – YP reengaged with peers and ward activities.
9	Clinical engage-ment	Mod	1. Argumentative, raising voice. 2. Scowling, foot shaking, verbalised anger, request to use sensory room (isolate/helpseek) 3. Foot shaking, self-soothing (blanket wrap)	1. Intermediate: Discontinued engagement with YP and observed (level of obs – constant) 2. Intermediate: Attended to YP request with no engagement	1. Engaged another nurse and continued argument 2. Started screaming	1. Limit-setting 2. Sensory modulation, close observations and *prn* medication	Level of distress reduced (from moderate to mild) after *prn* medication administration and time in sensory room. Further decrease in distress over time as medication became effective and YP reengaged with peers.

Episode	Trigger	Distress level	HSA/Coping	Initial Response	Reaction	Intervention	Outcome
10	Peer conflict, ward milieu	Mild	Verbalising emotive language to peers.	Person-centred: politeness (empowering)	Acceptance	Distraction technique	Reduced distress
11	Peer conflict	Mod	Verbalising suicidal intent, isolative, yelling and screaming, aggression toward inanimate object	Person-centred: Empathic engagement with body language and tone congruent	Accepting	Engagement and close observations	Reduced distress (10 minutes alone with intermittent checks by nurse)
12	Parental conflict	Mild	1. Verbalising frustrations to parent on phone, raising voice. 2. Isolative behaviour (room), screaming, DSH (hitting head with fist)	1. Person-centred: Eye contact, kneeling (down to level of YP) 2. Person-centred: soft, calm voice	1. Accepting 2. Accepting	1. Limit-setting 2. Sensory modulation (blanket wrap), distraction technique, therapeutic touch, close observations (incongrue	YP distress decreased with interventions when nurses were present but as soon as left alone distress increased (close obs ineffective). After numerous combinations of

Episode	Trigger	Distress level	HSA/Coping	Initial Response	Reaction	Intervention	Outcome
						nt with level of distress)	interventions YP distressed increased when left alone again at which point the YP engaged the researcher and observation was terminated by researcher due to ethical reasons (non-participant)
13	Milieu, clinical engagement	Mild	1. Crying, covering face with hands. 2. Isolative behaviour, aggression toward inanimate object	1. Intermediate: Acknowledgement ("but") 2. Intermediate: (tone-direct and confident but not coercive)	1. Rejection 2. Rejection	1. Limit-setting, silence, reflective questioning. 2. Close observations and *prn* medication.	Responses and first combination of interventions increased distress. Distress only reduced once *prn* medication became effective)
14	Peer conflict	Mod	Scratching at DSH wounds, non-	Intermediate: No initial response provided – no	No reaction as no initial	*Prn* medication.	Distress decreased over time with self-

Episode	Trigger	Distress level	HSA/Coping	Initial Response	Reaction	Intervention	Outcome
			communicative with peers/staff, shaky foot. Intimidation of peer – staring, self-soothing (blanket wrap),	engagement, straight to medication room for *prn.*			soothing and prn efficacy.
15	Clinical engagement	Mild	Argumentative, raised voice.	1. Intermediate – direct 2. Person-centred: Empathy	1. Argumentative 2. Accepting	1. Limit-setting 2. Therapeutic touch, distraction, sensory modulation (shower), close observations	Decrease in distress once YP accepted interventions based on change in type of nurse response.
16	Parental conflict/ clinical engagement	Mod	Crying, isolative behaviour, withdrawn, non-communicative.	Person-centred: knew not beneficial for YP to be on own when moderately distressed	Reluctantly co-operative	Distraction techniques, sensory modulation (shower), close	Reduced distress after shower- YP reengaged with ward program and peers.

Episode	Trigger	Distress level	HSA/Coping	Initial Response	Reaction	Intervention	Outcome
						observations	
17	Clinical engagement, medical review	Mod	Crying, non-communicative.	Person-centred: Empathy, explanation, collaboration.	Acceptance	Therapeutic touch, silence.	Reduced distress – good effect.
18	Medical review, family conflict	Mod	Verbalising concerns to peers, foot shaking, change of affect (scowl), screaming, crying, isolative behaviour (room),	Unknown – occurred in YP room, researcher unable to see initial response	Acceptance	*Prn* medications, deep breathing/mindfulness technique exercise, close observations.	Decrease in level of distress – good effect.

