THE PRACTICE OF CHILD MENTAL HEALTH NURSES

Kathleen R Delaney, Janice L. Cooper & Sylvia Nshemerewire

Kathleen R Delaney PhD, PMHNP, FAAN

Professor, Rush College of Nursing, 600 S Paulina Street, Chicago, Illinois 60210, USA

Conflict of interest: none declared

Janice L Cooper PhD, MPA

The Carter Center and Emory University School of Public Health, Atlanta, GA 30322, USA

Conflict of interest: none declared

Sylvia Nshemerewire MBChB, MMEd Psychiatry

Butabika Hospital, Kampala, Uganda

Conflict of interest: none declared

Suggested citation: Delaney KR, Cooper JL, Nshemerewire S. The practice of child mental health nurses. In Rey JM (ed), *IACAPAP e-Textbook of Child and Adolescent Mental Health*. Geneva: International Association for Child and Adolescent Psychiatry and Allied Professions 2018.

Child and adolescent mental health nurses (CAMHNs) are registered nurses who focus their work in supporting the optimal development of youth as well as the coordination and delivery of mental health care to children and their families. As one of the largest group of health care providers who come into contact with children and adolescents, nurses are vital to child mental health promotion and early intervention (RCN, 2016). Child mental health nurses bring a particular orientation to their work, the value of the relationship, a health focus, and a view of the child in relation to social systems such as school and community (American Nurses Association, 1985). They practice wherever health care is delivered, in hospitals, community health centers as well as schools and outreach agencies. Worldwide, psychiatric nurses are a major provider of services, particularly in low-income countries; the last available data indicate their numbers increased by 37% since 2011 (mean rate per 100,000 population) (World Health Organization, 2015). Recently there have been initiatives globally to train more psychiatric nurses, including CAMHNs, and thus increase access to child mental health services (Zegura et al, 2015).

In this chapter, the traditional role of CAMHNs in inpatient treatment settings will be discussed; highlighting how CAMHNs assume responsibility for the therapeutic milieu, its safety, structure and supportive functions. Also highlighted will be the role of CAMHNs in child mental health promotion, early identification and community-based care. Initiatives around workforce development in select countries will be presented as well as region-specific collaborations that support psychiatric nursing. The expanding role of CAMHNs will be explored particularly around the growth of pediatric primary care. To begin, the history of child mental health nursing in the United States (US) is outlined to exemplify the nursing perspective on child mental health and how the specialty developed. Unless specified otherwise, the word "child" refers to both children and adolescents.

HISTORY

In the US, child mental health nursing evolved alongside the formation of treatment structures such as the child guidance centers and, in the 1930s, the opening of specialized inpatient centers for children. In these hospital units, nurses cared for the children's physical needs, monitored medications but also used the time to build a relationship with the child (West & Evans, 1992). The specialty of CAMHN gained momentum in the 1950's through the 1970's when federal initiatives supported the training of 20,000 psychiatric mental health advanced practice nurses (APNs) which spurned the development of the psychiatric mental health graduate program in child psychiatric nursing. During this time, masters' degree programs in child psychiatric nursing graduated approximate 1,000 APNs. In 1985 the American Nurses Association published a scope of practice specific to child mental health nurses detailing their role in the treatment of child mental health disorders and highlighting their work with families and children, particularly within schools and communities. In these documents the CAMHNs' perspective on care evolved into one marked by collaboration with families, a developmental focus, holism, health promotion, and intervening via the relationship (West & Evans, 1985). The CAMHNs role in mental health continues to evolve with the movement toward community-based care and integrated pediatric primary care (Martin et al, 2014).

INPATIENT TREATMENT ROLE

Inpatient treatment of children and adolescents, while rare in low-income countries, is part of the care continuum utilized when youth are considered dangerous to self or others or in need of intensive services (Torio et al, 2015). During short-term child inpatient treatment, the multidisciplinary team prescribes regimes to help children regain a sense of control in their lives as well as align services so that children return to their communities and to optimal functioning. In brief treatment, the focus is stabilization of the behaviors and addressing the crisis that precipitated hospitalization, which often involves a thorough assessment and possibly change in medication (Gathright et al, 2015). This chapter focuses on short-term hospitalization of children. The principles are applicable to residential treatment but the issues and treatment in residential care settings may differ, particularly approaches to children with complex problems and trauma histories (Hodgdon et al, 2013; Zelechoski, 2013).

Child mental health nurses and mental health clinicians play a critical role in achieving the goals of hospitalization. Their 24-hour exposure to the child provides data useful for diagnosis. Observing how the child responds to milieu situations, copes, regulates, problem solves and relates to peers and adults informs the amount of structure and support the child will need to function at the optimal level (Delaney, 2006a). Since children and adolescents in acute distress need an environment that assures both safety and healing, staff has a split focus: attending to the individual child as well at the overall environment of care.

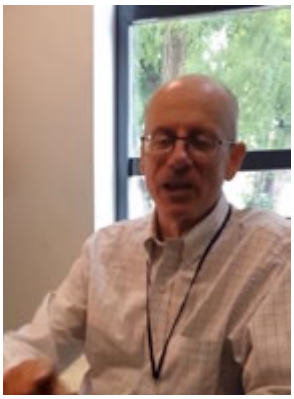
To build and maintain a therapeutic environment staff members must understand how program structure and staff presence blends to maintain the milieu. One way to think about this work is to organize interventions into four categories, safety, structure, support and self-management (*Four S* model) (Delaney et al, 2000). The idea of grouping therapeutic aspects of the environment into categories was first suggested by Gunderson (1978). In this nursing adaptation, the categories were updated and redefined to delineate how they are operationalized during short-term inpatient treatment (Delaney et al, 2008). Fundamentally, staff develops and maintains these milieu qualities by the way they attend to the physical environment, organize the program, develop relationships with the children, and partner with the child to improve self-regulation and self-management of behaviors. Explained below is how staff creates these elements of the *Four S* milieu model in their everyday use of space, group programming, and interactions with patients.

