**The Ward as Emotional Ecology: Adolescent experiences of managing emotional distress in inpatient settings.**

**Abstract**

Previous research on young people’s satisfaction of inpatient services has often relied on the responses of carers and relevant practitioners. It is difficult to ascertain to what extent such reporting accurately represents the satisfaction levels of young people, with emerging research suggesting wide discrepancies. As part of a wider study evaluating the effectiveness of a Supported Discharge Service (SDS) operating within South London & Maudsley NHS Foundation Trust, this paper examines how young people experience inpatient services, on a social and emotional level. Twenty young people, (10 SDS and 10 TAU) participated in a semi-structured visual-interview study to examine their experiences of admission, ward-life and treatment. A thematic analysis was conducted on the data and specific themes relevant to satisfaction and engagement with inpatient services was examined in-depth. These include a) Behavioural surveillance as care surrogate and b) Managing the delicate emotional ecology of the ward: openness, triggering, sterility and relational engagements. Finally, we explore some of the implications of these inpatient experiences for supported discharge services.

**Introduction**

This research is one component of a larger study evaluating the effectiveness of a Supported Discharge Service (SDS) operating within South London & Maudsley NHS Foundation Trust (SLaM). This service offers a period of intensive community or day service treatment beginning at inpatient admission and continuing for up to 12 weeks following discharge. This approach aims to improve the clinical outcomes of adolescents discharged from inpatient services while reducing the length of acute inpatient admissions and the likelihood of readmission (Ougrin et al., 2012). Of particular note here is the transitive aspect of the SDS model, which presently rests on the assumption that rapidly exchanging the landscape of the hospital for those of the home and community will be of benefit to young service users. Though the existing literature finds little difference in clinical outcomes for adolescents between short- and long-term hospital stays (Bloom, 2000), there is a scarcity of research exploring how adolescents subjectively experience inhabiting these unusual spaces (Biering, 2010). In order to fully understand what supported discharge might mean to young people, it is crucial to establish their views and experiences of the therapeutic landscapes that exist within adolescent inpatient treatment.

Current research seeking to evaluate young people’s understanding of inpatient services typically utilises ‘consumer satisfaction questionnaires’, which aim to establish a quantifiable measure of inpatient experience (Brown et al., 2012). Regrettably this area of research is beset by a number of methodological problems, perhaps the most significant of which is its reliance on the assumption that survey data can successfully capture the nature and meaning of satisfaction for young people specifically (Williams, 1994). Many such studies, for example, focus exclusively on input from parents and carers, rather than young people themselves (Moses, 2011), a practice which ignores the growing body of evidence demonstrating how parent/carers’ and young people’s criteria relating to ‘satisfaction’ can be vastly different (Dogra, 2005; Ford et al., 2011). It is not uncommon for self-reported ratings of satisfaction to not, or to only weakly, correlate with other aspects of the treatment process that are considered important. These include measures such as clinically rated reductions in symptoms and impact on functioning (Garland et al., 2003), individual patient characteristics (Bjorngaard et al., 2008) and parent/carer reports of whether change has been experienced (Stacey et al., 2002). Furthermore, it is troubling to note that consumer satisfaction surveys often restrict respondents to a set of pre-defined answers precluding discussion of negative experiences. It is perhaps then unsurprising that research using these tools often finds feedback to be consistently positive, yet lacking indication of how services could be improved (Bettmann & Jasperson, 2009).

**The Hospital Setting**

Psychiatric hospitals (formerly asylums) represent ‘reasonable’ societies’ response to the presence of those exhibiting the ‘unreasonable’ behaviours associated with mental illness. In the UK, the encroachment of capitalistic ideologies in the wake of the industrial revolution engendered the attachment of negative moral claims to perceived states of inactivity or idleness, and so those whose madness inhibited their ability to produce, particularly the poor, became considered troublesome to the social order (Parr & Davidson, 2009). The role of inpatient unit has historically been to eliminate this problem through mechanisms of *embarkation* and *confinement*: Psychiatric hospitals would ensure that those experiencing madness were not only transplanted, but that they were unable to return of their own volition, so that society might continue its business uninterrupted (Foucault, 1967; Giddens, 1987). Asylums came to be designed with this primary directive of distanced spatial confinement in mind, and subsequently tended to be placed in rural areas far removed from urban centres (Philo, 1987), imparting a sense of secrecy and otherness to these spaces that, in tandem with their mysterious residents’ supposedly immoral and unpredictable natures, served as foundation to a profound stigmatisation of patient, staff, and place that persists to the present day (Angermeyer et al., 2017; Parr et al., 2003; Parr & Davidson, 2009).

This removed nature of the psychiatric unit serves a further purpose as a demarcated space of refuge for those who cannot presently tolerate the demands of society, in particular urban living, and require a period of peace and recuperation (Curtis et al., 2007; Smyth, 2005). This sense of sanctuary is dependent upon the hospital affording patients agency with regards to social interactions: Sharing hospital spaces can engender a beneficial social climate in which service users can support one another’s personal and communal growth (Moos, 1997), and young people specifically identify supportive relationships with staff and peers as being the among the most positive aspects of inpatient treatment (Freake et al., 2007; Biering, 2010; Moses, 2011). However, the constitution of the ward as a place of refuge requires the presence of non-social spaces within the hospital setting to which service users can retreat in order to access space and privacy (Curtis et al., 2007; Parr et al., 2003). Presently, it would appear that these needs are not being met for adolescent inpatients, who identify a requirement for more privacy from staff and the presence of quiet/prayer rooms on inpatient units (Moses, 2011; Tulloch et al., 2008).

