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Title: Experiences of an adolescent inpatient model of care: adolescent and caregiver perspectives

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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.

Abstract

Problem: Adolescent inpatient units have been studied regarding their effectiveness, yet little is known about the experiences of young people who are admitted and their caregivers. It is important to address this gap to understand adolescent inpatient models of care and therapeutic outcomes to maximise the benefit. Our aim was to explore adolescent and caregivers' experiences of an inpatient model of care and perceived helpfulness.

Methods: A longitudinal prospective qualitative design was utilised. Semi-structured interviews were conducted with 16 adolescents and 12 caregivers at T1 (admission), T2 (discharge) and T3 (six months post discharge). Data were analysed first thematically and then using trajectory analysis. Themes from the three time-points are presented from the combined perspectives of adolescents and caregivers.

Findings: Experiences described followed a recovery narrative consisting of three key phases which included, 'waiting for help' (T1), 'help arrived' (T2) and having

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'returned to regular life' (T3). The overarching trajectory theme was a 'winding road to recovery'.

Conclusion: Findings provide insights into the lived experiences from adolescents who have had an inpatient stay and their caregivers of an adolescent specific inpatient model of care. These findings can help conceptualise quality adolescent models of care for young people and their families.

Introduction

Adolescence is a unique developmental period characterised by numerous biological and psychological changes (Jaworska & MacQueen, 2015). Experiencing mental health difficulties in this period of life has significant repercussions for young people and their families (Ward, 2014). For young people who experience mental ill health, active engagement in biopsychosocial treatment is important for achieving their potential and living fulfilling lives as adults (World Health Organization, 2018). Effective early intervention can reduce the risk of death by suicide or long-term disability characterised by incomplete education, social isolation and significant symptoms which interfere with daily living and impair overall quality of life experiences and opportunities (Gonzalez, Goplerud, & Shern, 2015; McGorry, 2011; Read, Roush, & Downing, 2018). Therefore, adolescence is a crucial time for early intervention and treatment engagement with the aim to assist recovery (Author; Copeland et al., 2015; Mock & Arai, 2011).

Research has slowly progressed from focusing on signs and symptoms alone as measures of clinical recovery (Schreiber, 1996). Recovery can be defined as "a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and or roles" and a "way of living a satisfying, hopeful, and contributing life even with the limitations caused by illness" (Anthony, 1993; Slade et al., 2014). Personal recovery is a subjective experience (Bellack & Drapalski, 2012). According to Slade et al. (2014), there can be overlap between individuals, but there will be many subjective definitions of recovery considering the individual's understanding of his/her own recovery will change over time. Whilst some individuals might follow a 'typical' recovery trajectory, we know that personal recovery is different for everyone. Furthermore, the recovery process is even more complex when overlaid with the developmental transitions involved in adolescence (Wood et al., 2018).

Many adolescents who seek help are treated and supported in the community (e.g. primary care and services such as Headspace in Australia and Jigsaw in Ireland) and outpatient settings (e.g. individual or group private practice) (Author; Delaney, 2017). However, some young people experience their challenges as life-threatening and they and their families seek more intensive interventions such as those delivered within an inpatient unit (Delaney, 2017). Adolescent inpatient units are specialist services providing a therapeutic environment for young people with the most complex mental health issues which families and young people feel cannot be safely resolved in community settings due to perceived risk to self (Duddu et al., 2016). An admission to an inpatient unit is a significant event for young people and their families (Stanton,

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Lahdenpera, & Braun, 2017). The experience is likely to be varied based on patient and service factors, such as length of stays and the Model of Care (MoC) in operation. Length of stays for young people range widely from four to 335 days including differences in philosophical and practical approaches to MoCs (Author).

As will now be described, research into adolescent inpatient units shows that they are effective in terms of symptom stabilisation (Author; Lee, Martin, Hembry, & Lewis, 2018). Studies demonstrate that for the majority of young people, their general mental health improves by the time they are discharged from an adolescent inpatient unit (Author). Despite the effectiveness of these inpatient stays, reviews highlight the limitations of current research in terms of insight into what a MoC is comprised of, additional experiences that contribute to symptom stabilisation and the overall experiences of young people and their caregivers (Author). Studies do not provide detailed descriptions of the MoC at each inpatient unit. A MoC should include the fundamental characteristics and components of which the inpatient unit is comprised, so that others may ascertain to what extent this MoC can be applied elsewhere (Author).

Why are inpatient units effective for adolescents?

Adolescent inpatient units are effective for many young people, but little is known about ‘how’ and ‘why’ these positive changes occur (Author; Lee et al., 2018). Effectiveness related to various areas of functioning, relationships, symptom severity related to anxiety, depression, psychosis and mania, as well as risk factors (Author). Other domains included internalising and externalising problems as well as academic abilities (Author). Most studies have utilised quantitative designs, providing answers to one part of the experience and effect of adolescent inpatient units. However, studies are limited in quantity as well as in detail about the phenomenological experiences of an inpatient MoC and ‘how’ and ‘why’ this might be helpful from the views of the adolescents and their families. This research gap suggests that quality inpatient units just happen and that any professional group could operate the therapeutic milieu as well as any other (Delaney, 2019). Consequently, it is crucial to focus on inpatient unit programmes, their effectiveness and how they relate to therapeutic outcomes (Delaney, 2017). Furthermore, perspectives on inpatient treatment will help build a quality process and implement a MoC suitable for adolescents with a range of complex mental health disorders.

Are caregivers of young people involved?

Caregivers, be that biological parents or legal guardians of young people play a significant role in supporting adolescents through crisis and recovery (Association for Young People's Health, 2016). However, caregivers of adolescents with mental health problems seem to be particularly unsupported and isolated (Association for Young People's Health, 2016). An admission to an inpatient unit is often a time when the young person’s family is already in a state of crisis (Scharer, 2002; Ward, 2014). Whilst the young person is in inpatient care, maintaining family solidarity, as well as other responsibilities is difficult, especially if travel distance is involved to visit their

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young person (Suiter & Heflinger, 2011; Ward, 2014). Conflict related to treatment might also arise, particularly if a family and young person disagree on what help is needed.

Delaney (2017) reports that struggles for caregivers of adolescents manifest on many levels, which include the journey to find treatment, building an environment which supports the young person's strengths, and in some instances, visualising a hopeful future. To support adolescents, caregivers need to be involved, particularly as this relates to more positive outcomes for young people (Svavarsdottir, Gisladottir, & Tryggvadottir, 2019). Ideally, in the inpatient setting, help is provided to each group, being caregivers and adolescents. Caregivers often appreciate time to talk with professionals or supportive others apart from their child. Supporting both adolescents and caregivers within a MoC can enhance recovery and reduce likelihood of future admissions. In addition, important protective skills and strategies can be developed during an inpatient stay. Despite the important role caregivers play in supporting adolescents, little research exists which includes them and their perspectives on inpatient MoCs and their experiences of support and a child receiving care.