Safety

Treatment environments must be psychologically and physically safe for hospitalized children. At the most basic level safety is maintained by creating a physical environment that is "aseptic" – free of any objects that could be used for self-harm or to easily harm others. Inpatient psychiatric units also have systems to monitor aggression or suicide risk that set out the frequency of monitoring commensurate with estimated risk. Safety also requires a system for unit safety checks, policies about visitors and contraband, and a system for tracking and monitoring risks, incidents, and safety breaches. The recent inpatient mental health standards published by the Ontario Cooperative provide an excellent listing of safety considerations and related standards of care (click on the side figure to

access). Staff also keeps units safe by the way they position themselves in the unit such that common spaces are within view, which allows them to stay aware of the tone and pace of the milieu as well as changes in a particular child's behavior. Anticipation is a key element of milieu safety since it facilitates early intervention and provides an opportunity to calmly interrupt a behavior that appears to be escalating (Delaney & Johnson, 2006).

But keeping a safe atmosphere in a unit requires much more. Safety demands staff engagement: deliberate, meaningful interactions aimed at developing a trusting relationship with the patient (Polacek et al, 2015). An interaction aimed at engagement is more than just talking. Rather, it is communication that operates at the interpersonal level; a genuine response that involves empathy, conveys caring, aims to grasp the child's experience, and responds in such a way that the child feels understood (Salamone-Violi et al, 2015). A researcher in the United Kingdom, Len Bowers, has studied safety for many years and recently developed *Safewards* (Bowers, 2014a). This model has many aspects, all aimed at reducing conflict and coercive measures. Staff engagement is one component. According to the *Safewards* model, the consistent engagement of staff members is critical, seen as dependent on interpersonal skills (such as empathy and respect) as well as staff members' emotional regulation and technical mastery. Thus, an escalating situation demands a staff member who remains calm and focused, has some relationship leverage with the patient, and good de-escalation skills (Bowers, 2014b). Readers interested in the *Safewards* model can access in the side column videos that explain its elements in detail. (Links to right).



Click on the image above to hear Len Bowers talks about the quality of the evidence for *Safewards* (11:03). Click on the image below for a detailed description of the model (59:07)

Engagement is particularly important in child inpatient units, especially in tense situations. Hospitalized children and adolescents may lack self-regulation skills, the ability to modulate strong feelings and emotional states (Eisenberg et al, 2014). Frustration can quickly move into anger and anger into rage. Regulation of emotional states requires control over attention, arousal, appraisal, and inhibition (Izard et al, 2002). Children use these skills to recognize the emotion they are experiencing, read the cues of the situation generating the emotion, and tolerate the negative emotion long enough to process what is occurring and what would be their next best step. When these controls are lacking, children and adolescents need adults who engage and read the situation, step in, and help them dampen down the emotion. This proactive engagement reduces reactive aggression (anger that erupts in response to a situation) and thus keeps the child, staff, and other patients safe (Delaney, 2009).

Early intervention into an escalating situation is also critical to reduce the use of physical restraints — any device, material or equipment attached to a person's body, which cannot be controlled by the person and is deliberately intended to prevent a person's free body movements to a position of choice. In the last twenty years, efforts to reduce, if not eliminate, the use of restraints has led to strategies including adopting a restraint-free unit philosophy, staff training in non-coercive interventions, assessing the patient and intervening early with less restrictive measures, and promoting a culture of negotiation and collaboration rather than coercion (American Psychiatric Nurses Association, 2014). In the US and elsewhere an effective approach for restraint reduction is outlined in the "Six Core Principles", developed for adults but also applicable to children (Azeem et al, 2011). The principles include how the unit's culture is developed, staff training

Physical Restraint

Any device, material or equipment attached to a person's body, which cannot be controlled by the person, and is deliberately intended to prevent a person's free body movements to a position of choice.

on de-escalation, the role of leadership, use of data to inform restraint-reduction efforts, and instituting debriefing. The video clips linked at the right discuss restraint reduction with children, use of the *six core principles*, and the responses of staff to restraint reduction efforts. They demonstrate that change is possible and positive for both staff and patients.

Click on the image above to access a PowerPoint presentation about the use of restraints and seclusion in a pediatric population (by Kimberly Allan).

Trauma-Informed Care

Threaded throughout this chapter is the concept of *trauma-informed care* and the role of trauma in emotional distress. Children with a history of trauma are a substantial portion of the inpatient populations and often present with complex behavioral pictures (Keeshin et al, 2014). Trauma-informed care emphasizes an understanding of behavior in light of trauma history and encourages approaches to avoid replicating traumatic experiences and building a sense of safety in interactions. In inpatient units, enacting trauma-informed care is not just instituting discrete interventions but demands embedding a broad understanding of the traumatic stress response and building a culture of non-violence, learning and collaboration (Bryson et al, 2017).

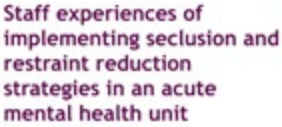
This is particularly important with children who have a history of trauma, who may react to perceived confrontation with reactive aggression. With all children, but particularly with traumatized youth, nurses strive to maintain a positive tone in their interactions, which not only dampens the child's negative affect but helps boost how children take in the situation at hand (cognitive information processing) (Delaney, 2009). A recent review of the literature about instituting trauma-informed care also highlights the steps a unit can take to introduce changes through leadership vision and by building staff competencies, particularly to reduce the use of restraint (Bryson et al, 2017).

Summarizing the strategies, the authors combine the six core strategies discussed above and the National Implementation Research Strategy. Unit leadership might use these strategies for trauma-informed care as a roadmap to reduce restraint. Keeping children safe and eliminating coercive measures should also be viewed as a moral imperative considering nurses' responsibility to safeguard the rights of children. An in-depth discussion about trauma-informed care is available via the videos in the right column.

