Case Study of a Child Experiencing a CPTSD Crisis, in Residential Care in Lockdown

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Lee Smith, director for practice development for Cove Care, explains how a child overcame her relapse and remained safely in the community, avoiding a third readmission into in-patient CAMHS. [30-Mar-2021]

Children in mental health crises in the UK are increasing in number and severity, day by day. Lockdowns and the coronavirus pandemic have already exacerbated this situation, and the 'children's mental health pandemic' that is certain to follow is expected to gather a 'tsunami' effect in the coming months and years. For mental health professionals working with these young people, many difficulties abound: With all professions and sectors so stretched already, how will we cope with increased demand? If in-patient children and adolescent mental health beds (tier 4 CAMHS) are already at capacity, how will we look after more children safely in the community when the tsunami hits? And can the children's mental health sector as a whole adapt to meet this crisis?

With such existential problems facing our sector, perhaps some solutions may begin to manifest from real, lived experiences of young people, and staff working with them, on the front lines. This article, a short case presentation of a 15-year-old girl ('F') with complex post-traumatic stress disorder (CPTSD), briefly describes support given in response to her own crisis within our specialist children's residential care setting during the UK's first lockdown (April 2020). F's story, like so many others, may well demonstrate how some of children's mental healthcare can safely be provided in a more uncertain future.

F came to our home two weeks before the country went into lockdown. She moved into the home straight from an in-patient child and adolescent mental health unit – known as 'tier 4 CAMHS', as the fourth and final 'layer' of specialist support for children with mental health problems – after her 2nd period in tier 4, detained on both occasions under section 3 of the

Mental Health Act 1983 (S3 MHA). Having experienced extensive complex trauma from a very early age, F was a high risk to herself. She wanted the suffering to end, the terrifying visions and flashbacks, caused by her traumatic history.

Tier 4: the case for and against

Tier 4 is essential for some young people, like F, to receive emergency assessment, care and treatment in crisis situations, to the extent that it is stretched beyond capacity. I know, because I have worked in and around this sector for twenty-four years and have seen the life-saving efforts of the professionals dedicated to these most vulnerable, and challenging, children. However, tier 4 is also a frightening place for many young people – also like F – and admission itself can, in some cases, actually cause PTSD. Compounded to this, due to a lack of community resources, many young people become 'stuck' in the system, detained for prolonged periods with nowhere else to go. This can also trigger secondary emotional, behavioural and mental health problems for many: isolated from friends, family, community and education, many become depressed, despondent, crippled with anxiety, and adopt many of the behaviours of their hospital peers, such as self-harming or eating disorders, which they often didn't present before their admission.

F's Case in Brief

F had been in tier 4 wards for a total of three years in the past four – 20% of her young life, the majority under S3 MHA. Our children's home, which specialises in and is registered to take young people with mental health problems, was determined to end F's well-documented historical cycles: F's abusive situations, or high stress, would trigger her CPTSD to relapse; which would lead to prolonged admission to tier 4; which was followed by discharge back into abusive situations or high stress; and repeat.

After a gradual period of moving her in from hospital under S17 MHA (granting leave from hospital whilst remaining under S3), F was cautious but was desperate for it to work. Our residential team started their fantastic work in establishing a therapeutic relationship, setting her in, reassuring her, establishing her structures and routines, getting to know F as a person. Our Clinical Nurse Specialist started her assessment, and our psychotherapist started introductory sessions with her. F was clearly struggling, especially at nights when she would appear fearful, unresponsive and distant. The team are trained mental health first aiders and are excellent at working with young people having flashback-type experiences.

Difficulties started early on in F's placement with the allocation of the local-based 'tier 3 CAMHS' – specialist community team – which should be a routine referral and is statutory under S117 MHA for everyone, like F, who have previous admissions under S3 MHA. The purpose of S117 is to provide a safety net of support within the community for the most vulnerable patients. In practice, it affords them an allocated consultant psychiatrist, key worker, and regular care and treatment planning reviews. Due to problems with the local authority resources, together with lockdown, the psychiatrist was not allocated. F was in the precarious position of having been just discharged from the hospital and S3 MHA, suddenly with no medical oversight available. For F, having otherwise skilled support for her emotional well-being from ourselves at the placement and the allocated S117 keyworker, this critical piece of the jigsaw was suddenly missing.