The psychiatric ward then can be said to exist within a point of discursive tension between these differing sociocultural understandings, one constituting the ward as a place of confinement, permanently removing an immoral and perhaps dangerous being from a society that will be unfettered by its transplantation (Foucault, 1967), and another invoking ideas of sanctuary and rehabilitation through healing (Philo, 1987). Just as community acceptance of former inpatients is largely dependent on those communities’ symbolic understandings of the ‘mad’ (Clark & Dear, 1984), the symbolic nature of the ward-place as understood by its staff, residents, and their communities is of importance to young people’s formation and understanding of their own identities, both pre- and post-discharge (Casey, 1993; Manzo, 2003).

**Adolescent Inpatients**

The environment in which mental health treatment takes place holds significant implications for that treatment’s success and the broader wellbeing of service users accessing that site (Curtis et al., 2007; Gesler et al., 2004; Urbanoski et al., 2013), though the mechanisms underlying this are not currently well understood. Proposed influential factors in inpatient settings include the ward atmosphere, respect given to service users, levels of surveillance, and social interactions with peers and staff (Brunt & Rask, 2007; Curtis et al., 2007; Jörgensen et al., 2009). For adolescents specifically, inpatient admissions appear to be a broadly effective intervention for treatment of a range of psychiatric diagnoses, with the majority of patients experiencing sufficient improvements in functioning following brief hospitalisation to be discharged back into the community (Bettmann & Jasperson, 2009; Tulloch et al., 2008).

Qualitative reports of satisfaction with these spaces, however, tend to be more mixed. Young people report experiencing inpatient environments as being particularly inflexible and unresponsive to their needs, at times not addressing issues that the patients themselves view as important as doing so would not fall strictly within the confines of the ward rules (Marriage, Petrie & Worling, 2001; Moses, 2011; Tulloch et al., 2008). Adolescents broadly feel that they are afforded little choice or autonomy by adult helping professionals, an issue compounded by the fact that these staff are strangers inhabiting an unfamiliar environment often far removed from family, friends, and other aspects of ‘homeliness’ (Curtis et al., 2007) that support wellbeing (Freake, Barley & Kent, 2007; Gusella, Ward & Butler, 1998). In attempting to understand having found themselves in these unusual places, young inpatients routinely invoke metaphors such as ‘fake spaces’ or ‘alternate realities’ into which they are transplanted while everyday life proceeds in their absence (Gill, Butler & Pistrang, 2016; Haynes, Eivors & Crossley, 2011).

It is well understood that mental health stigma has a strong presence in adolescent populations, and appears to be more strongly experienced by those who have received inpatient treatment (Martin et al., 2007; Moses, 2014). However, research rarely addresses the youth stigma that members of this population often find themselves required to negotiate in inpatient settings. Young people experiencing mental health crises in the UK must contend with a political climate that increasingly attempts to problematise and control (particularly working-class) youth (McDowell, 2009; Wright & Ord, 2015). Mirroring the capitalistic concerns that construct those experiencing madness as troubles-to-be-removed (Foucault, 1967), British institutional discourse surrounding the detention of youth identifies adults as being duty-bound to restore morality to the young (Fergusson, 2007; Muncie & Hughes, 2002). This institutionalised ageism presents itself within professional-client relationships on the ward. Research indicates that young inpatients’ opinions regarding their treatment are only deemed valid by staff when deemed ‘age-appropriate’, with communication styles that fall outside of these bounds being pathologised or silenced (LeFrançois, 2007).

This qualitative study aimed to expand upon our understanding of adolescents’ experiences of the inpatient environment with particular regard to the relationships formed with peers, staff, and the space itself. Specifically, it focused on differences in young inpatients’ ideas of self when on the ward than in the community, and how these were experienced as an (accompanying) aspect of treatment.

**Methods**

**Participants**

A total of 20 participants were recruited from a supported discharge group (SDS - N=10) and a treatment as usual group (TAU – N=10). The qualitative project was discussed with participants at six months follow up assessment in the wider SITE trial, and conducted on dates shortly following to avoid participant fatigue. Participants invited had stayed on at least 1 of 4 SLaM NHS adolescent wards, though several had experienced previous admissions to any of the additional 3 NHS and 7 independent adolescent wards recruited from in the SITE trial, and discussion of these was accepted in interview. Exclusion criteria included no profound learning disabilities and a sufficient level of spoken English. Potential participants who remained engaged with National & Specialist or inpatient services were only interviewed following a consultation with their care coordinators to ensure that the interview process would not prove distressing to them. A further five eligible potential participants were approached but declined to be interviewed.

Average length of inpatient stay was 65.8 days. All participants had received diagnoses of mental disorder (using ICD-10). Most participants also volunteered further diagnostic information, such as multiple diagnoses, as part of the interview. Attempts were made to match both groups on certain demographic features, including race, ethnicity, gender and diagnosis. Final demographic features are reported in the table below.

