

Keeping in Touch: opportunities and  
barriers for children and young people  
maintaining connections to friends,  
families and education during periods of  
inpatient mental health care using case  
study methodology

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## Abstract

**Background:** Existing research has identified risks to children and young people's (CYP) connections to their friends, family and education during periods of inpatient mental health care. However, to date there is a dearth of research on what interventions and processes support CYP to maintain these connections.

**Aim:** To explore the interventions and processes that promote or hinder children and young people's connections to their education, friends and families during periods of admission to hospital for mental health care.

**Method:** Case study methodology was used involving the generation of qualitative and quantitative data in a single CAMHS inpatient unit. Three outcome measures relating to mental health, friends, family and education were completed by adolescents admitted to hospital for care and treatment of their mental ill-health (n=26). A subset of children and young people (n=9), their caregivers (n=6) and health, social and education practitioners (n=11) were interviewed, multidisciplinary team (MDT) meetings were observed, and policy and procedure documents were examined.

**Results:** Demographic data were collected and results from three questionnaires indicate participants were in the abnormal banding for the total difficulties score on the Strengths and Difficulties Questionnaire (SDQ). Participants scored highest on the global scale and trust and communication subscales in relation to mothers in the Inventory of Parent and Peer Attachment-Revised (IPPA-R). Highest scores were recorded on the behavioural and emotional engagement subscales of parts A and B of the Student School Engagement Survey (SSES). Thematic analysis of interviews (n=26), observations and documentary analysis of policy and procedure documents identified five themes: 'Remote connections to friends and family', 'Physical connections to friends and family', 'Peers in hospital', 'Impact on families' and 'Connections to education'.

**Conclusion:** The study highlights significant barriers to children and young people maintaining connections to their friends, family and education during periods of inpatient mental health care. It identifies candidate interventions to help children and young people maintain these connections.

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## Abbreviations

A Level – Advanced Level

CAMHS – Child and Adolescent Mental Health Services

C&C – Capacity and Capability

CMHT – Community Mental Health Team

CORC – Child Outcomes Research Consortium

CP – Consultant Psychiatrist

CRP – Clinical Research Portfolio

CTIMP - Clinical Trial of an Investigational Medicinal Product

CTP – Care and Treatment Plan

CYP – Child and young person or children and young people

DfE – Department for Education

DoH – Department of Health

EPPI - Evidence for Policy and Practice Information and Co-ordinating Centre

FC – Family Connector

FOI – Freedom of information

GAU – General adolescent unit

GCSE - General Certificate of Secondary Education

G.P – General practitioner

HAS – Health Advisory Service

HCRW – Health and Care Research Wales

HIW – Healthcare Inspectorate Wales

HRA – Health Research Authority

IPA - Interpretative Phenomenological Analysis

IPPA-R – The Inventory of Parent and Peer Attachment - (Revised)

IRAS – Integrated Research Application System

KESS2 – Knowledge Economy Skills Scholarships

KS – Key Stage

LA – Local Authority

LHB – Local Health Board

LMT – Local management team

LSA – Learning Support Assistant  
LSU – Low Secure Unit  
MCA – Mental Capacity Act  
MDT – Multidisciplinary Team  
MSU – Medium Secure Unit  
NCSE – National Center for School Engagement  
NEET – Not in employment, education or training  
NG – Nasogastric  
NHS – National Health Service  
NICE – National Institute for Health and Care Excellence  
NIHR – National Institute for Health Research  
NMC – Nursing and Midwifery Council  
NVivo 12 – Qualitative data analysis computer software package Version 12  
ONS – Office for National Statistics  
OT – Occupational Therapist  
PICU – Psychiatric Intensive Care Unit  
PIS – Participant information sheet  
PPI – Patient and Public Involvement  
PSE – Personal and Social Education  
PTSD – Post Traumatic Stress Disorder  
QNIC – Quality Network Inpatient CAMHS  
R&D – Research and Development  
RCN – Royal College of Nursing  
RCT – Residential Treatment Center  
RE – Religious Education  
REC – Research Ethics Committee  
RMN – Registered Mental Health Nurse  
RSPH - Royal Society for Public Health  
SAG – Stakeholder Advisory Group  
SD – Standard deviation  
SDQ – Strengths and Difficulties Questionnaire  
ST – Speciality trainee

STS – School Transition Specialist

SPSS – Statistical Package for the Social Sciences

SSES – Student School Engagement Survey

TA – Thematic analysis

UK – United Kingdom

USA – United States of America

WARRN - Wales Applied Risk Research Network

WHO – World Health Organisation

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## **Chapter one – Background**

### **1.1 Introduction**

This thesis is about the connections children and young people (CYP) make to friends, family and education during periods of admission to hospital for care and treatment of their mental health.

Throughout the thesis, the abbreviation 'CYP' will be used to refer to 'children and young people' and 'child and young person'. This abbreviation will be used interchangeably with other terms found in the literature involving the mental health care of CYP such as 'adolescents', refers to individuals aged 11 to 18 and incorporates young people who were under the care of the Local Authority (LA). Furthermore, the term 'caregiver' will be used to refer to parents, grandparents, aunties and uncles, foster carers, and legal guardians and will be used interchangeably throughout the thesis.

### **1.2 Mental health difficulties in CYP**

There is growing concern over the prevalence of mental health difficulties in CYP which has become a significant public health priority. Global estimates suggest that one in seven 10 to 19-year-olds experience a mental health disorder, accounting for 13% of the global burden of disease within this age group (World Health Organisation (WHO), 2021). A previous US study found that rates of mental health disorders was 12% for CYP aged 11 to 16, with an increase of 20-39% in the rates for those aged 16-24 (Kessler et al, 2005). This study established that half of all lifetime cases of mental health disorders start by the age of 14 and three quarters were by the age of 24 (Kessler et al, 2005).

Until recently there was a dearth of research in up-to-date prevalence figures of mental health difficulties in CYP in the United Kingdom (UK). The first major survey of mental health difficulties was conducted on behalf of the Office for National Statistics (ONS) in 2004 (Green et al, 2005). This systematic survey of the mental health difficulties in CYP aged between five and 16 estimated that one in 10 CYP had a diagnosable mental health problem. In recent years the rates have increased, with a survey conducted in 2017 reporting that one in eight 5 to 19-year-olds had a mental health disorder (NHS Digital, 2018). When this survey was followed up in 2021, it concluded that the rate of mental health disorders in CYP aged 5 to 16 had

strikingly increased, to a rate of one in six (NHS Digital, 2021). It is thought that a contributing factor to this sharp increase is the impact of the global coronavirus pandemic on adolescent mental health (Department for Education) (DfE), 2022).

### 1.3 Child and Adolescent Mental Health Services (CAMHS) in the United Kingdom

The provision of mental health services for CYP in the UK is predominantly delivered through National Health Service (NHS) Child and Adolescent Mental Health Services (CAMHS). CAMHS is planned, commissioned, and delivered through a four-tiered model of service delivery first adopted in the NHS Health Advisory Service (HAS) report *'Together we Stand'* in 1995 (NHS Health Advisory Service, 1995). Whilst developed almost three decades ago, the four-tiered model remains the preferred framework to commission, manage and deliver mental health services for CYP with mental health problems (McDougall and Cotgrove, 2014). A diagram providing a brief overview of the four tiers can be found below in Figure 1.1 – The CAMHS four-tiered framework.

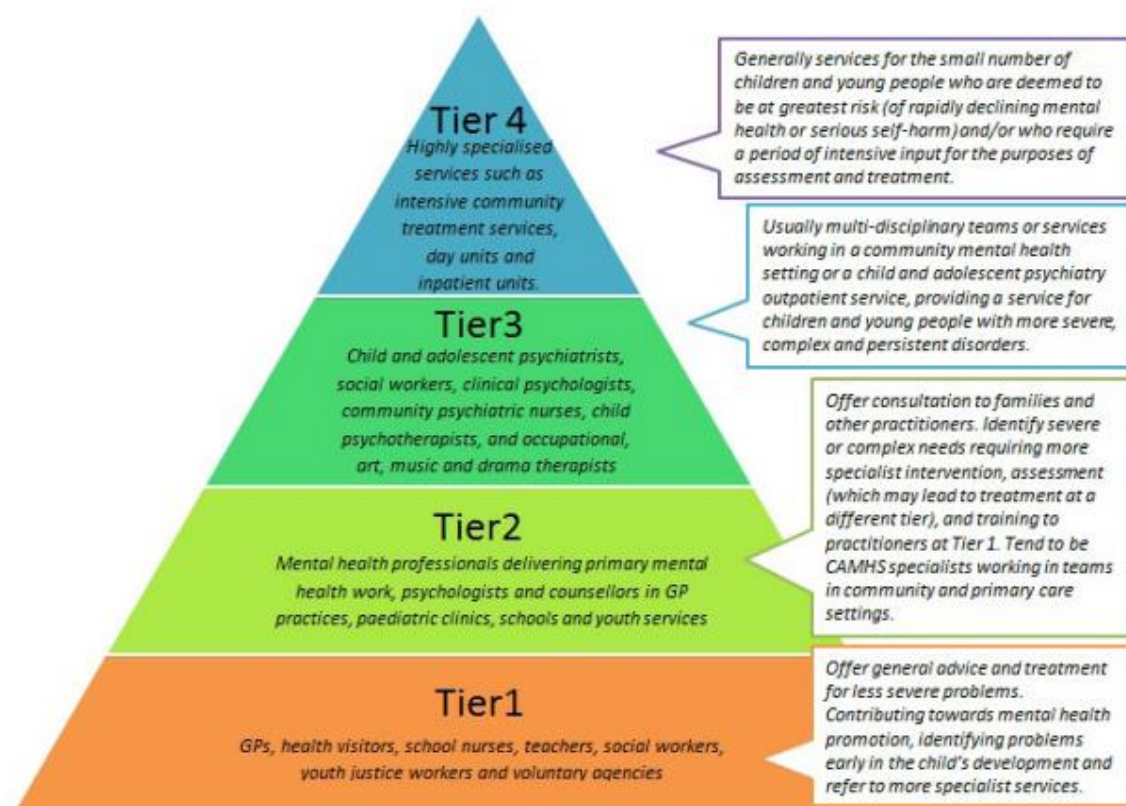


Figure 1.1 – CAMHS four-tiered framework (Department of Health, 2017)

Tier 1: at the first tier CAMHS are provided by professionals in primary, universal or front-line services. This consists of general practitioners (GPs), health visitors, school nurses, teachers and social workers. Although the focus of these professionals' training is not primarily mental health, they should have basic knowledge of difficulties such as self-harm (McDougall and Cotgrove, 2014) and are able to refer CYP to primary care or more specialist services.

Tier 2: second tier CAMHS are provided by mental health professionals with expertise and specialist training in the mental health of CYP. Their role is to provide assessment and treatment for CYP with less severe mental health problems that have not responded to tier 1 interventions, although they do not require more specialist interventions from tier 3 or 4 services. Another key role of professionals at this tier is to provide support and training to professionals in Tier 1 services.

Tier 3: CAMHS at the third tier involve dedicated multidisciplinary teams (MDT) located at a community mental health team (CMHT). Professionals within these services such as psychiatrists, psychologists, nurses, social workers and a variety of therapists, provide comprehensive assessment and treatment of CYP with more severe and complex mental health issues. This may involve the offering of a range of both pharmacological and psychological interventions.

Tier 4: tier 4 CAMHS are reserved for highly specialised services such as inpatient units, day units and intensive community services. They are required for CYP who have the most severe and complex problems or are experiencing a rapid deterioration in their mental health. The severity of these difficulties cannot be managed by tier 3 CAMHS at home or in a social care placement and therefore require an intense period of assessment and treatment of their mental health (Cotgrove and Northover, 2021). Tier 4 services may also include other specialist services such as eating disorder services, forensic CAMHS and residential facilities provided by organisations outside of the NHS.

#### **1.4 Tier 4 inpatient units**

Inpatient units are a part of a wider range of specialist CAMHS including non-bed-based Tier 4 services. They play an important role in meeting the needs of a small number of CYP who have the most complex or severe mental health difficulties and

are commissioned on a sub-regional, regional or supra-regional basis (McDougall et al, 2008).

The number of beds in and admissions to UK inpatient CAMHS units has increased over time. A previous study highlighted that across 91 UK CAMHS inpatient units there were approximately 1,130 beds taking around 2,500 admissions per year (O’Herlihy et al, 2007). In the autumn of 2020, there were 1,368 beds across 115 inpatient unit wards, with the private sector providing nearly half (47% in 2015) of beds (Hayes et al, 2021). A freedom of information (FOI) request in 2020 to the NHS by the independent charity Article 39, found that admissions have increased in recent years to around 3,500 per year (Article 39, 2021).

Different types of Tier 4 inpatient units exist, with the majority of inpatient units being classed as ‘general adolescent units’ (GAU’s) which account for 727 of the 1,368 beds available in the UK (Hayes et al, 2021). These units provide different interventions for CYP with a range of mental health disorders and usually admit CYP aged from 13-14 up to 16 or 18 (Cotgrove, 2014). Other units include more specialist units which treat specific disorders such as eating disorders where 248 beds are available, Psychiatric Intensive Care Unit’s (PICU) consisting of 124 beds, low secure unit (LSU) and medium secure unit (MSU) forensic CAMHS services with a combined 148 beds, with the remaining 56 beds being made up of beds across GAU’s, LSU’s and MSU’s (Hayes et al, 2021). There are approximately 80 GAU’s in the largest region of the UK (McDougall and Nolan, 2017), although this figure has increased to 107 when LSU’s, MSU’s and PICU’s were included (DfE, 2018).

Whilst there is some evidence to suggest that inpatient units are effective for CYP with mental health difficulties (Green et al, 2007), there is ongoing debate as to the advantages and disadvantages of admission to inpatient units. Generally, a mental health admission to an adolescent inpatient mental health unit is not the treatment of first choice for CYP (Hayes et al, 2021). Admission is often considered as a last resort (Kurtz, 2009), pursued when all other options have been exhausted and no equivalent alternative treatment to inpatient care has been identified (McDougall and Cotgrove, 2014 and Kennedy et al, 2020).

For CYP who need hospital admission, it is usually indicated by clinical factors such as risk, severity and complexity (Hayes et al, 2021). Treatment in inpatient units aim

to reduce risk, or severity, of long-term psychopathology through the provision of an intensive therapeutic environment (Hanssen-Bauer et al, 2011). Inpatient units can provide a more comprehensive assessment of an individual's clinical presentation, management of their risks associated with the mental health problem and the initiation of treatments where previously there may have been issues regarding concordance in the community (Hayes et al, 2021). A systematic review evaluating the effectiveness of adolescent inpatient units concluded that admission generally helped improve symptom stabilization (Hayes et al, 2018).

Although there have been perceived benefits of admission to an inpatient unit for CYP, there are also disadvantages that have been well documented. Admission to hospital presents risks to CYP with the disruption of their development, social networks, relationships with family and progress of their education (Evans et al, 2017). Removing CYP from their normal environment may expose them to additional stressors (Hayes et al, 2021) and can make them often feel deskilled, isolated, and more dependent on hospital care due to the loss of crucial support structures and links with their community (James and Worrall-Davies, 2015). A more in-depth account of the risks facing CYP's connections to their friendships, families and education will be discussed in Chapter two.

The financial costs associated with inpatient CAMHS are also very high (Cotgrove and Northover 2021), with hospital admission being regarded as the most expensive way of treating CYP with mental health difficulties (Hazell, 2021), and this has been highlighted when compared with intensive community-based treatment (Kwok et al, 2016). The average cost of an admission to a GAU is estimated to be around £60,000 and the annual operating cost of a GAU bed to be around £220,000 (NHS Benchmarking Network, 2016; 2019).

Despite the potential drawbacks to adolescent inpatient units, they remain a crucial part of mental health services for a small minority of adolescents with the most severe and complex mental health difficulties (Cotgrove, 2014).

## **1.5 The researcher**

During the final year of my mental health nurse education at Cardiff University in 2016, I had the opportunity to work at a Tier 4 CAMHS inpatient unit for my management placement. Throughout this placement I cared for patients with various

severe and complex mental health difficulties. During this placement I developed a passion for nursing CYP and would seek to pursue a position as a staff nurse upon the completion of my undergraduate studies.

After qualifying as a Registered Mental Health Nurse (RMN) I took up employment as a Staff Nurse at the same CAMHS inpatient unit. During Multidisciplinary Team (MDT) meetings with various health, social and education practitioners and in 1:1 engagement sessions with patients, I noticed recurring issues relating to their friends, family and education such as living significant distances from the unit.

Whilst in clinical practice I became aware of a jointly funded opportunity by Knowledge Economy Skills Scholarships (KESS2) and an NHS Local Health Board (LHB), to conduct research exploring the areas of CYP's connections to friends, family and education during periods of inpatient mental health care. The origins of this study stem from the further research recommendations of a previously published evidence synthesis into the risks to CYP in inpatient mental health care (Hannigan et al, 2015) which will be explored in further detail in Chapter two. It is through my previous experiences of clinical practice that I decided to apply to undertake this research project involving CYP in inpatient mental health care.

## **1.6 Overview of thesis**

The thesis highlights barriers to and interventions that promote CYP keeping in touch with their friends, family and education during periods of admission to hospital for mental health care.

Chapter one provides an overview of the chosen topic including the prevalence of mental health problems in CYP in the UK, service provision of mental health services and brief background of the researcher.

Chapter two reviews the literature of CYP in inpatient mental health units with a specific focus on the risks of connections to their friends, family and education and concludes with a rationale for the study.

Chapter three focuses on the design and development of the study, including the justifications for the chosen methods of data collection and analysis. The process of obtaining the necessary permissions from an NHS Research Ethics Committee (REC) to conduct the study are discussed, along with the process of gaining and

maintaining access to the research site. Finally, the key ethical issues that were considered such as safeguarding against potential psychological distress, consent and confidentiality procedures and the management of data are discussed.

Chapter four provides an overview of the research site and presents tabulated data collected of demographic information on the sample and the results from three validated outcome questionnaires/tools.

Chapters five, six and seven present the findings of CYP's connections to their friends, caregivers and education from the data collection and analysis of interviews, observations, and official documents. Themes pertaining to each chapter produced through thematic analysis are discussed.

Chapter eight draws together and discusses the findings of the study to provide an overview of the opportunities and barriers for CYP to remain connected to their friends, caregivers and education during inpatient mental health care. This chapter concludes with noting the limitations of the study, along with recommendations for further research to improve the experience for CYP in inpatient CAMHS maintaining social connections.

## **Chapter two – Children and young people’s connections to friends, family and education when in hospital – an evidence review**

### **2.1 Introduction**

This chapter provides a background to the study and places CYP’s experiences of keeping in touch with their friends, family and education when receiving inpatient mental health care within the wider context of literature relating to CYP’s inpatient mental health care.

This will begin with providing an overview of a recently published evidence synthesis into the risks to CYP using inpatient mental health services (Hannigan et al, 2015) on which this study directly builds. Following this, the methods utilised when conducting an updated review of the literature on this topic will be outlined, which will include the search strategy employed and the process of appraising research articles. The chapter will provide an updated review of the literature in the subsequent years that have passed since Hannigan et al’s (2015) evidence synthesis and will focus on the findings from more recent literature concerning the risks to CYP’s connections to their friends, family and education during periods of inpatient mental health care. Finally, this chapter will present a summary regarding the overall state of knowledge relating to these three areas of CYP’s inpatient mental health care and the gaps in knowledge which this study intended to explore further.

### **2.2 Summary of Hannigan et al (2015) evidence synthesis**

In 2015 Hannigan and colleagues published an evidence synthesis of risk identification, assessment and management for CYP using Tier 4 inpatient CAMHS (Hannigan et al, 2015). This research was funded by the National Institute for Health Research (NIHR) Health Services and Delivery Research programme and used a two-stage framework, the Evidence for Policy and Practice Information and Co-ordinating Centre approach (EPPI-Centre) (EPPI-Centre, 2010).

In this first phase of their study, searches were made to the electronic databases MEDLINE and PsychINFO with an applied end date of March 2013, to acquire citations related to the intersection between the following four key areas: young people, mental health, inpatients and risk. Of the 4539 citations found, 124 were finally included and were displayed in a series of evidence maps. Of the included articles, most predominantly focussed on the clinical risks to CYP in inpatient mental



health services such as the risks of harm to self, suicide, harm to others, and predictors of restraint or seclusion.

Between phases one and two of their study, a collaborator for the UK CYP mental health charity YoungMinds, conducted a series of conversation consultations with CYP who had been previously admitted to inpatient CAMHS. Additionally, a similar consultation conversation occurred with the mother whose child had been in hospital for care and treatment of their mental health. These conversations were recorded, and CYP were asked to identify the risks which the project team should concentrate on in their in-depth phase two part of their study.

Part of Hannigan et al's (2015) research included an independently chaired Stakeholder Advisory Group (SAG) meeting. In 2013, the Stakeholder Advisory Group members, consisting of the YoungMinds representative, CYP who had experienced inpatient mental health services, practitioners, and a senior manager, met with the project team. The descriptive maps from phase 1 of the study which mainly focussed on clinical risks and a presentation from the outcomes of the conversation consultations with CYP were presented to the group. Utilising principles of nominal group technique (Evans et al, 2017), the group participants independently generated lists of the risks to CYP transitioning into, through and out of inpatient mental health care. These lists were then personally ranked by participants with the purpose of prioritising the category of risk to take forward into the second, in-depth phase of the study. Phase 2 priority categories of risk which were individually generated and ranked from the stakeholder advisory group were put alongside both the priorities from the carer and YoungMinds consultations. Items were coded and themed by the project team and a list of ranked priority risk categories was created. The top risk category priorities highlighted by the SAG were all examples of 'less obvious' risks, unlike the more 'clinical' risks identified in phase 1 of their mapping of the literature. Following the SAG meeting, the project team created the concepts of 'dislocation' and 'contagion', terms used to describe the first and second priority risk categories to explore in the second part of their study. The concept of dislocation was used to refer to a set of risks to CYP of being removed from 'normal life' to CYP's loss of identity, of being stigmatised, to their friendships, to families, to education and to social and psychological development. The concept of contagion was used to refer to the risks of CYP making unhelpful friendships and of the

learning of unhelpful behaviours from other patients during periods of admission to mental health hospitals (Hannigan et al, 2015).

Phase two of the study focussed on the search, appraisal and synthesis of citations related to the risks to CYP in inpatient mental health care within the two broad categories of dislocation and contagion. The search strategy used for this phase of the study comprised of three main areas: young people, mental health and inpatient. 17 electronic databases were searched with a date limit of 1995-2013 applied. Of the 15,662 citations identified in this phase of the study, 40 papers reporting on 38 studies were included in Hannigan et al's (2015) review, along with 20 policy and guidance documents specifically addressing the inpatient CAMHS field. All evidence included for the final review was synthesised under a series of narrative syntheses within the following themes: Dislocation: Normal Life, Dislocation: Identify, Dislocation: Friends, Dislocation: Stigma, Dislocation: Education, Dislocation: Families, and Contagion.

For the purpose of this thesis, the following section will present a summarised account of the findings from the 40 articles and 20 supplemented policy and guidance documents included in the in-depth 'phase 2' of Hannigan et al's (2015) evidence synthesis, with specific attention being paid to the synthesised themes in the priority risks areas to CYP's friendships, education and family during periods of inpatient mental health care. These three themes were further categorised into the following nine sub-categories: *Dislocation: Friends – relationships with young people outside hospital, relationships with young people in hospital. Dislocation Education - Education provision and facilities, quality of inpatient education, academic progress and reintegrating with school after discharge. Dislocation: Families – Impact on family relationships, family involvement and maintaining contact with families.* Each item included in these synthesised sections relating to friends, family and education in Hannigan et al's (2015) review were obtained independently by the researcher and read in depth.

## **2.3 Friends**

The first theme to be summarised in Hannigan et al's (2015) research focussed on CYPs friendships outside and inside hospital. The theme of CYP's friends was further categorised into the following two sub themes: *Relationships with young people outside hospital and Relationships with young people in hospital.*

### **2.3.1 Friends - Relationships with young people outside hospital**

The first theme in Hannigan et al's (2015) evidence synthesis relating to CYP's friendships was synthesised through the subtheme of CYP's relationships with their friends and peers outside of hospital. Tier 4 CAMHS deliver specialist in-patient and day-patient care to CYP who experience severe and/or complex mental health conditions that cannot be adequately treated by community CAMHS (NHS Commissioning Board, 2013). Maintaining relationships, particularly with families, carers and friends is vital for CYP when their treatment involves in-patient admission. In policy and guidance documents specifically relating to CAMHS inpatient settings, guidance was found to be limited to recommending that there should be private spaces on inpatient units to enable visiting, along with there being specific policies and procedures on visiting in place (Solomon et al, 2011) and that inpatient treatment should enable improved peer relationships (NHS Commissioning Board, 2013).

Several studies explored pre-existing friendships between CYP in hospital and their friends at home. In one study, it was reported that CYP in hospital valued their friendships and maintained contact with their friends from home through writing letters and making telephone calls (Painter, 2008). Although for some, maintaining contact with friends was not always possible, making friendships difficult to preserve and leaving CYP feeling distressed when their friendships deteriorated (Painter, 2008). Multiple studies into CYP's experiences of inpatient mental health care reported the admission to hospital being a contributing factor to the deterioration of friendships (Puotiniemi and Kyngas, 2004; Painter, 2008 and Clemens et al, 2010). Some CYP experienced discomfort seeing their friends whilst in a mental health hospital (Moses, 2011) and experienced rejection by their friends outside of hospital (Clemens et al, 2010). Other CYP appeared to feel isolated from their friends due to their friends' limited understanding of mental health issues. This led CYP in some instances to distance themselves from their peers prior to being admitted to hospital (Offord et al, 2006). In one study, a CYP's friendship was broken off when it was discovered that they were in a mental health unit (Puotiniemi and Kyngas, 2004). In other studies, as part of their process of recovering from their mental health difficulties, CYP purposely disconnected from their friendships outside of hospital as

their friends were perceived as contributing to causing and maintaining the CYP's mental health difficulties prior to their admission to hospital (Painter, 2008).

Throughout policy and guidance documents, it is recognised that there are benefits for CYP in hospital maintaining contact with their friends from home (Solomon et al, 2011). However, certain barriers to maintaining outside friendships exist. In some studies, this involved specific rules around visitation, whether friends were able to visit and the conflicting priorities between CYP's home life and being in hospital (Painter, 2008). A conflicting barrier for some CYP maintaining friendships outside of hospital was the physical distance between their homes and inpatient units (Svanberg and Street, 2003 and Painter, 2008). A concern for CYP maintaining contact with their friends through visiting was that lifts for friends often had to be provided by their parents (Painter, 2008). It has also been reported that in some cases CYP recognised it being helpful to be away from their home lives with regards to the difficulties and pressures they faced (Svanberg and Street, 2003).

The concerns CYP had around reconnecting with their friends post discharge was reported in various studies (Offord et al, 2006; Painter, 2008; Clemens et al, 2010 and Moses, 2011). CYP reported feeling worried about explaining to their friends where they had been (Clemens et al, 2010), with some thinking their friends would treat them differently after they had been on an inpatient mental health unit (Offord et al, 2006 and Clemens et al, 2010). For others, they appeared to feel that their friends may reject them post discharge from hospital (Clemens et al, 2010) and in some cases, CYP did not want to inform their friends, or for them to find out where they had been (Moses, 2011). In one study, it was reported that CYP experienced the same social problems that they experienced prior to admission, and difficulties in explaining their absences to their peers and appeared worried about how this would impact their friendships (Clements et al, 2010). Furthermore, 'connectedness' with friends in a study was described as the way in which CYP perceived their relationships with their friends as close, confiding, satisfying and supportive (Czyz et al, 2012). In this study, perceived connectedness was reported to have changed after being on an inpatient unit and affected levels of depression and suicidal ideation (Czyz et al, 2012). Throughout the evidence synthesis, there appeared to be no intervention studies that were found to support CYP in inpatient mental health care maintain relationships with their friends from home (Hannigan et al, 2015).

### **2.3.2 Friends - Relationships with young people in hospital**

The second synthesised subtheme in Hannigan et al's (2015) research related to CYP's friendships explored their relationships with other patients in hospital.

Findings from previous studies involving CYP in inpatient mental health care report CYP found it positive being on an inpatient unit with others who had similar mental health conditions (Buston 2002; Svanberg and Street, 2003; Colton and Pistrang, 2004; Claveirole, 2005; Offord et al, 2006; Painter, 2008 and Moses, 2011). CYP appeared to find peers in hospital supportive (Svanberg and Street, 2003; Colton and Pistrang, 2004; Claveirole, 2005; Painter, 2008 and Moses, 2011). CYP experienced genuine acceptance and companionship from their peers (Offord et al, 2006 and Moses, 2011), and enjoyed the support and advice from others (Colton and Pistrang, 2004 and Painter, 2008). Often through the process of talking and listening to each other, CYP developed supportive relationships with their peers which appeared to help with the negative emotions associated with being in hospital (Svanberg and Street, 2003 and Painter, 2008).

However, studies also report negative aspects associated with CYP living in hospital with their peers. This appeared to cause distress in some CYP (Colton and Pistrang, 2004; Painter, 2008 and Moses, 2011), and concerns from caregivers around vulnerable CYP living together (Svanberg and Street, 2003). Distress in CYP appeared to be heightened, particularly after witnessing others exhibit bizarre or violent behaviour which they struggled to understand (Svanberg and Street, 2003). In the case of peer relationships in hospital, there were no intervention studies identified promoting positive peer relations among CYP who were inpatients (Hannigan et al, 2015).

## **2.4 Education**

The second theme to be summarised in Hannigan et al's (2015) research focussed on CYP's education when in hospital. The theme of education was further categorised into the following four sub themes: *Education provision and facilities, Quality of inpatient education, Academic progress and Reintegrating with school after discharge.*

### **2.4.1 Education – Education provision and facilities**

The provision of education in inpatient mental health care has been identified in both research and policy and guidance. In various UK policy and guidance documents the

importance of inpatient units working in partnership with education services has been highlighted (Department of Health (DoH), 2003; National Institute for Health and Care Excellence (NICE), 2004b; Royal College of Psychiatrists, 2003; Scottish Executive, 2005 Welsh Government, 2005; and DoH, 2011a).

Information regarding education provision in UK CAMHS inpatient settings has been published across studies and reports (Tulloch et al, 2008 and Mental Welfare Commission, 2009). A large UK wide study reporting on the cost, outcomes and satisfaction of 29 UK CAMHS inpatient units, it was reported that education was delivered across two different types of education modelling. Of the inpatient units surveyed in the study, 72% had a school integrated into the unit and 28% of units had education provision outside of the main unit but still within the main grounds of the hospital (Tulloch et al, 2008). In Scotland, all inpatient units were found to have specialist inpatient education provision on site (Mental Welfare Commission, 2009). A study conducted in the USA of CYP in hospital at a Residential Treatment Center (RTC) reported either partial or full attendance at the centre and found that during the admission there was no significant change in either CYP's attendance or academic performance (Shabat et al, 2008).

In some UK CAMHS inpatient mental health hospitals, the same approach to that of mainstream schools was adopted regarding the provision of education hours with some CYP receiving a full day of education as opposed to part day (Claveirole, 2005). Additionally, the importance of teachers having expertise in both teaching and mental health was emphasised by health professionals (Claveirole, 2005). In a study exploring education provision in UK CAMHS inpatient units, it was reported from two-thirds of teachers that access to local school facilities were available for CYP (Tulloch et al, 2008). When exploring CYP's perspective of inpatient education, CYP reported contrasting experiences. Some felt they were well supported by the unit with regards to their education (Svanberg and Street, 2003), whereas others wanted more frequent study sessions and felt the inpatient education provision was not enough in comparison to their mainstream education (Svanberg and Street, 2003).

In the case of CYP who are admitted to adolescent inpatient mental health hospitals and are over the age of 16, recommendations from policy and guidance state that hospitalised CYP should be able to continue with compulsory education (Solomon et

al, 2011) and where possible, students should be supported by education and training providers to remain on their courses or to keep their places on courses open (Welsh Government, 2012). The educational situation for some CYP over the age of 16 in the UK may have changed in recent times (Hannigan et al, 2015). As of 2015 legislation states there is a legal requirement to provide education and training to those who are under 18, and in 2013 the age for CYP to leave school was increased to 17 (Education and Skills Act, 2008). The provision of education for post 16's in some inpatient units in the UK appears to be underdeveloped, with one study reporting that there was limited provision for post 16's (Svanberg and Street, 2003). However, in a large UK wide study assessing CAMHS inpatient units, it was reported that of the post-16 CYP well enough to attend inpatient schooling, most were receiving some input with regards to their education (O'Herlihy et al, 2001). Providing CYP with access to education including appropriate classroom spaces and educational facilities when they are hospitalised is recognised in policy and guidance (DoH, 2003; NICE, 2004b; Solomon et al, 2011; NICE, 2013 and Welsh Government, 2013). Whilst this is recommended, there appear to be no UK studies reporting on this area of CYP's education during inpatient mental health care (Hannigan et al, 2015). One international study reported CYP were able to increase the volume of work they were doing whilst in hospital through having more opportunities for one to one teaching, teachers expertise in subjects and being in a smaller, multiclass learning environment (Simmernann,1997). In inpatient units, having the resources available to meet the demands of the national education curriculum and the various key stages, is stated in guidance documents and national service frameworks (NHS Commissioning Board, 2013 and Welsh Government, 2005). Recommendations are that the provision of core subjects of Mathematics, English and Science are facilitated (Solomon et al, 2011). The provision of the national curriculum has been documented briefly, with one study finding that only 35 of the 62 inpatient unit schools surveyed had the educational resources to cover the key aspects of the national curriculum (O'Herlihy et al, 2001). Although all units surveyed in the study reported having the resources available to cover teaching the different key stages depending on the age of patients (O'Herlihy et al, 2001).

