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The unheard voice of the clinician: Perspectives on the key features of an adolescent inpatient model of care

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Authorship

Claire Hayes, Victoria Palmer, Magenta Simmons, Christine Simons, Bridget Hamilton and Malcolm Hopwood supervised the design of this study, data collection and analysis. All authors revised the manuscript. All authors read and approved the final version of the manuscript.

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Abstract

Problem: Little has been reported from clinicians about the operations, interventions and outcomes of inpatient units and how these comprise models of care in such units. The aim of this study was to explore an inpatient model of care in operation at the study site by defining key features of the model from the perspectives of clinicians.

Methods: Semi-structured face to face interviews were conducted with ten clinicians working in a private inpatient unit in Melbourne, Australia. Interview data were analysed using thematic analysis.

Findings: Analysis resulted in the identification of three thematic features relating to containment, engagement and therapy. These included; (a) an environment conducive to containment, (b) adolescent engagement through shared experiences and (c) dialectical behaviour therapy embedded culture.

Conclusions: The findings provide insights into often unheard clinician perspectives on what the key features of an adolescent inpatient model of care are. These features relate to the interventions that are currently offered on the unit and ways of working as informed by philosophies and practices. These findings should be used to improve clinical services and inform research aiming to articulate exemplary adolescent inpatient models of care. Furthermore, the findings provide guidance and practical information to commissioners, clinicians and policy makers implementing models of care.

Keywords: adolescent, inpatient, model of care

Introduction

An increase in the admission rates of adolescents to emergency departments with mental health problems has been documented globally and is also reflected in Australia (Hagell, Coleman, & Brooks, 2013; Hiscock, Neely, Lei, & Freed, 2018; Office for National Statistics., 2011; Sawyer & Patton, 2018; Shanmugavadivel, Sands, & Wood, 2014). Despite attempts to treat adolescents with mental disorders in community settings and an increased focus on earlier intervention, inpatient units remain an important care option in the absence of evidence-based alternatives (Delaney, 2017). The importance of the inpatient role in mental health care is consistent with the increasing rates of adolescent admissions (Blader, 2011; Hiscock

et al., 2018; James, Clacey, Seagroatt, & Goldacre, 2010; Torio, Encinosa, Berdahl, McCormick, & Simpson, 2015).

The primary purpose of inpatient units is for containment of risk and dysfunctional distress responses, and to stabilise symptoms and assist in the development of problem solving skills (Hanssen-Bauer et al., 2011; McGorry & Mei, 2018; Tharayil, James, Morgan, & Freeman, 2012). An admission to an inpatient unit is an intense intervention for any adolescent, at a time in their life where they are particularly vulnerable. It is also one of the most critical times for appropriate and early intervention possibly setting the course of lifelong management of disorders. Consequently, there is an urgent need to focus on inpatient unit programmes, their effectiveness and how they relate to therapeutic outcomes, yet surprisingly little research has been conducted (Delaney, 2017).

Literature Review

The inpatient environment has been identified as providing refuge, asylum and respite; care and nurturing; safety, stability and containment; and activity and engagement (Casher, 2013). In Casher (2013) exploration of the writings of D.W Winnicott (1987), he identified that the therapeutic features of refuge, safety, stability and engagement contributed to healing relationships with patients. Winnicott emphasised that the patient does not exist in isolation. Instead, there is the *dyad* of patient and psychiatrist, a relation which can be extended to patient and inpatient unit, with all its components and clinicians. Furthermore, the dyad exists within a contextual and environment space that shapes the relationship. Casher (2013) noted that Winnicott's concept of the "*holding environment*," referring to an infant's dependency on the mother or environment to meet their needs, could be extended to inpatient units, where an individual is admitted in a heightened state of dependency on clinicians and may develop a relation with the environment reminiscent of the Winnicott's concept of "holding" (Casher, 2013). Here, Casher (2013) referred to a study which examined factors that assist in-patient treatment alliance (Johansson & Eklund, 2004). The study found that the dominant components in establishing treatment alliance were support, encouragement by clinicians and programme clarity. Here, adolescents utilise the hospital's holding function as respite from stress before gradual re-entry to the outside world.

