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Staff experiences of working with children and adolescents engaging in behaviours that challenge in mental health and paediatric inpatient environments: A qualitative exploratory study across four European countries.

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Abstract

There has been a recent global increase in the number of young people experiencing mental health challenges in both child and adolescent mental health settings and acute paediatric settings. In many of these settings, restrictive practices are used to manage behaviours that challenge, such as aggression and violence. However, little is known about staff's experiences with responding to behaviours that challenge in these settings. A qualitative descriptive design was adopted, with participants engaging in 1:1 interviews or focus groups in Ireland, Finland, Germany, and Bulgaria. Data were analysed using reflexive thematic analysis. Four themes were identified: 1) the importance of establishing a safe, therapeutic environment, 2) identified antecedents to behaviours that challenge, 3) how staff respond to behaviours that challenge, and 4) the needs of staff when maintaining a safe, therapeutic environment. Consideration needs to be given to the environments where young people are cared for, with an emphasis placed on safe, comfortable, therapeutic spaces to reduce behaviours that challenge. Staff should be better trained in trauma-informed practice, and both staff and service users should be provided with opportunities to de-brief following episodes of restrictive practices, with a focus on enhancing and maintaining therapeutic relationships.

Keywords: aggression, child and adolescent psychiatry, de-escalation, restrictive practices; trauma-informed care; violence;

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Conflict of Interest:

None to declare.

Ethics

This study received ethical approval from Committee on Scientific Ethics of the Medical University of Plovdiv (Log: 4/08.06.2022), Research Ethics Committee of Turku UAS, (Log: LP06_2022), Ethics committee of HAW Hamburg (Log: 2022-08), and the Social Research Ethics Committee (Log: 2022-086).

Staff experiences of working with children and adolescents engaging in behaviours that challenge in mental health and paediatric inpatient environments: A qualitative study.

Abstract

There has been a recent global increase in the number of young people experiencing mental health challenges in both child and adolescent mental health settings and acute paediatric settings. In many of these settings, restrictive practices are used to manage behaviours that challenge, such as self-harm, aggression, and violence. However, little is known about staff's experiences with responding to these behaviours ~~that challenge~~ in these settings. A qualitative descriptive design was adopted, with participants engaging in 1:1 interviews or focus groups in Ireland, Finland, Germany, and Bulgaria. Data were analysed using reflexive thematic analysis. Four themes were identified: 1) the importance of establishing a safe, therapeutic environment, 2) identified antecedents to behaviours that challenge, 3) how staff respond to behaviours , and 4) the needs of staff when maintaining a safe, therapeutic environment. Consideration needs to be given to the environments where young people are cared for, with an emphasis placed on safe, comfortable, therapeutic spaces to reduce ~~behaviours that~~behaviours that challenge. Staff should be better trained in trauma-informed practice, and both staff and service users should be provided with opportunities to de-brief following episodes of restrictive practices, with a focus on enhancing and maintaining therapeutic relationships.

Keywords: aggression, child and adolescent psychiatry, de-escalation, restrictive practices; trauma-informed care; violence;

1. Introduction

Globally, it is estimated one in six (14%) young people aged 10-19 years experiences a mental health challenge (Global Health Data Exchange, 2019). The prominence of this issue is accentuated, particularly in the aftermath of COVID-19, with a documented increase in mental health difficulties (Kauhanen et al., 2023). Consequently, a discernible rise in the provision of care has been observed for young people with mental health challenges within paediatric settings (Hudson et al., 2022).

Many young people require the support of Child and Adolescent Mental Health Services (CAMHS). CAMHS are designed to address the mental health needs of children and adolescents and can encompass a range of interventions such as assessment, diagnosis, therapy, and support (Weisz et al., 2013; Kutcher, 2017). CAMHS are currently facing substantial strain due to the socio-economic consequences of COVID-19, coupled with increased regional instability and violence (Deeker 2022; UNICEF 2023). Resource allocation and treatment modalities create a fragmented landscape that lacks EU-standardised guidelines and raises concerns about equity and consistency in care delivery (Michaud et al. 2020). It has been stated that these environments can be difficult to work in, with staff reports of encountering behaviours that challenge (McDougall & Nolan, 2017).