It has been noted throughout policy that partnership between education services and inpatient units is crucial (Royal College of Psychiatrists, 2002; DoH, 2003; NICE,

2004a; Welsh Government, 2005; Scottish Executive, 2005; DoH, 2011a and Solomon et al, 2011). Where CYP have been admitted to inpatient units specifically for the treatment of eating disorders, NICE guidance recommends the provision of age-appropriate facilities (NICE, 2004b). Partnership working between services has been highlighted as crucial in maintaining the continuity of CYP's education upon admission to an inpatient unit (Scottish Executive, 2005 and Solomon et al, 2011). The assignment of a key worker or named nurse within an inpatient setting to carry out liaison a role with schools and colleges has been recommended (Scottish Executive, 2005), in addition to maintaining communication with caregivers (Solomon et al, 2011). When reporting on the relationships between inpatient units and education services, a study found that most inpatient units had good relationships with their respective education authorities (Tulloch et al, 2008)

#### **2.4.2 Education - Quality of inpatient education**

The second subtheme within the education theme to be summarised from Hannigan et al 's (2015) evidence synthesis relates to the quality of inpatient education being provided to CYP admitted to hospital for care of their mental health. Inpatient and conventional schooling has been compared in two studies (Buston, 2002 and Svanberg and Street, 2003), and teaching staff have been explored in an additional four studies (O'Herlihy et al, 2001; Svanberg and Street, 2003; Claveirole, 2005 and Tulloch et al, 2008). The quality of inpatient education being provided to CYP has been addressed through policy and guidance (Scottish Executive, 2005 and NHS Commissioning Board, 2013). Studies report that CYP appear to appreciate the supportive aspect of inpatient schooling (Svanberg and Street, 2003), with only a minor number of CYP expressing concerns around the quality of education being provided when on an inpatient unit (Buston, 2002). The importance of the training needs of teachers providing the education to CYP in hospital has been highlighted in policy and guidance (Scottish Executive, 2005 and NHS Commissioning Board, 2013), and recommends that all teachers in hospital education services should hold formal graduate and post graduate Diplomas in Education. Further recommendations for teachers include continuous professional development and training in the area of child and adolescent psychiatry (Scottish Executive, 2005). When exploring the perspectives of experienced teachers in inpatient units, teachers reported that they were better equipped in understanding CYP's needs and problems after receiving



training in education and mental health, which they kept up through conferences and dedicated study days (Claveirole, 2005).

The ratios of teaching staff to students within the context of inpatient mental health education has been the focus of both policy and research. Although now dated, policy at the time recommended there be at least one full-time teacher for every eight CYP on the unit (Scottish Executive, 2005). Within other parts of the UK, many units reported to have a staff to student ratio of 1:3, with ratios of 1:4 and 1:10 being reported in a smaller number of units (O'Herlihy et al, 2001). Specifically in England, public sector NHS units were reported to have significantly lower staff-student ratios to that in private sector adolescent inpatient mental health units (O'Herlihy et al, 2001). A shortage of inpatient teachers was reported in one study, with unit staff reporting that on occasions they felt they needed more staff than they had available. This was especially highlighted when staff reported that although there may only be a few CYP on the unit, the severity of difficulties of those CYP may affect the unit schools capacity to accept more CYP (Svanberg and Street, 2003). CYP also reported feeling they needed more support staff in the unit school and commented that the teachers found it difficult to provide work for older CYP (Svanberg and Street, 2003). Despite teachers reporting that they had good working relationships with CYP's caregivers (O'Herily et al, 2001), this was not always reciprocated by caregivers who in some cases reported poor school liaison between the inpatient unit and mainstream school (Svanberg and Street, 2003). Additionally in some instances, CYP reported wanting to have more contact with their mainstream school/college during their admission to hospital to prevent them from losing contact (Svanberg and Street, 2003).

### **2.4.3 Education – Academic progress**

The third subtheme of CYP's education when in hospital for their mental health related to academic progress throughout admission to hospital. This issue was covered across multiple studies, with the effect an admission had on CYP's long-term goals and achievements being explored by a further two studies. When asked questions around what they feel they have missed out on during admission to hospital, CYP reported that they felt they had missed out on a chance to get an education, due to missing exams (Painter, 2008). CYP also reported falling behind

with their schoolwork and were concerned around having to re-sit the school year (Painter, 2008).

According to service standards and recommendations for adolescent inpatient mental health hospitals, units should be registered as examination centres (Solomon et al, 2011). When this issue was explored in a national study, findings showed that the majority of teachers from the inpatient units surveyed stated that there were opportunities for CYP to take their examinations, with staff from only one unit reporting that this was unavailable (O’Herlihy et al, 2001).

Studies have reported that pre-existing academic issues are prevalent in CYP who are entering mental health hospital for treatment (Anderson et al, 2008 and Clemens et al, 2010), such as typically obtaining below-average grades (Clemens et al, 2010). One study in the USA found that 79% of CYP on discharge reported doing either better or the same in school prior to being admitted to an RTC (Larzelere, 2001). CYP’s educational attainment post discharge has also been the subject of some studies. This has shown that hospitalised CYP were less likely to complete high school, obtain a bachelor’s degree or graduate degree when compared to non-hospitalised adolescents (Best et al, 2004). It has also been reported that hospitalised adolescents were less likely to take up a career post discharge (Halfon et al, 1995), and were more likely to be expelled from school (Brinkmeyer et al, 2004).

#### **2.4.4 Education – Reintegrating with school after discharge**

The fourth and final synthesised subtheme in Hannigan et al’s (2015) research focussed on CYP’s re-entry to school after discharge from mental health hospital. It has been suggested that the difficulties surrounding school reintegration for CYP following discharge is a significant barrier to academic progress (Hannigan et al, 2015). School re-entry and reintegration is especially of concern when an individual has been admitted to an inpatient unit far from their home (Svanberg and Street, 2003). As previously stated, government policy states that CYP should be able to remain on their courses or to have their place on their course held open where possible (Welsh Government, 2012).

Studies suggest there is a requirement for partnership working between both mental health services, mainstream and inpatient schools, patients, and their caregivers for

successful school re-entry and reintegration (Clemens et al, 2011). Education and mental health services working in partnership to promote successful school re-entry is also highlighted in commissioning policy (NHS Commissioning Board, 2013), which recommends effective liaison with schools on discharge to maintain the continuity of CYP's education. Additional policy and guidance documents further recommend a named nurse or keyworker from the inpatient unit undertake liaison with schools as part of their role (Scottish Executive, 2005),

A study exploring hospitalised adolescents' school re-entry suggests re-entry and reintegration should be a focus for services beginning at the point of a CYP's admission to the inpatient unit (Clemens et al, 2011). Another paper from the same author reporting on the same study recommends that jointly made plans for school re-entry should be made (Clemens et al, 2010). There was a particular emphasis on ensuring the plans were flexible however, and this study highlighted that CYP are not always ready to re-enter school despite being discharged from inpatient mental health services (Clemens et al, 2010).

Both CYP and health care professionals have provided an account of their experiences of school re-entry from an academic perspective (Offord et al, 2006 and Clemens et al, 2010). In one study health care professionals reported that CYP experienced further stress in addition to being in hospital, as they were concerned about how much work they had missed from their mainstream school and the thought of catching up (Clemens et al, 2010). CYP also reported struggling with knowing their friends were progressing with their education by doing their exams and moving on to university (Offord et al, 2006).

For CYP to have better opportunities to reintegrate back into mainstream school post hospitalisation, health care professionals indicated that this was better achieved when there was co-ordination with education staff (Clemens et al, 2011). When making the transition from hospital to mainstream school health care professionals also reported that having an identified adult to support the CYP was beneficial and helped with CYP's confidence and making them feel less alone when re-entering school (Clemens et al, 2011). It was also identified in this study that a key aspect of partnership between education and mental health services was open and honest communication. Similarly, a vital aspect in CYP's continuity of care with regards to

their education was through effective liaison with their mainstream school (Svanberg and Street, 2003). It was found however that work to be sent to inpatient units from some mainstream schoolteachers did not always occur, and links with mainstream schools were particular difficult to maintain when the CYP lived a significant geographical distance from the inpatient unit (Svanberg and Street, 2003). In another study however, liaison between the inpatient unit teachers and CYP's mainstream school was reported in the majority of inpatient units surveyed (O'Herlihy et al, 2001).

Studies have shown varied approaches to mainstream school reintegration (White et al, 2006 and Clemens et al, 2011). A study reporting on a school-based practice initiative described a programme in which CYP post hospitalisation, were provided with intensive support and care-coordination for 6-10 weeks. For the 67 students where data on their educational status were available, all students were successful in resuming their studies post discharge from hospital (White et al, 2006). In another study exploring school reintegration, an emphasis was placed on ensuring the process of reintegration was student led and recommended asking what students thought was important in addition to following up interventions (Clements et al, 2011).

## **2.5 Families**

The final theme to be summarised focussed on CYP's families when in inpatient mental health care. The theme of families was further categorised into the following three sub themes: *Impact on family relationships*, *Family involvement* and *Maintaining contact with families*.

### **2.5.1 Families – Impact on family relationships**

Documented throughout policy and guidance is that one of the objectives of treatment during an admission to inpatient mental health care should focus on improving family relationships (NHS Commissioning Board, 2013). Despite this, the impact an admission has on family life has been highlighted as a disadvantage of inpatient mental health care (Kurtz, 2009). Further guidance from adolescent inpatient service standards recommend support groups for caregivers (Solomon et al, 2011). As reported from the perspectives of caregivers, the need for additional support from within the inpatient unit has been described. Caregivers have reported contrasting experiences, with some reporting that that they received support from

unit staff, whilst others felt they did not get support from the unit (Claveirole, 2005). Some caregivers also described their relationships with other CYP's parents and wider members of their own family breaking down over the course of their child's admission to hospital (Puotiniemi and Kyngas, 2004).

Various studies have explored CYP's perspectives of their families when in hospital for their mental health. When interviewed CYP reported feeling homesick after being admitted to hospital for extended periods of time (Svanberg and Street, 2003; Claveirole, 2005 and Thurber et al, 2007). Others reported feeling a sense of rejection from their family or experienced isolation after being admitted to the unit.

Additionally, research has shown CYP's levels of depression and suicidal ideation changed after being on an adolescent mental health unit due a change in CYP's perceived connectedness with their families (Czyz et al, 2012). In this study, connectedness was described as a sense of closeness with friends and family, which CYP perceived as caring and supportive, and feeling a sense of belonging and having satisfaction with their relationships (Czyz et al, 2012). Findings from this study indicated that less severe depressive symptoms at 3 months after hospitalisation, as well as a lower likelihood of attempting suicide during the entire follow-up period, was significantly associated with a greater increase in connectedness with families (Czyz et al, 2012).

### **2.5.2 Families – Family involvement**

The second synthesised subtheme relating to families in Hannigan et al's (2015) evidence synthesis explored the involvement of CYP's families in their child's care whilst they were in hospital. Family involvement in CYP's care is advised through government policy and guidance (DoH, 2011b) and partnership working with families should be a focus for inpatient units (NHS Commissioning Board, 2013). This is particularly important in the context of the formulation of care planning and aftercare decisions (Solomon et al, 2011).

A study investigating the family-friendliness of the admission process to a mental health unit explored training staff through role playing and mindfulness (Singh et al, 2002). Findings indicated that role play did not appear to have any significant impact on the family-friendliness of treatment teams. During the 6-month follow up period

however, mindfulness did appear to be of limited benefit to treatment teams (Singh et al, 2002).

Studies reporting on the involvement of families in the CYP's care conceptualise the term 'family involvement' in various ways. Some studies reported family involvement through CYP having received visits from their parents while hospitalised (Lakin et al, 2004 and Charlemagne, 2011), and the frequency of visitation (Brinkmeyer et al, 2004). Additionally, family involvement was also described as parents taking part in family sessions being involved in treatment and discharge planning and participation in hospital activities (Brinkmeyer et al; Lakin et al, 2004 and Charlemagne, 2011).

The benefits of the involvement of families in CYP's care have been highlighted throughout research. Studies have shown a higher rate of readmission to psychiatric hospital in CYP who had poor family engagement throughout their treatment (Brinkmeyer et al, 2004). Furthermore, two studies reported that where parents were involved in their child's care, there was a significantly increased chance of maintaining therapeutic improvements in the community, and CYP were more likely to engage in aftercare services (Parmelee et al, 1995 and Lakin et al, 2004).

However, through perspectives of health care professionals, obstacles to families being involved in their child's care were reported due to issues around confidentiality, parent's own varying ability to get involved in their child's care, physical distances from home to inpatient unit and parents having the time to be available (Claveirole, 2005).

### **2.5.3 Families – Maintaining contact with families**

The final subtheme to be summarised from Hannigan et al's (2015) evidence synthesis focussed on CYP maintaining contact with their family throughout their stay in hospital. As discussed earlier in the summarised subtheme of *friends-relationships with young people outside hospital*, inpatient units should have specific policies and procedures around visiting for friends and family and this recommended by inpatient service standards (Solomon et al, 2011). Further recommendations on families visiting emphasise the importance of flexibility around visiting times (Scottish Executive, 2005). Studies have shown that some inpatient units followed this flexible approach to visiting (Mental Welfare Commission, 2009) however this was not the same for all inpatient units with some having inflexible visiting times and lack of private spaces to facilitate visiting (Offord et al, 2006). Studies have shown that a

particular challenge for CYP being admitted to inpatient units is the physical distance between the unit and their homes (Buston, 2002; Svanberg and Street, 2003; Claveirole, 2005; Tulloch et al, 2008 and Mental Welfare Commission, 2009). In policy and guidance, it is suggested that where possible inpatient services should be located as close to home as possible to enable frequent visitation (DoH, 2003 and Welsh Government, 2005), and within the first week of admission, it has been recommended that families should be offered family meetings (NHS Commissioning Board, 2013). Particularly in the case of CYP living a significant distance from an inpatient unit, guidance recommends alternative options to inpatient admission should be explored (NICE, 2013).

The provision of facilities in inpatient units to support families with visiting is suggested, with recommendations of private spaces being made available to families to visit and providing refreshments (Solomon et al, 2011 and NHS Commissioning Board, 2013). Other guidance suggests accommodating families who are required to travel a significant distance (Scottish Executive, 2005). This was achieved in some studies through the provision of overnight facilities for families travelling from outside of catchment areas (O’Herlihy et al, 2001 and Mental Welfare Commission, 2009).

Both CYP (Tulloch et al, 2008) and caregivers (Buston, 2002; Svanberg and Street, 2003 and Mental Welfare Commission, 2009) have described the financial aspects associated with frequent visitation to inpatient units which they perceived as inaccessible. CYP reported their parents struggling to visit regularly due to the cost of fuel (Buston, 2002 and Svanberg and Street, 2003). In some instances, inpatient units had access to funds to support families with the costs associated with travelling to the unit if they were in receipt of welfare benefits (Mental Welfare Commission, 2009).

When interviewed CYP reported wanting to keep in contact with their families (Offord et al, 2006 and Mental Welfare Commission, 2009), and studies have reported CYP using additional methods of communicating with their families such as through telephones (Claveirole, 2005 and Mental Welfare Commission, 2009). This method of communicating was of particular importance to CYP whose families lived long distances from the inpatient unit (Tulloch et al, 2008). However, restrictions placed

on and the prevention of access to mobile phones was an obstacle for some CYP (Offord et al, 2006 and Moses, 2011).

Earlier sections of this chapter summarised a previous evidence synthesis into the risks facing CYP in inpatient mental health care. The following sections will provide an update to the literature in the case of CYP's connections to their friends, family and education during inpatient mental health care.

## **2.6 Overview of literature searches**

An updated literature search was undertaken to bring specific areas of the evidence synthesis up to date and to ensure this thesis built on the most current available evidence. The review of the literature aimed to provide an overview of current knowledge relating to CYP's experiences of their connections to their friends, family and education during periods of inpatient mental health care.

The databases accessed were chosen depending on their relevancy to the topic area. Alongside research articles, current policies and guidelines were examined. The review was initially undertaken in January 2018, with a final updated review being undertaken in December 2021 and automatic updates were set up to capture any relevant studies published after these dates.

To understand the extent of the problem a comprehensive search of the literature was conducted. A total of 14 research articles were identified, reviewed, and included for the final review. Articles originated from the following countries: UK (n=2), Europe (excluding UK) (n=2), USA (n=4), Canada (n=2), Australia (n=3) and New Zealand (n=1).

An overview of the number of research articles identified through both electronic databases and hand searching reference lists of journal articles can be found in Table 1.1, a PRISMA flowchart. Information and in-depth details of the search strategy and the tables containing a summary of articles reviewed are presented in Appendices 1 and 2.



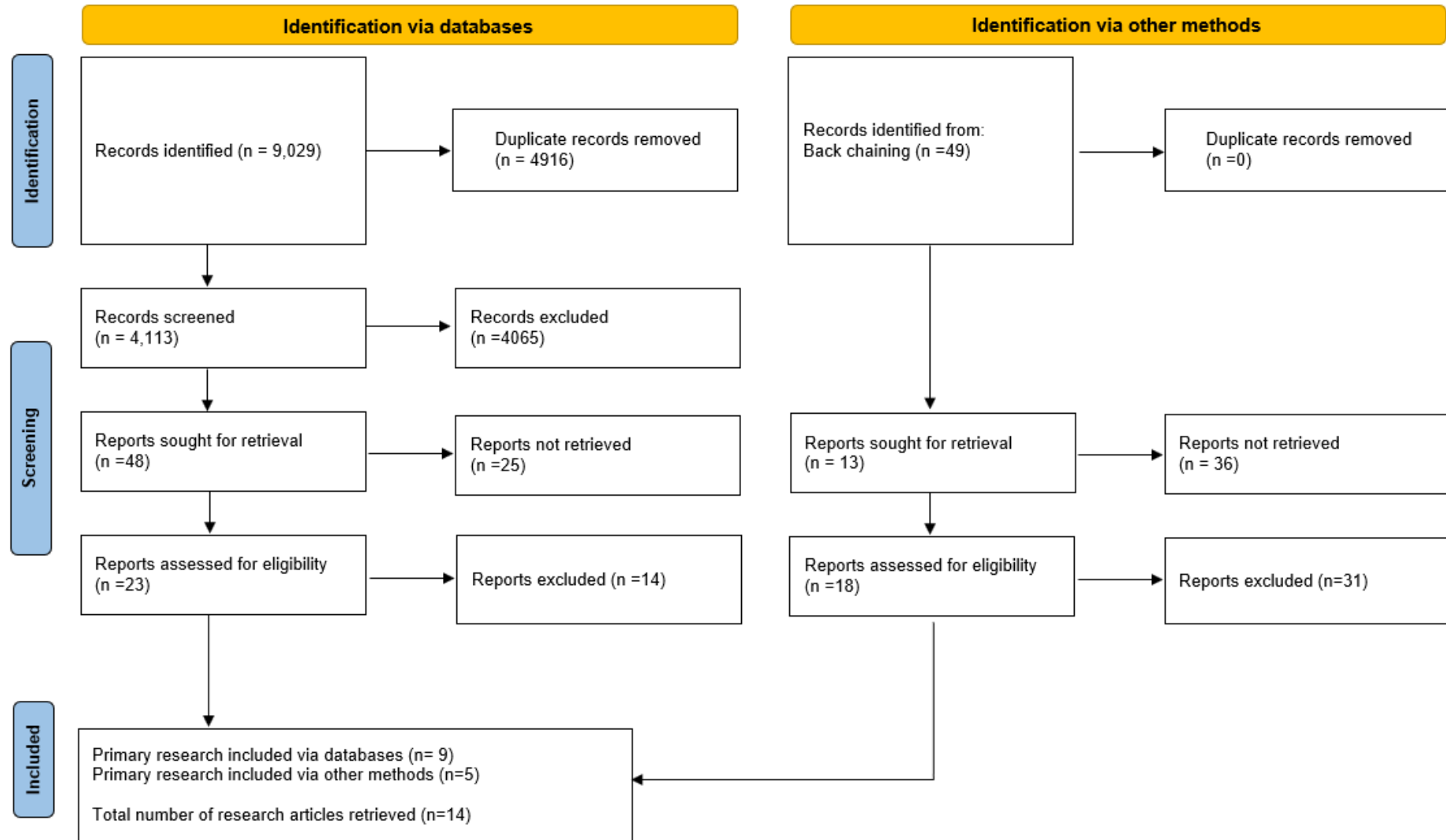


Figure 2.1 - PRISMA flow chart for primary research which included searches of databases and other sources

## **2.7 Friends**

### **2.7.1 Friends – CYP valuing their relationships with others in hospital**

As mentioned earlier in this chapter, CYP experienced acceptance and companionship from peers in hospital (Offord et al, 2006 and Moses, 2011). In more recent studies, a central aspect of the inpatient experience for CYP was the importance of feeling understood by other adolescents and staff in the unit (Gill et al, 2016 and Reavey et al, 2017). Gill et al (2016) undertook a qualitative study utilising semi-structured interviews to explore CYP's perspectives of adolescent inpatient mental health care. Participants in this study reported the inpatient experience as having a mixture of benefits such as supportive relationships with staff and peers, and drawbacks such as living in a 'fake world' and feelings of being 'wrapped in cotton wool' (Gill et al, 2016). CYP in this study referred to how some aspects of inpatient treatment disrupted established relationships with family and friends, however, also gave them new opportunities to develop valued relationships with peers and staff members. CYP also commented on having a sense of belonging and validation with fellow inpatients through having shared experiences. In addition, a theme in this study's results was that some participants described developing a significant relationship with either a fellow inpatient or staff member over the course of their admission to the unit. These relationships were described by several participants as being a 'life saver' and played an important role in CYP's experiences of inpatient treatment (Gill et al, 2016). Some CYP experienced feelings of isolation prior to being admitted to hospital, with one CYP reporting that they felt they did not have anyone to talk to including their parents and friends. In contrast, others reported highly valuing having people around for most of the time, including fellow peers and staff that they could talk to (Gill et al, 2016).

Another qualitative study which aimed to gain a better understanding of adolescents' experiences of inpatient care with a particular focus on staff and peer relations, and the ward space was undertaken by Reavey et al (2017). Some participants in this study felt forming supportive and trusting relationships with peers, was a safe and reliable way of expressing themselves on the ward (Reavey et al, 2017).

Furthermore, in situations where CYP were experiencing distress and there were no staff available to care for them in a crisis, patients would look after each other. This resulted in participants believing they had gained a greater sense of emotional

competence through the informal development of relationships with other patients (Reavey et al, 2017).

A study aiming to explore CYP's experience of acute mental health inpatient care was undertaken by Stanton et al, (2020). In this study, Self-determination theory (Deci and Ryan, 2002) was explored with CYP in relation to them meeting the three needs of self-determination theory of relatedness, autonomy and competence. Relatedness referred to "an experience of feeling connected to other individuals and a community", and included experiences of caring for, being cared for and accepted by others (Stanton et al, 2020). In this study, relatedness in relation to other CYP on the unit was described. CYP reported feeling connected to their peers and this continued post discharge from the unit. Most CYP spoke positively of their peers and there appeared to be a general sense of companionship between patients. CYP described others as helpful, particularly when orientating them to the unit, encouraging them to participate in group activities and offering advice and coping strategies. An important aspect between CYP in this study was having similar or shared experiences. CYP reported experiencing a sense of comfort knowing that other patients were going through similar challenges, and they reported feeling understood by the peers and less alone (Stanton et al, 2020).

A study by Schneidtinger and Haslinger-Baumann (2019) aimed to explore the lived experience and personal recovery of adolescent users of inpatient mental health services. Findings from this study indicated that personal recovery was influenced by external factors such as peers, family and treatment. During interviews with participants, patients discussed friendship and peer relations with fellow patients during hospitalisation. Participants in this study described friendships with fellow patients that were of great importance to them. They described groups of inpatients forming on the ward and stated that fellow inpatients were extremely helpful as they perceived they understood each other (Schneidtinger and Haslinger-Baumann, 2019). Many participants also saw themselves and other inpatients as a community in which they supported each other. Finally, some CYP described how fellow inpatients would orientate newly admitted patients around the ward.

Salamone-Violi et al (2015) researched CYP's perspectives of their referral and admission to a child and adolescent psychiatric inpatient unit in Australia. A theme in

their study focussed on CYP's interactions with other patients. The researchers in this study found that when CYP experienced some form of connection with their peers, they perceived this relationship as one of the driving forces in making them have a positive inpatient experience. This was most prominent in those who were more accepting of their inpatient admission (Salamone-Violi et al, 2015). Participants who were more open to the idea of inpatient admission reported perceptions of acceptance and non-judgement with other inpatients on the unit with whom they had some connection.

The positive influence of peers was an important aspect in two studies of clinician and adolescent and caregiver perspectives of inpatient care of (Hayes et al, 2019 and 2020). In the earlier study focussing on perspectives of ten clinicians, clinicians reported that once admitted to the inpatient unit, adolescents who may have previously struggled with 'fitting in' or felt different with regards to their peer group, suddenly had peers who understood them and people who they could open up to and share their problems with (Hayes et al, 2019). Another clinician described acceptance between adolescents in the inpatient environment because they understood each other, and that this was different for CYP's interactions with other groups of people such as their peers from school. An aspect that promoted peer relationships in hospital according to clinicians was the unit environment. Clinicians described the environment as one with no judgement, which provided a platform for CYP people to develop therapeutic relationships (Hayes et al, 2019).

In the later paper researching the perspectives of CYP and caregivers, CYP perceived their relationships with peers as helpful due to being around others who were in similar situations to themselves (Hayes et al, 2020). A key aspect to CYP making new friendships in this study was the feeling of being understood and developing trust with other CYP (Hayes et al, 2020). However, caregivers reported finding their child's peer relationships being difficult, with some caregivers feeling rejected. Caregivers also acknowledged the importance of CYP meeting new friends in hospital, although in some instances they were concerned about the intensity of these peer relationships (Hayes et al, 2020).

### **2.7.2 Friends - Negative interactions with other inpatients**

In addition to being reported in Hannigan et al's (2015) earlier evidence synthesis, more recent studies have also described positive interactions and experiences

between CYP when in hospital. However, there were also reports of some challenging and negative aspects of CYP living in hospital together.

In Gill et al's (2016) study, some of the participants described the challenges that arose from living with CYP with difficulties, including witnessing others in distress. Participants also reported the uncomfortable feelings they experienced in becoming too attached to peers and staff. This worried CYP and they felt it would make it more difficult for them to leave the inpatient unit and return home to their families (Gill et al, 2016). Several CYP in another study described how their peers could be annoying, and invade their personal space (Stanton et al, 2020). CYP also described being influenced negatively by their peers and they found it difficult to contain themselves when their peers were 'acting up' (Stanton et al, 2020). In Schneidtinger and Haslinger-Baumann's (2019) study, it was suggested that CYP's personal recovery was hindered by negative group dynamics. It was also noted that certain individuals were negatively influencing others, particularly younger adolescents. This study also describes CYP participating in internal groupings associated with self-harming such as cutting themselves and anorexia nervosa (Schneidtinger and Haslinger-Baumann, 2019). Participation in such groups were previously outlined in this chapter in Hannigan et al's (2015) review through the concept of 'contagion'.

The challenges of CYP living together when in hospital for their mental health was documented in Hayes et al's (2019) study. In their paper on clinicians' perspectives, clinicians reported that there were issues with CYP forming unhelpful friendships such as them being disruptive. Clinicians also reported that by becoming concerned with their peers' problems, this caused a knock-on effect in which CYP often avoided their own issues (Hayes et al, 2019).

Some of the challenges of CYP in hospital together in Gill et al's (2016) study also described the risk of CYP's behaviour "triggering each other off". Like Gill et al (2016), an aspect to Reavey et al (2017) was the concept of 'triggering' between CYP. A term commonly taken from social media websites, such as Tumblr or Reddit, was associated with the emotional distress from people who experience mental health difficulties such as anxiety or Post Traumatic Stress Disorder (PTSD) (Reavey et al, 2017). Participants defined an interdependency between what they were feeling and how it would negatively affect other CYP. This risk of potentially causing

emotional distress in others affected some participants to either purposely hide their feelings, attract attention, or invited further criticisms or scrutiny of their behaviours by other CYP (Reavey et al, 2017).

### **2.7.3 Friends – CYP explaining to friends where they had been**

One key theme throughout literature relating to CYP's relationships with friends outside of hospital was the difficulty they experienced in explaining to their friends where they had been, with some CYP feeling anxious and not wanting their friends to know where they had been (Moses, 2011). CYP were also concerned about how other people in the community might perceive their stay in hospital and how it may impact existing friendship groups (Reavey et al, 2017). In Gill et al's (2016) study, most participants expected they would have to answer difficult questions when they returned to school, and that they would be talked about behind their backs by their peers (Gill et al, 2016). Participants in other studies also expressed concerns about having to manage difficult enquiries from peers when returning home and this was a particular competence in which CYP felt the need to address to staff members (Stanton et al, 2020).

In one qualitative study focussing on the perspectives of parents whose children had been in inpatient mental health care, a subtheme of this study briefly focussed on the implications for CYP when entering their mainstream school. Whilst parents highly valued the support from their child's mainstream school, they reported their child being afraid of being judged negatively with regards to their peers (Merayo-Sereno et al, 2021).

### **2.7.4 Summary of friends**

In summary, recent research has highlighted some of the positive aspects of peer relations between CYP when in hospital for their mental health, such as having a sense of similar or shared experiences and feeling understood by each other. Studies have also reported some of the challenges of CYP living in hospital, including living with others who had difficulties with their mental health, witnessing distress in others and peers having a negative influence on one another. CYP also highlight concerns when explaining to friends where they had been post-hospitalisation.

## **2.8 Families**

### **2.8.1 Families - Visitation and Telephones**

In the most recent standards for services for UK inpatient CAMHS units, Quality Network for Inpatient CAMHS (QNIC) recommend adolescent mental health units have specific policies and procedures on visiting and ensuring there are private spaces on the ward available for families to visit (QNIC, 2021). Throughout the literature ward visits were seen as a prominent way in which CYP maintained contact with their parents. In Stanton et al's (2020) study there was evidence of the adolescent inpatient unit supporting 'relatedness' between CYP and their caregivers. Most CYP in this study described feeling well connected to their caregivers during admission to the unit, with some increasing the sense of connection with their family over the course of their admission (Stanton et al, 2020). Supporting CYP and their families with practical solutions to maintain contact included providing onsite accommodation, ease of making phone calls, staff members encouraging families to go on outings and supporting long visiting hours (Stanton et al, 2020). Receiving support from the family during hospitalisation was experienced by the participants in Schneidtinger and Haslinger-Baumann's (2019) study. Regular visits to the ward by family members were seen as highly positive for CYP, with one CYP reporting that she felt 'bolstered up' and strengthened by her mother visiting each day during the wards allocated visiting hours (Schneidtinger and Haslinger-Baumann, 2019). Visitation between CYP and their caregivers was also described as a key time throughout the CYP's stay for caregivers' relationship with their child and with the unit and its staff members in another study (Merayo-Sereno et al, 2021). However, in this study it was recommended that parents were to work on management strategies with their child during the visit as opposed to spending time with them. This often left parents feeling this task should have been undertaken by a therapist and not themselves (Merayo-Sereno et al, 2021).

Telephone calls to friends and family are an important method of contact for CYP and provision for this has been recommended by inpatient service standards (QNIC, 2021). The ease of making phone calls has been highlighted as practical support for patients (Stanton et al, 2020). Although in this study there were rules around the use of mobile phones which appeared to limit CYP's mobile phone usage in the evening. The restrictions on the use of mobile phones were described as beneficial by some CYP, particularly during the night-time where they would retire to bed at an earlier

time and incorporate sleep strategies into their bedtime routines (Stanton et al, 2020). Restrictions on mobile phones were not appreciated by all CYP however. One study sought to understand how adolescents perceived the hospital experience when hospitalised for medical stabilisation (Bravender et al, 2017). CYP in this study rated the limits put on mobile phones as the least helpful aspect of the inpatient experience.

### **2.8.2 Families – Parents’ understanding of their child’s mental health issues**

In Gill et al’s (2016) study, CYP identified the need for support from others such as friends, family and mental health aftercare services. All CYP reported feeling more confident in their family’s understanding of their difficulties due to the support they had received at the unit, with some CYP reporting that they had good support networks upon discharge from the unit. In some instances, it was staff members who were attributed with helping CYP’s families develop more of an understanding of their child’s mental health issues (Stanton et al, 2020). However, not all CYP reported feeling understood by their caregivers, with some reporting the feeling of their mental health issues not being taken seriously enough (Schneidtinger and Haslinger-Baumann, 2019). One CYP reported issues becoming more difficult as their family developed more of an understanding of the seriousness of what they were going through (Stanton et al, 2020).

### **2.8.3 Summary of families**

In summary there were two key methods of communication for CYP to remain in contact with their families when in hospital for mental health care, through visits to the ward and telephone calls. The provision of quiet spaces on inpatient units to enable visiting is recommended by CAMHS inpatient service standards. CYP reported visiting to be a positive aspect of the inpatient experience which helped them stay connected to their families. Despite restrictions being applied to telephones for some CYP, telephone calls were also seen as an important way for CYP to contact their families. CYP reported feeling their parents had a better understanding of their child’s mental health problems over the course of their admission to hospital. Although this was not the same for all CYP, with some reporting that they did not feel understood by their parents or that their parents did not take their mental health issues seriously enough.