Despite the limited research into adolescent inpatient units and the models of care within these, a recent systematic review evaluated the effectiveness of adolescent inpatient units (Hayes, Simmons, Simons, & Hopwood, 2018) and found that they tend to be effective in the reduction in symptoms for most adolescents admitted. However, few of the included studies described the settings, explored features of the models of care or provided detailed analysis of interventions, therapies or programmes that contributed to the effectiveness of inpatient units.

In a similar review, Indig, Gear, and York (2017) examined inpatient care and when it is most effective for adolescents in addition to appropriate models of care for the treatment of adolescents. The authors reported that few studies documented

comparable aspects of their model of care, including the various treatment components, to determine the active ingredients for effective treatment. There was also limited descriptions of how care was experienced from the perspectives of adolescents and caregivers (Gavidia-Payne, Littlefield, Hallgren, Jenkins, & Coventry, 2003; J. Green et al., 2007; J. Green et al., 2001; Indig et al., 2017). This has been recognised in other studies, where there have been claims of an increasing number of empirical studies published in psychiatric nursing journals, however, few focus on the perspectives of key stakeholders, such as clinicians, adolescents and caregivers (Zauszniewski, Bekhet, & Haberlein, 2012). These empirical studies have examined intervention studies which evaluated strategies, practices or procedures which promote mental health or prevent mental illness within inpatient contexts. The review authors were unable to identify any studies which examined the key features of an effective model of inpatient care (Indig et al., 2017).

To date, there is limited empirical evidence in relation to the effectiveness of adolescent inpatient units and the underpinning models of care. Of the research which exists, there are clear and well-documented limitations. The current evidence cannot be readily synthesised due to the diversity across models of care and treatment interventions provided (Hayes et al., 2018; Indig et al., 2017; Zauszniewski et al., 2012). This diversity relates to different intervention models, health care settings, treatment length and intensity as well as staffing profiles. Staffing profiles relate to the ratio of clinician to patient on an inpatient unit. Similarly, Bettmann and Jasperson (2009) reported significant deficits in the literature with few studies assessing specific programmatic features, that is, what interventions were offered during and post stays. Consequently, researchers and health professionals have been urged to re-evaluate current models of care and conduct research to identify the key features of these models (Davidson, Halcomb, Hickman, Phillips, & Graham, 2006; Regan, Curtin, & Vorderer, 2017).

Of the dearth of studies examining adolescent inpatient units, most have employed quantitative methods of inquiry (Hayes et al., 2018; Indig et al., 2017; Lee, Martin, Hembry, & Lewis, 2018; Patterson et al., 2015; Rouski, Hodge, & Tatum, 2017; Seckman et al., 2017). Whilst this approach might be appropriate for some effectiveness and outcome studies, there are limitations when attempting to understand a specialised inpatient service. To identify the key features of models of care in terms of operationalisation, interventions, programmes and philosophies, further qualitative studies are required. This is because a qualitative approach can provide an in-depth exploration of how the world manifests and operates, by describing behaviours, attitudes and practices, rather than describing statistical means, modes, t-tests and p-values (Rapport et al., 2018).

Clinicians, as key stakeholders play an important role in informing healthcare decisions, practices and processes (Unertl et al., 2018). Studies of adolescent inpatient units have predominantly sought clinician perspectives to understand new processes and the implementation and/or evaluation of a new service or intervention (Knowles, Hughes, Imran, & Fisher, 2017; Patterson et al., 2015) but few have sought to explore their views on the composition of models of care. Other studies have examined the

challenges and impact of working on an adolescent inpatient unit on clinicians (Matthews & Williamson, 2016; Rouski et al., 2017; Sosnowska, 2015). To the researchers' knowledge, no studies have been conducted which describe an adolescent inpatient model of care in operation from the perspectives of clinicians. As with any healthcare initiative, understanding human factors and features of a system, can influence the level of acceptance and ultimately effectiveness of the model of care (Carayon et al., 2014).