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| --- | --- | --- | --- |
| **Table 1: Sample Demographics** | |  |  |
| Characteristic |  |  | No. (%) or mean (range) |
| Sex |  |  |  |
|  | Male |  | 8 (40) |
|  | Female |  | 12 (60) |
| Ethnicity |  |  |  |
|  | White British |  | 13 (65) |
|  | Black British |  | 4 (20) |
|  | Eastern European | | 2 (10) |
|  | Asian |  | 1 (5) |
| Age, years |  |  | 16.8 (14-18) |
| Diagnosis*a* |  |  |  |
|  | Depressive Disorder | | 10 (50) |
|  | Anxiety Disorder | | 2 (10) |
|  | Psychotic Disorder | | 8 (40) |
|  | Autistic Spectrum Disorder | | 4 (20) |
|  | Personality Disorder | | 2 (10) |
|  | OCD |  | 1 (5) |
|  | PTSD |  | 3 (15) |
| Education/Employment |  |  |  |
|  | Full-time education | | 15 (75) |
|  | Part-time employment | | 1 (5) |
|  | No education/employment | | 4 (20) |
| Social classb |  | |  |
|  | Upper middle class | | 3 (15) |
|  | Lower middle class | | 6 (30) |
|  | Working class | | 6 (30) |
|  | Unemployed | | 5 (25) |
| *a*A number of participants received multiple diagnoses  bBased on parents’ self-reports of employment | | |  |

**Research Approach**

Mixed visual and interview techniques were used: Participants were asked to select ready produced photographs of the (SLaM) inpatient wards they had stayed in during the hospitalisation period (a photo-elicitation method) based on their having a ‘strong memory’ attached to it, alongside photographs that the participants had themselves produced of their everyday lives prior to having had contact with CAMHS. Interviews began with participants being asked to describe the self-produced photographs and explain their selection process, followed by an open discussion of each hospital photograph. The interview schedule was designed around a number of pertinent themes identified in the adolescent inpatient literature. During the interview, participants were asked to consider the ‘version’ of themselves that had inhabited the spaces in their selected photos as someone distinct from the ‘version’ grounded in the self-produced images. This concept was referred back to throughout the interview and used to elicit information regarding their experiences of the inpatient units and to explore experienced changes in their social and personal identities since the self-produced photographs were taken. This approach sought to acknowledge the inseparable relationship between place and human experience (Casey, 1993; Manzo, 2003), and to explore participants’ understandings of the ward space by evoking a contrast with their relationships to the everyday places of their communities prior to the formation of place identities (Moore, 2000) incorporating experiential knowledges of inpatient services.

Visual materials can prompt participants to discuss the settings and context of their experiences, as visual materials are themselves organised spatially (see**,** Bolton, Pole & Mizen, 2001; Knowles, 2000; Reavey, 2011). ‘Multi-modal’ methods can help participants to articulate aspects of experience which participants find difficult to put into words, as has been established by work investigating embodied experiences (e.g. Barker et al., 2008; Reavey, 2011; Cromby, 2012). Despite the effectiveness of this approach in eliciting specific spatial details, the main focus of the interview was to address questions developed by the researchers, in the face-to face interview schedule, in conjunction with their rich description of the physical spaces.

**Analytical Approach**

The interviews were transcribed verbatim.  The photographs were primarily understood as prompts which helped to elicit accounts of the various places in which difficulties were experienced, and hence given meaning by the participant in the context of the interview, rather than treated as data to be analysed independently (Reavey & Prosser, 2012).

Initially, the material was organised into specified places, separating those experiences described as located in the psychiatric ward, community services, and community living, in line with the structure of the interviews. As a second stage, we created four ‘analytical directives’, which guided further reading of the material, all of which were designed to explore the overall research question of how service users experience inpatient services, with specific attention paid to the ways in which feelings of distress are managed by the participant and service providers.

After notating and coding the material with these questions in mind, the data were re-organised into themes, as well as considered in the light of literature which could help to contextualise the analysis. A thematic analysis (Braun & Clarke, 2006), in particular one of a more ‘theoretical’ and ‘latent’ persuasion (rather than ‘inductive’ and ‘semantic’) was chosen to organise the data, through the identification of major themes. This thematic decomposition was achieved by carefully following Braun & Clarke’s (2006) six stages of analysis. This involved familiarising oneself with the data via repeated readings of the transcripts, generating initial codes by paying close attention to meanings embedded in every line of talk, followed by matching the initial codes together to form candidate themes and sub-themes. Each of the authors were involved in discussions around whether the theme titles and definitions adequately captured the essence of the data.

It is ‘theoretical’, as the data were read and notated from the beginning of the process of analysis in terms of how emotional distress and mental health was understood, constructed and accounted for by the participants. Nevertheless, the interpretation produced was also ‘inductive’, in the sense that the final reading produced was based on a close reading of the material, and not on previously fixed ideas about what the final themes would be. An interpretation also involved exploring the implicit meaning of the material, rather than a more descriptive, ‘semantic’ reading. The validity of the findings was ensured, using conventional qualitative procedures, including group analysis by key researchers and peer review, to ensure the analysis is sufficiently grounded in the data (Creswell & Miller, 2000).