Structure

Structure is a straightforward element of the therapeutic milieu. At the most basic level, it involves maintaining a schedule that organizes the child's day. Indeed, the unit's daily schedule is at the heart of the structure since it provides a sense of order and introduces predictability, which is particularly important for disorganized children or those who have difficultly responding to unexpected change (Kim et al, 2012). Staff must be alert to such issues particularly during transition times, which can be difficult for children who lack response flexibility. These children may also lack flexibility in their coping mechanisms and do not switch coping styles to match the demands of a situation. For instance, a child may respond to all frustrations, be they school difficulties or peer altercations, with confrontation rather than a problem-solving approach.

Click on the image above to access a detailed description of the six core strategies as adapted in New Zealand. Click on the image below to learn about the reactions of staff.



The daily schedule is usually a mix of activities: therapy groups, occupational therapy, school, and expressive therapies such as art or music. It should include pleasurable and demanding activities that are motivating and engaging. Ascertaining a child's response to a group and to particular task demands can be useful for assessment and to determine the amount of structure and stimulation a child needs to remain organized and in control (Delaney, 2006a). For instance, staff may note that a particular child becomes irritable or disruptive in a loud recreational group and may need the presence of additional staff (a staff member sitting nearby) to remain focused. A child may do well in occupational therapy but becomes avoidant and sullen in the classroom. This child may need extra help to decipher and structure work around the educational task at hand.

The overall aim in a children's unit is for youth to succeed and experience a sense of competency. That means, groups must have a sufficient number of staff such that the appropriate tone and activity level are maintained. In a poorly staffed unit, groups consistently become disorganized and too loud or, at the opposite end, become repetitive and boring. When this occurs, children may re-live their disorganization and their inability to focus.

Table J.11.1 Crossmatch of National Implementation Research Network (NIRN) implementation drivers with six core strategies (reproduced from Bryson S et al (2017).

Six Core Strategies to Reduce Seclusion & Restraint	Main NIRN Implementation Driver Required for Successful Implementation	Type of Implementation Driver	
Strategy 1: Leadership Towards Organizational Change	Leadership-Technical & Adaptive	Leadership	Single Driver
Strategy 2: Using Data to Inform Practice	Decision Support Data Systems Facilitative Admin Supports	Organization	
Strategy 3: Workforce Development	Selection Training Coaching Performance Assessment	Competency	
Strategy 4: Use of Seclusion/Restraint Prevention Tools	Systems Intervention Coaching	Competency & Organization	Multiple Driver
Strategy 5: Consumer Roles in Inpatient Settings	Adaptive Leadership Facilitative Admin Supports Systems Intervention	Leadership & Organization	
Strategy 6: Debriefing Techniques	Technical Leadership Systems Intervention	Leadership & Organization	

One difficult aspect is how to set expectations and implement rules. Providing structure demands that nursing staff reach a balance between maintaining order in the unit while not infringing on the youth's autonomy or sense of personal control (Voogt et al, 2014). Staff may have the mistaken notion that imposing stringent expectations will help control behavior and "shape up" the child. Quite the opposite is true. To nourish a child's coping abilities, staff should support autonomy and provide a rationale for rules and expectations (Skinner & Wellborn, 1994). Moreover, to reduce stress, staff should aim to elicit the child's cooperation and set coping demands that are within the child's reach (Delaney, 2009). For example, how long a child remains in a group should depend on staff's assessment of the child's current capacity to stay organized and focused on a task. If a child unravels at the end of a group, it is then planned that the child leaves the group 10 minutes prior to the end. As a general rule, unit expectations should be revised to ensure that they serve the needs of the child (Bowers, 2014a).

Finally, the way staff approaches decisions around children's participation and expectations sets the unit culture — the norms of the unit become commonly held assumptions about how the children there should be treated. The culture of a unit is evident in the moment- to-moment decisions and responses to children's behaviors. A culture can be rule-driven and dominated by efforts to enforce rules or it can be marked by a flexible interpretation of what is needed to maintain an orderly milieu, but one responsive to a child's needs. The later approach helps children develop coping skills and begin to see adults as helpful in their efforts to remain organized and in control. Using techniques such as collaborative problem-solving are helpful to explore the cognitive skills a child needs to navigate difficult situations and work with them to reach solutions (Ercole-Fricke et al, 2016). It is useful for staff to be aware of their own beliefs around how children in the unit should be treated and, given the unit's approach, how they will improve and grow.

Example of Unit Philosophy

- All behavior has meaning. To therapeutically intervene with a child, staff must first understand the meaning of a particular behavior.
- Families are a critical partner in the treatment.
- Children ask only for as much as they need. Staff works with the child to achieve an understanding of any limitations of what the adult world can provide.
- Relationships matter. Learning and growth occur in the context of a relationship.
- Rules and norms need to be flexible enough to service the needs of the child.
- Children should experience joy in their lives. The environment is structured to enhance the child's experience of joy and pleasure with themselves, peers and adults.
- Children vary in their ability to process information, sort stimuli, and manage their emotions. By experiencing the child's ability to meet milieu expectations staff determine the amount of structure and clarity the child needs to function.
- Competence matters. Staff structure educational and social experiences so the child experiences a sense of competence
- The goal of all interventions is to help the child achieve self-regulation.
- Empathic resonance with a child enables staff to intervene and bolster the child's faltering functions (the ability to deal with demands, frustrations and powerful affects). Through this repeated, reliable and consistent attuning, the child gradually takes on staff's organizing, affirming and soothing functions.

Guiding principles of a child/adolescent unit in the US, a list drawn up by staff and seen as a grounding philosophy for their work with children, can be seen in the box in page 7.

Support

Support is another deceptively simple element of the milieu. Novice members of staff may see it as providing encouragement or being empathetic with the child's emotions. While empathy is one element, providing support demands that staff forge a deeper level of engagement, one that affords the patient the experience of being recognized, responded to, and understood (Carlsson et al, 2006). The idea of support has been framed in psychiatry in line with professionals' response to crises, as a moderating effect of social support or, in the treatment literature, as a specific type of therapy (supportive). Psychiatric nurses view support in terms of the interpersonal aspects of care and within the context of the nurse-patient relationship. For nurses, it is within this relationship that individuals address anxieties and move towards greater health and wellbeing (D'Antonio et al, 2014).