What are the perspectives of caregivers and adolescents?

Whilst qualitative research about the experiences of adolescent inpatient services is growing, few studies include a broad range of perspectives surrounding an adolescent inpatient MoC (Hammarberg, Kirkman, & de Lacey, 2016). One study was found which examined the perspectives of adolescents, caregivers and clinicians in an adolescent inpatient unit (Ward, 2014). Ward (2014) found that relationships were important in recovery for adolescents as well as incorporating a developmentally-informed framework. Elements that were considered crucial to adolescent recovery were the importance of fit between adolescent and hospital environment, supportive management which contains the anxieties of staff and open collaboration between caregivers and staff.

Most inpatient studies concerning caregivers of adolescents with mental health problems are survey-based, measuring adolescent outcomes using standardised measures and at various time-points (J. Green et al., 2007; Greenham & Bisnaire, 2008; Madan, Sharp, Newlin, Vanwoerden, & Fowler, 2016; Mathai & Bourne, 2009; Tas, Guvenir, & Cevrim, 2010). Some qualitative studies were identified. One mixed-method designed study investigated the psychosocial resources and needs of caregivers (n=44) following their child's inpatient admission (Blizzard, Weiss, Wideman, & Stephan, 2016). The authors found high levels of strain, child symptomatology, and low levels of empowerment and social support. Caregivers identified a need for more knowledge concerning behaviour management strategies, improved caregiver/child relationship and more emotional support (Blizzard et al., 2016). The study concluded with the suggestion that incorporating caregiver's needs may result in more effective and acceptable interventions for families (Blizzard et al., 2016).

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In a mixed-methods study of adolescents with eating disorders and hospitalised for medical stabilisation, Bravender, Elkus, and Lange (2017) sought to understand how adolescents (n=23) and caregivers (n=32) perceived the hospitalisation experience. Adolescents considered “massage therapy” to be most helpful and “cell-phone limits” least helpful. Caregivers found “nursing staff” to be most helpful and “seeing other patients in the hospital” least helpful. Protocol components viewed differently by adolescents and caregivers included caregivers more strongly endorsing “staff supervision of meals” and “limits on physical activity”. Findings like this highlight that views between adolescents and caregivers may differ in relation to the specific eating disorder inpatient service provided and potentially other adolescent inpatient services.

To the author’s knowledge, studies have not explicitly investigated adolescent experiences of an adolescent inpatient MoC. In a recent descriptive review, Author examined non-pharmacological therapeutic interventions provided on adolescent inpatient units. There were two of the ten studies identified that included adolescent perspectives. Adolescent perspectives are a neglected voice in programme design, despite their perspectives being most important, as the people receiving these treatments and interventions. We acknowledge that whilst adolescents are entering a phase of autonomy, caregivers continue to have significant involvement with decision-making power, particularly in relation to medical treatment.

It is suggested that by investigating not only adolescents, but adolescent and caregiver perspectives together by attending to commonalities and differences that a more complete and holistic MoC picture can be created (Ward, 2014). The voices of these important stakeholders are currently absent (Tas et al., 2010). It is anticipated that these perspectives will not always align or be easily harmonised (Ward, 2014). However, incorporating adolescent and caregiver perspectives can guide policy development with the improvement of more helpful models of care for young people and their families. Despite the policy consensus, developing a recovery orientation in mental health services which gives primacy to individual’s understanding has proved challenging (Slade et al., 2014).

What are the characteristics of mental health recovery narratives?

Narratives of recovery from mental health issues have played a central role in the establishment of the recovery paradigm within mental health policy and practice (Llewellyn-Beardsley et al., 2019). To develop a conceptual framework characterising mental health recovery narratives, Llewellyn-Beardsley et al. (2019) synthesised published typologies in a systematic review. The authors found 45 studies, 96% of which were adult studies analysing 629 recovery narratives. A conceptual framework was developed, which included nine dimensions. These were, ‘genre’, ‘positioning’, ‘emotional tone’, ‘relationship with recovery’, ‘trajectory’, ‘use of turning points’, ‘narrative sequence’, ‘protagonists’ and ‘use of metaphor’ (See Table 1).

The ‘trajectory’ domain consists of the ‘upward spiral’, ‘up and down’, ‘horizontal’ and ‘interrupted’. The ‘upward spiral’ narrative describes a journey with an overall

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ascending progression toward recovery. These can be narratives of revelation or purposeful suffering, darkness to light towards a better future or overall improvement. Setbacks can occur, which are defined as solvable problems. 'Up and down' relates to a non-linear journey which challenges the progressive trajectory of moving toward health. These can be experiences as dramatic, "roller coaster" narratives or narratives with "downs as well as ups". Finally, the 'horizontal' domain consists of narratives with significant upturns or downturns, whilst the 'interrupted' constitutes a journey interrupted by an unexpected crisis or difficulty. During the latter domain, the individual's life has returned to its prior state. The 'narrative sequence' domain consists of three domains, which are, 'experience of distress', 'turning point' and 'experience of recovery'. The study concluded suggesting that recovery narratives are diverse and multidimensional, which may be non-linear and reject coherence. In addition, the authors emphasised the need for more research into the narratives of more diverse populations.

Insert Table 1

Where are we now?

There is an urgent need to articulate the inpatient role in facilitating recovery for young people (Author; Author). To the authors' knowledge, no study has explored the inpatient MoC experience over time, from the point of admission, discharge and post discharge from the perspectives of adolescents and their caregivers. To understand 'how' and 'why' an inpatient admission might be helpful for young people, it is most appropriate to ask those who experience it directly and for this to inform future inpatient development and design efforts. Furthermore, these time-points are likely to be associated with particular issues for adolescents and their families. Different ideas are likely to come forward over time, with changing priorities. The earlier phase may capture individual's expectations and sense of urgency. At discharge, people have opportunities to reflect on treatment received, as well as new challenges when returning home, perceived changes and gain another perspective on the impact of the episode of care. These perspectives can identify potential gaps in an adolescent inpatient MoC, as well as understand the recovery trajectory for adolescents.

Methods

Aim: This study aimed to understand how adolescents and caregivers experience an inpatient MoC and perceive the helpfulness of this over time. Ethical approval was given by the local external Human Research Ethics Committee review board (protocol number removed for review) at the site under investigation.

A longitudinal prospective qualitative design was adopted to understand how adolescents and caregivers experience an inpatient MoC and its perceived helpfulness over time. A longitudinal approach was chosen as individual's experiences of health care systems may change over time (Grossoehme & Lipstein, 2016). Interviewing participants at various stages provides a more dynamic picture of their experience rather than single interviews (Murray et al., 2009). However, this approach is rarely

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used. Longitudinal qualitative interviews offer considerable advantages over typical single 'snapshot' techniques in understanding individuals' changing experiences of illness and healthcare systems (Murray et al., 2009).