Episode	Trigger	Distress level	HSA/Coping	Initial Response	Reaction	Intervention	Outcome
19	Milieu	Acute	Running, attempt absconding, aggression toward inanimate object.	YP2: 1. Intermediate: Limit-setting, expected behaviour, direct. 2. Coercive YP1: 1. Intermediate: Limit-setting, expected behaviour, direct.	YP2: 1. Aggression, combativeness 2. Assaultive (punched nurse) YP1: 1. Cooperative with limit-setting request but highly distressed	YP2: 1. Physical restraint 2. Seclusion YP1: 1. De-escalation, physical restraint, prn medication, increased observations (constant to close)	YP2: Distress increased when nurses engaged in physical restraint and again when YP escorted to seclusion. Swearing and yelling once in seclusion. Over time distress abated. YP1: Distress levels reduced over time as *prn* medication became effective and YP was able to regain self-control.

Appendix 15: Nurse interview TAR^3 table

Interview	Clinical context	Trigger	HSA/Coping	Initial Response	Reaction	Intervention	Outcome
1	Free time at end of day (4pm)	Psychosocial – family and accommodation Patient - attachment	Isolating in room DSH (significant) with razor	1. Engagement, validation 2. Silence	1. Rejection (non-verbal) 2. Acceptance	Therapeutic touch Distraction (music on iPod)	Distress resolved: Young person went to clinic with N1 to have wounds dressed.
2	Clinical review with doctors	Restriction of leave (procedure/unit factor) Attachment: patient variable	Crying Aggression (kicking doors)	Presence, engagement.	Acceptance	Verbal de-escalation: Validation, limit-setting (expected behaviour – stop kicking doors), negotiation. Therapeutic touch Sensory modulation (weighted blanket)	Resolution of distress: Young person able to go n leave 30 minutes after incident once distress resolved.

Interview	Clinical context	Trigger	HSA/Coping	Initial Response	Reaction	Intervention	Outcome
3	Escorted leave with staff	Patient variable: Suicidal ideation	Absconding Suicidal/DSH actions (walk in front of cars).	3. Engagement 4. Presence	Rejection: Young person verbalised suicidal ideation then became silent, ignoring staff. Young person resisted physical restraint.	1. Physical restraint 2. Distraction 3. *PRN* medication	Initial escalation: Young person was resistive to physical restraint intervention however when returned to unit she stopped resisting and took oral *prn* medication. Coercive interventions appeared to increase level of distress. Resolution of distress: *PRN* medication took effect and distress resolved.

Interview	Clinical context	Trigger	HSA/Coping	Initial Response	Reaction	Intervention	Outcome
4	Free time on unit	Patient variable: Complex PTSD – visual and auditory hallucinations.	Isolative behaviour. DSH (banging head on concrete wall and floor, attempts to suffocate herself by pushing face into mattress). Screaming.	Code Black response: Duress alarm activation	Rejection: Young person "kept escalating and escalating", continued with DSH behaviour (head banging).	Physical restraint *PRN* medication (2x IMIs)	Distress resolved: Young person's distress levels reduced following second IMI.
5	Free time: Young people spending time in courtyard.	Peer conflict (2 females versus 1 male).	Aggression and violence (verbal and physical).	Code Black response: Duress alarm activation	Rejection: all three young people continued with verbal and physical aggression.	1. Seclusion event for one female. 2. PRN medication (IMI) for all three young people 3. Physical restraint (all 3 young people) 4. Deep-breathing technique	Initial escalation of distress. Distress resolved: All clients were resistive toward interventions and only after IMI medication took effect did the level of distress decrease.

						s (psycho-education) for male during event.	
6	Free time: Young people spending time in courtyard.	Patient variable: Psychotic symptoms – Auditory hallucinations (commanding type) and paranoid ideation.	Defiant, aggressive and antagonistic. Verbal aggression and threatening violence.	Engagement, presence.	1. Initially rejection: Based on level of paranoia (symptoms) 2. Acceptance	1. Verbal de-escalation: reassurance of safety and negotiation. 2. Oral *prn* medication	Resolution of distress: Young person retired to his room once medication became effective and agitation reduced.

