YOUNG PEOPLE'S EXPERIENCES OF RELATIONSHIPS

WITH STAFF AND PEERS

IN ADOLESCENT INPATIENT UNITS

DEBBIE SISCHY

D.CLIN.PSY. THESIS (VOLUME 1), 2006

UNIVERSITY COLLEGE LONDON

UMI Number: U592403

UMI

Dissertation Publishing

ProQuest®

OVERVIEW

This thesis comprises three parts. Part one is an overview and critique of the literature examining whether adolescent inpatient units are beneficial for young people. Part two presents the qualitative empirical paper, which explores young people's experiences of relationships with staff and peers on adolescent units. Finally, part three of the thesis will be presented and consists of a critical appraisal and reflection of the research process. This will involve discussing the challenges and dilemmas which arose when designing, conducting and writing up the research.

CONTENTS

LIST OF TABLES

PART II: EMPIRICAL PAPER

ACKNOWLEDGMENTS

PART ONE: LITERATURE REVIEW

Are Adolescent Inpatient Units beneficial for young people?

ABSTRACT

There are a number of questions that remain about the best way to organise and run adolescent units and deliver inpatient care to meet the need of this population. Questions also remain about the outcome effectiveness as well as the role of therapeutic processes in inpatient care. In relation to the overall service effectiveness and outcomes achieved in inpatient adolescent settings, there continues to be limited empirical evidence for this mode of service delivery. However, this lack of evidence relates to the significant methodological weaknesses in the existing studies that reflects the multiple, practical and ethical difficulties associated with carrying out outcome research in these settings. This review paper aims to discuss and examine whether adolescent inpatient units are beneficial for young people. The review will provide an overview and critique of the literature surrounding this debate, and then will draw conclusions and discuss associated clinical and research implications.

Are inpatient adolescent units beneficial for young people?

Section 1. Introduction

1.1 Summary of review sections

This review paper is made up of six main sections, some of which contain sub-sections. It aims to discuss and examine whether adolescent inpatient units are beneficial for young people. The review will provide an overview and critique of the literature surrounding this debate. It will begin by providing a brief introduction around the need for and nature of inpatient treatment for young people, followed by describing the history, policy, provision and aims of adolescent units. The review will then outline the outcome research literature on adolescent inpatient care and examine some of the current evidence to support this mode of treatment. Following this, the review will provide a brief overview of the literature and potential impact of therapeutic process variables in inpatient care, before going onto discuss the essential contribution that users' views can provide when examining whether adolescent units are beneficial to those who require them. Finally, the review will end by providing an overall conclusion summarising the debate and question at hand.

Throughout this review, the term adolescence will be used to describe the developmental stage. The term young person and adolescent will be used to describe young men or young women aged 12-18 years. As service delivery, models of care and policy differ so widely internationally, this review will primarily focus on literature and studies within the United Kingdom. However, it will also draw on research from the United States of America and other international sources particularly throughout Sections 2 and 3.

1.2. Prevalence of Mental Health Problems in Adolescence

Adolescence is an important stage of human development during which puberty, family separation, individuation, identity formation and other developmental tasks are negotiated (Erikson, 1968). It is also a period of heightened vulnerability to the development of psychological difficulties and the emergence of many serious mental health problems. Associated risk factors include family conflict and separation, low self-esteem, educational underachievement, parental mental health problems, and difficulties with peer relationships (Holmbeck et al., 2000; Masten, Best, & Garmezy, 1990). There is a change in the prevalence of mental health difficulties during adolescence, for example, internalising disorders increase in prevalence particularly amongst young women (Weisz & Hawley, 2002). There is also the emergence of new types of difficulties and disorders, which are more common of adulthood, such as psychosis, eating disorders, self-harming and suicidal behaviour, anti-social disorders and substance misuse (Carr, 2000; Parry-Jones, 1995; Weisz & Hawley, 2002). The prevalence of these difficulties varies across studies. This is often due to methodological factors such as sample characteristics, methods and measurement. However rates of mental health disorder appear to largely fall between 10% and 20% of the population (Cotgrove & Gowers, 1999; Cotgrove, 2001). Only a small minority of these young people receive specialist assessment and treatment from mental health services in the United Kingdom and many go undetected (National Service Framework for children, young people and maternity services, 2004; Parry-Jones, 1995). A small proportion of young people experience acute and severe mental health problems and go onto receive inpatient treatment, making up about 0.1% of those with a psychiatric disorder (Cotgrove & Gowers, 1999). However, questions still remain about the benefits of moving young people

with such severe and acute difficulties away from their home environment, school and friendships, and providing treatment in such intensive inpatient settings.

1.3 Who are adolescent inpatient units for?

Adolescent inpatient units in the United Kingdom are highly specialist scarce and costly Tier 4 Child and Adolescent Mental Health Services (CAMHS) that are commissioned regionally, and provided to the smallest critical mass of general population that is practical and as geographically close as possible to the community served (York & Lamb, 2005). Units usually cater for young people between the ages of 12-18 years, who largely present with the most complex and severe, acute and co-morbid mental health difficulties, and who are not able to be managed in community settings (Gowers, 2001).

Cotgrove and Gowers (1999) point out several reasons for non-admission to adolescent inpatient units. These include when specific expertise or treatments are not available for adolescents with specific problems; when adolescents are extremely violent and units are not secure; and when admission of particular patients is undesirable for themselves or others due to the particular case-mix at a given time, or when a high level of disturbance on the unit occurs, which could undermine the therapy and the treatment gains for those already admitted.

Section 2. History, Policy, Provision and Aims of Adolescent Inpatient Units

This section will describe the historical context, development and philosophy of inpatient adolescent units, before going onto describe the policy and current provision of these services in the United Kingdom. Following this, information

regarding the aims, rationale and different types of adolescent units will be presented.

2.1 Historical Context and Underlying Philosophy of Adolescent Units

Social concern for the mental health of adolescents has been very erratic. For example, in the 18th and 19th centuries, teenage "lunatics" and "idiots" with mental disorder were admitted to private madhouses and asylums (Cotgrove & Gowers, 1999; Parry-Jones, 1995). Clinical and academic interest in the "mental diseases" of this age group increased from the mid 19th century when puberty was considered an important physiological cause of mental illness (Parry-Jones, 1995). By the end of the 19th century this interest had flourished and more serious attention was being given to the 'disorders' of adolescence. This led to the emergence of two broad forms of residential mental health care for young people during the early 20th century (Green, 2002). The first type of setting (which included residential and therapeutic schools) drew on therapeutic community principles, where little individual therapy took place. It was based on the idea that a self-contained social environment could act as a therapeutic context or "milieu" which contributed in itself to clients' care and recovery (Peplau, 1989).

Milieu therapy was originally implemented in long-term care and residential adult settings, for example, therapeutic communities. The concepts and aims of milieu therapy have since been applied in medium, acute and short-term inpatient, day and community settings (Boyd & Nihart, 1998; Pines, 1979) and also been adapted for use in child and adolescent residential, educational and inpatient settings (Green & Burke, 1998). The premise of 'milieu therapy' is that the 'milieu' or therapeutic

context of the inpatient setting is considered a treatment modality in itself (Abroms, 1969; Peplau, 1989; Thomas, Shattell & Martin, 2002). The aims of the milieu approach are to set limits on the main types of pathological behaviour (e.g. destructiveness, disorganisation and dependency) and promote the development of basic psychosocial skills (e.g. orientation, assertion and occupation) by using all aspects of the therapeutic environment to construct a stable, coherent, social organisation to provide an integrated, extensive treatment context (Abroms, 1969; Thomas, Shattell & Martin, 2002).

The physical environment (i.e. therapeutic space design, safety and resources) and the quality of the human relationships (i.e. staff and peers) encountered in the ward environment are key to the therapeutic functioning of the milieu (Green & Burke, 1998). A successful milieu has been said to show responsiveness and flexibility in an environment of clear organisation and structure (Swartz et al, 1988), involvement and validation along with containment (Gunderson, 1978) and corrective relationships along with internalisation of external controls and the capacity to resolve conflicts (Fineberg et al, 1980). These key aims and therapeutic functions of the milieu involve 1) providing structure through the predictable organisation of time, place, and person, through the provision of patterns, routines, timetables, order and stability (Delaney, 1992) thereby reducing potential for group chaos, emotional expressiveness and regression, and encouraging a culture of reality orientation and relative control, 2) sustaining clients' physical and psychological well being and reducing self-destructiveness and physical deterioration by providing them with containment, safety, nurturance, shelter, behavioural management, boundaries, removing them from danger and enhancing their self-control (Gunderson, 1978),

7

3) providing support through the ward's social network i.e. staff and peers, including mutual support processes and therapy to enhance self-esteem and awareness (Thomas, Shattell & Martin, 2002), 4) ensuring client involvement in order to modify aversive or destructive interpersonal patterns and confront passivity by ensuring their active involvement in groups, ward and communal activities. This aims to enhance self-control and responsibility, encourage social skills and feelings of competence, and learn about group processes of co-operation, compromise, confrontation, conformity and social sensitivity. In addition, involvement in interpersonal relationships helps clients to develop more secure attachment patterns and work on dependency issues that reflect unmet needs (Fineberg et al, 1980; Gunderson, 1978), and 5) ensuring validation through ward processes that affirm a client's individuality (e.g. respecting their illness, privacy, failings and capacities (Gunderson, 1978).

The second type of residential mental health care for young people was based on the adaptations made for children within the asylums of the 19th century and the accelerated development of specialised medically based psychiatric units for children. These hospital units developed to provide a comprehensive approach to assessment and treatment based on a bio-psycho-social model, where the hospital environment was the location for assessment and treatment, rather than its primary agent. These historical themes and therapeutic community and milieu principles continue to be influential in many units and remain a useful way of conceptualising inpatient treatment process today.

The Child Guidance Movement emerged in the 1930's and helped to delineate a new multi-disciplinary specialty removed from the ethos of 'asylum psychiatry' and more

closely associated with paediatrics (Parry-Jones, 1995). During this period, younger adolescents were generally accommodated within these new community services and older adolescents, especially those with severe mental illness remained largely within the asylums and general adult psychiatry. By the 1940's, very few mental hospitals had adolescent wards. It was not until the late 1960's and early 1970's that the need for separate specialist inpatient care for adolescents with mental health problems was recognised (Cotgrove, 1997). These units were relatively small in number and served large catchment populations. Despite attempting to bridge the gap in services for adolescents, these units mainly developed in association with mental hospitals and were predominantly a reflection of the asylums, as opposed to the child guidance services (Parry-Jones, 1995).

Despite the growth of inpatient adolescent units over the last few decades, their development has been described as haphazard, idiosyncratic and lacking in overall strategic planning, and their function reported as capricious (Gowers & Rowlands, 2005; Kurtz, Thornes & Wolkind, 1995). Their existence was often determined by history, clinical special interests, an academic centre or the distribution of the health authorities (Parry-Jones, 1995). Units have been criticised for frequently running without any clear evidence for their effectiveness, diverse models of care and dependence on the beliefs and experience of a charismatic leader (Parry-Jones, 1995).

2.2 Policy and Service Context of Adolescent Inpatient Units

In light of this lack of organisation and diversity of care, a large number of policy documents and initiatives have emerged in the last 20 years which have impacted on

and influenced the current provision of inpatient services for young people in the United Kingdom. The Health Advisory Service (1986) raised concern about the provision for "psychiatrically disordered" adolescents and attempted to give broad guidelines and recommendations on psychiatric services needed for adolescents. The Health Advisory Service (1995) provided detailed advice designed to assist with the commissioning and delivery of a comprehensive child and adolescent mental health service, which included placing inpatient adolescent mental health services in the fourth tier, along with highly specialised services such as eating disorders and forensic units (Cotgrove, 1997). In 1997, the House of Commons Health Committee concluded that NHS inpatient units should predominantly be concerned with young people with psychiatric disorders rather than disruptive and anti-social behaviour and recognised the need for specialised services in areas of early onset psychosis.

2.2.1 Current Provision of Adolescent Inpatient Services in the UK

Historically, there has been a lack of systematic data on the number, distribution and activity of units in the UK, those who use them and their clinical outcomes (Green et al., 2001; Gowers & Rowlands, 2005). Recently the National Inpatient Child and Adolescent Psychiatry Study (NICAPS; O'Herlihy et al., 2001) which was designed to investigate the distribution, characteristics and national use of child and adolescent psychiatric inpatient units, revealed an uneven geographical distribution of units and marked variation in the distribution of beds across regions of England and Wales (O' Herlihy et al, 2003). Findings revealed where resources were limited, combined child and adolescent units still existed and some young people were inappropriately admitted to adult psychiatric or paediatric wards (O' Herlihy et al., 2003). The majority of inpatient units in the study were unable to accept emergency admissions,

or provide an admission service outside office hours or at weekends (O'Herlihy et al., 2001; 2003). In addition, units for young people with addictions and learning disabilities and secure and forensic units were found to be in short supply, (O'Herlihy et al., 2004) resulting in young people requiring care provided by a staff group with specialist experience were often admitted to general psychiatric units.

Findings of the NICAPS study also revealed variability amongst units in the staffing, type of treatment offered and the model of care provided. Evidence based practice was often lacking and some units offered acute admission facilities while some provided longer stay therapeutic treatment and some combined the two (O'Herlihy et al., 2001; Parry-Jones, 1995). Both NICAPS and related studies have revealed that many services had problems recruiting and retaining staff, heavily relied on untrained agency and bank nurses (Jaffa et al., 2004), employed unqualified nurses and lacked psychiatry input and a full multi-disciplinary staff team (Jaffa et al., 2004).

2.2.2 Recommendations from NICAPS and the NSF

In order to address these significant problems in service provision, NICAPS produced several recommendations (O'Herlihy et al., 2001). These are reflected in the National Service Framework for children, young people and maternity services (NSF, 2004) and have led to the development of several policy documents and practice guidelines which have been influential in underpinning the provision and shape of current inpatient adolescent services. For example, the findings from NICAPS (O'Herlihy et al., 2001) support the need for the regional commissioning of CAMHS care for young people with the most complex and severe difficulties that

includes emergency care, generalist inpatient facilities and specialist services, assertive outreach, day and community services (NSF, 2004; O'Herlihy et al., 2001; York & Lamb, 2005). Other recommendations include ensuring the availability of out of hours service provision and emergency beds, units being appropriate for patients' ages and stages of development (NSF, 2004; O'Herlihy et al., 2001) and the necessity for staff to conform to a set of quality guidelines, training and standards such as the (Quality Network for Inpatient CAMHS: QNIC, 2003).

2.3 What are the aims and rationale for adolescent inpatient treatment?

Adolescent inpatient units should aim to address the needs of the patient and their family, and the referrers (Cotgrove & Gowers, 1999). The aims of admission for the referrer usually focus on the treatment of the principal disorder and the 'symptoms' by pharmacological and psychological therapies (Cotgrove & Gowers, 1999). However, often the family's aims for admission relate more to non-specific factors (Cotgrove & Gowers, 1999; Cotgrove, 2001). It is interesting that little is known about young people's aims which appear so fundamental to their engagement in the treatment process.

The aims of admission to adolescent units include detailed and intensive assessments in complex cases when the formulation is unclear, in which the combination of the 24 hour setting, with the expertise of multi-disciplinary health professionals, makes the ward particularly able to address the interaction of biological, psychological and social aspects of these complex disorders (Cotgrove & Gowers, 1999; Green, 2002). In addition, the aims of admission extend to the management and treatment of complex problems where a young person's support system and outpatient work has

been insufficient and intensive and specialist input is required. Although the inpatient resource is held in reserve for the most complex and severe cases, if referral is not delayed, a well timed, intensive treatment aims to prevent further escalation and lead to a reduction of symptoms and reduce the risk of long term psychopathology (Cotgrove & Gowers, 1999). When the young person is at risk of serious harm to themselves or another person, for example, as a result of self-harm, neglect or psychotic processes, admission also ensures access to safety, intensive nursing and staff input in a controlled and secure environment, which includes risk management, stabilisation and treatment (Cotgrove & Gowers, 1999; Green, 2002).

The rationale for adolescent inpatient units also includes the opportunity for assessment and treatment of the young person to occur away from the family, which can be especially crucial when the role of the family in a presentation is unclear, complex symptoms seem to be confined to the home environment, the family appear to be contributing to further decline of the adolescent's difficulties and when risk issues are present within the family (Green, 2002).

2.4 What types of units currently exist and what do they do?

Current provision of inpatient units in the United Kingdom appears to fall into three major categories: generic, acute and specialist services. Although other residential and inpatient services do exist for young people, for example, secure units and therapeutic communities, they are in a minority. This review will therefore focus on the three main types of inpatient services for young people with acute and severe mental health needs.

2.4.1. Generic Units

The majority of adolescent inpatient units are 'generic' in nature and run by the NHS, for young people presenting with a diverse range of severe mental health difficulties. Treatment on these units is intensive and involves frequent contact and coordinated intensive therapy with the young person and their family, by a multi-disciplinary team, led by a consultant psychiatrist and managed by nursing staff. The treatment interventions draw on a range of approaches and typically consist of individual, family and group based interventions, using a range of cognitive, behavioural, psychodynamic, systemic and creative approaches, together with pharmacological interventions. Programmes also include schooling and daily communal activities. Generic units provide inpatient, day-patient and more intensive outpatient treatment, in order to facilitate transition back into the community.

The treatment in generic adolescent units aims to provide young people with an opportunity for a positive peer group experience, a chance to develop more secure attachments and 'functional' relationships with peers and staff and an opportunity to gain insight into understanding and managing their difficulties. This is achieved through the use of the group and milieu context and individual therapy in an environment where young people are given the opportunity to live independently and gain more autonomy resulting in positive psycho-social benefits (Cotgrove & Gowers, 1999; Cotgrove, 2001). It has been suggested that an intensive inpatient experience also has the potential to impact significantly on the personality development in a way that is not available with more limited outpatient interventions (Cotgrove & Gowers, 1999).

2.4.2. Specialist Units

In recent years, an increasing number of 'specialist' units have been set up, which cater primarily for a single type of disorder. These units are predominantly run by the private sector, primarily for young people with eating disorders or forensic problems. Specialist units also exist for adolescents with learning disabilities and substance misuse problems, although they are less common. The content of the treatment programmes largely reflects that of generic units though concentrating on the specific disorder being presented.

2.4.3 Acute Units

Acute units provide intensive care resources often for acutely disturbed or high risk adolescents with mental health problems including significant self-harm, suicidal behaviour and early onset psychosis. Units aim to achieve this by providing age appropriate, short-term (four to six weeks) acute residential care settings. The units are usually staffed by a high number of specialised professionals and largely run under a medical model of care. Acute settings usually provide a range of short-term group, family and individual therapeutic interventions and are involved in the stabilisation and management of difficulties and risk, discharge planning and referral onto other services (York & Lamb, 2005).

Length of stay across these three types of units typically varies from one month to a year across the different types of units and depending on the presenting problem and the availability of resources, with shorter stays in acute units and medium to longer stays in generic and specialist units (Gowers, 2001). The majority of adolescents are

admitted as inpatients and then usually graduate to day and outpatient status in order to facilitate their transition back into the community.

2.5 Decisions about who goes where

Due to the fact that limited provision currently exists for specialist services, for example, eating disorder or forensic services, young people are usually referred to their regional generic unit (Cotgrove, 1997). It is assumed that such units will be able to provide these 'specialist' services. However, this is not necessarily the case and raises questions about the quality and effectiveness of care for such young people.

In addition, due to the lack of resources available, current practice in adolescent units commonly involves combining young people with generic and acute mental health difficulties under the one roof. However, this can create problems related to staffing input and resources, the safety of the environment and the appropriateness of the case mix (Cotgrove & Gowers, 1999). At present, there is a lack of evidence to support the suitability and diversity of the case-mix and heterogeneous population in generic settings (Gowers, 2001).

2.6 Conclusions

In summary, it appears that despite recent developments, national standards and guidelines aimed at improving service quality and provision, inpatient child and adolescent services continue to vary in their distribution, eligibility and threshold criteria, staffing, models of delivery, aims and philosophy of care, treatment provided, and commissioning arrangements. Units continue to remain scarce and

expensive, where funding is often subject to tight guidelines, limiting the resources and quality of care provided (York & Lamb, 2005) and there remains a clear absence of evidence to support one type of unit over another. Alongside these difficulties, it is also important to consider the other large question about the impact and outcomes achieved by adolescent inpatient services and the evidence base for this mode of delivery.

Section 3. Outcome research in adolescent inpatient care

Evaluating the quality and effectiveness of adolescent units is complex. A number of questions remain about the best way to organise, intervene and manage these units and deliver inpatient care. Questions also remain about the best way to treat serious mental health problems and about the outcome effectiveness in inpatient care. Adolescent inpatient treatment has been reported to be the clinical intervention with weakest evidence base and the most costly and restrictive type of mental health services for patients (Burns, Hoagwood & Mrazek, 1999). There is a lack of disorder specific evidence for manualised inpatient care that reflects the co-morbidity present in inpatient populations and the multiple treatments delivered in such services. There is, however, some evidence on the outcomes achieved by inpatient services. This poor evidence is of concern considering the scarcity and expense of adolescent inpatient resources and the vulnerability, acute and severe need of the populations who require such settings (Gowers, 2001; Green, 2002).

This section will not attempt to comprehensively review all the studies which have been carried out in adolescent inpatient units. It will rather provide an overview of some of the kinds of outcome research which have been done and the resulting

conclusions which have been drawn in the area of adolescent inpatient treatment. This will be achieved by drawing on a diverse range of literature and studies using a range of research designs and methodologies based on journal articles, review papers and relevant book chapters. In addition, in order to answer the broader question being examined of whether adolescent units are beneficial for young people, this and the remaining sections of the review will draw on findings from exploratory studies, insights and literature from professional opinion and users' views.

In order to examine the question this review paper is addressing and for purposes of brevity, this review will exclude studies of (1) child or combined child and adolescent inpatient populations, (2) therapeutic communities or other residential types of care, (3) studies describing specific treatments delivered in inpatient settings, e.g. group therapy, or dialectical behaviour therapy in acute settings, (4) studies evaluating the benefits of specialist units, and (5) studies which have been carried out with adolescents with particular disorders who happen to be on inpatient units, but that are not relevant to the question being addressed. Rather the review will mainly include studies of acute and generic adolescent inpatient mental health units which look at the outcomes of inpatient care and address the question at hand.

This section will begin by describing some of the methodological difficulties associated with the existing outcome studies in inpatient care, followed by providing a brief overview of some of the evidence for inpatient versus alternative care for a few of the specific disorders typically found in adolescent units, before discussing studies of outcomes within generic and acute units. The review will then briefly discuss findings from predictors of outcome studies, followed by outlining some of

the issues and evidence for moving away from psychiatric admission to community care and shortening the length of inpatient stay. Finally, some of the pertinent themes surrounding the negative impacts of inpatient care will be discussed.

3.1 Methodological issues associated with outcome research in adolescent units

In relation to both the 'treatments' delivered and the overall outcomes achieved in inpatient adolescent settings, there continues to be limited empirical evidence for this model of service delivery and intervention (Cotgrove & Gowers, 1999; Fonagy, Target, Cottrell, Phillips & Kurtz, 2002; Gowers & Rowlands, 2005). A significant cause is the methodological weaknesses of existing studies which often reflect the scientific and ethical demands associated with carrying out outcome research in these settings (Epstein, 2004; Green & Jacobs, 1998). In addition, conducting inpatient research can often lead to practical demands on staffing and resources including a conflict of staff and service priority as well as perceived extra burden on and threat to staff (Epstein, 2004; Green & Jacobs, 1998). There has been a lack of systematic reviews, meta-analyses and specific studies that report on the outcomes of adolescent inpatient care. The outcome reviews which have been conducted (e.g. Blanz & Schmidt, 2000; Gosset, Lewis & Barnhart, 1983; Pfeiffer & Strzelecki, 1990) have highlighted that validity and reliability have been largely compromised by the designs and methods used in studies. The few studies that do exist to support inpatient admission have produced mixed, inconclusive and contradictory results making it difficult to draw firm conclusions (Blanz & Schmidt, 2000; Hoagwood, Jensen, Petti, Burns, 1996). Studies within the literature are mainly descriptive, uncontrolled, pre-post design, retrospective, effectiveness, routine outcome and

service evaluation (Ghuman, Jayaprakesh, Saidel & Whitmarsh, 1989; Klinge, Piggott, Knitter & O'Donnell, 1986).

3.1.1 Scientific issues of validity and reliability that beset the outcome research

1. Randomisation and Efficacy Studies

There has been a lack of randomised and rigorously controlled designs and efficacy studies carried out in adolescent inpatient units to date (Blanz & Schmidt, 2000; Gowers & Rowlands, 2005; Green, 2002; Jacobs et al., 2004; Wells & Faragher, 1993). This in part relates to the multiple research demands associated with carrying out highly controlled designs, the numbers needed for such studies and issues of multiple treatments and co-morbidity with inpatient populations, and the ethics of removing aspects of treatment from young people. However, there are also clinical and ethical issues to consider in the random assignment of young people with such acute and severe difficulties requiring inpatient care to no treatment comparison groups, less intensively monitored community based alternatives, and relatively long waiting list conditions in light of the time taken to complete an inpatient admission.

2. Multiple morbidity and manualising inpatient treatment

There has been an increasing amount of evidence about treatment efficacy for child and adolescent outpatient populations (e.g. Carr, 2000; Fonagy, Target, Cottrell, Phillips & Kurtz, 2002). Evaluating specific treatments for specific disorders is particularly difficult in inpatient adolescent settings due to the issues around non treatment control groups, and the complexity, heterogeneity and co-morbidity of the population and the multiple pharmacological and psychological interventions operating in parallel, by multiple professionals on multiple levels (Gowers, 2001) i.e.

individual, family and group. This, added to the nature of certain inpatient interventions i.e. group analytical therapy and the milieu and more spontaneous interpersonal aspects of care, makes interventions in acute and generic settings difficult to standardise, manualise and to disentangle which variables and components of care are responsible for change (Blanz & Schmidt, 2000; Green, 2002; Jaffa & Stott, 1999; Pottick, Hanssell, Gaboda & Gutterman, 1993).

3. Statistical Power

In addition to the small amount of people that require inpatient services, some adolescent units encourage a shorter length of stay resulting in a higher throughput and turnover of cases (Blanz & Schmidt, 2000; Pottick et al., 1993). Such low numbers and transient populations have made it more difficult to carryout outcome research and efficacy studies in clinical settings. The use of small sample sizes reflected in the majority of existing outcome studies (e.g. Corrigall & Mitchell, 2002; Cotgrove, 1997; Green et al., 2001) also relates to the fact that many of these studies are based on single service units (e.g. Cotgrove, 1997; Jaffa & Stott, 1999; Wells & Faragher, 1993) thereby reducing levels of external validity. However, difficulties exist in the ability to pool findings from different studies and carry out studies across multiple adolescent units as they differ so widely in population, policy, philosophy, interventions and models of care (Green & Jacobs, 1998). Studies have encountered such problems when trying to increase sample sizes and levels of statistical power by aggregating findings from residential and inpatient treatment, mixing children and adolescents (e.g. Green et al., 2001; Mattejat, Hirt, Wilken, Schmidt, Remschmidt, 2001) and pooling findings of varying length at follow-up making it unlikely to demonstrate the specific contribution made by hospitalisation (Pottick et al., 1993).

4. Additional issues related to methodology and measurement

Many outcome studies have also lacked information on both diagnosis and specific treatments provided (Mattejat et al., 2001) and made no systematic attempts to relate outcome to the specific and complex components of inpatient treatment (Blanz & Schmidt, 2000; Gowers & Rowlands, 2005; Jacobs et al., 2004; Rothery, Wrate, McCabe, Aspin & Bryce, 1995; Wrate et al., 1994). Furthermore, many of the studies have used unitary measures and single perspectives of outcome and focused on measuring changes in symptoms, diagnosis, impairment and behavioural change as determined by clinicians and researchers, thereby neglecting wider variables and domains such as intra-psychic, inter-personal and familial functioning (Blanz & Schmidt, 2000; Green, 2002; Green & Jacobs, 1998; Jaffa & Stott, 1999). Studies have also used measures which lack psychometric validity and reliability and medium and longer term follow-up (Blanz & Schmidt, 2000; Pfeiffer & Strzelecki, 1990; Wrate et al., 1994) raising questions about the sustainability of change achieved during inpatient care. In recent years, researchers have made significant progress in addressing these measurement difficulties and have developed more comprehensive, multi-dimensional and multi-informant models of outcome which involve the young person, and domains of social competency, education, quality of life and cost effectiveness (e.g. Hoagwood, Jensen, Petti & Burns, 1996; Jensen, Hoagwood & Theodore, 1996; King at al., 1997; Wrate, et al, 1994).

In light of these types of methodological difficulties which beset the adolescent inpatient outcome research, researchers and clinicians are constantly faced with the difficult task of trying to overcome such issues and obstacles and achieve a balance between the demands of internal and external validity when conducting their studies.

3.2 Studies of specific disorders

There continues to be a lack of quality data and little robust evidence comparing one model of inpatient care with another (Gowers & Rowlands, 2005; York & Lamb, 2005) or the benefits of specialized, disorder specific care versus generic adolescent inpatient services remain controversial. Although some studies have produced follow-up data as well as the differential effects of care across disorders, for example, that emotional disorder carries a better prognosis than conduct disorder or severe suicidal behaviour (Bobier & Warwick, 2004; Jaffa & Stott, 1999; North, Gowers, Byram, 1997), the majority of studies have failed to elicit data on which disorders respond better to which specific treatments and overall inpatient care. This section of the review will not examine the outcomes for specific disorders or compare types of treatment as this literature is too vast to cover for this paper. However, it will rather provide a brief overview of some of the current evidence and best practice guidelines around the use of inpatient treatment for a few of the disorders most commonly found in adolescent inpatient populations.

3.2.1 Anorexia Nervosa

There is unresolved debate on the value of inpatient treatment for young people with anorexia nervosa with outcome studies showing widely differing results (Green, 2002). Owing to the lack of controlled trials of treatment setting in this disorder, the costs and benefits of inpatient treatment have not been established (Crisp, Norton & Gowers, 1991), and more rigorous research designs are warranted. There is also a lack of empirical evidence to help guide decisions about the selection of the best setting for treatment interventions. In addition, there is no evidence for or against the effectiveness of specialist adolescent inpatient units over all-age eating disorder units

or generic inpatient care (Fonagy, Target, Cottrell, Phillips & Kurtz, 2002). Findings from a large RCT on admission versus outpatient management for adolescent anorexia nervosa showed few advantages for inpatient admission (Crisp, Norton & Gowers, 1991; Gowers & Smyth, 2004). However, there appears to be a clinical consensus that hospitalisation is indicated for severe weight loss in anorexia nervosa and preferably in specialist inpatient units. The impact of hospital admission on long term outcome in anorexia nervosa remains uncertain, and levels of relapse are high. However, it appears that hospitalisation for this condition often produces short-term benefits, for example, physical evaluation, monitoring and weight restoration, intensive support, respite from stresses outside the unit, and being in a safer and supportive environment.