Longitudinal interview studies can help identify changes in what adolescents and their families want, the best way to carry out interventions, and which outcomes matter most and at what times (Murray et al., 2009). Serial interviews also allow the participant-researcher relationship to develop over time, enabling the generation of more private accounts and descriptions of sensitive topics that are less accessible in a single interview (Murray et al., 2009).

This approach is appropriate when exploring evolving and complex processes such as an inpatient MoC. A prospective understanding of the longitudinal experience can provide insight and direction, an advance on current cross-sectional studies (Grossoehme & Lipstein, 2016). Semi-structured individual interviews were conducted with adolescents and caregivers separately at baseline or admission to the inpatient unit (T1), discharge from the inpatient unit (T2) and six months post discharge (T3).

The first author worked as a mental health nurse on the inpatient unit being studied. Consequently, measures were employed to limit potential bias and increase trustworthiness (Anderson, 2010; M. J. Green, 2014). The principles of Lincoln and Guba (1985) were adhered to, which ensure the trustworthiness of inquiry findings. This involved adopting the following techniques; persistent observation, triangulation, prolonged engagement, peer debriefing, compiling an audit trail and producing a reflexive journal (Agostinho, 2005; Lincoln & Guba, 1985; Sim & Sharp, 1998). These strategies were adopted by selecting those relevant to our study systematically. Furthermore, the first author adopted several other techniques to avoid potential bias. This included maintaining a reflexive journal and speaking with others regarding the experience to create distance and deconstructing the familiar world (Van Heugten, 2004). A final tool was employed, which was self-reflexivity, and particularly relevant for the first author employed at the inpatient unit and the relations between participants (M. J. Green, 2014; Van Den Hoonaard, 2003). The first author did not discuss the study with any adolescents or caregivers during clinical working hours. This did not create any issues during the study and the provision of care continued as normal.

Study setting and participants

Participants were recruited from a private adolescent inpatient unit in (Removed for review), Australia. The 10-12 bed adolescent inpatient unit known as '(Removed for review)' is part of a broader private mental health hospital setting, providing voluntary inpatient treatment for adolescents between the ages of 12 and 22 years old. Caregivers and adolescents provide formal consent for an inpatient admission. A detailed description of the setting and MoC has been described in previous work (Author). In brief, this MoC includes a 10-12 bed unit that is staffed with a multidisciplinary team. A range of therapeutic interventions are provided with

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Dialectical Behaviour Therapy (DBT) as the underlying theoretical basis of care. In establishing the MoC, a theoretical basis of care was necessary on the understanding that inpatient units with a theoretical basis deliver better outcomes. Furthermore, a theoretical basis encourages consistency of care, helps formulate management plans and work focus, and provides staff with confidence in their responses (Removed for review). The culture of the inpatient unit is to provide respect, safety, cooperation between adolescents, amongst clinicians, and clinicians to adolescents (Removed for review). Adolescent and caregiver inclusion criteria for the study are presented in Box 1.

Box 1 Eligibility criteria

Adolescent

Inclusion criteria

- Aged 12-22 years.
- Diagnosed with a mental health disorder.
- Receiving inpatient treatment.

Exclusion criteria

- Inpatient admission less than 24 hours.

Caregiver

Inclusion criteria

- Caregiver's child is between 12-22 years.
- Caregiver's child has a mental health disorder.
- Caregiver's child is receiving inpatient treatment.

Exclusion criteria

- Caregiver's child has an inpatient admission less than 24 hours.

Recruitment

Recruitment was conducted over an 11-month period, where any adolescent admitted to the unit was invited (alongside their caregiver) by the primary researcher to take part in individual interviews about their experiences (see Figure 1). Participation involved an interview at T1, T2 and T3. Information packets were provided to potential participants outlining details of the study as well as any potential risks. Participants were asked to contact the researcher if interested in participating. Formal written consent was obtained from all participants in writing prior to T1. All

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participants were aware that the primary researcher was conducting the interviews and that participation in the study would not impact their clinical care.

Insert Figure 1

Data collection

Consenting adolescents and caregivers were interviewed separately. Those who did not wish to participate did not contact the researcher after being introduced to the study. Face-to-face interviews were conducted in a location separate to the inpatient unit to maintain confidentiality. Semi-structured interview schedules were designed to be flexible, using non-directive questions (see Box 2). The median duration of adolescent interviews at T1 was 49 minutes (range 23-82), 29 minutes at T2 (range 14-52) and 42 minutes at T3 (range 19-76). For caregivers, the median duration at T1 was 51 minutes (range 29-87), 35 minutes at T2 (range 20-64) and 35 minutes (range 20-73) at T3. All interviews were recorded on an audio device and transcribed professionally. All transcripts were checked against audio files for accuracy and any details which identified participants were removed. Transcripts were stored in a password protected database and coded using NVivo V.10 (qualitative data management software) (QSR International Pty Ltd, 2012).

Box 2 Semi-structured interview schedule for adolescents and caregivers
• What were the precipitating factors leading to the inpatient admission? • What are your expectations of the inpatient model of care? • How was your experience of the inpatient model of care?

Data analysis

The longitudinal interview data from adolescents and caregivers were analysed in two ways. First, data were explored thematically, i.e across participants at the one time point such as T1 to understand the experiences of the MoC and interactions with different MoC elements, as well as areas for improvement. The same process was then completed for T2 and T3. Thematic analysis enabled the exploration of data as a first step preliminary analytical tool.

Second, data were analysed longitudinally case by case to understand themes that held over time and those that shifted. Trajectory analysis focuses on changes over time and is recommended to understand healthcare processes (Grossoehme & Lipstein, 2016). As suggested by Grossoehme and Lipstein (2016), time-ordered, sequential matrices were used to preserve the 'chronological flow' and permit understanding of what led to what (Miles & Huberman, 1994). Codes were identified from the interviews,

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clustered and formulated into themes. The thematically clustered data were organised within matrices, with one matrix per unit of analysis, such as the adolescents, caregivers, adolescents and caregivers or other grouping. The first set of matrices were organised with themes along the Y-axis and time along the X-axis (see Table 2 for example taken from adolescent and caregiver interviews). Once the coding had been completed, longitudinal analysis began. This step focused on how the data did or did not change over time. To organise the findings, another matrix was required (see Table 3 for examples taken from adolescent and caregiver interviews). The Y-axis was organised by themes whilst the X-axis was organised according to the primary units of analysis. Data analysis was conducted from the second matrix in which the codes were focused on time.

Insert Table 2 & 3

Although the first author undertook the primary coding and analysis, the analysis process was discussed and justified with supervisors at regular meetings. Furthermore, a smaller subsample was double coded during the initial stages of the thematic analysis. This did not occur during the trajectory analysis, as this would be too difficult and likely interfere with the analysis process. The data analysis process adhered to the quality criteria described by Lincoln and Guba (1985) to ensure rigour and trustworthiness of the study in terms of credibility, transferability, dependability and confirmability. Whilst member checking was not adopted, the first author regularly summarised key themes from each interview and clarified these with participants throughout each interview to minimise risk of misinterpretation. Finally, in terms of reporting, the Consolidated Criteria for Reporting Qualitative Research (COREQ) was utilised (Tong, Sainsbury, & Craig, 2007). COREQ is a 32-item checklist for interviews and can help researchers make transparent important aspects of the study in terms of research team, study methods, context of study, findings, analysis and interpretations (Tong et al., 2007).