As with adults, relationship-building with children in inpatient units does not necessarily involve a verbal "working through" of longstanding problems. Rather, supportive engagement involves interactions that help children deal with the more immediate issues of unit life, their current anxieties, and how they will integrate back into their life at home and at school. The child may not articulate these issues; thus, it is important to carefully observe milieu behavior, patterns of responding to unit expectations, and deciphering what is triggering the child's distress. Even with this understanding in hand, a child may not readily respond to adult overtures. Over time, children may have learned that adults are not useful to them in moments of distress or in helping them manage their emotions. If this is the case, initial overtures may be met with disdain; developing a relationship will require a consistent, empathetic response to the child's affect and to the underlying message of their behavior (Proffer, 1966).

How does one create a bridge of understanding with a child? There has been a good deal of research on engagement with adults hospitalized in inpatient units (McAndrew et al, 2014). That research tells us that engagment is facilitated when nurses are committed to making a connection with the patient, listening, and using a partnership model characterised by problem-solving and shared decision making (Gunasekara et al, 2013). To bring that connection to the interpersonal level (so that the patient experiences a connection), requires being present, empathy, self-awareness of one's responses to what is occurring in the interaction, and tailoring responses on the bases of the patient's experience and the meaning of the behavior (Delaney et al, 2017). The video link to the right is not about nursing, but about emotion, empathy, and connecting to experience. It reminds us of the need to connect via a shared emotion and the gains realized throgh interpersonal connections.

Click on the image to view.

Unfortunately, there are elements of inpatient treatment that hinder the development of empathy, engagement, and relationships. Being attuned to the child's experience takes energy, as does being emotionally available. It takes commitment to notice patterns of how children respond and to convey a true interest in their experience of the world. It requires staff to be generous with their time, which all too often is taken up with administrative demands, admissions,

medications, and paperwork (Seed et al, 2010). For staff to maintain engagement, the leadership of the unit must be supportive and take a genuine interest in the concerns of the staff. Thus, support must operate at multiple levels: staff support to the children and management support to the staff.

A final concern is how nursing staff balance this supportive stance with their aspiration of maintaining structure and safety in the unit. The staff member who is seeking to form a relationship with the child based on caring concern, may also be the person who sets limits in an escalating situation. These times can strain child-staff relationships. To deal with this conflict, staff must redouble their efforts to respect the child's need for autonomy, to adopt a non-authoritarian attitude, to deal with the situation in an authentic manner, and give the child room to save face (Carlsson et al, 2006; Delaney, 2009).

Self- Management

Self-management can be defined as the way one adapts day-to-day activities to maintain health or manage the symptoms associated with an illness. For instance, for individuals dealing with depression, self-management strategies may include efforts to control automatic negative thoughts (Hoffman, 2012). Children and adolescents in an inpatient unit have a wide variety of serious emotional disorders that may have specific self-management regimes (Torio et al, 2015) but there are general principles nurses can follow.

What might self-management mean for the child? Often children in inpatient units struggle with maintaining control of their emotions or behaviors. This may involve dampening down strong affects such as sadness or frustration. Children learn to decrease negative feelings and self-soothe during their early years when caregivers, sensing that their child was overwhelmed with emotion, responded with comfort and helped the child regulate affects such as anger, frustration, or sadness (Socarides & Stolorow, 1984). Children in an inpatient unit may lack these self-soothing skills. Moreover, they may lack the ability to detect an emotion, connect it to an event, and articulate the feeling to adults. In this instance they may express their distress in actions, not words. When staff observe loud, negative behavior what they might actually be seeing is a child who cannot handle frustration. A sulking child may be a lonely or an irritable one, or a youngster experiencing depressive feelings (Stringaris et al, 2013). The staff's role is to learn the pattern in a child's responses and the accompanying affective presentation, step in and bolster faltering regulation (McCluskey et al, 1999). Once the child is experiencing less distress, staff may attempt to teach the first steps in affect regulation, in identifying feelings and learning how they arise in particular situations (Delaney, 2006b).

For the adolescent, self-management efforts might focus on teaching specific techniques to reduce stress or to deal with depression and suicidal thoughts. Adolescent units may decide to adopt a specific form of group treatment such as Acceptance and Commitment Therapy (ACT). Here, using evidence-based techniques, the adolescent is taught a new set of coping skills to deal with distress and to accept their experiences. Using the ACT approach, staff encourages youth to move towards creating the kind of life they most want to live. Interventions are designed to help adolescents increase their awareness of environmental demands, their personal values, and to be able to live with challenging thoughts and feelings while taking steps to achieve necessary and desired life goals (Twohig et al, 2013).

The adolescent may be caught in a negative cycle, such as running away repeatedly or using drugs. During hospitalization, they may focus on the life they want to have, how they deal with inner turmoil, and how they might exercise control. As they become aware of internal experiences, they have an opportunity to consider new alternative behaviors. Understanding emotional regulation deficits and mapping alternative responses is at the heart of Dialectic Behavior Therapy (DBT), an approach that has been successfully implemented with adolescents in inpatient units (MacPherson et al, 2013). Through teaching and practicing techniques such as mindfulness, distress tolerance, and emotional awareness, the adolescent comes to understand the two poles of their experience and how to reconcile these opposing forces. For instance, one set may be the teen's emotional vulnerability at one end and self-invalidation at the other (MacPherson et al, 2013). With DBT techniques, the teen may come to reconcile emotional intensity and suffering at one end and dismissal/invalidation at the other (see video link on the side for a succinct explanation of DBT).

Click on the image to watch a short video clip about DBT (8:01).