Behaviours that challenge test organisations and staff's ability to respond in a safe therapeutic manner. These behaviours ~~that challenge~~ are characterised by their cultural deviation and pose a risk to the safety of the individual or others, attributed to the intensity, frequency, or duration (Emerson et al., 2001). ~~Challenging behaviour~~Child and adolescent behaviours that challenge ~~of children and adolescent~~s often manifest on the basis of accumulated biographical and environemntal stress and psychosocial risks. Adopting a social-ecological model (Jorgensen et al., 2023) allows an understanding of how behaviour can be influenced by biopsychosocial (pain, trauma, social or

interpersonal) and environmental factors. ~~Furthermore, b~~Behaviours of concern ~~that challenge~~ must always be reflected against the background of institutional conditions, the framework conditions for providing help and the characteristics and competences of the professionals themselves (Eweidna & Ibrahim, 2024; Jorgensen et al., 2023).

Behaviours that challenge can cover a broader spectrum of externalising (e.g. behaviour that injures others, disrupts the community or damages property) and/or internalising (e.g. listlessness or tendencies to withdraw) and/or self-harming behaviours. They be deliberate and directed or rather impulsive, uncontrolled and unpredictable and manifest as a loss of control. They can also occur over a longer period of time, can be observed repeatedly and occur with a certain frequency and intensity. These behaviours can be perceived as socially or culturally undesirable in a specific context by the individual or the environment (Büschi & Calabrese, 2019), and may also restrict the individual's capacity to participate in their broader community. Identifying early signs of behaviours that challenge is crucial for safeguarding the social inclusion of children and adolescents and mitigating potential problems. Prompt clinical intervention not only enables family support, but also promotes enhanced functionality, independence, integration, and relationship development (Braddick et al. 2009).

The background to ~~challenging~~ behaviours that challenge –in children and adolescents can be just as varied as the forms in individual cases. Regarding the genesis and maintenance of aggressive behaviour, a biopsychosocial and ecological aetiology can be assumed (Fairchild et al., 2019; Frick, 2016; Jorgensen et al., 2023). In the acute occurrence of behaviours that challenge, an interplay of personal, contextual, and situational factors can occur~~be assumed~~. The form, type and background of the crisis or escalation also play a role here. In psychiatric crises (e.g. psychosis, dissociation, suicidal behaviour, self-harm), for example, there is often a loss of control and less situational

traceability. In the case of psychosocial or educational crises, excessive situational demands can often lead to a mental imbalance and then to impulsivity, whereby fluid transitions can be assumed (Ellmer & Thun-Hohenstein, 2018). From a trauma-informed perspective, it is posited that all behaviours that challenge are underscored by a young person's unmet needs (SAHMSA, 2014). Consequently, an emphasis is placed on the development of meaningful therapeutic relationships, with a view towards enhancing communication and providing staff with opportunities to explore these needs (Kelly et al., 2023).

Healthcare staff's experiences of behaviours that challenge have been explored within the mental health services, with a particular focus on forensic adult mental health units (Ireland et al., 2021; Newman et al., 2023; van Leeuwen & Harte, 2015). Using individual-level therapeutic relationships, healthcare staff play a crucial role in the detection and management of these behaviours (Hartley et al., 2022). The organisational model of care can impact the methods in which staff attempt to limit behaviours that challenge, and the level of experience and self-awareness of staff was identified as a key contributor to management of behaviours that challenge (Maagerø-Bangstad et al., 2019). Moreover, the context in which care is delivered can in itself lead to increased instances of behaviours that challenge. Key contributory factors include design of inpatient units and therapeutic settings as well as staff attitudes and communication styles (Eweidna and Ibrahim, 2024). When children are cared for in the acute setting, the hospital environment, interaction with hospital staff and medical procedures have been identified as key triggers (Mitchel et al., 2022). Therefore, the organisations model of care needs to be considered from both a causative as well as a therapeutic perspective. A paternalistic model has been linked to increased inattentiveness and a reliance on coercive and controlling practices towards service users (Aberhalden et al., 2006).