This current study fills this gap, by identifying the key features of an inpatient model of care in a contemporary health system from the often unheard perspective of clinicians. This knowledge is important for determining whether these models of care may lead to benefits for adolescents in terms of their experiences of care and future management of disorders. Furthermore, this knowledge may be applicable to adolescent outpatient settings in terms of the identification of programmes, interventions and philosophies of practice. The ultimate goal is to guide operations of current and future inpatient services, as well as assist in the development of future exemplary models of care for adolescents.

This study aimed to describe an inpatient model of care in operation, by defining key features from the perspectives of clinicians. By model of care we mean the fundamental characteristics and components of which the inpatient unit is comprised. This includes defining features of the inpatient setting, which make up the model of care, including organisational structure, admission processes, provision and delivery of all interventions.

Unit's model of care

Participants worked within the current model of care, which has been in place since 2006. In establishing the model of care, a theoretical basis of care was sought on the understanding that inpatient units with a theoretical basis deliver better outcomes. Furthermore, a theoretical basis improves consistency of care, helps formulate management plans and work focus, and provides staff with confidence in their responses. A Dialectical Behaviour Therapy (DBT) model was proposed and presented to nursing and group therapy staff by the Medical Director at several staff meetings on the understanding that the implementation would not proceed unless there was buy-in. The change was supported by regular admitting psychiatrists at their monthly Psychiatrists' Meeting. The model was chosen for its specific delineation of skill sets which allow interventions in situations from a number of entry points. Adolescents with psychiatric morbidity are often compromised in their skill sets and generally are in an intense skill development life phase.

Staff supported the introduction of the model. Two nursing staff left in the ensuing 3 months finding the level of engagement more than suited their work style with staffing subsequently being stable. Staff were trained slowly with monthly sessions to ensure comfort and confidence with understanding and interventions starting with skill modules. This progressed to work requiring blending of skills such as crisis strategies and problem solving over 10 months. Training sessions for nursing staff and

therapy staff were conducted by the Medical Director and continue to be conducted to engage new staff (Rathus, Miller, Linehan, & Miller, 2015). Since 2006, all staff continued to attend sessions allowing training to enhance quality of care by referencing current patients in work examples. Staff tend to apply to work on the inpatient unit because of their appreciation of the model.

DBT was chosen as the foundation theoretical basis which informed all interactions staff to staff, staff to adolescents, staff to parents (Rathus et al., 2015; Tebbett-Mock, Saito, McGee, Woloszyn, & Venuti, 2019). The inpatient unit describes itself as DBT informed while including other therapeutic interventions. The specific DBT group therapy sessions are led by the inpatient unit OT who has formalised DBT training (Rathus et al., 2015). However, all staff receive training sessions from the Medical Director and work across the same model, using similar language and style. The purpose of the model is to provide a safe environment for adolescents experiencing mental disorders. The group-based programme runs on a two week cycle with session flexibility to suit the current patient cohort. Admission are typically 3-6 weeks as would be beneficial for symptom reduction and the development of management strategies. Adolescents work individually with their psychiatrists and in catch ups each shift with inpatient unit staff and most are in family therapy. Some adolescents have one admission, others may have several over a two even three year period. Any further work is manageable in outpatient care.

The culture of the inpatient unit is to provide safety, respect, cooperation between adolescents, amongst clinicians, and clinicians to adolescents. It aims to provide therapy, catering for a range of adolescents and tailored to individual needs. The emphasis of the model of care is on personal growth, connectedness, emotional health and overall well-being. The group programmes draw upon evidence-based therapies, such as DBT, Cognitive Behaviour Therapy (CBT), Supportive Psychotherapy, Psycho-education and Expressive Therapy (Dil, Dekker, Van, & Schalkwijk, 2016; Nielsen, Isobel, & Starling, 2019; Walter et al., 2010). The DBT principles cover four modules, which are core mindfulness, distress tolerance, emotional regulation and interpersonal effectiveness. The model of care offers a range of interventions and provides a flexible environment and culture as illustrated in the below figures based on the insider knowledge and document reviews conducted by author (See Figure 1 and 2).