Depending on the population treated in the unit, different strategies for self-management may be employed. Given the frequency of adolescents with suicidal ideation, specific strategies to address these thoughts may need to be implemented (Glenn, Franklin, & Nock, 2014). The critical element is that interventions are evidence-based and fit with the unit program, developmental level of the patient group, and overall goals for treatment

THE EXPANDING ROLE OF CHILD MENTAL HEALTH NURSES

Click on the image to access the publication "Mental Health in Children and Young People" by the Royal College of Nursing.

Early Identification – The Role of Prevention and Mental Health First Aid

Worldwide, the scope of child mental health continues to grow as does the urgency for early recognition of emerging issues in a child's life. Since nurses are the largest group of professionals who come in contact with children, their role in mental health promotion and prevention is critical. As the Royal College of Nursing (RCN) emphasized, every nurse should consider themselves a child mental health nurse (Royal College of Nursing, 2016). In addition to the mhGAP, which is discussed elsewhere in this book, additional toolkits exist to help nurses assess and respond to behaviors that may indicate a child's emotional distress (Royal College of Nursing, 2014).

Psychiatric nurses are also active in raising individuals' mental health literacy, particularly on how a behavior may be indicative of psychological distress. This educational format is increasingly adapted and delivered in low income countries, particularly after crises or disasters. Labadee & Bennett point out that reactions to disaster differ on its nature and scope but also depend on the individual's age. They remind us that children may lack the verbal and emotional skills to cope with tremendous upheavals in their lives. In line with WHO recommendations around psychological first aid for those who have experienced disaster, it is important to make contact, listen to concerns, and help the person feel calm.

Click on the image below to access a blog about community health that has extensive links to WHO documents dealing with mental health first aid.

For example, early recognition of stress and mental

health issues is a cornerstone of a project initiated in Malawi under the direction of Jerome Wright, from York University in the UK. This adaptation of a mental health curriculum was centered in a health model aimed at understanding stress and reaching people in distress, but also acknowledging the health beliefs and personal values of the community as well as the cultural context of rural Malawi (Wright & Chiwandira, 2016). After carefully designing a curriculum that met these goals, Wright and his team trained 430 "health surveillance assistants". In reporting on the progress of the initiative, Wright notes that these individuals were able to identify and intervene with people in distress through more than 850 mental health promotion activities. In the two-year evaluation of the project, 43,049 people attended 850 mental health promotion events. In the course of training groups to work with the health surveillance assistants, over 200 nurses were also trained (Personal Communication, J Wright, October 2017). Wright explains the project in detail in a blog (to access see link at the column on the right).

Click on the image to access Jerome Wright's blog about developing village-based community mental health care in Malawi.

Mental Health First Aid

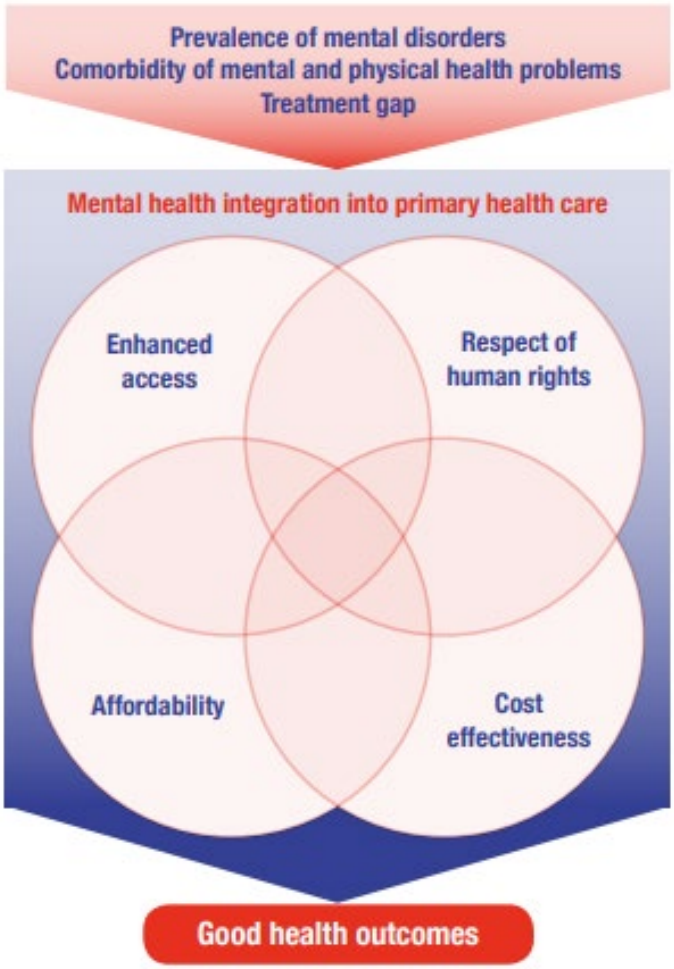
Mental health first aid is the help provided to a person who is developing a mental health problem, experiencing a worsening of an existing mental health problem or in a mental health crisis. The first aid is given until appropriate professional help is received or the crisis resolves.

Apart from being able to listen empathically, to provide mental health first aid is necessary to have a good understanding of the effects of mental ill-health on work and relationships, to know about the early signs, what emergency procedures to follow in a crisis, available community resources and how to use them.

Mental Health Integration into Primary Care

As outlined in Chapter J-5 on service delivery, a strategic direction for increasing mental health services is to integrate mental health into general health services (WHO, 2008). Integrated care recognizes the connection of mental and physical health, and that mental health issues often present as physical complaints. The WHO report on primary care documents best practice examples from South Africa and Brazil, where nurses are delivering mental health services or educating and training primary care workers. The benefits of integrated care are increasingly recognized in pediatric health services, including access to care, closing the treatment gap for mental health disorders and cost effectiveness (See Figure J.11.1). In industrialized countries there is an organized effort to optimize the role of nurses in integrated care, encouraging use of their education in screening and care coordination (Smolowitz et al, 2015). The movement of mental health nurses into primary care will require more than training in additional skills. Building working

Figure J.11.1 Seven good reasons for integrating mental health into primary care (World Health Organization, 2008).



relationships between nurse and general practitioner will demand educating the service on the role of nurses in primary care, their competencies and scope of practice (Meehan & Robertson, 2013).