## **2.9 Education**

### **2.9.1 Education - Inpatient education**

In a recent report exploring inpatient education in UK CAMHS units, survey responses were collected from 62 of 107 (58% response rate) inpatient units in England which accounted for around 75% of CYP in inpatient CAMHS care (DfE, 2018). Overall, survey responses from units found that the majority of CYP received over 16 hours of education per week (DfE, 2018). Findings from this report also indicated that education was mainly delivered through regular timetables, although there were varying models of delivering education. Inpatient CAMHS service standards recommend the provision of the core educational subjects of Mathematics, English, and Science (QNIC, 2021). In the report by the DfE, 92% of units responding to the survey's provided English, 90% provided Maths and 82% provided Science to all pupils (DfE, 2018). In addition to providing core subjects, units also provided a range of other subjects including Art, Personal Social Health and Citizenship Education (PSHCE/PSHE), Physical Education (PE), ICT, Music, History, and Geography (DfE, 2018).

Since the undertaking of Hannigan et al's (2015) review, there appears to have been two further studies briefly reporting on CYP's education within the context of education being provided inside inpatient mental health units (Hayes et al, 2020 and Stanton et al, 2020). In Hayes et al's (2020) study, CYP's education was reported from the perspective of CYP both prior to and during their admission to the mental health unit. Schoolwork was described as the focus of admission for some CYP, who stated that they were willing to accept an admission to the mental health unit if the admission helped them to do their schoolwork. For others who were asked questions around the key expectations of the admission, school was a priority. Some hoped to regain a structure to help them with returning to school. Other CYP were more explicit with their expectations however and hoped that the admission would help them to do schoolwork at the standard they were working at previously (Hayes et al, 2020). Some CYP had other expectations and commented that they realised the admission was not going to 'fix' them, but they hoped to feel better to the point where they could then continue attending their mainstream education (Hayes et al, 2020).

Adolescent inpatient mental health service standards recommend that all CYP are provided with a personal education plan, and that the unit provides a broad and

balanced curriculum, which is appropriate to the student's needs (QNIC, 2021). In Stanton et al's (2020) study the third pillar of Self-determination theory 'competence', was explored within the context of the inpatient mental health unit's school. Some CYP described the unit's school as pivotal in helping them get back into a routine as they felt they had lost competence in doing their schoolwork. CYP on attending the unit school as a good way to start off doing small tasks as some CYP had already missed one year of mainstream education. However, some CYP reported that the school within the mental health unit was not stretching them enough academically or felt that not enough was being done to keep them up with their studies (Stanton et al, 2020).

### **2.9.2 Education – Supporting CYP's re-entry into mainstream school post hospitalisation**

Since Hannigan et al's (2015) evidence synthesis one of the education subthemes, CYP reintegrating with school after discharge from a mental health hospital, has been discussed more recently in the literature through policy and new research.

New service standards for UK inpatient mental health units recommend unit staff support CYP with their reintegration if they are returning to their local education facility post discharge (QNIC, 2021). As mainstream schools are one of the key environments in which CYP will attend following discharge from hospital for mental health related issues (Marraccini et al, 2021), there has been an increased number of studies that have focussed on exploring the best practice for supporting CYP during reintegration to their mainstream school (Tougas et al, 2019). These studies have included exploring existing practice through conducting surveys with school psychologists (Marraccini et al, 2019), identifying some of the barriers and facilitators for CYP re-entering school (Clemens et al, 2010; 2011) and has focussed on the experiences of returning to school through the perspectives of adolescents (Preyde et al 2017;2018 and Marraccini et al, 2021) and caregivers (Blizzard et al, 2016).

Procedures for CYP reintegrating into their school typically involve meeting with families prior to the students return, communicating with hospital providers and the development of an individualised re-entry plan (Marracinni et al, 2019). In this study by Marracinni et al (2019), the following six domains were synthesised and outlined for consideration when CYP were reintegrating to their school post hospitalisation:

*School related stressors, Supports and interventions, School environment, Safety plan, Key individuals and Re-entry plan.*

Firstly, studies recommended that schools are encouraged to identify and provide support for students' academic, social and emotional school-related stressors in relation to their mental health (Clemens et al, 2010; Preyde et al, 2017;2018), including any anxieties students had about schoolwork and difficulties involving their peers (Savina et al, 2014, White et al, 2017 and Preyde et al, 2018). It has been suggested that students, families and school professionals should be provided with appropriate preparation and interventions to support CYP such as the teachers and school professionals who would be interacting with the returning student gaining knowledge or awareness about their mental health issues (Savina et al, 2014). It has also been suggested that parents and families may require information about the resources available for psychosocial support and information on the process of school reintegration (Blizzard et al, 2016). Suggested interventions for students may focus on certain adjustments to school such as additional academic support, behavioural support, counselling support and/or skill development. These interventions should vary in intensity depending on the individual needs of the CYP and be monitored with both short and long term goals (Savina et al, 2014; White et al, 2017; Preyde et al, 2017;2018). Recommendations from studies also include considering the CYP's school environment, and schools should identify methods to address peer reactions in support of a positive school environment in order to reduce discrimination and bullying (Savina et al, 2014 and Preyde et al, 2017;2018). Studies recommend the development of a safety plan for potential mental health and behavioural concerns to support CYP reintegrating to school (Savina et al, 2014 and White et al, 2017). Further considerations include identifying key individuals involved in the process of CYP's reintegration to school. These include a person overseeing this process such as a 'point-person' or 're-entry co-ordinator' to support the student during reintegration (Clemens et al, 2010 and Savina et al, 2014). Other studies have made recommendations for schools to develop an individualised re-entry plan in collaboration with other stakeholders (Savina et al, 2014; Tisdale, 2014 and Preyde et al, 2018;2019).

There has been a call from practitioners and researchers for improved communication between hospitals, families and schools both during and post

discharge (Savina et al, 2014; White et al, 2017 and Tougas et al, 2017). It has also been suggested that support for students returning post hospitalisation should be tailored to the individual needs of the person (Tougas et al, 2019), and to the specific context of their school (Marraccini et al, 2021).

Common services available to support CYP upon returning to their school may include support with time management, individual counselling and on-site tutoring (Marraccini et al, 2019). Other practical support for students in some studies included extended time to complete academic deadlines, being flexible with students' time of arrival and departure from school, and providing students with a universal pass to see a counsellor (Marraccini et al, 2019). However, it has been noted that the availability of these service and support may vary across communities and rural and high-poverty schools may have fewer resources to support returning students (Marraccini et al, 2021). Findings from this recent study exploring hospital recommendations for schools during CYP's discharge from psychiatric hospitalisation also reported that compared to schools located in urban and suburban areas, schools in rural areas were found to less likely to have school reintegration protocols for students returning (Marraccini et al, 2021).

Recommendations were made outlining a series of steps to prepare for school re-entry following discharge. These included considering a return to school throughout the hospitalisation period, discuss information sharing with families, providing school with a discharge summary, provide recommendations to schools supporting CYP returning to school tailored to their needs and finally to consider the variability across schools to provide support to returning students (Marraccini et al, 2019).

In a follow up study to an earlier piece of research highlighted in Hannigan et al's (2015) evidence synthesis, (White et al, 2006), researchers reported findings from a school-based transition program facilitating CYP's school re-entry following psychiatric hospitalisation (White et al, 2017). Of the 189 participants in the study situated across eight high schools, findings from this study indicate that there were improvements observed in CYP's day to day functioning, in addition to there being positive trends in participants' school attendance and rates of graduating high school (White et al, 2017).

Another study which aimed to support CYP's transition from inpatient hospitalisation to school implemented a school transition programme to support CYP (Weiss et al, 2015). In this study, CYP and families participating in the school transition programme were assigned a 'Transition Team'. This team consisted of a Family Connector (FC) and School Transition Specialist (STS) which would provide peer to peer support to CYP and their caregivers. STS's were social workers with extensive experience of working with CYP and families and would create transition plans for the school and would monitor the implementation of these plans over a period of three months (Weiss et al, 2015). Findings from this intervention reported that through providing transition specialists, outcomes for CYP and caregivers were improved, and it also promoted cross-system communication between schools and families (Weiss et al, 2015).

### **2.9.3 Summary of education**

Findings from recent research studies indicate education is a focus for CYP when being admitted to hospital, and CYP reported varying expectations of inpatient education. For CYP who had experienced inpatient education, some described the unit school as being helpful in regaining their competence with regards to their schoolwork. This was not the same for all CYP however, and some CYP reported not feeling challenged enough academically by the unit school.

Supporting CYP's to their mainstream school post discharge is reported in both service standards documents and research. Research studies have detailed some of the procedures and processes when considering CYP returning to their mainstream school and studies have also described interventions such as school transition programs to assist CYP returning to their school post discharge from inpatient mental health care.

### **2.10 Conclusion and study rationale**

This chapter began with the summary of three key areas from a previously published evidence synthesis exploring the risks facing CYP admitted to mental health hospitals. This literature was updated for the purpose of the current study which explored the risks pertaining to CYP's connections to their friends, family and hospital during periods of inpatient mental health care.

In the case of CYP's friendships, previous research has found that admission to adolescent inpatient units pose risks to the maintaining of CYP's relationships with

their friends. However, studies in the evidence synthesis and the subsequent updated review of the literature found a lack of research exploring actions to support adolescents in hospital to maintain relationships with their friends both inside and outside of hospital.

Admission to an inpatient mental health unit also poses a risk to adolescents' family connections. Although the review found some support for families to maintain contact, the review failed to highlight studies reporting interventions to promote family contact in UK inpatient units.

In the case of CYP's schooling, policy and guidance make clear recommendations that inpatient units provide education, including facilities and classroom space. Whilst a recent DfE report (2018) briefly surveyed education in UK inpatient units, no studies were found in the previous evidence synthesis or updated literature review exploring how CYP maintained connections to their education during mental health hospital in the UK.

Despite the updated review finding limited additional research uncovering risks to CYP's friendships, family connections and education, there is still a dearth of research of CYP and caregivers' views of staying connected during mental health hospital admission. There is also a lack of research exploring what everyday staff in adolescent inpatient mental health services do to promote CYP maintaining these connections. Gathering CYP and caregivers' experiences of maintaining connections during admission and inpatient staff members' views of facilitating connections would help address this gap in the literature. Highlighting potential barriers to social connections and identifying candidate interventions to facilitate connections would potentially help adolescent mental health services address these issues for CYP and caregivers.

## **Chapter three – The research process**

### **3.1 Introduction**

In this chapter details of the research process are outlined. This will begin with the aims, objectives, and purpose of the study. The research design, methods of data collection are described and some of the potential drawbacks of using case study methodology are considered. The process and challenges surrounding obtaining NHS ethical approval for the study and its implications for the research are described.

I then proceed to outline the process and my experiences of collecting data, which will begin with a reflection upon the challenges and successes during my attempts to gain and maintain access to the research site. I then describe my experiences of the practicalities of recruiting participants, conducting research procedures and outline the approach taken to manage the data and psychological welfare and safeguarding of participants.

### **3.2 Study aim, objectives, and purpose**

#### **3.2.1 Aim**

The aim of the study was to explore the interventions and the processes that promote or hinder CYP's connections to their education, friends and families during periods of admission to hospital for mental health care.

#### **3.2.2 Objectives**

- 1) To explore how health care, social care and education practitioners facilitate connections to education, friends and families when CYP in hospital receiving mental health care.
- 2) To explore CYP's and their caregivers' views and experiences of maintaining connections during admission to inpatient mental health care.
- 3) To assess the suitability of standardised tools used to measure outcomes related to mental health, friends, family and education for CYP in a mental health hospital.
- 4) To identify candidate interventions and processes helping CYP maintain their connections during periods of inpatient mental health care.

#### **3.2.3 Purpose**

The study reported in this thesis contributed to the body of knowledge relating to the social connections of adolescents when in hospital for mental health care. The

purpose was to understand how CYP kept in touch with their friends, family and education when in hospital for mental health care and to gain an understanding of how health, social and education practitioners facilitated maintaining CYP's social connections.

### **3.3 Study design**

Having outlined the purpose of the study, the focus turned to the epistemological considerations, methodology, methods of data collection and data analysis. It was therefore important to first establish my philosophical and epistemological position. In health and social care settings, research is conducted within 'paradigms' which guide or shape the researcher's understanding of a phenomenon under study (Polit and Beck, 2008). A paradigm has been defined as a 'world view' or way by which a researcher studies a phenomenon guided by a set of philosophical assumptions (Gerrish and Lacey, 2010 and Polit and Beck, 2017). Paradigms have been described as lenses that assist a researcher to focus on a phenomenon (Polit and Beck, 2017) and consequently influence what should be studied, how research should be conducted and how results should be interpreted (Bryman, 2016).

Research paradigms provide a framework for planning and implementing studies and are comprised of the four following four fundamental aspects; ontology, epistemology, methodology, and methods (Scotland, 2012). All paradigms are applicable to qualitative and quantitative research designs and different research paradigms have varied epistemological and ontological assumptions which will inform the methodology and methods that suit the researcher's topic (Scotland, 2012). It is therefore important to understand these concepts which are crucial in the planning and implementation of research.

Ontology refers to the world view and assumptions about the nature of reality which are rooted in researchers' philosophical backgrounds (Schwandt, 2007 and Creswell and Plano Clark, 2018). Ontology is described as 'the study of being' or the nature of social entities (Bryman, 2016). Researchers therefore need to understand their own ontological perspective in order to understand their interpretation of how real life scenarios are in relation to their research topic (Scotland, 2012).

Epistemology refers to the nature and forms of knowledge such as what is considered as knowledge or 'should be' knowledge (Bryman, 2016 and Cohen et al,



2017), how the knowledge is acquired, or concepts understood (Bryman, 2016). Furthermore, epistemology involves the nature of the relationship between the researcher and the participants, objects or phenomena under study (Creswell and Plano Clark, 2018 and Polit and Beck, 2017). Research methodology is linked closely with ontology and epistemology as they are both concerned with how researchers come to acquire knowledge. As different research approaches have varied bodies of knowledge (Gerrish and Lacey, 2010), a particular research methodology can influence the particular methods chosen for a study design (Bryman 2016). Furthermore, Scotland (2012) suggests that research methods can be traced back to a particular ontological position through methodology and epistemology and adds that it is not possible to conduct a study without an ontological and epistemological stance, therefore showing the crucial part these two concepts play in research.

A key paradigm involved in nursing research is the constructivist paradigm or naturalistic paradigm (Polit and Beck, 2017). The constructivist paradigm is one of 'relativism' which views reality as being subjective and different from person to person (Scotland 2012, Polit and Beck, 2017). Researchers using the constructivist approach aim to understand phenomena from an individual's perspective which can be achieved through the active interaction between the researcher and participants (Scotland, 2012, Polit and Beck, 2017).

It is suggested that this paradigm is suitable to study phenomena involving human behaviour in the social sciences (Bacon, 2014). Researchers in this paradigm believe that people interpret their environment and those interpretations are shaped by the context and culture in which they live in (Scotland, 2012 and Parahoo, 2014). Constructivists believe in active interactions between the researcher and the participants and aim to understand rather than predict (Parahoo, 2014). Parahoo (2014) also suggests that a constructivist approach strives to grasp the subjective meaning of situations and look at how meanings are developed through interactions. Constructivist researchers adopt a 'subjective' epistemological position which is based on real world phenomena (Scotland, 2012). Evidence in this paradigm is obtained through inductive processes and it is suitable in methodologies including case studies, phenomenology, hermeneutics, and ethnography (Scotland 2012, Polit and Beck, 2017).

Although the constructivist paradigm is sensitive to individual meanings and suitable for understanding human behaviour in social contexts, it has limited transferability and generalisations due to small sample sizes in the studies conducted (Polit and Beck, 2017). Additionally, the subjective nature of the findings of interpretive research are regarded as 'idiosyncratic' which questions whether two constructivist researchers studying the same topic area would arrive at the same interpretation of the phenomena under study (Polit and Beck, 2017).

Despite its limitations, a constructivist paradigm was chosen for this study which aimed to explore CYP, caregivers and staff experiences of connections to friends, family and education during periods of inpatient mental health care. The interactions between the researcher and CYP, caregivers and ward staff in the social setting (CAMHS inpatient unit) demonstrated the researcher's epistemological stand which aided in the construction of the knowledge being sought in the study. The researcher's prior experience and knowledge of CAMHS inpatient services combined with rich data from participants aided in obtaining an insight into the phenomena under study.

The decision to use multiple methods was based on the need to answer the study objectives and a review of previously used methods in the literature on the topic of CYP in inpatient mental health care. Along with qualitative and quantitative research, mixed methods research has been described as the third major research approach (Creswell and Creswell, 2018). While dating back to the late 1980s (Creswell and Plano Clark, 2018), this emerging research approach is increasingly used by health researchers in health services research (Tariq and Woodman, 2013). It has been defined as research that focusses on the combination of elements of both qualitative and quantitative research (Schoonenboom and Johnson, 2017), and the application of mixed methods research has been suggested as an effective way of exploring real-life situations in their contextual settings (Creswell, 2013). This approach involves the collection, analysis and mixing of both qualitative and quantitative data in single or multiple studies for the purpose of breadth, understanding and corroboration (Johnson et al, 2007). The underlying assumption of mixed methods research is that it can address some research questions more comprehensively and provides more evidence for studying a research problem than either quantitative or

qualitative research alone (Tariq and Woodman, 2013 and Creswell and Plano Clark, 2018).

Equal status was given to each method of data collection and analysis and were conducted concurrently. Qualitative research methods included semi-structured interviews, direct observations and documentary analysis and the quantitative element comprised of validated outcome tools. The mixed method design for the current study followed the core 'convergent design' (Creswell and Plano Clark, 2018). This popular approach to mixing methods is used when the researcher seeks to generate a more complete understanding of the research problem through collecting and analysing both qualitative and quantitative research data for the purpose of comparing or contrasting the results (Creswell and Plano Clark, 2018).

The procedures for conducting a convergent mixed methods design involve four key steps. First, both quantitative data and qualitative data are collected concurrently but usually separately by the researcher. Secondly both types of research are independently analysed using separate analysis procedures. The third step involves the merging on the two sets of results, with the final step involving the researcher interpreting the merged results through a format such as a discussion (Creswell and Plano Clark 2018). The convergent design is an efficient design in which both types of data are collected at approximately the same time. This is useful if there is limited time for collecting data in the field and both qualitative and quantitative data need to be gathered in one visit (Creswell and Plano Clark, 2018).

The core mixed method convergent design in the current study was applied to a wider case study methodology (Yin, 2018). Whilst Creswell and Plano Clark (2018) suggest that any of the main three core mixed methods designs (convergent, exploratory sequential and explanatory sequential) can be applied to a mixed methods case study approach, it has also been suggested that the most prominent design to use is a convergent design (Curry and Nunez-Smith, 2015). A mixed method case study design is a type of mixed methods study in which collection, results and integration of the quantitative and qualitative data are utilised to provide an in depth understanding of a case through gathering diverse sources of data (Creswell and Plano Clark, 2018). A case may be constituted as a person, activity, or organisation (Stake, 1995 and Yin, 2018) such as a family, school or medical clinic

(Creswell and Plano Clark, 2018). It is suggested that one of the first steps of case study methodology is to identify the case (Heale and Twycross, 2018 and Yin, 2018). In the current study, the case was identified as a single Tier 4 CAMHS inpatient unit. The specific choice of case study design was to be a holistic design, where the researcher is interested in examining the global nature of an organisation (Yin, 2018). A key rationale for the use of a single case design is for it to represent the common case (Yin, 2018). Here the objective is to capture the circumstances and conditions of an everyday situation. A further logical rationale for the selection of a single case study was due to the lack of Tier 4 CAMHS inpatient units within this region of the UK and limited resources of the doctoral study.

Despite the potential benefit of using more than one case study and the associated challenges regarding scope and scale of this, other research approaches to conducting the study were considered which may have been appropriate.

A popular approach to conducting research is ethnography. Ethnography is a versatile research method for studying social or cultural groups and refers to a type of research often used in behavioural or social sciences where an individual explores a particular group with the aim to better understand it (Kramer and Adams, 2017). The individual conducting ethnography research, or ethnographer, immerse themselves in a group, social setting or organisation for an extended period of time (Bryman, 2016). They actively participate in the group in order to gain an insider's perspective of the group and to have experiences similar to the group members (Kramer and Adams, 2017).

Ethnographic researchers regularly observe the behaviour of participants in a setting and listen and engage in conversations and conduct interviews with participants. Additionally, they collect documents about the group, and develop an understanding of the culture of the group and its behaviour within the context of the groups culture, while writing a detailed account of the setting (Bryman, 2016).

Ethnography has been applied to a wide range of groups, from small teams to larger organisations, multi-organisational collaborations, and community settings. Ethnographic research can provide valuable insights into how members of a group or organisation create and maintain culture through communication and social interaction with the understanding that the data collection and analysis are

conducted rigorously (Kramer and Adams, 2017). A potential disadvantage of adopting an ethnographic approach regarding the current study's CYP participants would be the requirement of long periods of time in the field with CYP combined with the unpredictability of their discharge from the unit.

Another research approach that was also under consideration was Interpretative Phenomenological Analysis (IPA). IPA is a form of qualitative research commonly used in health and social care research settings (Peat et al, 2019), and aims to offer insights on the understanding and experiences of participants, and how participants make sense of their own experiences through a process of in depth reflective inquiry (Smith et al, 2009). IPA is an interpretive process between the researcher and the researched and acknowledges that we are each influenced by the world in which we live in and the experiences we encounter. This approach has gained prominence across health and social sciences as a way to understand and interpret topics which are complex and potentially emotionally burdensome such as participants experiences of ill health.

However, as with IPA there is a particular focus on the experience of the individual, a limitation to adopting this approach in the current study is that it may not have provided sufficient insight into the context, structure and system of the adolescent inpatient mental health unit in the study. Furthermore, this approach would not have answered all of the studies objectives given that there was a specific sub objective of collecting data on organisational policies and documents.

### **3.4 Interviews**

Semi structured interviews were utilised to partly fulfil study objectives one and two. As there was a clear focus of the research being based around the topic areas of CYP's connections to friends, family and education, semi-structured interviews were chosen to allow for these specific topics to be explored in depth and provided a degree of flexibility (Clark et al, 2021). In addition, they help to uncover explanations to key events and provide insights reflecting participants' perspectives (Yin, 2018). Individual interviews were planned with CYP who were inpatients at the unit, their caregivers and a variety of health, social and education practitioners employed at the unit, who expressed an interest in participating in the study.

Considerations were given to alternative popular methods used in health care settings to gather the views and perspectives of participants such as focus groups (Gibson, 2007). They have been viewed as efficient and inexpensive to conduct (Fontana and Frey, 2005) and encourage participants to elicit personal or group's experiences, views and feelings and to build on each other's views (Leung and Savithiri, 2009).

For some however, there is great difficulty in talking about sensitive topics, particularly in a group setting (Gibson, 2007) such as experiences of mental health issues and hospital admission. In contrast where appropriate, interviews allow for sensitive topics to be discussed where individuals may not wish to discuss sensitive topics in group settings (Gill et al, 2008). Some of the challenges of undertaking focus groups with CYP include participants finding the group setting unsettling or feel pressured to agree with individuals who may dominate discussions (Raby, 2010). Therefore, interviews were planned as opposed to focus groups. Furthermore, gathering the subgroups of participants together in a focus group would have been extremely difficult logistically. CYP often have scheduled school timetables to adhere to (Gibson, 2007) and both ward staff and caregivers often had other work commitments or caring responsibilities.

#### **3.4.1 Rationale for questions**

Questions were designed to explore patients' experiences of keeping in touch with their friends, family and education, from the perspectives of CYP, caregivers and ward staff. A set of demographic questions were asked first, before exploring the context surrounding admission. Following this, questions covered friendships both in and outside of hospital, family and inpatient and mainstream education.

Questions specifically relating to ward staff included information on their position, an overview of the unit and questions in relation to how CYP connections to friends, family and education were addressed through their daily professional practice.

Interview questions were developed from the literature surrounding CYP's inpatient mental health care and involved an iterative process of adding questions if new concepts arose from interviews (Appendices 3-5).

### **3.4.2 Documents, direct observations and fieldnotes**

To support meeting objective one, the health care organisation's policies and procedures were treated as documentary data (Clark et al, 2021). Permission was sought from a Senior Manager at the research site to access these documents to explore how they facilitated or hindered CYP's connections to their friends, family and education. Official documents deriving from private sources such as an organisation's documents are likely to be authentic, meaningful and can be important in conducting case studies in addition to using methods such as interviews and participant observation (Clark et al, 2021). The advantages of documents include richness, relevance, natural occurrence and availability of data (Silverman, 2014).

Observations were undertaken to examine unit-based discussions between health, social and education professionals in group settings such as daily short MDT meetings known as 'pay over'<sup>1</sup>, and more in-depth weekly ward round MDT meetings. Of the CYP who agreed to participate in interviews, consent was obtained to observe their individual Care and Treatment Plan (CTP) meetings. Direct observations (Hammersley and Atkinson, 2007) of these meetings were conducted and recorded using fieldnotes to establish how connections to friends, families and education were addressed.

Field notes are an effective tool to keep track of qualitative research procedures that help researchers learn and understand information about a certain social group, culture, or event (Tenzek, 2017). They are detailed summaries of events and behaviour which include the researcher's initial reflections (Clark et al, 2021). It has been suggested to write field notes that provide a rich and detailed description of events, including who was involved and where the setting occurred (Phillippi and Lauderdale, 2017). Therefore, field notes that are descriptive can be seen as a tangible, physical and objective interpretation of what was being observed. The field notes recorded in the current study started out as brief notes but were converted into detailed formal field notes daily (Yin, 2018). They were stored in a physical journal and were backed up in electronic format.

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<sup>1</sup> Pay over – a daily MDT meeting where professionals discussed and reviewed the care and treatment of CYP. A brief meeting, shorter than the weekly Ward Round.

### **3.5 Outcome Measures**

To achieve study objective three, CYP were invited to complete three validated outcome questionnaires relating to friends, family, education and mental health.

The tools were presented to CYP individually in pen and paper format in a pack containing the tools, with the researcher distributing the questionnaires to participants and collecting them on completion. CYP were provided with a quiet room on the ward to complete the questionnaires whilst the researcher sat outside in the corridor. Participants remained in eyesight of the researcher in case they had any queries regarding phrases or questions with which they were not familiar.

Completion of the tools took on average 45 minutes to an hour. The following three outcome tools used in the current study are described in further detail below:

#### **3.5.1 The Strengths and Difficulties Questionnaire**

The Strengths and Difficulties Questionnaire (SDQ) (Appendix 6) is a screening measure of emotional and behavioural disorders designed for children aged 3-17 (Goodman, 2001). The brief self-report questionnaire consists of 25 items across five subscales and utilises a three-point Likert scale ranging from 0='not true', 1='somewhat true' and 2= 'certainly true'. The measure is comprised of the following five subscales: Emotional problems, Conduct problems, Hyperactivity scale, Peer problems and Prosocial behaviour and each subscale has five items. The four problem behaviour scales (Emotional symptoms, Conduct problems, Hyperactivity, and Peer problems) can be summed to generate a Total Difficulties score (Kovacs and Sharp, 2014). A Total Difficulties score can range between 0-40. A score of 0-13 is considered to be within the 'normal' band, 14-16 within the 'borderline' band and a score of 17 and above considered to be in the 'abnormal' banding. Results are not a judgement of CYP's mental health, but higher scores tend to correspond to CYP whose mental health and wellbeing are likely to be under considerable strain (Wolpert et al, 2012).

Items comprising the Emotional Symptoms scale include unhappy mood, fearfulness, headaches or stomach aches, clinginess, and worries. The Conduct Problems scale includes items pertaining to temper tantrums, obedience, lying or cheating, stealing, and fighting. The Inattention– Hyperactivity scale includes items pertaining to restlessness, fidgeting or squirming, distraction, concentration



problems, impulsiveness, and task completion. The Peer Problems scale includes items regarding preference for solitary play, friendships, being liked or bullied, and preference for adults. The Prosocial scale includes consideration of others' feelings, sharing, displays of kindness, and willingness to help others.

The SDQ is a widely used outcome measure for children, adolescents and carers (Brann et al, 2018). It has been used extensively by both researchers and clinicians (Lundh et al, 2008) for purposes including clinical assessment, evaluation of outcomes, epidemiology, screening and research (Child Outcomes Research Consortium (CORC), 2021). In a review of 48 studies, it was shown across a variety of settings both cross-sectionally and longitudinally that the SDQ had good reliability and validity (Sharp et al, 2005 and Stone et al, 2010).

### **3.5.2 The Inventory of parent and peer attachment-revised**

The Inventory of parent and peer attachment - revised (IPPA-R) was developed by Armsden and Greenberg (1987) to assess adolescents' perceptions of the quality of their relationships with parents and peers such as the degree of mutual trust, quality of communication, and feelings of anger and alienation. The original IPPA was revised by its authors to separately assess perceived quality of attachment to mothers and fathers as opposed to the original assessing parents together. Some of the wording was later revised for use in children and younger adolescents (Gullone and Robinson, 2005) and whenever possible, the authors recommend the revised questionnaire over the original version (Armsden and Greenberg, 1987).

The instrument (Appendix 7) is a self-report questionnaire with a five-point Likert scale response format. The revised version (Mother, Father and Peer version) is comprised of 25 items in each of the mother, father, and peer sections. It is scored by reverse-scoring the negatively worded items and then summing the response values in each subscale (Armsden and Greenberg, 1987).

For all scales of the IPPA-R, items are included to assess three aspects of attachment including trust, communication and alienation, with higher scores corresponding to more positive attachments (Gullone and Robinson, 2005). Specifically, the Trust subscale measures the degree of mutual understanding and respect in the attachment relationship, the Communication subscale assesses the

extent and quality of spoken communication, and the Alienation subscale assesses feelings of anger and interpersonal alienation (Gullone and Robinson, 2005).

The IPPA-R has been demonstrated to be a valid measure of attachment for the developmental periods of mid to late adolescence and early adulthood alienation (Gullone and Robinson, 2005). The sample of participants for the earlier development of the IPPA-R were 16 to 20 years of age, however the IPPA-R has been used successfully in studies with adolescents as young as 12 (Gullone and Robinson, 2005).

### **3.5.3 The Student School Engagement Survey**

The Student School Engagement Survey (SSES) (Appendix 8) is a set of two student self-report questionnaires (a short and longer version) of CYP's cognitive, behavioural and emotional engagement with their school. It was developed by the National Center for School Engagement (NCSE) as an outcome measure in evaluating interventions aimed at school truancy and focuses on psychological investment in learning, affective reactions in classroom and school conduct (Fredricks et al, 2011).

The questionnaires contain a total of 45 items across three subscales of cognitive (22 items), behavioural (7 items) and emotional engagement (16 items) (NCSE, 2006). Most items are answered on a Likert scale with responses ranging from "Strongly disagree" to "Strongly Agree", and "Very important" to "Not at all important".

Sample items for the subscales include: "I feel excited by the work in school" and "I am happy to be at my school" (emotional), "I check my schoolwork for mistakes" and "I learn a lot from my classes" (cognitive) and "When I am in class, I just pretend I am working," "I get in trouble at school," (behavioural). The SSES was initially tested at three intervention sites with 150 students and has been used in both low-income and ethnically diverse students. Target population for the questionnaire is CYP in middle school (ages 11-13) and high school (ages 14-18). Administration of the questionnaire is through a teacher or appropriate adult and is in paper and pencil format, with completion taking around 30-45 minutes. No information was provided for scoring and reporting procedures although items that are mapped onto scales can be summed to create scale scores (Fredricks et al, 2011). This was confirmed when the researcher contacted the authors about the outcome measure.

### **3.6 Data Analysis**

#### **3.6.1 Triangulation of data**

Collecting data from multiple perspectives offers the opportunity for triangulation which can be used to increase confidence in a study's findings (Heale and Forbes, 2013). Triangulation is the study of a social phenomenon by the combination of more than one method or source of data (Bryman, 2016). A combination of interviews, observations and documentary analysis with that of three outcome tools, built an overall picture of how CYP maintained connections to their friends, family and education during periods of inpatient mental health care.

#### **3.6.2 Descriptive statistics of questionnaires**

Single data entry was carried out with all patient reported outcome measures. A second person independently checked the data entry and any corrections were identified, verified and rectified. Data were entered into IBM Statistical Package for the Social Sciences (SPSS) Statistics 27 software (IBM Corporation, 2020). Baseline and demographic characteristics were summarised using descriptive statistics (percentages or means and standard deviations (SD) as appropriate) and results were tabulated. Additional data on gender, age on admission, admission rate, diagnosis, and average length of stay for the previous three years' worth of admissions and for the current study were recorded and calculated into percentages. Results were tabulated and are available in Chapter four.

#### **3.6.3 Thematic Analysis of interviews, direct observations and documents**

A number of major approaches to analysing qualitative data exist such as narrative analysis, content analysis, discourse analysis, grounded theory and thematic analysis (Barbour, 2014 and Silverman, 2019). Thematic analysis (TA) is a descriptive approach and has been described as "a method for identifying, analysing and reporting patterns (themes) within data" (Braun and Clarke, 2006). It is useful for exploring individuals' views, experiences and perceptions and was chosen as the most suitable way of analysing the data generated from the interviews, direct observations and documents. In recent years TA has developed significantly such as reflexive thematic analysis (RTA) (Braun and Clarke, 2019a;2021), an accessible and flexible interpretive approach that facilitates the identification and analysis of patterns or themes in a data set (Byrne, 2022).

A brief outline of the six stages of TA recommended by Braun and Clarke (2006) are described below, and as suggested stages were moved through back and forth in a recursive and iterative process (Braun and Clarke, 2020):

- 1. *Familiarisation of the data*: phase one is where the researcher becomes immersed in the data by actively reading, re-reading or listening to audio to gain an understanding of the depth and breadth of the content. It is recommended to take notes during this phase for future coding.
- 2. *Generating initial codes*: phase two involves systematically coding by working through the whole dataset to generate ideas.
- 3. *Searching for themes*: phase three is assembling codes into potential overarching themes by the combining, rearranging and splitting of codes.
- 4. *Reviewing themes*: in phase four the researcher rearranges themes, so they fit within the coded extracts for the whole dataset.
- 5. *Defining and naming themes*: in phase five there is ongoing analysis of refining the themes, generating clear names for each theme.
- 6. *Producing the report*: writing up the analysis selecting appropriate data extracts to showcase each theme.