Interview	Clinical context	Trigger	HSA/Coping	Initial Response	Reaction	Intervention	Outcome
7	Free time	Unit/ procedural factor: Length of stay (involuntary admission).	Absconding/exit seeking actions. Self-soothing – throwing ball at wall in courtyard.	Engagement, presence	Rejection: Young person rejected offers of use of sensory room and *prn* medication.	Verbal de-escalation: negotiation, limit-setting, reflective questioning.	Resolution of distress: Offers of interventions did not increase level of distress. Young person self-soothed by throwing ball against wall in courtyard.
8	Free time	Patient variable: Chronic suicidal ideation. Possible paradoxical effect from *prn* medication.	Isolative behaviour DSH/suicidal behaviour (self-strangulation with iPod headphone cord).	Engagement: Verbal de-escalation including explanation and limit setting. Presence	Acceptance	Physical intervention: remove cords from neck. Negotiated for young person to move rooms closer to work station for closer observation.	Resolution of distress.

9	Handover	Unit procedure/routines: Handover and allocation of duties (medications) Family conflict (perceived abandonment/insecure attachment). Ward variable: Unsettled ward/milieu – increasing distress of other young people.	1. Isolative behaviour 2. Verbal aggression (swearing). 3. Aggression toward inanimate object. 4. DSH (stabbing stomach with sharp pencil). 5. Aggression (threats to stab staff if the get close and attempt to stop DSH behaviour). 6. Verbalised suicidal intentions as distress increased.	1. Engagement, validation. 2. Verbal de-escalation: Validation, negotiating (oral *prn* medication), limit-setting. 3. Therapeutic touch	1. Acceptance: Young person sat with nurse and coloured in 2. Rejection: Oppositional behaviour, ignoring nurse's attempts to engage 3. Acceptance	1. Distraction technique (colouring-in). 2. Physical restraint (police). *PRN* medication (IMI sedation) 3. Therapeutic touch	1. Initial resolution: Young person engaged in distraction with nurse. 2. Escalation: Increasing distress until prn medication effective (~ 3 hour incident).

10	Free time	Patient variable: Complex trauma and poor attachment history	Isolative behaviour (disengaged from peer group social interactions). DSH behaviour (rubber band around neck).	Engagement Presence	Acceptance: Young person engaged with nurse (increased eye contact initially then verbal responses)	Verbal de-escalation: Validation, reassurance, negotiation.	Resolution of distress: Distress and associated suicidal/DSH behaviour ceased. Young person handed over ligature implement and went with nurse for a drink and engaged in ward activities again.

Appendix 16: Axial coding table – interview data

Distraction	It's hard at times when one of our distraction techniques is things like going for a walk and obviously the… the level of risk associated with risk of absconding isn't possible yet we don't really have… you know, we don't even have a punching bag on the ward you know? How many times when you're young and impulsive and you're angry have you ever wanted to lash out at things/ Yet we have nothing here to sort of have a healthy outlet to lash out with.	N1
	We do have a fair few options here on the ward but unless it's the option they're focussed on at the time, they don't use it. 'Cos you don't know, you've got very narrow thinking when you're upset and angry.	N1
	We had this situation where the patient ...when I came onto the shift and she was a little bit agitated. I was looking after her and I was trying to think of ways to distract her. So we sat down said, 'what can we do that would help?' And it was, 'nothing, nothing.' We eventually came to a point where we thought we could do a bit of drawing, colouring, that sort of thing. So I gave her a pencil 'cos there were none on the unit at that point due to an incident that had happened the night before	N9

Appendix 17: Review of researcher assumptions

Researcher assumptions	**Outcomes**	
	Observation data	**Interview data**
Responses and interventions to perceived distress in young people will lie along a continuum from a coercive position of power and control at one end to a person-centred/collaborative working partnership at the other.	This assumption was correct – nurses initial responses and subsequent interventions fell on this continuum. Some nurses were observed to shift along this continuum in response to the assessment of the adolescent's reaction to the initial response/ intervention. Nurses who used an authoritarian/custodial/ coercive approach were observed to be more inflexible, and disregarded the reaction of the young person (or labeled them oppositional/defiant). During an episode of aggression and violence two young people required physical restraint to manage these behaviours. One group of nurses physically restrained one	Nurses reported using coercive interventions but did so with a person-centred approach. This was congruent with some of the observational data. Nurses reported that a person-centred approach is paramount when responding and providing interventions for adolescents in distress. Nurses were varied in the styles and approaches they used to convey this. Nurses spoke of the importance of shifting the interventions to match the assessed levels of distress (dynamic) rather than taking a rigid stance and choosing the same intervention.