One of the individual interventions includes the 'distress table', which is located directly in front of the nurses' station. The young person can seek out staff support promptly at the distress table when they are experiencing a crisis. The 'Check In' intervention is an individual session each shift between the adolescent and the assigned contact person. These sessions involve discussions around day-to-day activities, thoughts and feelings, risk assessment, skills work and discharge planning. In group-based interventions, 'community meeting' relates to a daily morning group where each adolescent sets a personal and interpersonal goal. These are then discussed in terms of how they plan to achieve them. The group programmes are delivered by both internal and external staff. Of the participants interviewed, two

deliver the majority of group programmes, whilst remaining participants were involved in the community meeting group each morning.

Insert Figure 1

Insert Figure 2

Both Figure 1 and 2 are presented from insider knowledge to help with the preliminary description of the model of care. Figure 1 includes the range of interventions which occur throughout the day, whilst figure 2 exhibits some of the organisational and contextual elements relating to the physical environment, atmosphere, clinician characteristics and inpatient unit content. Both figures were devised from insider knowledge to provide further clarity regarding an inpatient model of care and core components. To explore the value of any inpatient unit, we first need to identify everything it provides. The purpose of Figure 1 and 2 was to help articulate and conceptualise the current model of care in operation. Such information would be helpful for those planning to develop or improve an inpatient model of care for adolescents.

Methods

This study of clinician perceptions of an inpatient model of care was a qualitative participatory designed interview study. Open-ended semi structured face to face interviews were conducted with clinicians and self-reflections from the main author as a clinician also employed at this site were included. The main author has been employed as a mental health nurse at the Albert Road Clinic for 5.5 years, working on the adolescent inpatient unit. The study was approved by the Ramsay Healthcare Ethics Committee (protocol number EC00242). Once approval was granted, the study was registered with the University ethics committee. Participation was voluntary.

Participants and recruitment

This study was conducted at the Albert Road Clinic in Melbourne, Australia. Albert Road Clinic is part of Ramsay Health Care, which provides private healthcare in the United Kingdom, Australia, France, Indonesia and Malaysia. The 10-12 bed adolescent inpatient unit, known as 'Pathways' is part of an 80-bed private hospital setting, which has been operating since 1975. Characteristics of adolescents admitted generally include adolescents 16 years of age, mostly females, Caucasian and with a primary diagnosis of a mood disorder. The typical length of stay is 3-4 weeks.

Clinicians were recruited for interviews as they were immersed in the everyday operations of the model of care, as well as responsible for the delivery of care. During the inpatient unit handover periods, the main author informed clinicians about the study and provided information packets. The documents in the information packets explained to participants their rights and potential risks of being involved in the study. Participants were invited to contact the main author, using the contact details provided in the information packets if interested in participating in an interview.

The staff who worked on the inpatient unit and were invited included Registered Nurses, Endorsed Enrolled Nurses, an Art Therapist, Occupational Therapist (OT) and a Psychologist. All staff ran adolescent groups. The only inclusion criterion was that participants worked on the inpatient unit with adolescents during daylight hours and had at least one year of experience working with adolescents. The criterion of daylight hours was to ensure the clinicians being interviewed had knowledge of the operations of the model of care, as it functioned during the day. The rationale for this was the therapeutic programmes did not operate at night. Fourteen clinicians were invited to participate in the study (N=14). Ten clinicians agreed to participate. Therefore, a response rate of 71% was obtained for this study. The aim was for a sample size of 12 participants as it was envisaged that shared and repeated themes across participants would become apparent at this stage (Guest, Bunce, & Johnson, 2006). In addition, thematic saturation was observed at this stage.

Data collection

Self-reflections from the main author were used to describe the model of care. This data relied on insider knowledge having worked on the inpatient unit for 5.5 years. Insider knowledge relates to research which is conducted within a social group or organisation of which the researcher is also a member (M. J. Green, 2014). As well as insider knowledge, hospital leaflets and brochures were used to describe and articulate the model of care. Semi-structured face to face interviews were undertaken with 10 participants by the main author between December 2017 and July 2018 at a day and time convenient to participants. All interviews were digitally recorded and conducted in a private room, on a separate level to the inpatient unit at the Albert Road Clinic. Participants were asked to provide an overview of their experiences of working within the inpatient model of care. The mean duration of interviews was 28 minutes (range 16.58-48.25).