Transcribed recordings from the interviews, fieldnotes of direct observations and documents were entered into NVivo 12 software (NVivo, 2018). A second person independently coded an interview transcript to reduce coding bias and improve rigour.

### **3.7 Permissions Process**

#### **3.7.1 Ethics**

When undertaking research involving patients in NHS premises in the UK, researchers must first obtain ethical approval for their studies which are reviewed and approved by a Research Ethics Committee (REC). The primary role for REC is to protect and promote the interests of patients and the public in health research. However, they are also responsible for the streamlining of regulations in research. Before the research can proceed, both the Health Research Authority (HRA) and Health and Care Research Wales (HCRW) through local health board research and development (R&D) and the REC must approve the same research protocol and accompanying documentation. A key part of obtaining ethical approval for research involves researchers completing an online research ethics application form known as

the IRAS system (Integrated Research Application System). The process of the application form depends on the nature of the study such as whether the study is a single or multi-site study, the type of research being undertaken and whether the study involves clinical interventions. Each IRAS application differs slightly, and the number of questions will be increased or reduced according to relevance of the research. Obtaining ethical approval for this project involved the completion of a 78-question IRAS application, including a 'Part B' section for research projects specifically involving children, a 10,000 worded research protocol and accompanying research documentation. All documents were reviewed by a local health board R&D department and an NHS REC before awarding approval.

### **3.7.2 Sponsorship**

The policy framework for health and social care research emphasises that studies are required to have identified a suitable sponsorship organisation before submitting research applications to REC (HRA, 2017a). For the current study, the research protocol and all study documents were submitted to the University's Research and Innovation service to be reviewed and approved to be eligible to act as the study sponsor.

### **3.7.3 Patient and public involvement**

In more recent years the value of patient and public involvement (PPI) in research has become apparent to improve the quality of projects (Wicks et al, 2018 and Tomlinson et al, 2019). Some researchers have argued that research should be designed by and with the people it is meant to benefit (Fletcher et al, 2021). To ensure CYP's voices were heard in the design of the research, the following strategy was utilised before applying to the NHS REC.

CYP with experiences of mental health difficulties were consulted in the design of the research. CYP aged 12-17 receiving care and treatment from a local Tier 3 CAMHS were involved with the development of patient facing materials such as consent forms, participant information sheet (PIS) and the proposed interview schedule. This involved forwarding the documents to primary mental health nurses within the CMHT, to distribute to CYP on their caseloads. The community mental health nurses then provided the CYP's feedback through email format. Initial feedback indicated a mixture of understanding with CYP making the following comments: *"It's fine, I understand what it says and what it's asking. It seems pretty clear to me. I think I'd*

*be able to answer all of these if I had to” Respondent 1. “I get some of it, but I don’t understand some of what it means really. I might need some help if I was doing it properly” Respondent 2. “I think it should be a little bit easier to understand. I understand it, but I’m not sure if younger people might get it. I think the language might need to be a bit simpler” Respondent 3.*

The feedback was taken forward for refinement and the patient facing materials were subsequently changed to aid potential participants’ understanding. In addition to the PPI strategy, I consulted with health care professionals with experience of inpatient CAMHS such as staff nurses, senior staff nurses and a NHS Consultant Nurse when developing participant facing materials, to ensure documents such as interview questions were appropriate and suitable.

#### **3.7.4 REC meeting and obtaining favourable opinion**

Following the submission of the IRAS form and associated documentation, an appointment was made to attend a regional REC meeting on 15<sup>th</sup> November 2018 via telephone conference to discuss the research. This REC meeting involved a panel of fourteen committee members, nine with a range of medical professional backgrounds and five lay people. Specialities for this REC included research involving children and research involving adults lacking capacity. In the meeting, the proposed research was discussed along with the IRAS application, protocol and supporting documentation such as consent forms and PIS. In the meeting attention was paid to the design and value of the research, the benefit/risk ratio to participants, the care and protection of participants in terms of data protection, maintaining confidentiality and obtaining informed consent. Members of the committee were satisfied with the main points raised in the meeting and comments were made on the ease of reading and understanding of PIS and consent forms. The REC requested that the questionnaires were modified to remove any requests for identifiable data from participants. The subsequent modifications were made to the questionnaires to reduce identifiable information, removing requests for names, date of birth and the adding of more option selections for gender. Finally, the REC recommended that in accordance with the Welsh Language Act (1993), participant-facing study documentation needed translating and Welsh copies should be available to participants. The local R&D department were consulted and I was informed that

HCRW would provide a translation service if required. A short time after the REC meeting, I received a letter of favourable opinion subject to conditions (Appendix 9). After amendments had been made to the research protocol, PIS and consent forms, these were updated on the IRAS submission and a letter of favourable opinion was obtained from the REC, granting ethical approval for the study on December 4<sup>th</sup>, 2018.

### **3.7.5 HRA and HCRW Approval**

Running simultaneously with the REC review is the HRA and HCRW approval. This is the process of the assessment of governance and legal compliance for studies taking place in the NHS in England and Wales. After the IRAS form and supporting documentation were reviewed by specific staff at HRA and HCRW, a formal letter of approval was issued on 5<sup>th</sup> December 2018.

### **3.7.6 Capacity and Capability Assessment**

The final stage in the process of obtaining ethical approval and before the study could officially commence was for the local R&D department to arrange a Capacity and Capability (C&C) assessment. This involved the R&D department liaising with the research site to establish whether the research site is equipped to support the study. The assessment considered the patient population and who is responsible for the identification of participants, staffing requirements and what costs and resources would be involved to deliver the study such as equipment, space and location. Additionally, the availability of suitable clinical/management supervision to support the study and to provide study oversight was assessed and approval from the clinical director of the research setting was sought before a 'green light' to start the study was issued.

It was also deemed by the HCRW portfolio team that the study would be registered on the National Institute for Health Research (NIHR) Clinical Research Portfolio. The Clinical Research Portfolio (CRP) is a register of active health and social research studies in Wales that are deemed high quality by meeting a set of specific eligibility criteria. Gaining registration onto the CRP is essential to receive Activity Based Funding, obtaining NHS support costs for research studies and to access HCRW resources such as specific training (HCRW, 2017). It is also a requirement of the

CRP that all recruitment data is uploaded online to a portfolio monthly to verify the recruitment activity for the month.

### **3.7.7 Post approvals delays and barriers to beginning fieldwork**

Despite having formal REC approval on 26<sup>th</sup> November 2018 and HRA & HCRW approval on 5<sup>th</sup> December 2018, I did not begin my fieldwork until the 13<sup>th</sup> March 2019 due to delays between the research site and Health Board R&D department in completing the Capacity and Capability assessment and issuing a “letter of access” for me to begin the study. This was due to several reasons. During the time spent developing the protocol and IRAS form in preparation for the REC meeting, there had been restructuring of managerial staff within the NHS research site with a change in head of department of which I was unaware. Information regarding the research study appeared not to have been communicated to the new in-post head of department and therefore I had to explain the purpose of the study to the new senior management team at the research site. Eventually after several weeks of delays, in January 2019 I was invited along with a Health Board R&D research officer to discuss the research with a senior manager who would also be acting as a research site supervisor. In this meeting the site supervisor had queries around maintaining the safety of myself and participants during the interviews, particularly as I would be working with vulnerable CYP in the capacity as a lone worker. Despite explaining the procedures to follow in the research protocol in the event of safety concerns such as a participant becoming distressed, the site supervisor insisted a staff member act as a chaperone during interviews to protect myself against potential allegations from participants. Although the chaperone was initially recommended, they were subsequently not required during the fieldwork.

Following this meeting there were consultations between the R&D department and the research site via email in order to complete the C&C assessment. During this time, I attended two planned introductory visits to the research site. The first visit involved an induction to the unit by a member of staff and to complete the necessary induction paperwork. The second visit involved me briefly attending a Multi-Disciplinary Team (MDT) meeting to discuss the research with the Clinical Lead and a variety of health, social and education practitioners at the unit. In this meeting, I gave a presentation of the research to around 15 professionals and I received a mixed response. Some individuals seemed hesitant in participating and were



concerned with anonymity and how I would protect their identities when writing about the research. Other professionals openly stated that they would like to participate and welcomed research being undertaken at the unit for the first time. After C&C was confirmed by the R&D department on 13<sup>th</sup> March 2019, I was issued a letter of access and commenced nine months of fieldwork which finished a few months prior to the beginning of the global Covid-19 coronavirus pandemic.

### **3.8 Data Collection**

#### **3.8.1 Gaining and maintaining access to the research site**

The initial steps to gaining access to the research site were relatively straightforward. After the introductory visits I was issued with a key-fob to gain access to the building/wards and inducted in the health and safety and fire safety procedures. I was also provided with a desk space to work from in an unused room away from the main wards.

Initial stages of fieldwork involved me attending a weekly 'ward round' meeting each Wednesday. This professionals-only meeting was led by a Child and Adolescent Consultant Psychiatrist (CP) involved various health, social and education practitioners. The meeting was an opportunity for staff members to discuss each patient individually and would provide an overview of the patients' care for the previous week. This meeting originally served two purposes. Firstly, to begin recording anonymised fieldnotes of patient cases. Secondly, to provide an opportunity for the CP to discuss and identify potentially suitable participants for the research. Participant inclusion criteria stipulated that CYP needed to be aged between 11-18, comfortable talking about their experiences of their friends, family and education, able to converse in English, provide informed consent and were willing to participate in the study. A detailed description of study inclusion and exclusion criteria for CYP, caregivers and ward staff can be found in Appendix 10. During the first week of fieldwork, the CP stated that he was very busy at the end of the meeting and was unable to identify suitable participants for the research. The following week the CP was away and the ward round was chaired by a speciality trainee (ST) Doctor. Although this Doctor was able to discuss potential patient participants with me, he preferred me to liaise with the CP when back from teaching. I therefore scheduled a meeting with the CP for the following week. In this meeting I

outlined my research with the CP, who suggested to recruit patients on the ward, I drafted a letter to send to CYP on his behalf, inviting them to take part in the research which he would sign. I explained my reluctance to go against research procedures that were not in the research protocol which may result in seeking amendments with the REC. I recommended that when discussing patients in the ward round, he take time to consider whether they would be suitable to approach for the research by staff on the ward. For the next weekly ward round, I proceeded to bring a copy of the participant inclusion and exclusion criteria (Appendix 10) for the CP to refer to when identifying participants for the study.

### **3.8.2 Identifying and recruiting CYP**

CYP deemed approachable for participation in the research were identified by the direct clinical care team in the weekly ward round meeting. Once clinical discussions by the MDT about individual CYP had finished, the MDT would proceed to check against the participant inclusion/exclusion criteria and discuss whether each adolescent would be suitable for participation. Once identified, members of the nursing team would approach identified CYP to see if they were interested in taking part. Other members of the MDT such as therapists and education workers, would discuss the study with eligible CYP in 1:1 therapy and teaching sessions. In addition, there was a community meeting held on the ward each week which was facilitated by a therapist and a nurse. In this meeting study leaflets (Appendix 11) were distributed to CYP. If a CYP expressed interest in participating, members of the nursing team and MDT would inform me.

### **3.8.3 Identifying and recruiting caregivers**

During fieldwork, the strategy for recruiting caregivers was similar to that of recruiting CYP. As outline in the study's research protocol, the identification of suitable caregivers would mainly come from weekly MDT meetings. After identifying suitable caregivers, members of the MDT would first approach them to introduce them to the research. If caregivers expressed interest in the study, I would arrange to meet with them in a consultation room at the unit. Additionally, study leaflets were placed on coffee tables in the building's reception area in hope that it would attract the attention of caregivers. These study leaflets provided an easily readable summary of the

research. Therapists at the unit also provided families with these leaflets during therapy sessions involving the CYP's family.

#### **3.8.4 Identifying and recruiting health, social and education practitioners**

To identify and recruit suitable health, social and education staff, I spent the first three weeks attempting to recruit in MDT meetings. After initial struggles, I met with the research site supervisor to discuss the slow recruitment process. Additionally, I requested individual meetings with the head of the therapies team and ward manager to discuss the research and recruitment.

I first met with the ward manager and discussed the research with her. It was agreed in this meeting that the ward manager would compose an email with a summary of the study and what it would involve for professionals. The ward manager sent this email to all health, social and education staff at the unit. This prompted responses from staff within the unit, the majority of whom were from the nursing team and ranged from health care support workers to qualified nurses and senior staff nurses. To increase the prospect of recruiting therapists, the head of therapies suggested I attend a therapist specific meeting held on the unit each week to explain the research. After attending this meeting and discussing the research, I received a positive response from therapists and four agreed to take part in the study.

### **3.9 Consent**

The principle of informed consent is applied in nurses' and other health care professionals' everyday clinical practice and is underpinned by the Nursing and Midwifery standard for professional Practice (Nursing and Midwifery Council (NMC), 2015). Informed consent in clinical practice is often obtained through verbal communication with patients and should be accurately documented (NMC,2015). The same principle of informed consent also applies in research (WHO, 2011). Prior to recruitment to the study all participants were provided with a detailed PIS (Appendices 12-16), given ample time to consider their participation in the study and had frequent opportunities to ask the researcher questions. It is suggested that there is no definitive period of time that participants should be allowed to consider taking part in research (HRA, 2017a). Consideration should be given to factors such as the type of research, research setting, and participants' level of understanding of the

research. After discussing with the researcher what involvement in the study would include for participants, they were given 24 hours to consider participating.

For people to decide whether or not they wish to participate in research, common practice is for informed consent to be obtained by the researcher prior to recruitment. This is taken voluntarily from an individual, without coercion or undue influence after receiving comprehensive information and who has adequately understood this information (WHO, 2011). After obtaining written informed consent (Appendices 17-24), participants were informed of their right to their withdraw consent at any time without their care being compromised.

### **3.9.1 Obtaining consent from CYP**

The CYP participating in the study were admitted to the unit for an assessment of their mental health or had various mental health conditions. Sometimes, our mental health can impact our capacity to make decisions. The assessment of CYP's capacity was undertaken by the direct clinical care team in the weekly ward round meetings. It was also not assumed that the researcher would carry out the assessment of capacity in CYP and that capacity would be assumed. The Mental Capacity Act (MCA) (2005) specifies that a person must be assumed to have capacity unless it has been established that they do not have capacity. As capacity to make informed decisions is often situation specific, it was explained to CYP that time would be given during the consent process to ensure they understood their involvement in the study and that there were no misunderstandings.

Consideration was given to incorporating 'proportional consent' into the consent process for the questionnaires, whereby the act of completing the questionnaires would warrant consent and written consent would not be needed (HRA, 2017b). However, many CYP only taking part in the questionnaire stage of the study requested PIS. Therefore, a decision was made to provide all CYP with copies of consent forms and PIS for their own records and for a copy to be placed in their medical notes.

Due to the research being undertaken on a CAMHS inpatient unit, the patients were aged 11-17. Consent procedures involved obtaining consent from patients for them to participant in a semi structured interview, complete questionnaires and to be observed in meetings about their care. However, as there was the possibility of some

participants being under the age of 16, advice was sought from the HRA on the best practices to follow when involving CYP in research. The guidelines for consenting a person under the age of 16 into a Clinical Trial of an Investigational Medicinal Product (CTIMP) are clear (HRA, 2021). There are also guidelines for researchers to follow when consenting an under 16 for treatment purposes (Medical Research Council, 2004). However, guidance is less clear for researchers when consenting a person under 16, specifically for research purposes.

Guidelines state that it can be commonly assumed for case law for 'Gillick Competence' to be applied when consenting a CYP into research (HRA, 2021). However, an important aspect to consider is the child's understanding of the research being imposed on them and their ability to assess and understand the risks involved. Another important aspect to consider when obtaining consent from someone is their capacity and developmental age. It is also good practice to involve the family in the consent process wherever possible. Although it may be more beneficial in certain situations to obtain assent from the CYP and to obtain consent from their caregiver or guardian (HRA, 2021).

Considering this guidance, I made the decision to seek assent from CYP aged 11-15 and to also seek consent from their caregiver. If aged 16-17, I sought consent from the CYP. Under 'common law' it is assumed that those aged 16 and over can consent (HRA, 2021). However, the involvement of the CYP's family in the research was promoted where possible, whilst respecting the wishes of CYP regarding whether they wanted their family involved. Prior to providing written valid informed consent, participants were informed of their right to withdraw from the study at any time without their care being affected.

### **3.9.2 Obtaining consent from caregivers**

Consent forms (Appendix 20) sought the consent from caregivers to take part in the research by attending an interview which would be audio recorded. It was deemed that caregivers would have the capacity to consent to take part in the research.

### **3.9.3 Obtaining consent from health, social and education practitioners**

Consent forms (Appendix 21) sought the consent from health social and education to take part in the research by attending an audio recorded interview, and to be observed in meetings at the unit. It was deemed that staff at the unit would have the capacity to consent to take part in the research.

#### **3.9.4 Emotional distress and safeguarding**

Researchers have a moral and ethical responsibility to consider the impact the research will have on participants (WHO, 2011). For some participants, talking about their experiences could be distressing, whereas others may find it beneficial to have the opportunity to open up and talk about their experiences of inpatient mental health care. As this study explored mental health problems, there was a possibility that participants may find the topics discussed sensitive. The questions and wording used on the PIS, consent form and interview schedules for CYP, caregivers and staff members went through public involvement to ensure the most appropriate language was used. As the researcher and a mental health nurse who has worked in a CAMHS inpatient environment prior to the commencement of the study, I have experience in discussing sensitive issues with CYP and caregivers.

A previous discussion with a consultant CAMHS nurse provided guidance on what would warrant contacting the nursing team at the research site. The recommendation was a disclosure of risk of harm to self or others would warrant an immediate contact with the nursing team. Guidance was also sought from local Community Mental Health Team (CMHT) CAMHS nurses, who provided additional guidance on the referral process. For CYP and caregivers requiring immediate support, contact with the senior staff nurse in charge of the shift was advised.

Consent was sought from CYP completing the questionnaires, taking part in the interviews, and caregivers taking part in interviews to contact the direct nursing team on the ward should a serious safety concern arise. PIS also indicated that staff were there to support participants should they become distressed due to participating in interviews.

#### **3.10 Data management**

Permission was sought and obtained from the senior nurse and participants at the research site to collect data from NHS patient records. Participants were given reassurance that personal information or details of the interviews would only be accessed and shared within the research team, unless there was a disclosure of a safety concern such as a participant disclosing themselves or others were at risk of harm. Participants were also aware that information regarding safety concerns could be passed on to relevant authorities with or without their permission as detailed in

the PIS. In the event of a safety concern disclosure, the University's and Health Board's safeguarding procedures were to be followed.

The study recruitment log containing participant personal information was kept in a password-protected Microsoft Excel spreadsheet and kept separately from the questionnaires, transcripts and clinical data which was only linked together by the participant's study identification number. Paper copies of data such as signed assent & consent forms, questionnaires and unit policies and procedures were only accessible by the research team and were kept in a ring binder file separate to the study site file. The files were stored in locked filing cabinets either at the hospital site or University and access to both premises required card-key access. Audio recordings were uploaded and stored on a password protected server maintained by the universities network. In concordance with University's Research Governance Framework Regulations for clinical research, the data will be kept for 15 years after the end of the study.

Maintaining the privacy and confidentiality of CYP taking part in interviews and completing questionnaires was a challenging process. This was due to all CYP being placed on 'special observations' (Chu, 2016) and there were limited rooms on the locked ward that could be used for research purposes and procedures. The special observations ranged from being observed every 15 minutes, to 1:1 (within eye contact or at arm's reach) by staff members. Despite these challenges a suitable room on the ward was identified, providing some privacy for CYP to complete consent forms, questionnaires and to be interviewed. Maintaining the privacy and confidentiality of caregivers and staff members was less complicated. This was due to there being plenty of consultation rooms available to be used for research purposes within the unit which were away from the main wards.

Consent was obtained from participants to allow for anonymised quotations to be used in all publications related to the project. Participants were informed of data which may identify them would not be published but direct quotations may be used. Participants were reassured that quotes may be edited sensitively, if necessary, to reduce the risk of identification. Audio recordings were anonymised after transcription, with a confidentiality agreement in place between the University, research team and transcription company. Data extracts containing first names

correspond to CYP. They were given pseudonyms to help protect their anonymity and had the opportunity to choose their own pseudonym.

### **3.11 Researcher Positionality**

Reflexivity is an important aspect of qualitative research, allowing researchers to continuously examine how their own experiences may influence the research process (Dowling, 2006). The researcher was previously employed as a registered mental health staff nurse at the research site 18 months prior the commencement of the study.

To assist being an 'outsider' to the research, I had provided no nursing care to any of the patients involved in the study prior to the fieldwork. As expected, some of the staff members who I had previously worked with, particularly in management positions remained in these posts during fieldwork. However, the majority of the therapies team and most of nursing staff I met for the first time.

I ensured I met regularly with my academic supervisors for discussions on ethical considerations with aspects of the fieldwork, with some of these discussions taking place whilst in the field. I also kept a research journal containing my general thoughts, feelings and ethical considerations, an important facet of reflexivity (Barrett et al, 2020).

### **3.12 Chapter Summary**

This chapter has provided an overview of the research process, with the study design being based on the aims and objectives of the study. Multiple methods of data collection and analysis were planned to provide an overview of CYP's, caregivers' and health, social and education practitioners' perspectives of keeping in touch with friends, family and education. Descriptive statistics were used to describe questionnaire data and thematic analysis (Braun and Clarke, 2006) was chosen to analyse data generated from interviews, observations and policies and procedures.

A Tier 4 CAMHS inpatient unit was selected as the site for recruitment of participants. Permissions from an NHS REC and local R&D were obtained prior to recruitment. Obtaining these necessary approvals was a challenging process requiring a comprehensive review of all documentation and procedures to maintain the safety of participants and the researcher. Ethical, consent and data management



procedures were discussed, along with the safeguarding of psychological welfare of participants.

Chapter four will provide an overview of the location where the research was conducted and will report the results of demographic data of the sample of CYP and three outcome measures completed by CYP relating to mental health, relationships with friends and family and education.

## **Chapter four – Overview of inpatient unit and results of outcome measures**

### **4.1 Introduction**

This chapter provides a background of the research setting, including the selection of the site, its architectural layout, and facilities. Also included is the process of referral, assessment and admission to the unit. Demographic statistics of CYP admitted to the unit are tabulated. The study's methodology, data collection and analysis methods and permissions process were outlined in Chapter three.

This chapter presents the results of the three outcome questionnaires completed by CYP which related to their mental health, friends, caregivers and education: The Strengths and Difficulties Questionnaire (SDQ) (Goodman, 2001); The Inventory of Parent and Peer Attachment (IPPA) (Armsden and Greenberg, 1987) and The Student School Engagement Survey (SSES) (National Center for School Engagement) (NCSE), 2006). Finally, a section will be embedded within this chapter which will reflect on some of the difficulties encountered when conducting the questionnaire phase of the study.

### **4.2 Unit Background**

This section will provide an overview of the NHS CAMHS inpatient unit where data collection was undertaken. As previously mentioned in Chapter one, CAMHS throughout the region is planned, commissioned, and delivered through a four-tiered strategic model consisting of four tiers (Figure 1.1). The model allows CYP to access various services across the four tiers, depending on the level of risk and clinical presentation. At the top of the tier system, is Tier 4. Tier 4 consists of highly specialised CAMHS community treatment, day unit and inpatient services. These services are usually reserved for the small number of CYP who are deemed to be at highest risk of rapidly declining mental health who may require a period of intensive support for the purpose of assessment and treatment (McDougall and Cotgrove, 2014).

#### **4.2.1 Selection of research site**

The Tier 4 CAMHS inpatient unit was chosen as the research site for its practicality and location. One of only two NHS adolescent inpatient mental health hospitals within the region, the 15 bedded mixed-gender hospital comprised of two wards: a ward for general psychiatric admissions and a second ward, a high intensive care

area. CYP admitted to the general ward may have experienced a wide range of complex mental health conditions and be at risk of further rapidly declining mental health such as harm to self or others including suicidality and aggression towards others (McDougall et al, 2008). The high care area allows CYP whose needs cannot be met on the general ward, to access a low stimulus environment with additional nursing support. The purpose of this ward was to provide short term extra care, enabling a prompt transition back to the general ward. The unit covers a wide geographical area across the southern half of the region with a total population of approximately 2.2 million people (Welsh Government, 2021a) and included a diverse population group in terms of socio-economic status. CYP were admitted to this unit on the basis of a two-week assessment period (Organisation's Information Booklet, 2019 page 5) although admissions to CAMHS inpatient units tend to be considerably longer than two weeks (Hayes et al, 2021).

The research site was deemed appropriate for the study as it was a CAMHS inpatient unit, commissioned to deliver care for CYP aged 11-17 with the highest level of need with various mental health difficulties including major mood disorders, emerging personality disorders, psychotic and eating disorders (James and Worrall-Davies, 2015 and McDougall and Nolan, 2017). The consultant led team at the unit included a multidisciplinary team (MDT) providing assessment and treatment to CYP. The MDT consisted of health, social and education practitioners including consultant psychiatrists, junior doctors, psychologists, nurses, therapists and social and education workers. Education is provided through an on-site school, which is representative of most adolescent inpatient units in the UK (O'Herilhy et al, 2001). Despite more a recent survey also confirming most UK adolescent inpatient units provide onsite education, at present there is no central register of education within inpatient settings (DfE, 2018).

#### **4.2.2 Unit layout**

The unit opened in 2011 and was situated within a building on the grounds of an NHS general hospital site, located in the South of the region. The two-storey, hexagonal shaped building had a ground floor consisting of a reception area, two electronically locked hospital wards, a variety of visiting rooms, sports hall and outdoor courtyard access. The second floor of the building had two main corridors. The first corridor on the second floor is made up of administration offices and

therapist's rooms. The second corridor comprised of the Visitors' Suite and Learning Centre. Consent procedures and interviews and questionnaires with CYP were conducted in either of the two quiet rooms located on the general admissions ward. Interviews with caregivers and health, social and education practitioners were conducted in the visiting rooms and therapists' rooms located away from the hospital wards but still within the building.

#### **4.2.3 Visitors' Suite**

The Visitors' Suite, commonly referred to as the 'unit flat' by staff, patients and caregivers was located on the second floor of the building and was separated from the two wards. It enabled caregivers, some who may have had to travel a significant distance to the unit, to stay in the flat with their child overnight. It was also used by health care professionals such as the Dietician, Family Therapist and Nurses to conduct 'family meals' as part of the weight restoration process for patients with eating disorders. The Visitors' Suite consisted of a main living room area, with sofa beds and a T.V, telephone access to the main ward, a kitchen area, a bedroom, and bathroom facilities. Additional information regarding the availability, access and process of booking the Visitors' Suite will be described in further detail in Chapter six.

#### **4.2.4 Learning Centre**

Located on the second floor of the main building, the Learning Centre was comprised of three small to medium sized classrooms. Access was restricted for CYP unless accompanied by staff members such as education workers and nurses. The first classroom facilitated up to 15 CYP at a time, and consisted of tables and chairs, a white board area, and an area with an ample amount of desktop computers. The second was utilised as an art and crafts room but was also the room which was used to facilitate examinations such as GCSE's. The final classroom was the largest of the three classrooms and was used for specific timetabled events such as group art therapy and music therapy. Further details pertaining to the Learning Centre such as opening times, how it is organised and operates, timetables and the level of education provided will be outlined in Chapter seven.

### **4.3 Referral, assessment and admission process**

#### **4.3.1 Process of Referral**

Before a referral to Tier 4 CAMHS services can be made, an assessment must first be undertaken by a Tier 4 CAMHS Psychiatrist. CYP being referred should be

thought to require treatment or further specialist assessment of a severe mental illness or disorder (James and Worrall-Davies, 2015). It is recognised that admitting CYP to hospital for psychiatric care can be traumatic for them and their families (Kurtz, 2009). Therefore, all community-based alternatives to admission must be considered before an assessment by Tier 4 services is made.

Usually the CYP, their caregiver's and referrers views will be taken into consideration when discussing which service will likely be most beneficial. This will be informed by the level of risk to the patient and community, and by the local services which are available.

The process of referral to Tier 4 CAMHS inpatient services is primarily made through a community CAMHS consultant psychiatrist, although referrals can be made from other CAMHS inpatient units. The referring Psychiatrist is required to complete a comprehensive referral form, a widely utilised risk assessment (Wales Applied Risk Research Network (WARRN) (Snowden et al, 2019) and community Care and Treatment Plan (CTP) (Welsh Government, 2010a).

#### **4.3.2 Referral Criteria**

There are specific guidelines to adhere to when referring patients to regional NHS Tier 4 CAMHS inpatient care services and community intensive support and treatment services. Referral to adolescent inpatient mental health services within the region are widely viewed to be appropriate when admission would be seen as the least restrictive, effective and safest option to manage a clinical situation that would require 24-hour observation which cannot be provided by community services and all other options have been considered and exhausted (McDougall and Cotgrove, 2014).

#### **4.3.3 Admission Criteria**

The admission criteria to an adolescent mental health inpatient unit are dependent on several factors such as age, level of risk and clinical presentation (Evans et al, 2018). A more detailed description of the admission inclusion and exclusion criteria for the unit which acted as the research site is outlined below:

##### *Admission Inclusion Criteria:*

- CYP must be of secondary school age (aged between their 11<sup>th</sup> and 18<sup>th</sup> birthday).

- The CYP has had or is expected to have a comprehensive assessment for a primary diagnosis of a mental health illness.
- The CYP has severe and complex needs that are unable to be managed within Community CAMHS.

*Admission Exclusion Criteria:*

- CYP over 18 years of age.
- CYP with a diagnosis of moderate to severe learning disabilities.
- CYP with a primary diagnosis of substance misuse or conduct disorder with no co-morbid mental illness.
- CYP with a primary diagnosis of severe autism spectrum disorders where it has been clinically assessed that care would be more appropriately provided in a specialist unit.
- Situations where there is a primary need for accommodation due to breakdown with the family or current placement.
- CYP whose risk profile suggest referral to adolescent forensic services, including those who need admission to low secure/medium secure inpatient services.
- Those who are in secure placements provided by local authorities, who would initially have been referred to adolescent forensic services or to a low secure inpatient unit.

#### **4.3.4 Assessment process for admission to Tier 4 Inpatient CAMHS**

After an assessment has been undertaken by a Consultant child and adolescent psychiatrist and referral has been received by Tier 4 CAMHS inpatient services, an admission assessment will be made by inpatient services staff. This will consist of a CAMHS inpatient services Psychiatrist and senior staff nurse. This psychiatric assessment will cover several factors such as the CYP's current presentation, identified risks, and care and treatment needs (McDougall and Cotgrove, 2014).

If an assessment is to take place outside of normal working hours, the on-call consultant psychiatrist and senior staff nurse will assess the patient. Inpatient services aim to complete all urgent referral assessments within 24 hours and complete non-urgent referrals within 72 hours. A comprehensive referral pathway to

NHS Tier 4 CAMHS inpatient services and to out of area placement can be found in Appendix 24.

### **4.3.5 Admission to Tier 4 inpatient CAMHS**

During the two-week period of admission, the unit provided an assessment programme in a therapeutic environment by nursing, medical, therapies and educational teams. The focus for the unit was to provide an understanding of the current difficulties experienced by the CYP whilst providing support for the increased difficulty. The unit offered 24 hours a day supervision by a multidisciplinary team to gather information to further guide and support the management of the CYP and their caregivers difficulties. The inpatient assessment included observing specific behaviours or allowing time for a range of investigations to be carried out. These included physical and cognitive assessments with CYP and caregivers.

### **4.4 Anonymised demographic data for 2016, 2017 and 2018**

Data on gender, number of admissions, length of stay and partial data on primary diagnosis were acquired from a child and adolescent consultant psychiatrist employed at the unit, who provided three years' worth of anonymised data prior to the study's fieldwork. The following tables present anonymised data on admission rates, primary diagnosis and average length of stay for the years 2016, 2017 and 2018.

Table 4.1- Gender and admission rates for 2016,2017 and 2018

2016	2017	2018
Female admissions n=32 (78.4%)	Female admissions n=69 (68.3%)	Female admissions n=56 (67.5%)
Male admissions n=9 (22.0%)	Male admissions n=32 (31.7%)	Male admissions n=27 (32.5%)
Total number of admissions for 2016 n=41	Total number of admissions for 2017 n=101	Total number of admissions for 2018 n=83

The table above presents data on CYP's gender and rates of admission to the unit for 2016, 2017 and 2018. Across the three years there were significantly more female admissions and whilst admissions increased from 2016 to 2017, they decreased in 2018.

Table 4.2- Admission by primary diagnosis in 2018

Primary diagnosis	Number and percentage of patients with primary diagnosis n/n & %
Emotional Dysregulation	N=22 (26.5%)
Psychotic Illness	N=15 (18.1%)
Eating Disorder	N=12 (14.5%)
Depression	N=10 (12.0%)
Attachment Difficulties	N=8 (9.6%)
Acute Trauma	N=3 (3.6%)
Autistic Spectrum Disorder	N=3 (3.6%)
Anxiety	N=2 (2.4%)
Learning Difficulties	N=2 (2.4%)
Somatoform Disorder	N=1 (1.2%)
Obsessive Compulsive Disorder (OCD)	N=1 (1.2%)
No Formal Primary Diagnosis	N=1 (1.2%)
Total number of admissions for 2018	N=83

The above table presents data on the primary diagnosis of CYP admitted in 2018. Although data on primary diagnosis were only available for the year of 2018, there was complete data for all 83 patients admitted regarding their primary diagnosis.