3.2.2. Psychosis

There is a lack of studies comparing admission with alternative forms of treatment for young people with psychosis. However, several studies have indicated that a high percentage of patients are continuously ill following their admission (Cawthorn et al, 1994). Studies have also reported that treatment for young people presenting with their first episode psychosis is more successful using intensive intervention in the least restrictive settings, such as the home or community, using anti-psychotic medications, assertive outreach and early intervention teams (Spencer, Birchwood & McGovern, 2001; Fitzgerald & Kulkarni, 1998). Reasons for this include minimising the trauma and adverse experiences associated with acute inpatient admission, maximising therapeutic engagement, and building on resources and family support in the community.

3.2.3 Anti-social behaviour problems and conduct disorder

There have been no controlled studies on the effects of hospitalisation on conduct disorders. Research in areas of anti-social behaviour problems and conduct disorder support the view that effective mental heath services should be community and family-based, intensive, longer term and multifaceted, showing difficulties are linked with multiple characteristics of adolescents, their families, peer relations, schools and neighbourhoods (Henggeler et al., 1999). Research has shown that Multi-Systemic Therapy (MST) which is an intensive, family-based community intervention addressing the multiple social context of an individual has demonstrated long-term reductions in anti-social behaviour and institutional placements for chronic and violent juvenile offenders (Henggeler, et al., 1999). It has also been shown to be the most effective treatment for delinquent adolescents in reducing recidivism and ameliorating individual and family problems (Fonagy, Target, Cottrell, Phillips & Kurtz, 2002).

Although these are only a few of the disorders commonly found in adolescent care, the existing evidence, recommendations and current best-practice guidelines show little benefit for inpatient care over outpatient care, questioning the reasons apart from the obvious factors of risk management of why they are there.

3.3 Studies of outcome by type of unit

Although researchers have put much effort into trying to maximise the level of scientific validity and reliability in studies conducted in generic and acute inpatient units, findings must be interpreted with some caution due to methodological issues.

3.3.1 Outcome studies in generic units

A variety of quantitative studies using different sample sizes, methodology and outcome measurement have been carried out in generic adolescent inpatient units to evaluate their benefits and effectiveness (e.g. Jacobs et al., 2004; Jaffa & Stott, 1999; Mattejat, Hirt, Wilken, Schmidt & Remschmidt, 2001; Wells & Farragher, 1993; Wrate et al., 1994). In contrast to the disorder specific literature described above, results generally showed a picture of positive health gain and improvement in psychiatric symptoms which remained stable for at least two years, suggesting that inpatient treatment may be an acceptable and beneficial mode of delivery (Jaffa & Stott, 1999).

An example of a recent outcome study of adolescent inpatient treatment using more sophisticated and rigorous methodology yielded important findings. "The Children and Young Persons Inpatient Evaluation" (CHYPIE: Jacobs et al., 2004) was the first systematically designed study to investigate in detail the process and outcomes of CAMHS inpatient treatment with the largest, most comprehensive cohort studied to date. CHYPIE used a prospective design in which subjects acted as their own controls, pre- and post-treatment to a one-year follow-up. Around 150 families were drawn from eight NHS generic inpatient units. The study used multi-informant and sophisticated, valid and reliable outcome measures assessing various domains of health need, taken from family, teachers, professionals and young people. These included a range of quantitative measures including the Children's Global Assessment Scale (Schaffer & Gould, 1983) and measures of social functioning, educational performance and psychopathology. The study also measured economic

costs, predictors of outcome and the relationship between process variables and outcome, milieu and therapeutic alliance.

Findings of CHYPIE revealed substantial treatment effects associated with inpatient admission over a range of diagnostic groups, maintained into one year follow-up. This is contrary to findings from studies where patients relapse upon discharge. Improvements related particularly to levels of psychopathology, functioning, social adjustment and relationships. However, this study also revealed negative findings. For example, only 10% of cases received their full recommended discharge package of care and young people showed an increase in dangerous and risky behaviours.

A more wide-ranging perspective on outcome of generic adolescent inpatient treatment was supplied by Wrate et al. (1994), who conducted a prospective multi-centre research study over three years of 276 consecutive admissions to four adolescent psychiatry inpatient units in the United Kingdom (Rothery, et al., 1995; Wrate et al., 1994), in order to build on existing research and present a new model of assessing outcome. This model consisted of using 16 defined treatment goals, related to 4 areas of adolescent functioning which included: remission of symptoms, improvement in significant relationships, facilitating accomplishment of age-appropriate maturational tasks and improvements in intra-psychic functioning. Findings revealed that a broadly favourable clinical outcome at discharge of psychiatric hospitalisation was recorded for most patients, irrespective of their diagnosis (Rothery, et al., 1995). Different goals were identified to be important for different disorders, and with the exception of anti-depressant and neuroleptic medication in producing symptomatic change, no single, predominant treatment

method was identified in relation to observed improvement for any treatment goal. It is evident that in generic treatment settings, it may be useful to think about outcomes in relation to goals relevant to the individual and the disorder in hand. In addition, findings of this study suggested that the 'milieu' was considered an important subsidiary treatment, having a role in the improvement of several goal-outcomes, and that supportive and group psychotherapy contributed to improvement in goal outcomes, suggesting the importance of the settings in which treatments take place (Rothery, et al., 1995). Strengths of this study included the fact that all treatment interventions used in relation to treatment goals were recorded and an attempt made to relate them to outcome (Blanz & Schmidt, 2000; Rothery, et al., 1995) highlighting this linkage mechanism and allowing specific treatments to be identified as effective in the treatment of specific problems.

A similarly broad perspective on the study of outcomes of generic adolescent in-patient treatment is evident in the work of Green, Kroll, Imrie, Frances, Begum, Harrison & Anson (2001). Their two-year study of treatment process and outcome was designed to apply a multiple perspectives methodology to the conceptualization and measurement of health gain and its predictors during inpatient treatment in two combined child and adolescent inpatient units in the UK (Green et al., 2001). Assessments of health gain were made from multiple perspectives at referral, admission, discharge and six-month follow-up, and inferred by changes on measures of standardised instruments of symptom severity, behavioural checklists, family functioning and therapeutic alliance. Results found that significant health gain during hospitalization was found on most measures and sustained to follow-up, where there was no symptom change or health gain during the pre-admission period

(which represented a waiting list control). In addition, findings revealed the largest reduction of symptoms occurred between the pre-admission and one month ratings. These findings highlighted that inpatient treatment had a therapeutic effect, and suggested that the majority of treatment gains may have taken place during the early weeks of hospitalization, and that duration of the latter parts of treatment may have been more important in maintaining those gains (Green et al., 2001).

Although the literature clearly shows some benefits of adolescent inpatient treatment and highlights strengths of these studies, including wider ranging ways of measuring outcome and paying attention to process issues such as the therapeutic alliance and using multiple informant measures (Jacobs et al., 2004; Wrate et al., 1994), it is important to consider the methodological limitations which beset the outcome studies in generic units and thereby limit the conclusions which can be drawn. These include the lack of non-inpatient controls and randomisation against alternative treatments, (Green et al., 2001; Jacobs et al., 2004; Wrate et al., 1994), the lack of information around the relative effective components of inpatient care (Jacobs et al., 2004; Wrate et al., 1994), high attrition and absence of long-term follow-up (Green et al., 2001; Wrate et al., 1994), small sample sizes and heterogenous populations.

3.3.2. Adolescent Acute Units and Emergency Admissions

Until recently, there has been a lack of separate and emergency provision in the UK for adolescents presenting with urgent need and acute psychiatric disturbance or life-threatening behaviour (Cotgrove, 1997). Historically, adolescents in crisis have been referred to alternative services in the community and, to a lesser extent, been admitted to regional generic units. Young people requiring emergency access have

also frequently been inappropriately admitted to adult and paediatric wards (O'Herlihy et al., 2001). However, within the last decade, acute and short-term inpatient services have been set up in the United Kingdom to cater for young people presenting with difficulties such as severe psychosis, self-harming and suicidal behaviour, and for those requiring emergency and 'all hours' admissions.

Although few in number, some interesting studies have been carried out in the area of acute inpatient settings. These investigated the feasibility and effectiveness of shorter-term and emergency stays (e.g. Corrigall & Mitchell, 2002; Cotgrove, 1997; Goldston et al, 1999; Ivarsson, Larsson & Gilberg, 1998; Katz, Cox, Gunasekara & Miller, 2004). Evidence to support and substantiate emergency admissions to adolescent units is sparse (Cotgrove, 1997). Debate has arisen around the benefits of combining emergency access in inpatient units with regular treatment cases. Although young people may require respite or 'asylum' from their families, and a level of safety and psychiatric input, a lack of evidence exists to support the admission of urgent cases to inpatient units, where they could potentially be managed in local and community services, or social services settings for longer term care (Cotgrove, Zirinsky & Black,1995; Cotgrove, 1997). Moreover, several problems have been identified in relation to combining emergency admissions with treatment cases on adolescent units (Cotgrove, 1997). These have included disruption to the therapeutic programme, longer waiting lists for treatment beds, potential loss to the safe and containing environment, and the loss of planning prior to admission.

Research has shown that although adolescents are commonly admitted to acute psychiatric inpatient units for depressive symptoms, suicidal ideation and suicide

attempts (Larsson & Ivarsson, 1998; Shaffer & Piacentini, 1994), there have only been a few longitudinal studies looking at the effects of admission, and the prevalence, incidence and stability of these difficulties over a substantial period of time (Ivarsson, Larsson & Gillberg, 1998; Katz, Cox, Gunasekara & Miller, 2004).

One such study was conducted by Ivarsson, Larsson & Gillberg (1998), who monitored the progress of 111 adolescents, admitted to two short-term psychiatric inpatient emergency units in Sweden. Although the majority of young people reduced their depressive symptoms over time, a substantial proportion continued to report a high level of depressive symptoms, suicidal ideation and suicide attempts (at a rate of 40% of patients) in the follow-up period. Goldston et al. (1999) found similar findings in a prospective naturalistic study examining risk for suicide attempts during the first five years after discharge from an inpatient psychiatric unit.

It appears that although findings have suggested both positive and negative aspects to providing emergency admission alongside regular treatment cases, the overall evidence points towards reforming existing provision to encourage greater flexibility and inclusiveness of these populations being treated in the same settings. However, due to the small sample sizes and single unit studies, it is difficult to draw any firm conclusions or generalise findings from these studies.

3.3.3. Comparison of inpatient treatment versus community alternatives

The minimal evidence to support adolescent inpatient treatment raises questions about the benefits of inpatient care. These questions should be examined alongside the benefits of community based alternatives. In light of the lack of rigorously

controlled trials comparing inpatient treatment with alternative forms of treatment, there remains a lack of evidence to support the effectiveness of community, outpatient, home and family based alternatives (Burns, Thompson & Goldman, 1993). However, a limited number of studies conducted in Europe and the United States using more rigorous methodology have shown the efficacy of community and home-based treatment compared to inpatient treatment for adolescents presenting with various disorders including substance abuse, externalising disorders and those in 'crisis' (e.g. Henggeler et al., 1999; Lay, Blanz & Schmidt, 2001; Remschmidt & Schmidt, 1988, cited in Mattejat, Hirt, Wilken, Schmidt, Remschmidt, 2001). Although these studies lend support to the possibility of randomisation of adolescents requiring inpatient care, many of them do not have long-term follow-up measures, making it unclear whether effects remained stable over time.

One example of an impressive study which used both randomisation and included longer term follow-up was conducted by Mattejat et al., (2001) following that of Remschmidt and Schmidt (1988). Mattejat et al., (2001) aimed to compare the efficacy of generic inpatient and home treatment for children and adolescents with severe psychiatric disturbance over a long-term period across two psychiatric centres in Germany. Outcome was evaluated through interviews with patients and carers in relation to adaptation at school and number of marked symptoms. Findings revealed no differences in therapy outcome between the two treatment modalities. Furthermore, in a three-year follow-up assessment of the two treatment groups, results revealed the number of symptoms and adaptation at school or work exhibited the same type of course over time. Improvements post-treatment were evident in both groups, and gains were maintained at follow-up, where no differences in effect

sizes were found between the two groups, and any tendency towards difference favoured home treatment. Although the study does not clearly specify the components of treatment in either of the two conditions, these results suggest that the long-term therapeutic outcome for home treatment is stable and persistent over time where the substantial cost investment pays dividends and may avoid some of the adverse effects associated with inpatient admission.

Another example of a comparison study was conducted by Henggeler et al. (1999) who randomly assigned young people to home based or inpatient hospitalisation. This study investigated whether Multi Systemic Therapy (MST) could serve as a viable community-based alternative to psychiatric hospitalisation in addressing mental health emergencies presented by children and adolescents, for example, psychosis, suicidal and self-harming behaviour. Findings revealed that MST was both equally and more effective than hospitalisation at decreasing externalising symptoms based on both caregiver and teacher reports and decreasing rates of self-reported emotional distress. Findings also showed care-giver and teacher reports of internalising problems being similar in both conditions, families receiving MST showing improved cohesion and increased structure based on caregiver and youth reports and youths receiving MST having greater school attendance than those in the hospitalised group. However, differences in the groups dissipated by 12-16 months post-recruitment showing that MST did not achieve lasting treatment differences.

3.4 Predictors of Outcome Studies

In light of the difficulties of conducting tightly controlled studies within adolescent inpatient settings, several attempts have been made at carrying out predictors of

outcome studies in this area (e.g. Gossart, Lewis & Barnhart, 1983; Green et al., 2001; Jacobs et al., 2004; Pfeiffer & Strzelecki, 1990).

Pfeiffer & Strzelecki (1990) reviewed 34 of the outcome studies of child and adolescent residential treatment and inpatient psychiatric hospitalisation reported in the literature from 1975 to 1988, in order to extend and build on the findings of previous reviews of treatment efficacy in these settings (Blotcky, Dimperio & Gossett, 1984; Durkin & Durkin, 1975; Maluccio & Marlow, 1972). Pfeiffer & Strzelecki's review attempted to identify robust predictors of inpatient outcome. Ten predictor variables were explored each providing a weighted predictive value where only two studies reported means and standard deviations. In addition, (Gossett, Lewis & Barnhart, 1983, cited in Blanz & Schmidt, 2000) conducted a review of 22 studies (with up to 6 month follow-up) with adolescents receiving inpatient psychiatric treatment identifying factors that correlated with long-term outcome, and Green et al. (2001) and Jacobs et al. (2004) similarly identified the predictors of health gain and positive outcome in their studies.

Consistent findings across the studies revealed that robust and favourable predictors of outcome included the severity of patient psychopathology, the absence of parental psychopathology, good family functioning pre-admission, the absence of psychosis, completing a well-organised specialised adolescent treatment programme, continuing therapy post discharge, and having good aftercare and planned discharge (Blanz & Schmidt, 2000; Curry, 1991; Durkin & Durkin, 1975; Pfeiffer & Strzelecki, 1990). Other common positive predictors of outcome identified in the reviews included longer length of stay (Jacobs et al., 2004), having an emotional disorder and the

presence of a positive therapeutic alliance (Green et al., 2001; Jacobs et al., 2004; Pfeiffer & Strzelecki, 1990). However, Green et al., (2001) and Jacobs et al., (2004) found that the child and parental alliance were independent predictors of positive outcome. Consistent findings also revealed that gender, age, diagnosis, length of hospital stay had little predictive value (Gossett, Lewis & Barnhart, 1983; Pfeiffer & Strzelecki, 1990; Pottick, 1993).

The findings from these reviews also revealed that poor predictors of long-term outcome included low intelligence, the extent of 'organicity' of symptoms, and the presence of anti-social conduct disorder (Gossett, Lewis & Barnhart, 1983; Green et al., 2001; Pfeiffer & Strzelecki, 1990). Although findings from (Green et al., 2001; Jacobs et al., 2004) were consistent with (Pfeiffer & Strzelecki, 1990) where conduct disorder and externalising problems predicted a poorer outcome for inpatient treatment, findings revealed that young people with conduct disorders did well when accompanied by a positive general child and parental therapeutic alliance. Additional poor predictors of outcome included a history of previous inpatient hospitalisation, patient and family history of drug abuse, and a lack of family involvement with treatment (Ghuman, Jayaprakesh, Saidel & Whitmarsh, 1989).

3.5 Length of Stay

There has been a recent trend in the United States and globally within the child and adolescent population, following that of the adult population, in moving away from institutional and longer term psychiatric care towards shorter admissions and treatment in the community (Blanz & Schmidt, 2000; Fennig, Fennig & Roe, 2002; Henggeler et al., 1999). This move has been largely driven by financial pressures

and also influenced by political pressures aiming to reduce the negative effects of 'institutionalisation' and impact of prolonged hospitalisation on psychosocial functioning (Swadi & Bobier, 2005). In addition, the move towards community reintegration has been supported by the emerging documentation around the contra-indications and effects of admission (Bobier & Warwick, 2004; Jaffa & Stott, 1999) and the lack of empirical evidence to support the appropriateness, effectiveness, and cost-effectiveness of inpatient services (Burns, Hoagwood & Mrazek 1999). Changes in service delivery in the UK have also started to reflect similar changes in patterns of inpatient provision internationally in practice shifting from hospital admission to outpatient and community care (Gowers, Clarke, Alldis, Wormald & Wood, 2001).

The economic and political pressures in favour of shorter stays have been paralleled by a reconsideration of the tasks and goals of inpatient psychiatric treatment, particularly in the USA (Blanz & Schmidt, 2000; Foster, 1998). This has often resulted in inpatient services catering for more acute and emergency presentations, including severe psychosis or self-harming behaviour where treatment focuses more on evaluation, stabilisation, management, short-term and crisis intervention.

Although there is a lack of literature within the adolescent population documenting the benefits, contra-indications and outcomes of shorter hospital stays, the existing evidence suggests a trend similar to the adult population where longer hospitalisation does not necessarily decrease readmission rates nor improve outcomes such as social adjustment (Bobier & Warwick, 2004; Swadi & Bobier, 2005). However, results from various studies on length of stay have yielded mixed and inconclusive findings

and further research is warranted before conclusions can be made regarding the most beneficial length of admission for adolescent inpatients. Some examples of studies conducted within adolescent inpatient units to determine the length of stay and treatment outcome have revealed some evidence to support shorter admissions (Green et al., 2001; LaBarbera & Dozier, 1985; Swadi and Bobier, 2005) where findings suggested that the majority of clinical change occurred within the first few weeks of admission. Several authors have argued that shortening admissions beyond a certain limit might well produce spurious health gains, based on symptom inhibition early in admission, or the effects of admission reliving possible contextual causes or maintenance of symptoms in the adolescent's environment.

However, several studies have also been conducted revealing contrasting findings and advocating longer admissions to adolescent inpatient psychiatric care (Bobier & Warwick, 2004; Fennig, Fennig & Roe, 2002; Jacobs et al., 2004). Green (2002) and Jacobs et al. (2004) proposed that although the removal of patients from the adverse factors maintaining their psychopathology in their local community may result in some temporary benefit, a reduction in length of stay was likely to negate the value of the therapeutic milieu as a treatment modality and the specialised educational interventions received in these settings. In addition, several studies have found evidence to suggest that reducing the length of hospital stay has resulted in increased rates of repeated admissions to inpatient care, questioning the effectiveness of shorter hospital stays (Bobier & Warwick, 2004; Fennig, Fennig & Roe, 2002).

3.6 Negative Components of Inpatient Treatment

There is a dearth of systematic literature documenting the potentially adverse affects, negative consequences and counter-therapeutic processes that may arise within inpatient treatment for adolescents (Bobier & Warwick, 2004; Gowers & Rowlands, 2005; Gowers, Weetman, Shore, Hossain & Elvins, 2000; Green, 2002; Green & Jones, 1998; Jaffa & Stott, 1999) raising significant concerns and questions around the benefits and cost of residential care for this population. Implications for multiple parties would exist if inpatient treatment was to result in adverse consequences, including the young person, their family and their professional network. Reasons for the lack of literature in this area may relate to the bias in publication on this topic, the lack of recognition of users' views and experiences of their care, and clinicians and referrers' needs and wishes for referrals to be appropriate and treatment to be successful. Where literature exists on this fundamental issue it has often been from theoretical or anecdotal concerns, clinical and professional opinion, and professionals perspectives as opposed to young people themselves questioning the validity of accounts (Green, 2002).

Some of the main themes associated with the negative impacts and unwanted effects of inpatient treatment have included risking disruption and loss of normal and family life, missing out on social, education and occupational opportunities, and noxious stigmata and labelling (Blanz & Schmidt, 2000; Green, 2002; Jaffa & Stott, 1999). Although many young people may enter the inpatient ward with a profound sense of relief to have respite from external and negative events in their lives, for some, admission to the inpatient culture can be a frightening and bewildering experience (Green, 2002; Green & Jones, 1998). This includes the intensity and challenges of

the milieu and the frequent hostility and abusive nature encountered within the environment. In addition, studies and reports have documented the negative affects of peer relationships and the powerful influences young people have on each other in adolescent units. These include being subject to peer pressure and the contagious effects of dysfunctional and illness related behaviours, forming 'enmeshed' relationships, being influenced by or competing over others' illnesses, and the exposure of the effects and threats of violence, abuse, bullying and aggressive behaviours (Bobier & Warwick, 2004; Colton & Pistrang, 2004; Green & Jones, 1998; Jaffa & Stott, 1999; Newbald & Jones, 1998).

Other negative consequences of inpatient care include the loss of support in the family, school, local services and community and the development of institutional dependence (Blanz & Schmidt, 2000; Green & Jones, 1998). Professionals have also documented the difficulties with staff's behaviour towards young people which can be unhelpful and anti-therapeutic (Green & Jacobs, 1998; Green & Jones, 1998). Examples of this include staff becoming abusive, over-involved and over-protective and trying to 'rescue' and provide 'substitute' care for adolescents whilst blaming their parents for their predicament (Green & Jacobs, 1998; Green & Jones, 1998).

Finally, the few existing studies that look at the perceptions and responses of adolescents to seclusion, holding and restraint in inpatient units have showed these interventions are primarily viewed negatively and punitively where young people feel fearful, angry, abused, rejected and abandoned when confronted with these restrictive measures (Fryer, Beech & Byrne, 2004; Sourander, Ellila, Valimaki, & Piha, 2002).

3.7 Suggestions for future research

Although researchers have tried to overcome the methodological difficulties they face when measuring outcome within adolescent inpatient settings, the majority of studies lack internal and external validity making it hard to draw firm conclusions.

As randomised controlled trials (RCT) have been carried out in the adult inpatient population, and with patients with acute, severe and co-morbid difficulties, such as those with psychosis, and as limited evidence currently exists to support the effectiveness of inpatient care, it appears that there is a strong and ethical argument for conducting more rigorously controlled trials with adolescent inpatients. Some possible solutions could involve randomising young people to inpatient treatment or intensive community interventions involving psychiatric nursing input to monitor risk, or identifying a control group of adolescents with severe mental health needs based in residential or social care settings and in need of treatment. In addition to the random assignment to different treatments to control the influence of extraneous variables (Blanz & Schmidt, 2000; Pfeiffer & Strzelecki, 1990), future research also would benefit from using multi-dimensional outcome domains, large samples across different settings to avoid spurious selection effects and longitudinal studies to disentangle the predictors of outcomes over time (Pottick et al., 1993). In addition, future studies need to delineate the critical dimensions of inpatient treatment, explore the nature of aftercare interventions, and identify the necessary and sufficient elements of successful components of the treatment process as distinct from the superfluous and unhelpful elements (Blanz & Schmidt, 2000; Green et al., 2001; Pfeiffer & Strzelecki, 1990). Future research could also concentrate on identifying which types of patients respond most favourably to which types and combinations of

treatments, including comparison studies of inpatient versus alternative forms of care (Blanz & Schmidt, 2000; Jensen, Hoagwood & Petti, 1996; Pfeiffer & Strzelecki, 1990). Finally, it is important for researchers to develop manualised treatments for inpatient care which accounts for the multiple treatments and co-morbid populations present in such settings. However, in order to make progress in the area of outcome research, it appears that greater clarity and specificity is needed regarding what inpatient units are doing and trying to achieve.

Section 4. Process issues in adolescent units

This section will briefly outline the current research associated with process issues in adolescent inpatient units and will discuss the potential importance of investigating these factors in these settings with such populations.

As discussed in Section 3, the majority of the existing outcome research in adolescent inpatient settings focuses on treatments, symptom reduction, level of impairment and behavioural changes, thereby neglecting other variables known to be associated with outcome, such as inter-personal processes and therapeutic process variables (Blanz & Schmidt, 2000; Green & Jacobs, 1998; Jaffa & Stott, 1999).

Research in the adult literature has highlighted the importance of therapeutic processes in relation to outcome, and shown that they consist of a number of key elements including the therapeutic relationship and therapeutic alliance within the client-therapist dyad (Ackerman & Hilsenroth, 2003; Bordin, 1979; Bergin, & Garfield, 1994). The process literature has shown that the therapeutic relationship is an essential component of treatment across modalities and contexts and may account

for equivalent outcomes and psychotherapeutic change (Stiles, Shapiro & Elliot, 1986). Specific psychological conditions have been shown to be important elements of the therapeutic relationship and include empathy, warmth, openness, acceptance, genuineness, respect, listening and understanding (Bergin, & Garfield, 1994; Rogers; 1957). Their importance has also been reinforced by evidence elicited from users of child and adolescent mental health services, who identified a set of similar 'helper characteristics' that they articulated were of value and significance in their relationships with professionals, including collaboration, warmth, understanding, personal respect, and the ability to listen and relate in an open and inclusive way (NSF: Baruch & James, 2003; Worrall, O'Herlihy & Mears, 2003; Day et al., 2006; Hart et al., 2005). Alongside these therapeutic relationship factors, research has also highlighted the importance of the therapeutic alliance as essential for engagement and as a robust predictor of outcome in treatment (Ackerman & Hilsenroth, 2003; Bordin, 1979, Safran & Muran, 2000).

Recent years has seen more recognition of therapeutic process variables in outpatient child and adolescent care, where process factors have been assessed in efficacy studies and service effectiveness studies (e.g. Fonagy et al., 2002; Green, 2006; Green & Kroll, 2001). For example, a meta-analysis of 23 studies of differing methodology examining associations between therapeutic relationship variables and treatment outcomes in child and adolescent therapy yielded similar findings to the adult literature (Green, 2006; Shirk & Karver, 2003). The results showed a robust and consistent therapeutic relationship-outcome association, both across developmental levels and across diverse types and contexts of therapy. Findings also revealed that the alliance was reliably measurable at all points in the treatment cycle

and was more salient in externalising disorders than internalising disorders (Shirk & Karver, 2003) which is important to consider with such populations in inpatient settings. Researchers have suggested that the alliance may be even more critical to examine with young people than other populations, in light of the fact they rarely initiate their own referral to services or acknowledge the extent of their difficulties and need for treatment, which is in turn, likely to affect their motivation and engagement (Shirk & Karver, 2003; Shirk & Russell, 1998).

Despite the evidence about the significance of process variables and their association with outcome in the community child and adolescent literature, it is very surprising that little is currently known about the role of such therapeutic processes in adolescent inpatient units (Green et al., 2001; Green & Jacobs, 1998; Kroll & Green, 1997). However, research has highlighted the significance, value, and helpfulness of individual therapeutic relationships with young people in residential settings, in relation to re-educating, helping, and working with them (Brendtro, 1997; Coleman, 2004). This lack of evidence on process variables could relate to that fact that little efficacy and outcome research has been conducted in these settings in general, added to the fact that overall outcomes and experiences of inpatient care have largely neglected to investigate these processes. The assessment of therapeutic processes is arguably even more important in adolescent inpatient settings as therapeutic, social, and developmental factors are likely to intensify such processes for young people in these units. Several factors appear to account for the potential importance of therapeutic relationships in inpatient settings. These include (1) Inpatient settings by their very nature potentially extend therapeutic relationship factors beyond the traditional therapist-client dyad to include client-client therapeutic processes and

relationships, i.e. between peers. This evidence is very pertinent to adolescent inpatient care because of the significance of peer relationships during this developmental life stage (Masten, Best & Garmezy, 1990), (2) within adolescent inpatient settings, the therapeutic relationship and therapeutic alliance with staff and peers are largely used as devices within the milieu approach as a common curative factor, and (3) young people and peer support are mobilised for therapeutic intentions as a result of the milieu approach.

There is a limited amount of research that considers that therapeutic processes are likely to be operating on various levels in inpatient units which may be useful to investigate when assessing their impact and effect. In addition to measuring the outcome association of therapeutic processes as part of the more 'formal' treatments and therapy with individuals and staff, and peers and peers, for example, in group therapy, research on the significance of therapeutic processes would be likely to benefit from moving beyond these 'traditional' ways of measuring outcome association. This could include exploring and investigating the nature and impact of relationships and processes per se, in the context of the milieu and the more informal parts of inpatient care, for example, peer support processes, peer relationships, relationships with staff, and the more dysfunctional and anti-therapeutic aspects of relationships and inpatient care (see Section 4.6). A few examples which have captured the impact of some of these wider relational processes such as peer support have included findings from exploratory studies with young people with psychosis and anorexia nervosa in inpatient settings (Billings, 2005; Colton & Pistrang, 2004). These findings revealed that being with 'similar others' was perceived as beneficial

in relation to providing support, sharing experiences, feeling understood and less isolated and having the freedom to discuss the effects of certain illnesses.

Despite these attempts at investigating the wider aspects of therapeutic processes in inpatient care, the majority of the findings have focused on the therapeutic alliance and its association to outcome. These findings have indicated that the therapeutic alliance is a strong predictor of health gain across diagnoses in child and adolescent inpatient settings (Green et al., 2001; Jacobs et al., 2004; Kroll & Green, 1997). Furthermore, Kroll & Green (1997) recognised the need to extend the concept of the therapeutic alliance, in order to take account of the multiple and separate alliances formed in child and adolescent inpatient settings. Findings from their study showed that alliances were formed between parents and young people, as well as with the whole staff team, peer group and the therapeutic context, and were replicated by Jacobs et al. (2004). Following their study, Kroll & Green (1997) developed the "Family Engagement Questionnaire" as a reliable tool to measure multiple alliances in relation to outcome association in inpatient settings, which has since been used in several outcome studies.

As multiple relational processes appear to be the cornerstone of adolescent inpatient treatment, it is essential that future research evaluates their impact at various levels. Future research needs to explore further both the outcome association of therapeutic process variables and multiple alliances formed in inpatient settings, and also investigate aspects of young peoples' relationships with staff and peers and the impact of these on therapeutic engagement and participation in the treatment programme, and on their overall experiences of inpatient care and psychological

well-being.