Findings

Sample characteristics

There were 95 adolescents admitted to the inpatient unit between the 22nd May 2017 and 3rd April 2018. Of these, 23 (24%) were readmissions from the same period of time. The repeat admissions were excluded from analysis, leaving a total of 72 adolescents for the period in question. Adolescents who had a previous admission were still invited to do the interview but were not counted twice in the overall numbers to avoid duplication of cases. Characteristics of the entire admitted sample (N=72) are presented in Table 4 as well as the subgroup of adolescents interviewed (N=16).

For the total sample (N=72), ages ranged from 13 years to 21 (mean 16.2, SD= 1.6). Fifty-nine were female (81.9%) and 13 male (18.1%). In terms of ethnicity, 66 (91.7%) were Caucasian, with the remaining 8.3% (n=6) from other ethnic groups (specific cultural background information was not collected as it would be too

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identifiable to include). The length of stay varied from one day to 67 days (mean 28.0, SD= 15.8). The majority of adolescents had a primary diagnosis of a mood disorder such as Major Depressive Disorder (n=41/56.9%) followed by an anxiety disorder such as Generalised Anxiety Disorder (n=18/25%). Diagnostic co-morbidity was present in 75.7% (n=53) of the sample, with all adolescents receiving more than one mental health diagnosis on discharge.

Insert Table 4

The average length of stay was longer in the interview subgroup (n=16) (35.3 days; SD=15.5) in comparison to the overall sample (28.0; SD= 15.8). However, this difference was largely explained by one participant who had a long stay of 67 days and the groups did not vary on any other characteristics. In terms of caregivers, 12 participated at T1, 12 at T2 and 11 at T3. Most caregivers were mothers (91%, n=11) with one remaining father.

Experiences of adolescents and caregivers

To meet the aim of this study, the findings of the trajectory analysis for adolescents and caregivers are presented together to capture their collective experiences of the MoC and perceived helpfulness. Thematic analysis revealed similar patterns of experiences and perceived helpfulness. Where relevant, similarities and differences between the views of adolescents and caregivers are reported. The trajectory of recovery became prominent during the thematic analysis as core themes related to seeking help, getting help and returning to normal life reflected other narrative work in recovery and the 'up and down' trajectory. The findings are organised around the trajectories of recovery and presented as themes from the three time-points to help understand what led to what.

Waiting for help (T1)

At T1, adolescents and caregivers focused on experiences prior to their inpatient admission. This consisted of sharing the story of how the young person was coping prior to the admission and reaching a point where adolescents and caregivers felt they had exhausted all other mental health treatment options. Holding on for the admission revealed a sense of both relief and uncertainty, whilst key expectations related to the MoC being one step in recovery.

Getting through the day

At the first interview, adolescents and caregivers focused on how the young person was functioning prior to the inpatient admission. With an accepting tone, one adolescent described a typical day prior to the admission, "wake up around twelve in the afternoon… wash the dishes… sit up all night, smoking cones or watching movies" (Adolescent 3). Alternatively, other young people continued to attend school and were "coping externally", "yet in the background…really struggling" (Caregivers 1,2). Similarly, one adolescent recalled how she would "force" herself to "exercise and make friendships" but "never enjoy it" (Adolescent 10).

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Although the level of functioning for each young person varied, some caregivers sounded particularly exasperated. One caregiver reported how her child, "can't function, maintain a relationship… go to school…she barely gets through the day" (Caregiver 3). Similarly, another caregiver claimed, "there isn't a part of her life which is normal" (Caregiver 7). The same caregiver discussed how her daughter presented in her daily life:

"she can go to school…she can present as if there aren't any issues… but she can't do things in the way everyone else is expected to do them. She needs to either be doing it at a different time or on her own".

For some caregivers, maintaining safety for their child in terms of suicide and self-harm was required at home prior to the inpatient admission. One caregiver described this intense period of time:

"It was often quite intense and difficult to be on watch…had to put a safe in the kitchen for knives and things like that…a combo lock that everyone else knows and he doesn't, obviously lock the cupboards. Those little things you know, they're not hard to manage and deal with, but every time you go to unlock it, I guess, it's symbolic of what the circumstances are…heightened vigilance that meant we were on edge" (Caregiver 5)

Regular life lacked normalcy for many families prior to the admission, the experiences were described as being on-edge and on-watch and this was prominent at T1. For adolescents, there was a focus specifically on their daily mental health struggles, whilst caregivers considered their child's mental health struggles in addition to the family environment, emotional impacts and managing this.

Tried everything

Adolescents described reaching a point prior to their admission where they were struggling to manage life to their potential and mental illness. One adolescent reported that the admission occurred, "because I haven't been getting any better", whilst another claimed, "if I keep going like this, I'm going to end up in jail" (Adolescents 8,5). Schoolwork was the focus for others and "all that matters to me" and "if this [admission] helps me do schoolwork, I'm willing to try it" (Adolescent 13). Another adolescent spoke of how her sibling urged her to have an admission stating, "I'm not allowed go [suicide] until I've tried everything [admission]" (Adolescent 4).

Despite strained circumstances at home prior to T1, for many families, the decision to have an inpatient admission was difficult and not "something we do lightly" despite having "tried everything" (Caregiver 2). The decision to have an inpatient admission was poignant for some caregivers, invoking feelings of failure, self-blame and powerlessness. One caregiver questioned, "Am I doing the right thing? Am I a complete failure as a parent?" (Caregiver 11). Another described, "feeling like we are in over our heads as parents" and "looking to the professionals to guide us" (Caregiver 5). Many young people (n=10) indicated that the decision to have an inpatient admission was mainly led by their parents or mental health professionals. Adolescents did not describe this as a positive or negative experience, adopting a relatively neutral tone. At T1, adolescents and caregivers considered decisions leading

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to the admission and running out of ideas with the inpatient admission being the final option.

Holding on

The experiences of waiting for the inpatient admission were frequently voiced during T1 interviews particularly for families whereby it was their first admission. Although waiting was associated with much tension, for some, the confirmed admission appeared to provide a sense of relief and comfort to many families with a calming influence on their young person's mental health. One adolescent recalled this experience stating, "my mood was still low but I was more rational…then I went to the hospital on the Monday" (Adolescent 16). However, it was the first admission for one young person, who recalled feeling "a bit anxious" about the admission, stating, "you don't really think good things when you say mental hospital" (Adolescent 8). More tension was observed amongst caregivers, as one described "hanging on by our fingernails", whilst waiting eight weeks for an admission (Caregiver 10). For another caregiver, it was described as a "period of limbo":

"Just doing circles around the airport waiting to land. He [adolescent] *was wanting to come in, and while he was in the holding pattern, he stayed really low, but once he had an interview here, then a phone call for a placement the next day, his mood was actually really good those couple of days because he could see that something was going to help him"* (Caregiver 5)

The admission process was quick for one family with "a couple of days' notice" for the admission (Caregiver 7). This created some worry, as to whether her young person had enough time to prepare for the admission stating: "relieved and apprehensive about telling her…I was worried she would refuse it [admission] because she hadn't got enough time to prepare herself". Waiting for the admission was a tense time for many families consisting of both relief, uncertainty and hope for help.