While there is a growing body of evidence on behaviours that challenge in adult settings, there is a dearth of evidence on the experiences of staff in CAMHS and paediatric settings (Derscheid & Arnetz, 2020). As such the identification of CAMHS and paediatric healthcare providers' experiences and responses to behaviours that challenge is imperative. This study aims to answer the following question: what are ~~explore~~ staff's experiences and responses to behaviours that challenge in children and adolescents within inpatient mental health and acute paediatric settings in Ireland, Finland, Germany, and Bulgaria. The consortium was formed based on existing working relationships and knowledge of the expertise that each partner could bring. Furthermore, it was believed that the healthcare systems in each of the countries were different in structure and organisation, and as such the data collected would be diverse and of relevance at European rather than national level.

2. Methods

2.1. Design

A qualitative descriptive approach facilitated "a comprehensive summary of an event in the everyday terms of those events" (Sandelowski 2000, p.336). It is a particularly suitable approach to use when developing an understanding of phenomena in a straightforward manner from the perspectives of participants (Schroeder et al. 2023).

2.2. Data collection

A purposive sampling approach was used. Health, social, and educational care staff working in child and adolescent mental health inpatient units and paediatric wards in Bulgaria, Ireland, Finland, and Germany were recruited through an information leaflet distributed by the Director of Services in each area. Potential participants were asked to contact the researcher directly.

Data were collected through individual interviews and focus groups. A semi-structured interview guide was used. Interviews were conducted by experienced researchers via Microsoft Teams, which automatically generated transcripts, or in-person, where they were recorded and transcribed by the team.

2.3. Data analysis

Reflexive thematic analysis (Braun & Clarke, 2021) was used to analyse data. This form of analysis has been widely embraced by those conducting health and health services research (Ahmed et al., 2022~~1~~).

All transcripts were coded in researchers' native language. Next, transcripts and codes from Finland, Bulgaria, and Germany were translated into English and sent to the research team in Ireland, who read through transcripts numerous times to facilitate immersion in the data and cross-checked codes. Codes from Ireland's transcripts were cross-checked by the team in Germany.

The relationship between codes was reviewed independently by XX and YY, which led to the generation of initial themes. These themes were debated and refined by XX and YY, until consensus was reached, and were then presented to the entire consortium for further refinement. Once agreement was reached, themes were drafted, supported by participant quotations. This process is reflected in **Figure 1**.

Insert Figure 1. about here

Lincoln and Guba's (1985) principles were followed to maintain rigour. Credibility was maintained through methodological triangulation (using focus groups and individual interviews) and investigator triangulation (involving several researchers) (Korstjens & Moser 2017). Regular reflexive conversations took place between the research team to enhance confirmability (Yurdakul & Ayhan 2021). Dependability was achieved through

researchers generating themes independently, then meeting to reach consensus (Fransson et al. 2016). Transferability was maintained by providing illustrative quotations from each partner site (Lincoln & Guba 1985; Goodwin et al. 2022)

2.3. Ethics

Ethical approval was granted by <REDACTED>. Core moral principles were used to ethically guide the study (Beauchamp & Childress 2013). All participants were aware that their participation was voluntary, thus adhering to autonomy, and were treated equitably, thus adhering to justice. Participants were provided with the researchers' contact details in the event of experiencing distress, thus adhering to beneficence.

3. Results

Across the four countries, nine individual interviews and five focus group interviews were held. Full demographic details are listed in **Table 1**.

The interviewees worked in inpatient, psychiatric and paediatric routine care, most in the field of nursing and education, others in medical and psychotherapeutic care. Evidence-based guidelines as well as established concepts and procedures of systemic therapy and counselling, cognitive behavioural therapy, trauma pedagogy and psychodynamics guide the medical-therapeutic care of the young people and the educational approach. Participants recruited from the acute paediatric setting worked in ward environments designed for medical interventions rather than therapeutic care. The ward environment, staff training and workloads were focused towards acute child and family care. Guidelines and procedures for systematic therapy, counselling and trauma informed care were not universally available.