Section 5. Users' views of adolescent inpatient care

This section will briefly review the existing literature on users' views of adolescent inpatient care and discuss the current drive and importance of involving users in trying to improve the quality of service provision and aspects of their care. Although research on consumer and users' views of child and adolescent mental health services commonly refers to parents as well as young people, where views often differ (Marriage, Petrie & Worling, 2001), for the purpose of brevity, this section will solely focus on young people's views.

Despite the fact that the inpatient adolescent literature has yielded some interesting and important findings related to inpatient care and outcome research, the majority of studies have failed to adequately elicit the views of the adolescents themselves (Gowers & Rowlands, 2005; Marriage et al., 2001; Worral, O'Herlihy & Mears, 2002). This clearly contradicts the current drive towards user involvement and participation, which has become more recognised and valued at both policy and service level, for example, child-centered care is now a core feature of the NHS in the UK (NSF, DOH, 2003). Listening to young people's views of mental health care is important for several reasons. (1) Views can be used to improve service quality and provision so that they better reflect young people's own concerns and priorities (Day, Carey & Surgenor, 2006; Department of Health, 2002a), (2) Young people value participation and are enthusiastic to contribute their views and ideas about services (NSF: Baruch & James, 2003), (3) Views of what makes services, clinicians and treatments effective have largely been determined by clinicians and researchers.

The user involvement movement has highlighted the value of enabling experiences and phenomenon to be viewed by young people, in order to draw out unique insights from both the 'patient' perspective and a developmental perspective, which can then be reported back to services and (4) Young people can describe their hopes and expectations for treatment and clarify the outcomes and goals they wish to achieve, in order for these to be addressed and targeted by clinicians, helping to promote the therapeutic alliance, enhance service satisfaction and achieve better and more meaningful outcomes (Marriage et al., 2001), (5) Existing treatment efficacy and service effectiveness research in child and adolescent mental health settings has provided important information about outcome effectiveness and overall change in symptoms, impairment or diagnosis, however has failed to elicit information about what components or particular aspects of treatments and care were beneficial or 'effective', which could be investigated by listening to users' views (Marriage et al., 2001).

Work on users' views in child and adolescent mental health care is at an early stage where existing studies have primarily focused on outpatient populations, been quantitative in nature, largely related to service effectiveness and evaluation studies, and used insufficient measures often adapted for use with the adult population and eliciting minimal information (Marriage et al., 2001). Emerging recognition has also been given to the importance of conducting qualitative research with young people about their experiences of mental health care, in order to gain fundamental, richer and more meaningful information related to what they perceive to be the 'effective', helpful, unhelpful, essential and superfluous components of treatments and overall care. Contrary to more traditional beliefs, developmentally sensitive research has

highlighted that children and young people are able to describe and reflect on their experiences of care (Day, Carey & Surgenor, 2006). Some examples of qualitative studies which have explored young people's experiences of community child and adolescent mental health services include (Day, Carey & Surgenor, 2006; Hart, Saunders, & Thomas, 2005). Evidence from research and practice involving users' views has consistently pointed to the pivotal role and value attached to the quality of young people's relationships with professionals and has identified a set of key 'helping characteristics' (see section 4) (NSF: Baruch & James, 2003; Worrall, O'Herlihy & Mears, 2002; Day et al., 2006; Hart et al., 2005).

Although there is a paucity of research on users' views in inpatient adolescent settings, the limited research available focuses more on quantitative than qualitative studies (e.g. Gowers & Kushlick, 1992; Marriage, Petrie & Worling, 2001; Worrall, O' Herlihy & Mears, 2002). Findings from these studies revealed that young people reported both positive and negative interpersonal and treatment experiences in inpatient settings. Positive experiences included feeling safe on the ward, valuing daily routines and the milieu environment, feeling staff helped them to understand their difficulties, always having nurses to talk to, finding interactions with staff helpful, caring and supportive, and having peer support. These findings were also consistent with those of Svanberg & Street (2003) who carried out a qualitative study into users' experiences of adolescent inpatient care (see below). Some examples of negative experiences included finding the ward confining, restrictive and inflexible, having a lack of freedom and privacy on the unit, struggling with ward rules and harsh discipline for behaviour, feeling staff members were untrustworthy and did not listen, and the lack of consistency amongst staff on shift.

Although there have been a few exploratory studies carried out within specialist adolescent inpatient services, for example, in the areas of psychosis and anorexia (Colton & Pistrang, 2004; Billings, 2005), there have been even less qualitative studies examining young people's experiences of using generic adolescent inpatient units. One exception was a two-year in-depth study conducted by Young Minds into developments within inpatient care for young people with complex mental health problems (Svanberg & Street, 2003). Participants included adolescents, parents and professionals, recruited across six inpatient adolescent units throughout England and Wales. Key issues of concern and gaps identified in service provision included staffing shortages and suitability, the need for units to feel safe and be non-institutional and homely, and the importance of daily and therapeutic activities (Svanberg & Street, 2003). Findings from the study also highlighted young people's needs to be actively involved and informed about their treatment, the importance and influence associated with being in a peer group (which could be both highly supportive but also difficult) and the value of the relationships made with staff (Svanberg & Street, 2003).

These studies of users' views of adolescent inpatient treatment clearly lend support to the fact that young people have the ability to reflect on their experiences and provide valuable and unique information and insights about 'effective', helpful, necessary, and more subtle aspects of treatments and care. This information can then be fed-back into services to improve the quality of provision and make services more adolescent-led, and can also be used in parallel to the data generated from the multiple outcome measurements used to evaluate outcomes in inpatient treatment. In light of the multiple methodological difficulties attached to carrying out efficacy and

effectiveness research in inpatient settings, evaluating users' views and carrying out exploratory research with this population appears to be a logical and viable alternative to investigating 'outcomes' and experiences of inpatient treatment. Inpatient services are likely to benefit from listening to users' views in order to modify and adapt treatment interventions to reflect the needs, wishes, concerns, goals and outcomes of the young people. However, it is also likely that the scientific community and future efficacy studies would benefit from using information from both quantitative and qualitative studies of users' views of adolescent inpatient care alongside their research, in order to create more of a complete picture and provide additional information into the possible factors related to why treatment and care were perceived to be helpful and 'effective'. In addition, treatments and outcome measures used in the efficacy studies would benefit from being constantly modified to reflect and integrate users' views, wishes and goals for adolescent inpatient treatment.

Section 6. Overall conclusions

6.1 Summary and conclusions

The aim of this review was to examine whether inpatient units are beneficial for young people. This review has found that several attempts have been made to conduct outcome research in adolescent inpatient settings. However, the majority of studies are full of methodological limitations related to the complexity of the inpatient settings and populations who require inpatient care. This lack of evidence is related to both practical, scientific and ethical difficulties that researchers are faced with, and the questionable choice of some of the design and methods used in the majority of the existing outcome studies. The pattern that emerges from reviewing

the evidence is that there is a lack of evidence to both support both specific treatments used in inpatient settings as well as a lack of evidence to support the settings themselves. However, some consistent evidence exists on the predictors of outcome, for example, pre-admission family functioning and post discharge aftercare. The existing data clearly highlights overall outcomes achieved by inpatient services but fails to explain which components of inpatient care were associated with change. Less empirical research has been conducted into the negative components of inpatient care, however, professional opinion highlight some major problems. The existing research has also failed to account for the significance and impact of process factors and users' views of inpatient treatment.

6.2 Clinical Implications

It is evident that the population served by adolescent inpatient services has complex and difficult problems. What emerges is that there needs to be a differentiation between the containment of young people in their acute phases (risk reduction and stabilisation), and the medium to long term inpatient treatment for those with different presentations and who are not in an acute phase. Questions which should concern service providers remain as to whether medium to long term inpatient treatment is the most effective form of intervention as opposed to short-term acute care or community based interventions. The responsibility of the clinician is to incorporate evidence-based practice in inpatient units wherever possible, to define the aims of treatment and services, and to clarify, specify and monitor the use of existing interventions. In addition, steps should be taken to ensure that treatments and provision reflects users' views.

51

6.3 Research Implications

Research needs to be clearer about what is trying to be achieved in relation to outcome research in adolescent inpatient care. Research would benefit from the use of more rigorous and controlled studies and from a adopting a broader understanding of measuring outcome taking account of users' views. There needs to be clearer differentiation for the development of manualised intervention for young people with complex mental health difficulties and more rigorous evaluation of inpatient services.

In relation to the clinical and research implications above, it would be hoped that moving forward in these ways would give the opportunity of the needs of young people with complex mental health difficulties to be met more effectively than they appear to be through the systems of inpatient care available in the UK at present. Finally, progress needs to be made in understanding the expectations and needs of young people and their families to ensure that their needs are both understood and reflected in the quality and outcomes that inpatient care aims to achieve.

REFERENCES

Abroms, G.M. (1969). Defining milieu therapy. *Archives of General Psychiatry, 21,* 553- 555.

Ackerman, S.J., & Hilsenroth, M.J. (2003). A review of therapist characteristics and techniques positively impacting the therapeutic alliance. *Clinical Psychology Review, 23,* 1-33.

Barker, C., Pistrang, N., & Elliot, R. (2002). *Research Methods in clinical psychology: An introduction for students and practitioners* (2nd ed.). Chichester: Wiley.

Bergin, A.E., & Garfield, S. (1994). *Handbook of Psychotherapy and Behavior Change* (4th Edn.). New York: Wiley.

Billings, J. (2005). Making Sense of First Episode Psychosis. Doctorate in Clinical Psychology, University College London.

Blanz, B., & Schmidt, M.H. (2000). Practitioner Review: Preconditions and Outcome of Inpatient Treatment in Child and Adolescent Psychiatry. *Journal of child Psychology and Psychiatry, 41* (6), 703-712.

Blotcky, M.J., Dimperio, T.L., & Gossett, J.T. (1984). Follow-up of children treated in psychiatric hospitals. *American Journal of Psychiatry,* 141, 1499-1507.

Bobier, C., & Warwick, M. (2004). Factors associated with readmission to adolescent psychiatric care. *Australian and New Zealand Journal of Psychiatry, 39,* 600-606.

Bobier, C., & Warwick,M. (2005). Factors associated with readmission to adolescent psychiatric care. *Australian and New Zealand Journal of Psychiatry, 39,* 600-606.

Bordin, E.S. (1979). The Generalizability of the Psychoanalytic Concept of the Working Alliance. *Psychotherapy: Theory, Research and Practice, 16* (3), 252-260.

Boyd, M.A., & Nihart, M.A. (1998). *Psychiatric Nursing: Contemporary Practice.* Philadelphia: Lippincott.

Brendtro, L.K. (1998). Synergistic relationships : The powerful SR of re-education. *Residential Treatment for Children and Youth, 15 (3),* 25-35.

Burns, B.J., Hoagwood, K., & Mrazek, P.J. (1999). Effective treatment for mental disorders in children and adolescents. *Clinical Child and Family Psychology Review, 2*(4), 199-254.

Buston, K. (2002). Adolescents with mental health problems: what do they say about health services? *Journal of Adolescence, 25,* 231-242.

Carr, A. (2000). *What Works with Children and Adolescents: A critical Review of Psychological Interventions with Children, Adolescents and their Families.* London Routledge.

Cawthorne, P., James, A., Dell, J. et al (1994). Adolescent onset psychosis. A clinical and outcome study. *Journal of Child Psychology and Psychiatry*, 35, 1321-1332.

Coleman, J. (2004). Therapeutic communities for children and young people. *Journal of Adolescence, 27* (3), 375-377.

Colton, A., & Pistrang, N. (2004). Adolescents' Experiences of Inpatient Treatment for Anorexia Nervosa. *European Eating Disorders Review, 12*, 307-316.

Cornwall, A., & Blood, L. (1998). Inpatient versus day treatment for substance abusing adolescents. *The Journal of Nervous and Mental Disease, 186*(9), 580-582.

Corrigall, R., & Mitchell, B. (2002). Service innovations: rethinking in-patient provision for adolescents. *Psychiatric Bulletin, 26*, 388-392.

Cotgrove, A. (1997). Emergency admissions to a regional adolescent unit: piloting a new service. *Psychiatric Bulletin, 21*, 604-608.

Cotgrove, A.J. (2001). The Adolescent Unit. In S.G. Gowers (Ed). *Adolescent Psychiatry and Clinical Practice* (pp 321-345). London: Oxford University Press.

Cotgrove, A.J., & Gowers, S.G. (1999). Use of an adolescent in-patient unit. *Advances in Psychiatric Treatment, 5*, 192-201.

Cotgrove, A.J., Zirinsky, L., Black, D., Weston, D. (1995). Secondary prevention of attempted suicide in adolescence. *Journal of Adolescence*, 18, 569-577.

Crisp, A.H., Norton, K., Gowers, S. et al (1991). A controlled study of the effects of therapies aimed at adolescent and family psychopathology in anorexia nervosa. *British Journal of Psychiatry*, 159, 325-333.

Curry, J.E. (1991). Outcome research on residential treatment: Implications and suggested directions. American *Journal of Psychiatry, 621*, 348-357.

Day, C., Carey, M. & Surgenor, T. (2006). Children's key concerns: piloting a qualitative approach to understanding their experience of mental health care. *Clinical Child Psychology and Psychiatry, 11*(1), 139-155.

Delaney, K.R. (1992). Nursing in child psychiatric milieus. *Journal of Child Psychiatric Nursing, 5* (1), 10-15.

Department of Health (2004). *National Service Framework for Children, Young People and Maternity Services.* London: Department of Health.

Durkin, R.P. & Durkin, A.B. (1975). Evaluating residential treatment programs for disturbed children. In M. Guttentag & E.L. Struening (Eds), *Handbook of evaluation research*, vol. 2 (pp. 25-149). Beverly Hills, CA: Sage Publications.

Enns, M, Cox, B & Inayatulla, M. (2003). Personality predictors of outcome for adolescents hospitalized for suicidal ideation. *Journal of the American Academy of Child and Adolescent Psychiatry, 42,* 720-727.

Epstein, R.A. (2004). Inpatient and residential treatment effects for children and adolescents: a review and critique. *Child and Adolescent Psychiatric Clinics of North America, 13,* 411-428.

Erickson, E. (1968). *Identity, Youth and Crisis.* New York: Norton.

Farnfield, S., & Kaszap, M. (1998). What makes a helpful grown up? Children's views of professionals in the mental health services. *Health Informatics Journal, 4,* 3-14.

Fennig, S., Fennig, S. & Roe, D. (2002). Physical recovery in anorexia nervosa: is this the sole purpose of a child and adolescent medical-psychiatric unit? *General Hospital Psychiatry, 24* (2), 87-92.

Fineberg, B.L., Sowards, S.K. & Kettlewell, P.W. (1980). Adolescent inpatient treatments: a literature review. *Adolescence, 15* (60), 913-925.

Fitzgerald, P., & Kulkarni, J. (1998). Home-orientated management programme for people with early psychosis. *British Journal of Psychiatry*, 172 (Suppl. 33), 39-44.

Fonagy, P., Target, M., Correll, J.P., Phillips, G., & Kurtz, Z. (2002). *What Works for Whom? A critical review for Children and Adolescents*. New York: The Guilford Press.

Fryer, M.A., Beech, M., & Byrne, G.J.A. (2004). Seclusion use with children and adolescents: an Australian experience. *Australian and New Zealand Journal of Psychiatry, 38*, 26-33.

Ghuman, H.S., Jayaprakash, S., Saidel, D.H., & Whitmarsh, G. (1989). Variables predictive of the need for placement in a long-term structured setting for adolescents. *Psychiatric Hospital, 20*, 31-43.

Goldston, D.B., Daniel, S.S., Reboussin, D., Reboussin, B., Frazier, P.H., & Kelley, A.E. (1999). Suicide attempts among formerly hospitalized adolescents: a prospective naturalistic study of risk during the first 5 years after discharge. *Journal of the American Academy of Child & Adolescent Psychiatry, 38* (6), 660-671.

Gosset, J.T., Lewis, J.M., & Barnhart, F.D. (1983). *To find a way: The outcome of hospital treatment of disturbed adolescents*. New York: Brunner/Mazel.

Gowers, S.G. (2001). *Adolescent Psychiatry and Clinical Practice*. London:Oxford University Press.

Gowers, S.G., Clarke, J., Alldis, M., Wormald, P., & Wood, N. (2001). In-patient admission of adolescents with mental disorder. *Clinical Child Psychology & Psychiatry, 6* (4), 537-544.

Gowers, S.G., & Cotgrove, A.J. (2003). The future of in-patient child and adolescent mental health services. *The British Journal of Psychiatry, 183,* 479-480.

Gowers, S., & Kushlick, A. (1992). Customer satisfaction in adolescent psychiatry. *Journal of Mental Health, 1,* 353-362.

Gowers, S.G., & Rowlands, L. (2005). Inpatient services. *Current Opinion in Psychiatry, 18,* 445-448.

Gowers, S.G., Weetman, J., Shore, A., Hossain, F., & Elvins, R. (2000). Impact of hospitalisation on the outcome of adolescent anorexia nervosa. *The British Journal of Psychiatry, 176,* 138-141.

Green, J. (2002). Provision of Intensive Treatment: Inpatient Units, Day Units and Intensive Outreach. In M.Rutter & E.Taylor (Eds.), *Child and adolescent psychiatry, modern approaches, 4th ed.* (pp.1038-1950). London: Blackwell.

Green, J. (2006). Annotation: The therapeutic alliance – a significant but neglected variable in child mental health treatment studies. *Journal of Child Psychology and Psychiatry, 47* (5), 425-435

Green, J.M., & Burke, M. (1998). The ward as a therapeutic agent. In J.M. Green & B.W. Jacobs (Eds.), *Inpatient Child Psychiatry: Modern Practice Research and the Future* (pp 93- 110). London: Routledge.

Green, J., & Jacobs, B. (1998). *Inpatient Child Psychiatry: Modern Practice, Research and the Future.* London, Routledge.

Green, J.M., & Jones, D. (1998). Unwanted effects of inpatient treatment: anticipation, prevention, repair. In J.M. Green & B.W. Jacobs (Eds.), *Inpatient Child Psychiatry: Modern Practice Research and the Future* (pp 212-220). London: Routledge.

Green, J. M., Kroll, L., Imre, D., Frances, F.M., Begum, K., Gannon, L., & Anson, R. (2001). Health Gain and outcome predictors during inpatient and related day treatment in child and adolescent psychiatry. *Journal of the American Academy of Child and Adolescent Psychiatry, 40,* 325-332.

Gunderson, J. (1978). Defining the therapeutic processes in psychiatric milieus. *Psychiatry, 41,* 327-335.

Harnett, P.H., Loxton, N.J., Sadler, T., Hides, L., & Baldwin, A. (2005). The Heath of the Nation Outcome Scales for Children and Adolescents in an adolescent in-patient sample. *Australian and New Zealand Journal of Psychiatry, 39,* 129-135.

Hart, A., Saunders, A. & Thomas, H. (2005). Attuned practice: a service user study of specialist child and adolescent mental health, UK. *Epidemiologia e Psichiatria Sociale, 14* (1), 22-31.

Hawton, K., Arensman, E., Townsend, E., Bremner, S., Feldman, E., Goldney, R., Gunnell, D., Hazell, P., Van Heeringen, K., House, A., Owens, D., Sakinofsky, I., & Traskman-Bendz, L. (1998). Deliberate self harm: systematic review of efficacy of psychosocial and pharmacological treatments in preventing repetition. *British Medical Journal, 317,* 441-447.

Health Advisory Service. (1986). *Bridges Over Troubled Waters: A Report on services for disturbed adolescents.* London: HMSO

Health Advisory Service. (1995). *Child and Adolescent Mental Health Services – Together we stand.* London: HMSO

Henggeler, S., Rowland, M., Randall, J., Ward, D., Pickrel, S., Cunningham, P.B., Miller, S.L., Edwards, J., Zealberg, J.J., Hand, L., & Santos, A.B. (1999). Home-based multisystemic therapy as an alternative to the hospitalization of youths in psychiatric crisis: clinical outcomes. *Journal of the American Academy of Child and Adolescent Psychiatry, 38*(11), 1331-1339.

Hoagwood, K., Jensen, P.S., Petti, T., & Burns, B.J. (1996). Outcomes of mental health care for children and adolescents: I. A comprehensive conceptual model.

Journal of the American Academy of Child and Adolescent Psychiatry, 38, 1055-1063.

Hoger, C., Zieger, H., Presting, G., Witte-Lakemann, G., Specht, F., & Rothenberger, A. (2002). Predictors of length of stay in inpatient child and adolescent psychiatry: failure to validate an evidence-based model. *European Child and Adolescent Psychiatry, 11,* 281-288.

Holmbeck, G. N., Colder, C., Shapera, W., Westhoven, V., Kenealy, L., & Updegrove, A. (2000). *Working with Adolescents: guides from developmental psychology.* In P. C. Kendall (Ed.), Child and Adolescent therapy: *Cognitive-behavioural procedures* (pp.334-385). New York: Guilford Press.

Imrie, D. & Green, J.M. (1998). Research into Efficacy and Process of Inpatient Treatment. In J.M. Green & B. Jacobs (Eds.), *Inpatient Child Psychiatry: Modern Practice Research and the Future* (pp. 333-339). London: Routledge.

Ivarsson, T., Larsson, B., & Gillberg, C. (1998). A 2-4 year follow up of depressive symptoms, suicidal ideation, and suicide attempts among adolescent psychiatric inpatients. *European Child and Adolescent Psychiatry, 7,* 96-104.

Jacobs, B., Beecham, J., Briskman, J., Tobias, C., Green, J., Kroll, L., Dunn, G., & Baird, L. (2004). CHYPIE - *Two and a half thousand hours. The Children and Young Person's Inpatient Evaluation Study into Process and Outcome of Inpatient Child and Adolescent Psychiatric Care.* Report for the Department of Health.

Jaffa, T. Lelliot, P., O'Herlihy, A., Worrall, A., Hill, P. & Banerjee, S. (2004). The staffing of inpatient child and adolescent mental health services. *Child and Adolescent Mental Health, 9,* 84-87.

Jaffa, T., & Stott, C. (1999). Do inpatients on adolescent units recover? A study of outcome and acceptability of treatment. *European Child and Adolescent Psychiatry, 8,* 292-300.

Jensen, P.S., Hoagwood, K. & Petti, T. (1996). Outcomes of mental health care for children and adolescents: II. Literature review and application of a comprehensive model. *American Academy of Child and Adolescent Psychiatry,* 35, 1064-1077.

Kahila, K., Kilkku, N., & Kaltiala-Heino, R. (2003). Psychiatric treatment and research unit for adolescent intensive care: the first adolescent forensic psychiatric service in Finland. *Journal of Psychiatric and Mental Health Nursing, 11,* 240-244.

Katz, L., Cox, B., Gunasekara, S., & Miller, A. (2004). Feasibility of dialectical behaviour therapy for suicidal adolescent inpatients. *Journal of the American Academy of Child and Adolescent Psychiatry, 43*(3), 276-282.

King, C. A., Hovey, J.D., Brand, E., & Ghaziuddin, N. (1997). Prediction of positive outcomes for adolescent psychiatric inpatients. *Journal of the American Academy of Child and Adolescent Psychiatry, 36*(10), 1434-1442.

Kiser, L.J., Millsap, P.A., Hickerson, S., Heston, J., Nunn, W., Pruitt, D.B., & Rohr, M. (1996). Results of treatment one year later: child and adolescent partial hospitalization. *Journal of the American Academy of Child and Adolescent Psychiatry, 35*(1), 81-90.

Klinge, V., Piggott, L., Knitter, E., & O'Donnell, A. (1986). A follow-up study of psychiatrically hospitalized adolescents. *Adolescence*, 21, 697-701.

Kroll, L., & Green, J. (1997). The therapeutic alliance in child inpatient treatment: development and initial validation of a family engagement questionnaire. *Clinical Child Psychology and Psychiatry, 2*(3), 431-447.

Kurtz, Z., Thornes, R., & Wolkind, S. (1995). *Services for the mental health of children and young people in England: Assessment of needs and unmet need.* London: Public Health Directorate, South Thames Regional Health Authority.

LaBarbera, J.D., & Dozier. J.E. (1985). A honeymoon effect in child psychiatric hospitilization: a research note. *Journal of Child Psychology and Psychiatry, 26*(3), 479-483.

Larsson, B. & Ivarsson, T. (1998). Depressive symptoms and suicidal ideation amongst depressed and suicide attempting adolescent psychiatric inpatients. *European Child and Adolescent Psychiatry.* 7: in press.

Lay, B., Blanz, B., Schmidt, M.H. (2001). Effectiveness of home-treatment in children and adolescents with externalising psychiatric disorders. *European Child and Adolescent Psychiatry. (Suppl. This issue).*

Maluccio, A.N., & Marlow, W.D. (1972). Residential treatment of emotionally disturbed children. *Social Service Review, 46,* 230-250.

Marriage, K., Petrie, J., & Worling, D. (2001). Consumer satisfaction with an adolescent inpatient psychiatric unit. *Canadian Journal of Psychiatry, 26,* 969-975.

Masten, A. S., Best, K.M., & Garmezy, N. (1990). Resilience and Development: Contributions from the study of children who overcome adversity. *Development and Psychopathology, 2,* 425-444.

Mattejat, F., Hirt, B.R., Wilken, J., Schmidt, M.H., & Remschmidt, H. (2001). Efficacy on inpatient and home treatment in psychiatrically disturbed children and adolescents: Follow-up assessment of the results of a controlled treatment study. *European Child and Adolescent Psychiatry, 10, Suppl. 1,* 71-79.

North, C., Gowers, S., & Byram, V. (1997) Family functioning and life events in the outcome of adolescent anorexia nervosa. *British Journal of Psychiatry,* 171, 545-549.

O'Herlihy, A., Worrall, A., Banerjee, S., Jaffa, T., Hill, P., Mears, A., Brook, H., Scott, A., White, R., Nikolaou, V. & Lelliott, P. (2001) *National In-Patient Child*

and Adolescent Psychiatry Study (NICAPS). Final Report to the Department of Health. London: Royal College of Psychiatrists' Research Unit.

O' Herlihy, A., Worrall, A., Lelliott, P., Jaffa, T., Hill, P., & Banerjee, S. (2003). Distribution and characteristics of in-patient child and adolescent mental health services in England and Wales. *British Journal of Psychiatry, 183,* 547-551.

O' Herlihy, A., Worrall, A., Lelliott, P., Jaffa, T., Mears, A., Banerjee, S. & Hill, P. (2004). Characteristics of residents of in-patient child and adolescent mental health services in England and Wales. *Clinical Child Psychology and Psychiatry*, 9, 1359-1045.

Parry Jones, W. (1995). The future of adolescent psychiatry. *British Journal of Psychiatry, 166,* 299-305.

Peplau, H. (1989). The history of milieu as a treatment modality. In A. O'Toole & S.R. Welt (Eds.), *Interpersonal theory in nursing practice: Selected works of Hildegard E. Peplau* (pp. 75-79). New York: Springer.

Pfeiffer, S.I., & Strzelecki, S.C. (1990). Inpatient psychiatric treatment of children and adolescents: a review of outcome studies. *Journal of the American Academy of Child and Adolescent Psychiatry, 29*(6), 847-853.

Pottick, K., Hansell, S., Gaboda, D., & Gutterman, E. (1993). Child and adolescent outcomes of inpatient psychiatric services: a research agenda. *Children and Youth Services Review, 15,* 371-384.

Rogers, C.R. (1957). The Necessary and Sufficient Conditions of Therapeutic Personality Change. *Journal of Consulting Psychology, 21* (2), 95-103.

Remschmidt, H. & Schmidt, M.H. (1988). Alternative Behandlungsformen in der-Kinder-und Jugendpsychiatrie. Stuttgart, Enke.

Roth, A. and Fonagy, P. (1996). *What works for Whom?* New York: The Guilford Press.

Rothery, D., Wrate, R., McCabe, R., Aspin, J., & Bryce, G. (1995). Treatment goal-planning: outcome findings of a British prospective multi-centre study of adolescent inpatient units. *European Child and Adolescent Psychiatry, 4*(3), 209-221.

Royal College of Psychiatrists' Research Unit. (2003) QNIC- Quality Network for In-patient CAMHS: Service Standards. London: Royal College of Psychiatrists' Research Unit.

Safran, J.D., & Muran, J.C. (2000). Introduction. *JCLP/In session: Psychotherapy in Practice, Vol. 56* (2), 159-161.

Schaffer, D.M.S. & Gould, D. (1983). A children's global assessment scale (CGAS). *Archives of General Psychiatry*, 40, 1228-1231.

Seligman, M.E.P. (1995). The effectiveness of psychotherapy: The consumer reports study. *American Psychologist*, 50, 965-974.

Shaffer, D. & Piacentini, J. (1994). Suicide and attempted suicide. In M. Rutter, E. Taylor, L. Hersov (Eds). *Child and Adolescent Psychiatry. Modern Approaches. Third Edition* (pp. 407-424). Oxford: Blackwell.

Shirk, S.R., & Karver, M. (2003). Prediction of Treatment Outcome From Relationship Variables in Child and Adolescent Therapy: A Meta-Analytic Review. *Journal of Consulting and Clinical Psychology, 71* (3), 452-464.

Shirk, S.R., & Russell, R.L. (1998). Process issues in child psychotherapy. In A. Bellack & M. Hersen (Eds.), *Comprehensive clinical psychology* (Vol. 5, pp 57-82).

Simpson, E.L., & House, A.O. (2002). Involving users in the delivery and evaluation of mental health services: systematic review. *British Medical Journal, 325*, 1265-1269.

Sourander, A., Ellila, H., Valimaki, M., & Piha, J. (2002). Use of holding, restraints, seclusion and time-out in child and adolescent psychiatric in-patient treatment. *European Child and Adolescent Psychiatry, 11*, 162-167.

Sourander, A., Helenius, H., Leijala, H., Heikkila, T., Bergroth, L., & Piha, J. (1996). Predictors of outcome of short-term child psychiatric inpatient treatment. *European Child and Adolescent Psychiatry, 5,* 75-82.

Spencer, E., Birchwood, M., & McGovern, D. (2001). Management of first-episode psychosis. *Advances in Psychiatric Treatment, 7,* 133-140.

Street, C., & Svanberg, J. (2003). *Where Next? New directions in in-patient mental health services for young people. Report 1. Different models of provision for young people: facts and figures.* London: Young Minds Publications.

Stiles, W.B., Shapiro, D.A., & Elliot, R. (1986). "Are all Psychotherapies Equivalent?" *American Psychologist, 41* (2), 165-180.

Swartz, M.S., Hargett, A.B., Fraker, W.W., & Noll, B.K. (1988). The inpatient milieu: organisational and functional principles. *Psychiatric Annals, 18,* (2), 80-84.