Table 4.3– Age on admission to the unit March – December 2018

Age on admission to unit	Number of CYP admitted
11 years old	N=2 (4%)
12 years old	N=1 (2%)
13 years old	N=5 (10%)
14 years old	N=12 (24%)
15 years old	N=6 (12%)
16 years old	N=14 (28%)
17 years old	N=10 (20%)
Number of admissions March–December 2018	N=50



Table 4.3 presents anonymised data of CYP's age on admission to the unit. Data were only obtainable for 50 of the 83 patients admitted in 2018 between March and December 2018.

Table 4.4– Average length of admission to the unit in 2016, 2017 and 2018

Year and number of admissions	2016 (data available for all 41 admissions)	2017 (data available for 100 of 101 admissions)	2018 (data available for 79 of 83 admissions)
CYP's average length of stay in days N= number of days	N= 73.6 days	N= 48.1 days	N= 47.3 days

Table 4.4 presents anonymised admission data for CYP's average length of stay at the unit in the previous three years prior to data collection. Admission and discharge dates were available for all 41 admissions in 2016, however data were only obtainable for 100 of the 101 patients admitted in 2017 and 79 of the 83 patients admitted in 2018. Length of stay ranged from 2-407 days in 2016, 3-535 days in 2017 and 3-203 days in 2018.

The following series of tables correspond to the nine month period of fieldwork for the study and are first presented for the total number of patients screened for participation in the study n=42, followed by a series of tables corresponding to the number of participants included in the study's sample n=26.

#### **4.4.1 Demographic data for total number of patients screened N=42**

Demographic data of the total sample of CYP screened for potential participation in the study are tabulated by gender, admission rates, primary diagnosis, age, and average length of stay in days.

Table 4.5– Gender and admission rates for total number of patients screened (March – November 2019)

Gender	Number and percentage of admissions
Female	n= 31 (73.8%)
Male	n= 11 (26.2%)
Total number of admissions during March – November 2019	n= 42

The table above provides information on gender and admission rates for the total number of patients screened for participation in the study.

Table 4.6– Admission by primary diagnosis for total number of patients screened (March – November 2019)

Primary Diagnosis	Number and percentage of patients with primary diagnosis
Emotional Dysregulation	n= 15 (35.7%)
Psychotic Illness	n= 8 (19.0%)
Eating Disorder	n=15 (35.7%)
Depression	n= 1 (2.4%)
Acute Trauma	n= 1 (2.4%)
Autistic Spectrum Disorder	n= 0
Anxiety	n= 1 (2.4%)
Learning Difficulties	n= 0
Somatoform Disorder	n= 0
Obsessive Compulsive Disorder (OCD)	n= 0
Neurological Illness	n= 1 (2.4%)
No Formal Primary Diagnosis	n= 0
Number of admissions for March – November 2019	n= 42

The table above presents data on number of admissions by primary diagnosis for the total number of patients screened for participation in the study.

Table 4.7– Age on admission to the unit for total number of patients screened (March – November 2019)

Age on admission to unit	Number of admissions
11 years old	n= 0
12 years old	n= 0
13 years old	n= 0
14 years old	n= 4 (9.5%)
15 years old	n= 6 (14.3%)
16 years old	n= 16 (38.1%)

17 years old	n= 16 (38.1%)
Number of admissions March –November 2019	n= 42

Table 4.7 presents data on CYP's age on admission to the unit for the total number of patients screened for participation in the study.

Table 4.8– Average length of admission to the unit for total number of patients screened (March – November 2019)

Year and number of admissions	March – November 2019 (data available for 38 of 42 admissions)
CYP's average length of stay in days N= number of days	N= 78.8 days

The table above presents anonymised admission data for CYP's average length of stay at the unit for the total number of patients screened for participation in the study. Admission and discharge dates were available for 38 of the 42 admissions from March-November 2019. Length of stay ranged from 5-292 days.

#### **4.4.2 Demographic data for total number of participants in the study**

The following section presents a series of tables providing demographic data of the sample of CYP who were included in the data collection phase of the study from March-November 2019 n=26, by gender, admission rates, primary diagnosis, age and average length of stay in days.

Table 4.9– Gender and admission rates for participants included in the study (March – November 2019)

Gender	Number of admissions March-November 2019
Female admissions	n= 21 (80.8%)
Male admissions	n= 5 (19.2%)
	Number of admissions included study n=26

The table above presents data on gender and admission rates for the participants included in the study.

Table 4.10– Admission by primary diagnosis for participants included in the study (March – November 2019)

Primary Diagnosis	Number and percentage of patients with primary diagnosis
Emotional Dysregulation	n= 13 (50%)
Psychotic Illness	n= 2 (7.7%)
Eating Disorder	n= 10 (38.5%)
Depression	n= 1 (3.8%)
Attachment Difficulties	n= 0
Acute Trauma	n= 0
Autistic Spectrum Disorder	n= 0
Anxiety	n= 0
Learning Difficulties	n= 0
Somatoform Disorder	n= 0
Obsessive Compulsive Disorder (OCD)	n= 0
No Formal Primary Diagnosis	n= 0
Number of admissions for March-November 2019	n= 26

Table 4.10 presents data on number of admissions and their primary diagnosis for the participants included in the study n=26.

Table 4.11– Age on admission to the unit for participants included in the study (March – November 2019)

Age on admission to unit	Number of CYP admitted within age range
11 years old	n= 0
12 years old	n= 0
13 years old	n= 0
14 years old	n= 2 (7.7%)
15 years old	n= 3 (11.5%)
16 years old	n= 11 (42.3%)
17 years old	n= 10 (38.5%)

Number of admissions March –November 2019	n= 26
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This table presents data on CYP's age on admission to the unit for the participants included in the study n=26.

Table 4.12– Average length of admission to the unit for participants included in the study (March – November 2019)

Year and number of admissions	March – November 2019 (data available for 26 admissions)
CYP's average length of stay in days N= number of days	N= 88.6 days

This table presents anonymised admission data for CYP's average length of stay at the unit for the participants included in the study. Admission and discharge dates were available for all 26 participants who took part from March-November 2019 and the length of stay ranged from 5-292 days.

## 4.5 Description of demographic data

### 4.5.1 Gender

Results of the population of CYP who participated in the questionnaire phase of the study indicate that the most common gender of the sample were females n=21 (80.8%), followed by males n=5 (19.2%). This was in line with the overall number of CYP screened for potential participation in the study, which stood at 31 females (73.8%), and 11 males (26.2%). The sample of CYP included in the study was typical with regards to gender and was consistent with the previous 3 years' admissions. Previous years also indicated that there were more female admissions compared to male admissions, despite the higher number of admissions in 2017 and 2018.

### 4.5.2 Admission rates

42 CYP were admitted during the data collection period and all were screened for potential participation in the study, of which 26 were recruited. Of the remaining 16

CYP who did not take part, 1 declined to participate, 6 experienced a deterioration in their mental health and were therefore unable to be included. A further 9 were either discharged as I began data collection or were on extended leave and were discharged soon after, without returning to the unit.

In comparison to previous years, the sample size is consistent with 2016 when there were 41 admissions but contrasted with the higher admission rates in 2017  $n=101$  and 2018  $n=83$ . An explanation for the lower than average admission rates and by default the lower number of participants, could be that period of data collection was limited to 9 months from March-November. There were significant challenges to recruitment during this period such as ward closures, which will be discussed later in this chapter.

#### **4.5.3 Primary diagnosis**

CYP's primary diagnosis during their admission to the unit was collected as part of demographic data. The results indicate that half of the participants included in the study,  $n=13$  (50%) were diagnosed with emotional dysregulation. The next most common diagnosis was eating disorders, which accounted for  $n=10$  (38.5%) of the sample, while 2 patients (7.7%) had a psychotic illness, and 1 patient (3.8%) had a diagnosis of depression.

When compared with the total sample of 42 screened CYP, primary diagnosis was comparable between the samples with the most common primary diagnoses again being emotional dysregulation  $n=15$  (35.7%) and eating disorder  $n=15$  (35.7%). The next most common diagnosis was a psychotic illness  $n=8$  (19.0%), with the remaining 4 CYP in the sample who were recorded as having  $n=1$  depression,  $n=1$  acute trauma,  $n=1$  anxiety and  $n=1$  neurological illness.

In comparison to the primary diagnoses recorded for 2018  $n=83$ , the results of the study sample were consistent with 2018 records and the most common diagnosis was emotional dysregulation. This contrasted the second most common diagnosis, which was a psychotic illness  $n=15$  (18.1%), followed by eating disorder  $n=12$  (14.5%), depression  $n=10$  (12%) and  $n=8$  (9.6%) with attachment difficulties, while the remaining 13 CYP were split between various other mental health conditions.

#### **4.5.4 Age on admission**

CYP age on admission to the unit was collected as part of routine demographic data. These results indicate that for the study sample, the majority of CYP admitted were aged 16  $n=11$  (42.3%) and 17  $n=10$  (38.5%), followed by 3 who were 15 and 2 who were 14. When compared with the full sample of CYP who were screened for potential participation, the spread of age ranges was consistent between the two samples. The most common age on admission was 17  $n=16$  (38.1%) and 16  $n=16$  (38.1%), followed by 15  $n=6$  (14.3%) and 14  $n=4$  (9.5%).

These results contrasted the anonymised admission data with regards to age for the CYP admitted in 2018. Although records were only available for 50 of the 83 CYP admitted in 2018, the most common age was 16  $n=14$  (28%), followed by aged 14  $n=12$  (24%). The next most common age was 17  $n=10$  (20%), followed by 15  $n=6$  (12%). An additional contrast between the sample of 2018 and the study sample was the inclusion of CYP younger than 14, with  $n=5$  (10%) aged 13,  $n=2$  (4%) aged 11 and finally 1 person (2%) aged 12.

#### **4.5.5 Average length of stay**

The admission and discharge dates of the sample were also collected as part of routine CYP's demographic data and an average length of stay in days was calculated. The average length of stay of the sample of CYP included in the study was 88.57 days. This was a higher average length of stay when compared to the full sample of screened CYP which was 78.79 days. When compared with the previous three years of admission data, the average length of stay for the study sample was higher than the sample for 2016 which was 73.59 days. However, the data for 2017 and 2018 indicates a far lower average length of stay at 48.12 days in 2017 and 47.26 days in 2018 respectively.

### **4.6 Results of outcome measures**

This section tabulates data from the questionnaire pack consisting of three tools, the SDQ, the IPPA-R and SSES part A (SSESA) and part B (SSESB) administered to 26 CYP who were recruited into this phase of the study.

The SDQ (Goodman, 2001) is a brief behavioural screening tool intended to measure child and adolescent psychological functioning. It consists of 25 items on psychological attributes split across five subscales: emotional symptoms, conduct

problems, hyperactivity, peer problems, and prosocial behaviour (Stone et al, 2010 and Brann et al, 2018).

The IPPA-R (Gullone and Robinson, 2005) is a tool used to measure the quality of communication, feelings of trust, and degree of alienation that adolescents and young adults perceive in their parental and peer relationships and is comprised of 25 items in each of the three sections of mother, father, and peers (Andretta et al, 2017).

The SSES (NCSE, 2006) is a questionnaire designed to measure adolescents behavioural, emotional, and cognitive components of school engagement (Moreira et al, 2020). Items are organised into three subscales: behavioural engagement, cognitive engagement, and emotional engagement. The Survey focuses on psychological investment in learning, affective reactions in the classroom, and school conduct (Fredericks et al, 2011). Additional details regarding the three measures were outlined in section 3.5 of the previous chapter.

#### 4.6.1 The Strengths and Difficulties Questionnaire (SDQ)

Table 4.13– Strengths and Difficulties Questionnaire (SDQ) overall scores

SDQ Subscales	Proportion n/n	Percentage %
Emotional problems scale	n=26	
‘Normal’	8	30.8%
‘Borderline’	2	7.7%
‘Abnormal’	16	61.5%
Conduct problems scale	n=26	
‘Normal’	18	69.2%
‘Borderline’	2	7.7%
‘Abnormal’	6	23.1%
Hyperactivity scale	n=26	
‘Normal’	13	50%
‘Borderline’	8	30.8%
‘Abnormal’	5	19.2%
Peer problems scale	n=26	
‘Normal’	8	30.8%
‘Borderline’	10	38.5%
‘Abnormal’	8	30.8%



Prosocial scale	n=26	
'Normal'	22	84.6%
'Borderline'	4	15.4%

Table 4.13 presents the SDQ and its five subscales - Emotional problems scale, Conduct problems scale, Hyperactivity scale, Peer problems scale and Prosocial scale and the cut-points ('Normal', 'Borderline' and 'Abnormal') for each subscale. Note, there is no 'Abnormal' cut-point for the Prosocial scale. Data were collected from all 26 CYP indicating that was is no missing data.

Results indicate that over half of the CYP in the sample n=16 (61.5%) scored in the abnormal category on the emotional problems subscale. The next most common category was 'normal' with n=8, while only 2 CYP classed as borderline. This contrasted the conduct problems subscale where the majority of the sample n=18 (69.2%) were categorised as normal, while n=6 (23.1%) scored within the abnormal category, and finally 2 CYP (7.7%) were classed as borderline. For the hyperactivity subscale, exactly half of the sample n=13 (50%) scored in the normal category. The next most common category was 'borderline', with n=8 (30.8%), while n=5 (19.2%) CYP were classed in the 'abnormal' category on this subscale. Contrasting the results of the hyperactivity subscale scores, in the peer problems subscale CYP scored relatively similarly in all three categories, with n=10 of the sample (38.5%) were classed as borderline, while the remaining sample n=16 were both equally classed as abnormal n=8 (30.8%) and normal n=8 (30.8%). Finally for the prosocial subscale, as previously noted there is no abnormal category for this subscale. The overwhelming majority of the sample n=22 (84.6%) were classed in the normal category, while the remaining 4 (15.4%) scored within the borderline category.

Table 4.14– Strengths and Difficulties Questionnaire (SDQ) Mean, Standard Deviation and Median (Min, Max) scores

n=26	Mean (SD)	Median (min,max)
Emotional problems scale	6.8 (2.2)	7 (3,10)
Conduct problems scale	2.3 (1.9)	2 (0,5)
Hyperactivity scale	5.2 (2.1)	5.5 (1,10)
Peer problems scale	5.0 (2.3)	5 (2,10)

Prosocial scale	8.1 (1.6)	8 (5,10)
Total sum of SDQ	19.3 (6.5)	19 (8,33)

Table 4.14 presents the overall and subscale Mean, Standard Deviation and Median scores for the sample of CYP for the SDQ. Results from this table indicate that of the five subscales, CYP reported higher levels of prosocial behaviour followed by the second highest scale indicating CYP perceived to have emotional problems. Scores of the next highest scale indicate hyperactivity problems, closely followed by problems regarding their peers. The lowest scoring subscale within the SDQ indicated CYP had conduct problems. Despite the small sample size, these results are consistent regarding Mean and SD with a previous study involving 532 adolescents in CAMHS (Brann et al, 2018). The total sum of SDQ (19.3) placed the participants in the 'abnormal' band of the total difficulties scale of the SDQ, indicating that their emotional health and wellbeing was likely to be under considerable strain.

#### **4.6.2 The Inventory of Parent and Peer Attachment - Revised (IPPA-R)**

Table 4.15– Inventory of Parent and Peer Attachment Global and subscale scores

	Mean (SD)	Median (min,max)	N
Global Mother Score	89.5 (25.0)	92 (39,125)	25
Global Father Score	69.1 (25.7)	75 (5,108)	19
Global Friends Score	84.6 (17.9)	84 (50,117)	25
Mother Trust Score	39.5 (9.6)	42 (17,50)	25
Mother Communication Score	31.0 (10.4)	31 (12,45)	25
Mother Alienation Score	17.0 (6.4)	17 (6,28)	25
Father Trust Score	31.2 (11.8)	33 (3,47)	19
Father Communication Score	22.8 (7.7)	24 (12,36)	19
Father Alienation Score	18.4 (5.2)	18 (10,28)	19
Friends/Peer Trust Score	37.2 (8.7)	38 (18,50)	25
Friends/Peer Communication Score	28.4 (6.7)	27 (17,40)	25

Friends/Peer Alienation Score	23.0 (4.9)	23 (15,32)	25
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Table 4.15 presents the Inventory of Parent and Peer Attachment - Revised (IPPA-R) Global scores and its three subscale's of Trust, Communication and Alienation across the three individual tools for Mother, Father and Friends/Peers. There were incomplete data, with n=25 out of the full sample of n=26 completing the sections asking about their relationship with their mother and friends. The section of the tool asking about CYP's relationship with their father, had more missing data with n=19 out of the sample of n=26 completing questions. Despite the missing data, the results suggest that for IPPA-R global scores and its subscales of trust and communication, CYP scored highest scores with regard to their mothers, followed by friends/peers and finally their fathers in terms of Mean and Median. For the alienation subscale, CYP scored highest in regard to friends, followed by fathers and finally mothers.

Table 4.16– Inventory of Parent and Peer Attachment Revised - Global Scores by Family status on admission

	n=	Cared for by family on admission n=25		n=	Not cared for by family on admission n=25	
		Mean (SD)	Median (min, max)		Mean (SD)	Median (min, max)
Global Mother Score	20	92.7 (20.5)	93.5 (40,125)	5	76.8 (39)	61 (39,123)
Global Father Score	17	70 (26.3)	75 (5,108)	2	62 (26.9)	62 (43,81)
Global Friends/Peers Score	20	83.9 (16.6)	85 (50,116)	5	87.6 (24.7)	81 (65,117)
Mother Trust Score	20	41.2 (7.5)	42 (17,50)	5	33 (14.8)	28 (19,49)
Mother Communication Score	20	32.1 (9)	32.5 (14,45)	5	26.4 (15.1)	21 (12,45)

Mother Alienation Score	20	16.7 (5.7)	16.5 (6,27)	5	18.4 (9.4)	23 (6,28)
Father Trust Score	17	31.8 (12.1)	36 (3,47)	2	26 (9.9)	26 (19,33)
Father Communication Score	16	23.4 (7.7)	24 (12,36)	2	18.5 (9.2)	18.5 (12,25)
Father Alienation Score	17	18.4 (5.7)	18 (10,28)	2	18.5 (7.8)	18.5 (13,24)
Friends/Peers Trust Score	20	37 (8.4)	38 (18,50)	5	38 (11.1)	38 (25,50)
Friends/Peers Communication Score	20	28.1 (6.2)	25.5 (21,39)	5	30 (9.3)	28 (17,40)
Friends/Peers Alienation Score	20	23.2 (4.9)	23 (15,32)	5	22.4 (5.9)	23 (15,29)

Table 4.16 presents Mean, Standard Deviation and Median of the Inventory of Parent and Peer Attachment Revised (IPPA-R) Global and the three subscale's (Trust, Communication and Alienation) across the three individual questionnaires for Mother, Father and Friends. Data were split into two different categories, with CYP being grouped into either being cared for by their family on admission, or not cared for by their family on admission. The data collected were incomplete, with N=25 of the sample completing the sections on relationships with their mother and friends, and N=19 of the sample completing the sections on relationship with their father. Results suggest that for the section of the questionnaire focusing on CYP's relationship with their mothers, CYP who were cared for by their family before their admission to the unit, had slightly higher scores in terms of Mean and Median in the global score, trust and communication subscales when compared to the CYP who were not cared for by a family member. In the alienation subscale, the CYP who were not cared for by a family member on admission scored slightly higher in this subscale than the CYP who were cared for by a family member.

For the questionnaire relating to CYP's relationships with their father, again there were higher scores in terms of Mean and Median for the CYP who were cared for by a family member on admission for the Global, trust and communication subscales.

For the father alienation subscale, there appeared to be very little association in scores between the two categories of CYP.

For the questionnaire which relates to CYP's relationships with their friends and peers, results indicate that in terms of Mean, the CYP who were cared for by family on admission scored slightly higher in the global scores in comparison to the CYP in the not cared for by family category, but this was not the same for Median scores. For the trust, communication and alienation subscales of this section of the questionnaire, there also appears to be no association between the scores in the two category groups of CYP.

It is important to note that these results need to be interpreted with caution due to incomplete data and small sample size, as only 5 CYP were not cared for by their family on admission to the unit, in comparison to the 20 CYP who were cared for by a family member on admission.

#### **4.6.3 The Student School Engagement Survey (SSES)**

Table 4.17– Mean, Standard Deviation and Median Student School Engagement Survey Global Scores for parts A and B

n=26	Mean (SD)	Median (min, max)
SSES A Behavioural Engagement	19.4 (4.6)	21 (7,25)
SSES A Cognitive Engagement	15.0 (5.1)	16 (5,24)
SSES A Emotional Engagement	14.0 (5.0)	13.5 (5,23)
SSES A Global Engagement	48.4 (13.8)	52.5 (19,70)
SSES B Behavioural Engagement	12.4 (1.4)	12 (10,16)
SSES B Cognitive Engagement	49.6 (12.5)	55 (19,67)
SSES B Emotional Engagement	52.6 (13.1)	55.5 (24,74)
SSES B Global Engagement	116.5 (26.7)	123 (60,154)

The data displayed in table 4.17 present Mean, Standard Deviation and Median of CYP's global scores of the parts A and B of the Student School Engagement Survey (SSES) and across the three subscales (Behavioural, Cognitive and Emotional). Data for this questionnaire were collected from all CYP recruited to complete this tool n=26 and there were no data missing. Results indicate that for part A of the questionnaire, the highest scores were found in the Behavioural Engagement

subscale. The second highest scores were in Cognitive Engagement, followed closely by Emotional Engagement. These results contrast Part B of the questionnaire where highest scores were found in Emotional Engagement, then Cognitive Engagement and finally Behavioural Engagement.

Table 4.18– Student School Engagement Survey Global Scores parts A and B by education status prior to admission

	In education prior to admission n=12		Not in education prior to admission n=14	
	Mean (SD)	Median (min, max)	Mean (SD)	Median (min, max)
SSES A Behavioural Engagement	22.4 (2.0)	23 (17,25)	16.9 (4.8)	17.5 (7,24)
SSES A Cognitive Engagement	17.4 (3.9)	18 (12,24)	13.0 (5.3)	15 (5,21)
SSES A Emotional Engagement	16.2 (4.0)	17 (11,23)	12.0 (5.0)	11 (5,23)
SSES A Global Engagement	56.0 (8.2)	59 (42,70)	41.9 (14.4)	45 (19,65)
SSES B Behavioural Engagement	13.0 (1.4)	13 (11,16)	12.0 (1.2)	12 (10,15)
SSES B Cognitive Engagement	56.2 (6.6)	57.5 (41,67)	44.0 (13.8)	48.5 (19,62)
SSES B Emotional Engagement	57.5 (11.1)	58 (32,72)	48.5 (13.6)	51 (24,74)
SSES B Global Engagement	129.7 (17.9)	134 (86,154)	105.2 (28.3)	111.5 (60,153)

The data displayed in table 4.18 presents the Mean, Standard Deviation and Median of CYP's global scores of the parts A and B of the Student School Engagement

Survey (SSES) and across the three subscales (Behavioural, Cognitive and Emotional).

This table is split into two categories, with CYP being grouped into either being in education prior to admission, or not in education prior to their admission. Data for this questionnaire were collected for the whole sample of CYP N=26 and there were no missing data.

The results from this table suggest that the CYP who were in education prior to their admission to the unit, had higher global scores with regards to Mean and Median and across all subscales in both parts A and B of the questionnaires when compared to the CYP who were grouped into the 'not in education prior to admission' category.

#### **4.7 Reflections on outcome measures**

This section outlines some of the difficulties and challenges when undertaking the quantitative aspect of the study with regards to recruiting participants, administering the questionnaires and obtaining complete data for the sample.

##### **4.7.1 Recruitment challenges**

As mentioned previously, there were 16 potential participants that were unable to take part in the study and were excluded due to reasons such as a deterioration in mental health and being on extended leave before the commencement of the study. There were also issues with the organisation's capacity to admit new patients.

It was initially anticipated to allow six months to collect and generate sufficient data from participants. When writing the study's research protocol, it was anticipated to recruit 30 CYP into the questionnaire phase of the study. Over the course of the data collection between March and November 2019, I encountered two periods that had a direct impact on the study and significantly hindered my ability to recruit new participants. I had been informed by a member of the management team that they were not accepting any new admissions to the unit during these periods:

*"I have been informed by the locality manager about the current admission rates and the level of acuity is being assessed in conjunction with the current mix of young people admitted. I am informed that the unit has been closed for any new admissions over the past fortnight, but new referrals are still being accepted and discussed by the MDT." (Fieldnote, Managerial Staff Conversation)*

This situation occurred twice during the data collection period and in total the unit was closed for admissions for approximately seven weeks. During both time periods I maintained a good relationship with the senior nurse at the research site and focussed on other aspects of the fieldwork such as recruitment of staff members, caregivers, and reviewed the organisation's policy and procedure documents. Ultimately the fieldwork phase of study was extended for a further two months to allow for additional time to recruit potential participants into the questionnaire aspect of the study. By the end of November 2019, I had collected questionnaire data from a total of 26 participants.

#### **4.7.2 Questionnaire completion rates and missing data for IPPA-R and SSES**

Although most CYP recruited into the questionnaire phase of the study completed all three with little difficulty or concern, there were some issues regarding the completion of the IPPA-R and SSES which resulted in there being incomplete and missing data. As mentioned earlier, there were missing data from up to seven CYP regarding the IPPA-R. Some CYP informed me that they had completed the friends section of the IPPA-R questionnaire but had decided to base their responses in relation to their siblings instead:

*“Carly completed the questionnaires this afternoon and when handing the questionnaires back to me, she stated that she does not have any friends so when completing the inventory of peer and parent attachment survey, she completed the friends section on behalf of her siblings as she stated her siblings are the closest resemblance to friends. Carly wrote ‘siblings’ at top of the questionnaires, crossing out friends.” (Fieldnote, Patient Conversation)*

As mentioned previously, seven CYP did not complete the father section of the IPPA for various reasons. Heidi for example, informed me that she had not been in contact with her father:

*“When handing the questionnaire pack back to me this morning, Heidi informed me that she did not complete the father section of the IPPA-R as she has not seen or spoken to her father in 11 years.” (Fieldnote, Patient Conversation).*

There were also some issues with the completion of the questionnaires. Two participants, Heidi and Kayleigh, during the consent process informed me that they were going to have difficulties completing the questionnaires due to their dyslexia. At



their requests I supplied the PIS sheet, consent form and questionnaires on yellow or blue coloured background paper to assist them with their difficulties. Another issue encountered when administering the SSES to CYP was that a significant proportion of the sample  $n=14$  informed me that they were not in education immediately prior to admission and asked me whether they should be completing the SSES questionnaire in relation to their previous mainstream school or the Learning Centre. I therefore gave CYP the opportunity to base their answers on the school they felt was most appropriate.

#### **4.8 Chapter Summary**

This chapter began with an overview of the research site. Next, tabulated demographic data of the study sample and the previous three years' admissions were presented and compared. The results of the demographic data collected for the study sample suggest there were similarities in terms of gender, admission rates, primary diagnosis and age on admission. For average length of stay, the study sample was longer than the previous two years.

Results for the three outcome measures were tabulated. For the SDQ subscales, most of the sample scored in the abnormal category for the emotional scale and in the normal category for the conduct problems, hyperactivity and prosocial scales. However, for the peer problems scale, CYP scored similarly across the three bandings. The total sum of SDQ scores indicated that CYP were placed in the 'abnormal' band of the total difficulties scale, suggesting that their emotional health and wellbeing was likely to be under considerable strain.

For the IPPA-R, results indicate CYP scored highest in global and trust and communication subscales regarding their mothers, followed by friends/peers and finally their fathers. For the alienation subscale, CYP scored highest in regards to friends, followed by fathers and mothers. When split into the two categories of either cared for or not cared for by a family member on admission, CYP who were cared for by a family member on admission scored higher in global, trust and communication scales across all three questionnaires. For the alienation subscale, results were similar between both categories.

For the SSES, results indicate that for part A of the questionnaire, the highest scores were found in the Behavioural Engagement subscale. The second highest scores

were in Cognitive Engagement, followed closely by Emotional Engagement. These results contrast Part B of the questionnaire where highest scores were found in Emotional Engagement, then Cognitive Engagement and finally Behavioural Engagement. When split into either being in education prior to admission and not in education prior to admission, CYP who were in education prior to admission scored higher scores across all four engagement scales in both parts of the questionnaire.

Some of the challenges encountered when administering the questionnaires such as missing data and completion rates were discussed. In Chapter five, findings from interviews with CYP, caregivers, ward staff, observations and policy and procedure documents relating to CYP connecting to their friends are discussed.

## **Chapter five – Connections to Friends**

### **5.1 Introduction**

This chapter will explore the key methods in which CYP were able to keep in touch with their friends when admitted to hospital for care and treatment of their mental health. This chapter is split into three themes, with the first theme exploring the remote connections between CYP and their friends. The second theme will focus on CYP physically keeping in touch with friends and the third theme of this chapter will explore CYP's relationships with peers in hospital.

It is important to note that whilst some CYP stated in interviews that they had close friends and supportive friendship groups, this was not the same for all who participated in the interviews. Some reported that they had pushed their friends away and many stated that they were not very confident in making new friendships. Others stated that they had lost friendship groups whilst being on the ward. This was also acknowledged by staff members, who informed me that one of the areas a CYP may be struggling with prior to being admitted to the unit is a limited friendship group.

### **5.2 Theme one – Remote connections with friends**

#### **5.2.1 Unit policy on mobile phones**

Theme one will begin with exploring the health care organisation's policy and procedure document which relate to CYP remotely keeping in touch with their friends.

In the list of documents I was provided with by the unit's senior manager, policies and procedures relating to CYP keeping in touch with their friends were first outlined in the organisation's (2014) Information Booklet. This was a document produced by the organisation for CYP and caregivers and provided information about the unit such as what type of unit it is, what professionals work at the unit, the education and therapies available, information about visiting, meals and restricted items. In this document devices such as mobile phones and tablet computers were classed as restricted items and were not allowed on the unit for safety reasons including confidentiality and potentially interfering in CYP's treatment plans. Instead, the unit offered a 'ward mobile phone' which could be used to contact family and friends, and gave CYP two options of either having one, 15 minute call per day or 3 five minute calls per day:

*“Whilst we understand that mobile phones / iPads etc are very important items for young people we do not allow them to be used in the Unit as they may compromise confidentiality and can be an unhelpful distraction to your treatment programme. However, we recognise how important communication with friends and family is and therefore offer use of the ward telephone as outlined below: 15 minutes per day or 3 calls of 5 minutes each per day.”*  
(Information Booklet 2014, page 13)

In the following years, the organisation implemented a specific policy to allow CYP access to their mobile phones whilst being on the unit. As part of this policy, CYP were required to sign a contract with the nursing staff and their caregiver on admission to the unit. This contract discussed safety concerns of using mobile phones such as breaches of confidentiality, safeguarding issues, and stipulated what media could be accessed, or supervised and restricted, by the nursing staff:

*“The internet holds both helpful and useful information; however, it can also be a place for people to share dangerous information or a platform for bullying. All contracts will agree stipulated access to mobile media... ..the contract takes into account individual risk assessments including safeguarding and emotional well-being, this may indicate that some young people require limited phone use/supervised phone use.”* (Patient Access and Use of Smart Phones Policy 2017, page 4)

Key principles of the policy stipulated that during the initial two-week assessment period, all CYP who have been recently admitted would be informed that mobile phone use would be limited to one hour per day from 6pm-7pm. After the two-week assessment period, limits on mobile phone use were increased to four hours per day from 4pm-8pm on weekdays and from 10am-8pm on weekends.