Development of the Child Mental Health Nursing Workforce

A key to increasing access to mental health care is building the strength and size of the mental health workforce, particularly nurses. Reported below is one country's success in educating a cadre of child mental health nurses.

LIBERIA'S POST-BASIC TRAINING PROGRAM IN CHILD & ADOLESCENT MENTAL HEALTH

There are efforts around the globe to develop the mental health nursing workforce. Initiatives specific to child nursing include a recent program in Liberia where children and adolescents make up over half of the population. An estimated 20% of children and adolescents globally suffer from a debilitating social, emotional, behavioral or mental health disorder (Kieling et al, 2014). No data exist on prevalence in Liberia. However, data from low- and middle-income

countries suggest that child mental health disorders in sub-Saharan Africa account for 14% of individuals with a psychological problem and 9.5% of individuals with a diagnosable psychiatric disorder (Cortina et al, 2012). Compounding this is the legacy of 14-years of civil conflict, parenting by former child soldiers, poverty, and sexual violence (Johnson et al, 2008; Samuels et al, 2015).

When the Ministry of Health and the Carter Center Mental Health partnered to produce a new corps of mental health workers focused on children and adolescents, we turned to professionals in the global mental health field with experience from Africa, Europe and America. Through the University of South Caroline Medical School, we developed a curriculum tailored to the Liberian context. We recruited a child psychiatrist and a child psychologist from Uganda and other experts from the sub-continent with prior experience in Liberia who co-lead the courses with Liberian professionals.

The intensive six-month post-basic training program for nurses, midwives and physician assistants comprises of six courses varying in length from three to six weeks with concurrent clinical practice at both the national mental health referral hospital, health facilities, and community-based mental health practices, including school-based clinics and a group home for youth. Core texts include: WHO's mhGAP-IG. 2.0, Principles of Psychiatric Nursing, the IACAPAP eTextbook and, where there were no child psychiatrists, Dulcan's Textbook of Child & Adolescent Psychiatry and Family Psycho-Education for Children & Adolescents (The Carter Center, 2016). Key competencies taught and tested included the use of validated assessment tools to detect biopsychosocial, developmental, psychiatric, mental health and substance use disorders, relying on the DSM-5 and the British National Formulary for Children & Adolescents, and setting-specific evidence-based mental health treatments and psychosocial interventions. Core training on advocacy, human rights, anti-stigma interventions and frameworks, determinants, and evidence for practice was also delivered. Assessment of knowledge, skills and attitudes included pre-and post-program tests, assessment of therapeutic skills, and course- and module-specific competency exams. The program is conducted alternatively in Liberia's capital, Monrovia, and at the Kakata Rural Training Institute in Margibi.

To date, the Liberia Board of Nursing & Midwifery has certified 64 child and adolescent mental health clinicians for independent practice through a state board examination. They practice in all but one of Liberia's 15 counties. The program also runs eight inservice courses per year and supports community practices in 45 facilities and six school-based clinics with funding from UBS Optimus and the World Bank. Other core components of the course include clinical blogging and competency in using computers as learning and investigative tools. All graduates receive paper and laminated copies of key screening tools, individual copies of core textbooks, including IACAPAP's, copies of the pocket DSM-5 for children and adolescents, and a laptop computer and modem to upload and report cases based on patient encounter forms.

Supporting clinicians in developing the practice of outcomes reporting and management is a core course component. Approximately 40% of graduates have school-based or school-linked mental health practices. A recent adaptation of the WHO EMRO School Health Manual for Liberia is another step toward increasing

Twenty-one clinicians specializing in child and adolescent mental health graduated in 2017 in Kakata City, Liberia, from a training program developed by The Carter Center in partnership with the Liberia Ministry of Health, Ministry of Education, and the Ministry of Gender, Children, and Social. Click on the picture to view a report (2:42)

the number of schools with child and adolescent mental health clinicians in full or part-time roles. In the schools with school-based clinics, parent advisory groups are being trained to support work with the clinics. Among the challenges graduates face upon returning to practice include: poor remuneration, medication stock-outs, and lack of space for practice. The goal is to train 100 child and adolescent mental health clinicians and over 280 teachers who can work to support the health, socio-emotional development, and mental health needs of children across the county. The program plans to conduct its first national school-health conference early in 2018 (access the video link on the right for more information about the graduates of the program).

SUPPORTING THE WORK OF CHILD MENTAL HEALTH NURSES

Around the globe, the role of nursing continues to expand with an emphasis on child mental health prevention and promotion. Many international and regional WHO centers provide both vision and materials that will assist child mental health nurses in delivering programs, particularly about community outreach and prevention. The Pan American Health Organization (PAHO) has collaborating centers supporting nursing as well as a wealth of information on mental health in their region. The PAHO Mental Health Bulletin, available on the web, lists the training programs occurring in various regions, of which nurses are an integral part. An interesting new resource comes from Canada, a website that educates and informs both professionals and teens about mental health. Here the vision of a healthy culture extends directly to teens, reducing stigma via education and opportunities to dialog about their own mental health

Click on the image to access the Pan American Health Organization's (PAHO) website that lists collaborating centers supporting nursing and lists training programs taking place in various regions.