Insert Table 1 about here.

Four themes were identified. The first theme addresses how participants established a safe, therapeutic environment, and comprises two subthemes related to opportunities and threats. Under the second theme, antecedents to behaviours that challenge are reported. The third theme addresses responses to behaviours that challenge, comprising two sub themes on avoiding restrictive practice and using restrictive practice. Under the fourth theme, staff safety in the context of a safe, therapeutic environment is presented.

3.1. Theme 1. Establishing a safe, therapeutic environment.

Participants described opportunities and threats in relation to the establishment of a safe, therapeutic environment. The physical and relational environment were identified as significant in either promoting or disrupting safety.

3.1.1. Opportunities enhancing safety and therapeutic engagement.

Participants were motivated to provide a home-like environment, a place of safety with adequate facilities, space, and privacy. Open spaces were noted to have a positive impact on young people who needed to de-stress or reduce tension:

> *"We have great facilities in and outside the building. The park outside is really relaxing." (Participant [P] 8, Bulgaria)*

There was a perception that risk was always being assessed, with changes made to practice following incidents. Participants described switching glassware for plastic

utensils, securing furniture, and the need for vigilance and clear communication to maintain everyone's safety:

"Situations in which they fight, throw objects or food, break items or tear clothes are usual here. Within two weeks, one of the children broke two glass doors… the glass has already been replaced with plastic panels." (P6, Bulgaria)

Participants noted the importance of reassuring young people that an adult is available. They also described how young people appeared to like being physically close to staff:

> *"When given the choice they will all sit on bean bags around the nurses' station. That's their choice of place." (FG1, Ireland)*

Teamwork and team relationships were uncovered as essential components in the provision of a safe and therapeutic setting. Support from management eased work burden and having a relationship with colleagues reduced the risk of misinterpretations as to how to respond when dealing with aggression:

> *"We get full support; our team works together very well. Our managers are always responsive to our needs." (P9, Bulgaria)*

3.2.1. Environmental and relational threats

Participants discussed challenges with staffing levels and the focus of care, the need for specialist input, and the appropriate use of space or low stimulus areas. Across all jurisdictions, insufficient staff on duty increased the risk of staff tiredness and aggression in young people:

> *"The main problem is the lack of personnel. At the weekend there is only one person responsible for 13 children." (P4, Bulgaria)*

When access to specialist support such as CAMHS teams was limited, care was paused and this delay corelated with participants' concern for the safety and wellbeing of the young person and other young people or families. They worried that other young peoples' needs may not be met because of demands or additional needs of a particular young person:

> *"It could take days for the child to actually be reviewed by a CAMHS person… then you know the child would come in, a referral would go, like, into the abyss […] and then you have another 29 children, parents, visitors […] a newly diagnosed diabetic, a child seizing over here, you could have a palliative patient"* (P4, Ireland)

There were challenges identified relating to restrictions inherent or imposed within the physical environment. Participants described buildings as unsuitable with labyrinth-like structures. Walls or corners, malfunctioning technology (alarm systems) or unit layout impeded their ability to respond to incidents, adequately supervise, or escort young people from one area to another safely:

> *"Our labyrinth here, that when the unit is not to be a psychiatric unit, especially when we transfer the patient, there is always a wall or a corner in our way and I have also been in such a situation where I was trapped in between the child's foot and the wall." (FG4, Finland)*

3.3. Theme 2. Antecedents to Behaviours That Challenge

Under this theme, the events or precursors leading to behaviours that challenge are addressed. Participants noted that poor family dynamics negatively impacted on young people, and that their presentation to health services was often a consequence of high

expressed emotions at home. For some young people, continued family involvement led to recurring aggressive incidents:

> *"I don't want to blame their parents, but sometimes they hinder the therapeutic process. The same behaviour is expressed in their home as well. For instance, the girl I mentioned has damaged more than 20 TV screens at home." (P4, Bulgaria)*

Setting boundaries was perceived as a key role of healthcare staff. It was acknowledged that young people often perceived this role in a coercive, authoritarian context, and in response, would act aggressively towards staff:

> *"And yes, disappointment in limiting situations is indeed so common that a child wants something and then doesn't get it. And then it goes from there: fists are swinging." (FG5, Finland)*

Physical space was also addressed in the context of boundary setting. In high levels of supervision, young people were often within arm's distance of staff. This was frustrating for young people, and often eroded their sense of privacy/dignity, which could then lead to behaviours that challenge:

> *"I wonder if kids maybe not being allowed to have access to the bedroom […], they're supervised all the time, unless they're in the bathroom and then a lot of them are supervised in the bathroom too. So, I wonder if having more personal space or free space away from other people, away from staff might be helpful?" (FG1, Ireland)*

Participants observed that, during the summer, young people were more physically active, and provided with the space to exercise outdoors. However, during colder

seasons, young people were not afforded such opportunities, leading to a sense of "containment" and more aggression:

> *"In Winter season, when there is less sun, aggression is more common – children spend more time indoors and aren't as physically active as in the summer. When weather is warmer children usually are taken out - on excursions, or they play sports such as badminton" (P4, Bulgaria)*

Despite recognising a variety of antecedents to behaviours that challenge, participants also recognised that there were times when young people act in very unpredictable ways. This indicates that, even when they were aware of young people's personal situations and specific factors that may trigger behaviours that challenge, staff sometimes encounter unforeseen situations which may prove difficult to address:

> *"There are situations that are completely unpredictable. So that it starts just, like, suddenly, in a peaceful situation, so, one might jump up and get serious and grab your throat, or to hit or kick." (FG4, Finland)*

3.4. Theme 3. Responding to Behaviours that Challenge

Although participants attempted to avoid restrictive practices, this was sometimes considered inevitable. This theme addresses alternative approaches taken, in addition to the forms of restrictive practice they sometimes engaged in.

3.4.1. Avoiding Restrictive Practices Through De-escalation

There was an agreement that, whenever possible, restrictive practices should not be used with young people. Coercion and restraint were avoided using de-escalation practices in the context of distraction techniques such as engaging in 1:1 conversation, encouraging the use of creative therapies and employing the use of technology:

"I try to distract the child attention by talking to him or giving him a smart phone to play games or watch videos on YouTube or Tik-Tok. Sometimes books for paintings also work." (P5, Bulgaria)

The effectiveness of de-escalation was predicated on the relationship staff have with young people. Participants highlighted the importance of being transparent with young people, communicating with them in a respectful, open manner, and giving them sufficient time to communicate:

"So, I think that transparency helped a bit. […] So, then build trust somehow a little bit. […] Probably this relationship, which you then have even after a second time: it's always worth its weight in gold." (FG3, Germany)

At times verbal de-escalation was ineffective. Participants emphasised the importance of offering young people a range of different options to help then self-regulate their emotions such as encouraging them to express their emotions physically. It was noted that this would need to be facilitated in a safe manner:

"Whether it's about stamping the floor, punching the pillow, tearing up newspapers, going to the room for a while, breathing, […] as long as you don't hurt yourself, or others, […] it's acceptable to show that feeling." (FG5, Finland)

An alternative approach was to provide young people with a low-stimulus environment. This helped minimise intrusive background noise and fostered a sense of reflection for young people, thus reducing the risk of violence and aggression:

"If there was kind of, like, signs that she was going to kick off or kind of get worse in regards to her aggression, maybe even try to get her outdoors, do you know, that she's not so enclosed, like, out into the garden." (P2, Ireland)

3.4.2. Use of Restrictive Practices

Despite the importance assigned to using de-escalation practices, participants recognised that restrictive practices would sometimes need to be used. Strictly speaking, this was during events when there was a perceived risk to the young person or to others. It was noted that staff would often attempt to restrict a person's movement initially:

"My first reaction was to hold his hand and try to calm him down." (P4, Bulgaria)

However, there were cases where such practices were not effective, and young people would continue to demonstrate behaviours that challenge. In such instances, a risk to self, others, or property was perceived, meaning staff would need to engage in full restraint:

"She actually was kind of restrained in the bed. […] She was a very strong child. So, it nearly took one person per limb to hold her down." (P2, Ireland)