In conjunction to the organisation’s specific policy on access to mobile phones, their inclusion and the limits placed on their use were later added to the organisation’s revised information booklet (2019):

*“We understand that keeping in touch with your friends and family is very important to you. To support you in these important contacts all young people have an hour access to their mobile phones each day between 6pm and 7pm*

*for their first 2 weeks of assessment. This is to support the team in getting to know you.” (Information Booklet 2019, page 14)*

During the first week of data collection, I had been informed that in the previous week there had been incidents on the unit whereby patients had broken the organisation’s data protection and mobile phone policy. Patients had allegedly taken confidential photographs on their phones of clinical areas and had recorded conversations with staff members and had posted them on the internet. These incidents prompted a series of discussions within the MDT leading to an investigation being undertaken and the amount of time CYP were allowed on their mobile phones was reduced from 4pm-8pm on weekdays and 10am-8pm on weekends, to a blanket one hour per day between 6pm-7pm. This reflected a previous mobile phone policy and continued to be the policy throughout the entire 9-month period of data collection:

*“The MDT debate reviewing the mobile phone policy. The Consultant Psychiatrist states the mobile phones of the patients who have posted confidential information should be removed. Other MDT members agree the issue of inappropriate social media use needs to be investigated by the Local Management Team (LMT) and some phones will be confiscated until the investigation concludes. After discussions between the MDT and ongoing investigations regarding social media use, the mobile phone policy has reverted to a previous policy of one-hour mobile phone use each day Monday-Sunday.” (Fieldnote, MDT Meeting)*

### **5.2.2 Access to mobile phones**

The most common way in which CYP remotely kept in touch with their friends was by using mobile phones. Of the nine CYP interviewed for the study, seven reported having a mobile phone and two stated that they did not own a mobile phone. Many who were interviewed reported that they used their mobile phone or tablet to keep in touch with their friends by messaging, texting and occasionally calling them:

*“You get your phone for an hour a day. So you got like social media, Snapchat and Facebook messenger... yeah I mean it’s either that or texting... so you’ve got pretty much everything you need to speak to everyone.” (Interview, Jenny)*

CYP would access their mobile phones between the allocated time slot of 6pm-7pm in the wards main communal lounge and were supervised by members of the nursing team. Staff members reported that they supervised CYP not only for confidentiality reasons, but also to support CYP if being on their phone seemed to have an impact on their emotional wellbeing:

*“They have an hour a day, up in the lounge whereby a staff member would be present. So, they’ve got their phone which obviously gives them access to their messages, their phone calls, internet access. They could potentially be using WhatsApp, Facebook, Instagram. But obviously the staff member would be present so if they can see that anybody is struggling or seems to have been an impact on their emotional wellbeing then that would also factor into it.”*

*(Interview, Ward Manager)*

For some, mobile phone contact was the most appropriate way of keeping in touch with their friends due to factors such as geographical location. For one CYP, living in a remote location within the far west of the region meant that contact between friends was difficult and was mostly made over the phone:

*“The Community Mental Health Nurse states that the patient lives in a remote area where there is a large catchment area with her friends. There are not many groups or clubs available to her and therefore contact between the CYP and her friends is mostly made using mobile phones.” (Field Note, MDT Meeting)*

### **5.2.3 Time constraints on mobile phones**

Almost all CYP who took part in the interviews reported that the one-hour time slot between 6pm-7pm was not enough time to spend on their phone. Jenny whose parents were divorced, described being allowed to use her phone for one hour going by very quickly, especially when CYP may have wanted to speak to friends and multiple family members during the allocated time:

*“It’s not enough [time] when like you want to ring parents and then you want to speak to your friends, I just feel like an hour goes really, really quickly when you like spend about 20 minutes on the phone to your mum but they [parents] might be separated so you might spend another 20 minutes on the phone to your dad*

*and that's 40 minutes gone just speaking to family members without even wanting to like check on social media or stuff like that." (Interview, Jenny)*

Joanna described having to juggle between doing different things on her phone during the allocated hour, whereas outside of hospital she would have her phone all day. When asked what she would have liked to have changed regarding the policy, she informed me that she would prefer to increase the time limit to a couple of hours:

*"...I'm used to having my phone like every hour of the day instead of just an hour. You're like what do I do? Do I text my friend? Do I watch YouTube? Do I do this? Do I do that? It's really limited. It's quite stressful for me because... ..I have to do a hundred things at once on my phone to get everything done. So, it's really difficult." (Interview, Joanna)*

When discussing the change from the previous mobile phone policy to the current policy, some staff members appeared to relate to what CYP had said regarding the restrictiveness of the policy and acknowledged that they have not quite figured out the right balance of time to allow CYP their phones. Some staff even stated that they would struggle if they were only allowed access to their phones for one hour per day:

*"I think, I don't think that we've got it right... ..I wouldn't be happy with that, just one hour especially at the weekends. I think maybe we've gone from one extreme to another." (Interview, Senior Staff Nurse)*

When discussing the previous phone policy, a staff reported that despite the current access to phones limits seemingly being more restrictive, allowing more time for CYP to spend on their phones was not necessarily a positive step and at times hindered staff's opportunities to assess and engage with patients.

#### **5.2.4 Mobile phones impacting assessment and engagement**

A Staff Nurse stated that particularly during the first two weeks of the holistic assessment period, there needed to be a balance between allowing CYP access to their phones and therapeutic engagement with staff and other peers:

*"...young people need their mobile phones in 2019. We want them to keep those friendship groups open and stay in contact with their friends. We also want them to recover and engage with other CYP and with professionals and*

*they're not going to do that if they're on their phones all the time.” (Interview, Staff Nurse)*

Despite the restrictions to mobile phones, CYP seemed to cope with this outside of school and mealtimes by utilising ward facilities such as the art room to paint, draw and colour books. Other patients often read books, completed puzzles, or watched films and TV shows in the communal lounges.

One parent of a patient admitted to the unit for difficulties with regulating her emotions, reported his daughter would have the tendency to spend more time on her phone when she was struggling with her thoughts and emotions. When asked about restrictions around mobile phone use on the unit, he appeared to be surprised that his daughter was able to cope well without her phone for long periods and attributed this to her taking part in other ward-based activities:

*“It’s amazing how well she’s done by not having her phone as much... .. because when she’s very bad she does shrink away into her phone and it’s made me be a bit more determined... ..not take it away because that’s not what life is today, but just to limit the times, and say “that’s enough phone now, you have to do something else.” (Interview, Parent)*

Not all CYP felt the access to mobile phones was so restrictive. When asked whether she felt she had enough time to spend on her phone, Nia stated that she did and that she frequently kept in contact with her friends. She also stated that whilst the limited access may be difficult for some, she did not spend a lot of time on her phone and attributed this to having just one or two close friends as opposed to having many friends and occasionally receiving visits from them:

*“It’s enough time for me because I don’t really go on my phone a lot anyway. Sometimes I don’t even go on it for the whole hour. I text them every other day and I probably see them about once every two weeks... I guess the one hour would be quite restrictive for some. I don’t really find that because I don’t have that many friends. I just have a couple of good friends.” (Interview, Nia)*

For some, restrictions on the access to mobile phones gave a sense of relief. During a discussion with a therapy staff member, the therapist described how some CYP were relieved to have their phone less, due to previous instances of cyberbullying:



*“I’ve got a number of youngsters who’ve been at the receiving end of cyberbullying and bullying. I know some have been relieved when we’ve reduced the phone time because they’re not being subjected to some of those subjections.” (Interview, Therapist)*

#### **5.2.5 Requests for additional mobile phone access**

CYP requested in both individual and community-based meetings to discuss the current limitations to mobile phone access and to have it increased. Some requested this in the weekly ward round meetings through ‘ward round requests’, which were specific topics the CYP would like the MDT to discuss on their behalf. On one occasion, a CYP requested in their individual MDT meeting for mobile phone access to be increased. This was discussed in the meeting and was denied due to the investigation into misuse of social media by some CYP:

*“Staff Nurse states Carly has a ward round request for the current mobile phone policy to be changed and to be extended. If not, she requests if patients can have access to mobile phones from 1pm-7pm during half term.*

*The Ward Manager and Consultant Psychiatrist state that this is difficult to change at present but will be discussed in the monthly LMT meeting.”*

*(Fieldnote, MDT Meeting)*

Other CYP preferred to discuss this collectively with staff and their peers in the weekly ‘community meeting’. Each Tuesday afternoon a community meeting was held between members of the nursing and therapies staff, and all CYP on the unit. This provided CYP with an opportunity to voice their opinions on issues which might be impacting them, and to provide feedback on areas the unit is doing well at or can improve on. During a community meeting, CYP raised the one-hour phone time slot as an issue which they felt was too restrictive and requested the policy to be changed and for mobile phone access to be extended. This request was discussed in the following weekly MDT meeting and despite the difference of opinion between staff, was subsequently denied until the unit’s management team had finished their investigation:

*“The Consultant Clinical Psychologist states that young people brought up the restrictions and privacy issues with mobile phone use in the community meeting. The Consultant Clinical Psychologist states that 1 hour per day is not*

*very much for young people in comparison to the outside world and states “we live in a mobile world”. The Ward Manager acknowledges that many young people want more time on their mobile phones but states it still needs to be reviewed by LMT before a decision can be made.” (Fieldnote, Weekly MDT meeting)*

When discussing the restrictions on mobile phone access with a therapist, she appeared to empathise with CYP and stated that due to the unit's mobile phone policy, some were going to find the reduction of time for telephones difficult:

*“I think maintaining contact is so fundamental. Likewise, there are challenges as well... ..it's hard when you've got a group of youngsters, you've almost got to make a blanket policy which is going to be positive to some, but really harsh on others. I was at a community meeting when we had to announce that we were reducing the telephone contact. It was an interesting response! We had some effing and jeffing, and you'd expect it, if someone told me I can't go near my phone for an hour I wouldn't be happy!” (Interview, Therapist)*

#### **5.2.6 Friends' limited availability**

CYP described feeling frustrated having to rely on friends being available and online between 6pm-7pm, to stay in touch and message them on social media applications such as Facebook, Instagram, and Snapchat. Emma reported feeling annoyed after sending messages to her friends but did not receive any back during the hour:

*“Int: How often do you keep in touch with your friends?”*

*I try and talk to them each day but sometimes you can send a message at the beginning of the hour and you won't get a response by the end because they might be busy when it's our phone time so, you're buggered, really.” (Interview, Emma)*

This was acknowledged in an interview with a Staff Nurse who commented that CYP's friends were not always available. Since the policy had been changed to allow CYP to spend less time on their mobile phones, consequently it may have reduced the frequency of contact they had with their friends:

*“I think certainly since the phone policy has changed to one hour, while there's been benefits to that, it has limited the amount of [contact] because your friends*

*aren't necessarily always around for that one hour. It has probably reduced the frequency of their contact with their friends. If they can't get in contact with someone then obviously once that hour is up, then that's it for the day."*

*(Interview, Staff Nurse)*

Routine interventions known as 'key working' or 'nurse engagement' sessions would take place in the evenings on the ward between staff and CYP. Despite these sessions potentially clashing with the allocated time for mobile phones, some staff were flexible in their approach to this:

*"They're [staff] quite flexible... ..the other day I was with a Nurse and she was like "you can have the phone until 20:00" because she was talking to me and I'd done a key working session so she gave me my phone until 20:00 which was cool." (Interview, Joanna)*

#### **5.2.7 Ward mobile phone**

Although most CYP who were interviewed had a mobile phone, they were reassured that a 'ward mobile phone' was also available between 9am-9pm if they did not own a personal mobile phone or preferred to use the ward phone. This phone was not a smartphone but could be used for up to 15 minutes per day, either through one 15-minute phone call, or through 3, 5-minute phone calls. Although the organisations Information Booklet to patients and family members stated the ward mobile phone would be available to contact friends in addition to family, it appeared to be mainly used outside of the allocated one-hour phone slot for CYP to make short phone calls to family members, health and social care professionals or mental health advocates rather than to contact their friends. This method of remote communication will be explored further in the following chapter in relation to connections to family.

#### **5.2.8 Letter and card writing**

Although the most common way CYP remotely kept in touch with their friends was through mobile phones, some were able to keep in touch with their friends remotely by making cards and writing letters to them. Staff reported CYP made cards and received them from their friends, and commented how this helped when CYP missed out on important events at home such as friends' birthdays:

*"We have had young people that have written letters and received them as well, which has helped to keep them connected, even if they just know what's going on and all the gossip that's going on at home..."*

*Int: Right*

*...other times, there was one young person whose best friend, it was their birthday when they were in here... ...so you know, if they're upset that they're not going to be there, maybe sitting with them in the art room to make like a birthday card and getting that sent for them." (Interview, Staff Nurse)*

Although there appeared to be a difference of opinion with other staff suggesting CYP writing letters to friends was not actively discussed as frequently between the MDT:

*"We have encouraged some letter writing on maybe a handful of cases, its not something that we [MDT] discuss frequently to be honest." (Interview, Social Worker)*

Other staff members highlighted that although writing letters to friends may be appropriate for some CYP, others may have found it easier to have kept in touch superficially over the phone as opposed to writing letters:

*"I think on the phone it's probably easier to connect maybe on like a more superficial level I suppose, writing like letters... ...you need to be a bit more okay with being in hospital I guess." (Interview, Senior Staff Nurse)*

#### **5.2.9 Social media**

CYP remotely kept in touch with their friends by contacting and messaging them through social media platforms such as Facebook, Twitter, Instagram, and Snapchat. Before CYP were able to access their social media accounts on their mobile phones and tablets, they first had to sign the organisation's mobile phone contract along with their caregivers and a Nurse. This contract had the following 5 key components:

- "1. Discuss and document any concerns regarding potential smart phone use, taking into account [the] history of young person and safeguarding issues.*
- 2. Stipulate agreed parameters for smart phone use; including requirement to restrict/supervise use*

3. *Stipulate agreed access to media*
4. *Young person consents to the history of the phone being reviewed by staff as indicated as necessary by the multi-disciplinary team*
5. *Young person demonstrated understanding of the smart phone procedure and understands that breaches in the terms of usage set out/confidentiality will result in the phone being confiscated.” (Patient Access and Use of Smart Phones Policy 2017, pages 6 and 7)*

When asked how they kept in touch with their friends, the majority of CYP stated that they mostly communicated with their friends online through various social media platforms. Emma, who was on her second admission to the unit, spoke of using social media to stay connected to friends that she had made on the unit during her first admission:

*“On my first admission, it was my first time being in this type of unit. I was very quiet and being very like reserved, very nervous... ...but towards the end I was relatively chatty and made a few friends and I had like kept in some contact when I was on home leave through social media.” (Interview, Emma)*

Not all CYP kept in touch this way however and some like Sarah, stated that she did not use her mobile phone very much or use social media. Instead, she preferred to see her friends face to face when on home leave:

*“Int: Have you managed to keep in touch with your friends?”*

*When I go home on leave, I meet up with some of them, but when I’m here I don’t really talk to them, because I don’t really use social media or anything.” (Interview, Sarah)*

Staff members reported that it was common for the current generation of CYP to likely want to keep in contact with friends virtually through social media as opposed to face to face interactions:

*“I would say there is more virtual contact. I would prefer face-to-face contact. However, the generation of 11–18-year-olds are quite used to keeping in touch with each other virtually, or through the phone.” (Interview, Therapist)*

One parent spoke about his daughter having more virtual contacts rather than close friends. The parent described these virtual contacts his daughter had on the unit with her friends through social media as being a “sticking plaster”, and felt the interactions she had with her friends were not ‘proper interactions’:

*“When Emma was first admitted onto the ward I don’t think any of her friends visited here at all, certainly none on her second admission. So, she keeps in touch as much as you can keep in touch via social media. She readily will be messaging them on her phone, via snapchat, but I don’t see that as a solid communication. It’s a sticking plaster, rather than anything else. It’s not a way of keeping in touch really rather than face to face, so I think she was potentially on the fringe of a discussion rather than it being you know, proper interaction.”*  
(Interview, Parent)

An issue that concerned staff members and parents regarding CYP’s social media usage was the accessing of social media pages and websites that were potentially harmful to their wellbeing. A therapist described CYP accessing harmful websites whilst referring to the previous incident of CYP inappropriately sharing images of the unit on social media:

*“In recent months we were becoming increasingly concerned about how phone use was being used, because we’re all mindful of social media and the impact that can have, and what kids can access. There were circumstances where our unit was being shared on social media in not an appropriate manner, and we were mindful that some of the children in our care were accessing pages and sites that was unhealthy to their mental health.”* (Interview, Therapist)

On one occasion, the MDT discussed CYP allegedly participating in an online game which contained elements of self-harm:

*“The MDT are concerned that patients are participating in inappropriate social media use with others on the ward. Two patients have been playing a game called ‘yellow bird’ which originates from an online social network phenomenon the ‘blue whale challenge’ which includes ‘challenges’ instructing people to self-harm by cutting and refuse food and drink. Members of the MDT state they are unsure how to proceed with managing this game and state it could potentially influence others. The MDT discuss increasing supervision in the communal*

*lounge during the allocated time for mobile phones and tablets.” (Fieldnote, MDT Meeting)*

Another example of how CYP were potentially accessing social media and websites that were unhelpful to them was when a Staff Nurse described CYP with eating disorders accessing ‘pro-anorexia’ internet webpages and Instagram accounts. These websites relate to the promotion of behaviours associated with the eating disorder Anorexia Nervosa:

*“...[those] with eating disorders, they would be on Pro-ana websites, Instagram accounts, they’ve got Instagram accounts where they’re friends with anorexic people who will be motivating them. We’ve had instances of patients taking selfies on the ward with NG tubes in and it’s just promoting things. Then we’ve got safeguarding concerns and confidentiality concerns... ..during that initial two-week period of assessment we want them to open up to staff and not be fixated on negative images online.” (Interview, Staff Nurse)*

Caregivers also felt strongly about the potential negative effects associated with social media, as during a discussion one father described the negative impact of social media posts were having on his daughter’s mental health:

*“Dad stated that his daughter would look at pictures and images of female fitness models on social media platforms such as Instagram and she would be upset. Dad stated that what his daughter does not realise is that social media is a place where there is unregulated marketing and sales tactics, and ‘influencers’ are getting paid a fortune to post pictures on social media.” (Fieldnote, Post Parent Interview)*

Despite the potentially positive and negative effects associated with CYP accessing and using social media on the unit, many staff members acknowledged the difficulties on how this was managed on the ward. Firstly, a staff member acknowledged that were difficulties with technology changing and how this affected the unit’s mobile phone policy:

*“The big one for me is social media. I think we’ve hit a paradigm shift really. Technology is going so fast and it’s such a big part of people’s lives, the literature and the policies can’t really keep up. Ours has changed in the last two days, because what was relevant last year and what was relevant last month*

*isn't relevant now, so I feel like mental health services are playing catch-up." (Interview, Staff Nurse)*

One of the conditions of the mobile phone policy was that during the one hour allocated for CYP to spend on their mobile phones and tablets in the evening, there had to be staff members present in the communal lounge. Staff members recognised that although CYP were allowed to access social media, they also highlighted the issues associated with monitoring and observing CYP's social media use:

*"We can't ban people from using social media. Young people can do what they want, that's their discretion completely. Although we have seen a huge increase in self-harm in the effect of social media has on young people's well-being. We know that's happening, but then at the same time, our hands are tied in terms of what can we do to stop it... ...we can't. It's things that we can do, let's say "not looking at articles on pro-anorexia websites whilst you're here on the ward", but realistically how can we police that? We say to young people, think of confidentiality, you're not to take pictures on the ward. Realistically, we're not going to have eyes on a 14-year-old all the time. If they're going to take pictures of their friends and upload it to Facebook, how can we really stop that? We can't. So, you've got policy saying one thing, and reality saying another and that's constantly changing." (Interview, Staff Nurse)*

Another example of where social media was an issue for staff was when CYP who were out on leave, were messaging and sending images to peers who were still on the ward. When asked questions around how social media is managed on the unit, a Staff Nurse acknowledged that it is a difficult issue to manage, and through key working sessions with CYP, staff tried to educate them around the appropriateness of using social media:

*"It is really difficult for us to manage. Our hands are tied in some respects with social media. I know that there's been some young people that have made a group chat. We do sit with the young people and try and explain that relationships that develop while in hospital are not always very helpful... ... but for young people, it's very difficult for them to take that on board and to listen to us rather than their peer group." (Interview, Senior Staff Nurse)*



To summarise, this theme has discussed the organisations policy and procedure documents on how CYP remotely connected with their friends when in hospital. It has also detailed the remote ways in which CYP make these connections through mobile phones, writing letters, making cards and the unit's ward phone. It has discussed some of the issues highlighted by CYP with regards to time constraints on mobile phones and the impact this has on staff's assessment. Finally, it has discussed some of the issues related to CYP using social media whilst on the unit.

### **5.3 Theme two – Physical connections with friends**

This theme will explore the physical means in which CYP kept in touch with their friends. CYP admitted to the unit were able to keep in touch with their friends physically in two distinct ways, through visitation and seeing them whilst on home leave from the unit. The first part of this theme will focus on friends visiting the unit and the second will explore how CYP kept in touch with their friends as part of having leave from the unit.

#### **5.3.1 Visiting policy relating to friends**

Information regarding friends visiting the unit is relatively limited throughout the organisation's policy and procedure documents. In the original organisation Information Booklet (2014), there was no mention of friends being able to visit and information regarding visiting rather focussed on visits from caregivers:

*"When can I see my family and other visitors?"*

*We strongly encourage contact and visits from family and carers throughout a young person's stay in the unit." (Information Booklet, 2014 page 14)*

The lack of recognition for friends visiting is also highlighted in one of the organisations two policies relating to visitation. In this policy there was also no mention of friends visiting and instead the term 'visitor' was used to describe family members and various health and social care professionals:

*"The term "Visitors" can be defined in a number of ways; for clarity, professionals from other agencies, employees from other Health Boards, employees from other parts of the CAMHS Network and family members should be considered visitors." (Procedure for Dealing with Unauthorised Visitors or Intruders, 2016 page 4)*

In a later policy relating to visiting, it was explicitly stated that people outside of the core family such as friends and other visitors must first be permitted to visit through the MDT before they are allowed access to the unit:

*“Outside Visitors/Additional Family or Friends – No visitors/additional family or friends will be allowed on the premises without prior consent from the core professionals team.” (Use of Visitors Suite, 2017 page 7)*

In the organisations revised Information Booklet (2019), friends were recognised in the visiting section of the document. In this document it was specified that visiting hours were between 6pm to 8:30pm on weekdays and any time after 12 midday on weekends. Although friends and family were unable to visit on the main ward due to confidentiality reasons, the unit had specific areas off the ward but still within the vicinity of the building where visits took place:

*“Informal visits from family and friends are actively encouraged throughout your stay. [the organisation] houses visiting rooms and a Visitors’ Suite to support this. Visiting is not permitted on the main ward areas to support confidentiality of all young people.” (Information Booklet 2019, page 13)*

### **5.3.2 Staff members views on friends visiting**

According to the unit management staff, exploring the possibility of friends visiting is something which was focussed on at the very beginning of an admission to the inpatient CAMHS unit and started with the assessment for admission:

*“Int: How does the unit promote young people keeping in touch with their friends when they’re on the ward?”*

*It would start from the initial Tier 4 assessment, that is one of the questions which a staff nurse would be interested in, “what does their friendship group look like outside of the unit?” because they’re things that you need to be working with.” (Interview, Ward Manager)*

The ward manager later described how it can be more difficult to support discharges where the patient reduces their risk-taking behaviours, the longer they are away from normalised friendships, activities and education. Through nurse engagement sessions, staff nurses identified potential supportive friends which can help with the recovery process for CYP:

*“So when they’re admitted we would be using our nurse engagement sessions to identify if there was a friendship group who were pivotal to support the recovery process. That is something that we would put in the care plan straightaway and we would be encouraging. An example would be mum to fetch in a significant peer or a group of significant peers from the offset of the admission.” (Interview, Ward Manager)*

When asked questions around CYP keeping in touch with their friends when they were on the ward, various staff members stated that receiving visits from friends was encouraged at the unit and they emphasised being flexible as possible regarding facilitating friends visiting:

*“So we’ve had multiple groups of friends come to visit the young people all at same time, which is nice. It’s about being flexible and not having a blanket rule. If we can facilitate them meeting their friends then we’ll absolutely do that. It’s only when there’s an outright risk, we’d have to do something about it.” (Interview, Staff Nurse)*

When discussing friends visiting, a staff member from the medical team described how it was important for friends to visit and commented on its therapeutic value and how it contributed to a CYP’s recovery:

*“Generally, we encourage that [friends visiting] because we believe that to be part of the healing process for young people. So it’s not just kind of for the social aspect of it, although it is encouraged on its own, but also in therapeutic terms we believe it to be kind of something that - that should be encouraged. So yes, that’s another resource we encourage, we encourage friends to visit.” (Interview, Medical Team)*

Requests for friends to visit were usually made through either the CYP or caregiver, and this was then agreed with the ward staff on shift or through discussions in MDT meetings. When asked if there were any restrictions regarding visiting, an education team member reported that in addition to being dependent on clinical factors such as mental state, visits from friends had to occur in the evenings, away from scheduled education and therapy timetables:

*“Friends wouldn’t be able to visit in line with the educational and therapeutic timetable. But outside of that we are very flexible, we would be encouraging friendships from the outside as much as we possibly could.” (Interview, Education Team)*

### **5.3.3 Experiences of friends visiting**

According to CYP who were interviewed in the study, only three out of nine stated they had received visits from friends whilst being in hospital. This was due to several reasons. Some preferred for family members to visit rather than friends, and described preferring to focus on their own recovery during what was a particularly difficult period for themselves before being comfortable with friends visiting:

*“Int: Have you had visits from your friends?”*

*I’ve had visits from professionals and my family but not friends or anything like that.*

*Int: Would you want them to visit you if they could?*

*Probably not because I’d rather focus on myself first and get myself better before they come and see me.” (Interview, Jenny)*

As previously stated at the beginning of this chapter, some CYP stated in interviews that they did not have many, if any, friends. Therefore, some did not expect to receive any visits from friends. Recognising that CYP do not have a friendship group prior to being admitted to the unit was acknowledged by staff members:

*“Int: Do young people have visits from friends when they stay here?”*

*Some do, for others it is more difficult because for other young people they haven’t got that strong friendship group within the community prior to an admission and that may be one of the areas which they’re struggling with.” (Interview, Staff Nurse)*

Kayleigh who regularly received visits from friends, described them coming to see her as helpful, especially when she was experiencing periods of low mood:

*“Int: Have your friends come to visit you here?”*

*Yeah they’ve come every Sunday with my mum. Sometimes they come in the week as well. It all depends how my week’s going. So, if I’m having a bad*

*week, like if I'm feeling low, they'll come in and try cheering me up.” (Interview, Kayleigh)*

For one CYP, her friends asked at the beginning of her admission if they were able visit her. Emma stated she did not feel comfortable with this, so she purposely informed them only family members were allowed to visit her:

*“Int: Have your friends come to visit you?”*

*No.*

*Int: Would you want them to come and visit you if they could?*

*I've told them I'm not allowed visitors. They've asked to come and visit but it wasn't... ..something I was comfortable with so I said only my family could visit me.*

*Int: I see*

*It was just easier than telling them I didn't want them here.” (Interview, Emma)*

#### **5.3.4 Friends' supervised visits**

Through interviews with CYP, caregivers and staff, I had been made aware that any visitor to the unit under the age of 18 had to be accompanied by an adult. This was due to the variety of ages on the unit and for the safeguarding of a vulnerable client group, CYP with complex physical and mental health needs. Despite this restriction, there did not seem to be any information in the organisation's visiting policies stating under 18's needed to be accompanied by an adult when visiting.

Interestingly, this restriction was the topic of discussion during a ward round meeting when a CYP's boyfriend who was over the age of 18, wanted to visit her on the unit. Despite being over 18, the MDT insisted on him being supervised by the CYP's mother, as there were concerns about whether the visit was appropriate:

*“Senior Staff Nurse states a CYP's boyfriend is due to visit today and he is over 18 years of age. The MDT discuss whether the visit should be supervised as the young person's mother has previously stated to staff members that the boyfriend may have been supplying her daughter with illegal substances.*

*The MDT debate whether there is sufficient evidence to support the mother's claim. The Consultant Clinical Psychologist states that the young person's*

*boyfriend is an adult male and that she is a vulnerable child, and questions if the MDT should allow this visit to go ahead unsupervised and asks what the visiting policy states. The Ward Manager admits more needs to be done regarding the visiting policy, as there are more 'grey areas' cropping up.*

*The MDT conclude that as per the unit's visiting policy, it is the responsibility of the parent to ensure the safety of their child during visiting hours. The MDT decide that the boyfriend can visit during visiting hours, if he is always in the presence of the patient's mother. A Staff Nurse states she will contact the mother to explain this to her and her child." (Fieldnote, MDT Meeting)*

The unit's policy of certain visits having to be supervised, appeared to be a barrier for some friends visiting but also CYP wanting their friends to come and visit. Some stated that they purposely would not want visits due to the supervision involved:

*"Int: So what ways do you have access to your friends when you're in hospital?*

*Just phone, really. They don't really come and visit me. Just through the phone.*

*Int: Ok... Is that something that you've asked for?*

*No, they just don't really come. Because if they come, they've got to be supervised because they're not over 18. It means like a parent or Nurse must sit in for it all, they have got to be inside the room with us." (Interview, Lilly)*

### **5.3.5 Observation levels**

All patients on the unit were under various levels of observations by nursing staff. To maintain their safety, staff members would intermittently observe them and check up on them throughout the day. The frequency and intensity of observations were dependant on what level of observation the CYP was placed on by the medical and nursing staff. It was also recognised by CYP and caregivers that during visiting times the caregiver would be responsible for supervising the visit.

A parent described expecting to have to supervise his daughter's visit with her friends due to her being placed on an intermittent level of observations. He also reported how having to do this upset his daughter:

*"They [friends] came at the weekend. There had to be an adult in the room because they're under 18, which Jessica was upset about, but to be honest she*

*was on quarter hourly observations so I kind of thought I'd have to be there anyway so I just said – I put headphones in and brought the papers and I could hear them talking but I didn't really listen but as long as I could see that she was safe I was happy with that.” (Interview, Parent)*

This interview with the parent took place in the family therapy room. This room was utilised by a therapist and was dedicated to family therapy sessions in the day and was used as a visiting room in the evening. This room was attached to another consultation room where a two-way mirror had been installed on the wall to allow for observations to take place into the family therapy room. The parent wondered whether it would have been possible to prioritise the family therapy room for when friends visit in the evenings, as parents could observe from the joining room to whilst still maintaining privacy:

*“I think it's difficult for teenagers to talk with a parent there. It is hard but, I wonder, that's a viewing room next to the family therapy room isn't it? [parent points at two-way mirror on the wall] I wonder whether it would have been all right just to watch from a distance? I don't know, possibly. It seems a bit of a shame to have to sit there with them.” (Interview, Parent)*

### **5.3.6 Ward staff views on supervising visits**

When asked about CYP's visits having to be supervised by an adult, some staff members were very clear about the visiting policy and the restrictions around supervising CYP:

*“Friends can come and visit the young people on the ward. However, there are restrictions in that the young people that come to the ward, if they are under the age of 18 they must be supervised by an adult and an adult must be in the presence of the visit at all times.” (Interview, Healthcare Support Worker)*

Despite the restrictions, other staff seemed to empathise with CYP and stated that supervised visits were important due to the parents' concerns around the appropriateness of friends visiting:

*“It's difficult because lots of the friends are under an age that we would necessarily feel is appropriate for them to just spend time, just alone on a ward. For example, we recently had a young person that came in and potentially her friendships were felt by parents as not necessarily to be the healthiest, so it*

*would involve a parent being in the room with the young people or even a staff member. I know it's not necessarily what the young person wanted, and it wouldn't be what I wanted, you don't want a parent necessarily sitting in there when you're a teenager." (Interview, Therapist)*

Caregivers also played a vital role ensuring CYP connected with their friends through helping arrange visits and provide friends with transport to the unit. Kayleigh, spoke of how she managed to stay 'in the loop' with her friendship group due to her mother's efforts with transport:

*"Int: Could you talk to me about how you manage to keep in touch with your friends while you're here?*

*From my phone and I've rung my mum as well. My mum's tried very hard to keep the girls in the loop. My mum brings them in to see me when they text her and ask her." (Interview, Kayleigh)*

It appeared visits from friends had the potential to impact the visits with other family members, however. The mother of Jessica described the process of friends visiting, and only wanting the occasional visit from friends as she felt it was important that other family members also visited. Jessica's mother also described having to give up her own time when friends visited:

*"Int: How has she managed to keep in touch with them then?*

*So, they've [friends] offered and it's been mostly me then saying, "You come when". If they come, I don't get a visit really. I gave up Saturday's visit for her friend to be there and I just put headphones on in the corner and spoke to her for five minutes at the end... ..she needs to have a visit maybe once a week, but I've not done it more than that because the family need to come too."*

*(Interview, Parent)*

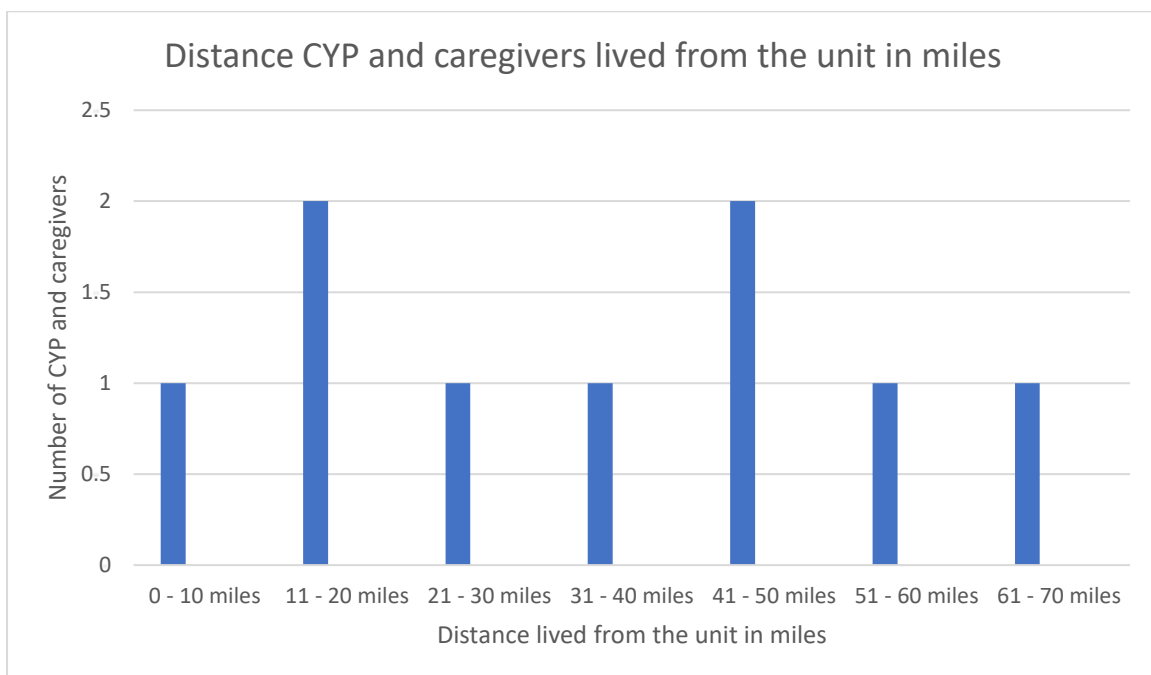
When discussing the barriers associated with friends visiting, a Staff Nurse mentioned caregivers sometimes wanting to limit the visiting to family rather than to focus on friendships:



*“It can be quite difficult because sometimes their parents can feel quite protective of the young person and naturally, cannot really want any visiting time and want to keep it to themselves.” (Interview, Staff Nurse)*

### 5.3.7 Distance impacting friends visiting

Another key issue preventing CYP staying connected to their friends physically was the distance they lived from the unit. Of the nine CYP interviewed for the study, four lived a significant distance of more than an hour drive from the unit. A breakdown of the distance the nine CYP and families lived from the unit can be found below in figure 5.1.