Data analysis

As an insider researcher, measures were taken to limit potential bias and increase trustworthiness (Anderson, 2010; M. J. Green, 2014). To minimise potential bias, the principles of Lincoln and Guba (1985) were adhered to, which ensure the trustworthiness of inquiry findings. This involved the stringent criteria in qualitative research, which were credibility, transferability, dependability and confirmability (Lincoln & Guba, 1985). This involved employing the following techniques; persistent observation, prolonged engagement, triangulation, peer debriefing, compiling an audit trail, member checking and producing a reflexive journal (Agostinho, 2005; Lincoln & Guba, 1985; Sim & Sharp, 1998). We adapted these strategies point by point by selecting those techniques that applied to our study systematically. Furthermore, the main author adopted several other techniques to avoid potential bias for the insider researcher. These included interviewing oneself, stream of consciousness writing and speaking with others regarding the experience to create distance and deconstructing the familiar world (Van Heugten, 2004). A final tool, which is important for all research was also employed. This was self-reflexivity,

and particularly relevant for the main author, and the relations between participants (M. J. Green, 2014; Van Den Hoonaard, 2002).

In terms of clinician perspectives, a thematic analysis was conducted to identify patterns and themes of responses present in the interview data. The stages of thematic analysis outlined by Braun and Clarke (2006) were followed, which included: (1) familiarisation of the data set by the researcher, who transcribed and then re-read the transcripts, (2) development of codes that described features of the data relevant to the research questions, (3) grouping of codes to generate initial themes, which produced an initial thematic map, (4) checking and verifying themes across the data set, (5) further analysis and synthesising of the data in order to refine, review and name the themes, and (6) selection of quotations from the transcripts to illustrate the themes and provide a rich description of the data. The data analysis process took place during the data collection phase to identify thematic saturation.

The preliminary model of care description was derived from the main author's own knowledge of the inpatient unit having worked within, as well as available documents. This was added to by identification of clinician perspectives from interviews. Participant characteristics are not included in this paper to protect confidentiality due to the small number of clinicians working on the inpatient unit. However, all participants had worked on the inpatient unit for more than one year. The majority were permanent part-time clinicians and predominantly from nursing disciplines and allied health. Participants worked on average 4 shifts per week.

Findings

Clinicians' perspectives of key features of an inpatient model of care

Three overarching themes were identified in the analysis: (a) environment conducive to containment, (b) engagement through shared experiences and (c) theoretically embedded culture. Each of the themes are described in greater detail below, with illustrative quotes provided as exemplars of each theme. Overall, there was considerable consistency amongst participant's perspectives of the most important features of the model of care for adolescents.

Environment conducive to containment

Clinicians expressed the view that the inpatient model of care provided an environment conducive to containment with emotional safety and security. This included a sense of safety through their physical environment as well as containment of overwhelming feelings and behaviours, which were managed therapeutically. The DBT informed intervention of validation by staff leading to a capacity to self-validate by the adolescent was identified as a powerful factor. One clinician stated that it was respite or "time away from what was stressing them out, such as school and social groups. The environment in which they weren't coping" (Clinician 3). Another clinician felt the environment offered individuation for the adolescent, as they were no longer distracted by their surroundings. Without these external distractions, the

adolescent is provided with a supported space to go “through the pain to be able to find a way they can deal with it (problems), to learn” (Clinician 1).

In the context of containment, structure and collaborative goal setting were also viewed as important. Clinicians focused on the importance of structure and consistency within the environment in terms of setting expectations with adolescents. To establish expectations, consistent messaging was provided in a safe environment by clinicians. Clinicians ensured that adolescents had an organised agenda for the day. This involved an everyday routine, as stated by clinician 2, where adolescents were woken each morning, had a structured timetable, as well as “structure around sleep”. Clinician 10 stated, “They're down at breakfast together at eight thirty. The first group is at nine o'clock which is the community meeting...[it] involves telling them what's going on for the day, they set personal goals for the day.” Similarly, clinician 7 stated that the environment provides, “structure in the day...they're (adolescents) always doing certain things at certain times”.