Key expectations

Adolescents and caregivers had key expectations for the MoC. These included obtaining "stability", "structure" and "skills" to "function" and "cope" in "daily life a bit better" (Caregivers 2,3,6,7,8,9,10,11,12) (Adolescent 3,6,7,8,9,12,14,15,16). There was also an understanding or acceptance that one admission would not "fix" or "cure" everything, such as "my anxiety" or "depression", but "hopefully this is the first major step in his recovery" (Adolescent 1,5,16) (Caregiver 1,5,9,10). For adolescents, school was a priority. One adolescent wanted "structure" to help with returning to school (Adolescent 9), as others declared their expectations:

"Help me to be able to do work at school, at least at the standard that I used to" (Adolescent 13)

"Obviously not everything to be fixed but feel a bit better so I can keep going to school" (Adolescent 16)

Safety emerged as a key expectation particularly from caregivers. One caregiver hoped that her child, "will see a future for herself…have some hope in life and realise how amazing she is and be able to hear that" (Caregiver 7). Some adolescents felt differently appearing to have no expectations of the inpatient MoC, stating, "To be

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honest, I'm not planning on staying [on inpatient unit] for very long" (Adolescent 7). Another when asked about their expectations of the MoC declared, "I have none" (Adolescent 2). At T1, the key expectations of the MoC were for young people to return to their lives and function to the best of their ability, to continue engaging in "normal things…the way normal teenagers do" (Caregiver 10). However, for some young people, they remained ambivalent and uncertain about what they expected. Adolescents seemed understandably inwardly focused and reserved at T1. This might be related to being at the initial stages of an intensive process having just been admitted to hospital for treatment.

Help arrived (T2)

At T2 interview points, adolescents had been admitted to hospital and thus were immersed in the inpatient MoC. Therefore, young people had more to say in terms of the MoC at this point than their caregivers. At this time, caregivers could be considered somewhat outside observers of the MoC. Adolescents and caregivers relayed their experiences of the MoC, particularly how young people adjusted to the environment initially and views of perceived helpfulness. Discharging from the inpatient unit was an uncertain time for many families filled with many worries related to uncertain recovery.

A safe environment

Adolescents described the MoC environment as "safe" and "comfortable" (Adolescents 1,2,5,12,14,16). For one young person, the environment helped them feel, "safe…more comfortable being myself", whilst others claimed, "I could be whatever mood…show it…communicate it more" and be in, "a safe place to express your ideas in a visual way" (Adolescents 5,1,12). However, for some adolescents, settling into the unit took some time. One adolescent recalled, "it took me about a week to settle in…to actually speak about what was on my mind" (Adolescent 9). Most adolescents appeared to adjust to the inpatient unit environment with ease, much to the surprise of some caregivers:

"Been initially disturbingly surprised but now pleasantly surprised that he was so comfortable and independent when he came in here. I'd expected it to be tougher but I guess it took him away from a lot of things…just like the honeymoon period I guess…whatever he didn't like around home or in his life situation, it was a total break from that and okay, it's not a tropical island but in a sense, it probably was for him" (Caregiver 5)

Although one caregiver acknowledged that the inpatient environment was helpful for her child's anxiety, the concept that she was "happily settled in a psychiatric unit" was a "struggle":

"She seems happy, it worries me that, at 16, she's happily settled in a psychiatric unit. I struggle with that. Struggle with how I feel about that every day…I think her anxiety has probably gone from 100 to nothing in here, she's safe. She's got some thinking time, she's happy in here" (Caregiver 4)

Most young people appeared to adjust to the inpatient unit with ease, suggesting that the environment was helpful in making young people feel "comfortable". For some caregivers, their child's ability to tolerate the inpatient environment was unexpected,

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considering their level of functioning prior T1. For other caregivers, although the inpatient environment was a relief by being helpful, there was some mild resentment.

Relationships

Relationships with staff played a key role in terms of perceived helpfulness and were valued by many adolescents and caregivers. Staff attitudes and support were comforting to adolescents and provided an opportunity to connect with people who understood what they were going through. As well as being "supportive", "friendly" and "approachable", "they [staff] can relate to you which makes everything better" (Adolescents 5,9). Furthermore, adolescents described feeling confident in staff being "well trained" and able to, "deal with unfortunate situations" (Adolescents 14,8). "Respect" within the inpatient unit was observed by one caregiver reporting, "a respectful tone with the other patients to each other…within the staff of the hospital…respect going both ways" (Caregiver 12). Caregiver 7 stated, "I didn't expect every single staff member to be so amazingly kind and supportive".

Peer influence was important and reflective of adolescents and their developmental stage. Relationships with peers and "being around other people who are also suffering in similar situations" was perceived as helpful (Adolescent 8). Being understood and trust was a key aspect in developing friendships on the unit as one young person claimed, "to find new friends in here…I trust people in here" (Adolescent 11). At times, these peer relationships were difficult for caregivers. One caregiver recalls a week where, her child's "gone through the cycle of not needing us to visit", thus indicating some feelings of rejection (Caregiver 6). The same caregiver acknowledged the importance of "making friends" but worried about the "intensity" of some peer relationships within the MoC.

Skill development

Following the inpatient admission, caregivers spoke less of skill development having been apart from their young person during the admission and thus being outside observers. Although adolescents discussed a range of interventions provided within the inpatient MoC, group therapy appeared to be the most powerful for young people. The DBT skills group helped young people find strategies to manage their own distress. When discussing episodes of "crisis" or intense distress during their inpatient admission, many young people described DBT "distress tolerance" skills to manage (Adolescent 1,5,10,16). One adolescent planned to use the DBT skills in the event of experiencing a crisis post discharge:

> *"I would turn to distress tolerance…doing things that calm myself down because they are the things* [skills] *that I know work…like a walk away tactic where you walk away from the situation before it explodes…that is something I can do"* (Adolescent 5).