**Analysis**

Two over-arching themes are presented here, entitled: a) Behavioural surveillance as care surrogate and b) The delicate emotional ecology of the ward: openness, triggering, sterility and relational entanglements. These do not represent the entirety of the themes emerging from the data, but they do address the central research question, ‘How do young people feel during their time in hospital?’ Other themes drawn from the data, omitted from this analysis, included experiences of community discrimination, coping communities, gendered expressions of distress and diagnostic hierarchies of value, which will be discussed elsewhere.

Provided here are indicative extracts from data transcripts to illustrate the major themes that were commonly found in the interviews. Not all extracts pertaining to these themes are presented, due to word constraint.

**Behavioural Surveillance as Care Surrogate**

The wards were described by many as holding places, to contain behaviour rather than serve as a treatment for mental health difficulties. Metaphor was used to describe these spaces, such as ‘holiday camp’; ‘Butlins’; ‘a youth club’, through to more negative descriptions, such as ‘zoo’; ‘a prison’; ‘a cardboard box lined with cotton wool’; a ‘place of horror’, representing participants’ attempts to discursively frame their expectations and (often distressing) understandings of the ward in a manner that connects their memories of having physically inhabited these spaces to the broader affective experience: Here the container metaphor of ‘a zoo’ is used to communicate a spatial understanding using symbolism that is socioculturally encoded. Inhabiting this landscape entails not just physical containment but also the absence of one’s humanity, and consequential observation by an audience as an object of fascination and threat (Kearns & Barnett, 1999; Kövecses, 2003). A number of participants experienced inpatient settings as reinforcing the stressors that had resulted in their admission, a key aspect of which was the perceived substitution of ‘care’ for constant observation and monitoring not relating to the mental health diagnosis as such, but *accompanying behaviours* deemed problematic by staff. More specifically, it was the severing of the connections between feelings and behaviour that were most confusing for participants.

***P:*** *She said “We don’t want you acting up like last time, you know? You just need to go to bed and stop acting out.” And I was like “You do realise I’m in a psychiatric ward, don’t you? I’m here because there’s something up. And if you tell me to just go away when there’s something up then what’s the point of being here? At all? And it was just like, you people can’t cope. We’re* (the patients) *coping, you’re not. The staff, you know, they don’t get it. You can’t send me home. I haven’t been treated or anything. I am not in the place to go home and if I go home I’ll end up acting on thoughts and feelings again.*

In the above extract the participant describes being reprimanded for ‘acting out’, though she constructs her behaviour as a symptom of her underlying mental health problem, and points to the missing link in staff’s perceptions of her *coping mechanisms* and the reading of her problematic behaviour. These are the grounds for her viewing the hospital stay as pointless, as the connections between behaviour and emotion are not forged by trained staff who are there to treat her illness. A large number of participants believed that staff paid undue attention to overt behaviours, without requisite attention to underlying distress. The experience of surveillance and checking fell short of participants’ understandings of acts of ‘care’, which required an active engagement or attempt to read affective meaning into the behaviour being expressed. Rather, the attitudes of ward staff were often panoptic in nature, emphasising the importance of patients’ docility (often described as individuals or the ward itself being ‘settled’) as the primary marker of successful ongoing treatment, and attempted to engineer this through use of constant observation and the implied threat of confinement (Foucault, 1979):

***P:*** *You just feel like everyone’s watching you. You can’t do anything. It’s not care.*

Though some participants valued the relationships they built with other patients (and, to a lesser extent, with staff), many felt they needed much greater assistance with making sense of the thoughts and feelings underpinning their behaviour and the coping mechanisms they had built up over their lifetimes to manage their difficulties. A number of participants reported that they had not been given any information about the outcome of their assessment on admission, and had been offered medication, without understanding what it was for, beyond being told they were ‘ill’. The separation of behaviour from thoughts and feelings was thus understood to serve the purpose of temporary *observation* and *stabilisation* of the illness and attendant behaviours, rather than *care* or treatment per se:

***P:*** *It depends on who you are but doesn’t really help. ‘Cause it’s more like, it’s more like you’re in prison. Or like, when they come up with the keys and stuff, and you know, I don’t know I think, when they kind of treat you, I don’t know like a-, like, I think sometimes they forget that you’ve got mental health.*

The perceived absence of explanation and information regarding their difficulties was experienced as frightening, not only in the present moment but in terms of its consequences for the future. Being told they were ‘unwell’ and being constantly monitored (though understood to be part of the institutional rules) was experienced as a weak substitute for enabling them to make greater sense of what the meaning of the distress or illness. Furthermore, concerns extended to their future plans and prospects, including how other people in the community might perceive their stay in hospital, and how it might affect existing family and friendship groups. As previous research has noted, hospital admissions can lead to increases in low self-esteem, due to high levels of experienced stigma (Martin et al., 2007; Moses, 2014). Even those participants whose inpatient stays had been in urban areas close to home struggled with the social distance created by their spatial confinement, often feeling as though they now inhabited an artificial landscape or ‘nested reality’ removed from the ongoing business of ‘real life’ (Gill, Butler & Pistrang, 2016; Haynes, Eivors & Crossley, 2011; Malpas, 2009). In short, a greater sense of agency and choice was desired, via the exchange of information and forward planning, throughout the process of hospitalisation and discharge.