Often, when a young person was restrained, staff would also need to administer intramuscular medication (IM). Use of medication was not always permitted, depending on the facility where staff worked, or the regulations/governance within individual countries. Where IMs were permitted, attitudes were positive amongst participants, as it was believed that medication quickly mitigated both the risk of physical injury and further escalation:

"They were on top of him: two on top, two on bottom, and one in the middle. And then we gave him sedation, IM sedation, so that took maybe five to ten minutes." (P1, Ireland)

Another commonly used form of restrictive practices was locking doors. Some areas had a dedicated "time-out" room for young people to avoid stimulation for a period and regain a sense of calm. Staff working in other areas restricted access to certain rooms; for example, staff might lock bathrooms to ensure young people were within their field of vision:

"I would say that locking rooms is very common. […] I think the […] most frequently used coercion that takes place here is locking rooms, […] that they are forced to be here and are probably not allowed to leave at first." (FG2, Germany)

In addition to being "contained" within the healthcare setting, further restrictions were often implemented when young people were considered a risk to self or others. Personal items that could be used to inflict harm might be removed.

"There are so many different levels of restrictive measures that it can also be restrictive measures such as taking things out of the room. If the child has misused them, or, for example, threatens with them or throws." (FG5, Finland)

Following a critical incident, participants identified the importance of reconnecting with the young person. This involved physical check-ups, debriefing and individual time with an adult that they had a relationship with. It was hoped that this reconnection would help create change for the young person in the future.

"Trying to develop a rapport with him as well… trying to discuss it out like with them and say like look, we know you're kind of like, you know, this isn't the best place for you and we're just trying to help you and we're trying to figure it out." (P3, Ireland)

3.5. Theme 4. Maintaining a safe, therapeutic environment: Staff's needs

Participants were asked to consider what went well or could have been done differently during or after a critical incident. Situations were considered to have gone well when communication and roles were clear between staff and when nobody (staff or young person) was injured:

"I suppose things that went well for my incident was that no one was hurt really, no staff was hurt. Like none of us were injured or dead." (FG1, Ireland)

Participants reflected on the emotional impact that coercive practices had on them. Feelings of fear, stress and anxiety were illuminated. Participants also described feeling intimidated, helpless, and powerless in the face of escalating aggression:

"Many colleagues later handed in notes, two or three weeks later, that they felt really stressed by this incidence and overloaded." (FG3, Germany)

There was a distinction evident between immediate needs following a critical incident and longer-term needs. In the short-term, participants spoke of the need to be able to rely on each other to ease distress. Mentoring and informal and formal debriefing, with the right person at the right time, were also elucidated as essential components of an appropriate response in the aftermath of incidents:

"Multidisciplinary team meetings are conducted sometimes – we try to point out all perspectives and learn from each case." (P4, Bulgaria)

Participants lacked knowledge, understanding and skill to minimise or manage critical incidents. In future, they agreed that training should contain both theoretical and practical components. Theory relating to trauma-informed care was identified as having the potential to support staff in understanding the reasons why a young person may become distressed or aggressive:

> *"And still to maintain this trauma-sensitive attitude and to say 'The behaviour has a good reason and the intention is for the child to protect itself as much as possible.'" (FG2, Germany)*

Appropriate training on aggression and violence was identified as necessary. Barriers to engaging with training included the COVID-19 pandemic and insufficient time to undertake training. Participants working in paediatric services noted that specialist training was not available to them outside mental health services:

> *"I don't think there's any staff nurse that is mental health trained on the children's ward. There definitely should be some degree of CAMHS training." (P2, Ireland)*

Participants believed that all personnel should engage with training or education. They also thought training in the de-escalation or management of aggression and violence should begin at undergraduate level, be mandatory and include regular refresher courses:

> *"Doctors, therapists, nurses all train together on a basic course and then build freshup every year, which is the minimum standard for us… in the last few years a recognisable procedure has crystallised on all wards." (FG2, Germany)*