**Figure 5.1 – The distance CYP and caregivers lived from the unit in miles**

Sarah, who lived over a two-hour drive away from the unit reported that she had not seen her friends very much and one of the reasons for this was due to the distance between the unit and where she lived. She also stated that she would have liked for them to have visited her if they could:

*“Int: How often would you say you keep in touch with your friends from back home?”*

*Not very often.*

*Int: Ok...*

*It's just that its quite a long way for them to come, really.” (Interview, Sarah)*

Sarah's parents reflected on whether they could have brought friends in to see her. However, they stated they would have felt uncomfortable with having to sit with their daughter and her friend in the visiting room and they also felt that the distance was too far:

*“It is a long distance to come down and maybe we could have brought a couple of friends down, but we didn't... ..it might have been difficult and of course it is always awkward when you are just meeting in a room with them.” (Interview, Parent)*

Other caregivers felt the distance between the unit and where they lived was a barrier to friends visiting. Emma's father highlighted that his daughter was at the age where people would begin to start driving but may not have their own transport yet. He also referred to the poor public transport links in the area and his daughter's friends would visit more often when she was in a paediatric unit before her admission to the CAMHS unit as it was located closer to her home:

*“Int: What do you think the reasons are for Emma's friends not coming to visit in this unit?*

*I think there's a couple of things... ..the logistics. It's an hour's drive away and for young people that haven't got a car, some have just passed their driving tests, but most of them aren't drivers. Really, it's over an hour's drive away. I mean they could come by train but that's not always easy. They're at college and they've got lives themselves.*

*When the proximity was easier, in the local hospital as a paediatric patient, they [friends] were visiting. I think if this unit happened to be close by, and they could drop in after college or that type of thing, then I think they would. I think there's that barrier of distance.” (Interview, Parent)*

Other caregivers reported feeling awkward having to potentially ask other parents if they could visit with their son or daughter instead and described physical distance as being a barrier to friends visiting:

*“Int: What do you think the barriers or issues are for Jessica keeping in touch with her friends when she's in hospital?”*

*Probably distance, physical distance. It's quite a big ask, I mean I've done a couple of bringing friends myself, I feel awkward about asking the friends parents to drive like over an hour, stay for an hour, I'm asking them to kind of give up four hours of their time and obviously there's petrol and they've got other children to think about.” (Interview, Parent)*

Staff members also acknowledged the difficulties for CYP and caregivers whose friends lived far away from the unit, and that for others on the ward were able to meet their friends frequently due them living closer by:

*“I think coming here onto the ward given that some young people can live geographically, miles and miles away if they're very, very West [of the Country], that can be really difficult to maintain contact with peers. So yeah, distance is probably a massive one. Obviously we do have young people that are a lot closer by and in that case it's, it is easier for their friends and family to just pop in or keep a more regular contact rather than it being a really big thing.”*  
*(Interview, Staff Nurse)*

### **5.3.8 Home leave**

The other primary method in which CYP were able to physically keep in touch with their friends was through having periods of leave from the unit. Discussions on whether to allow CYP to have time off the unit were made during MDT meetings. Regardless of whether CYPs' admissions to the unit were on a voluntary or involuntary basis, MDT discussions regarding home leave were usually made in partnership with the patient and their caregiver. The organisation did not appear to have a specific policy & procedure document on CYP having permitted leave from the medical staff to go home from the unit. Despite this, having time off the unit to go home was referenced in both unit information booklets when discussing supporting them to return home:

*“Our aim is to help you get well as quickly as possible and return to your own home and life away from the Unit as soon as you can... ..when you are ready, we usually send you home for short periods of home leave. If this goes well, we*

*will gradually increase the time you spend at home until you are spending most of your time at home.” (Information Booklet 2014, page 11)*

The unit's revised Information Booklet (2019) further recognised CYP gradually having home leave. In this document however, more of an emphasis was on CYP going home as being part of the process of the two-week assessment:

*“We consider time off the unit to be an essential part of the assessment process and will seek feedback from you and your parents/carers... ..a gradual approach will be taken to increase the time that you spend off the unit and at home.” (Information Booklet 2019, page 14)*

### **5.3.9 MDT discussions on CYP having home leave**

Discussions between the MDT on patients having home leave usually took place during daily meetings and within the weekly MDT ward round. In these meetings staff would discuss whether a CYP should have leave based on a range of factors such as if they have had any leave previously, and if so, how it went, the period of leave, whether caregivers have the capacity to facilitate the leave, what the current level of risk was, and whether the period of leave can be supported by a CMHT.

Discussions by the MDT on matters such as clinical presentation had the potential to impact CYP going home to see their friends. In some instances, CYP with eating disorder presentations often had to gain weight, sometimes in consecutive days to be able to go on home leave. This issue will be discussed in further detail in Chapter six.

When questioned around home leave, a Staff Nurse explained that keeping CYP connected to their friends through home leave was an intervention that was promoted by staff at the unit. He explained that the unit tried to facilitate leave and tried to keep some normality in CYP's lives:

*“We want to try and keep life as normal as possible for the young people while they're here, and that means keeping their friendship groups going by facilitating leave. We'll always try and facilitate leave and we'll always try to keep them going to things like clubs. We've got young people that we've facilitated into gymnastics groups. We'll try and get them out as much as we possibly can to keep those links in.” (Interview, Staff Nurse)*

Despite unit staff wanting to reintroduce normality in CYP's lives such as outside friendships and school by promoting leave to go home, one staff member reiterated that this was often based on the level of risk:

*"Int: Do young people have leave from this unit to go home?"*

*Yes, it would be to be encouraged that they would go home to be with their families, but also go home to establish their peer relationships again and go back to school. [the consultant] is very keen on people returning back to normality, so they would be granted leave quite quickly depending on the risk."*  
(Interview, Education Staff)

One member of the therapies team stated that home leave is usually considered by the MDT when they are working towards discharging a CYP from the unit. She also stated that despite the MDT encouraging CYP to have leave, it does not happen often enough:

*"Young people have had visits from friends and certainly when you get further towards the sort of discharge process, we [MDT] would encourage, yes, going home to see family but also to reconnect with friendship groups, whether it be going to the cinema or doing something with their friends, so yeah it does happen, but probably not as frequently as we would like."* (Interview, Therapist)

#### **5.3.10 Adolescents' views on home leave**

Nearly all adolescents who participated in the interview part of the study, stated that they had gone home on leave at least once over the course of their admission. One described how being at home meant she was able to see her friends more often:

*"Int: How different is life on this unit compared to life back home?"*

*At home there is a lot more freedom. I get to see my friends a lot more, see my boyfriend a lot more. I can just, I can do what I want."* (Interview, Kayleigh)

For Sarah, being on home leave was important in seeing her friends as she did not use her mobile phone very often or have visits from her friends when on the unit:

*"Int: Have you managed to keep in touch with your friends?"*

*When I go home on leave I meet up with some of them. But when I'm here I don't really talk to them, because I don't really use social media or anything...  
... I suppose it would be nice to see them more often, but I think I would prefer to do it when I go home, because then it's in more of a normal environment."*  
(Interview, Sarah)

Emma described how along with having enough time when on leave to see her friends, an element of her treatment programme called 'rest'<sup>2</sup> impacted her going out of her home to meet her friends:

*"Int: What do you like doing when you go home?"*

*I just tend to relax at home. Sometimes I see my friends but it depends on their schedule and mine and how long I have the leave for and it's hard because 'rest' still applies when you're at home so that it's hard to work around that throughout the day." (Interview, Emma)*

CYP were also able to keep in touch with their friends face to face by seeing them in their own schools. This was usually dependant on the duration of leave from the unit that had been agreed between the patient, caregiver and MDT. Sarah, commented on how her friends from school missed seeing her. Sarah enjoyed going into her own school when she went on leave, and having increased periods of leave from the unit as she was getting closer to being discharged:

*"Int: I'd like to ask you about your friends from back home, how are they?"*

*Yes, they're all good. They really miss me in school though.*

*Int: How often would you say you keep in touch with your friends from back home?"*

*Not very often right now. I like it when I go into school because then I see them more. I usually do that for a few hours when I'm on leave from here." (Interview, Sarah)*

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<sup>2</sup> Rest – a period of thirty minutes or an hour, when CYP admitted with eating disorders would sit and rest as part of their treatment plan.

Nia commented on how not being in school meant that she was unable to keep in touch with most of her other friends and instead, had to focus on keeping in touch with her closest friends:

*“Not being at school is quite a big one for not being so frequently in touch with them [friends] and it’s not as easy to keep in touch when you’re not in school so it’s only with my closest friends that I do keep in touch with now.” (Interview, Nia)*

Staff members acknowledged that CYP not being in their own school was a barrier to them keeping in touch with their friends. An education staff member noted that it does not take long for CYP to feel isolated and left out of their friendship groups, especially if they may have not been engaging with their friends prior to their admission:

*“...even one day away from a group of teenagers can make you feel like you don’t know what’s going on. It’s probably an issue of feeling left out, isolated, that starts quite quickly with teenagers. They might have started whilst they were at home anyway, because they might not have been attending school, or engaging with friends.” (Interview, Education Team)*

A social care staff member also noted that often CYP had not attended their own schools months prior to being admitted to the unit, and therefore had already struggled to keep in touch with their friends in their own school:

*“Well, I think school is a real big one, some of the cases with young people they’ve been managing distress for so long, maybe they haven’t been able to access school for some months prior to coming into the inpatient environment, and I think that in itself creates a barrier, because tentatively they may have been keeping in touch with their school peers via social media, texting, or Facetiming.” (Interview, Social Worker)*

For some CYP, the risk of being observed and supervised due to their level of risk continued beyond the unit. One parent described how although his daughter was able to have leave from the unit to see her friends, he or his wife still had to be present when she would arrange to meet up with her friends due to her level of risk.

The father of Emma also noted how his daughter was not pursuing these relationships anymore:

*“Int: How are Emma’s relationships with her friends from home?”*

*Emma has had some home leave and on some of the occasions, she’s made arrangements to meet with people, but she still can’t be unsupervised on a home leave. If Emma was meeting her friends, let’s say, if she went out to a coffee shop with them, myself or her mum would have to be there and that’s not a natural environment for young people to be chatting about whatever they want to chat about. It’s definitely been limiting.” (Interview, Parent)*

This theme has discussed the physical ways in which CYP were able to keep in touch with their friends. It has discussed the organisation’s policies in relation to friends visiting and how CYP’s friendships are considered by ward staff during the admission process. It has explored the views of ward staff promoting visits from friends and CYP’s experiences of friends visiting. The role of the caregivers in facilitating visits from friends, CYP having home leave to see friends along with geographical issues such as distance and physical barriers of lack of contact with school to keep CYP connected to their friends have also been discussed.

#### **5.4 Theme three - Relationships with peers in hospital**

This theme will discuss CYP’s relationships with other patients on the unit. It will report some of the interventions utilised by staff promoting peer interactions and it will explore CYP’s, caregivers, and staff members views of peer relationships in hospital, including some of the positive and negative aspects associated with CYP living together in hospital.

According to staff members, interventions which helped CYP interact with their peers was through participation in ward-based activities. Along with the unit’s principles such as treating others with mutual respect on the ward, various activities for CYP promoting interactions were organised in the evenings and at the weekends by ward staff:

*“In the evenings and on the weekends, there will be a number of activities to promote relaxation and fun! This may also include time off the unit with staff,*



*day trips at weekends (depending on the individuals Ward Management Plan) or leave with your family and carers.” (Information Booklet, 2019 page 7)*

Staff members reported how unit activities such as arts and crafts, cooking, music groups and team games helped CYP interact with their peers:

*“... I think just the way that we’re set up is that we do tend to do things together, we go down to the sports hall to play rounders a lot... ...the kids seemed to really like rounders and naturally, you’re on teams and working as a team together. Other things like when we use the activity room or the art room, they would tend to be doing that together and just talking can often promote that sort of friendship.” (Interview, Staff Nurse)*

Another staff member whose role was to facilitate activities on the ward, commented that staff encourage CYP to be involved with group activities when they are admitted to the unit:

*Yeah we do actively [promote friendships], when somebody comes onto the unit, we encourage them to come over and do this, do that, come up to the art room. And I think as young people, they just naturally flock towards other children that they’ve got things in common with.” (Interview, Therapist)*

CYP described being able to make new friends with peers on the unit due to having things in common with each other:

*“Int: Is there anyone that you’ve made friends with on the ward?*

*I’d say so yeah.*

*Int: Ok, how has that been?*

*“I think we had a lot of similarities and hobbies, so it was quite easy to talk.”  
(Interview, Emma)*

Emma’s father also acknowledged that through participating in ward-based activities and by having common interests, his daughter had managed to form a friendship with another patient:

*“Int: How do you think it’s been for Emma staying in hospital with other young people?*

*Emma's been able to share that she has formed some sort of relationship with some of the young people. There are some young people who were playing musical instruments and Emma plays musical instruments, so they've bonded with that in some of the group therapies, media and TV shows, that type of thing."* (Interview, Parent)

#### **5.4.1 Making new friendships**

When asked questions around what it is like being on the unit with other CYP, over half of who were interviewed stated that they had formed at least one friendship with another peer on the unit. CYP reported being in hospital with peers they had met on a previous admission which helped them to re-form a bond. Some even reported making friendships on previous admissions which lasted beyond their discharge. For Jenny, being on the unit with other CYP was helpful in feeling at ease:

*"Int: Have you managed to mix in with other young people?*

*It's a really welcoming unit. It's nice because you've got a bit of everything like not everyone's the same, not everyone's got the same story, the same background, it's nice to just mix with everyone and just feel at ease with everyone on the ward.*

*Int: Is there anybody that you have made friends with?*

*Yeah, I've made friends with a couple of patients, all from different backgrounds and it's just been really nice."* (Interview, Jenny)

Other CYP reported being on a mental health unit with others helped them to feel less isolated and alone during periods where family were not always around to support them:

*"Int: What is it like being on the unit with other young people?*

*It makes the time go by quicker and you don't feel as alone because without your own support system of your family and friends you do feel quite alone here."* (Interview, Emma)

Caregivers also reported feeling reassured that their child were having contact with their peers:

*“She tells us who she has done things with, who she knows best, who she likes, who she has chats with, that kind of thing. So that's reassuring for us that she is getting that contact with her peers.” (Interview, Parent)*

In addition, CYP reported finding it helpful to be around other peers who they perceived to have more of an understanding of mental health issues:

*“It's kind of nice to talk to people that sort of understand mental health.”  
(Interview, Nia)*

Caregivers also agreed that their child had managed to form friendships with others who had also experienced mental health difficulties, even after they had been discharged. The mother of Kayleigh reported that her daughter kept in touch with them through social media:

*“She's made some good friendships I think, people who understand, rather than her outside friends who try to understand but don't. So I think there's some ongoing friendships even if it's just via Facebook or Instagram.” (Interview, Parent)*

According to some staff members, CYP's shared experiences helped them to form friendships on the unit. One therapist reported that CYP remained friends' post-discharge from the unit, and described how there was an acceptance between peers:

*“I think they find a sense of shared identity... I've seen total acceptance on a peer-to-peer perspective, and that must be such an intense relief, and I think friendships quickly develop. They may not always be the healthiest of friendships, and we as a unit have to be mindful of that, you know, but I'm mindful that kids go on leaving here maintaining friendships that they've developed.” (Interview, Therapist)*

A Senior Staff Nurse further described how CYP were able to form bonds and connect with each other as they potentially had similar experiences and difficulties:

*“I often think the young people that come into the ward have been experiencing difficulties with their friends or just with life in general, things have been a struggle. So often when they do come onto the wards they find, it's like all of us*

*isn't it, we find people we have similar experiences, you can connect on a certain level and often their experiences, their difficulties, their suffering brings them together because they've found other young people that actually understand them on a level that other people haven't. So quite often yeah we do have young people that form friendships and quite strong bonds on the ward." (Interview, Senior Staff Nurse)*

In addition to ward rounds focussing on patients' clinical presentations, CYP's interactions with others on the ward were frequently discussed in MDT meetings by the health, social and education professionals:

*"A Student Nurse states she spoke with William yesterday and he stated that he is very lonely. Consultant Psychiatrist states that William has told him he has no friends, struggles to find new friendship groups, and struggles with social interactions with peers on the ward. Trainee Psychologist suggests William has regular key working sessions with nursing staff around friendship groups. Staff Nurse recommends William is signposted to friendship groups in the community when he is having periods of home leave." (Fieldnote, MDT Meeting)*

Some CYP felt that they were not ready to make friendships however, and stated that they were too unwell to make friends at the time:

*"I don't really hang out with the people that are here. I'm not really ready for that. I just sort of isolate myself in my room because that's what's best for me right now. I do know this girl that I met last time when I was here. She's here today so... ..she was asking for me and I was like "I'm busy" and stuff. I don't want to speak to anyone right now other than my mum." (Interview, Carly)*

Despite some not feeling ready to make friendships, in some instances this appeared to happen naturally. When asked whether she had made any friendships on the unit, Heidi reported that she wanted to focus on getting better and was not expecting to make any friendships, but ended up making some friendships regardless through interactions with her peers:

*"To me it was not [important to make friends] because I kept saying "I'm not here to make friends. I'm here to get better and that's it". But I ended up making friends so that was quite nice." (Interview, Heidi)*

Some CYP reported struggling initially with their interactions with their peers. Although after being encouraged by ward staff, reported feeling more comfortable talking to others unit's communal lounge:

*"When I first came in, I was keeping myself to myself really and I wasn't talking to anyone.*

*Int: Did anyone help you with getting to know the other young people?*

*Some of the staff helped me. They wanted me to go into the lounge to say hi to the girls. They were like 'It'll do you good'. So I just tried it and it helped me right away.*

*Int: Ok*

*So yeah, then I slowly came around inside and started to talk to people."*

*(Interview, Joanna)*

In some instances, the nature of the assessment model of the unit had the ability to hinder CYP making new peer relationships on the ward. Some described it being difficult to make new friendships with peers due to the two-week admission process and high turnover of patients, with some being discharged either before or after two-weeks of admission to the unit:

*"It's a bit hard sometimes, especially in somewhere like this, because you never know when somebody is going to leave. You never know if somebody is going to be discharged, or how long they're going to be here." (Interview, Sarah)*

#### **5.4.2 Difficulties of being in hospital with others**

During the interviews with CYP, some stated that they found it difficult being on a ward with their peers. Some stated that this was due to the difference in age ranges of CYP, but also witnessing others being distressed and displaying symptoms of mental health issues:

*"It can be challenging because obviously you've got older patients, you've got nearly 18-year-old patients and you can have 11-year-old patients. You might have a 17-year-old who might be very unwell and can be quite aggressive or [be having] psychotic episodes, challenging behaviour or self-harm episodes and it can be quite daunting and scary for a younger child. It could scare them*

*when you see older patients like going through things like that.” (Interview, Jenny)*

Some CYP described ‘triggering’ others and feeling also ‘triggered’ themselves, terms of which were used to describe a person’s emotional state being affected by distress:

*“Int: What has it been like for you staying here with other young people?”*

*It can be difficult. People have been banging doors trying to get out. Sometimes it would all get scary.*

*Int: I see...*

*It has been hard because some of them are really unwell, especially when like one young person has an incident and it upsets another young person and then it’s like dominos. Sometimes it’s good, but sometimes it’s quite triggering.*

*Int: What do you mean by the term triggering?*

*Like you could upset someone or it could trigger an emotion that they don’t want to have and they say a lot of bad things that you don’t really want to hear.” (Interview, Jenny)*

During an MDT meeting a staff member also reported a CYP feeling ‘triggered’ by other young people which was causing her to have an increase in risk-taking behaviours:

*“A young person reported to a Nurse that she is being ‘triggered’ by other young people on the ward and has been an increase in risk taking behaviours such as purging, pacing, exercising and self-harming.” (Fieldnote, MDT Meeting)*

#### **5.4.3 Forming unhelpful relationships with others**

An issue that was frequently discussed in the interviews with ward staff and between staff members in daily handovers and MDT meetings, was CYP forming ‘unhelpful’ relationships with their peers. Senior Staff Nurses described how the ward staff tried to manage these unhelpful relationships:

*“There can definitely be some unhealthy friendships that happen and people connect in an unhealthy way, and it’s about trying to figure out what’s helpful*

*and what's unhelpful. They could keep two young people apart by different activities, sitting them in different places in the dining room, for example."*  
(Interview, Staff Nurse)

When discussing CYP being around their peers on the ward, a Staff Nurse reported that although CYP can sometimes help each other, they can also escalate each other's distress:

*"An in-patient environment is quite unique, it's definitely a shared experience when you're on the ward with another young person at the same time. I think that has both positives and negatives, positives being that they can help with one another's experience, and I guess they can help one another tolerate any distress on the ward. But likewise, it can also escalate your distress when you're around someone who could be quite escalated at a given time."*  
(Interview, Staff Nurse)

During an interview with a member of the medical team, a Doctor reported that there were incidences of CYP encouraging each other to self-harm, and explained how there were specific policies to manage this such as special observations:

*"[sighs] the philosophy is that you promote normality... ..I remember recently, one patient brought nail varnish to another patient. Sad thing is, it wasn't to be used nail varnish. It was to be used as glass to cut herself with. They do supply each other with blades and things like that sometimes. So we have to control that with a different procedure, by checking when they come in and out and back from leave. But generally we encourage them to engage in something positively. That's how we try to manage it."* (Interview, Medical Team)

Interestingly, a therapist offered a different point of view with regards to CYP aiding others to self-harm on the ward and described how they often wanted to help one another:

*"We've had some young people for instance who say they're struggling with self-harm, other young people help them or aid them to do things, or give them items that they could self-harm with and I don't think that comes from a negative place, they understand possibly what that serves the other young person, so they want to help."* (Interview, Therapist)

CYP forming unhelpful relationships with peers was also an issue that was frequently discussed by staff members in MDT meetings. An example of these discussions came when there were incidents of violence and aggression on the ward involving a group of CYP:

*“MDT discuss a series of incidents on the Weekend involving multiple patients in the communal lounge. A Staff Nurse states patients were ‘pushing boundaries’ and ‘egging each other on’ to cause damage to unit property and display violence and aggression towards staff. A Healthcare Support Worker states a patient instigated the incidents and ‘sat back and watched it play out’. Ward Manager states that all patients apart from two were involved in incidents. The Staff Nurse states one young person appeared to be pre-occupied and influenced by a group of peers at the time. Consultant Psychiatrist states he is concerned that this young person is becoming like other young people and is increasing her risk-taking behaviours especially when “her family and social construction is so different to that of other young people’s”. Ward Manager states that Violence and Aggression Manager is attending the ward today to speak to the young people involved in the incidents.” (Fieldnote, MDT Meeting)*

Of the CYP who did not participate in these series of incidents on the ward, the incidents nevertheless appeared to affect their wellbeing:

*“A young person reported to a Nurse that they are finding it difficult on the ward as it is loud and noisy and uses a blanket to avoid the current ward environment and certain young people. Young person reported to a Healthcare Support Worker that she felt intimidated by other YP and stated, “I don’t want to end up like that”. MDT feel ward environment is causing her distress which is causing her mental health to decline.” (Fieldnote, MDT Meeting)*

During interviews with caregivers, some stated that they were worried about their child becoming involved with other CYP and that they knew there was a risk of their daughter learning different coping strategies from her peers:

*“It worries me because I know one of the things coming in here is there’s always a risk to everything, a risk that she’ll pick up more bad habits and I think she has, she’s learned a few more behaviours. I think also she has had an*



*audience to play to sometimes, so she has upped her behaviours.” (Interview, Parent)*

#### **5.4.4 CYP comparing themselves to others**

In some instances, staff had discussions in MDT meetings about CYP with eating disorders ‘comparing’ themselves to other patients who were also admitted for difficulties with their eating. There were instances on the ward of patients refusing to eat their food which on occasions meant that staff had to feed them through a Nasogastric (NG) tube. CYP were purposely maintaining eye contact with other patients who had eating disorders during mealtimes and were refusing to comply with the rest period after meals:

*“MDT discuss Emma’s clinical presentation on the ward. Staff Nurse states young person’s mood is low. Staff nurse also states she has been “pushing boundaries” at times such as not following her meal plan or rest periods. Emma stated to a Healthcare Support Worker that she struggles with comparing herself to other young people with eating disorders on the unit. MDT agree that this is likely due to another young person with an eating disorder who has recently been admitted to the unit.” (Fieldnote, MDT Meeting)*

One staff member reported that although there were issues with CYP ‘competing’ against each other, there were other examples of CYP with eating disorders being a support network for each other when recovering from their eating difficulties:

*“I think they can be a supportive network. Most of what I’ve seen with the pros and cons, with the children with eating disorders, is that they can be really helpful if they’re helping each other recover. But the flip side of that is if they’re competing against each other as to who can be the best anorexic, then that’s when you’ve got problems.” (Interview, Healthcare Support worker)*

When discussing his daughter being in hospital with other CYP, the father of Emma spoke about how he and his wife felt nervous that his daughter would be around other CYP with eating disorders when on the unit.

*“I think she has had quite an important feeling of contact with other anorexic patients that I think that might have been something that she wanted before she was admitted that she wanted to meet other anorexics, which was something*

*that we were obviously nervous about because they can have very negative influence.” (Interview, Parent)*

In summary this theme has explored CYP’s peer relationships in hospital. It has described how ward staff promoted ward-based activities encouraging interactions between CYP, and how through having common interests and a sense of a shared experience, CYP interacted with their peers. It has explored CYP’s views of being in hospital with their peers, including making new friendships and the difficulties involved with CYP forming relationships that were potentially unhelpful to their wellbeing.

## **5.5 Chapter summary**

In conclusion this chapter has reviewed and explored the data generated from interviews with CYP, caregivers, various ward staff and documents such as policies and fieldnotes.

The first theme in this chapter discussed how CYP remotely kept in touch with their friends when they were in hospital for care of their mental health. Interventions keeping CYP in touch with their friends remotely such as mobile phones and tablets, writing letters and cards were outlined. This theme also discussed social media and some of the issues associated with CYP’s social media use whilst on the unit. The organisation’s policies and procedures were outlined which provided guidance for the appropriate use of mobile phones and tablets.

Theme two within this chapter focussed on exploring the physical means in which CYP maintained connections to their friends, through visitation and having periods of leave from the ward to go home and to see friends in their own school. This theme also provided a review of the organisation’s policies on visitation and CYP having leave from the unit to go home.

The final theme of this chapter explored CYP’s peer relationships in hospital. It described how ward staff encouraged interactions between peers through activities, and how CYP were able to interact with their peers, especially when having common interests and shared experiences of mental health difficulties. CYP, caregivers and staff’s views of CYP being in hospital with others were also explored. This theme discussed CYP making new friendships and explored the difficulties associated with CYP potentially forming relationships that were unhelpful to their wellbeing.

In Chapter six, findings of interviews with CYP, caregivers, ward staff and policy and procedure documents relating to CYP keeping in touch with their families will be discussed.

## **Chapter six – Connections to Family**

### **6.1 Introduction**

The previous chapter explored CYP's connections to their friends when in hospital for care and treatment of their mental health. This chapter will focus on connections to their family. Data collected from CYP, caregivers and staff members which was generated through interviews, observations, and documentary data will be presented in the following three themes: Theme one will focus on remote connections with family. Theme two will explore physical connections with family and theme three will focus on the emotional, employment and financial implications an inpatient unit admission had on caregivers. It is important to note that whilst some CYP were a part of a nuclear family and were in frequent contact with their caregivers, this was not the same for all CYP who participated in the interview phase of the study. Of the nine CYP who were interviewed, four had either been in the care system such as a residential or foster placement prior to being admitted or were due to go into a foster care placement upon being discharged from the unit.

### **6.2 Theme one – Remote connections with family**

As explored during the previous chapter, a key method of communication enabling CYP and their friends and family members to keep in touch was through personal mobile phones and the ward mobile phone. The previous chapter also identified and outlined the key principles of the organisations policy with regards to the use of mobile phones.

Many CYP who had access to their mobile phone utilised the allocated hour between 6-7pm to call, text message and occasionally video call caregivers through applications such as Facetime and WhatsApp. When discussing this with Emma, she informed me that she was able to contact her parents and other family members each night by using her mobile phone:

*“Int: How have you managed to keep in touch with your family?”*

*Phone time.*

*Int: Ok*

*I ring mum and dad each night, and sometimes I text my brother. I ring my aunt occasionally.” (Interview, Emma)*

Parents informed me that he kept in touch with their child through the messaging application WhatsApp and regularly used this app in the evenings to text and video call her. They also informed me that they created WhatsApp group chats between their daughter and the rest of the family which allowed them all to communicate under a single conversation:

*“...she’s going through a very difficult time and it’s massively important we feel that she knows she’s cared for and part of the family... ...and just because she’s in hospital having treatment, it doesn’t mean she’s not part of the family. So you know, we think it’s really important to keep in touch... ...but also to know about other things going on in the family, everyday life. We use group chat as a family so, her sister can join in. So, we think that’s really important and I think it’s helped as well.” (Interview, Parent)*

As discussed in the previous chapter, CYP reported struggling with the time constraints around mobile phone access and friends’ availability during the one-hour timeframe where they could use their phones. This appeared to be the same experience for some those trying to keep in touch with their family when using their mobile phones. CYP found it difficult during conversations with parents due to these time restrictions:

*“It’s strictly 18:00-19:00 so... ...it’s quite hard because I’m like on the phone to my mum and then I’m like, “I have to go now. Sorry”, and I just like, leave the conversation.” (Interview, Joanna)*

When discussing the allocated phone hour with a staff member, they highlighted that unfortunately some parents were not always available between 6-7pm due to other commitments such as work and therefore were not able to speak to their child. Some parents described struggling with only being able spend time talking to their child at certain times of the day and disliked this aspect of their child’s admission to the hospital. They also highlighted the previous mobile phone policy where access to mobile phones was increased and felt it was unfair that all CYP were affected with restricted access to mobile phones despite some not being involved in the incident regarding inappropriate social media use:

*“Certainly, as far as communication goes not being able to get hold of her apart from the set times. I think initially the first two weeks it is very restricted when*

*they can and can't have phones. Then it was a bit more open. Then there was some incident and it was restricted really tightly. So, she was only allowed it for an hour a day and that... I just found that really hard because you are thinking, oh you know, I can't start doing anything at home because Emma is going to ring... ..rather than just being able to think, oh well I will just do this... ..and that seems very harsh on those that obviously weren't involved in the incident that everybody has to be treated the same.” (Interview, Parent)*

Another parent reported having to get used to the ‘small window’ of mobile phone contact with her daughter due to the limited access to mobile phones and described this being difficult, especially when she had other responsibilities to attend to during the evening:

*“The limited access to mobile phones does make it quite hard because if we're, I don't know, say cooking supper or doing something else or another phone call comes during that hour window, you know... ..several times it was like, 'oh no, we forgot to say that to Nia and now it's 7 o'clock and we won't be able to.' I mean we know that we can get messages to her by phoning the ward but that direct communication, you know, it's a matter of getting used to, and being organised about having that small window between six and seven.” (Interview, Parent)*

### **6.2.1 Limited privacy**

The organisation's policy on mobile phones stipulated that their use had to take place in the ward's main communal lounge under supervision from staff members. Due to this ward rule, some described finding it difficult to have private conversations with their family. One parent informed me that his daughter struggled with having telephone conversations with him in the ward's communal area due to privacy and described this as being a barrier to communication with her:

*“Emma doesn't feel comfortable having conversations or discussions when she's in a communal area, so if we phone her at six o'clock... ..particularly if she's had a tough day, it can be very much we lead the conversation, she says, “Yes”, “No”, but it will be a superficial conversation, It's not ideal.*

*Equally, a lot of the time, they can't be in an area with privacy... so, I don't know. It's a difficult one to find a solution for but it's definitely a communication barrier." (Interview, Parent)*

Another parent informed me that her daughter preferred to communicate by text messaging and through using mobile phone apps such as WhatsApp, as opposed to talking over the phone with her due to the lack of privacy in communal areas:

*"Int: What has it been like keeping in touch?"*

*Difficult. She doesn't really like speaking on the phone that much, it's only ever quick calls, but mostly we've been text messaging or through WhatsApp."*  
*(Interview, Parent)*

When discussing the one hour allocated time for mobile phones with participants, some described finding it upsetting being unable to have private conversations with their parents:

*"Well phone time you have to use your phone in like communal areas so if you want to call somebody in your phone time, people can hear your half of the conversation which, if it's quite personal it can be quite upsetting that you can't have that privacy when you have your phone calls." (Interview, Heidi)*

Patients who appeared to struggle with staff members supervising the communal lounge during the phone time, highlighted the possibility of upsetting other patients when wanting to discuss sensitive issues with their parents:

*"Int: Are you able to have telephone conversations with your family?"*

*Yes but I wouldn't say they're private because the phone time, it has to be supervised in the lounge so it's like you can't really speak about anything private... ..you should be able to talk to your family about stuff that's happened but you can't because you're in a room full of other patients that could get triggered. I find it quite hard that I can't just ring my mum and have a conversation about it without staff just watching everything I'm doing."*  
*(Interview, Jenny)*

Whilst she acknowledged the lack of privacy when using her mobile phone, Lilly

informed me that in a previous policy, patients were able to have their mobile phones in their bedrooms which enabled them to have more privacy when talking to their family:

*"...we're not even allowed them in our rooms for the hour. Before you could have them anywhere.*

*Int: How has that been for you?*

*It's a bit awkward because you can't really talk about anything that personal, because people are going to be listening. You just have to try and talk quietly."*  
*(Interview, Lilly)*

CYP informed me that whilst they acknowledged the lack of privacy when using their mobile phone to contact family, some were able to use the ward telephone and one of the units meeting rooms when contacting their family which provided them with more privacy:

*"There's a mobile phone here that I can go on, it's a phone in the meeting room. So when the staff are available you can use that, but only for three five minute phone calls, or one 15 minute phone call. That's the only really private one you get is if you go over to the meeting room."* *(Interview, Carly)*

### **6.2.2 Ward telephones**

Telephones situated in the ward office were used routinely by staff to communicate with caregivers and to provide them with regular updates or significant changes to certain aspects of their child's care such as medication or outcomes of the weekly ward round. This was often done more informally however, when updating caregivers on how their child had been throughout the day. When interviewing a Senior Staff Nurse, I was informed that she regularly provided families with updates as it helped them to keep in touch and feel involved in their child's care:

*"I like to make sure the family are kept up to date with everything that's going on... I think that it helps in turn with the family keeping in touch."* *(Interview, Senior Staff Nurse)*

As discussed in the previous chapter, some CYP who did not have access to a personal mobile phone or wanted to contact their family outside of the allocated time for mobile phones, were reassured by staff that they were able to contact their parents by using the ward-based mobile phone:



*“They can use their own mobile phone to contact their parents, but they can also make use of the ward phone. So, the ward phone is available to young people whenever they need to speak to their parents.” (Interview, Therapist)*

When discussing CYP’s limited access to mobile phones and their contact with their parents, some staff members acknowledged that it was difficult for CYP, but they tried to ensure they were able to speak to their parents outside of the allocated hours through access to the ward mobile phone:

*“It’s really difficult and all they want to do is speak to their mum. I mean we’ve had young people in as young as 11, which is really sad and we do our best to facilitate using the telephone. If they come to the point, and it’s in the day, and they desperately want to speak to their parents they could phone up and they could even come into the ward. We’re not a case of, “right well no more”. We are very boundary driven, there has to be boundaries for it to work. However, if a young person is that distressed and they want to speak to or see their family then they can, it’s not something that we are ogres about. So it is difficult for the young person to keep those links but we do our best.” (Interview, Healthcare Support Worker)*

Although there was a ward phone that CYP could use to contact their parents outside of the allocated phone time, it appeared to only be available for 15 minutes a day, either through three 5-minute or one 15-minute phone call. When discussing the organisations phone policy with a staff member, they acknowledged the restrictions on access to both mobile phones and the ward phone:

*“I think another barrier is the phone policy, so families will need to be aware of when the young people have their phones. If they need to use the ward phone, that’s quite limited, I think it’s about only 15 minutes they’re allowed.” (Interview, Staff Nurse)*

Despite the short period the ward phone could be used for, those like Nia who did not have access to a mobile phone and mostly relied on visiting and the ward phone to speak to caregivers, informed me that the ward phone was a helpful intervention which enabled her to keep in touch with them daily:

*“I found it quite hard being away from them... ..I felt like I needed to savour every moment they were there. The ward phone is quite a nice facility though, I used to phone them pretty much every day.” (Interview, Nia)*

During interviews with caregivers, some reported that they found it reassuring that their child had access to the ward phone that they could use to contact them, in addition the allocated hour for mobile phones in the evenings:

*“The availability of the ward phone, Emma can have access to a ward phone, any time of the day or night. If she wants to speak to us at any stage, it’s always available.” (Interview, Parent)*

Whilst acknowledging the availability of the ward phone, one of the unit’s therapists I interviewed reported trying to think of additional remote methods in which CYP could connect with their caregivers whilst in hospital. She informed me that she was thinking of setting up a video conference system for CYP to virtually contact their parents. The therapist stated that this system would be particularly useful as the population of adolescents admitted to the unit is spread across the region:

*“We do have a video system, a conference system here, which is used to facilitate conference-style meetings. It’s used for professionals, but I have often thought whether there could be a system set up even in the meeting rooms where it could have a video system where people could virtually meet with their families. I guess it can happen on Facebook, Facetime and those sorts of things... ..particularly because [the region] is notoriously spread-out, our population is in pockets, I do wonder whether we could make more use of technology.” (Interview, Therapist)*

In summary theme one reviewed the remote methods enabling CYP to keep in touch with their family whilst in hospital. This began with exploring CYP’s and caregivers experiences of using mobile phones to contact each other through texting, phone calls, and social media. Following this some of the issues associated with mobile phone usage on the unit were highlighted such as time constraints and the lack of privacy for CYP to converse with their parents.