Clinicians also considered the personal attributes of clinicians in terms of creating consistency and containment within the environment as important. They listed qualities such as being, “positive”, “transparent”, “supportive”, “validating” and “confident” (Clinicians 1,3,5,6,7,8,9,10). Amongst these qualities, transparency appeared to be most important, particularly in terms of consistency for adolescents and for young people to “know where they stand”. Transparency also appeared to be important as the majority discussed being upfront and establishing clear boundaries with adolescents. Clinician 6 stated, “Being really transparent with the adolescents so that they know what the boundaries and guidelines are”. Similarly, transparency was also vital for clinicians as they unanimously shared the same view that “being on the same page” was crucial for containment. Such cohesiveness amongst clinicians helped address commonly noted issues such as competition, contagion or splitting amongst adolescents. Clinician 1 stated, “No matter what staff member the adolescent asks, they (adolescents) will get the same response from each person”.

Clinicians considered consistency within the environment to be an important feature of providing initial containment. One clinician suggested it was integral to engagement, stating, “it can take some containment in order for them (adolescents) to find confidence to participate more” in relation to therapies (Clinician 3). Similarly, another clinician found that initial containment was necessary before any therapeutic engagement could commence. They stated, “If you don't give that containment, you can't have a trusting relationship. If you don't give the validation, you can't get anywhere because the perception is that you can't help, you're not listening” (Clinician 5). Similar views were expressed by clinician 8, who stated, “I think they get a lot of validation and support. I think that is the biggest thing”.

Engagement through shared experiences

In addition to clinicians noting how individual attributes and the environment were essential for containment, they also mentioned the importance of shared experiences particularly in the context of many adolescents tending to feel “different” or have

issues “fitting in” prior to their inpatient admission (Clinician 1). The same clinician said that as a result of their mental health symptoms, many may have been socially “isolated for a very long time”. However, once admitted to the inpatient unit, the adolescent is surrounded by peers with similar mental health problems in a shared space. This is a significant transition from being isolated, as one clinician stated from the adolescents’ perspective; feeling alone and “different” to having “all these friends” who “understand where I’m at, feel what I feel, I open up and tell all my problems to” (Clinician 1). This perspective was shared by Clinician 4 who explained that, “dealing with anyone else, anyone from school, parents or whoever, they don't understand, but the adolescents are all in a similar boat. They're in here getting treatment. They lean on each other and accept each other.”

According to clinician 10, this was a unique experience, suggesting the model of care was “much bigger than just what the skills they learned in the group, it's having an experience. A lived shared experience”. This shared experience allowed adolescents “to feel really truly vulnerable and know that that is ok” (Clinician 9). This was considered an extremely powerful experience for adolescents and fostered that environment where “they (adolescents) can literally talk about anything, where there is no judgement” (Clinician 3). This was a supported view in other interviews also, “...[the unit] gives that platform of a therapeutic relationship for them to open up and start talking about their problems” (Clinician 5). Whilst shared experiences were considered important, clinician 7 considered potential issues in relation to unhelpful friendships as another factor for consideration, which can be “disruptive”. This clinician suggested that when, “they're worried about someone else's problems [they] avoid their own issues”. Other relational issues were expressed by clinician 8 when discussing group dynamics, suggesting there can be a “particularly oppositional group that are easily led”. The Interpersonal Effectiveness strategies of DBT informed principles facilitate boundary setting and learning in a validating way thus being helpful not withholding.

DBT embedded culture

In addition to clinicians facilitating an environment of containment and shared experience, the importance of therapies and programmes were noted. All but one clinician shared the same view that DBT principles were the “most powerful change agent” in the model of care and what it provided adolescents. For clinician 4, the focus was more on engagement and adolescents accepting each other rather than on therapeutic care. Although a range of interventions were provided, the unit culture was embedded in DBT principles, offering validation as well as flexible approach to care. Clinician 10 claimed, “they (adolescents) actually get immersed in a culture that represents DBT, so there's a lot of validation. A lot of respect... that's incredibly powerful for young people that might not have had that experience before”.