4. Discussion

The aim of this study was to explore staff experiences and responses to behaviours that challenge in children and adolescents within inpatient mental health and acute paediatric settings. Developing a therapeutic relationship was considered central to care delivery, particularly as it pertains to maintaining safety from a physical and emotional perspective. Evidence suggests that children and adolescents who have experienced early adversity are more likely to engage in self-harm and behaviours that challenge (Russell et al. 2022, Scocco et al. 2019). When this occurs, restrictive practices are utilised to maintain safety. However, utilising restrictive practices can potentially escalate, rather than de-escalate a crisis (Cusack et al. 2018), thus increasing the risk of re-traumatisation (Beattie et al. 2019, Cusack et al. 2018). Within the inpatient setting, witnessing restrictive practices of peers can be distressing (Snyder et al. 2019), and may negatively impact the therapeutic milieu of the inpatient environment (Cusack et al. 2018). Furthermore, restrictive practices can challenge staff's capacity to build or maintain this therapeutic alliance (Steckley & Kendrick, 2008), which in turn may influence the perception of the delivery of restrictive care as problematic (Beattie et al. 2019). Research shows that trust and therapeutic engagement can act as buffers to mitigating negative outcomes as a result of mental health emergencies (Hidalgo et al. 2016). Increased focus on therapeutic engagement is therefore required, underpinned by a person-centred approach and the utilisation of co-regulation and clinical validation (Ramaiya et al. 2023). Exploring collaborative de-escalation approaches to mitigate retraumatising adverse incidents is also recommended (Mental Health Commission 2022).

This type of person-centred care is a key principle of trauma informed practice (TIP). TIP is underpinned by a strengths-based approach that seeks to acknowledge

childhood trauma and sets out to deliver care safely and avoid retraumatisation (SAMHSA, 2014). In promoting a needs-based understanding of behaviours that challenge with a focus on the role of attachment, trauma-informed interventions typically address the psychological, emotional, and behavioural consequences of trauma while fostering resilience and healing. There is growing evidence of TIP's effectiveness, with studies showing the potential to reduce the use of restrictive practices amongst staff caring for children and adolescents with behaviours that challenge (Dublin et al., 2022; Kelly et al., 2023). When it comes to preventing and de-escalating ~~challenging~~ behaviour that challenges, many professionals emphasise the importance of communication and relationship building. Even if a biopsychosocialsocial-ecological —aetiology of ~~challenging~~ behaviours that challenge can be assumed in principle, attachment losses and relationship breakdowns, as well as an invalidating environment and unpredictable living conditions appear to play a central role. Trauma informed care tries to counter these circumstances in everyday work with the children with a reliable relationship, empathic communication and a safe, predictable place (e.g. Goddard 2021). A trauma-informed approach has been increasingly implemented in a variety of settings including adult and child and adolescent mental health services (Palfrey et al. 2016; O'Dwyer et al. 2021), child welfare services (Barto et al. 2018, Lang et al. 2016), paediatric settings (Thakur et al. 2020), residential (Baker et al 2018), judicial settings (Branson et al. 2017), maternity services (Sperlich et al. 2017), education services (Davis et al. 2022), first responders (Ko et al. 2008), and in primary care settings (Cullen et al. 2022). The growing evidence base for the effectiveness of TIP, coupled with the concerns raised by participants about restrictive practice, indicate a need to ensure training in TIP is made more available to staff, in a more consistent manner.

This study also highlights the role of antecedents to behaviours that challenge, such as the importance of the physical environment in mental health care. It underscores the significance of effective design in clinical settings, as it can lead to improved clinical outcomes and reduced stress levels for both service users and staff, which is particularly crucial for those receiving mental health care. The association of behaviours that challenge and the inherent problematic way in which they are perceived is queried as the root of the issue may not lie within the individual, but in external factors such as societal expectations, relationships, or even the therapeutic approach itself (Osborne et al., 2018; Doyle, 2004). Sui et al. (2023) identified four significant dimensions of physical environments as crucial for mental well-being and personal recovery: sensory design elements, engagement qualities, social relational aspects, and affective experiences. Furthermore, the study recognises the influence of familial dynamics on behaviours, advocating for healthcare professionals to collaborate with families. Coordinated treatment planning in interdisciplinary case rounds involving users and their families have been shown to promote de-escalation and person-centred care (Dublin et al. 2022).