Svanberg, J., & Street, C. (2003). *Where Next? New directions in in-patient mental health services for young people. Report 2. Issues emerging: views from young people, parents and staff.* London: Young Minds Publications.

Swadi, H., & Bobier, C. (2005). Hospital admission in adolescents with acute psychiatric disorder: how long should it be? *Australasian Psychiatry, 13*(2), 165-168.

Teggart, T., & Linden, M. (2006). Investigating service users' and carers' views of child and adolescent mental health services in Northern Ireland. *Child Care in Practice, 12* (1), 27-41.

Thomas, S.P., Shattell, M., & Martin, T. (2002). What's therapeutic about the therapeutic milieu? *Archives of General Nursing, XVI* (3), 99-107.

Weisz, J. R., & Hawley, K.M. (2002). Developmental Factors in the Treatment of Adolescents. *Journal of Consulting and Clinical Psychology, 70* (1), 21-43.

Wells, P., & Faragher, B. (1993). In-patient treatment of 165 adolescents with emotional and conduct disorders: a study of outcome. *British Journal of Psychiatry, 162,* 345-352.

Worrall, A., & O'Herlihy, A. (2001). Psychiatrists' views of in-patient child and adolescent mental health services. *Psychiatric Bulletin, 25,* 219-222.

Worrall, A., O'Herlihy, A., & Mears, A. (2002). Child and adolescent psychiatric in-patient units: young people's views. *Childright, 196,* 10-11.

Wrate, R.M., Rothery, D.J., McCabe, R.J.R., Aspin, J., & Bryce, G. (1994). A prospective multi-centre study of admissions to adolescent inpatient units. *Journal of Adolescence, 17,* 221-237.

York, A., & Lamb, C. (2005). Building and Sustaining Specialist CAMHS, Child

and Adolescent Faculty, Royal College of Psychiatrists.

PART TWO: EMPIRICAL PAPER

Young People's Experiences of Relationships with Staff and Peers in Adolescent Inpatient Units

ABSTRACT

There is little evidence to support the effectiveness of inpatient adolescent treatment, and limited information exists into which components of care effect which changes. Even less is known about adolescents' experiences and views of inpatient treatment or about the significance of process variables and relationships in these settings, which appear so fundamental to young people's overall experience. The present study therefore sought to investigate adolescents' experiences of inpatient units with a particular focus on the relationships they made with staff and peers, and the perceived impact of these on their engagement and participation in the treatment programme. This was achieved by carrying out semi-structured interviews with thirteen adolescents who were inpatients or daypatients on three adolescent units at the time of the study. Interpretative phenomenological analysis (IPA) was used to analyse the data and yielded eight key themes grouped within two broad domains: 'making human connections' and 'difficulties, dilemmas and dangers on inpatient units'. Participants' accounts highlighted the complex ways in which relationship factors and processes operated in their units and how these affected the different aspects of their experiences.

Key terms: Adolescents, inpatient unit, relationships, users' views, peer support.

_____

INTRODUCTION

Adolescence is a period of heightened vulnerability to the development of psychological difficulties and the emergence of serious mental health problems (Weisz & Hawley, 2002). There is a change in the prevalence of mental health difficulties during adolescence, for example, internalising disorders increase particularly amongst young women. New types of difficulties which are not commonly seen in childhood but are more reflective of adulthood, such as psychosis and eating disorders also emerge at this time (Carr, 2000; Weisz & Hawley, 2002). Although the prevalence of mental health difficulties in adolescents varies across studies due to methodological factors such as sample characteristics and measurement, rates largely fall between 10% and 20% of the population (Cotgrove & Gowers, 1999). A small proportion of young people experience acute, severe and co-morbid mental health problems, associated with high levels of risk and impairment for which inpatient treatment is required.

Adolescent inpatient units in the United Kingdom are highly specialist, scarce and costly Tier four services, which usually cater for young people between the ages of 12-18 years who present with the most serious and complex difficulties that can not be managed in outpatient or community settings (Gowers, 2001). There are different types of adolescent inpatient units serving different populations and delivering different aims and treatment programmes. Current provision falls into three main categories: acute units, generic units and units for specific disorders (specialist units) e.g. eating disorders. Length of stay may vary from one month to a year, with shorter stays in acute units and medium to longer stays in generic and specialist units. The majority of units in the United Kingdom are generic in nature, serving a

heterogeneous population of young people presenting with a wide range of diagnoses, difficulties and life events. The majority of young people are admitted to these units as inpatients, following which some of them then become day and outpatients in order to facilitate their transition back into the community. Generic units are largely run by nursing and medical staff and a range of health-care professionals who offer multi-disciplinary assessments and therapeutic interventions that reflect the individual and multiple needs of the adolescent (Gowers, 2001). The treatment interventions draw on a range of approaches and typically consist of individual, family and group based interventions, using a range of cognitive, behavioural, psychodynamic, systemic and creative approaches, together with pharmacological interventions. Programmes also include schooling and daily communal activities. These units draw on the consistent use of the therapeutic context or 'milieu', which aims to offer young people the opportunity for a positive peer group experience and the formation and development of more 'secure' attachments and relationships, in an environment where they can live more independently and autonomously (Cotgrove & Gowers, 1999; Gowers, 2001; Green, 2002). In addition, these units provide young people with a chance to understand and manage their difficulties through use of the group context and individual sessions. Peplau (1989) suggested that the milieu was a treatment modality in itself, providing safety, structure, containment and validation, and thereby reducing distress, destructiveness and enhancing psychological well-being.

Adolescent inpatient services have been criticised for their variability, uneven distribution and lack of resources across the United Kingdom (O' Herlihy et al., 2003). Until recently, there has been a lack of data collected on the number and

distribution of these units, those who use them, or information to evaluate their nature, function and clinical outcomes (Gowers & Rowlands, 2005). This lack of information led to the National Inpatient Child and Adolescent Psychiatry Study (NICAPS; O'Herlihy et al., 2001), a large scale study of 80 adolescent units in England and Wales, which highlighted significant problems in provision, concerns about effectiveness, and the absence of clear models of care and use of evidence-based treatments. The NICAPS (2001) has subsequently been used to inform policy, service planning and future investment in inpatient adolescent care. Key recommendations, for example, have been incorporated into the National Service Framework for children, young people and maternity services (2004) and the Quality Network for Inpatient Child and Adolescent Mental Health Services (QNIC, 2003). This body aimed to improve the quality of inpatient services by setting and annually reviewing standards for desirability and excellence, and auditing areas of care such as staffing and treatments. However, despite these recent measures to improve service quality and delivery, it appears that inpatient services continue to vary, and it remains unclear whether standards are being met and adequate resources are being put in place to meet young people's needs.

Although recent years has seen an increasing body of evidence regarding treatment efficacy in child and adolescent outpatient populations (Carr, 2000; Fonagy, Target, Cottrell, Phillips & Kurtz, 2002), the evidence for adolescent inpatient populations remains limited. Evaluating the effectiveness of specific treatments is particularly difficult within these settings due to the complexity, heterogeneity and co-morbidity of the population. In addition, care often consists of multiple treatments making it difficult to establish internal validity and disentangle which variables are responsible

for change (Blanz & Schmidt, 2000; Green, 2002; Green & Jacobs, 1998). In relation to the overall service effectiveness and outcomes achieved in inpatient adolescent settings, there also continues to be a lack of empirical evidence to support this mode of service delivery (Fonagy, Target, Cottrell, Phillips & Kurtz, 2002; Gowers & Rowlands, 2005). The lack of evidence for inpatient treatment and care relates to the practical and ethical difficulties associated with carrying out outcome research in such settings, added to the significant methodological weaknesses in existing studies that often compromise both internal and external validity and make it difficult to draw firm conclusions (Green & Jacobs, 1998). Methodological limitations include the lack of tightly controlled studies, the use of unitary measures of outcome, and the use of small sample sizes and single units (Blanz & Schmidt, 2000; Gowers & Rowlands, 2005; Green, 2002).

Very little research has focused on the therapeutic processes that might account for positive outcomes within adolescent inpatient units. Research in the adult literature has shown that therapeutic processes consist of a number of key elements within the client-therapist dyad, including the therapeutic relationship and therapeutic alliance (Bergin & Garfield, 1994; Bordin, 1979). The process literature has shown that the therapeutic relationship is an essential component of treatment across modalities and contexts and may account for equivalent outcomes and psychotherapeutic change (Stiles, Shapiro & Elliot, 1986). Specific psychological conditions have been shown to be important elements of the therapeutic relationship and include empathy, warmth, openness, acceptance, genuineness, respect, listening and understanding (Bergin & Garfield, 1994; Rogers; 1957). Their importance has also been reinforced by evidence elicited from users of child and adolescent mental health services, who

identified a set of similar 'helper characteristics' that they articulated were of significance in their relationships with professionals, including collaboration, warmth, understanding, personal respect, and the ability to listen and relate in an open and inclusive way (Worrall, O'Herlihy & Mears, 2002; Day, Carey & Surgenor, 2006; Hart, Saunders, & Thomas, 2005). Alongside these therapeutic relationship factors, research has also highlighted the importance of the therapeutic alliance as essential for engagement and as a robust predictor of outcome in treatment (Bordin, 1979). Studies within child and adolescent inpatient and outpatient settings have also indicated that the therapeutic alliance is a strong predictor of health gain across diagnoses (e.g. Green et al., 2001; Jacobs et al., 2004; Kroll & Green, 1997).

There has been greater recognition of the importance of studying therapeutic process variables in outpatient child and adolescent populations (Green, 2006; Green et al., 2001). Whilst the evidence on therapeutic processes is at an earlier stage with this population, the evidence that does exist on therapeutic processes suggests that there is emergent consistencies with the adult findings. For example, emerging research has shown a robust and consistent association between the therapeutic relationship and outcomes across both developmental levels and diverse types and contexts of therapy (Shirk & Karver, 2003). Despite this evidence, little is known about the role of therapeutic processes and relationships in adolescent inpatient units which are likely to be particularly important because therapeutic, social, and developmental factors are likely to intensify such processes. For example, in inpatient settings, the therapeutic relationship and alliance are largely used as devices within the milieu approach as a common curative factor and young people and peer support are

mobilised for therapeutic intentions as a result of this approach. Inpatient settings by their very nature also potentially extend therapeutic relationship factors beyond the traditional therapist-client dyad to include client-client therapeutic processes and relationships. This evidence is very pertinent to adolescent inpatient care because of the importance of peer relationships during this life stage. Although few in number, certain studies have recognised the existence of multiple therapeutic processes in inpatient adolescent units and have pointed to the occurrence of multiple and separate alliances in such settings, for example, between parents and young people, as well as with the whole staff team, peer group and the therapeutic context (Kroll & Green, 1997).

Although there is an extensive body of knowledge documenting the importance of peer relationships during adolescence (Weisz & Hawley, 2002), there is a dearth of research into the potential significance and role of peer relationships and peer support within adolescent inpatient settings. Peer support has been defined as a process by which people come together to address common problems or shared concerns, and has been seen as a positive intervention for adults with severe mental illnesses in community and inpatient settings (Borkman, 1999; Davidson et al., 1999). This also closely reflects one of the fundamental processes known as 'universality' experienced in psychotherapeutic groups, which involves individuals discovering that their feelings and experiences are not unique, and consequentially feeling relieved and less isolated (Yalom, 1995). Involvement in peer support processes has been shown to provide individuals with acceptance, understanding and empathy, in addition to assisting them to make sense of their experiences, learn new information, problem solve and find coping strategies (Kennedy & Humphreys,

1994; Kurtz, 1990; Loat, 2006). Findings related to these processes have been supported by qualitative studies with young people with psychosis and anorexia nervosa in inpatient units (Billings, 2005; Colton & Pistrang, 2004). On the other hand, research has also shown that close peer relations and peer group interventions that increase contact amongst 'deviant' adolescents can exacerbate problems and have detrimental effects (Dishion, McCord, & Poulin, 1999). However, a lack of literature exists on the nature and effects of group and social processes, for example, social conformity and peer pressure in adolescent inpatient settings. This is surprising considering the impact of these processes during adolescence and the likelihood that these will be intensified as a result of the milieu. The few existing studies have pointed to the negative effects of social processes in inpatient settings, including young people learning destructive behaviours, competing over illnesses, and being subjected to bullying, violence and aggressive behaviours (Bobier & Warwick, 2004; Colton & Pistrang, 2004).

Despite the current drive towards user involvement and participation (NSF, DOH, 2003), the majority of studies in the adolescent inpatient literature have failed to adequately elicit the views of the adolescents themselves (Gowers & Rowlands, 2005). Listening to users' views of mental health care is important for improving service quality and provision so that they better reflect young people's concerns and priorities (Day, Carey & Surgenor, 2006; Department of Health, 2002a). In addition, views of what makes services and treatments effective have largely been determined by professionals and parents, highlighting the value of enabling experiences and phenomenon to be viewed by young people in order to draw out unique insights from both 'patient' and developmental perspectives (Hennesey, 1999). Although recent

years have seen the emergence of more qualitative studies exploring young people's experiences of community child and adolescent mental health care, (e.g. Day, Carey & Surgenor, 2006; Hart, Saunders, & Thomas, 2005), very few studies have been carried out into adolescents' experiences within generic inpatient units. One exception was a qualitative study conducted by Young Minds across six adolescent units across England and Wales into developments within inpatient care for young people with complex mental health problems (Svanberg & Street, 2003). Findings from this study pointed to difficulties of staff shortages and suitability, the need for units to feel safe and be non-institutional, the importance and influence of being in a peer group (which could be both highly supportive but also difficult) and the value of the relationships made with staff, where talking, being understood and feeling cared for were identified as being important and helpful aspects of these relationships.

A number of studies have examined the views and experiences of adult users of psychiatric and acute inpatient care (e.g. Quirk & Lelliott, 2001, Quirk & Lelliott, 2004; Thomas, Shattell & Martin, 2002; Wood & Pistrang, 2004) and therapeutic community settings (Loat, 2006). Results from these studies have highlighted several major and consistent themes which corroborate findings of young people's experiences of inpatient care. These include the therapeutic aspects of inpatient care, for example, the peer support processes operating in units (Borkman, 1999; Loat, 2006; Wood & Pistrang, 2004) and the counter-therapeutic aspects of care, undermining the ward as a 'therapeutic' environment, including the degradation, disempowerment and vulnerability experienced by psychiatric inpatients (Goffman, 1959; May, 2000; Newnes, Holmes & Dunn, 2001; Wood & Pistrang, 2004).

Adult users of inpatient care have reported a range of positive and negative experiences and views regarding their care and their relationships with staff and other patients on inpatient units. In relation to positive factors and experiences, users have described benefiting from 1) engaging in mutual support processes and developing friendships with fellow patients, leading to an increase in self-esteem, self-efficacy and validation as a result of providing support, feeling needed and valued by others, and feeling less isolated and abnormal and more cared for, supported, genuinely understood and accepted by others with similar difficulties, experiences and predicaments (Lieberman, 1993; Loat, 2006; Thomas, Shattell & Martin, 2002; Wood & Pistrang, 2004), 2) valuing the opportunity of 'talking therapy' and therapeutic activities (which were felt to be lacking on acute wards) and a relationship with their named nurse whom they wanted to talk about their difficulties and form more intimate and interpersonal relationships with (Quirk & Lelliott, 2004; Rogers & Pilgrim, 1994; Rose, 2001; Thomas, Shattell & Martin, 2002), 3) valuing nurses and staff who were active listeners, possessed humane and therapeutic qualities such as warmth, empathy and respect (Quirk & Lelliott, 2001; Rogers & Pilgrim, 1994) and who were consistently available for purposes of continuity and trust in light of the high staff turnover (Quirk & Lelliott, 2004; Sutherland, 1977; Thomas, Shattell & Martin, 2002), and 4) experiencing the milieu as a refuge from self-destructiveness and a safe place to escape stress factors, other people and illness (Jackson & Stevenson, 2000; Thomas, Shattell & Martin, 2002).

Negative experiences which users of adult inpatient care have clearly described include 1) finding the ward a disturbing, threatening, frightening and unsafe place due to the presence of illicit drug and alcohol use (Baker, 2000; McGeorge &

Lelliott, 2000) and witnessing or experiencing racism, violence, sexual assaults, threats, harassment and boundary violations by fellow patients and staff (Baker, 2000; Kumar, Guite, Thornicroft, 2001; Quirk & Lelliott, 2001, Quirk & Lelliott, 2004; Wood & Pistrang, 2004), 2) feeling helpless, unsupported and unprotected by staff who were perceived as unavailable, unapproachable, uncaring, lacking an appropriate knowledge base, and unable to listen or act on their concerns, ensure their safety and support them in distressing and threatening situations (Beech & Norman, 1995; Quirk & Lelliott, 2001; Wood & Pistrang, 2004), 3) experiencing a sense of fear and powerlessness from staff who did not listen to their views and wishes for treatment, misunderstood and pathologised their concerns, actions and behaviour (Quirk & Lelliott, 2001; Rosenhan, 1973; Wood & Pistrang, 2004) and administered forms of restrictive treatment without their consent, including seclusion, restraint and medication often for inappropriate reasons (Wood & Pistrang, 2004), and 4) experiencing a loss of personhood, identity, social roles, freedom and privacy (Goffman, 1961; Rosenhan, 1973), and perceiving staff as separate, emotionally distant and condescending resulting in them feeling stigmatised and devalued (Goffman, 1961; Quirk & Lelliott, 2004; Wood & Pistrang, 2004).

In summary, establishing positive peer relationships and engaging in social processes are important protective factors for the psychological well-being of adolescents. The therapeutic alliance and relationship have been shown to be prerequisites for engagement and change in psychological intervention. As adolescent inpatient units are largely centred around social and group processes, relationships with peers and staff and place high value on the significance of the milieu, the concept of the 'therapeutic relationship' may provide a helpful framework for studying adolescents'

experiences of treatment in these settings. Little evidence exists about the effectiveness of inpatient adolescent units and even less is known about users' views of treatment and relationships in these settings which appear so fundamental to their experience. The present study therefore sought to investigate adolescents' experiences of inpatient units with a particular focus on the relationships they made with staff and peers and the perceived impact of these on their participation in the unit programme. A qualitative, phenomenological methodology was used to explore and examine young people's narratives, perceptions and meaning related to their inpatient experience. Interpretative Phenomenological Analysis (IPA; Smith & Osborn, 2003) was chosen as the approach to conducting in-depth interviews and analysis of the data as it is particularly suited to exploring individual and novel experiences as well as identifying commonalities across participants.

The research questions to be addressed were:

1. What are young people's experiences of relationships with peers and staff on adolescent inpatient units?

2. What are the impact of these relationships on their engagement and use of treatment and on their psychological well-being?

METHOD

Setting

The research took place in three generic adolescent inpatient units in London, ranging in bed capacity from 10-18. These units were chosen as they all conformed to a set of common characteristics and met the following inclusion criteria. All of the treatment programmes provided multidisciplinary assessment and intervention for young people between 12 and 18 years, presenting with a range of complex and co-morbid mental health difficulties. The majority of young people were admitted to the units as inpatients, and then some graduated from inpatient to daypatient status. Length of stay in the units ranged from 2 to 18 months, however, young people were commonly admitted for 8-10 months. The units were led by a consultant psychiatrist and run predominantly by nursing staff and multidisciplinary professionals. The inpatient and daypatient treatment programmes followed the same structure during the day and were influenced by several therapeutic modalities, including milieu, behavioural, systemic and psychodynamic approaches. The treatment programme was similar in nature across units and included individual sessions, therapeutic groups and meetings, on-site school, recreational and leisure activities, and residential unit trips.

Ethical Approval

The study was granted ethical approval by the Local Research Ethics Committee (see Appendix A). All participants were provided with verbal and written information prior to participation, outlining the details, process and ethical considerations of the study (see Appendix B). Parents or guardians of all participants aged under 18 were

also given detailed information which included a letter (see Appendix C) and an information sheet (see Appendix D). Written consent was then sought from the parents or guardians for their children's participation (see Appendix E) and from the young people taking part (see Appendix F).

Participants

Prospective participants were identified within each unit by the researcher and clinical psychologists working there. The research interviews were conducted over a seven-month period between August 2005 and February 2006.

The inclusion criteria were that participants were: (1) an inpatient or daypatient, (2) had been on the unit for a minimum of three months (in order to ensure that they had sufficient time to have established relationships with staff and peers), (3) aged 14-18 years and (4) fluent in English. In order to ensure sufficient numbers, the first criterion was extended to include one young person who had left the unit three months prior to being interviewed. There were no restrictions in relation to the type of disorder or difficulties participants presented with. Young people were excluded from the study if they were too acutely unwell or at risk as judged by clinicians, in order to protect them from taking part in a task they might find potentially stressful or difficult.

Twenty-five young people met the inclusion criteria of whom fourteen participated in the research interviews. Reasons for non-participation included not wanting to be taped or interviewed, concerns about confidentiality and disclosing information, not returning consent forms, and being absent from the unit. One young person

(Participant 4) withdrew from the study following their interview due to not wishing to share personal information; demographic and interview data for this participant has therefore not been included.

The 13 participants comprised ten young woman and three young men, ranging from 14-18 years old (mean = 16 years). Ten participants described themselves as White British, one as Black British Caribbean, one as Black British, and one as Mixed Race. Seven participants were currently inpatients, five were daypatients, and one had been discharged from the unit. At the time of their interview, participants' duration of stay on the unit ranged from three months to one year (mean = 7 months). All participants had informal status when interviewed and seven out of thirteen had spent time in other inpatient units prior to their current admission. Participants presented with a range of diagnoses, problems and life events typical to generic adolescent inpatient settings. These included depressive and anxiety disorders, trauma related difficulties, neuro-developmental disorders, psychosis, deliberate self-harm, history of abuse, emotional and behavioural problems, relationship difficulties, school phobia, anger problems and antisocial behaviour, and bereavement and loss (see Table 1). Further information about individual participants has not been included in order to preserve anonymity and confidentiality.

Table 1. Participant Information [a]

Participant	Age	Gender	Length of Stay [b]	Day/Inpatient	Reason for Admission
P1	15	Female	7 months	Inpatient	Anti-social Behaviour/ Self-Harm
P2	17	Female	1 year	Daypatient	Depression/Self-Harm/ Psychotic Episode
P3	15	Female	10 months	Daypatient	Depression/Self-Harm
P4 [c]					
P5	17	Female	4 months	Inpatient	Depressive episode
P6	17	Female	5 months	Inpatient	Post Traumatic Stress Disorder
P7	18	Female	9 months	Discharged	Depressive episode/ Psychotic symptoms/ Self-harm
P8	16	Male	6 months	Daypatient	Emotional and Behavioural Problems/ History of Abuse
P9	15	Female	7 months	Daypatient	Emotional and Behavioural Problems
P10	15	Female	7 months	Inpatient	History of abuse/trauma
P11	14	Female	6 months	Inpatient	History of abuse Depressive Episode
P12	17	Female	3 months	Inpatient	Depressive Episode Dissociate Phenomenon
P13	17	Male	4 months	Daypatient	Psychosis
P14	15	Male	8 months	Inpatient	Obsessive Compulsive Disorder/Tourettes

(a) Information on participants' ethnicity has been left out for purposes of confidentiality and anonymity
(b) Length of Stay is calculated from the time of interview
(c) P4 has not been included in the table as they withdrew from the study following their interview

The researcher

My decision to conduct this study was largely influenced by my experience, prior to clinical training, of working in one of the adolescent units used for this study. It was also affected by my sister's experiences as a user of both specialist and generic adolescent units (see Critical Appraisal: Part 3 of the thesis). These personal and professional experiences gave me an insight into the powerful nature of the peer group and the value and significance that young people attributed to their relationships with staff and peers on these units, as well as learning about the more negative and destructive elements of these relationships. Examples of these experiences included being struck by the intensity of peer support and the depth and meaningful nature of friendships formed, and being moved by young people's accounts of connecting with and feeling finally accepted by other young people also experiencing severe mental health needs. Examples of negative experiences included feeling concerned by staff's attitudes and abuse of power towards patients, the quality of care provided and amount of staff absence, and the fact patients were picking up 'illness' behaviours from each other.

These personal and professional experiences motivated and inspired me to explore further young people's experiences of relationships with staff and peers on adolescent units and investigate what aspects of these they found helpful or unhelpful. However, they also led to my entering into this research with several assumptions, preconceptions and beliefs, related to the positive and negative factors and influences of these relationships. With this in mind, I attempted to put my assumptions and preconceptions aside and maintain an actively neutral stance when conducting the interviews (Smith & Osborn, 2003). This included using an

exploratory approach to encourage participants to describe their individual and unique experiences, being open to accepting accounts at face value, and trying not to look for evidence or search for material to confirm any existing ideas. When conducting the analysis of the data, I also took an active stance to stick closely to the data and set my assumptions aside. Finally, it is important to consider that my theoretical orientation and adherence to more systemic and psychodynamic approaches, in addition to my personal commitment to placing importance on eliciting users' views, may have also influenced the results throughout the stages of the research process.

Semi-Structured Interviews

A semi-structured interview schedule was designed to capture young people's experiences of relationships with staff and peers on adolescent units (see Appendix G). The schedule was devised from existing theory and literature and on the research questions to be addressed. The interview covered a number of areas including (1) the development, nature and depth of relationships with peers and staff, (2) experiences of helpful and unhelpful relationships, (3) the impact of these relationships on young people's engagement, participation and use of the treatment programme, (4) group dynamics and peer group experiences, being with 'similar' others, peer support, and (5) changes in the understanding of difficulties, ways of coping and thoughts and feelings.

Although each interview had a broad focus of areas to be explored, the questioning did not strictly follow the schedule and was adapted and developed according to the information elicited during individual interviews and feedback from previous

interviews. The style of interview was one of "directed conversation" (Pidgeon & Henwood, 1996) and was intended to be as flexible and open-ended as possible. The purpose of this was to help establish rapport, enable participants to tell their story, and facilitate exploration and elaboration of any issues and new areas that might be raised. Prompts, reflections and summaries were used to guide discussion, provide more structure to those who found it difficult to talk at length, and help achieve a more in depth and richer quality data set.

The interviews took place in a quiet room on the units and were conducted by the researcher. They lasted between 45 – 150 minutes and were carried out over one to three meetings. The interviews were audio taped with the participants consent and then transcribed verbatim.

Qualitative Data Analysis

The interview transcripts were analysed using Interpretative Phenomenological Analysis (IPA: Smith & Osborn, 2003). This method of analysis was chosen as it aims to explore systematically and in depth, individuals' perceptions and subjective experiences, and look at the belief and meaning they attribute to these experiences. The approach is idiographic, with themes evolving into categories of increasing abstraction. It is "phenomenological" in that it is concerned with exploring individual, personal and subjective accounts of an experience. However, it is also interpretative, in that it recognises the role and influence of the researcher as an active participant in the dynamic process of data interpretation and analysis.

The analysis closely followed a number of predetermined steps (Smith & Osborn, 2003). The initial stage involved reading each transcript several times in order to identify emerging ideas, associations, contradictions, dilemmas, processes, and meanings being expressed. This information was annotated in the margin (see Appendix H). The second stage involved re-reading the annotated transcripts and making more abstract conceptualisations which were again annotated (see Appendix I). Following this, the third stage involved clustering similar ideas from the data into tentative categories or themes which were recorded on coversheets for each individual transcript (see Appendix J). Following this, in the fourth stage, common themes were then identified from drawing across all the cover sheets (see Appendix K). The fifth stage then involved integrating and making connections between the themes, where related themes were grouped together, resulting in a final set of themes that were applied to all the data (see Table 2). Through this cyclical, inductive process, the final set of themes were then organised and structured into two broad domains, each comprising four themes. At each stage of the analysis, quotations illustrating each theme were recorded.

Credibility checks were undertaken to ensure that the themes generated accurately represented and truly reflected the data (Elliott, Fischer & Rennie, 1999). Two supervisors were involved in reviewing the transcripts and discussing evolving themes and ideas throughout the process of the analysis. Following several discussions, the themes were restructured and modified and the theme labels refined, until a consensus was reached. The supervisors also helped to ensure that a coherent narrative ran from the raw data to the final set of themes as recommended by (Smith, 1996).

RESULTS

Participants described a range of positive and negative experiences of their relationships with staff and peers on their units. Their accounts vividly illustrated the nature, benefits and consequences of these relationships and demonstrated the complex relational and social processes operating in inpatient units, resulting in various dilemmas and conflicts.

The interpretative phenomenological analysis yielded eight key themes which were grouped within two broad domains (see Table 2). Each theme is presented in turn and illustrated by quotations from the participants. (The source of each quotation is indicated by the participant's number). Where quotes have been edited for brevity, missing words are denoted by "...". When describing participants' psychological difficulties, terms such as 'illness' and 'problems' will be used interchangeable to reflect the language they used.

Table 2. Domains and Themes

Domain	Theme
1. Making Human Connections	1. Being normal in an abnormal environment
	2. Talking openly about feelings and difficulties
	3. Feeling heard, understood and accepted
	4. Being supported through difficult times
2. Difficulties, Dilemmas and Dangers on Inpatient Units	5. Uncertainty of living alongside other illnesses
	6. Being influenced by other young people
	7. Not getting my needs met
	8. Hope or despair

Domain 1: Making Human Connections

The themes in this domain illustrate the therapeutic aspects, processes and implications of participants' relationships with staff and peers on adolescent inpatient units.

Theme 1: Being normal in an abnormal environment

The majority of participants described that despite being in such a "strange and abnormal" environment they were still able to create and preserve a sense of normality. Although several expressed a sense of sadness and loss about being away from home, family and friends, and missing out on important social, educational, and occupational opportunities, they continued to be involved in the social processes and milestones associated with adolescence. This helped participants to feel like "normal teenagers" and less aware and aggrieved at losing out on such an important developmental stage. However, in contrast, two participants felt anxious and resentful towards their unit for their 'compulsory' admission and the duration of their stay, resulting in several losses and consequences.

> *"I wanted to be with my friends outside of here and I wanted to go back to college and live my normal life as I was before, I just wanted to just get better, and they wouldn't let me go, and that's the main thing that hurt me, because my college left me [number] weeks to get back, but I lost my place, I lost all my friends." (P13)*

Several conveyed a sense of relief in being able to engage in "normal" relationships, social interactions and activities with other young people in their unit. By their use of the term normal they appeared to mean routine, ordinary and familiar interactions. This was often contrary to their expectations and fears of being "lumped together" with "mad" people, whose problems would interfere with their ability to relate to others.