One adolescent labelled art therapy "empowering" stating, "Yesterday's theme was 'my anxiety lives' and then we'd do a visual representation of what that meant to us…it's quite empowering particularly for someone who has trouble articulating what's wrong and understand it" (Adolescent 12). The psychotherapy group, "it's

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almost like a one on one because he [therapist] goes around and talks to each person…sometimes he has a theme and then we talk about it" (Adolescent 16). Another adolescent elaborated on one of the psychotherapy group topics:

> *"The iceberg…the tip is the anxiety and the bottom of it…fear behind the anxieties, all the hidden stuff…and then everyone is different with what they say and what their anxieties are so it would be based on what each person would say"* (Adolescent 1)

For some adolescents, a one on one session was more helpful. One adolescent found his psychiatrist sessions most helpful stating, "one on one time is personally better…I feel I can open up more easily" (Adolescent 11). Outside of group therapy hours, clinicians were available to talk to adolescents who sat at the "distress table" located in front of the nurses' station (Adolescents 4,5,9,10,14). Many young people created a "sensory box" during their admission consisting of sensory items to help manage difficult emotions (Adolescents 1,2,3,4,6,9,16) (Caregivers 2,3,4,7). This was often used in examples caregivers shared of how their child managed distress whilst on leave from the hospital (Caregivers 2,3,4,7). Although there were various perceptions of what interventions were most helpful, young people appeared to obtain a sense of self and confidence in mastering skills to manage their symptoms.

Returning to the real world

At T2, there was an acknowledgement that whilst adolescent general health had improved, there was still "a long way to go" on "the road to recovery" (Caregiver 1, Adolescent 3). To assess whether the MoC was helpful, adolescents would have to go "back to the real world" (Caregiver 1). For one young person, "I've done the most I can do with this admission and I think that's the point where you need to go home and put these things [skills] into practice" (Adolescent 12).

The most prominent concern for adolescents and caregivers when discharging was the concept of uncertain recovery and returning to how the family functioned prior to the admission. The inability for the young person to transfer the skills they have learned to their home environment. One young person feared, "my mood could get worse…it might get better…I don't know" (Adolescent 16). Other worries related to family dynamics on return from the inpatient unit and whether "my family are ready to have me home yet" (Adolescent 11). Similarly, caregivers were "nervous" stating, "we don't know whether we are going back to the same level of monitoring her safety constantly or not" (Caregiver 6). Discharge was a significant concern for many families, particularly those whereby it was their first admission. Transitioning from an inpatient unit staffed 24/7 to the home environment was worrying and uncertain for many families.

Returned to regular life (T3)

Six months following the inpatient MoC, young people appeared more skilled in managing life and coping with their mental illness. However, there were still many many 'ups and downs' on the 'winding road to recovery'.

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The winding road of recovery

At T3, many young people continued to require inpatient and outpatient support. For some young people, there were setbacks in life disrupting their recovery. Despite these setbacks, many young people spoke of being able to accept and manage their symptoms more skilfully. One adolescent continued to experience anger but was able to "map it out" utilising skills learned. The same young person would, "distract until I'm out of that cycle…journaling and writing it down and why I have been feeling that way" (Adolescent 1). The adolescent's caregiver claimed, "she's bouncing back…that's the difference… she's still experiencing the low moods but able to reason with herself and then move on and deal with it" (Caregiver 1). Similarly, adolescent 8 reported to have, "a lot more knowledge and understanding of ways I can help myself". In terms of everyday life, many young people were better able to manage life at T3 in comparison to T1. One caregiver considered her daughter to have, "an immensely better quality of life" stating, "she has a purpose each day…working towards a future…coping with everyday life…not crying nearly as much…rarely voicing hopelessness" (Caregiver 7).

Whilst the adolescents with previous admissions appeared better able to use skills to manage difficult emotions, others were only beginning to recognise them. One adolescent acknowledged feeling angry, "so that's a step forward", however "I haven't gotten how to verbalise what I'm feeling" (Adolescent 2). According to the young person's caregiver, "the anger was hiding all the pain that was underneath…now she knows there are issues and there is pain and that she will have to deal with it…but I believe she has more knowledge and skills about it now" (Caregiver 2).

At T3, many adolescents reflected on their inpatient experience and considered events which might have impacted their recovery. These included unhelpful relationships in their life, denial of their mental health issues or trying to fit in with peers. One adolescent reported, "being emotionally manipulated" in a relationship prior and during her admission (Adolescent 3). The adolescent's caregiver believed this relationship influenced her daughter's decision to discharge "prematurely" from the inpatient unit. They stated, "she was getting pressure from her boyfriend to get out. So, I think she didn't have enough reflection time" (Caregiver 3). Another young person claimed she was "in denial" in terms of relationship problems, suggesting, "it [admission] was all about my parents… I was in denial with those problems" (Adolescent 2).

Some adolescents and caregivers acknowledged that change and recovery needed to come from the young person and until that time happens, "we're all going to just be going in a loop" (Caregiver 10). In agreement, one adolescent claimed, "it took a while to learn that" stating:

> *"I remember when I was sixteen, I used to just say when I was in sessions, "Why aren't you helping me?" Because you want them to do something but then once you realise that you're the one that has to do it, then you're like, oh s**t. It's not a fun thing to realise. It's hard, but yeah, once you realize that, I feel like you're on the road to recovery"* (Adolescent 14)

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For one family, there was a significant loss of one of their family members which contributed to a change in perspective at T3. This shift in perspective mainly related to value for life, consequently altering the young person's view on suicide which was significant at T1. The young person discussed her improved relationship with her caregivers in response to their significant loss:

> *"My relationship with my parents is the strongest it's ever been because first of all, I've been making an effort to be a better person…When I'm angry at something I'll try to just swallow it and continue on because I don't want to bring that upon them* [parents]…*It sucks that it had to get stronger through a situation like this but we've just been closer as a family"* (Adolescent 5)

The road to recovery for many families included many uncontrolled obstacles. Although not 'fixed', many young people were equipped with more coping skills to face the tempestuous journey to recovery.

Discussion

This study sought to understand how adolescents and caregivers experienced an inpatient MoC as well as perceived helpfulness and this was configured within a trajectory of recovery. Experiences followed a recovery narrative consisting of three key phases which included 'waiting for help' (T1), 'help arrived' (T2) and having 'returned to regular life' (T3). The overarching trajectory theme was 'on a winding road to recovery'. The three time-points reflected the narrative sequence of recovery, which include the 'experience of distress' as adolescents and caregivers wait for the MoC, a 'turning point' when they experience the MoC intervention and the diverse and multidimensional 'experience of recovery' after the MoC.

Waiting for help

In terms of recovery, T1 resembled the 'experience of distress' in the narrative journey as participants waited for help (Llewellyn-Beardsley et al., 2019). Some research has considered the effect of waiting time on health and quality of life outcomes (Tuominen et al., 2009). In a randomized clinical trial, Tuominen et al. (2009) found that those waiting a shorter time for admission had better health-related quality of life outcomes and thus potential to move towards recovery. Although the MoC in the current study was not a crisis unit, there was much distress within the family environment prior to T1 despite all admissions being elective. The significance of family support for young people has been established, as well as how this relates to their journey through treatment and toward recovery (Association for Young People's Health, 2016; Hornberger & Smith, 2011; Svavarsdottir et al., 2019). Consequently, this period is likely significant in relation to the early experience of the MoC, therapeutic outcomes and recovery trajectories for young people.