The predominant methods used to manage behaviours that challenge ~~i~~was behavioural. Focussing on ~~the behaviour~~this approach alone is limited and can result in clinicians trying to modify the behaviour rather than focussing on the complexity of what is causing it (Havighurst et al., 2009). While quick behaviour changes may occur, it does not facilitate longer term coping skills, that, coupled with the intervention been driven by crisis, leads to a reactive rather than proactive approach to care and can fall short in meeting the young person's needs (Allender, 2020) Responding to escalating and threating situations on a regular basis, particularly when using high-risk interventions such as restraint and seclusion, has been shown to have a negative long-term impact on both service user and staff well-being (NICE, 2015). Debriefing has been shown to be an

effective method to foster learning and change in clinical practice (Asikanen et al., 2023) and found to be among the most effective strategies to reduce aggression or violence in mental health settings (Asikainen et al., 2020). De-escalation training (e.g. Sawyer et al., 2023) has been developed for mental health and other medical and residential care settings and service user cohorts (Brenig et al., 2023; Slaato et al., 2021). This training offers background knowledge on causes for behaviours that challenge, specific communication skills, and safe physical restriction techniques. Furthermore, the deeply personal nature of work involved in the use of self in building therapeutic relationships, a lack of effective interventions for children and young people with multiple and complex needs, as well as limited resources are all factors that put staff at risk of experiencing a lack of self-efficacy and gratification resulting in negative effects on personal health and burnout (Chirico et al, 2021; Dall'Ora et al. 2020). In-depth self-reflection and awareness training of personal strengths and biographical trigger points (Eyni et al., 2023), as well as stress-reduction programs based on mindfulness (Coversano et al., 2020) have also been shown to provide staff with needed capacities to deal with professional demands in this field. The emerging evidence suggests that TIP can be beneficial for children, adolescents (Matte-Landry & Collin-Vézina, 2022, Isobel et al. 2021) and for staff (Robey et al. 2021, Purtle, 2020). However, the evidence base is preliminary and there are still comparatively few specific and tailor-made services for CAMHS settings (Kelly et al. 2023; Slaato et al., 2021).

5. Limitations

This study has limitations. Potential sample bias, where those who volunteer to take part in interviews may have personal reasons for doing so (Walsh et al., 2022) could have influenced the study. There may be others who chose not to volunteer with different views on restrictive practice. It should also be acknowledged that more females than

males took part in this research. While low male sample sizes are a common issue in research (Goodwin et al., 2023; Kilty et al., 2021; Walsh et al., 2022), it should be acknowledged that this impacts the transferability of findings. Finally, while a combination of focus groups and individual interviews was used to enhance triangulation, it should be noted that these approaches can yield different responses, e.g., broader responses from individual interviews and more sensitive responses from focus groups (Guest et al., 2017); however, similar responses were observed in both formats.

6. Conclusions

This study unveils vital insights into managing behaviours that challenge in therapeutic environments for young individuals. It emphasises the crucial role of creating a safe and therapeutic environment, underlining the impact of physical and relational dimensions on safety and the need for private and comfortable spaces. The insights gained from this research offer valuable guidelines for optimising physical environments to support mental health recovery, especially in the evolving landscape of mental health care. Additionally, the findings highlight the importance of de-escalation techniques and the ethical considerations of restrictive interventions, all within the context of maintaining the well-being of healthcare staff. Post-incident debriefing should be offered to staff and service users after all critical incidents to allow mutual reflection on the events leading up to aggression and violence. Gaining self-competence and learning self-care strategies should therefore play a sufficiently important role in the training of child mental health professionals and CAMHS services. The study underscores the significance of a trauma-informed environment in promoting optimal care and recovery for young individuals facing behavioural challenges. Training in TIP is essential if this approach is to be successfully adopted. Given the variety of trauma-informed training approaches being

used, attention could also usefully be focused on building our understanding of which models of trauma-informed training most effectively increase the short- and medium-term outcomes for staff and young people.

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