**Monitoring relations with others**

Mirroring previous research on acute care environments, participants in this study valued the opportunity to talk through difficulties, in the context of a one-to-one trusting relationship, and to learn how to better read and make sense of their thoughts and feelings (Papoulias et al., 2014). Interestingly the process of interpreting thoughts and feelings was accomplished informally through the development of peer relationships that stretched beyond the boundaries of the inpatient admission, continuing after discharge. A number of participants believed they had gained a greater sense of emotional competency via their relationships with other patients, especially when staff were not present to care for them in crisis:

***P:*** *Sometimes the patients have to deal with stuff going on until we can find a member of staff. Basically you just sit there and try to calm them down, and try to do the things that staff would do. You have to watch what the staff basically do all the time.*

Any form of physical contact between patients was officially prohibited, despite its role in relationship development and wellbeing (Simão & Seibt, 2015). Young people sharing intimacy with others was accepted by some staff, and discouraged or even punished by others, on the grounds of risk or inappropriateness. This was experienced by participants as not only confusing but hindering, in terms of the potential benefits of a trusting relationship for emotional expression and a valued means of support.

***P:*** *There was one staff person, she was really nice. She was there saying, “It’s really nice you’re looking after* (another patient) *and holding her hand.” But then there’d be this other woman that’s going, “You can’t sit next to her, you can’t do this for her, because you’re in here yourself. And you’ve got to stop holding her hand, it’s personal space.” So there’d be two different people, which kind of confused us all, there’s one person saying do it and one person saying don’t do it.*

Inconsistency in staff attitudes towards patient relationships increased the sense of isolation for some participants. Certain positive aspects of peer relationships, such as learning and sharing similar experiences, and feeling ‘normal’ were neglected by some staff, due to perceived concern over risk and predatory behaviours. Many participants felt their relationships to staff were also important, though many had not been given the opportunity to share their experiences with staff members, or had only felt a connection through informal recreational activities. Once again, participants’ attributed this to a belief that staff time was occupied with behaviour and medication monitoring, rather than therapeutic contact.

***I:*** *How could you tell that a staff member’s not listening?*

***P:*** *Because after I’d speak to them they’d say, “Ok, we’ll change your medication,” or, “We’ll take you off,” or just saying, “Just smile and everything’s gonna be better. You just have to get through it.”*

By focusing on overt behaviours, hospital came to be seen as a space for the *deferral* of emotions. This approach was perceived to be unhelpful, adding further layers of distress, such as paranoia, anxiety and depression that then required additional management. Though some participants felt temporarily safe due to the *containment* offered by hospital (see, Gill et al., 2016), every participant perceived there to be punitive elements attached, and did not believe it was an appropriate place to be treated for mental health difficulties. In fact, the hospital for many was perceived to represent a form of rehabilitation that was akin to an idealised correctional facility, as particular behaviours, described as ‘staying well’ and ‘being stable’ but focusing on remaining docile and limiting expression, often by devising better ways of hiding their distress or dampening their problems via medication in order ‘not to feel anything’, was the only means by which to evade re-admission (Foucault, 1979).

***P:*** *When I was in hospital I was really stressed out about it and I thought that it was just making me feel worse, but after I left I realised that maybe it was good because that experience scared me and made me want to stay out of the hospital again.*

In the next section, we examine the ways in which participants were not only *invited* to engage in this process of emotional displacement during inpatient admission, they were encouraged to manage the risks of emotional contagion (Hatfield et al., 1994), often described as ‘triggering’ emotional reactions in others patients, as well as managing the emotional inconsistencies of the staff. We conceptualise the ward then as a delicate ecology of emotional relations, which participants must navigate and manage without formal assistance or knowledge.

**The Delicate Emotional Ecology of the Ward: Openness, Triggering, Sterility and Relational Entanglements**

Certain participants discussed positive relations on the ward, from kind and supportive staff, to nurturing relationships with their peers who were able to empathise with their distress (Moses, 2011). A central aspect of positively perceived relationships was the opportunity to talk through emotional distress, and to build a form of support based on openness, equality and mentorship (Moos, 1997). Building connections and trust was regarded as essential by the vast majority of participants, and was seen to be the central mechanism in enabling the expression of difficult and complex emotions.

***P:*** *I myself, I don’t like showing emotions in front of other people, like crying and stuff like that. I don’t like doing that in front of other people. I refuse to do it as much as I can. Whereas in the ‘one to ones’, because I built a connection with my doctor, I was able to cry if I got upset, and I was able to show my emotions adequately.*

The opportunity to ‘deal with emotions adequately’ was perceived to be the most important skill to learn during their time in mental health services. The chance to learn for themselves was valued over reducing their illness ‘symptoms’ or increasing instances of ‘good behaviour’. However, participants believed that the way they managed their emotions was in part determined by the needs of other people, including staff who were responsible for the safe running of the ward. In short, participants identified an interdependency between what they were feeling and how it would (negatively) affect other people. This risk of emotional contagion prompted some participants to hide their feelings, so as not to contaminate other people (Hatfield et al, 1994), attract attention, or invite criticisms or further scrutiny of their behaviour by staff and/or other patients.