"you think there's gonna be some proper nutters here, but it was fine, because you get to know people and that they are normal, we talk about just normal girl things that make you feel that you aint in a hospital place and you just feel normal." (P5)

"When I first came here I was a bit worried that people might be unsociable or something, like that their problems might cause them to be difficult to get on with. However, they're just like any other bunch of teenagers really, and you can have a good laugh with them, and I've made some really good friends." (P12)

Young people described making connections and friendships through bonding over being 'normal' teenagers and common factors outside of their illness, including being of a similar age and life stage, having similar personalities, interests, beliefs, outlooks on life and aspirations. They also described valuing certain qualities in their friendships on the unit, including feeling able to trust others, and relating to those who were open, genuine and honest. Such interactions helped participants cope with their inpatient experience, manage their difficulties and feel more supported in participating in the programme.

"it would have been difficult if I didn't have any friends here, I would have been frustrated and more aggravated to get out, but the more I had friends, the more better they made me to come over my illness and just to move on." (P13)

Participants expressed the importance of having fun together and enjoying themselves on the unit, by "mucking about" and "laughing and joking". This helped to normalise their inpatient experiences and allowed them to feel like typical teenagers. Having fun also helped participants to feel less "depressed", more able to "switch-off", cope with the intensity of the therapeutic programme, and feel supported.

"Me and that girl, we used to support each other by just having fun and laughter... you do need to have a laugh and have fun, otherwise everyone would be walking around like (inaudible) crying, so you need to have a laugh." (P7)

Participants described the value of looking behind the 'exterior' and seeing each other as a whole person rather than as a "problem or diagnosis".

> "You get to actually see people as teenagers (inaudible) as a person rather than somebody just been diagnosed with schizophrenia or something like that." (P10)

> "I've realised that there's a lot more to everyone behind their problem, like they've got their own unique personality and stuff like that, so that's been good." (P6)

Young people also valued when staff made them feel like normal teenagers apart from their problems, through, for example, having conversations about topics and interests typical of their life stage and by having fun together. In addition, several participants found it helpful when staff shared aspects of their own personal life and interests, and related to them in an informal, "natural", "down to earth" and non-hierarchical manner. Participants described that these processes led to the development of "mutual respect" and being "on an equal level", feeling more validated and respected, less viewed as 'patients' and more able to develop personal, authentic, meaningful and less distancing relationships with staff. These experiences were also described as facilitating conditions for the processes described in Theme 3, for example, talking openly about problems.

> "it shows that the staff can still play with us as teenagers, so it's really good, so we can relate to them in our age...we can joke about with them as well as the young people as well, we can have fun with them even tho they are still working." (P13)

Theme2: Talking openly about feelings and difficulties

The majority of participants valued the opportunity to talk openly and honestly about their feelings and difficulties with young people and staff. They described their feelings of relief and emotional release associated with this, which they described as more helpful than "keeping things in" and engaging in "destructive" behaviours.

"If I didn't have someone to talk to, I'd just bottle up a lot more and then eventually it would explode somewhere and then I'd just go mental, at everyone." (P6)

However, a few found this process unhelpful, a "new and strange" experience, and questioned its purpose.

Participants described that talking with each other about their "personal struggles" and the "real issues" helped them to develop "closer", "deeper" and more meaningful relationships and friendships. For many, feeling safe to open up was a new opportunity, facilitated by trust, not feeling judged, and feeling accepted and understood by those in a 'similar' position. This contrasted with previous, more superficial relationships at school, where participants had felt mocked, bullied and rejected.

"Just, talking [with peers in unit] and not being judged because they wouldn't judge because they just knew what it was like," (P7)

"When I told my friends how I was feeling and my self-harm, nearly every single one of my friends, just kind of left me. They couldn't understand, they bullied me, they took the piss, they made fun of me, and just ended up hurting me." (P10)

Young people described finding it easier to talk with staff than with other adults or parents. This was connected to perceiving staff as having the skills and experience to manage their issues and wanting to protect family members from becoming distressed. Staff were viewed as more "neutral" and less emotionally involved, judgemental and pathologising of their difficulties, leaving them with less feelings of guilt.

"Like with family you can't really tell them everything that's gone on because they're too close to the person. You don't want to upset them, but with staff you can just open up and tell them everything... their reaction is just normal because they've been trained for it, so they know what to do... you don't feel

bad after you've told them because they don't react and be like that's terrible."
(P6)

Contrary to the above, a few participants described feeling uncomfortable, vulnerable and pressured into talking about their difficulties to staff and peers. Some talked solely for obligatory purposes to avoid being sent home and found talking about personal information 'anti-therapeutic', especially with peers and staff whom they disliked or mistrusted, leaving them feeling distressed and disloyal. Talking openly also left some participants feeling exposed and anxious about possible repercussions from peers.

> *"You just feel trapped. You feel like, well if I don't speak then I'm going to be discharged or I'm going to be timed out but if I do speak I'm going to be left feeling uncomfortable with myself and feel that I've said too much and feel really depressed and feeling really like just that I've betrayed myself by saying certain things." (P11)*

Young people described feeling reluctant to disclose information to staff for fear of being "over-analysed". They referred to staff constantly "festering" on issues which they felt they had "put to bed", preventing them from "moving on" and making them worse. Young people also expressed irritation with staff "searching for a hidden meaning", misinterpreting "innocent chat", fun and behaviour as distraction and avoidance of "the real issues", and desperately "digging" for material related to their "bad past".

> *"My difficulties I had under control...it was a can of worms that was closed... and it got opened when I started [unit] and then I just went downhill." (P8)*

> *"I'm the only one who hasn't had difficult past experiences...why can't they just accept that...they always try and relate stuff from the past to you." (P14)*

Feeling over-analysed led to participants acting in a more inconspicuous and withdrawn manner, in order to avoid being misconstrued. However, this behaviour and "not talking" was then interpreted as a defence and denial of their difficulties.

"It's really awkward when you feel like everyone's always analysing everything you do...if you become aware of it then you can feel that it can make you change, and act in a way that you think isn't going to draw any attention to you." (P12)

A couple of young people were sceptical about the value of talking openly and appeared to lack faith in the treatment process, particularly when they perceived their peers as not having gained any therapeutic benefit. A few nearing discharge felt angry and exposed having previously talked about their past with staff whom they felt no longer cared.

"Staff are happy to keep you here for a bit, and try and make people talk about every single thing, and make them come up with all history...they're happy to, like, yeah, we've heard what we've need to heard, and like dump them off." (P14)

"It can be difficult... some people that leave here aren't better, so it kind of makes you feel a bit, what am I going to be? Am I going to be better or is this just going to be a whole waste of time, me talking and telling everyone everything." (P11)

Theme 3: Feeling heard, understood and accepted

The majority of participants described feeling heard, understood and accepted by young people and staff. For many, this experience brought about positive consequences, including a sense of hope, belonging and liberation. However, a few encountered a more negative experience, where they felt misunderstood and pathologised by staff.

Several young people valued the importance of staff genuinely listening, and working collaboratively to learn about their difficulties and individual experiences. They found it particularly helpful when staff did not make assumptions and generalisations, or give out "diagnoses from text books", but rather "checked things

out" with them. These factors helped them to build up engagement and trust in the therapeutic process.

> *"He [staff member] says do you feel like this when such and such happens, and he doesn't make assumptions and things and so I trust him."* (P12)

> *"Somebody that's not sitting there with a big book and analysing you and giving you like a diagnosis, but somebody that doesn't know what's going on...they can help you to discover like together about your problems."* (P10)

Several participants alluded to the value of feeling supported, accepted and understood by staff who were empathic and sensitive, and who 'normalised' their problems and placed them in the context of their past experiences, family background and relationships. They implied that this helped them to feel less stigmatised and pathologised, reducing feelings of blame and shame. Being understood by staff and peers also helped them to accept their own 'illness' and make sense of their experiences.

> *"They [staff] don't see me as somebody completely different and just really mad and stuff like... They say we see a lot of this every day. It kind of makes me feel OK, I'm not abnormal."* (P11)

> *"You can't talk to most people in your life about sexual abuse or rape or any of those things, it's like...you don't know what they're thinking. But in here, we don't try to see it as a shameful thing that we don't have to talk about it."* (P10)

Participants valued feeling understood for "who and what" they were by staff and peers, which helped them to disclose personal information and express and display "all parts" of themselves and their illness while continuing to feel accepted. This process was facilitated when they felt others were not judging them or reacting to their moods, destructive and "unusual" behaviours, but rather trying to make sense of their experiences. Participants also described feeling safe to display their "true self", including their "highs and lows", aggressive and "angry outbursts". The above

factors helped them to develop a sense of belonging, use support and become involved in the programme.

>*"It's strange because nothing really seems to shock people like in here... If you told somebody outside, yeah I self harmed last night they'll be like, what are you talking about? But in here, it's not like why do you do that, what's wrong with you." (P11)*

>*"I could let rip a load of shit in here, how I feel, just when I'm angry... They could handle it better in here and they talked to you about it." (P8)*

>*"Like you're not putting up a mask constantly, you can be yourself and then people know what to do when you're in that mood, you don't have to put up a front." (P6)*

A few participants had disparate views, where they felt misunderstood and disbelieved by staff, whom they perceived as ignorant, unsympathetic and not accepting of their difficulties, doubting their genuineness and lacking understanding into their illness.

>*"They used to tell me off and say I'd got to get up now, even though I'd be feeling really dizzy. And they'd be, oh stop messing around, and go to school and get up... I remember one staff member saying to me when I was struggling to get up, well I'm not helping you, and I really needed help." (P12)*

Some participants described not feeling listened to or understood when staff made generalisations and assumptions about them, or recorded inaccurate information in their notes based on a "lack of evidence". They also referred to staff "misrepresenting the truth", "spreading rumours" and having the power to influence each other and the patient group about young peoples' difficulties and diagnoses. This made participants feel disempowered and mistrusting of staff members.

"Even if there is a rumour, they [staff] will all talk about it, then they'll believe it, then they'll start asking questions as if it is that... I've told them what's going on, but they've still got a fixed idea in their head... like they just brainwash themselves with it, then brainwash you and the community with it." (P14)

Theme 4: Being supported through difficult times

Most young people valued the availability and accessibility of having "24 hour" support from unit staff and peers. However, a few participants described the conflicts, dilemmas and consequences associated with supporting other young people.

The majority of young people described how staff and peers supported them to manage difficult issues and "get through each day", including motivating them to attend sessions, acknowledging their struggles, praising their efforts and achievements. Participants found it especially helpful to be in groups with staff and peers who were aware of their individual difficulties in order to support them in discussing these.

> "we tend to say so and so managed to get up in the morning even though they were struggling and we all give them a clap in the meetings, and just being able to just say a quick well done, and have it said to you": P12

Young people valued being supported by their keyworkers and other staff in their parental capacity and caring role, as well as in practical and therapeutic ways. This was highlighted by staff setting boundaries, and providing a comforting and nurturing approach, practical support around their care package and more formal 'therapeutic' support. This included helping young people to gain insight into and control of their difficulties, and providing advice and "tool-kits" to manage their problems.

> "if we're trying to cope with stress or just get to sleep, staff will help us and give us like advice on just how to cope with it...I found it much better because if I can't do something on my own, like I usually tend to go to medication but if there's someone there instead to help me and give me advice that like I can do it by myself." (P11)

Participants described the reciprocal nature of peer support, which included providing "a shoulder to cry on", listening, empathising, comforting others through physical contact and "just being together".

> *"I don't want somebody that will give me a solution or give me the answer to everything. I want somebody that can feel what I'm feeling and can understand, not even have to say anything, just to sit there, and just look at me and put their hand on my shoulder...or a hug, that says a lot more than any word." (P10)*

Although participants described having both similar and different problems to each other, the majority felt able to relate to and support others over "common experiences", coping with serious difficulties and being in a similar predicament. Several felt that the support was more genuine coming from peers as it was not perceived as "just words".

> *"The other young people understand more because obviously they're going through a difficult time...they can say look, I've been through the same thing, don't worry about it... it comes better coming from someone that's in a similar situation than someone that knows nothing about it at all." (P6)*

There were a range of positive consequences of being supported and surrounded by young people with 'similar' problems. These included developing friendships, feeling more normal, understood and less isolated. In addition, most appreciated learning from others and sharing ideas and coping strategies of how to manage situations and difficulties in more safe and functional ways.

> *"I've learnt that you've always got someone to fall back on in life...just to talk to someone as opposed to being destructive and punching things." (P6)*

> *"learning you're not, kind of the only one who has these problems, like a lot of people experience them as well, and you are in the same boat... feels like you're not on your own and yeah, just helpful to think that other people go through it as well, so it's a bit comforting." (P2)*

> *"[Re: self-harming] a patient might say, if you feel really bad, if you hold ice cubes that might help...so you can discuss things and strategies and discuss*

ideas, and just kind of see what works for some people and what doesn't work for others." (P10)

However, a few young people felt "overburdened" by the constancy of having to support other young people with their problems and act as "therapists" especially when this was not reciprocated. They referred to not having the "head-space" or energy to listen and contain others' problems, when they had enough of their "own shit" to deal with.

> *"I come here and you're around people with problems and they go on and on about like their issues... and I found that quite annoying because I'm here with problems as well. And it's like I really can't be bothered to listen to it because I've got my own stuff going on...they see me as some kind of agony uncle."* (P8)

Although some young people were conscious of not wanting to "burden" and depend on peers with more "serious" problems, and wanting to protect them from carrying the additional responsibility and stress of looking after their needs, they often felt there was no other option due to staff being unavailable (Theme 7). Although several encouraged each other to seek help from staff when they truly felt "out of their depth" or were holding unsafe information, some felt this was more difficult as they felt an obligation to support their peers, keep secrets and preserve confidentiality despite the consequences.

> *"staff you can offload to like serious problems to but you can't do it to young people here coz you shouldn't, it's not fair, because they got to deal with their own things rather than listening to you and helping you...if you've got a serious illness like you want to kill yourself, go and talk to staff, don't talk to young people."* (P5)

> *I didn't say anything to staff about my friend, and then she took an overdose and I felt guilty."* (P5)

Domain 2: Difficulties, Dilemmas and Dangers on Inpatient Units

The themes in this domain reflect participants' accounts of the complex relational and social processes, 'deviant' sub-cultures and anti-therapeutic aspects arising from 'living' together in the intense inpatient milieu.

Theme 5: Uncertainty of living alongside other illnesses

Young people found living amongst others with different "illnesses" an interesting, enriching, and empowering experience. However, for the majority, it also engendered feelings of fear and uncertainty because of the unfamiliar, unpredictable and inexplicable problems and behaviours of others which many felt unequipped to deal with.

Participants valued the opportunity of being amongst other young people with a range of difficulties, personalities and social backgrounds. They implied that this widened their learning experience and outlook on life, altered their perspectives on mental illness, and helped them "get along" with different people, problems and challenging situations.

> *"you come here and you do see people with other problems and it makes you more open minded in life. It does shape you a bit. I'm going to give credit to it... it does broaden your mind and make you open minded to things that before you'd never heard of." (P8)*

Although young people were curious and inquisitive about certain illnesses, many felt baffled and confused, lacking knowledge and understanding into their causes and nature. Participants felt anxious, frustrated and disempowered because of their lack of skills, information and experience to "handle" others' problems, resulting in their feeling "under pressure" to use their own judgment and knowledge when advising

and supporting their peers. Several described feeling uncomfortable, hesitant and frightened when confronted with "strange and bizarre", unpredictable and dangerous behaviour.

> *"coz there was a boy... and we was told he has psychosis and he was just saying all these things to everyone, and he was like making rude like offers... so it just got a bit strange, I didn't know what to do, I just sat there." (P5)*

> *"one boy was here and he sort of had a tendency to just sort of strip, and it's just, you know, it's very awkward and you don't know what to do... and one person was setting fires and you know that's very dangerous and you kind of... you feel worried about being in a place with somebody like that." (P12)*

Young people were concerned that staff failed to provide sufficient explanation and guidance about the nature and management of different illnesses. This left several feeling unsupported and resentful towards staff for making them carry the additional responsibility of managing others' behaviours "in the right way".

Several young people described fearing being "triggered" themselves, or "triggering off" other young people, in relation to past experiences and presenting difficulties. Participants found it difficult when painful and sensitive issues, experiences and memories were triggered off by their own or others' interactions with peers and staff.

> *"It's not a nice place to be if people are arguing all the time, especially if your home life has been like that... I get really frightened by loud noises because ever since I've grown up that's all I've heard... you're supposed to come here for treatment and then there are just people shouting and yelling and things." (P11)*

Participants also expressed the need to learn about and be sensitive to other young people's issues and feelings, in order to avoid "setting them off" and making them distressed and angry. This resulted in several maintaining more superficial relationships for self-protection and preservation by carefully monitoring what they said, "treading on eggshells" and withdrawing from potentially difficult discussions.

"it's hard, when people have got different illnesses, like what to say and what not to say and if you say something it could be really triggering for someone... but as you stay here you'd sort of, you know where you stand with people and you learn to, what to say and what not to say to them." (P6)

Several participants alluded to the tensions of being in a fragile and unsafe environment. This related to feeling frightened and threatened by angry and violent young people who were unpredictable in nature. Participants' fears included being "started on" or hurt, others harming staff or peers, and the unit being damaged. Although the aggression was often attributed to young people's difficulties, most participants found these behaviours and "outbursts" difficult to accept or comprehend. A few even suggested that staff were "scared" and intimidated by angry young people and referred to a sense of despair at having to "diffuse" and manage threatening situations by themselves. Several participants stated their preference for being on a unit without angry people, suggesting the case mixes should be reassessed.

"People can do some serious damage and it can be really quite scary when people kick off... you see them snap at people that they're usually really friendly with and you worry, you know, that they could really hurt somebody." (P12)

"Some people new are very angry, they're more angry than depressed, and they kick off and they throw things, and some people are depressed because of violence and I don't think they should mix the two in one." (P3)

Theme 6: Being influenced by other young people

Participants emphasised the strong influence of other young people and the powerful nature of the patient group in their unit. Although this had some positive consequences, such as supporting and motivating each other to engage in the programme, many also highlighted the negative influences.

Participants referred to the conflicts and dilemmas associated with peer pressure and social conformity and described the processes and consequences of being drawn into dangerous, risky and destructive behaviours and situations. Although some behaviours, such as sex and experimenting with drugs and alcohol were typical of adolescence, they were often taken to the extreme on the units. Participants described "going along" with their peers in order to be accepted, avoid "losing credibility" and "being outed" from their group. Several felt judged and victimised when they refrained from these behaviours and engaged in safer and more "boring" alternatives. These feelings led to some joining in with destructive behaviours and thereby experiencing a loss of identity. However, despite their joining in, they still felt judged by peers who were "surprised" by their behaviour and conformity.

"There was a girl who became close to us and then she started to do it [drinking] because she wanted to be in with us, and we were like, no you shouldn't be doing this just because we do it, it's not the way to go, we have a problem with it." (P7)

"People are always thinking, oh my god, she's such a boffin...and it makes you feel that people are judging you...and you just try and fit in more, and then like if you try and fit in more and you take drugs and you drink, people are just judging you even more because you're doing something even more extreme." (P11)

Several participants alluded to the 'underworld' of inpatient culture, describing a disparity between their own and staff's reality of life on their unit. This included certain staff appearing oblivious to the extent of the peer pressure and alcohol and illicit substances brought onto the unit. A few participants felt angry towards the young people who were responsible for this, whom they felt were insensitive and ignorant to the harmful effects of substances on those taking medication and presenting with certain illnesses. At the same time, these participants experienced

dilemmas in reporting their peers to staff and suffering adverse consequences as a result.

> " *Sometimes people smuggle things onto the unit and OK, people have problems with drugs but like, bringing them into a hospital, especially when people have psychosis and things and depression which drugs like cannabis and marijuana can make really bad and worse, and alcohol can affect your medication and your mood and things and that's really not helpful.* " *(P12)*

> "*it can be really difficult because yeah, I've been called a grass before, I've been called somebody that tells, like staff's pet and things...and it's like, sometimes you really know you should tell but then you really consider the consequences and know the next day's just going to be hell for you with the other patients.* " *(P11)*

A few participants referred to the difficulties associated with the negative influences of those who appeared to deliberately undermine the treatment programme. This included being intoxicated in groups and sessions, and mocking discussions and activities, making others feel "self-conscious" and bad for "working".

> "*I've been in certain groups that are like movement instead of words... and I've heard people say, oh this is stupid, like you shouldn't be doing it. It kind of makes you feel a bit stupid and childish for actually wanting to do it, so I'd probably just stop. I'd feel really bad and I'd feel like they're totally attacking me.* " *(P12)*

The consequences of breaking unit rules and boundaries included tensions arising amongst the staff and patient groups, including staff complaining about the breach of trust, loss of respect, and breakdown of collaboration. Several participants expressed frustration and resentment around these relational issues dominating group discussions, resulting in their immediate needs, agendas and the "real and therapeutic issues" being pushed aside. A few alluded to these 'impasses' being counter-therapeutic, exacerbating destructive and negative behaviours and increasing patient dishonesty and secrecy.

"People aren't listening to each other, there's no mutual respect, and everyone's living a lie, and not working with each other, it's just so silly, when everyone knows the score and could easily be straight with each other."
(P14)

Another anti-therapeutic aspect of the inpatient stay was that participants described young people learning new "habits" and self-harming behaviours from each other, such as cutting or bingeing, which were thought to make them worse off. These behaviours were seen as ways through which young people could gain attention, be taken more seriously by staff and young people, become accepted, and affiliate with those with similar presentations.

"I've seen like really ill people, people with psychosis, I've seen them start taking drugs and seen them start drinking. I've seen a lot of ill people, I've seen depressed people just pick up cutting and pick up just like, just really destructive behaviour and things and I don't understand it. Why come to get worse." (P11)

"People come in here with little self harm scratches on their arm and it like starts to get out of control. It's like splitting the skin open and stuff, cutting through to the bone, they learn new techniques on how to self harm." (P8)

Theme 7: Not getting my needs met

Several young people described not getting their needs met by staff who they felt were absent, unavailable or inadequate. As a result, they felt disappointed, angry and anxious which led to difficulties with therapeutic engagement. Staff's lack of availability often resulted in participants feeling the need to compete for attention and exaggerate their difficulties in order to be heard. In addition, young people ended up relying heavily on each other for support due to the intensity and immediacy of their needs.

Young people found it difficult, disappointing and frustrating when staff members whom they trusted, valued and relied on, such as their key workers, were absent or

on leave. They felt that such absences compromised the continuity of care and meant that they had to repeat themselves with staff who were less familiar and understanding of their needs. Participants found it difficult when key staff left their unit permanently making them feel anxious and sad, and question their ability to build new therapeutic relationships.

> *"If your keyworker or your nurse is on nights, and then there's nobody you can talk to... that is a big problem... you've built up such a relationship with certain staff and they automatically know if you say bad day, they know probably what it's about...you don't want to have to keep on re-explaining it to different people." (P7)*

> *"Because like you started here with them [keyworker], and you got to know them, and you told em, you kinda worked through your problems with them, and then they leave, and you have to start all over again with someone knew, so it's just a bit unhelpful... coz it's kinda hard to build up another relationship again." (P2)*

Participants felt that some staff were inadequate and incompetent in their professional capacity, and expressed their lack of faith and trust in these people. This included questioning their "natural ability" to work with and understand both adolescents and complex mental health needs. Staff were described as lacking the "common sense", skills and expertise to understand, manage and support them.

> *"Sometimes with some of the staff I just feel like why are they working here...staff don't tend to understand the ways that young...certain things we do are just the same sort of things as anybody, any other young person would do outside of here and it's not because we're in here that we do that sort of thing." (P12)*

A few participants described that staff's "ignorance" about certain illnesses led to young people being placed at risk when resources were not put in place to meet their physical needs. This was highlighted by an example of a patient hurting herself when staff failed to put a pillow behind her head when she had collapsed.

Several young people described feeling abandoned, disappointed and frustrated when staff did not meet their needs or offer sufficient time with them. When this

occurred, participants were more likely to rely more heavily on each other for support leading to some difficulties (see theme 4). Participants attributed staff not meeting their needs to spending time with those they favoured, being preoccupied with other duties, and attending to the needs of those with more severe difficulties or "in crisis". This annoyed several, making them question whether their own difficulties were serious enough to warrant help, and led to envy and resentment towards those perceived to dominate staff's time. Some participants felt intensely irritated by peers who appeared to "compete for attention" by exaggerating their difficulties and "upping the anti", for example, by increasing self-harming and being aggressive and disruptive. However, a few described feeling guilty by those who were in more need or "worse off" than themselves, making them underplay the extent of their own difficulties and push their own needs aside, thereby not accessing the support they required.

> *"Some people did feel that they wasn't getting their needs met because other people were sucking up all the staff time... that's why there was a lot of tension sometimes between young people... and then the young people who probably needed it more weren't getting it." (P7)*

> *"Sometimes when they [staff] bring me into a conversation about how I'm feeling, I feel kind of guilty because I know there's a lot of people going through bad things." (P11)*

Theme 8: Hope or despair

Although young people described a mixed picture in relation to their inpatient stay, the majority felt that they had more positive than negative experiences. Several participants described their admission as worthwhile and helpful, implying their hopes and expectations had been fulfilled. Other participants felt disappointed and disillusioned with the system and angry that their stay had contributed to worsening their difficulties.

Young people described their relief in leaving home and entering a new and protective environment. Several expressed gratitude to the unit for saving them from a stressful situation or helping them to "survive". Most appreciated the opportunity to be in a safe, supportive and containing environment and have the space to think more calmly about their difficulties and "sort their head out". Moving into a different setting seemed to help to reduce the intensity of their illness and prevent further deterioration by changing the pattern and "spiral" of their difficulties.

> *"it was good because it was sort of a safe place to stay, it's away from like the madness of your world and your life and it's like totally you're in a bubble and you're just there, you're kind of away from your parents, you're away from all the situations that got you where you are." (P7)*

> *"well coming here, kind of rescued me out of a position, sometimes you need a place where you are out of life for a bit and there is a bit less pressure." (P14)*

Participants described a range of positive experiences with regard to relationships formed on the unit with staff and peers. They implied that staff and other young people had helped them to make changes in areas of 'intra-psychic' and 'inter-personal' functioning. Examples included participants developing more insight and understanding into their difficulties, learning how to support and care for others, feeling more comfortable and accepting of themselves, and becoming more assertive and confident. In addition, several referred to learning to trust other people, developing attachments that were more secure and forming deeper and more meaningful relationships.

> *"Being in unit helps you to socialise more. It helps you with your confidence and your self-esteem...I'm confident in my mood and the way that I see myself, in the way that I see other people and how supportive and caring I am towards other people. And just trust, and it's kind of like a learning process and it's kind of like learning about yourself." (P10)*

Several young people described that being on the unit helped them to feel better in themselves. This included experiencing a decrease or absence in presenting symptoms and difficulties, a reduction in self harming behaviour and discontinuation of medication use. Participants valued learning a range of helpful and more adaptive coping strategies and resources from staff and other young people, which appeared to help them to feel more in control of their illness and increase their sense of agency. These included learning to reduce aggressive and self-destructive behaviours by accessing support, talking about difficult feelings, learning anger management and relaxation strategies. Young people also learned new ways of expressing themselves, such as using diaries to record their thoughts and feelings, or using the creative medium of art or drama.

> *"I don't put myself in too much danger as I used to with self harming and things. And I think I've got less depressed and I've got less medication than I was on in my past unit."* (P11)

> *"Instead of self-harming, I write my feelings in a book, before I used to let my anger out, I cut my wrists and now I just write it down, and it lets my anger and frustration out."* (P9)

In relation to the longer term, several participants described their sense of hope and optimism for the future which enabled them to move on from their illness and focus more on their goals and aspirations.

> *"As with most people who seen a little light, seeing happiness and a future, and especially football, I always loved it, but now I can start playing it, and I can see a future."* (P14)

However, a few felt let down and angry as they felt their inpatient stay had been pointless, stressful and detrimental. Some felt exposed and vulnerable from the effects of disclosing information they wanted to suppress, and unsupported and uncared for by staff. Others felt rejected and alienated from peers for not conforming to group and social pressures, and having such different needs and difficulties.

Several young people described their hopelessness about recovery near their discharge, due to feeling their and others illnesses had deteriorated or that they had developed new and more severe difficulties.

> *"Their [young people's] self harm increases, and it gets worse. Cuts get deeper and wider and they take overdoses and they drink to excess and they sleep around to feed their habits of drugs." (P8)*

DISCUSSION

The young people in this study talked articulately and at length, with a great deal of emotion and insight, about the complex ways in which relationship factors and processes operated in their units and how these affected the different aspects of their experiences. They reported both positive and negative experiences of relationships: many accounts were characterised by conflicts, confusion and dilemmas. The findings suggested that young people experience similar therapeutic processes and qualities in their relationships with staff and peers, which result in a range of positive consequences. Although this is consistent with research on the benefits of peer support processes within inpatient mental health settings, this study also highlighted the more dysfunctional and anti-therapeutic aspects of relationships, peer support and social processes in adolescent inpatient settings.

Therapeutic Relationships with staff and peers

The themes in Domain 1 reflected the value that young people placed on meaningful and 'therapeutic' relationships with staff and peers. Participants described several conditions, processes and personal characteristics which they believed helped to establish and were important components of these therapeutic relationships; these were similar for both staff and peers. These therapeutic and helpful qualities included staff and peers being empathic, personable, genuine, down to earth, honest, open and trustworthy. In relation to therapeutic processes, participants articulated the importance of feeling respected, validated, heard, understood, accepted and not feeling judged or pathologised by staff and other young people. These findings are consistent with the adult literature on therapist attributes, interpersonal processes and therapeutic relationships (Ackerman & Hilsenroth, 2003; Lambert, 2004; Rogers;

1957), adult users' experiences of relationships with staff and peers on their inpatient units (Loat, 2006; Quirk & Lelliott, 2001; Rogers & Pilgrim, 1994; Rose, 2001; Thomas, Shattell & Martin, 2002; Wood & Pistrang, 2004) and existing research on users' views of 'helper characteristics' in child and adolescent mental health services (Day, Carey & Surgenor, 2006; Hart, Saunders, & Thomas, 2005; Worrall, O'Herlihy & Mears, 2002).

The majority of the literature on therapeutic processes and relationships has been carried out within adult settings where such concepts have been defined by adult populations, theorists and clinicians. It is therefore interesting that similar findings on therapeutic relationships were expressed by the participants in the current study, who were not only users of services but also at a different developmental stage. Furthermore, similar therapeutic processes were described to be occurring and be equally valuable and important amongst the young people, as well as between the young people and staff, extending the concept of such processes beyond the client-therapist relationship to include the client-client dyad. These findings lend further support to theories of "informal helping" (Barker & Pistrang, 2002) suggesting that generic processes of 'formal helping' such as psychotherapy may also extend to 'informal helping' such as social support, provided by peers, partners or fellow patients, and may be particularly significant in light of the nature and importance of peer relations in adolescence (Selman, 1980; Weisz & Hawley, 2002). The findings corroborate research by Loat (2006) and Thomas, Shattell & Martin (2002) on mutual support processes within adult therapeutic community settings and users' experiences of the milieu in adult acute inpatient settings. Participants' accounts are also consistent with Kroll and Green (1997) who extended the concept of the

therapeutic alliance in inpatient child and adolescent settings, from young people and staff, to young people and peers and the therapeutic context.