	of the young people and did so using language, tone, and body language that appeared to be confrontational. The outcome of this resulted in a physical assault of a nurse and a seclusion event for the young person. In contrast the other young person was also physically restrained but the nurses used de-escalation and negotiation to administer *prn* medication. The person-centred approach and congruent language/tone/facial expression was evident and resulted in a different reaction from the young person.	
Young people may not respond appropriately to nursing interventions for a number of reasons, including pre-determined framework of adults based on life story (eg. past trauma); self-loathing (not worthy of care); hopelessness and	Adolescents did not seek help from nurses but rather exhibited both overt and covert behaviours to try and cope with the distress, or elicit care. Young people reacted to the nurse's initial response. They would accept or reject the initial	Nurses interviewed provided comments that supported the observational findings that young people's reaction to nursing responses and interventions were a result of the initial response offered by the nurse. Furthermore, nurses suggested that a general

helplessness associated with depressive/anxiety symptoms. NB: No young person interviews to verify	response offered by the nurse.	person-centred approach also contributed to the young person accepting the care offered.
Nurses with a previously established therapeutic relationship with a young person will be more able to alleviate distress.	Nurses were observed to use information gained from a pre-existing relationship to respond to young people as individuals showing understanding of like/dislikes and other personal preferences. Young people were observed to respond well to this, however there were instances where the nurses approach impacted on the relationship and the adolescent's reaction was evidence of this.	Many nurse participants commented that this was a key factor in reducing the difficulties in engaging and responding to an adolescent in distress. Nurses spoke of the importance of engagement and reading medical files to get to "know your patient".
When in distress young people will seek out a nurse with whom they have a previously established therapeutic relationship.	Young people did not seek help by approaching nurses with a verbal request. Rather coping or help-seeking behaviours were demonstrated which attempted to gain the attention of the nurses.	Nurses did not provide any examples of a time when a young person approached them for assistance. The nurses reported adolescent behaviours consistent with those observed (coping/help-seeking).

Nurses who work from a person-centred approach will be more willing to establish therapeutic relationships with young people in their care (to build a foundation and use it when times of distress occur).	Nurses who displayed practice behaviours consistent with a person-centred approach spent time, supervising (milieu), getting to know and connecting with young people. Nurses who exhibited nursing behaviours consistent with a more controlling approach spent more time in the nurse's station and only engaged with young people when necessary.	Nurses spoke of the importance of engagement and reading medical files to get to "know your patient". Many nurse participants commented that this was a key factor in reducing the difficulties in engaging and responding to an adolescent in distress.
Some nurses will mostly utilise coercive interventions (primarily *prn*) when assisting young people in distress, irrespective of assessed level of distress. This will be based on skill and confidence levels, and attitudes towards young people. These nurses are most likely to work from the custodial approach, whereas nurses operating from a person-centred approach will negotiate, problem-solve, and work	Those nurses who were more coercive/custodial would use intermediate (increased obs/limit-setting) and coercive interventions to monitor, assess and respond to adolescent distress. This approach and congruent attitude impacted on the willingness of these nurses to respond to young people (1 episode where nurses refused to engage due to judgments about young person's behaviour).	Nurses reported using coercive interventions but did so with a person-centred approach. This was congruent with some of the observational data. Nurses reported that a person-centred approach is paramount when responding and providing intervention for adolescent in distress. Nurses varied in the styles and approaches they used to convey this. Nurses spoke of the importance of shifting the interventions to match the