This was most visible in concerns related to ‘triggering’, a term participants had appropriated either through social media sites, such as ‘Tumblr’, or through medical discourses on the risks associated with PTSD or self-harming behaviours. A number of young people believed it was safer to withdraw from certain activities in order to hide difficult emotions which might trigger negative reactions in others. Some participants accepted that experiences of trauma lurked beneath the surface for many of the patients, but this was something that shouldn’t be expressed due to the risks involved:

***P:*** *Say if I’m not feeling safe, and everyone wanted to go up to the games room…I couldn’t say anything about how I feel to the other people ‘cause it would trigger them, it’s really risky. Because they know what you’re going through. It is hard to spread all your stuff out and get it out in the open, but it’s like should you be saying it?*

Others described how policies around covering up evidence of self-harm were also designed to prevent the triggering of destructive emotions across the ward which might result in problematised behaviours, such as self-harm.

***P:*** *And obviously when you’re in there, like patients, you’re meant to cover up and stuff so you have to wear a hoodie and you have to wear jeans. You can’t show any skin and stuff like that. You can’t show scars, obviously, because it triggers people, and don’t ask me. Everyone thought it was shit. That was the worst-, not the worst thing, but in the summer, I was there in like June, July, August, like proper hot weather, and we all had to wear a cardigan, ‘cause obviously I had bad scars and stuff. We had to wear a cardigan or a hoodie or something and we was literally sweating our head off.*

Of interest here is the manner in which the covering up of self-harm evidence is conceived. Though the participant comprehends that scars are covered to prevent triggering, they are nonetheless ‘hidden in plain sight’. By wearing clothing to hide scars, paradoxically, it is perceived that this creates an even greater visibility around self-harming behaviour and the (latent) emotions that accompany them. Thus, the idea that covering up behaviours may prevent ‘triggering’ in others was viewed with apprehension by certain participants, and the policy flouted by some. Attempts by staff to prevent triggering rested on the assumption that obscuring evidence of harmful emotion might successfully secure emotional latency, and thus not disturb self or others. However, the existence of self-harm (even if historical) was acknowledged by many participants; rather than covering up, they suggested talking about the reasons for self-harm as a coping strategy, which they believed would lead to a more supportive perspective from peers and staff, and foster greater emotional literacy in both.

Talking about emotions in the context of the inpatient setting, however, was not always perceived to be beneficial to well-being. Part of the problem once more, surrounded the concept of ‘triggering’, because the ward was not set up to manage difficult or complex feelings. Particularly troubling to a number of participants were the group therapeutic activities provided, such as art therapy and mindfulness groups. In principal, such activities had been introduced by services to encourage greater openness of emotional expression, and to harness discussions around how to link previous experience and current distress. However, many expressed how difficult it was to publicly explore feelings in therapy that were then shut down once they had returned to the ward environment.

***P:*** *It’s alarming for me but then you do get the staff afterwards asking if you need some ‘one to one’ time with them to kind of work out why you did that, kind of make you understand.*

***I:*** *Okay. The other young people in there, in art psychotherapy, do you ever find that alarming, or is it just your own stuff?*

***P:*** *Sometimes certain people can draw things that do trigger me off so then, um, I get myself out of the room, so I’m not in that kind of environment.*

The environment for intense emotional disclosure is directly referenced here by the participant, as is the importance placed upon being provided with a space to follow up on some of the ‘triggers’ that can arise from therapeutic activities.

In the context of some wards, these activities were provided without providing a means to adequately explore the emotions that emerged from the sessions. ‘Triggers’ happened but were not pursued in some cases, either in the session or once the participant re-entered the ward space. Opening up in the first place was then deemed risky, leading to avoidance for some. The possibility of triggering in therapy led some to rejecting the activity entirely. Instead of exploring emotions, some retreated to the isolation of their rooms to independently manage emotional difficulties or ‘triggers’. For some this involved using well-rehearsed withdrawal techniques or self-harm:

***P:*** *I went to* (the mindfulness group), *what* (staff member) *ran, but I just couldn’t go to it. I wouldn’t sit there or nothing, I was always fidgeting, I was always crying, it was just like really hard, especially like art therapy. That shouldn’t be on the ward because that like really triggers people. That’s one thing I would take off the flipping timetable…it triggered loads of people. After* (the mindfulness group) *finished, people would be in their rooms cutting themselves, they’d be in the bathroom; they wouldn’t come out for dinner. They wouldn’t even talk to no one. It’s just such a bad idea.*

Regrettably, the very benefit that such activities might proffer – an extended space to openly talk about emotions – chimes poorly with the space of some wards, which encourage a degree of caution around emotional expression, such that isolation and withdrawal become accepted ways of managing and in turn, obfuscating complex feeling.

A further layer of difficulty was the sense of emotional restriction fostered by staff. A common difficulty was both neglect from staff, or emotional inconsistency, which led many to keep their feelings to themselves. When discussing the issue of emotional triggers and how they might be dealt with on the ward, one participant described how the environment itself was not set up to enable emotional disclosure, due in part to the emotional distance of the staff, and the substitution of care for surveillance or ‘watching’.