Health services are now considering texting interventions as a form of follow up care post discharge (Chen et al., 2019; Reback, Fletcher, Fehrenbacher, & Kisler, 2019; Ross et al., 2017). Reback et al. (2019) aimed to use text messaging to improve linkage, retention and health outcomes for young women along the HIV care continuum. Such services should be considered prior to an inpatient admission to allow families to feel involved in the process, connected to the MoC and less

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distressed as they wait for help. Although research has established the importance of post-discharge care, the current study suggests the significance of pre-admission care (Gill, 2014; Gregory, Sukhera, & Taylor-Gates, 2017).

For adolescents and caregivers, the MoC was viewed as a 'last resort' treatment option. There is evidence to support the effectiveness of adolescent inpatient units, and therefore it is a concern that admissions are viewed in this way (Author; Lee et al., 2018). This might relate to stigmatised views of hospital admissions, and thus be a significant barrier to care and recovery (Pellegrini, 2014).

Help arrived

Participants focused on the therapeutic processes of the MoC as a'turning point' when they were discharging from the inpatient unit (Llewellyn-Beardsley et al., 2019). As indicated in previous research, the inpatient MoC offered an environment conducive to containment where young people described feeling safe and secure (Author). Whilst this was a relief for many caregivers, it invoked mild resentment from some. Ward (2014) also found that for some caregivers, there was the dual experience of positive gratitude but negative displacement due to the hospital admission and loss of control. The MoC in the current study provides a voluntary parents group to support caregivers during the admission (Author). This can be helpful for those who wish to attend, providing opportunities to express any thoughts, feelings or concerns. The importance of family involvement for adolescent models of care has been recognised (McDougall, Worrall-Davies, Hewson, Richardson, & Cotgrove, 2008; McGorry, 2007). Further research should examine the wider impact for families as they are separated from their child when they are in hospital.

Participants considered relationships with peers to be helpful for young people, allowing them feel respected and understood. This has been acknowledged in previous adolescent inpatient studies (Author; Salamone-Violi, Chur-Hansen, & Winefield, 2015; Ward, 2014). The power of peer solidarity and shared experiences has been reported in other research (Biering & Jensen, 2017; Hart, Saunders, & Thomas, 2005). Author found that engagement through shared experiences amongst adolescents was a key element of an adolescent inpatient MoC and has been observed in other specific therapeutic programmes adapted for young people. However, whilst there are positive relationships, negative ones also need to be considered and monitored, for example, an adolescent trusting another and oversharing personal information, which might be distressing for others. Another example might be an adolescent feeling responsible to comfort another rather than alerting a clinician. Whilst these relationships are powerful in terms of the recovery process, they need to be carefully monitored to ensure each adolescent is not becoming distracted from their own recovery journey.

In terms of relationships with clinicians, J. Green et al. (2007) found that positive therapeutic alliance in adolescent inpatient units predicted better therapeutic outcomes for young people. These positive relationships are perhaps an undervalued source of healing potential in adolescent inpatient units (Biering & Jensen, 2017). A recent

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study found that clinicians did not recognise their relationships with adolescents as a key feature of an adolescent inpatient MoC (Author). It's important that clinicians and adolescents understand their key role in enhancing the MoC experience and therapeutic outcomes. Participant experiences of the relationships with clinicians were positive and might reflect an experienced and cohesive team within the MoC. Author found that an underlying theoretical basis of care such as DBT was a primary foundation guiding clinicians in how they delivered an adolescent inpatient MoC.

Although adolescents explored a range of MoC therapeutic interventions, group therapy was perceived to be most helpful. This might be related to the peer solidarity and support. J. Green et al. (2007) claims that an admission in itself is part of the overall effectiveness, through a combination of removal from external stressors such as school and/or positive effects of the group milieu. Most of the young people in the current study were diagnosed with mood and anxiety disorders. The DBT literature has predominantly focused on people diagnosed with Borderline Personality Disorder (BPD) (Barnicot & Crawford, 2019; Edel, Raaff, Dimaggio, Buchheim, & Brüne, 2017). However, in the current study many young people valued the DBT skills intervention regardless of their mental health diagnosis. The current inpatient MoC has been described elsewhere and DBT was chosen as the theoretical basis of care (Author). This was sought for the unit with the understanding that inpatient units with a theoretical basis deliver better outcomes. Research is scarce in relation to other therapy frameworks for adolescent inpatient models of care (Author; Indig, Gear, & York, 2017). Further research needs to explore therapeutic interventions within adolescent inpatient models of care, their theoretical basis and how they relate to therapeutic outcomes.

At the end of the admission, many adolescents and caregivers expressed fear and uncertainty in the context of being discharged home. This has been observed as a challenge and concern in relation to outcomes in many medical studies (Aislinn et al., 2015; Genis, Camic, & Harvey, 2016). Less has been researched in youth mental health inpatient settings. It's important to consider that adolescent inpatient effectiveness studies measure outcomes at the time of discharge (Author). Improving the discharge-home transition for adolescents and caregivers could enhance more positive short and long-term outcomes for young people and their families. Researchers and clinicians alike need to share knowledge in improving the discharge experience for adolescents and their families.

Returned to regular life

Six months following the inpatient admission, young people continued to utilise inpatient and outpatient supports and services. Most adolescents reported being better able to problem solve and manage their mental health symptoms. In a quantitative study, J. Green et al. (2007) found that health gains following an inpatient admission were sustained one year post discharge. Whilst many young people were more in control of managing their symptoms, some were only beginning the process of discovering emotions such as anger and able to identify and recognise it. In terms of adolescent inpatient models of care, it's important to consider the differences in skill

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levels between those admitted for their first admission and those who have been admitted several times. Additionally, it's important to include information on participants lost to follow-up in terms of whether they improved or worsened. A recent study explored adolescent experiences from the public mental health system to understand what constitutes "good outcomes" (Kristina, Marius, Helga, Per-Einar, & Christian, 2018). Thematic findings resembled the current study, including: (1) I've discovered and given names to my emotions and (2) I've learned how to cope with challenges in life. The authors claimed that "good outcomes" in youth mental health services should be understood as recovery oriented and sensitive to developmental phases (Kristina et al., 2018). The two previous studies suggest that adolescent health gains can be sustained post-discharge and for adolescents, these gains relate to identifying emotions and learning to cope in life. For some young people, readmission might constitute further development towards recovery.