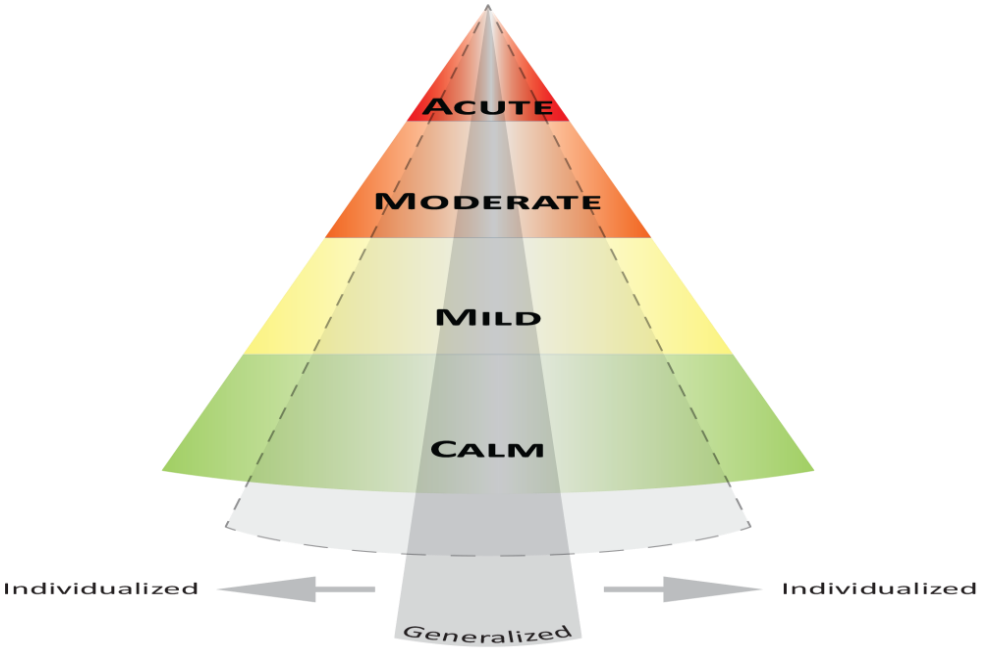
towards assisting the young person and based on an assessment of level of distress will suggest congruent interventions and responses.	When nurses displayed a person-centred/ collaborative approach they were observed to be more likely to: a) Provide an initial response and intervention that is consistent with the principle of least restrictive care b) Use combinations of interventions as they assessed the young persons reactions to their initial response. They had more interventions available to them to achieve collaboration because they started lower.	assessed levels of distress (dynamic) rather than taking a rigid stance and choosing the same intervention. Nurses also suggested that clinical experience impacted on their ability and choice of responses/interventions for adolescents in distress. Some commented that this impeded their ability to provide assistance ("Just don't know what to do").
Ward dynamics, peer interactions, and ward routines will be an influencing factor in the nurses' abilities to assist the young person in times of distress; nurses will need to take into account ward dynamics,	Nurses were observed to have numerous competing duties that impacted on their ability to provide adequate supervision, recognise and monitor escalating distress, and respond to distress (2	Many of the nurse participants provided details of how the ward environment, routines, and dynamics impacted on their ability to respond and provide interventions to alleviate distress.

peer interactions, and ward routines when intervening.	missed incidents). Nurses needed engage young people to assist in alleviating distress by connecting to a young person when they were part of a peer group. Some nurses were successful at this while others would attempt to draw the distressed young person away from the group before providing assistance.	Nurse participants offered insights into how they had to consider these factors when providing assistance. Nurses provided insights into how a lack of managerial support impacted their ability, willingness, and confidence in responding to young people.
Favourable staff-patient ratios mean that nurses will observe and be able to respond to most episodes of distress in young people.	Nurses were more likely to miss episodes of distress during the day shift due to the vast number of duties required. It was observed that nurses were spread further across the unit during day shift compared with evening shifts when nurses were more concentrated together. Despite more staff being present during day shift the ratios were lower due to the ward program (e.g. school, groups) and routine (ward rounds,	Nurses did not indicate that ratios were important but rather many commented on: a) The importance of teamwork b) The impact of poor teamwork on their ability to respond c) Differing styles/approaches/decision-making of those within the nursing team (sometimes added to difficulties)

	medical reviews, ADLs). Mealtimes were rarely supervised by more than one nurse. Many times the Hospital Assistant would be responsible for supervision of meals.	
Young people will share concerns/feelings/thoughts with peers before they seek help from nurses. Nurses will view this unfavourably.	Young people were observed on numerous occasions to discuss their mental health problems, reasons for admission, and psychiatric treatment with each other. On many occasions nurses were not present to monitor this but when they were nurses would attempt to engage the young person and offered to discuss these things in private.	Nurses reported that young people share their personal information with each other. Nurses reported that at times young people struggled to hear their peers problems when dealing with their own.
The five main reasons/contributors to young people becoming distressed on the unit will be: a) Manifestations of, or worsening of symptoms.	Not observed in observation component of study	Nurses spoke of different types of mental health problems and psychopathology and how these contributed to

		distress.
b) Ward rules, routines, and the restrictive nature of unit.	There were a number of ward factors that contributed to adolescent distress (see sub-themes)	Many nurse participant provided details regarding these factors
c) Fears/concerns about being discharged.	One episode where young person verbalised these concerns to parent (phone).	Nurses did not comment on this assumption.
d) Staff-patient interactions.	This was one of the Social/Relational factors that contributed to adolescent distress. The type of initial response impacted on the young person's reaction and would either increase or decrease distress.	Nurses commented on the importance of using a person-centred approach to minimise patient-nurse conflict and minimise this as a trigger for distress – (general approach). They also provided examples of their own observations of times when nurse-patient interaction triggered or escalated distress.
e) Reliving traumatic experiences.	Trauma history was a contributing factor in triggering distress but mostly manifested from a relational/social perspective.	Nurses provided examples of their understanding of individual trauma histories of young people and how these triggered or escalated distress. "Knowing your patient"