***P:*** *Because even when they are there, most of the time they’re just not there. They’re just sitting there watching you instead of actually socialising with you, having a chat, talking to you about how you feel, or joining in a game of cards or just generally kind of socialising with us and actually generally being there rather than just sitting there and watching us like we’re dogs.*

Staff spending time with patients was perceived to be the most valuable aspect of life in hospital, and yet a number reported that this did not always happen, due to staff being overwhelmed, not caring, or having too great a turn-around (in particular, the use of agency staff) (Tulloch et al., 2008). As discussed earlier, gaining trust and establishing a connection, especially on a one to one basis, was believed to create a safe space for the discussion of complex emotional issues. Without this, participants struggled to appreciate what the inpatient setting could provide, due to some of the perceived inconsistencies in how staff managed emotional distress on the ward.

***P:*** *They’d just walk past us. I was having a really bad day and we were all like just crying or something like that, they’d just walk past us and be with* (another patient) *all the time, so you could tell she was the favourite. So that was a bit hard. It wasn’t hard for me. I don’t really care, but the other people, they said to me like, “What’s the point of me being here?” and stuff like that.*

Many described how their most treasured moments were in feeling like they mattered to someone, even if informally, in the context of a game or physical activity, or being take away from the communal space to deal with arising difficulties.

***P:*** *Yeah. I mean you had, you had certain staff members who were great, and you could just sit and have a laugh with them, and they played on the Xbox with us, whatever, and everyone would-, they-, they joined in with the karaoke one. One girl would join karaoke with us.*

Feeling important and establishing a relationship with staff members was also perceived to generate the necessary conditions for emotional disclosure and importantly, emotional management and coping. Interestingly, removing the patient from the ward was perceived to be an active way of pursuing the exploration of emotions, again on a one to one basis:

***P:*** *We go to the sports hall. Say, for example, I’m feeling very agitated and I can’t really help my feelings or my emotions, they’ll take me to a room and talk about it and ask you how you feel. Sometimes they’ll actually just bring you out away from the compound and make you do an activity or something by yourself, and I think that’s very supportive.*

Finally, medication played a key role in the management of emotions on the ward (and of course beyond), but here we explore how participants perceived the role of medication, to more fully examine the implications of its use, in relation to emotional distress and recovery.

For those who did not experience any means to talk through their emotions, or discuss the origins of their difficulties, medication was seen as the primary way in which emotions could be managed – that is through blunting or removal. The positive effects of this were very clear for many. The participants who reported finding medication useful, for example, were the ones who did not believe that they had the space or means to adequately deal with their feelings, or appeared to invest in the idea that they were ill, without understanding how this might change.

***I:*** *So do you think the medication’s helped you?*

***P:*** *I think it’s done really well, I’m not feeling anything.*

Many participants had an ambivalent relationship to medication, either because it did not remove their difficulties, caused side effects, or because their diagnosis kept changing. This led to a mistrust of certain professionals, and their ability to adequately address the underlying problem. Though a number of participants welcomed the calming effects of some medications, others felt that its success was in part due to its ability to ‘blunt’ (as opposed to ‘treat’), not just unpleasant emotions, but also the need to understand their source:

***P:*** *They can’t actually diagnose me with bipolar unless they actually saw me like it which they don’t ‘cause they’re not at my house. But I know I got a personality disorder, but yeah, then they diagnosed me with psychosis and stuff and dissociative something disorder. Basically everything, but the same medication’s for everything so it doesn’t really matter what I’ve got anyway.*

A number of participants reported being confused by a diagnosis that changed over time, and believed medication was used only to stabilise, rather than treat the underlying mental health problem.

***P:*** *I’ve had like three* (diagnoses) *(laughs). Personally, my view of mental health and how to treat it is to delay medicating someone for as long as possible, because I don’t feel that it has-, I was really willing to try it. I think sometimes it’s essential and sometimes it’s just an easy option rather than going through all the therapy, which is a really useful way of dealing with mental health, and I think try and stay out of an inpatient unit for as long as possible.*

In general participants did not perceive stabilisation and emotional blunting to be *necessarily* problematic, in the short term, as it was a key way to minimise risk, control behaviour and keep them safe. However, many expressed the need to explore and to learn how to manage their emotions, in a setting and context which provided adequate support, usually in the form of one to one therapeutic care. However, the ward was often seen as an inadequate space in which to be able to follow up on some of the emotions that arose during such therapy, such that it was safer to blunt, rather than express them.