The DBT embedded culture was the primary foundation guiding clinicians in how they helped adolescents with problem solving and skill development. First, the basic underlying principles of listening, transparency and validation helped clinicians establish a therapeutic rapport with adolescents. It allowed clinicians to have a

“straight forward plan”, “guide how we (clinicians) conduct ourselves”, as well as “point us in the right direction” (Clinician 2,5). Furthermore, clinicians found that the theoretically embedded culture provided a consistent framework to follow when managing challenging behaviours. Clinician 1 claimed, “DBT was the biggest change... clinicians were educated in a program... to provide the in between bits, how to manage their distress... how to manage their emotions... helping contain that adolescent”. The culture allowed clinicians to model the use of skills during their distress.

The DBT embedded culture helped provide, “skills to deal with life and to think about a life worth living outside of here how to deal with everyday things and how to deal with all of their destructive behaviours as well”. The model of care culture aimed to teach problem solving in the moment, as well as learning to live life in problem solving mode. Clinicians made several references to the educational quality of the inpatient model of care, which aimed to help adolescents apply the skills to their outside environment. This was also reinforced in terms of safety, learning to be less reactive and having the skills to manage symptoms or seek help when needed. Clinician 3 spoke about what the model of care sought to achieve, which was, “To get them (adolescents) to start practicing long term skills to manage better. Giving them the ability to manage themselves in a healthy way as opposed to hoping they figure it out on their own”. A similar view was expressed by clinician 1, who stated the model of care was about, “getting them back to a functioning level... so they (adolescents) can go back home, still function, still try and work but with a bit more extra support or a bit more extra knowledge.”

Discussion

This study sought to describe an inpatient model of care in operation, by use of insider knowledge and incorporating the unheard voices of clinicians. Similarly to Winnicott’s *holding environment* (See box 1) clinicians in this study found that an environment conducive to containment was a pivotal feature of an inpatient model of care. The importance of the inpatient environment has been established in previous studies (Biering & Jensen, 2017; Delaney, 2006; Vella, Page, Edwards, & Wand, 2017). In the current study, clinicians focused on ‘consistency’ and ‘transparency’ as critical professional attributes. It is likely that these terms related to building trust with adolescents within the inpatient environment to facilitate engagement. It has been globally accepted that adolescents have difficulties with engagement (O’Brien, Fahmy, & Singh, 2009; Tindall, Francey, & Hamilton, 2015). By establishing an environment, which is ‘reliable’, adolescents can know what to expect, and thus feel safe and contained, as a prerequisite to engagement.

Engagement through shared experiences amongst adolescents was identified as a key element of the model of care from this group. Although ‘care and nurture’ often refers to support from clinicians, clinicians in this study focused on shared experiences between adolescents. This is an interesting finding, possibly suggesting that clinicians might undervalue their key role on inpatient units or that the model of care is user-driven which is important in the context of growing momentum for peer models of

support. The power of peer solidarity and shared experiences have been acknowledged in other adolescent inpatient studies (Biering & Jensen, 2017; Hart, Saunders, & Thomas, 2005). One study found that relationships with peers influenced adolescents' satisfaction with the inpatient experience (Salamone-Violi, Chur-Hansen, & Winefield, 2015). Another recent study confirmed that adolescents place significant value on social connection (Phillips, Lawler Whatson, Wells, Milson, & Hartley, 2018). In the current study, clinicians discussed shared experiences in terms of acceptance of conditions and a prerequisite for engagement. Biering and Jensen (2017) claim that peer support is an unexploited source of healing potential in adolescent inpatient units. This appears to apply to these findings also.