Simultaneously, F deteriorated rapidly. She was dissociated, almost continuously switched off, and unresponsive. She would suddenly stare into a corner of a room, brush her hands frantically over her thighs, or she might hold her arms out in front of her in disgust, muttering about them being covered in blood. She was vividly reexperiencing traumatic events and

responding to a phenomenon that no-one else could see or hear, which we understood as flashbacks, associated with auditory, visual and tactile hallucinations. She became paranoid, refusing food and drink, suspicious that the staff were trying to drug or poison her. And she was hypervigilant – she couldn't sleep, would not rest, constantly looking out from her sheets, afraid of a perceived threat or danger.

One day, she left the home in this dissociated state, followed and supported by the staff, although unresponsive to them. Heading towards a nearby bridge over a dual carriageway, the police were called by our team due to the high levels of concern and risk. Immediately attending the scene, with the staff team physically guiding F away from danger, the police intervened and placed F on an S136 MHA – their power to temporarily detain people, presenting with high-risk behaviours and suspected mental health problems, in a place of safety, for further mental health assessment. F was taken to a local adult psychiatric in-patient unit for this assessment.

Relapse Prevention Pathway: The Route to Success

With F having the security of the specialist home, the independent assessment discharged her from the psychiatric unit the following day, back to the home. Her mental state remained fragile, and it was clear to us that we needed a robust care plan: aiming to support her through this current crisis, galvanise the support she needed, and keep her out of hospital if safe to do so. Consequently, in liaison with our specialist clinical team, F's S117 keyworker, the local emergency crisis team, F's social worker and with the involvement of F herself, we implemented the '*Relapse Prevention Pathway*' immediately:

F's Relapse Prevention Pathway

1. Baseline: F stable in placement and is provided with general care and support at home.
2. Trigger: F is experiencing low-level anxiety, distraction, disrupted eating, drinking, sleep. She requires an increase to 1:1 support in the home and 2:1 in the community.
3. Escalation: Increased risk signs - some dissociation, hallucinated, expressing suspicions about food and medication, self-harming, disengaged. Requiring continuous 1:1 support, 15-second prompts in the bathroom, and community access.
4. Acute: Highly dissociated, unusual behaviours including tactile hallucinations, aggression to staff and attempts to leave the home. The intervention requires Mental Health First Aid/restrictive physical interventions and medical treatment if necessary.
5. Crisis: F in a continuous dissociated state, she might successfully access community in an at-risk state. If F is at risk either return to home, relocate to A&E, or utilise police support.
6. Crisis/Support: Requires multi-agency assessment/interventions to prevent serious risk of harm - emergency independent assessment to be conducted in whichever location; the desirable outcome for F to return to home at Phase 2/3.
7. Crisis/discharge to T4: The undesirable outcome, F continues to display signs of mental illness, requiring T4 detention to maintain her safety.

Fortunately, there was so much written clinical information from F's previous hospital admissions and extensive care history. The Pathway was devised with our analysis of these records, and the recognition that F's behaviours exhibited at various stages of her relapses and recoveries of the past were quite linear – similar behaviours were associated at each step in a reasonably predictable way. The goal has been to pre-emptively intervene at Phase 2 and above, preventing crises and relapse.

Conclusion

A year into F's admission to the home, we are confident that we can continue to keep F out of tier 4 and look after her safely in the community. The signs are good: her mental state has been relatively stable, and we have managed any early warning signs pre-emptively at Phases 2 and 3 in the Relapse Prevention Pathway, avoiding any further crises. She has recently enrolled in a local college, which would have been quite untenable even six months ago.

Alongside the sub-optimal conditions associated with prolonged and repeated tier 4 admissions experienced by many young people mentioned above, there is an even more compelling reason for young people like F to receive adequate care in the community. As we emerge from lockdown restrictions into our uncertain future, we anticipate a considerable surge in children's mental health difficulties, many caused by the social, economic and health costs of the pandemic. In the same way that much of the government's early COVID strategy was to protect the NHS, this should also be an essential strategy for the children's mental health crisis that, according to many, is fast approaching.