**Discussion**

The young people in this study described CAMHS inpatient treatment as offering a number of benefits (eg. containment, safety, supportive relationships) and disadvantages (eg. lack of autonomy, artificial landscapes, inconsistent staff). These findings are consistent with similar research conducted with adolescent inpatients in the UK (eg. Gill et al., 2016; Haynes et al., 2011) and overseas (eg. Biering, 2010; Moses, 2011). Participants overwhelmingly believed that their inpatient stays would have been more helpful to them had they been shorter, often explaining this in terms of the ward space being unequipped to facilitate exploration of and progression through one’s traumatic experiences and emotional difficulties. Of particular note were the feelings of disconnection experienced by young people as a consequence of spending time inhabiting these unusual landscapes, often expressed as concern regarding becoming too ‘settled’, in this instance representing an acceptance of becoming a docile body (Foucault, 1979) and no longer wishing to proceed beyond the nested reality of the ward: A fear of belonging. Similarly, the minority of young people who perceived their preference for shorter stays as being primarily dependent on factors external to the ward uniformly described experiencing a sense of ‘placenessness’ (Kearns & Barnett, 1999), fearing that the truer landscapes of home and community were continuing without them.

The participants of this study would often utilise metaphor to better express a symbolic understanding of the hospital space. In particular, container metaphors such as ‘a zoo’ or ‘a holiday camp’ were often used to convey to the researchers a sense of the qualities found *here*, on the ward, rather than elsewhere (Kearns & Barnett, 1999). Use of these linguistic symbols establishes the ward as a demarcated space; a container in which place-specific processes can be anticipated to occur. Equally, our understanding of the ward as an emotional ecology allows us to conceptualise its residents as having been transformed into ‘pressurised containers’, a metaphor previously used by Kövecses (2003, pp. 155) to identify cross-cultural folk understandings of anger, and which in this instance can be adapted to aid us in exploring the relationship between young person, overwhelming distress, and place. The basic mappings of this metaphor are as follows:

The container is the young person.

The container’s contents are their distress.

The pressure of the contents on the container is the force of this distress on the young person.

The cause of the pressure is the root causes of the distress.

Trying to keep the contents within the container are the ward-endorsed blunting strategies and fear of triggering others.

The contents that unintentionally escape the container do so in the form of problematised behaviours such as self-harm.

The physical dysfunctionality of the container is the social unacceptability of the young person’s behaviours.

And, departing from Kövecses (2003):

The release valve is therapeutic spaces in which distressing emotions and their causes can be explored.

The contents that are intentionally released from the container may take the form of problematised behaviours, but may also represent enhanced understanding and resilience.

These containers are stored in close proximity to one another, and release of one’s contents may provoke release of others’.

Where Kövecses’ metaphor exists to demonstrate that expression of anger can be understood regardless of culture or place, our adapted form is tied to the spaces identified by participants as underpinning the emotional ecology of the ward: As with pressurised containers in reality, pressure release valves are not safe to use in all locations and under all conditions. Group therapies (art psychotherapy in particular) and the rooms in which these take place were identified by our sample as a particularly risky settings in which they were expected to unpack their distressing emotions in the presence of their peers before being dispersed back into areas of the ward that demanded suppression. Many responded to this risk by attempting to avoid the groups entirely, but felt coerced by high levels of staff encouragement and the lack of alternative activities. One to one sessions were generally viewed more favourably due to not having to manage the risk of triggering others (Gill et al., 2016). The majority of young people interviewed did not recall being offered these as a part of inpatient treatment, with several describing feelings of disappointment and betrayal at the cessation of individual sessions (and, occasionally, any contact outside of care planning meetings) with their community care coordinators during inpatient treatment. Rather, most participants felt that the safest and most reliable way to express themselves was by utilising supportive relationships with trusted peers (Freake et al., 2007; Moos, 1997; Moses, 2011).

Notably, some participants reported attempting to communicate their internally experienced distress with ward staff and learning that sometimes the only effective way to accomplish this was to escalate their problematised behaviours. They often felt themselves to be considered unreliable narrators of their inner lives, due both to their dual status as youth and mental patient (Foucault, 1967; McDowell, 2009), and described staff as not reliably addressing claims of distress if they were not supported by accompanying behaviours. Conversely, some participants disclosed having rapidly developed an understanding of the disproportionate value of overt behaviours and modifying these in pursuit of early discharge. Washing, dressing smartly, and making jokes were identified as useful mechanisms to facilitate this, and were sometimes successful even in instances where, with hindsight, the adolescents did not believe themselves to be ‘well enough’ to be discharged.

Where trusting bonds with staff were formed, participants in our study noted having witnessed expressions of caring, listening, empathising, and a non-judgmental stance, as has been found elsewhere in the literature (Freake et al., 2007; Moses, 2011). These young people also found it important for staff members to involve themselves in non-scheduled activities that were not formally *therapeutic*, such as playing games or simply actively engaging with them in ‘ordinary’ conversation. Engaging with participants informally served to deconstruct the symbolic power of both the diagnostic labels and imposing structures by which they found themselves confined, reconfiguring the ‘placeless’ wards into everyday social spaces in which they felt they could belong, albeit temporarily (Parr & Davidson, 2009).

**Conclusion: Towards a Supported Discharge Model**

Supported discharge aims to provide an alternative, more rapid pathway to community services for young people who are engaged with inpatient treatment (Ougrin et al., 2012), and this approach appears to be very much in keeping with what the young people in this study considered to be important. Though psychiatric wards are broadly effective at producing desired clinical outcomes (Bettmann & Jasperson, 2009; Tulloch et al., 2008), inconsistencies in how emotional expressions and peer relationships are tolerated present challenges that generate additional, unnecessary distress for young inpatients.

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