Therapeutic relationships with staff and peers seemed to have positive consequences, including helping them to engage in the therapeutic process and treatment; talk about, gain insight and make sense of their difficulties; make more meaningful relationships and normalise their experiences and freely express their feelings about their illness. This is consistent with literature on peer support and interpersonal processes (Davidson et al., 1999; Lambert, 2004; Rogers; 1957) and supports the findings of Colton & Pistrang (2004) and Kennedy & Humphreys (1994). On the other hand, young people also described some relationship processes with staff as less therapeutic, for example, feeling misunderstood and pathologised, leading to difficulties with therapeutic engagement, which corroborate findings of Quirk & Lelliot (2001) and Wood & Pistrang (2004) of adult users' experiences of inpatient care.

Although participants described the significance of their therapeutic relationships with staff and peers and clearly articulated the qualities and conditions which facilitated these, it was not possible to establish careful links between these relationships and clinical outcomes or to determine possible mechanisms of change. However, three possible ways of understanding the beneficial influence of these relationships include (1) Therapeutic relational conditions and processes could have facilitated change themselves; (2) Alternatively they may have provided the necessary prerequisite conditions for change to occur, for example, by facilitating therapeutic engagement (Green, et al., 2001; Jacobs et al., 2004; Kroll & Green,

1997) therefore making it easier to adhere to the 'techniques' of treatment such as psychodynamic interpretations; or (3) These therapeutic conditions merely allowed participants to have better experiences and relationships whilst on the unit, for example, helping them feel better about themselves and increasing their self-worth and confidence. Whatever the mechanisms of change might be, participants' accounts highlight the need for adolescent units to be aware of the multi-dimensional therapeutic processes and relationship factors operating in such settings and the potential benefits of such processes. In addition, participants' beliefs of the helpful and therapeutic qualities in their relationships provide valuable information for adolescent units in relation to providing high quality care reflecting the wishes and needs of young people.

The social processes of adolescence

One striking aspect of participants' accounts was the value they placed on being viewed as people outside of their problems and the relief associated with continuing to be normal adolescents in such unusual settings and engaging in the social processes and peer relationships typically associated with adolescence (see Theme 1). This was achieved by, for example, conversing with staff and peers about topics unrelated to their illnesses. Although these social interactions are often seen as a part of the routine life in inpatient settings, participants' accounts highlighted the significance of such interactions and support findings of Rose (2001). These included helping participants establish good and helpful relationships through feeling more validated and respected and making their inpatient experiences more manageable. It is interesting that even though these units were located within psychiatric hospital settings, run by mental health professionals and used

pharmacological and psychological interventions, participants still described being able to separate themselves from their difficulties, 'patient' identity, feel like normal teenagers and focus on engaging in normal adolescent activities. This phenomenon may be explained by the units' efforts to be non-institutional and minimise the impact of the 'illness' philosophy, or by participants' needs to avoid missing out on the typical aspects of their developmental stage, where peer relations and social interactions are key to the psycho-social and adaptive functioning of adolescents (Holmbeck et al., 2000). Alternatively, focusing on normal social activities and interactions may have enabled some to avoid facing their difficulties.

Although the desire to be normal adolescents in an abnormal environment appeared to facilitate developmentally appropriate behaviour, participants also described throughout themes 5-7, the more dysfunctional and anti-therapeutic aspects and consequences of group and social processes on their units supporting the findings of other studies with young people (Colton & Pistrang, 2004; Green & Jones, 1998; Jaffa & Stott, 1999) and with adult users of inpatient care (Baker, 2000; McGeorge & Lelliott, 2000). These processes included participants being subjected to peer pressure, engaging in extreme forms of substance abuse, and learning new destructive behaviours such as self-harming, resulting in some cases in young people's deterioration, loss of identity and undermining of the work carried out in therapeutic groups. Such dysfunctional behaviours and processes may have been intensified in these settings as a result of the 'milieu' approach and the intensity of the inpatient environment and relationships, and the effects and severity of the young people's difficulties. This is consistent with the findings of Dishion, McCord & Poulin (1999) around the iatrogenic effects of peer aggregation with certain groups.

However, the occurrence of these 'deviant' behaviours and social processes could be understood and expected in relation to aspects of adolescent development where certain groups commonly engage in anti-social, rebellious or destructive behaviours often as a result of peer pressure, group affiliation and internal difficulties (Brown, Clasen & Eicher, 1986; Weisz & Hawley, 2002). Despite these possible explanations, it is concerning that these behaviours and processes led to such detrimental consequences in these units. Participants described feeling the need to conform to such anti-therapeutic social processes and pressures in order to be accepted and gain attention from peers despite the costs. This is consistent with Erikson's (1968) stage theory of psychosocial development in which adolescence requires individuals to negotiate the processes of group identity versus alienation. This involves the need for adolescents to become affiliated with, belong to and be accepted by a peer group in order to avoid isolation. It may be that in addition to experiencing these normal adolescent developmental processes, participants were more desperate to belong to a peer group in light of their previous experiences of rejection, making them more susceptible to peer pressure and engaging in deviant behaviours with their inpatient peers.

In addition to factors of social conformity, these dysfunctional behaviours and social processes could be understood in a similar way to the functional aspects of such adolescent social processes and seen as a defensive manoeuvre in order for young people to avoid the more difficult aspects of the therapeutic programme. Although it is unlikely that experienced clinicians were oblivious to the deviant 'sub-culture' on the units, it may have been possible that they were unaware of the extent, pull and implications of such processes, which therefore need to become more transparent to

prevent experiences becoming anti-therapeutic and further deterioration occurring. Participants' accounts also highlighted a conflict occurring between the patient and staff group, where a mismatch of expectations, goals and agendas was sometimes evident amongst both parties, resulting in a therapeutic impasse (Safran & Muran, 2000). On the one hand, staff were described as needing to explore the nature and causes for such dysfunctional behaviours, and address issues of rules, trust, respect and collaboration with the patient group in order for reparation to occur. On the other hand, participants felt that this resulted in the more 'pressing' issues e.g. their suicidal attempts being pushed aside, and those who had not been involved in such behaviours resented their therapy time being 'wasted' on discussing such issues.

Difficulties and challenges may arise in a number of ways in relation to how to address and manage the dysfunctional behaviours and social processes which exist in such settings. Adolescent inpatient populations are very complex: presenting problems and issues could be attributed to the individual patient, the therapeutic dyad (peer-peer or patient-therapist) the peer group or even the milieu, resulting in difficulties being addressed and support being received at these various different levels. Staff are therefore faced with the complex task of trying to manage which types of difficulties should be addressed, in what ways, and at what level. It may be important for staff to be able to address issues related to deviant behaviours and issues related to young people's other difficulties in separate forums, in order to meet patients expectations and goals, preserve the therapeutic alliance and ensure that all young people have sufficient time to discuss their needs. In addition, units may benefit from having a set of therapeutically informed procedures to address and manage these dysfunctional processes involving boundaries, limits and

consequences. However, in doing so, clinicians face the challenge of preserving their therapeutic role and relationship with clients whilst simultaneously adopting a management and authoritative parenting style role (Maccoby & Martin, 1983).

Peer support

Theme 4 clearly reflected participants' experiences of the functional aspects and positive consequences of peer support on the unit, for example, being encouraged to participate in the therapeutic programme, and sharing common experiences which resulted in them feeling more normal, understood and less isolated. These findings are consistent with other studies (Billings, 2005; Colton & Pistrang, 2004; Davidson et al., 1999; Loat, 2006; Yalom, 1995; Thomas, Shattell & Martin, 2002; Wood & Pistrang, 2004) which have highlighted the benefits of peer support with young people and adults with severe mental illness in inpatient, community and group settings. Participants also expressed the value of peer support in helping them to learn different, safer and more adaptive coping strategies to manage their difficulties, supporting findings of other studies (Kennedy & Humphreys, 1994; Kurtz, 1990; Stewart, 1990). On the other hand, the themes reflected in Themes 4, 5 & 7 highlighted some of the more dysfunctional aspects and dilemmas surrounding peer support processes, for example, participants feeling burdened and overwhelmed by the demands of their peers. Consequences of this included young people carrying the additional responsibility of supporting others, putting their own needs aside, and holding information with potentially dangerous consequences in order to preserve confidentiality and remain loyal to their peers, supporting the findings of Loat (2006) and corroborating the nature of typical peer relational processes in adolescence. In addition, although participants demonstrated a curiosity to learn about their peers'

difficulties, many felt anxious and disempowered in lacking the knowledge and skills to understand and manage unfamiliar and unpredictable presentations, resulting in their feeling unable to effectively support others (Loat, 2006). Furthermore, participants described their fear and uncertainty when confronted with angry and threatening adolescents, leading to the formation of more superficial relationships for self preservation, and their taking on of further responsibility when managing difficult situations without staff. These findings are consistent with Bobier and Warwick (2004), and also support research carried out in adult inpatient wards (Baker, 2000; Quirk & Lelliott, 2001; Wood & Pistrang, 2004) and raise important implications regarding the safety and fragility of the inpatient environment.

These results present another challenge and dilemma to clinicians working in adolescent units in relation to the complex issue of how to empower young people and provide them with the necessary tools to support each other and maximise the use of peer support and the milieu approach in these settings. Although the young people appeared to want more information and guidance on the nature, aetiology and management of certain difficulties in order to support their peers, staff are faced with the ethical and moral dilemma of preserving patient confidentiality. One possible solution may be to incorporate more psycho-educational approaches into the unit programme around typical presentations found in these settings. Alternatively ideas could be used from the emerging literature on the expert-patient approach with mental health populations (Davidson, 2005), where young people could educate each other about the nature of their difficulties in order to help with their management. Another solution may be to follow the wishes of some participants and re-assess the case mix with a view to separating young people presenting with anger and anti-

social difficulties from those presenting with more internalising difficulties. However, this may be very difficult to achieve and out of clinicians' control, in light of the scarcity of inpatient resources, the need to ensure high bed occupancy, and high levels of co-morbidity in this population.

Participants described being supported by staff in therapeutic, practical and nurturing ways, reflecting their dual roles in parenting and professional capacities. However, young people's accounts also demonstrated differing views and perceptions around feeling unsupported by staff, for example, when keyworkers were absent, or staff were unavailable and unable to sufficiently meet their needs, supporting findings of adult research (Quirk & Lelliott, 2001; Thomas, Shattell & Martin, 2002; Wood & Pistrang, 2004). Furthermore, young people reported that some staff who were present, lacked the skills, knowledge and understanding to work with both adolescents and with specific mental health difficulties (Thomas, Shattell & Martin, 2002). Participants described that the unavailability and inadequacy of staff resulted in them becoming over-reliant and dependent on each other for support, and also competing for attention from certain staff by exaggerating their difficulties in order to be heard (Quirk & Lelliott, 2001). Young people's perceptions of staff being unavailable and incompetent may be explained by typical aspects of the developmental stage of adolescence and resulting hostility towards adult efforts (Holmbeck, 1996; Laursen, 1995), or influenced by the effects of their illness and previous experiences, such as being abandoned or rejected by parental figures. However, participants' views may also reflect the reality of the limited resources on these units where there are often high levels of staff absence and not enough staff to meet the needs of the population.

These findings point to a number of important implications for clinicians working in these settings. It is essential that units are made aware of and address the extremes which young people are going to in order to gain their attention and get their needs met. Units would also benefit from ensuring that adequate and consistent staffing, support, resources and training are available to ensure provision of high quality care which could meet young people's needs sufficiently and reduce the likelihood of staff absence (QNIC, 2003). For example, training could be set up for clinicians on the developmental processes of adolescence and the nature and management of severe and complex mental health difficulties.

Methodological Limitations

The findings of this study should be considered in the context of a number of methodological limitations. Although the inclusion criteria clearly reflected the heterogeneity of generic inpatient populations, several young people selected for the study refused or were unable to participate. This resulted in the exclusion of young people who might have had different perspectives on relationship and social processes, for example, those presenting with autistic spectrum disorders, or those who may have been withholding information in fear of disclosure and confidentiality.

When considering the validity of participants' accounts, a number of issues must be taken into consideration. First, participants were interviewed whilst they were still on the unit which may have resulted in them being less able to stand back and think more objectively about their experiences. Different results may have been obtained once participants had time to reflect on their experiences following their discharge

from their unit. Second, although qualitative research involves capturing experiences and hearing subjective accounts of people's narratives whatever the nature of their difficulties, young people's perceptions of their inpatient experiences and relationships may have been influenced by the severity, nature and effects of their difficulties. For example, those presenting with depressive features or paranoid ideation may have interpreted their relationships in a more negative or mistrusting way which may have changed at a different stage of their illness. It may therefore have been useful to use some quantitative measures alongside this research to measure the severity of participants' illness and impairment and gain more insight into how their difficulties may have impacted on their general well-being, interpersonal functioning and perceptions. Third, in relation to the well recognised issue of researcher subjectivity in qualitative research, the effects of this was managed by carrying out credibility checks and an audit of the analytic process with two supervisors to ensure that the themes generated accurately represented the data. However, testimonial validity was not assessed with the participants in order to check that the results and themes accurately reflected their accounts (Elliott, Fischer, & Rennie, 1999).

Future Research and Clinical Implications

This study used an exploratory approach to examine young people's perceptions of their relationships with staff and peers and the impact of these on their treatment in generic inpatient adolescent units. One next step for further research would be to quantify these findings by designing a measure defining the therapeutic relationship conditions articulated by the participants in the current study. This could then be used in quantitative studies to measure the extent to which these factors are present

127

in other adolescent inpatient units and then be used as a tool to assess the effects of these factors on outcomes and service satisfaction.

One of the implications of the findings in this study is that therapeutic processes in adolescent units should be conceptualised as extending to peer relationships; that is the therapeutic alliance and the therapeutic relationship in adolescent inpatient settings needs to be viewed in a multi-dimensional way (Kroll & Green, 1997). However, because no quantitative measures were used, information on direct associations to outcome and which variables may have led to specific effects and change was not obtainable. Future studies may benefit from using therapeutic relationship or multiple alliances measures such as the Family Engagement Questionnaire (Kroll & Green, 1997) alongside qualitative interviews in order to further explore the significance of relationships, and measure the relationship between process and outcome variables with young people, staff and peers in inpatient settings.

More research is clearly needed on the negative and dysfunctional effects of peer support, group and social processes in inpatient adolescent settings which appear to be intensified as a result of the milieu, nature and developmental stage of this population. Future research could explore staff experiences of the peer and social processes operating in adolescent units and investigate the potential difficulties and dilemmas that clinicians face arising from these processes.

In addition, further research may benefit from piloting interventions which aim to maximise the positive effects of peer and social processes and reduce the iatrogenic

effects of these processes on adolescent units in order to maximize patient benefit. This could be achieved by ensuring maximum staffing input to meet patients' needs, incorporating ideas from the expert patient approach into the treatment programme, and providing staff with training aimed at helping them understand and manage the complex relational and social processes and deviant sub-cultures that may be operating in their units.

Conclusions

Although some participants alluded to socialising into inpatient culture and seemed to value the protective and 'containing' environment of the unit supporting findings of (Thomas, Shattell & Martin, 2002), some described finding the 'milieu' and 'talking' culture too intensive and difficult to manage, lacking understanding into its purpose and experiencing analytic interpretations as unhelpful and detrimental. In addition, although participants described benefiting from the therapeutic and social processes with peers and staff, accounts also highlighted the dysfunctional nature of these processes. It is therefore important to consider that inpatient treatment may not be suitable or beneficial for all young people with complex and severe difficulties, and more stringent measures appear to be needed to assess the case-mix and the type of young people who may benefit from this type of care. For example, young people with autistic spectrum disorders may not benefit from such intensive social interactions and those who do not find analytical models of intervention helpful may have difficulties in engaging and making the most of the therapeutic programme. In addition, young people with anti-social behaviour often appear to have a negative influence on their peers in adolescent units, therefore questions should be asked about whether the potential benefit they may gain from using inpatient services outweighs the cost of the majority of the adolescent inpatient population. However, the major difficulty faced by service providers at present is that there appears to be a lack of suitable alternative services for this population.

REFERENCES

Ackerman, S.J., & Hilsenroth, M.J. (2003). A review of therapist characteristics and techniques positively impacting the therapeutic alliance. *Clinical Psychology Review, 23,* 1-33.

Baker, S. (2000). *Environmentally friendly? Patients' views of conditions on psychiatric wards.* London: MIND.

Barker, C., & Pistrang, N. (2002). Psychotherapy and social support. Integrating research on psychological helping. *Clinical Psychology Review, 22,* 361-379.

Barker, C., Pistrang, N., & Elliot, R. (2002). *Research Methods in clinical psychology: An introduction for students and practitioners* (2nd ed.). Chichester: Wiley.

Bergin, A.E., & Garfield, S. (1994). *Handbook of Psychotherapy and Behavior Change* (4th Edn.). New York: Wiley.

Billings, J. (2005). Making Sense of First Episode Psychosis. Doctorate in Clinical Psychology, University College London.

Blanz, B., & Schmidt, M.H. (2000). Practitioner Review: Preconditions and Outcome of Inpatient Treatment in Child and Adolescent Psychiatry. *Journal of child Psychology and Psychiatry, 41* (6), 703-712.

Bobier, C., & Warwick, M. (2004). Factors associated with readmission to adolescent psychiatric care. *Australian and New Zealand Journal of Psychiatry, 39,* 600-606.

Bobier, C., & Warwick,M. (2005). Factors associated with readmission to adolescent psychiatric care. *Australian and New Zealand Journal of Psychiatry, 39,* 600-606.

Bordin, E.S. (1979). The Generalizability of the Psychoanalytic Concept of the Working Alliance. *Psychotherapy: Theory, Research and Practice, 16* (3), 252-260.

Borkman, T.J. (1999). *Understanding self-help/mutual aid: Experiential learning in the commons.* New Brunswick, NJ: Rutgers University Press.

Brown, B.B., Clasen, D.R., & Eicher, S.A. (1986). Perception of peer pressure, peer conformity dispositions, and self reported behaviour among adolescents. *Developmental Psychology, 22,* 521-530.

Carr, A. (2000). *What Works with Children and Adolescents: A critical Review of Psychological Interventions with Children, Adolescents and their Families.* London, Routledge.

Cole, M., & Cole, S.R. (1989). *The Development of Children.* New York, Scientific Books.

Colton, A., & Pistrang, N. (2004). Adolescents' Experiences of Inpatient Treatment for Anorexia Nervosa. *European Eating Disorders Review, 12,* 307-316.

Cotgrove, A.J., & Gowers, S.J. (1999). Use of an adolescent in-patient unit. *Advances in Psychiatric Treatment, 5,* 192-201.

Davidson, L. (2005). Recovery, Self-Management and the expert patient-changing the culture of mental health from a UK perspective. *Journal of Mental Health, 14* (1), 25-35.

Davidson, L., Chinman, M., Kloos, B., Weingarten, R., Stayner, D., & Tebes, J.K. (1999). Peer Support Among Individuals With Severe Mental Illness: A Review of the Evidence. *Clinical Psychology: Science and Practice, 6* (2), 165-187.

Day, C., Carey, M. & Surgenor, T. (2006). Children's key concerns: piloting a qualitative approach to understanding their experience of mental health care. *Clinical Child Psychology and Psychiatry,* 11(1), 139-155.

Department of Health (2004). *National Service Framework for Children, Young People and Maternity Services.* London: Department of Health.

Dishion, T.J., Andrews, D.W., & Crosby, L. (1995). Antisocial boys and their friends in early adolescence: Relationship characteristics, quality, and interactional process. *Child Development, 66,* 139-151.

Dishion, T.J., McCord, J., & Poulin, F. (1999). When interventions harm: Peer groups and problem behaviour. *American Psychologist, 54,* 755-764.

Elliot, R., Fischer, C.T., & Rennie, D.L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology, 38,* 215-229.

Erickson, E. (1968). *Identity, Youth and Crisis.* New York: Norton.

Fonagy, P., Target, M., Correll, J.P., Phillips, G., & Kurtz, Z. (2002). *What Works for Whom? A critical review for Children and Adolescents.* New York: The Guilford Press.

Goffman, E. (1959). The moral career of the mental patient. *Psychiatry, 22,* 123-142.

Green, J. (2002). Provision of Intensive Treatment: Inpatient Units, Day Units and Intensive Outreach. In M.Rutter & E.Taylor (Eds.), *Child and adolescent psychiatry, modern approaches, 4th ed.* (pp.1038-1950). London: Blackwell.

Green, J. (2006). Annotation: The therapeutic alliance – a significant but neglected variable in child mental health treatment studies. *Journal of Child Psychology and Psychiatry, 47* (5), 425-435

Green, J.M., & Burke, M. (1998). The ward as a therapeutic agent. In J.M. Green & B.W. Jacobs (Eds.), *Inpatient Child Psychiatry: Modern Practice Research and the Future* (pp 93- 110). London: Routledge.

Green, J., & Jacobs, B. (1998). *Inpatient Child Psychiatry: Modern Practice, Research and the Future.* London, Routledge.

Green, J.M., & Jones, D. (1998). Unwanted effects of inpatient treatment: anticipation, prevention, repair. In J.M. Green & B.W. Jacobs (Eds.), *Inpatient Child Psychiatry: Modern Practice Research and the Future* (pp 212-220). London: Routledge.

Green, J. M., Kroll, L., Imre, D., Frances, F.M., Begum, K., Gannon, L., & Anson, R. (2001). Health Gain and outcome predictors during inpatient and related day treatment in child and adolescent psychiatry. *Journal of the American Academy of Child and Adolescent Psychiatry, 40,* 325-332.

Gowers, S.G. (2001). *Adolescent Psychiatry and Clinical Practice.* London:Oxford University Press.

Gowers, S.G., & Rowlands, L. (2005). Inpatient Services. *Current Opinion in Psychiatry, 18,* 445-448.

Gunderson, J. (1978). Defining the therapeutic processes in psychiatric milieus. *Psychiatry, 41,* 327-335.

Hart, A., Saunders, A. & Thomas, H. (2005). Attuned practice: a service user study of specialist child and adolescent mental health, UK. *Epidemiologia e Psichiatria Sociale*, 14 (1), 22-31.

Holmbeck, G.N. (1996). A model of family transformations during the transition to adolescence: Parent-adolescent conflict. In J. Graber, J. Brooks-Gunn, & A. Peterson (Eds.), *Transitions through adolescence: Interpersonal domains and contexts* (pp. 167-199). Mahwah, NJ: Erlbaum.

Holmbeck, G. N., Colder, C., Shapera, W., Westhoven, V., Kenealy, L., & Updegrove, A. (2000). *Working with Adolescents: guides from developmental psychology.* In P. C. Kendall (Ed.), Child and Adolescent therapy: *Cognitive-behavioural procedures* (pp.334-385). New York: Guilford Press.

Imrie, D. & Green, J.M. (1998). Research into Efficacy and Process of Inpatient Treatment. In J.M. Green & B. Jacobs (Eds.), *Inpatient Child Psychiatry: Modern Practice Research and the Future* (pp. 333-339). London: Routledge.

Jacobs, B.W., Beecham, J., Briskman, J., Tobias, C., Green, J., Kroll, L., Dunn, G., & Baird, L. (2004). CHYPIE- The children and Young Persons Inpatient Evaluation Study: Two and a Half Thousand Hours. Report for the Department of Health, UK.

Jackson, S., & Stevenson, C. (2000). What do people need psychiatric and mental health nurses for? *Journal of Advanced Nursing, 31* (2), 378- 388).

Jaffa, T., & Stott, C. (1999). Do Inpatients on adolescent units recover? A study of outcome and acceptability of treatment. *European Child & Adolescent Psychiatry, 8,* 292-300.

Kendall (Ed.), Child and Adolescent therapy: *Cognitive-behavioural procedures* (pp.334-385). New York: Guilford Press.

Kennedy, M., & Humphreys, K. (1994). Understanding worldview transformation in mutual help groups. *Prevention in Human Services, 11,* 181-189.

Kroll, K., & Green, J. (1997). The Therapeutic Alliance in Child Inpatient Treatment: Development and Initial Validation of a Family Engagement Questionnaire. *Clinical Child Psychology and Psychiatry, 2* (3), 431-447.

Kumar, S., Guite, H., & Thornicroft, G. (2001). Service users' experience of violence within a mental health system: A study using grounded theory approach. *Journal of Mental Health, 10,* (6), 597-611.

Kurtz, L. F. (1990). The self-help movement: Review of the past decade of research. *Social work with groups, 13,* 101-115.

Lambert, M.J. (2004). In Bergin & Garfield (Eds.), *Handbook of Psychotherapy and Behaviour change.* New York: Wiley.

Laursen, B. (1995). Conflict and social interaction in adolescent relationships. *Journal of Research on Adolescence, 5*, 55-70.

Lieberman, M.A. (1993). Self-help groups. In H.I. Kaplan & B.J. Sadock (Eds.), *Comprehensive Group Psychotherapy*. Baltimore: Williams & Wilkins.

Loat, M. (2006). Sharing the Struggle: An Exploration of Mutual Support Processes in a Therapeutic Community. *Therapeutic Communities: International Journal for Therapeutic and Supportive Organizations, 27* (2), 211-228.

Maccoby, E. & Martin, J. (1983). Socialisation in the context of the family: parent-child interaction. In P.H. Mussen (Ed.). *Handbook of Child Psychology, Vol 4*. New York: Wiley.

Masten, A. S., Best, K.M., & Garmezy, N. (1990). Resilience and Development: Contributions from the study of children who overcome adversity. *Development and Psychopathology, 2*, 425-444.

May, R. (2000). Routes to recovery from psychosis: The roots of a clinical psychologist. *Clinical Psychology Forum, 146*, 6-10.

McGeorge, M., & Lelliot, P. (2000). *Managing Violence in psychiatric wards: Preliminary findings of a multi-centre audit*, Royal College of Psychiatrists' Research Unit, Report. London.

Newnes, C., Holmes, G., & Dunn, C. (Eds.). (2001). *This is madness too: Critical perspectives on mental health services.* Ross-on-Wye: PCCS Books.

O'Herlihy, A., Worrall, A., Banerjee, S., Jaffa, T., Hill, P., Mears, A., Brook, H., Scott, A., White, R., Nikolaou, V. & Lelliott, P. (2001) *National In-Patient Child and Adolescent Psychiatry Study (NICAPS).* Final Report to the Department of Health. London: Royal College of Psychiatrists' Research Unit.

O' Herlihy, A., Worrall, A., Lelliott, P., Jaffa, T., Hill, P., & Banerjee, S. (2003). Distribution and characteristics of in-patient child and adolescent mental health services in England and Wales. *British Journal of Psychiatry, 183,* 547-551.

Parry Jones, W. (1995). The future of adolescent psychiatry. *British Journal of Psychiatry, 166,* 299-305.

Peplau, H. (1989). The history of milieu as a treatment modality. In A. O'Toole & S.R. Welt (Eds.), *Interpersonal theory in nursing practice: Selected works of Hildegard E. Peplau* (pp. 75-79). New York: Springer.

Pigeon, N., & Henwood, K. (1996). Grounded Theory: Practical Implementation. In J.T.E. Richardson (Ed.), *Handbook of qualitative research methods for psychology and the social sciences.* Leicester: BPS Books.

Quirk, A., & Lelliott, P. (2001). What do we know about life on acute psychiatric wards in the UK?: a review of the research evidence. *Social Science and Medicine, 53* (12), 1-10.

Quirk, A., & Lelliott, P. (2004). Users' Experiences of inpatient services. In P. Campling, S. Davies & G. Farquharson (Eds.), *From Toxic Institutions to Therapeutic Environments*. London: Gaskell.

Rogers, C.R. (1957). The Necessary and Sufficient Conditions of Therapeutic Personality Change. *Journal of Consulting Psychology, 21* (2), 95-103.

Rogers, A., & Pilgrim, D. (1994). Service users' views of psychiatric nurses. *British Journal of Nursing, 3* (1), 16-18.

Rose, D. (2001). *Users' voices: The Perspectives of Mental Health Services Users on Community and Hospital Care.* London Sainsbury Centre for Mental Health.

Rosenhan, D.L. (1973). On Being Sane in Insane Places. *Science, 179:* 250-258.

Royal College of Psychiatrists' Research Unit. (2003) QNIC- Quality Network for In-patient CAMHS: Service Standards. London: Royal College of Psychiatrists' Research Unit.

Safran, J.D., & Muran, J.C. (2000). Introduction. *JCLP/In session: Psychotherapy in Practice, Vol. 56* (2), 159-161.

Safran, J.D., & Muran, J.C. (2000). *Negotiating the Therapeutic Alliance: A Relational Treatment Guide.* New York: The Guilford Press.

Selman, R.L. (1980). *The growth of interpersonal understanding: Developmental and clinical analysis.* New York: Academic Press.

Shirk, S.R., & Karver, M. (2003). Prediction of Treatment Outcome From Relationship Variables in Child and Adolescent Therapy: A Meta-Analytic Review. *Journal of Consulting and Clinical Psychology, 71* (3), 452-464.

Smith, J.A. (1996). Evolving issues for qualitative psychology. In J.A. Smith, R. Harre & L. Van Langenhove (Eds.), *Rethinking methods in psychology.* London: Sage. 9-26.

Smith, J.A., & Osborne, M. (2003). Interpretative Phenomenological Analysis. In J.A. Smith (Ed.), *Qualitative Psychology: A Practical Guide to Research Methods.* London: Sage.

Stewart, M.J. (1990). Expanding theoretical conceptualizations of self-help groups. *Social Science and Medicine, 31,* 1057-1066.

Stiles, W.B., Shapiro, D.A., & Elliot, R. (1986). "Are all Psychotherapies Equivalent?" *American Psychologist, 41* (2), 165-180.

Sutherland, S. (1977). *Breakdown: A Personal Crisis and a Medical Dilemma.* London: Granada.

Svanberg, J. & Street, C. (2003). *Where Next - New directions in inpatient mental health services for young people.* London: Youngminds.

Thomas, S.P., Shattell, M., & Martin, T. (2002). What's therapeutic about the therapeutic milieu? *Archives of General Nursing, XVI* (3), 99-107.

Weisz, J. R., & Hawley, K.M. (2002). Developmental Factors in the Treatment of Adolescents. *Journal of Consulting and Clinical Psychology, 70* (1), 21-43.

Wood, D., & Pistrang, N. (2004). A Safe Place? Service Users' Experiences of an Acute Mental Health Ward. *Journal of Community & Applied Social Psychology, 14,* 16-28.