Nurses are delivering basic mental health interventions, assuring health literary, and combating stigma in low income countries (World Health Organization, 2015). In that regard many

of the chapters in this textbook are applicable to the work of child psychiatric nurses who assess, screen, and identify presenting behaviors/symptoms and their associated precipitants. Child psychiatric nurses around the globe also utilize principles of communication to establish family engagement and understand caretaker priorities for helping the child and adolescent. They understand how to use available coping resources and coping mechanisms within the family and within the community

CONCLUSION

Child mental health nurses are vital to improving access to mental health services and the well-being of children and their families. In most countries there are too few mental health nurses to serve the needs of the citizenry (WHO, 2015). Nurses report practicing in contexts of significant unrest, often in an atmosphere of stigma, with a substantial lack of resources, and in the absence of an organized system to support mental health (Marie, Hannigan, & Jones, 2017). As the roles of child mental health nurses and community workers expand so must the documentation of their efforts: whom they see, what needs they address, and with what outcomes. With increasing ownership of their practice, nurses' efforts and innovations can be disseminated and scaled up to provide services to a greater number of individuals and improve the mental health of children.

REFERENCES

American Psychiatric Nurses Association (2014). *Position Statement: The Use of Restraint American*

American Psychiatric Nurses Association (2014). *Position Statement: The Use of Restraint and Seclusion.*

American Nurses Association (1985) *Scope and Standards for Child and Adolescent Psychiatric and Mental Health Nursing Practice.* Kansas City, MO: Author.

Azeem MW, Akashdeep A, Rammerth M et al (2011). Effectiveness of six core strategies based on trauma informed care in reducing seclusions and restraints at a child and adolescent psychiatric hospital. *Journal of Child and Adolescent Psychiatric Nursing* 24(1):11-15.

Bowers L (2014a). Safewards: A new model of conflict and containment on psychiatric wards. *Journal of Psychiatric and Mental Health Nursing* 21(6):499-508.

Bowers L (2014b). A model of de-escalation: Len Bowers provides advice, based on the latest research, on the safest way for staff to deal with conflict and aggression. *Mental Health Practice* 17(9):36-37.

Bryson SA, Gauvin E, Jamieson A et al (2017). What are effective strategies for implementing trauma-informed care in youth inpatient psychiatric and residential treatment settings? A realist systematic review. *International Journal of Mental Health Systems 11*(1):36.

Carlsson G, Dahlberg K, Ekebergh M et al (2006). Patients longing for authentic personal care: A phenomenological study of violent encounters in psychiatric settings. *Issues in Mental Health Nursing 27(3)*:287-305.

Cortina MA, Sodha A, Fazel M (2012). Prevalence of child mental health problems in Sub-Sahara Africa: A systematic review. *Archives Pediatric Adolescent Mental Health Medicine* 166(3):2879-2281.

D'antonio P, Beeber L, Sills G et al (2014). The future in the past: Hildegard Peplau and interpersonal relations in nursing. *Nursing inquiry 21(4)*:311-317.

Delaney KR (2006a). Learning to observe in context: Child and adolescent inpatient mental health assessment. *Journal of Child and Adolescent Psychiatric Nursing* 19:170-174.

Delaney KR (2006b). Following the affect: Learning to observe emotional regulation. *Journal of Child and Adolescent Psychiatric Nursing*, *19*(4), 175-181.

Delaney KR (2009). Reducing reactive aggression by lowering coping demands and boosting regulation: Five key staff behaviors. *Journal of Child and Adolescent Psychiatric Nursing* 22:211-219.

Delaney KR, Johnson ME (2006). Keeping the unit safe: Mapping psychiatric nursing skills. *Journal of the American Psychiatric Nurses Association* 12:198-207.

Delaney KR, Perraud S, Johnson ME (2008). Creating a therapeutic environment: The work of psychiatric nurses. In SS Sharfstein, FB Dickerson & JM Oldham (eds). *Textbook of Hospital Psychiatry.* Arlington, VA: APA Press (pp. 389-401).

Delaney KR, Perraud S, Pitula C (2000). Brief psychiatric hospitalization and process description: What will nursing add? *Journal of Psychosocial Nursing* 38 (3):7-13.

Delaney KR, Shattell M, Johnson ME (2017). Capturing the Interpersonal Process of Psychiatric Nurses: A Model for Engagement. *Archives of Psychiatric Nursing.* 31(6), 634-640.

Eisenberg N, Hofer C, Sulik MJ et al (2014). Self-regulation, effortful control, and their socioemotional correlates. In JJ Gross (Ed.), *Handbook of emotion regulation*. New York: Guilford Press (pp. 157-172).

Ercole-Fricke E, Fritz P, Hill LE et al (2016). Effects of a collaborative problem-solving approach on an inpatient adolescent psychiatric unit. *Journal of Child and Adolescent Psychiatric Nursing 29*:127-134.

Gathright MM, Holmes KJ, Morris EM et al (2015). An innovative, interdisciplinary model of care for inpatient child psychiatry: An overview. *The Journal of Behavioral Health Services & Research* 43, 648–660.

Glenn CR, Franklin JC, Nock MK (2015). Evidence-based psychosocial treatments for self-injurious thoughts and behaviors in youth. *Journal of Clinical Child and Adolescent Psychology* 44 (1).

Gunasekara I, Pentland T, Rodgers T et al (2014). What makes an excellent mental health nurse? A pragmatic inquiry initiated and conducted by people with lived experience of service use. *International Journal of Mental Health Nursing* 23(2):101-109.

Gunderson JG (1984). Defining the therapeutic processes in psychiatric milieus. *Psychiatry* 41:327-335.

Hoffman M (2012). *Cognitive Therapy for Depression*. https://www.webmd.com/depression/features/cognitive-therapy#1

Hodgdon HB, Kinniburgh K, Gabowitz D et al (2013). Development and implementation of trauma-informed programming in youth residential treatment centers using the ARC framework. *Journal of Family Violence*, *28*(7), 679-692.

Izard CE, Fine S, Mostow A et al (2002). Emotion processes in normal and abnormal development and preventive intervention. *Development and Psychopathology* 14:761-787.

Johnson K, Asher J, Rosborough S et al (2008). Association of combatant status and sexual violence with health and mental health outcomes in post-conflict Liberia. *JAMA* 300(6):576-690.