Appendix 18: Example of individualised *Auteenome* response and intervention plan



Triggers: Feeling lonely; Darkness (of depression); Feeling pressured (often by self); People yelling/arguments; Loud noises; "hyperactive people around when I am feeling low"

Level of distress	Expression of distress: Coping and help-seeking behaviours	Responses and Interventions
Calm	Social, smiling, good eye contact, talkative, engaging, relaxed (facial expression), good concentration and attention span, spending time with others, engaging in activities and conversations, present (in the moment- not 'living inside her head'), not restless or fidgety, accepting of others, follows requests from others, self-directed in activities/tasks.	No intervention required. Promote autonomy and independence. Spend time with _____. Encourage social activities. Encourage down time - relaxation activities.

Mild	Wringing hands, fidgety, restless legs (bouncy), sweaty hands (wipes hands on legs/blankets etc), teary, can't sit still, less social, ruminating (not present - 'living inside her head), less attentive (often have to repeat yourself as she is distracted), frown, reduced eye contact, snappy/irritable, eating more/less (changes to appetite), biting finger nails, will often say "leave me alone" (message is 'please support me'), "I'm fine" (message is 'I am struggling to cope' - this is often the thoughts/words prior to moving to the moderate stage), feeling overhwelmed (often tells people to shut up or stop being loud), 'shuts down' (stays in company of others but stops conversing) , reduced motivation/lethargic.	**Response:** Provide validation and acknowledge feelings (e.g. "You look upset/worried/angry, sad - how about you…..[e.g. listen to music] and I will come and check on you soon".), encourage _____ to cope using interventions but monitor her progress, ask _____ to name how she is feeling/thinking (if she is able to) **Interventions (Distraction and soothing techniques):** Sitting with others, blanket wraps, watching TV/movies, writing in journal, dancing, colouring-in, going for a walk, getting a hug/holding hand, playing video games, humour, screaming into a pillow, punching a pillow. Listening to music, calling a friend, spending time with family/friends, doing activities/chores, Exercising, taking a hot shower, deep breathing

		(mindfulness activities), drawing, ripping paper, crying
Moderate	Clecnched teeth and fists, crying, not taking care of herself (not cleaning room, showering, dirty clothes etc), hitting things with fists (head, objects), breathing hard, isolates herself and withdraws from others (will often walk purposefully to let others know she is going), poor concentration and attention, picking at self-harm wounds, sleeping less/more (changes to sleep patterns) dismissive of others, does not follow requests, occasional swearing, feelings of hopelessness ("what's the point", "no future", can't do it anymore"), cold demeanour (passive aggressive behaviours)	**Response:** Maintain presence. Validate feelings. Remain calm ('Be the Lighthouse'). Try and guess the emotion and if possible get _____ to confirm (____ may not be able to). Decide on supervision/obs (time frame e.g every 5 minutes or line of sight). **Interventions (Distraction and soothing techniques):** See above suggestions (mild distress) but increase supervision. Call CAMHS: _____ MH contact centre: _____ **eheadspace** 1800 650 890 www.eheadspace.org.au **Lifeline** 13 11 14 www.lifeline.org.au (chat-

		room)
Acute	**Non-life threatening behaviour:** Self-harming behaviours - scratching skin, burning, cutting) Aggression - slamming doors, kicking things, breaking objects) Suicidal thoughts (verbalising these thoughts and plans) Running away (absconding) **Life threatening behaviour:** Suicidal behaviour Self-harm with suicidal intent (e.g. overdose or significant cutting)	**Response:** Be present; provide reassurance, calm voice/tone and congruent body language. **Interventions:** Supervision– stay with_____ (line of sight). For **non-life threatening** behaviours or verbalisation of suicidal/self-harm thoughts provide support until level of distress abates to moderate, then offer soothing/distraction techniques. **Other options:** Call CAMHS : MH contact centre: For **life threatening behaviour** – contact emergency services 000 for support as required.