Although focused on adults, Dixon, Holoshitz, and Nossel (2016) suggests and support the concept of recovery-oriented care, which prioritises autonomy, respect for the person receiving treatment and empowerment. This is a difficult concept in terms of an adolescent inpatient MoC when key consent decisions are made by caregivers. Person-centred care, which includes shared decision-making is a helpful framework to follow in terms of tools to enhance engagement. When participants reflected on the admission, many considered events which might have hindered their ability to engage in the MoC at that time. Further research is warranted in adolescent inpatient settings and ways to enhance engagement. On a practical level, it's important to consider how engaged the young person is in the MoC. Adolescent engagement should be seen as an ongoing process and therefore not one point of care (Tindall, Simmons, Allott, & Hamilton, 2018). Adolescent engagement needs to be considered prior to treatment, during treatment and after. Poor engagement can lead to worse clinical outcomes, symptom relapse and rehospitalisation (Dixon et al., 2016).

Limitations

This study explored one private inpatient unit in Melbourne, Australia. Therefore, findings may not be generalisable to other adolescent inpatient settings. However, the sample characteristics in the current study reflect samples in previous studies. The current study included predominantly Caucasian adolescents and families in advantaged socioeconomic circumstances. In terms of other cultural groups, further research is required to investigate whether these models of care are suitable for people from diverse cultural, educational socioeconomic backgrounds. Whilst the sample size might be considered small, analytical generalisability was sought rather than statistical. The sample size is considered substantial for qualitative research, especially given the longitudinal nature of the data collection (Guest, Bunce, & Johnson, 2006). Another limitation might relate to the low response rate and potential for bias. Adolescents and caregivers were asked to contact the primary researcher if interested in participating in the study. This might have affected the number of people willing to participate in the study. Notwithstanding the above limitations, the present study has many important implications.

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Conclusions

The purpose of this study was to explore adolescents and caregiver's experiences of an inpatient MoC as well as perceived helpfulness. The findings demonstrate that waiting for the MoC was a difficult period for many young people and their families. Minimising waiting list times is a potential solution, as well as finding ways to appropriately and adequately prepare families for the admission. MoC features perceived to be helpful included a safe environment, the young person's relationships with clinicians, peer support and skill development. Once participants had returned to regular life, young people and families considered they were more equipped to manage life's challenges. However, there were many uncertainties 'on the winding road to recovery'. Further research is warranted on this complex topic to understand adolescent inpatient models of care, their theoretical basis of care and therapeutic outcomes to maximise the benefit.

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Figures and Tables

Table 1: Characteristics of mental health recovery narratives

Table 2: Sample matrix

Table 3: Sample longitudinal analysis matrix

Table 4: Characteristics of overall representative sample (N=72) and subset of adolescents interviewed (N=16)

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Figure 1 Flow diagram of recruitment strategy

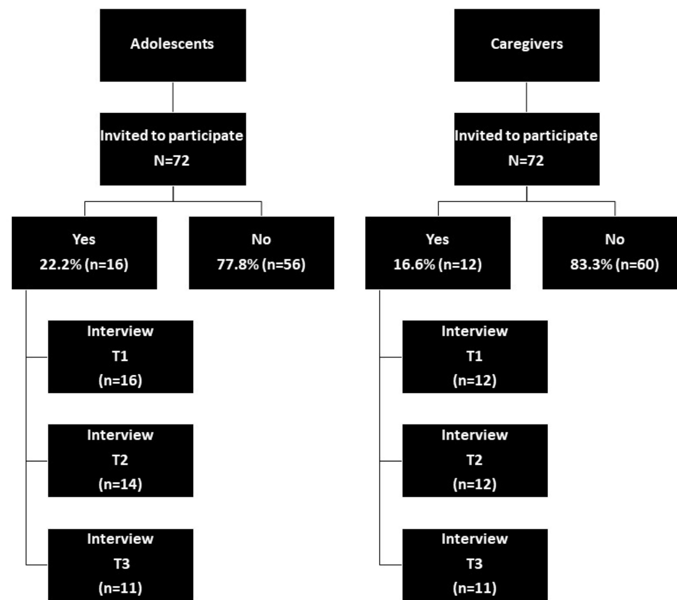

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Table 1: Characteristics of mental health recovery narratives (Source: Llewellyn-Beardsley et al. 2019)

Superordinate Category	No.	Dimension	Types			
Form	**1.**	**Genre**	Escape	Enlightenment	Endeavour	Endurance
	2.	**Positioning**	Recovery within the system	Recovery despite the system	Recovery outside the system	-
	3.	**Emotional tone**	Challenging	Disenfranchised	Reflective	Buoyant
			Shaken	Tragic	-	-
	4.	**Relationship with recovery**	Recovered	Living well	Making progress	Surviving day-to day
Structure	**5.**	**Trajectory**	Upwards spiral	Up and down	Horizontal	Interrupted
	6.	**Use of turning points**	Restorying	Change for the better	Change for the better or worse	-
	7.	**Narrative sequence**	Experience of distress/trauma	Turning point	Experience of recovery	-

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Content	**8.**	**Protagonists**	Personal level	Socio-cultural level	Systematic level	-
	9.	**Use of a metaphor**	Distress metaphors	Recovery metaphors	-	-

Table 2: Sample matrix			
	Adolescent		
Themes	**T 1**	**T 2**	**T 3**
Theme A (example: acceptance)	Lots of worries about not being accepted by their family.	Feeling worried that other adolescents won't accept them.	Less worry about acceptance from family and friends. *Less worry about being accepted.*
	Caregiver		
Themes	**T 1**	**T 2**	**T 3**
Theme A (example: family stress)	Lots of stress in terms of family functioning.	Feeling stressed about inpatient unit friendships.	Less stress about family functioning. *Less stress since child is improving.*

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Table 3: Sample longitudinal analysis matrix	
Adolescent	
Themes	**Adolescent 1**
Theme A (example: change in acceptance over time)	Change from worried about acceptance within the family to acceptance by peers. *Moved towards acceptance after admission.*
Caregiver	
Theme A (example: change in family stress over time)	Change from family stress to stress about inpatient friendships. *Moved toward less stress after treatment started.*

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Table 4: Characteristics of overall representative sample (N=72) and subset of adolescents interviewed (N=16)		
	Characteristics of all adolescents admitted to the unit (N=72)	**Characteristics of adolescents interviewed (N=16)**
Age: Mean years (SD)	16.2 (1.6)	16.8 (1.5)
Gender: (% female)	81.9% (n=59)	87% (n=14)
Length of stay: Mean days (SD)	28.0 (15.8)	35.3 (15.5)
Ethnicity: (% Caucasian)	91.7% (n=66)	93.8% (n=15)
First hospitalisation: (%)	50.7% (n=34) Yes 49.3% (n=33) No	50% (n=8) Yes 50% (n=8) No
Primary diagnosis on discharge	1. Mood disorders 56.9% (n=41) 2. Anxiety disorders 25% (n=18) 3. Psychotic disorders 4.2% (n=3)	1. Mood disorders 43.8% (n=7) 2. Anxiety disorders 37.5% (n=6) 3. Psychotic disorders 12.5% (n=2)
Diagnostic co-morbidity on discharge	75.7% (n=53) Yes 24.3% (n=17) No	68.8% (n=11) Yes 31.3% (n=5) No

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