Keeshin BR, Strawn JR, Luebbe AM et al (2014). Hospitalized youth and child abuse: A systematic examination of psychiatric morbidity and clinical severity. *Child Abuse & Neglect* 38(1):76-83.

Kieling C, Graeff-Martins AS, Hamoda H et al (2013). Child and adolescent mental health. In Patel V, Minas H, Cohen A, Prince M (Eds.). *Global Mental Health* London, England: Oxford University Press (pp. 335-353).

Kim P, Jenkins SE, Connolly ME (2012). Neural correlates of cognitive flexibility in children at risk for bipolar disorder. *Journal of Psychiatric Research* 46:22-30.

MacPherson HA, Cheavens JS, Fristad MA (2013). Dialectical behavior therapy for adolescents: theory, treatment adaptations, and empirical outcomes. *Clinical Child and Family Psychology Review 16(1)*:59-80.

Marie M, Hannigan B, Jones A (2017). Challenges for nurses who work in community mental health centers in the West Bank, Palestine. *International Journal of Mental Health Systems*, 11:3.

Martin MP, White MB, Hodgson JL et al (2014). Integrated primary care: a systematic review of program characteristics. *Families, Systems, & Health*, *32*(1), 101-115.

McAndrew S, Chambers M, Nolan F et al (2014). Measuring the evidence: Reviewing the literature of the measurement of therapeutic engagement in acute mental health inpatient wards. *International Journal of Mental Health Nursing* 23(3):212-220

McCluskey U, Hooper C-A, Miller LB (1999). Goal-corrected empathic attunement: Developing and rating the concept within an attachment perspective. *Psychotherapy: Theory, Research, Practice, Training* 36:80-90.

Meehan T, Robertson S (2013). Mental health nurses working in primary care: Perceptions of general practitioners. *International Journal of Mental Health Nursing* 22:377-383.

Polacek MJ, Allen DE, Damin-Moss RS et al (2015). Engagement as an element of safe inpatient psychiatric environments. *Journal of the American Psychiatric Nurses Association* 21:181-190.

Proffer AA (1996). The interpersonal treatment of young children: Principles and techniques. *Psychotherapy: Theory, Research, Practice, Training* 33:68-76.

Seed MS, Torkelson DJ, Alnatour R (2010). The role of the inpatient psychiatric nurse and its effect on job satisfaction. *Issues in Mental Health Nursing* 31(3):160-170.

Salamone-Violi GM, Chur-Hansen A, Winefield HR (2015). "I don't want to be here but I feel safe": Referral and admission to a child and adolescent psychiatric inpatient unit: The young person's perspective. *International Journal of Mental Health Nursing 24(6)*:569-576.

Samuels F, Jones N, Hamad BA et al (2015) Rebuilding adolescent girls; lives in fragile and post-conflict context: The importance of mental health and psychosocial support in Gaza, Liberia and Sri Lanka.

Skinner EA, Wellborn JG (1994). Coping during childhood and adolescence: A motivational perspective. In RD Lerner, D Featherman & M Permuter (Eds.), *Life Span Development and Behavior, Vol 12.* Hillsdale: Erlbaum (pp. 91-123).

Smolowitz J, Speakman E, Wojnar D et al (2015). Role of the registered nurse in primary health care: Meeting health care needs in the 21st century. *Nursing Outlook* 63(2):130-136.

Socarides DD, Stolorow RD (1984). Affects and selfobjects. *The Annual of Psychoanalysis* 12-13:105-119.

Stringaris A, Maughan B, Copeland WS et al (2013). Irritable mood as a symptom of depression in youth: prevalence, developmental, and clinical correlates in the Great Smoky Mountains Study. *Journal of the American Academy of Child & Adolescent Psychiatry* 52(8):831-840.

Royal College of Nursing (2014) *RCN's Mental Health in Children and Young People: An RCN Toolkit for Nurses Who Are Not Mental Health Specialists*. London: RCN

Royal College of Nursing (2016) *Children and Young People's Mental Health – Every Nurse's Business. RCN Guidance for Nursing Staff*. London: RCN.

The Carter Center. (2016). *Family Psychoeducational Manual-Child and Adolescent.Post-Basic Mental Health Training Program*. The Carter Center. Monrovia, Liberia.

Torio CM, Encinosa W, Berdahl T et al (2015). Annual report on health care for children and youth in the United States: national estimates of cost, utilization and expenditures for children with mental health conditions. *Academic Pediatrics*, *15*, 19-35.

Twohig MP, Woidneck MR, Crosby JM (2013). Newer generations of CBT for anxiety disorders. In G Simos & SG Hofmann (Eds.), *CBT for Anxiety Disorders: A Practitioner Book.* United Kingdom: Wiley-Blackwell (pp. 225-250).

Voogt A, Goossens PJ, Nugter A et al (2014). An observational student of providing structure as a psychiatric nursing intervention. *Perspectives in Psychiatric Care* 50:7-18.

West P, Evans CLS (1992). The specialty of child and adolescent psychiatric nursing. In P. West & C.L.S. Evans (Eds), *Psychiatric and Mental Health Nursing with Children and Adolescents* Gaithersburg, MD: Aspen (pp. 1-16).

World Health Organization (WHO) (2008). *Integrating Mental Health into Primary Care: A Global Perspective.*

World Health Organization (WHO) (2015) *2014 Mental Health Atlas.*

Wright J, Chiwandira C (2016). Building capacity for community mental health care in rural Malawi: Findings from a district-wide task-sharing intervention with village-based health workers. *International Journal of Social Psychiatry* 62(6):589-596.

Zegura E, Derkits E, Cooper JL (2015). *See My Work: Sustaining a Data Reporting Practice by Mental Health Clinicians in Liberia*. (Paper presented at the International Conference on Information and Communication Technologies and Development, Singapore.)

Zelechoski AD, Sharma R, Beserra K et al (2013). Traumatized youth in residential treatment settings: Prevalence, clinical presentation, treatment, and policy implications. *Journal of Family Violence*, *28*, 639-652.