Worrall, A., O' Herlihy, A., & Mears, A. (2002). Child and Adolescent Psychiatric In-patient units: young people's views. *Childright, 196,* 10-11

Yalom, I.D. (1995). *The theory and practice of group psychotherapy.* New York: Basic Books.

York, A., & Lamb, C. (2005). Building and Sustaining Specialist CAMHS, Child and Adolescent Faculty, Royal College of Psychiatrists.

PART THREE: CRITICAL APPRAISAL

A reflection on the process of conducting research with young people in adolescent inpatient units

Introduction

This paper is a critical appraisal and reflection of the research process. It will discuss the challenges and dilemmas which arose when designing, conducting and writing up the research, in relation to personal, professional and methodological issues. The paper is split into four main sections and will consider (1) personal reflections and previous experiences influencing my choice of study, (2) challenges and rewards of interviewing adolescent inpatients, (3) methodological issues related to the validity and accuracy of young people's accounts, and (4) conclusions and importance of eliciting users' views.

1. Personal Reflections

My decision to conduct this research and explore young people's experiences of relationships with staff and peers in adolescent inpatient settings was largely influenced by two major factors. Firstly, my personal experiences of living with my sister who suffered throughout her adolescence and then died from anorexia nervosa made me question the availability and benefits of the treatments available for young people with such complex and severe illnesses. During her battle with anorexia, she received inpatient treatment from both specialist eating disorder and generic adolescent inpatient units. Although I believe that she gained some benefits from these services, I also questioned the nature, quality and effectiveness of care being delivered, for example, the 'mixture' of treatments received and the quality and professionalism of the staffing. My scepticism about adolescent units grew when hearing her accounts of some of the negative experiences encountered in these

settings, for example, learning about one of the treatment regimes delivered in an eating disorder service using the force feeding approach, which I perceived to be punitive, ineffective, and unethical.

My motivation to carry out this study also related to my experiences of working in my first clinical post as a 'Groupworker' in one of the generic adolescent units in London used in this study. This experience left me with very mixed views about the positive and negative aspects and consequences of these units, reinforced my scepticism about the benefits of such care for young people with such severe and acute difficulties, and motivated me further to explore young people's experiences of what they found to be helpful or unhelpful experiences of such care. When working in this unit, I was particularly struck by the intensity of this type of environment, and how easy it was as a professional to become drawn into the 'milieu' and inpatient culture, the staff and patient group dynamics which were so interlinked, and the politics and hierarchies inherent in such settings.

In relation to the positive aspects of inpatient adolescent treatment, my personal and professional experiences allowed me to gain insight into the value and significance that young people attributed to their relationships with staff and peers during their stay. These experiences included being struck by the intensity and reciprocity of support and care provided between young people, learning about the importance and meaning attached to making trusting and non-superficial friendships, and being moved by accounts of young people feeling able to relate to others also experiencing mental illness and feeling accepted and a sense of belonging often for the first time. In addition, my experiences allowed me to observe the significance of young people

forming positive, trusting and 'secure' attachments and relationships with staff, which for some, was a novel experience contrasting with previous experiences of parental and adult relationships. However, despite these positive consequences, I also learned about the difficulties associated with staff members whom young people were close with or depended on, being frequently off sick or on leave, leaving young people feeling very disappointed and anxious.

My optimism was further overshadowed from accounts and observations of the more negative aspects of adolescent units, for example, becoming concerned by the more unhelpful and destructive elements of young people's relationships with staff, especially in light of their vulnerability and the severity and effects of their difficulties. This included witnessing some staff's abuse of power, controlling and authoritarian approaches towards young people, and observing professionals display favouritism and seductive behaviour to certain adolescents. In addition, my experiences enabled me to gain insight into the powerful influences of the peer group including the effects of peer pressure, bullying, forming unsafe and 'enmeshed' relationships, and the influence of learning destructive behaviours from each other. Finally, my observations on this unit made me question the value of having such a heterogeneous case-mix in generic settings when some young people felt afraid, confused or negatively influenced by others' illnesses and behaviours, and were unable to relate to those whose difficulties and backgrounds were perceived as so different.

In addition to these personal and professional experiences, my quest to find answers about whether adolescent units were sufficient resources in themselves to help young

people with very severe and life threatening illnesses survive, and my interest in exploring which factors may be associated with young people benefiting or deteriorating from their inpatient treatment also led me to carrying out this study.

When designing the research, I chose relationships with staff and peers to be the main focus of the study as they appeared so fundamental to the inpatient philosophy and milieu, a central aspect of the therapeutic programme and overall experience, and key to young people's developmental life stage. I opted for a qualitative study as it fit with my beliefs around the importance of eliciting rich and meaningful information and unique insights about individual experiences and situations (Smith & Osborn, 2003). In addition, I felt that it was particularly important to listen to and empower the young people to talk about their views and perceptions of relationships and the impact of these on their experience and treatment, and to discover more about which aspects they found helpful or unhelpful. In doing this, I aimed to gain unique insights from the users themselves, which could be then fed back into similar services, with a view to improving the quality of care and practice and making services more adolescent-led (Day, Carey & Surgenor, 2006).

On the one hand, having such a personal interest in this study was helpful in maintaining motivation and interest throughout the duration of the research. However, on the other hand, this led to me developing extremely high standards and expectations for this study, and becoming over-inclusive in the material covered in the literature review and within the different stages of the research process.

2. The challenges and rewards of interviewing adolescent inpatients

In interviewing adolescents with serious mental health difficulties I faced several challenges and obstacles which had to be overcome throughout the interview process in order to try to achieve the best quality and richest data set possible.

Establishing engagement

Before carrying out the qualitative interviews, I was conscious of the importance of establishing rapport and engagement with the young people in the units (Green, 2006) in order to increase the likelihood of their participation, help them to feel comfortable to talk, and try to ensure that the best quality of information could be elicited from the interviews. I perceived that engaging this population could prove to be particularly challenging for several reasons. These included the potential difficulties of motivation and adolescent attitudes towards talking to unfamiliar adults, and asking young people with complex backgrounds and severe difficulties to talk about personal feelings and issues related to their care and relationships with somebody whom they did not know or trust. Furthermore, I anticipated that the majority of the young people were unlikely to have initiated their own referral to inpatient services and may not have acknowledged the need for such treatment or resented having to be on the unit (Shirk & Russell, 1998). These factors may have impacted on young people's wish to talk about their inpatient experiences and resulted in their resistance to take part. The following steps were therefore taken in order to try and overcome these potential obstacles to engagement.

1. Recruiting participants for the study

When recruiting participants and trying to establish rapport, the following measures were taken to try to ensure that participants would feel safe and comfortable to take part (1) giving a clear rationale for the purpose of my research study, (2) strongly emphasising that confidentiality and anonymity would be preserved throughout the interviews and when writing up the study, (3) explaining exactly what would be done with the information following the interviews, and (4) discussing the purpose and importance of conducting this study and hearing young people's views with a view to making a difference and improving such services in the future. In addition, before conducting the interviews, I spent some time on the units getting to know the young people informally, for example, when eating lunch with them, and chatting during their free time about their interests or hobbies and their general experiences of being on the unit. I also tried to establish rapport by sharing some of my interests and previous experiences of working on adolescent units which helped them to become more familiar with me, and realise that I was actually interested in working with young people and hearing their views, rather than wanting to collect information from them solely for the purposes of my research, which helped them to take me more seriously. Finally, I tried to motivate young people by providing a £10 HMV voucher due to most adolescents' interest in music and DVDs. This incentive was extremely successful and several young people approached me when visiting the units thereafter, referring to me as the "HMV lady" and asking if they could do the research for a voucher! All of the above factors appeared to help to build rapport, enhance motivation and allow participants to feel more comfortable and more trusting of me.

2. *Designing the interview*

When designing the interview schedule several questions arose as to the language used, how to phrase the questions and the amount and nature of information to include, in order to maintain rapport and engagement throughout the interview process. This included trying to ensure that the language was adolescent-friendly and avoiding psychological and medical jargon wherever possible. In order to do this, I went through the interview schedule in detail with my 15 year old cousin prior to conducting the research; this led to the identification of some 'unsuitable' terminology and language, which was replaced by that more attune to this age group. In addition, I had to try to overcome the difficulties of being over-inclusive and decide what to focus on or leave out wherever possible. As the study covered many areas and drew from several bodies of literature (e.g. therapeutic relationships, parenting, peer support, peer relationships, group processes and informal and formal helping), this was a very difficult challenge. On reflection, my interview schedule was both too long and over-inclusive which had both positive and negative implications. Although a great deal of rich data was elicited from the lengthy interviews, the amount of material covered especially in the initial interviews was slightly overwhelming for me and possibly the young people. However, the young people provided valuable feedback about the questions and areas which they felt were repetitive and about the length and amount of information covered in the interviews which was taken into account in future interviews, and resulted in helping to maintain young people's engagement and interest throughout their interview.

3. Conducting the interviews

When conducting the interviews I was conscious of the importance of making participants feel at ease and trying to help young people feel empowered and that their views were both interesting and important. I also hoped that they would find reflecting on their experiences therapeutic, for example, by helping them to think about what they may have gained from certain aspects of their treatment and relationships in their units, rather than merely helping me to achieve my aims in collecting the data. When carrying out the interviews, I was faced with several challenges in relation to both achieving good quality data and the practicalities and politics of carrying out research on the units, which I tried to overcome in various ways.

Firstly, during the initial stages of the data collection phase, I found it difficult to achieve the balance of following the interview schedule and eliciting the information that I wanted to capture, and allowing the young people to freely talk about and express ideas and matters which they felt were important, but which may have been less relevant to the focus of my study. This was overcome by developing more confidence throughout the data collection process to stick less closely and rigidly to the interview schedule, and concentrate more on listening and following up what the young people were expressing, whilst keeping the broad areas of interest to cover in mind. My familiarity with the interview schedule, added to using valuable feedback from the interviews around significant issues, ideas and tentative themes which appeared to be commonly emerging, allowed me to modify and adapt the schedule accordingly. It also helped me to learn about the information that appeared to be

necessary and helpful to focus on, and what could be omitted in order to achieve the best quality results.

When carrying out the interviews, whilst maintaining a professional stance, I tried to be as 'natural' as possible and get onto the young people's level, in order to maintain rapport and engagement. This was also achieved by providing positive reinforcement and feedback for their efforts during the interviews, and following up their insights and ideas with prompts, reflections, summaries and statements such as "that's interesting" or "tell me more", aimed at helping them to feel their views were valued, important and of interest. Interestingly, there were similarities between the ways in which I approached the interviews and related to the young people, and some of the attributes which they described to be helpful in their relationships with staff, such as feeling heard, empowered and valued which appeared to help them to connect with me.

Another challenge when conducting the interviews was to remain empathic and listen to young people's accounts, whilst trying to remain neutral and objective, and not give advice, opinions, interpretations, or act as their therapist. In addition, I was unable to report information disclosed back to staff unless issues of risk were apparent during the interviews, which was challenging when certain issues of concern were raised, or when young people discussed the anti-therapeutic aspects of their relationships. Finally, it was challenging at times to remain professional when feeling very moved and tearful by some of the accounts. However, I managed this by using support outside of the units to debrief and process the emotional impact of these interviews.

In relation to the practical difficulties of interviewing young people on adolescent units, several interviews had to be carried out over two or three sessions, primarily due to competing demands in the therapeutic programme. This proved to be challenging as when trying to complete the interviews, young people were often unavailable, absent or on leave, "not in the mood" to continue, or preoccupied by other events going on in their unit. Although I managed to persevere and encourage all the young people to complete their interviews at some point or other, it was often more difficult to continue from where we left off and follow the thread of the discussion. To try to overcome this difficulty and maintain rapport, I transcribed and read through the initial parts of their interviews before meeting with the young people again, and used this information to summarise and refresh their memories of what we had previously discussed, and ensure that I avoided repetition which many described finding irritating. In addition, by reflecting on what was previously discussed, this helped to demonstrate to the young people that I had been actively listening and taking their accounts seriously.

Finally, I was faced with the challenge of the politics of the staff team and their attitudes towards research and an unfamiliar psychologist coming into their unit and 'taking' the young people out of the therapeutic programme. This was managed by becoming familiar with some of the staff during the informal times of the programme, talking to them about my research study, attending meetings in the unit, and talking to them about my previous experiences of working in an adolescent unit. In addition, I tried to involve staff who appeared interested in the study in helping with the recruitment process, however the psychologists took the most active role in this, and were extremely supportive throughout this stage of the research. From

previously working in one of the adolescent units used for the study, I questioned whether there might be some issues, questions or confusions amongst the staff team about my returning in a different role and capacity, or about my motives for going back to the same unit and asking young people questions about their inpatient care and relationships with staff. However, interestingly, since I had left the unit several years ago, there had been a merger with another service and the majority of staff whom I worked with had already left.

4. Information elicited

Young people provided very rich and meaningful data which could be attributed to several factors. (1) The rapport which I established with the adolescents and my interest in what they had to say, seemed to help them feel comfortable, gain my trust and thereby talk openly; (2) the amount and quality of information elicited was a reflection of the amount of information and areas covered in my interview schedule; (3) the 'talking culture' of the units helped to socialise the young people into talking about their feelings in the interviews; (4) the young people had a lot to say about their experiences of relationships on their units, which they appeared to feel strongly about and attach great significance to, and may have wanted something to be done to improve their or others' experiences in these units in the future; (5) the young people valued being asked about their views and opinions and responded accordingly and (6) the young people may have suppressed feelings and information or had not had a chance to reflect properly on their experiences, which meant they valued the opportunity the interview gave them to do this.

When debriefing with the young people about the experience of the interview, the majority indicated they had valued and enjoyed talking with me and having the space to reflect and think about things they had not thought about before with someone who was not directly involved in their care. Despite the challenges and obstacles faced in collecting the data, I greatly enjoyed interviewing the young people and learning from them about their unique experiences of relationships on their units.

3. Methodological Issues

Heterogeneity versus homogeneity of the sample

When designing this research, I debated whether to carry out the study in generic or acute adolescent inpatient units, or to use a combination of both, where comparisons could potentially be made from the results across the two populations. When thinking about which types of settings to use (e.g. acute and or generic settings), this related to the fact that little research had previously been carried out with young people in such settings, and that relationships with staff and peers appeared to be so fundamental to these units' philosophy, the engagement and participation in the therapeutic programme. My final decision to solely use generic units was related to reducing the complexity of the study, and achieving some degree of homogeneity in the sample in light of (1) the differences inherent in acute and generic populations and the treatment approaches used in these settings, and (2) conducting research in settings with such a heterogeneous population, presenting with a diverse range of difficulties and high levels of co-morbidity, and engaging in multiple 'interventions' from a number of professionals and peers. In addition, to further increase the homogeneity in the sample, I decided to include only those between 14 and 18 years, because this age range is thought to fall between the heart and the end of the

developmental period (Weisz & Hawley, 2002). However, in doing so, I thereby excluded young people aged 12-13 years whose perspectives and perceptions of relationships were likely to have been different in the context of such a different developmental life-stage. Although achieving a degree of homogeneity in the sample is desirable in qualitative research (Smith & Osborn, 2003), this made it less possible to generalise findings to acute or specialist units, or to those of a younger age and developmental stage.

Validity and accuracy of participants' accounts

When thinking about the validity, reliability and accuracy of the young people's accounts, several issues emerged which I took into consideration throughout the research process.

1. 'Illness' effects

As the young people who took part in this study all presented with severe and complex illnesses and difficulties, one could question whether their perceptions and meaning attached to their inpatient experiences and relationships may have been influenced by the nature and effects of their difficulties. However, this issue of validity will not be discussed in this paper as it has already been addressed in the discussion section of the empirical paper (Part 2 of the thesis).

2. Disclosure and confidentiality

Several young people who met the inclusion criteria decided not to take part and expressed fears around confidentiality and disclosing information, despite several measures taken to assure them that confidentiality and anonymity would be

preserved. This resulted in my questioning the root of such strong fears, and considering some of the possible reasons and potential implications for young people's refusal to take part. These included (1) Questioning whether young people were withholding significant and concerning information about their units or relationships, for example, involving unethical issues or professional misconduct, and may have feared the repercussions if certain material was disclosed; (2) participants may have feared becoming distressed or angry when reflecting on certain experiences related to their relationships, especially if they had been more negative or if they wanted to forget them; (3) certain young people may have felt less confident and comfortable articulating and sharing their feelings and personal experiences with someone they were unfamiliar with, which could have related to differences in personality characteristics or the nature of their difficulties, such as those with autism who refused to take part. Whatever the case, this resulted in the exclusion of young people with potentially different perspectives and views to those interviewed, raising questions about whether the sample was representative of the population typically found in generic inpatient settings.

Issues related to the validity and accuracy of young people's accounts were also considered when conducting the interviews. For example, a couple of participants appeared to remain very loyal to their unit and downplay any negative aspects of their treatment or relationships. Although this may have reflected the reality of their experiences, it may have also been possible that they were holding back, due to feeling concerned about disclosing certain information that might 'leak' out, in fear of possible repercussions from staff, for example, their treatment being affected, or from peers, for example, being the victim of bullying or ousted from the peer group.

It is important therefore to bear in mind that different results may have been obtained if young people felt safer to disclose information, for example, following their discharge from their unit. On the other hand, one young man told his story very dramatically, and acted as if I was a reporter from the local newspaper, wanting me to take note of all the unit's downfalls and limitations, and was keen that this information was fed back to other sources, which again made me question the validity of the accounts.

Although I clearly explained to the young people that I was independent of the units, and that the information they provided would not be shared with staff unless I was concerned about issues of risk disclosed during the interviews, I was conscious that some may have still associated me with the staff team, questioned my motives for carrying out the research and thereby have been more reluctant to disclose information. This was especially related to the fact that they were aware that I previously worked on one of their units, and was on the same training course as one of their staff members. However, this didn't appear to affect the information elicited, which contained very balanced accounts of both negative and positive experiences with staff and peers.

3. Interviewing whilst on the unit versus once discharged

In aiming to gain an in-depth understanding of participants' experiences whilst on the units, I considered the question of whether to interview young people whilst they were current patients or following their discharge, as the themes and content may have changed accordingly. Although the former seemed to be of value in ensuring a 'captive' audience for recruitment, capturing the immediacy and realness of young

people's 'lived' experiences, and ensuring memories were more accessible and less subject to retrospective bias, interviewing young people whilst on the units also had potential disadvantages and implications for the validity of their accounts. This included the factors related to confidentiality and potential implications of disclosure of information about staff and peers whilst still on the unit, and the fact that some participants may have been less able to stand back and reflect more objectively on their overall experience as they were so immersed in their relationships and the intensive nature of the treatment programme. Although some young people may not have wanted to be contacted or think about their inpatient experiences once discharged, further studies exploring similar issues at this point in time could provide valuable and potentially different information after young people have had the chance to process and reflect on experiences and feel safer to disclose information.

4. Researcher subjectivity versus objectivity

Although I actively tried to maintain a neutral and objective stance and put my preconceptions, assumptions and beliefs aside when designing and conducting the interviews and analysing and presenting the data (Smith & Osborn, 2003), I found this particularly challenging in light of my personal experiences and having worked in one of the units, and thereby being familiar with the therapeutic programme, group and staff dynamics. I tried to reduce the likelihood of these experiences influencing the data by thinking about each participant as an individual with their own unique experience, and trying not to look for evidence to confirm and support my existing beliefs. However, due to having been so struck by the distressing, unhelpful and anti-therapeutic encounters young people had on these units, I was conscious throughout the interviews, of having a tendency to look for the more negative aspects

of relationships when they may not have existed. I was therefore mindful to accept accounts at face value, and not to search for material based on pre-existing ideas. In addition, when analysing and interpreting the data and defining the themes, I took an active stance to stick closely to the data and try to ensure that the analysis was based solely on the interview transcripts.

4. Conclusions and importance of eliciting users' views

I found the process of carrying out this research study with young people extremely rewarding and valuable on several levels. The young people appeared to enjoy and value the opportunity to reflect on and talk about their experiences in such detail, with someone whom they felt listened to and valued what they had to say and took their views seriously. They reported that they found being interviewed a cathartic and helpful experience which allowed them to think about aspects of their experiences which they had not yet considered, and reflect on what they had learnt and gained from their relationships on the unit and what aspects of these they found helpful. These positive experiences of being interviewed about their aspects of care lend support to the benefits of conducting qualitative research with young people and hearing their ideas and views.

In addition, the findings from this research provide strong evidence to support the idea that both young people of this age and developmental stage and those who present with such severe and complex disorders are able to clearly think about and reflect on their experiences of complex processes and phenomena, and provide rich, meaningful data and unique insights to this area of investigation. This again provides further support for carrying out qualitative research and highlights the importance of eliciting users' views.

In light of the fact that little is known about the importance, nature and effects of process variables and relationships in adolescent inpatient units, and that existing research has not adequately elicited young people's views on such matters, this study has provided a contribution to this area of research. However, future qualitative research is necessary in order to further explore young people's views of relationship processes on adolescent units as they appear to be so influential and fundamental to their overall experiences and well-being, the multiple aspects of inpatient care, and engagement and participation in the therapeutic programme.

REFERENCES

Day, C., Carey, M. & Surgenor, T. (2006). Children's key concerns: piloting a qualitative approach to understanding their experience of mental health care. *Clinical Child Psychology and Psychiatry*, 11(1), 139-155.

Green, J. (2006). Annotation: The therapeutic alliance – a significant but neglected variable in child mental health treatment studies. *Journal of Child Psychology and Psychiatry, 47* (5), 425-435

Shirk, S.R., & Russel, R.L. (1998). Process issues in child psychotherapy. In A. Bellack & M. Hersen (Eds.), *Comprehensive clinical psychology* (Vol. 5, pp 57-82). T. Ollendick (Vol. Ed.) *Children and Adolescents: Clinical formulations and treatment.* Oxford, England: Pergamon.

Smith, J.A., & Osborne, M. (2003). Interpretative Phenomenological Analysis. In J.A. Smith (Ed.), *Qualitative Psychology: A Practical Guide to Research Methods.* London: Sage.

Weisz, J. R., & Hawley, K.M. (2002). Developmental Factors in the Treatment of Adolescents. *Journal of Consulting and Clinical Psychology, 70* (1), 21-43.

APPENDIX A: ETHICAL APPROVAL

Camden & Islington Community Local Research Ethics Committee

06 July 2005

Miss Debbie Sischy
Trainee Clinical Psychologist
Dept of Clinical Health Psychology
University College London

Dear Miss Sischy

Full title of study: **Young people's experiences of relationships with staff and peers in inpatient adolescent mental health units**
REC reference number: **05/Q0511/51**

Thank you for your letter of 28 June 2005, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair,

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

The Committee agreed with your declaration that this is a "no local investigator" study. Site-specific assessment is not required for sites involved in the research and no information about the study needs to be submitted to Local Research Ethics Committees. However, you should arrange for the R&D Departments of all relevant NHS care organisations to be notified that the research will be taking place before the research commences.

Conditions of approval

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	Version	Date
Application	1	28 April 2005

An advisory committee to North Central London Strategic Health Authority

164

Investigator CV		(None Specified)
Protocol	1	28 April 2005
Peer Review		08 December 2004
Interview Schedules/Topic Guides	1	28 April 2005
Letters of Invitation to Participants	2 - Parents	28 June 2005
Participant Information Sheet	2 - Young people	28 June 2005
Participant Information Sheet	2 - Parents	28 June 2005
Participant Consent Form	2 - Young People	28 June 2005
Participant Consent Form	2 - Parents	28 June 2005
Response to Request for Further Information		28 June 2005
Supervisor CV		(None Specified)

Management approval

The study should not commence at any NHS site until the local Principal Investigator has obtained final management approval from the R&D Department for the relevant NHS care organisation.

Membership of the Committee

The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

Notification of other bodies

The Committee Administrator will notify the research sponsor and the R&D Department for NHS care organisation(s) that the study has a favourable ethical opinion.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

05/Q0511/51	Please quote this number on all correspondence

With the Committee's best wishes for the success of this project,

Yours sincerely

Chair

Email:

Enclosures: Standard approval conditions

APPENDIX B: PARTICIPANT INFORMATION SHEET

Sub-Department of Clinical Health Psychology

UNIVERSITY COLLEGE LONDON

Debbie Sischy, Trainee Clinical Psychologist (Researcher)
Dr. Nancy Pistrang, Senior Lecturer in Clinical Psychology (Supervisor)
Telephone: (Debbie Sischy)

Date: 28.06.05
Version 2

Young people's experiences of relationships in inpatient adolescent units
Information Sheet for Participants

You are being asked to take part in a research study. Before you decide if you would like to take part, it is important for you to understand why the study is being done and what it will involve. Please take time to read the following information and discuss it with other people if you wish. Please ask me if there is anything that is not clear, or if you would like more information.

What is the point of this study?

This study aims to find out about young people's experiences of living on adolescent inpatient units and hopes to learn about their views of the treatment and care they receive there. We would like to find out about young people's experiences of relationships with other young people and staff on these units. We are interested to hear how young people think these relationships may affect their treatment and general experience on the unit, and also on how they are feeling. There has been little research carried out in this area before and most of the studies that have been done have used questionnaires to collect information, rather than talking to young people themselves about their experiences. This study gives you a chance to think about your experiences of treatment so far, and about the relationships you have made on the unit.

The information from this study will be used to try to improve services in adolescent units. A summary report about the study will be sent to you, your unit and your parent(s)/guardian(s). The study may also be written up in a scientific journal. However, before the study is written up, I will ask you to check that the information and ideas in the report accurately describes and represents what you talked to me about and explained to me in the interview.

Why have you been chosen?

You have been chosen to take part in this study as you are at currently attending XXX unit, which is one of the units being used for the study. There are several young people who have been asked to take part in the study, who have been chosen from 2 or 3 adolescent inpatient units in London.

Do I have to take part?

This study is voluntary and it is up to you to decide whether or not to take part. You do not have to take part if you or your parent(s)/guardian(s) do not want you to. If you decide you

167

would like to take part, you will be asked to sign a consent form to let us know that you have agreed to participate. Your parent(s)/guardian(s) will also be given a consent form which they will be asked to sign if they agree to you taking part. If you decide to take part, you can leave the study at any time, without giving a reason for this. Your treatment and care on the unit will not be affected in any way if you decide not to take part or leave the study at any point.

What does taking part involve?

If you decide to take part in this study, you will be interviewed by me, on one occasion, for 60-90 minutes. There will be no other people around during the interview. The interview will take place in a quiet room on the unit, when you are not involved in any therapy sessions, groups or activities. It will give you the chance to discuss your experiences in the unit and to think about the relationships you have made there. If you agree, I will tape record your interview to make sure I have an accurate note of everything you have said. The information from the tapes will be typed up word for word, and then the tapes will be destroyed following the study. As part of the study, I may need to look through your clinical notes to get information about why you are in the unit. If you take part in this study, you will be given a £10 gift voucher from Virgin Record Stores.

What are the advantages of taking part in the study?

We hope that you will benefit from taking part in the interview, by having the chance to talk to someone about your experiences of your treatment and relationships in the unit. We hope that you will find it helpful to think about how the treatment and your relationships may affect the way you are thinking and feeling in yourself.

What are the disadvantages?

It is possible that the interview may bring up some distressing or sensitive issues, related to your experiences in the adolescent unit. This may include, for example, talking about feeling unhappy with aspects of your treatment, or the relationships you have had with staff and other young people (e.g. being bullied, feeling powerless or feeling alone and rejected). In order to deal with this, I will make sure there is time at the end of the interview, for us to talk about how the interview went and how you are feeling. Staff in the unit will also be told when the interview is taking place, so they can be available to give you support if necessary.

Will my taking part in this study be kept confidential?

All the information from the study will be kept confidential (private) and kept in a safe, locked place. This means that only my university supervisors (who are not involved with your treatment) and I will know what was talked about in the interview. Staff on the unit will not be given any information about what you said. However, if you talk about anything which worries me about your stay on the unit, I will discuss this with my university supervisors. Following this, I may need to discuss this with the manager of your unit. However, before I did anything, I would discuss this with you first.

All the interviews will be anonymous (without names) and it will not be possible to recognize or identify you from the information in the interviews, or from the summary report or articles based on this research. Although I will be extremely careful to remove any names, places, situations, circumstances or incidences that you referred to, which may make you and the information easier to identify, it is important to acknowledge that due to the small numbers of participants in the study, there is always a small chance that it may be possible that some young people may be able to identify others, despite the fact that no names will be used in the write-up of the study. However, as I am using two or three

adolescent units, all the information collected from the interviews will be put and analyzed together, therefore this will make it harder to identify particular participants. If you take part in this study, the consultant psychiatrist in your unit will be told, as they are responsible for your care and what you are involved in when you are on the unit.

What compensation arrangements have been made in the event of harm?

In the very unlikely event that you are harmed by this study, there are arrangements in place for compensation. If you wish to complain or have any concerns about any aspects of the way you have been approached or treated during the study, the normal National Health Service complaints procedures should be available to you. If you require further information, please contact me on the details below.

Who has reviewed the study?

All proposals for research using people are reviewed by an ethics committee before they can go ahead. This study was reviewed by Camden And Islington Community Local Research Ethics Committee.

Who are the researchers?

I am the main researcher (Debbie Sischy), and am a Trainee Clinical Psychologist in my 2nd Year of the UCL Doctorate in Clinical Psychology. The other two researchers are my university supervisors: Dr. Nancy Pistrang (Senior Lecturer in Clinical Psychology at UCL) and Dr. Crispin Day (Consultant Clinical Psychologist) at South London and Maudsley NHS Trust/Institute of Psychiatry.

Contact for Further Information

I would be very happy to talk to you and discuss the study further and to answer any questions or queries that you may have about the study, before you make a decision as to whether you wish to take part. I have written my contact details at the bottom of this letter.

I will contact you in a few days to find out whether or not you are interested in taking part.

Thank you very much for taking the time to read this.

Debbie Sischy   XXX
(Researcher)   (Clinical Psychologist/Manager of XXX Unit)

Contact details:
Debbie Sischy (Researcher)
Address: Sub-Department of Clinical Health Psychology, University College London,

Telephone:
Email:

APPENDIX C: LETTER TO PARENTS

Sub-Department of Clinical Health Psychology

UNIVERSITY COLLEGE LONDON

Debbie Sischy, Trainee Clinical Psychologist (Researcher)
Dr. Nancy Pistrang, Senior Lecturer in Clinical Psychology (Supervisor)
Telephone: (Debbie Sischy)
Email:

Date: 28.06.05
Version 2

(Letter to be on unit headed paper and co-signed by Clinical Psychologist or Manager of the Unit)

Dear Parent(s)/Guardian(s)

I am currently training at University College London to be a Clinical Psychologist, and am undertaking a research study at XXX unit as part of my course. I was given your contact details by XXX (staff member), who informed me that your son/daughter was currently an inpatient at XXX unit. I am writing to you, as 1 would like your permission for your son/daughter to take part in this study.