The DBT embedded culture was found to be a key feature of the inpatient model of care according to clinicians. The culture of any organisation is crucial to how it operates and functions (Davis & Cates, 2018; Garcia et al., 2017). Studies of adolescent inpatient units have focused on the importance of culture models in improving quality of care (Hallman, O'Connor, Hasenau, & Brady, 2017; Slemon, Jenkins, & Bungay, 2017; Vella et al., 2017). Regan et al. (2017) reported that in order to create a therapeutic milieu, a philosophy of care needs to be established to guide the culture and structure of the unit. The clinicians in this current study appeared reassured that the culture had a consistent solid theoretical base in DBT. This created a sense of consistency and cohesiveness amongst clinicians. It also allowed clinicians to feel confident and competent in their work, which can help with containment. This relates to Maslow (1943) hierarchy of needs. Just as adolescents need to feel safe and contained, clinicians have similar needs. The more clinicians had a sense of a structured pathway and model for providing care, they appeared to feel secure and confident in their work, in turn this is helpful for adolescents in creating a safe environment (Hallman et al., 2017).

Limitations

There are limitations which pertain to this study. Qualitative methods are generally employed to explore a specific phenomenon in a specific place and time, with a specific group of people (Leung, 2015). Interviews and transcripts can be open to multiple interpretations. The study did not include the views of adolescents and caregivers. The study specifically aimed to understand clinician's views of the most important features of an inpatient model of care. Therefore, the inclusion of adolescents and caregiver was not considered for this study. Semi-structured interviews were purposeful in nature, and therefore interviews were conducted with an informed and knowledgeable population (Dicicco-Bloom & Crabtree, 2006). Whilst the findings might not be generalizable across all adolescent inpatient units, views reported here may translate to clinicians based in other inpatient settings. All interviews were conducted on site. Whilst this enabled attendance, it might have constrained participants' honesty regarding their views of the inpatient model of care. Furthermore, considering the lead author was also a clinician on the inpatient unit, this might have impacted participants' honesty of data collected, despite consideration of minimising same.

Future implications

The findings identified suggest a need for further research on adolescent inpatient models of care and in particular to identify the views of adolescents and carers of such models. This would be of great value as current adolescent inpatient models need to be identified, revised and refined. Models also need to be reviewed and evaluated regularly to ensure that they continue to consist of best evidence practice. A longitudinal exploratory, mixed-methods study, including adolescent and caregiver perspectives would help identify and articulate an exemplary model of inpatient care for adolescents. This longitudinal information is critical for clinicians and managers undertaking clinical and service planning for adolescent inpatient settings. In addition, further research will inform those planning to improve or develop similar inpatient services. This will help strengthen the quality of services and influence their direction with the aim to improve the inpatient experience and therapeutic outcomes for adolescents and their families.

Conclusion

The purpose of this study was to describe an inpatient model of care in operation, by defining key features from the perspectives of clinicians. The findings demonstrate that an environment conducive to containment is pivotal for an adolescent inpatient model of care. Clinicians also identified engagement through shared experiences and the DBT embedded culture as key features of the model. The findings of this study provide insight into clinicians' perspective of what constitutes an adolescent inpatient model of care, an area with little research. However, further research is warranted on this complex topic to help articulate an exemplary inpatient model of care for adolescents and to identify adolescent experiences of such models.

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Figures

Figure 1: Interventions provided as part of the model of care

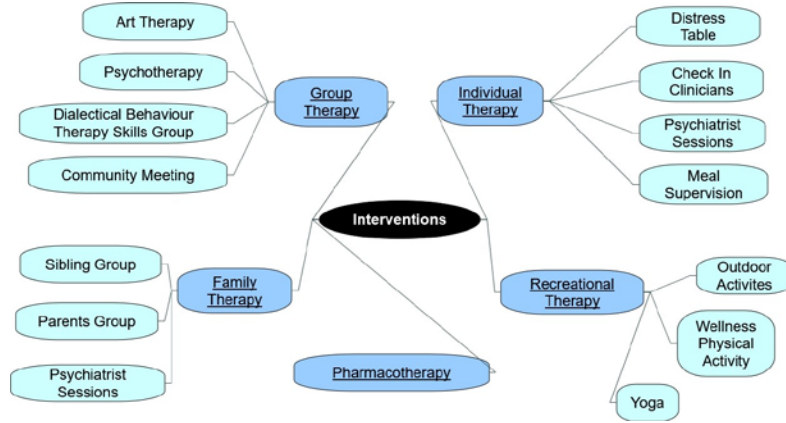


Figure 2: Environment and culture of the model of care