The research study aims to find out about young people's experiences of living on adolescent inpatient units and the treatment they receive there. It is very important to hear the young people's views about what is important to them, in order to improve their care. I am particularly interested to find out what young people think about the relationships they make on these units with other young people and staff, and how these relationships may affect their treatment, well-being and general experience on the unit.

I am writing to ask if you would like your son or daughter to take part in the study. I have enclosed an information sheet which explains the details of the study and what taking part would involve. I have also added a consent form, in order to get your written permission for your son/daughter to take part. If you agree to this, I would be very grateful if you could fill in the details and sign the consent form, and return it to me within the next week in the stamped addressed envelope provided. I will also be asking your son/daughter for their written consent to participate in the study.

I would be very happy to talk to you and discuss the study further and to answer any questions or queries that you may have about the study, before you make a decision as to whether you wish your son/daughter to take part. I have written my contact details at the top of this letter.

Thank you very much for your time.

Yours faithfully,

Debbie Sischy (Researcher)   XXXX (Clinical Psychologist/Manager of XXX Unit)

APPENDIX D: PARENT INFORMATION SHEET

Sub-Department of Clinical Health Psychology

UNIVERSITY COLLEGE LONDON

Debbie Sischy, Trainee Clinical Psychologist (Researcher)
Dr. Nancy Pistrang, Senior Lecturer in Clinical Psychology (Supervisor)
Telephone: (Debbie Sischy)

Date: 28.06.05
Version 2

Young people's experiences of relationships in inpatient adolescent units
Information Sheet for Parent(s)/Guardian(s)

Your son/daughter is being invited to take part in the above research study. We are asking you for your permission for him/her to take part. Before you decide if you would like him/her to participate, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information and discuss it with other people if you wish. Please ask me if there is anything that is not clear, or if you would like more information.

What is the purpose of this study?
This study aims to find out about young people's experiences of living in adolescent inpatient units. We would like to know what young people think about the treatment and care they receive on these units, and we are interested to find out about their experiences of relationships they have with other young people and staff. We are keen to learn about how the young people think that these relationships may affect their treatment, well-being and general experience on the unit. There has been little research carried out in this area before, and the few studies which have been done have mainly used questionnaires to collect information, rather than talking to young people themselves about their experiences. This study will therefore give your son/daughter a chance to think about his/her experiences of treatment and relationships on the unit.

The information from the study will be used to try to improve services in adolescent units. A summary report will be sent to you and your son/daughter's unit, and will be also be available to everyone who took part. The study may also be sent to a scientific journal for publication. However, before the study is written up, I will ask the participants to check the accuracy of the information in the report, to ensure that I have fully understood and accurately represented the information and ideas that were discussed and came out of the interviews.

Why has your son/daughter been chosen?
Your son/daughter has been chosen to take part in this study as they are at currently at XXX unit, which is one of the units being used for the study. There are several young people who have been asked to take part in the study, who have been chosen from 2 or 3 adolescent inpatient units in London.

Does my son/daughter have to take part in this study?
It is up to you to decide whether your son/daughter takes part. This study is voluntary and your child does not have to take part if either you or they do not want to. If you decide you would like him/her to take part, you will be asked to sign a consent form to let us know that you have agreed to this. Your son/daughter will also be given a consent form to sign if they agree to take part in the study. If he/she decides to take part, they are able to leave the study at any time, without giving a reason for this. Your child's treatment and care on the unit will not be affected in any way if they decide not to take part or leave the study at any point.

What does my son/daughter taking part involve?
If your son/daughter decides to take part in this study, they will be interviewed by me, on one occasion. The interview will last between 60 and 90 minutes. There will be no other people present during the interview. It will take place in a quiet room on the unit, at a time when your son/daughter is not involved in any therapy sessions, groups or activities. The interview will give him/her the chance to discuss their treatment and experiences on the unit so far, and to think about the relationships they have made there. If both you and your child agree, I will tape record the interviews to make sure I have an accurate note of everything that was said. The information from the tapes will be typed up word for word, and then the tapes will be destroyed following the study. As part of the study, I may need to look through your son/daughter's clinical notes to get information about why they are in the unit. If your son/daughter takes part in the study, they will be given a £10 gift voucher from Virgin Record Stores.

What are the advantages of my son/daughter taking part?
It is anticipated that your son/daughter will benefit from taking part in the interview, by having the opportunity to talk to someone about their experiences of their treatment and relationships in the unit. We hope that he/she will find it helpful to think about how their relationships and treatment may affect the way they are thinking and feeling in themselves.

What are the disadvantages?
It is possible that the interview may bring up some distressing or sensitive issues, related to your son/daughter's experiences in the adolescent unit. Examples of these issues may include, your child talking about feeling unhappy with aspects of their treatment, or the relationships they have had with staff and other young people (e.g. being bullied, feeling powerless or feeling alone or rejected). In order to address this, I will make sure that there is time, at the end of the interview, for your son/daughter to discuss how the interview went and how they are feeling. Staff on the adolescent unit will also be told when the interview is taking place, so they can be available to provide support to your son/daughter if necessary.

Will my child taking part in this study be kept confidential?
All the information which is collected from your son/daughter at all stages of the study will be kept confidential and stored in a safe, locked place. This means that only my university supervisors (who are not involved with your child's treatment) and I will have access to the information from the interview. Staff on the unit will not be given any information about what was said. However, if your son/daughter talks about anything which concerns me about their stay on the unit, I will discuss this with my university supervisors. Following this, I may need to discuss this with the manager of your son/daughter's unit. However, before I did anything, I would discuss this with your son/daughter first.

The information from the interviews will be kept anonymous (without names) and all measures will be taken to try to ensure that it will not be possible to recognize or identify your son/daughter from this information, or from the summary report or articles based on this research. Although I will be extremely careful to remove any names, places, situations, circumstances or incidences that the young people are referring to which may make them

and the information more identifiable, it is important to acknowledge that due to the small numbers of participants in the study, there is always a small chance that it is possible that some young people may be identifiable to others, despite the fact that no names will be used in the write-up of the study. However, as I am using two or three adolescent units, all the information collected form the interviews will be collated, combined and analyzed together, therefore this will make it harder to identify particular participants. If your son/daughter takes part in the study, the consultant psychiatrist in their unit will be told about this, as they are responsible for his/her care and what he/she is involved in when they are on the unit.

What compensation arrangements have been made in the event of harm?
There are arrangements in place for negligent harm compensation through my employee scheme. Although this is a very low risk study, indemnity for non-negligent harm will be provided by UCL as part of their sponsorship, which is currently in the process of being arranged. If you wish to complain or have any concerns about any aspects of the way your son/daughter has been approached or treated during the study, the normal National Health Service complaints procedures should be available to you. If you require further information, please contact me on the details below.

Who has reviewed the study?
All proposals for research using people are reviewed by an ethics committee before they can go ahead. This study has been reviewed by Camden And Islington Community Local Research Ethics Committee.

Who are the researchers?
I am the main researcher (Debbie Sischy), and am a Trainee Clinical Psychologist in my 2nd Year of the UCL Doctorate in Clinical Psychology. The other two researchers are my university supervisors: Dr. Nancy Pistrang (Senior Lecturer) in Clinical Psychology at UCL, and Dr. Crispin Day (Consultant Clinical Psychologist) at South London and Maudsley NHS Trust/Institute of Psychiatry.

Contact for Further Information
I would be very happy to talk to you and discuss the study further and to answer any questions or queries that you may have about the study, before you make a decision as to whether you wish your son/daughter to take part. I have written my contact details below. As you can see, I have enclosed a consent form with this information sheet. If you would like your child to take part, I would be very grateful if you could fill in and sign the consent form, and return it to me within the next week in the enclosed stamped addressed envelope.

Thank you very much for taking the time to read this.

Debbie Sischy   XXXX
(Researcher)   (Clinical Psychologist/Manager of XXX Unit)

Contact Details:
Debbie Sischy (Researcher)
Address: Sub-Department of Clinical Health Psychology, University College London,

Telephone:
Email:

APPENDIX E: PARENT CONSENT FORM

Sub-Department of Clinical Health Psychology

UNIVERSITY COLLEGE LONDON

Name of Researchers:
Debbie Sischy, Trainee Clinical Psychologist (Researcher)
Dr. Nancy Pistrang, Senior Lecturer in Clinical Psychology (Supervisor)
Telephone: (Debbie Sischy)

Date: 28.06.05
Version 2
Unit No:
ID No:

Young people's experiences of relationships in inpatient adolescent units

CONSENT FORM FOR PARENT(S)/GUARDIAN(S)

Please read the following information carefully and put your initials in the box if you agree. Please could you return this to me in the enclosed stamped addressed envelope within the next week. Thank you very much for you time.

1. I confirm that I have read and understand the information sheet dated 28.06.05 (version 2) for the above study and I have had the opportunity to ask questions and discuss the study. ☐

2. I understand that my son/daughter's participation in this study is voluntary and that they are free to leave the study at any time, without giving any reason and without it affecting their treatment in any way. ☐

3. I understand that the interviews will be taped and then typed up, however the tapes will be destroyed following the study, and all the information from the interviews will remain confidential, anonymous, and stored in a locked cabinet. ☐

4. I understand that the consultant psychiatrist on my son/daughter's unit will be told that he/she is taking part in the study. ☐

5. I give my permission to the researcher (Debbie Sischy) having access to my son/daughter's clinical notes in the unit. ☐

6. I agree to my son/daughter taking part in the above study. ☐

Name of Parent/Guardian   Date   Signature

Name of Researcher   Date   Signature

APPENDIX F: PARTICIPANT CONSENT FORM

UNIVERSITY COLLEGE LONDON

Name of Researchers:
Debbie Sischy, Trainee Clinical Psychologist (Researcher)
Dr. Nancy Pistrang, Senior Lecturer in Clinical Psychology (Supervisor)
Telephone: (Debbie Sischy)

Date: 28/06/05
Version 2
Unit No/ID No

Young people's experiences of relationships in inpatient adolescent units

CONSENT FORM FOR PARTICIPANTS

Please read the following statements carefully and put your initials in the box if you agree. Thank you.

1. I confirm that I have read and understand the information sheet dated 28.06.05 (version 2) for the above study and I have had the chance to ask questions and discuss the study. ☐

2. I understand that taking part in this study is voluntary and that I am free to leave the study at any time, without giving a reason and without it affecting my treatment in any way. ☐

3. I understand that the interviews will be taped then typed up, and the tapes will be destroyed following the study, and that all the information from the interviews will be kept confidential, anonymous (without names) and stored in a safe, locked place. ☐

4. I understand that the consultant psychiatrist on my unit will be made aware that I am taking part in the study. ☐

5. I give my permission for the researcher (Debbie Sischy) to access and look through my clinical notes in the unit. ☐

6. I agree to take part in the above study. ☐

Name of Participant   Date   Signature

Name of Researcher   Date   Signature

APPENDIX G: INTERVIEW SCHEDULE

Title: Young people's experiences of relationships in inpatient adolescent units

Qualitative Interview Schedule

Introduction: Getting to know the participant: Aims of this: Icebreaker/getting to know each other chat about general interests/topics not related to illness or treatment:

- Can you tell me how old you are?
- How long have you been here for?
- How do you spend your time here on the unit?
- What is it like to be here?
- What have been the most/least helpful aspects of your stay?

RELATIONSHIP WITH PEERS (3 Sections):

Areas to tap in this section: Description & Development of Rships (positive and negative), Depth/Quality of Peer Rships/Goodness of Fit:

- How do you get on with the other young people here?

- Are there any young people that you know well here/get on well with?

- Are there any YP you do not get on well with?

- Can you describe your relationships with these people?

- What led up to you getting to know each other well/not getting on so well?

- Can you describe what is it in particular about X, Y, Z that has led you to spend time with/want to be with them/makes you feel unable to talk to them?

- What makes these better/worse than the relationships you have with other YP here?

- What do they do/say that you think is most/least helpful?

- Are your relationships with X,Y different from those you have at school/outside here? What makes the ones here more/less helpful?

- What do they like/dislike about being with you/why would they choose to go to you?

Areas to tap in this section: How rships with YP affect engagement/participation/learning in therapy groups:

- Can you tell me about some of the groups you have here?
- Which ones do you find most/least helpful?
- What is the point of having these groups/what are they meant to be for?
- Are there any YP who have helped or prevented you from getting involved and taking part in the groups?

181

- What did they say or do to make it easier/harder for you to speak out/take part?

- Does having these good/bad "relationships" with X,Y, Z make any difference in how you participate in groups?

- What have you learnt from the groups? How did you learn this?

- In what ways have the other YP helped you make use of/learn from the groups?

Areas to tap in this section: Outcome/Effects of Peer Rships on insight/changes in thoughts/ feelings and general well-being:

- What differences do having these relationships with YP make to being here?

- What are the good/bad things that have come out of being with other YP?

- Is there anything you have you learnt about yourself and your difficulties/the reasons that brought you here, from being with the other YP? How did you learn this?

- Is there anything that the YP have taught you/you have learned (which you could take away from here) about managing your feelings/difficulties in other/different ways?

- Are there any differences in the way you think or feel now (compared with when you first came here) which you think are related to being with the other YP here?

- What would have to happen for you to get along even better with other YP here?

RELATIONSHIP WITH THE WIDER "GROUP" (3 sections):

Areas to tap in this section: Nature/Development of group/experience of being in the "group":

- How much do you do things together/ "hang out" as a group when you are here?

- Are there divisions in the group or does everyone stay together? What led to this?

- Are there people that take over, or is there a group leader? Do you find this helpful?

- To what extent have you felt included/left out or unhappy in the group? Examples?

- What do staff do or say to get involved at these times?

- What do you think leads to you or others being included or excluded in the group?

- Have your relationships with the YP you mentioned before made any differences to how you take part/feel within the larger group in general?

Areas to tap in this section: Advantages/disadvantages of group/learning from others/group v's indiv needs/peer support.

- Do you think that your needs/concerns are similar or different to the other YP here?

- What is it like being with people who have some similar/different needs? Pros/Cons?

- What are your views about being here with other YP of different ages?

- What are the helpful/unhelpful things you have learnt about yourself and coping with difficulties from spending time with the group and YP with similar/different needs?

- Has being in a group given you enough time to think about your individual concerns?

- What is your experience of getting and giving support to the other YP here? What differences does this make to you being here and the way you feel in yourself?

Areas to tap in this section: Outcome of group/being in adolescent unit:

- What would need to happen to make your experience of being in a group even better?

- Has being part of a larger group helped/prevented you from making use of the overall programme here?

- What would you change about the general program/unit here to make it a more helpful/useful experience for YP?

RELATIONSHIP WITH STAFF (3 Sections):

Areas to tap: Description/Development of Rships/Quality/Depth/Goodness of Fit:

- What are your relationships like with staff here?

- What do you think is the point of having staff here on the unit? Pros/Cons of this?

- Are there any staff here that you get on well with/get on badly with/feel distant from?

- How are they involved with your care/treatment programme?

- Can you describe your relationships with these staff members?

- What led up to you getting on/not getting on so well?

- What is it about X,Y,Z that makes you want to or feel able/unable to talk to them?

- What makes these relationships better/worse than other rships with staff?

- What does X,Y,Z say or do that is helpful/unhelpful?

- Are these relationships different from the ones you have with adults outside of here?

- What do you bring to the relationship to make it work well/not work? What would they say about you?

- Do you think there are any differences in what the staff and the YP do to help and support people with their needs here?

Areas to Tap: How rships with staff affect engagement/participation/learning/insight:

- Are there any staff here who have helped you/made it difficult for you to get involved and take part in the individual and group sessions here?

- What do they say/do to help you feel more/less able to join in/take part and make use of the groups/sessions?

- What could staff do to help you feel more able/comfortable to take part and make use of the groups/sessions here?

- How has the staff helped you learn about yourself and your difficulties and how you make sense of them? What did they say/do to help you understand these things?

- Is there anything here that staff have done or said (that you have taken away from the here) to help you cope with/manage your difficulties?

Areas to Tap: Effects of Rships with staff on outcome/changes in thoughts/feelings:

- What differences do having relationships with staff make to your experience here?

- How have your relationships with staff affected the way you think and feel in yourself? How is this different to when you first came here?

- What would need to happen for you and other YP to have better rships with staff?

Closing the interview:

Prompts:
- Thank you very much for talking to me

- How has it felt to discuss these things?

- Do you have any questions?

- Is there anything that you felt you said that I did not really understand or that you would like to say a bit more about?

- What are you doing for the rest of the day?

184

APPENDIX H: STAGE ONE OF THE ANALYSIS

Extract from the initial interview with participant 7

First Stage of Analysis

Because in like school situations no-one didn't know was going through, what you what you've gone through, no-one's feeling what you're feeling. They might be but not to the extent you would to get into hospital and like people who come into hospital obviously are in pretty much a bad way like you were and so they can understand and relate to you more. But my friends outside wouldn't understand what I was going through, so the people here know what you're going through... so you think that you're not alone, basically, because when you're out in the real world you feel alone but when you're in here you know that people are in here because of what's happened and you know that you're not the only person this happens to... In here [unit] we talked more openly about what was wrong and like a lot of people I knew here self-harmed... It was one [self-harming] that we could actually bring up and there would be questions like, after we'd come in from day patients or something like that it would be like, oh did you have a good night? Did you self harm? If not, well done. So we support each other like that, but like if I was at school and someone said do you self harm, I'd get shouted at by my mates for it... They wouldn't understand it... None of my mates thought it was for attention but they just didn't understand it. They couldn't understand why I would do that to myself, but because other people were doing it here they knew what it was like.	▪ In school, no-one knew what I was going through, no-one really feeling what you feel ▪ people in unit also in bad way: they can relate to you and understand you ▪ friends outside don't understand what you're going through, but peers in unit do ▪ don't feel alone in unit: people in unit due to what's happened to them: not being the only person this happens to. ▪ can talk openly about problems in unit, i.e. self-harming ▪ supporting each other with difficulties, how you managed ▪ school mates don't understand self-harming behaviour, would shout at me ▪ in unit others self-harming, they know what it is like

APPENDIX I: STAGE TWO OF THE ANALYSIS

Extract from the initial interview with participant 7

Second Stage of Analysis

Because in like school situations no-one didn't know was going through, what you what you've gone through, no-one's feeling what you're feeling. They might be but not to the extent you would to get into hospital and like people who come into hospital obviously are in pretty much a bad way like you were and so they can understand and relate to you more. But my friends outside wouldn't understand what I was going through, so the people here know what you're going through... so you think that you're not alone, basically, because when you're out in the real world you feel alone but when you're in here you know that people are in here because of what's happened and you know that you're not the only person this happens to... In here [unit] we talked more openly about what was wrong and like a lot of people I knew here self-harmed... It was one [self-harming] that we could actually bring up and there would be questions like, after we'd come in from day patients or something like that it would be like, oh did you have a good night? Did you self harm? If not, well done. So we support each other like that, but like if I was at school and someone said do you self harm, I'd get shouted at by my mates for it... They wouldn't understand it... None of my mates thought it was for attention but they just didn't understand it. They couldn't understand why I would do that to myself, but because other people were doing it, here they knew what it was like.	▪ Feeling others don't understand you/your predicament ▪ Harder to relate to schoolmates ▪ Feeling connection with peers over common experiences. Feeling understood ▪ Not feeling alone or isolated: relieved ▪ Feeling accepted for difficulties/ability to be open/free to express difficulties ▪ Feeling supported and encouraged for managing problems ▪ Not feeling judged like by school mates ▪ Feeling understood by peers who also know what it's like to have problems

188

APPENDIX J: STAGE THREE OF THE ANALYSIS

Prelim Analysis: Summary of ideas, categories and tentative themes from P11

Not being judged/feeling understood and accepted:
It's ok for others to know your history as although embarrassing, you're not judged: Pg 2
Not being judged by other patients as they're in same situation as you, with same problems (less stigmatising etc): Pg 2
Yp having same sort of/similar things, all come under 'vague headlines' i.e. self-harming but different types, abuse etc: Pg 3
Helpful to have yp with similar problems (depression/s-h) as understand what you're going through more (and more caring/understanding than outsiders): Pg 3, pg 21
Not feeling people are mad or bad with mental illness: acceptance of illness (quote: pg 3), others not reacting to behaviours/ not feeling shocked by self-harm etc like outsiders, not feeling pathologised, blamed, weird for diff's: pg 7 (common theme) being accepted/normalisation of difficulties:

> *"they don't see me as somebody completely different and just really mad and stuff like. I just... yeah they're just not really shocked that, yeah I have (unclear)... I used to be much worse than I am now and yeah, it doesn't really shock them. They say, OK, we see a lot of this every day. It kind of makes me feel OK, I'm not abnormal, a lot of people do have depression, a lot of people do go through what I've been through"*

School people naïve around what could happen/go wrong at such an early stage: here all been through difficult times and had to grow up fast pg 7
Having deeper, less superficial friendships with yp in unit than outside as yp know more about me and can talk about the "real" issues, outside they haven't been through it: pg 7
Talking with staff/yp help you understand causes of problems: the why's, what's, dangers in context of life stages and what others have done to you: Pg 3, 21, 23 (not judging and being afraid to explore diffs and aetiology and taking away self-blame and reducing self-harming behvrs. Not feeling told off/threatened for self-destructive behaviours: pg 23
Feeling understood helps me talk more/be less withdrawn, not always be alone: pg 3, helps me feel able to trust staff and therefore be more open with them: pg 35

> *"sometimes they can show you that, and you're not the one that's in the wrong. You're the one that's ill and you're the one that's come away with difficulties from them but you're not always the one that's in the wrong. Like people do bad things to you and it's not your fault that they've done it. It's actually that they've done it. It's their actions. So it's kind of like".*

Not being only one with problems: (normalising experience)
Good to have yp older than you as realise problems not age/stage specific and not just a 'phase' or over-reaction: pg 6
Good being around patients my age with similar problems: Pg 1, feeling not alone with problems, sharing common experiences is a good thing: pg 20, helps yp bond: pg 21
Learning your not alone and that no-one is perfect and problem-free: pg 21 (relief)
Sometimes hard to relate to different problems if not experienced them yourself: p20

Helpful to talk and be open:
If you don't talk, there's no point in coming here so you must be prepared to talk about difficult things: Pg 2, expected to talk: unit's philosophy but v. difficult facing deeper/painful issues: pg 24 (dilemma) fear of being left exposed/vulnerable (see below)

Hard to talk to/tell your story to staff/yp you dislike or have had arguments with: pg 31

People know your history, everything about you, no secrets, don't have to continuously repeat your story: good as can take it from where your at: Pg 1, pg 18

Won't survive here if don't form relationships with yp, and it's difficult to talk if you don't know/trust anyone and openness is main key of unit: pg 8, pg 36

> *"You just feel trapped. You feel like, well if I don't speak then I'm going to be discharged or I'm going to be timed out, but if I do speak I'm going to be left feeling uncomfortable with myself and feel that I've said to much and feel really depressed and feeling really like just that I've betrayed myself by saying certain things"*

Feeling supported/cared for/supporting others:
Yp won't leave me, seek me out, check I'm not self-harming, prevent you from self-deprecating/blaming and persuade me to join in, showing me they care: Pg 3 (taking me out of myself and helping me feel better, yp protecting/caring for other yp

Encouraging yp to go to staff about serious issues/problems and disclose: pg 10, pg 30

Friends know signs/can detect when you are distressed/ can see through your laughs to serious side and help you face difficulties/support you/talk about concerns: pg 10 (see through pretence/avoidance), takes me seriously, makes me feel important: pg 11

Yp protecting each other from harming, discourage destructive behaviours, cheer each other up when down, making you happy, distract each other from problems: pg 11, pg 15, others with more severe difficulties helping to prevent yp going down same route: pg 23

Getting strategies, ideas from yp and staff re managing/coping with difficulties and helpful/unhelpful ways to manage: pg 22, pg 37

Staff taking you seriously, giving you time, listening to you more, being sincere and genuine, being direct and telling you how it is: v. helpful (common theme): pg 34

Staff being friendly, open, feeling valued, respected, empowered, cared for: pg 34, pg 35

Trusting staff as trained professionals, able to contain difficulties, not feeling burdened to look after/protect them (like parents) so more free/more space to focus on you: pg 35

Good to make friendships and 'secure attachments', helps to make you more confident and to talk and get through groups (feeling supported/encouraged by yp: pg 29)

Staff/yp knowing your history/problems and encouraging/supporting you through groups
helps you make use of them: pg 37

Getting to know staff and getting something back:
Good to get staff involved with groups, gd to learn something about them: pg 16, pg 35
Hard when your paranoid and question why they want to know our business when we know nothing about theirs: pg 16
Difficult/strange experience talking to strangers about most intimate/personal problems history especially when you know nothing about them:pg 16 (feeling vulnerable/exposed)
Wanting to know something about staff (not life history) basics of training, experience: pg 17 (lack of trust/faith in staff)
Wanting to spend more time informally with staff and get to know them outside problems, wanting to learn more about them, trust them more and feel they're genuine from knowing they've experienced problems and have had stuff in their lives: pg 32
Wanting staff to "hang out" with yp, watch tv, chat about their interests, but needing balance: not being too 'over-friendly, in your face and intrusive v's not being too problem-focused and formal, wanting them to be "familiar": pg 32, pg 33

> "Like you don't always have to chat about like, um, oh meetings and what your problems are, you can just talk about everyday life like music and stuff, and it kind of makes you gain their trust a little bit more, and just kind of helps you to befriend them a little bit more".

Conflict around feeling hope/optimism for recovery prospects: pg 7 v's seeing other yp leave who are not better, questioning whether tment will work and whether talking, opening up and investing time and energy in will make any difference: pg 8

Outcomes: "I've become more confident. I can trust people a lot more. I also don't put myself in too much danger as I used to with self harming and things. And I think I've got less depressed and I've got less medication than I was on in my past unit"

Being sensitive to other's needs/difficulties: (other end of triggering off spectrum?):
Learning to avoid certain words/sentences that may trigger negative experiences for others: pg 21
Learning about others issues/problems/sensitive spots and acting sensitively accordingly: pg 2, pg 21,

Feeling disempowered/lack of control about what's said about you:
(esp with 'illness effects'/paranoia): feeling no control over what is recorded in notes/written about you: pg 18, pg 19
Being overanalysed: Pg 16, Pg 18, pg 19: effects of this: tend to shut down so they have no material/evidence/ can't go into things in their notes if nothing to write about: pg 19 (being misinterpreted/labelled/judged): staff making inaccurate interpretations: pg 20

> "I think everyone's cautious about exactly what they say. Before I came in here I didn't think before I spoke. I just said anything. But when you read some of

the things they say and stuff like what you've said, you can't believe that you said it, so I think people become more aware of what they're saying and more cautious..."

Unhelpful rships/aspects of being with yp/not taking treatment seriously:

Yp not taking the treatment seriously, taking the piss in groups, egging each other on, being stupid/ preventing serious/therapeutic work being done (avoidance): pg 13, pg 30

making yp feel "stupid", bad for wanting to participate, making you discontinue, making you feel less able/unsafe to talk about painful things: pg 14 (undermining yp's problems)

Some yp intimidating: fear of them attacking you: pg 28

bringing drugs/alcohol on unit: effects everyone, everyone suffers consequences (unfair), again takes focus of certain yp's issues for a while...

Effects of 'bad habits'/Self-destructive behaviours /peer pressure:

Yp being drugs/alcohol in unit: not helpful/insensitive, esp to yp with psychosis/depression/on medication: can make them worse therefore makes you protective over other yp: pg 9, yp getting worse from illness

Annoying, makes yp take step back when they are doing so well/wasting treatment: pg 9

Being scared of being around other on drugs/alcohol: pg 9

Dilemma between wanting to report yp and being called 'grass', becoming bullied, suffering the consequences, feeling guilty if others are sent home: pg 10, pg 27

Most yp join in with drugs/alcohol, succumb to peer pressure, follow crowd to be accepted. Yp get into risky situations, tempting, hard to keep own mind and refrain as get excluded: pg 10, pg 26, pg 28

Many yp are 'sheep': copy fashion, music, behaviour to be included/accepted: (loss of identity) best outcome's to maintain personality/individuality and still be accepted: pg 28,

Fear of being labelled/judged as square, "boffin" if studying or engaging in "boring" or 'passive' behaviours: pg 25, pg 26

> *"I've seen people like really ill people, people with psychosis, I've seen them start taking drugs and seen them start drinking. I've seen a lot of ill people, I've seen depressed people just pick up cutting and pick up just like, just really destructive behaviour and things and I don't understand it. Why come to get worse?"*

Other's dominating staff time and attention/getting needs neglected:

Being pushed aside/not getting needs met when other yp going through difficult time/crisis: Pg 4, pg 14

If major stuff's going on with yp/on unit it dominates staff time and agenda in meetings and your individual needs/time gets neglected (common theme: P11, P14 and more): pg 4

Being quiet/passive v's loud/dominant re getting needs met: Hard to learn to let other's know I needed help or was distressed as when quiet and withdrawn easy not to be noticed: pg 5

APPENDIX K: STAGE FOUR OF THE ANALYSIS

QUOTATIONS FROM PARTICIPANTS ILLUSTRATING THEME 2

'TALKING OPENLY ABOUT FEELINGS AND DIFFICULTIES'

"If I didn't have someone to talk to, I'd probably just bottle up a lot more [I: right] and then eventually it would explode somewhere and then I'd just go mental, at everyone": P6

"Well the people I meet in here, my friends in here know a lot more about me obviously, than the people outside, and I can talk to them about like real issues. But the people that I know outside tend to just be having fun and just going out and stuff": P11

"Just, talking and not being judged because they wouldn't judge because they just knew what it was like, so they just didn't judge, you could have a... just talk to them about what you felt or what's gone on, and they would talk to you about it": P7

"Like with family you can't really tell them everything that's gone on because they're too close to the person. You don't really want to upset them, but with staff you can just open up and tell them everything... like their reaction is just like normal because obviously they've been trained for it and stuff [I: mm-hm] so they know what to do, but it's not like, you don't feel bad after you've told them because they don't react and be like that's terrible or whatever": P6

"It's really awkward when you feel like everyone's always analysing everything you do...if you become aware of it then you can sort of feel that it can make you change the way you're acting and sort of try and act in a way that you think isn't going to draw any attention to you": P12

"It can be difficult... some people that leave here aren't better, so it kind of makes you feel a bit, what am I going to be? Am I going to be much better or is this just going to be like a whole waste of time, me talking and telling everyone everything, or am I actually going to get slightly better or a lot better?": P11

"My difficulties I had under control, well fairly under control, and um... it was a can of worms that was closed that I worked for years to keep closed [I: right] and it got opened when I started [unit] and then I just went downhill": P8