This theme explored the telephone contact between nursing staff and caregivers, which often occurred when caregivers were informed of updates about their child

regarding their care. Finally, the ward-based phone was explored as a further method for CYP to remotely contact their caregivers. This was particularly helpful for the few who did not possess a mobile phone. Despite the availability of the ward mobile phone, the time constraints around its usage were also highlighted.

### **6.3 Theme two – Physical connections to caregivers**

This theme will explore the physical means in which CYP connected to their family. A key physical method of contact which enabled CYP keep in touch with their family face to face was through visitation, which occurred between the hours of 6-8pm on weekdays and at any time after 12 midday on weekends. Informal visiting between CYP and caregivers occurred on the unit, but away from the main wards in areas such as the reception, unit's atrium, in specific visiting rooms, and the Visitors' Suite. CYP and family members were aware of the visiting policy and its times and rules through the organisation's (2019) Information Booklet. In addition to visiting times, this document stipulated that visiting would take place away from the main ward areas to protect the confidentiality of other patients. Whilst not clearly stated in the organisation's 2019 Information Booklet, I was informed by staff members and parents that visiting had to take place away from certain times of the day such as school and mealtimes which were protected.

When discussing visiting with one of the management staff, I was informed that soon after a patient was admitted to the ward, visiting was promoted by the nursing team to give the MDT a better understanding of the CYP's and family's interactions:

*"It's [visiting] very much promoted. So we would look at first of all getting the family in to visit, seeing how the young person and the family are interacting with each other." (Interview, Ward Manager)*

When interviewing staff members, I was informed that whilst family members visiting was promoted by staff members at the unit, the frequency of visiting by parents was different for each family and was dependent on factors such the family's own capacity to visit:

*"Generally speaking, young people can have their parents here every single day, some young people, they may not see their family from one week to the next. We do as much as we can to promote visitation, and we acknowledge the benefits of having family and friends. But unfortunately, it is not our decision, it's*

*the family's decision, and we can only facilitate the visiting as and when they feel they're able to come."* (Interview, Education Team)

I was informed that the distance parents lived from the unit had the potential to impact them visiting, and that other family members would visit if parents were unable to. I was also informed that visiting became more difficult for some CYP if they were under the care of the LA:

*"...it really depends on where the parents live... ...some parents may come every evening, some parents may come every other day... ...if they don't come to visit then an auntie or an uncle, or another family member will come. But for some people, particularly if it's a looked-after child, they may not have a visit at all, they may have one visit a week if that."* (Interview, Therapist)

Most of the CYP who were interviewed in the study informed me that they had regular visits from their caregivers and other family members. When exploring how they kept in touch with their parents when they were on the ward, Kayleigh informed me that she had frequent visits from her parents and wider members of her family if her parents were unable to attend:

*"My mum and my dad come and visit me pretty much every day. It's about an hour's drive for them so it's still nice they make the effort to come and visit... ...my parents try and alternate or if they come at the same time and if they can't make it they try and ask another member of the family to come and visit like my grandparents."* (Interview, Kayleigh)

Another adolescent described to me the feeling of looking forward to seeing her parents and feeling happier after she had spent time with them:

*"...when my parents came that was really exciting because you're sitting around all day and then you're like, 'Oh my God, there's something to look forward to,' and then they came and then I chilled with them and then I come back on the ward and then I feel much happier because I saw my parents."* (Interview, Joanna)

The official periods for visiting were in the evenings on weekdays and additionally there were protected times of the day where visiting was unable to take place such as during school or mealtimes. Although there were protected times, one of the

health care support workers I interviewed, informed me that the nursing team tried to be as flexible as possible when accommodating parents visiting:

*“There probably are official visiting times... ..but my understanding and my experience is that we are very, very flexible, and we will always try to promote any visiting as long as its having a benefit.” (Interview, Healthcare Support Worker)*

When discussing the topic of visiting, one parent I interviewed also reported that nursing staff members were accommodating towards her and her husband and were flexible with the time allocated for visiting:

*“Int: Have there been any issues with visiting at all?”*

*No, as far as that’s concerned, there’s never a problem. There’s always a room. If Kayleigh wants to go out, that’s never been a problem, and the times, they’ve been very flexible on the times.” (Interview, Parent)*

As there was less of a structure on weekends and during holiday periods, such as no school or therapies for CYP to attend, there were more ward based activities organised by the nursing team. There were also more relaxed visiting hours, with the unit allowing visiting after midday. In addition to having more time to visit their daughter on weekends, a parent also reported visiting and taking their daughter off the ward after her CTP ‘review’ meeting, which was outside of visiting official visiting hours:

*“...we were told six to eight in the evenings... .. so we’ve been coming then but I presume half term there’s no school and weekends are more flexible, so nobody said we couldn’t visit and even when we came at 5 o’clock one day after the review, we took her out then. I don’t think it would be a problem if we wanted to visit more.” (Interview, Parent)*

Emma’s father informed me that his daughter struggled on occasions with the ward environment. He also reported trying to visit the ward as much as possible and to take her off the ward:

*“We visited the majority of days I guess. Emma was told it helps to see us and to have time off the ward, but doesn’t always find it here a very positive*

*environment so we've tended to visit as much as we possibly can. There have been other visitors for Emma as well, other family members, who are able to visit and who've been able to call her."* (Interview Parent)

Not all parents were able to visit their child frequently however. On occasions, some CYP were unfortunately unable to see their parents through visits due to their parents' work commitments. When discussing some of the issues CYP had with keeping in touch with their family, Heidi described how due to her mother working afternoon shifts, she was unable to visit most evenings during the week:

*"I think sometimes the visiting hours aren't great because my parents work... my mum and dad work different times and shifts, my mum works in the afternoon, she could come and visit in the morning but obviously I have school."* (Interview, Heidi)

In some instances, siblings also found it difficult to frequently visit. One parent described how due to a combination of their other daughter being in university and working, she struggled with having enough time to regularly visit. She also informed me that their other daughter had found it difficult seeing her sister in a mental health hospital. Despite this however, I was informed that she had managed to visit on occasions after attending a family therapy session:

*"...so her sister is in the midst of her exams at the moment, she also works part time, so generally work, study and visiting hasn't been easy. I guess it's also been the emotional aspect of things. She's found it difficult at times, so she hasn't been down to the unit an awful lot. She came down on the train and brought loads of activities and things and movies on the laptop and they had a really nice evening together. Jenny was talking about it this morning really fondly and her sister said, "Once the exams are over now, if you're still an inpatient I'll be able to come down much more often" So, that's been positive."* (Interview, Parent)

Another issue for some CYP and caregivers was the clash between the allocated time for visiting and access to mobile phones. In some circumstances, parents described the challenge between wanting to visit their child during visiting hours, but balancing this with their child wanting to spend time on their mobile phone:

*“In terms of the visiting time, that clashed with phone use so that was a bit of a challenge because if we were visiting the unit between six and eight... if we’ve come down at six o’clock to see Emma and she’s given her phone, then she’s [like], “Oh, thanks for coming”, and wants to be on her phone. So, we were trying to avoid that phone time if we could, or just accept that we could be in a room with her, but you know, not to press any sort of conversation while she’s on the phone.” (Interview, Parent)*

Staff members also acknowledged the issue of mobile phone and visiting times clashing. A therapist I interviewed reported to me that some families would avoid visiting between 6-7pm as it was likely that the CYP would want to spend that time on their mobile phones:

*“...what I heard from families was that the parents would avoid visiting between six and seven, because they knew the young person wanted to be on their mobile, because they’d want to look at their social media, they’d want to text their friends, and they didn’t want to prevent that happening.” (Interview, Therapist)*

She also described a dilemma facing families with having to juggle between allowing their child to spend time on their mobile phone during visiting, but in doing so would mean they would end up spending less time with them and with the previous policy of extending the period of time for mobile phones was more helpful for parents:

*“...that was quite a juggling act for some parents because what do they do? Do they come at seven which means they get less time with the young person, and if they’ve come from a long way is that possible? Also, they didn’t want the young person to lose out on their telephone time.” (Interview, Therapist)*

### **6.3.1 Visiting rooms**

Visiting mainly occurred in specific visiting rooms outside of the main ward area.

There were two rooms used for visiting which were just outside the main ward area but were still situated along a corridor leading to the ward and were behind magnetically locked doors. The remaining visit rooms were located further away from the ward area and were also the rooms used to conduct interviews with CYP, caregivers and staff members. When discussing visiting between parents and CYP,

a Nurse described the process of visiting and informed me that there were usually enough visiting rooms available:

*“We’ve got side rooms like this one, so when they come to visit, families will come and have a sit down. We’ll usually chat with mum or dad first, and then the young people will come in. Then just go from there.” (Interview, Staff Nurse)*

Another staff member informed me that visiting times were often busy periods of the day, requiring the nursing team to find rooms to accommodate CYP and family members. She also informed me that the type of rooms used for visiting was often based on risk and special observation levels:

*“We’ve got two rooms just before you go into the main ward that families can use, we’ve got a family therapy room, and we’ve got two rooms behind the family therapy room area that we can utilise as well. The difficulty is looking at what the observation levels are for the young person, so if their risk is high and they’re on a 1:1 obs, it’s probably not best that they’re off the ward, but remain in on the ward in one of those family rooms behind the maglock doors. That’s because observation levels can change quite quickly, so that’s always factored into it.” (Interview, Social Worker)*

When discussing visiting with caregivers I was informed that they felt accommodated by the ward staff with regards to private spaces for visiting, and one family informed me that they did not have any issues with finding a room that could be used for visiting:

*“Sometimes it’s, “Oh, we’ll go to that room”, and you find somewhere, that’s not a problem at all, and the staff have always been great in being able to accommodate.” (Interview, Parent)*

When discussing the visiting rooms with staff members, I was given an overview of the different visiting rooms available. The staff member also described the layout of a room, and I was informed of how they tried to make it feel homely for families by providing activities for them such as games and books:

*“Yeah, so dedicated visiting rooms. They’re not big, but they’ve got a window, probably seats for four, five people. If there are more people or if there are lots of families visiting all at once, it tends to be in the evenings when the other*



*rooms on the ward aren't being used, so by other therapists or members of the MDT, so we would use other rooms. Sometimes family bring in like board games or cards, we do have them on the ward as well which we've given to families and a box of books for younger children." (Interview, Senior Staff Nurse)*

When discussing a parent's experiences of visiting their daughter on the unit, they reported to me that when they first visited, they assumed they would be visiting their daughter in her own bedroom, similar to visiting in most general hospitals. Despite the rooms being made to look homely and inviting, the parent informed me that they were neither too clinical or homely:

*"We had no idea what to expect to be honest, we just assumed we would take her through to her room because they said that she'd have her own room". The visiting rooms are something we didn't expect." (Interview, Parent)*

When describing the visiting rooms to me, parents also informed me of an issue with visiting rooms which was that because they were located next to another visiting room, on occasions they could hear upsetting conversations coming from other families which affected their own visit with their daughter:

*"So, if you're in a room next to somebody who's also in a room and they've got troubles, or they could be upsetting things going on, you can hear absolutely everything. So, that can be difficult for conversation, you know, sets a mood for a visit sometimes." (Interview, Parent)*

### **6.3.2 Distance**

As identified in Chapter four, the CAMHS inpatient unit selected as the research site for the study was located in the south of the region, covered a large geographical area and admitted patients from a wide range of distances from the unit. During an interview with a Senior Staff Nurse, I was informed of the sheer scale the unit covered, which incorporated other health and social care organisations within the region:

*"We're based in [a southern region town], so we're under [name of health care organisation], but we're the only Tier 4 CAMHS in-patient unit in [the region]. We've got one in [in the North of the Country], but that means we cover 16 local*

*authorities, and seven [health care organisations], so it's a huge geographical area that we cover." (Interview, Senior Staff Nurse)*

The distance some families lived from the unit had the potential to be a barrier for them to frequently keep in touch with their child face to face. When discussing some of the barriers to CYP keeping in touch with their families, I was informed by a Senior Staff Nurse that some parents were required to travel long distances to visit the unit:

*"...we've had young people from all over so that could be like half an hour or maybe two, three hours away. Some of our young people's parents are coming two and half hours drive each way. Others not so far but it does cover a really wide area." (Interview, Senior Staff Nurse)*

Another staff member informed me that when the unit was in its planning phase, it was moved from a more easterly location to a southern location to be closer to the west of the region. Despite this, the staff member acknowledged that face to face contact between CYP and caregivers can be significantly difficult. I was also informed that in rare circumstances, if the CAMHS inpatient unit in the north of the region was full, the southern inpatient unit admitted patients from the north and vice-versa. The distance for families travelling from the north of the region would be over four hours' drive each way:

*"There's distance, which is quite a big one, we run from [town to town], but saying that we have had people from [the north] when the [name of north inpatient unit] is full, and the transport down is four hours. So, the face-to-face contact can be difficult due to the geographical location." (Interview, Education Team)*

Despite the location of the unit, staff members highlighted the difficulty some parents had with travelling to the unit. I was informed that this was especially difficult for parents who relied on public transport and lived in rural areas within the region:

*"We're in a town in the South which the transport links to the [Motorway] is very-very close to the bus service and the train service, so it is possible to catch a bus or catch a train here, but that can be quite tricky if there are transport issues. You've got parents who can't drive so somewhere like [City] is a bit of a minefield. And if you've got to get a bus from one part of [City] to the train*

*station, then from the train station to [Town], [Town] by bus here... I've known parents that have got off at [Town] and walked to get here. I think it can be difficult. Also, if we think we may have a young person admitted from the West; our catchment goes up to [a town] all the way down through to [another town], so that's a huge geographical area for which [the country] is quite notoriously badly connected transport wise." (Interview, Therapist)*

### **6.3.3 Experiences of distance being a barrier to seeing family**

The issue of distance being a barrier was also voiced by CYP in MDT meetings and interviews. In one weekly MDT meeting I attended, a CYP who had been on the unit for just over a week, expressed to a Nurse how upset she was that her parents were unable to frequently visit her due to living in the West of the region:

*"The Staff Nurse reports that the young person has kept a low profile on the ward and lots of encouragement has been needed from staff for her to engage with staff and her peers. The young person stated in a nurse engagement session that she is sad because her parents live so far away from the unit and struggle to see her regularly." (Fieldnote, MDT Meeting)*

When discussing what the potential issues or barriers were seeing parents whilst being on the unit, Sarah informed me that due to her parents living 90 minutes away from the unit by car, the most realistic way for her to keep in touch with them regularly was through the use of her mobile phone:

*"Int: So how do you keep in touch with your family when you're in hospital?"*

*Just through the phone really. That's basically the only way you can do it...they do come down and visit, so it's distance as well that can be a barrier. Because if you lived in [a town close to the unit] then they could come down every night because they'd only be 10 minutes away, but it's about an hour and a half drive for them." (Interview, Sarah)*

When discussing some of the issues they had with their daughter's admission, Sarah's parents informed me that they had done a lot of travelling back and forth to the unit which had taken a lot of time. Whilst they found the travelling due to the distance an issue, they acknowledged there was not a lot that could have been done to change this:

*“R1: “It’s taken a huge amount of time out of our lives with all the travelling...”*

*R2: Yes... it is a lot to ask because obviously it is an hour and quarter drive, each way.*

*R1: We can’t blame the unit for where it is so, it’s just the practicality really.”  
(Joint Interview, Parent)*

#### **6.3.4 Visitors’ Suite**

A facility frequently promoted by staff to support CYP keeping in contact with their families was the ‘Visitors’ Suite’, more commonly referred to as the ‘unit flat’. The Visitors’ Suite was situated away from the two hospital wards on the upper ground floor within the main building. According to the organisation’s policy, the main purpose of the Visitors’ Suite was to enable caregivers to be more actively involved in their child’s care and treatment through promoting therapeutic working which was facilitated by staff at the unit:

*“The prime function of the Visitors’ Suite within [the organisation] is to promote specific therapeutic work between patient and family, facilitated by a core team of professionals. This will allow parents/carers to be more actively involved in the care and treatment of their child as well as having increased direction and support from identified staff.” (Use of Visitors Suite Policy 2017, page 4)*

The Visitors’ Suite was a self-contained apartment. Within it was a series of rooms consisting of a main lounge area with sofas and a TV, a kitchen with a dining area and cooking facilities, a bedroom area with two single beds and a bathroom with a toilet and shower. The Visitors’ Suite was booked by caregivers through the nursing team and if available, could be used flexibly by families throughout the day and even for overnight stays. The process of booking the Visitors’ Suite was straightforward for families, they liaised with the nursing team who diarised the date. There did not appear to be any specific criteria for caregivers to meet in order to use the Visitors’ Suite, with bookings being taken on a first come, first served basis. There was high demand for the Visitors’ Suite and it was often booked weeks in advance throughout the period of fieldwork.

One of the primary functions of the Visitors’ Suite was to promote therapeutic working between the patient, caregivers and staff members and to deliver interventions such as family meals. It was also utilised informally and provided

caregivers with an opportunity to spend time with their child in a quiet setting. One staff member described to me how the Visitors' Suite enabled a caregiver to sensitively provide care, away from the main hospital wards:

*"One of our young people currently wears a wig, she's supposed to take it off for a few hours every evening but doesn't feel safe enough to do that on the ward, so, as a result of that there's some sores developed on her head. She will allow her maternal grandmother to come and visit, she will take her wig off in front of her, and she will allow her grandmother to rub cream on her head. So, for that to happen in a respectful way, we can utilise the flat to make sure there's no-one passing the window." (Interview, Social Worker)*

When discussing the Visitors' Suite with CYP, one person informed me that they had enjoyed the facility as they were able to have family meals which she felt provided her some normality with her parents:

*"Int: Ok and just to go back to talking about the flat, what's the flat like?"*

*It's quite basic... beds and then a kitchen but there's a table in there so I have family meals which it sounds quite silly, but it's really nice to have to have that conversation and a sense of normality." (Interview, Emma)*

When discussing the Visitors' Suite with a parent, she reported that she and her husband had used it occasionally for overnight stays, but they had also used it to spend time with their child throughout the day on weekends watching TV programmes:

*"A couple of times we just used it in the day because you don't actually have to stay, you can use it just during the day as well. Lots of effort has been made to make it feel more homely... ...we put the television on and we watched our soaps and cwtched<sup>3</sup> up together." (Interview, Parent)*

Another parent described the Visitors' Suite being useful when wanting to provide his daughter with personal care. During an interview he informed me that the Visitors'

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<sup>3</sup> Cwtch – a word used by the local population meaning a cuddle or embrace, although with a sense of offering safety.

Suite provided an opportunity for his wife to give personal care to their daughter in a safe environment, and without this facility it would have been more difficult:

*“The second time we used the flat... this sounds bizarre, young people aren’t allowed razors on the ward, I guess for obvious reasons. Emma had really hairy legs and was getting really sort of agitated about it, that kind of effected the mood and the esteem and all those sorts of things, so Emma mum booked the flat literally for an hour one evening so Emma could use the shower and bathroom facilities so mum could supervise Emma shaving her leg with a razor, so that’s something that her mum could do for her that made her feel better, that the flat allowed to happen, and that was great. So, without that flat, we probably wouldn’t have had that same opportunity, so it’s a very good facility here.” (Interview, Parent)*

With the distance to travel to the unit being an issue for some families, the Visitors’ Suite was especially useful in supporting families who lived far away from the unit. The issue of distance was highlighted within the Visitors’ Suite policy, and direct reference was made to the facility with supporting these families:

*“This facility will also be therapeutically invaluable in working with families that do not live in close proximity to [the organisation], due to the large geographical area covered by the unit... working with and increasing contact with families in difficult to reach areas would therefore be via the provision of the Visitors’ Suite.” (Use of Visitors Suite 2017, page 7)*

I was informed that the staff regularly promoted caregivers using the Visitors’ Suite as an overnight facility to keep them connected with their child and to minimise the travelling required for visits:

*“We get a lot of families who struggle to come here. They may come here maybe once a week, but they want to be here much, much more often, which is when we’ve tried to utilise the flat as much as possible. I think for the parents, particularly if they are coming from far away, it can be a real lifeline for them to feel, even if the young persons not staying there with them, to feel closer to their child.” (Interview, Social Worker)*

Joanna whose mother who travelled to the unit by public transport, described to me how the Visitors' Suite became beneficial for her mother on the night of her admission as there was a lack of public transport available at the time:

*"I think twice I've used it. My mum, she wanted to stay with me obviously on the first night that I came in... ..she stayed in the flat on her own because she couldn't go home on the train because it was so late, so she stayed in the flat. The next day I saw her and she went home then and then the other time, we both stayed in the flat together and we had a lovely time and watched movies and stuff like that. It was lovely." (Interview, Joanna)*

### **6.3.5 Using the Visitors' Suite to support home leave**

As previously mentioned by staff, the Visitors' Suite was promoted particularly for parents who struggled with transport to the unit to allow them to spend longer periods with their child. Another key feature of the Visitors' Suite was that it could be used by caregivers to stay overnight. Not only was this helpful for caregivers who were travelling from a distance, but it was also promoted by the MDT in preparation for discharging a CYP from the unit and transitioning back into the community. On occasions, discussions between the MDT centred around the use of the Visitors' Suite being utilised as part of the process of home leave. When discussing the Visitors' Suite being used in the build up to CYP having home leave with staff members, I was informed that the facility was often considered if the parents were unsure if they were able to manage having their child home and may have needed further support from the unit:

*"...if we're looking further down the line, maybe more towards discharge or as a first step towards home leave, the young person will stay in the flat with their family. It really depends on how safe the families feel about having their child back home, so if they feel they can manage some overnight time with them, but they're not quite ready for it to be in their home environment, it could be a stepping-stone that they use the flat first where they've got access to the support downstairs on the wards if they need it, or the young person can return to the ward if they feel they need to." (Interview, Therapist)*

During a ward meeting I observed, the MDT were discussing the process of home leave for a CYP who had been admitted to the unit one week prior to the meeting.

This CYP was under the care of the local authority and professionals discussed how best to keep the foster carers involved in the child's care:

*"The Consultant Clinical Psychologist states the foster carers are supportive. A Staff Nurse states that when the foster carers visited, they stated to staff that they need help and guidance before taking the young person on home leave. The Consultant Clinical Psychologist states that it is vital for the foster carers to feel supported. The remaining MDT members agree and suggest it is a good idea for the foster carers to utilise the Visitors' Suite with the young person before considering home leave."* (Fieldnote, MDT Meeting)

When discussing the experiences of having their son or daughter home on leave from the unit, some caregivers described how the Visitors' Suite was first used as a way of safely building up leave to eventually having overnight leave from the unit:

*"...the first time we used it, it was a little bit of the unknown, but actually it worked out pretty well. We got to spend the night with her [daughter] before she got home leave, it was actually really good, a really positive step. It feels like a safe step for us to do first before taking her home as if we have any issues in the flat we could be supported."* (Interview, Parent)

#### **6.3.6 Home Leave**

One method which enabled CYP to stay connected to their family face to face was through having leave from the unit. Home leave from the unit was an intervention that many CYP admitted to the unit experienced, with eight of the nine CYP who took part in the interview phase of the study informing me that they had gone home from the unit at least once throughout their admission.

#### **6.3.7 Organisation's policy on home leave**

As stated in the previous chapter, the organisation did not appear to have a specific policy or procedure document in relation to CYP leaving the unit to go home. Having leave off the unit to go home was mentioned in the organisation's Information booklet (2019), which included spending time off the ward with parents to visit local amenities. CYP gradually spending increased periods of time at home once the process of home leave had started was also emphasised within the Information Booklet:



*"We consider time off the unit to be an essential part of the assessment process and will seek feedback from you and your parents/carers. When you are ready a gradual approach will be taken to increase the time that you spend off the unit and at home. This might start with spending time with your parents and carers going on a short walk or outings locally." (Information Booklet 2019, page 14)*

### **6.3.8 Discussions on home leave as part of MDT meetings**

Discussions between various health, social and education practitioners regarding whether a patient should have home leave would usually take place in the daily MDT handovers and weekly MDT ward round meetings. These discussions were debated by the MDT routinely as part of each patient's care. I was informed by a Staff Nurse that home leave discussions could also be prompted through CYP indicating that they would like to have leave on their ward round request sheet:

*"...generally we will try and get families in to visit as often as we can and also get the young people out if we can. If the young person has put in a request and said, 'I would like leave', we'll have a ward round meeting on a Wednesday, and that will be discussed at the MDT and they'll decide if that is feasible. We'll feed that back to both the young people and their families and try and organise when they can go." (Interview, Staff Nurse)*

I was also informed that if a CYP had recently been admitted to the unit, it was unlikely that they would be able to go home within the first few days. In these circumstances, a Nurse informed me that the MDT would promote the use of the Visitors' Suite:

*"If someone's new on the ward or they've been at risk, and we're a bit unsure about promoting leave we have a flat upstairs, so that's really good so parents and young people can stay overnight." (Interview, Staff Nurse)*

### **6.3.9 The process of home leave**

CYP having leave from the unit to go home was a gradual process. I was informed by staff members that this would usually begin with the CYP and caregivers having time off the ward together for a few hours using the facilities within the hospital's grounds, going to the local shopping centre, or to spend time in the Visitors' Suite. Following this, the nursing team would arrange leave for a period of 24 hours from

the unit. As time progressed, CYP would gradually spend increased periods of time from the unit at home as they worked towards being discharged.

When discussing home leave with staff members, I was informed that after the first few home leaves, the subsequent periods of leave that a CYP would spend at home were generally based on how much the parents felt they could manage. For CYP on the ward who were under the care of a CMHT prior to being admitted, staff also informed me that they discouraged periods of 24-48 hour leave over the weekend as the community teams were unavailable to support CYP on leave over the weekend:

*“...we don’t like to do a 24 or 48 hour over the weekend because what we’re aware of is, the community teams don’t work weekends.” (Interview, Social Worker)*

A staff member explained the process of home leave to me as a ‘phased transition’, which would normally begin with 24 hours leave from the unit and would gradually increase until the CYP is discharged. For the CYP who were receiving support from a community CAMHS team prior to being admitted to the unit, I was also informed of how the MDT linked local community CAMHS teams to support periods of home leave:

*“We like to do what’s called the phased transition. If it’s safe, we’ve done our risk assessments, they’ve received a medic review and it’s all agreed, family feel they’re onboard with the plans, ideally what would happen is, if they’ve had leave off the ward and they want overnight leave, we will link into the community team to let them know it’s happening, so they’ve got access to support in case anything goes wrong. Then it will be 24 hours come back to the ward, we get feedback from the family, and review how that leave went.” (Interview, Social Worker)*

The social worker further informed me that if the first leave were to be positive, longer periods of time away from the unit would be arranged over the subsequent weeks working towards discharging the CYP. Support from CMHT’s would also continue where possible:

*“If it’s positive we can then arrange a 48 hour leave home. Again, we link that in with the community team so they know that young person is going to be home*

*for that amount of time, and if it's a 48 hour leave they may want to do a home visit to maintain their own working relationship. Then they return to the ward, and if that goes well its 72 hours, 96 hours, and then we're looking towards a discharge pathway." (Interview, Social Worker)*

When discussing home leave in an interview with the unit's clinical lead and responsible clinician, I was informed of the average length of stay of an admission to the unit, which was suggested to be far lower than the rest of the general adolescent inpatient mental health units in the UK. The consultant also stated that the length of admission was longer for patients diagnosed with eating disorders such as Anorexia Nervosa and that home leave was promoted more frequently by this unit compared to other CAMHS inpatient units in the UK, including CYP who were admitted with eating disorders:

*"We are the top of the country in giving home leave... .. 58 [nights] for general adolescent unit per episode, of these, eight would be home leave. Eight of the 58. When in our case it's 18 and 12... ..so the patient's contact with us will be 30 days, but 12 of those will be at home. The anorexic patients, because it takes longer, so we have 35 and 30. While there are 144 in the general [unit], there's 10 at home. I believe that's part of why this unit is unique... ..If you have a patient in a mental health institution for 58 days, and of these, eight days you go home, then your allegiance, your belonging, your identity, has become mental health. While in our case 18 plus 12, so the exposure to the community is far more." (Interview, Medical Team)*

I was also informed that home leave was encouraged by the unit soon after CYP had been admitted to the unit and in general, they would have stayed overnight at their own home at least once after the first couple of weeks after admission. However, this was also dependent on other clinical factors such as level of risk and severity of mental health issues:

*"...we start this contact as soon as we can. It may be in the first week, it may be in the second week, definitely by the third week unless it's clinically unsafe to do it. A patient is suicidal, for example, or they are very unwell with anorexia and stuff like that. Then we have to wait until it's clinically useful." (Interview, Medical Team)*

When interviewing the one of the unit's managers around CYP having home leave, she acknowledged that despite staff promoting CYP having home leave, decisions on whether CYP will go home were on an individual case by case basis and were assessed by factors including risk and clinical presentation. She also stated that home leave enabled parents to feel empowering with looking after their child, and that parents sometimes felt disempowered by health care professionals being involved in their care:

*"Most young people have home leave. It is different for every individual dependent on their risks and their illness. But it is definitely encouraged that a young person has as much leave as possible. Because like I said, you know, it is about empowering the parents to be able to look after their children. When a young person comes into hospital it can often be a little bit disempowering for the parent, like professionals are taking over and that's not what we want."*  
(Interview, Ward Manager)

In some instances, parents did not feel ready for their child to be home after being admitted to the unit, as they felt that it was too soon and that they would be unable to cope. In these circumstances, the MDT often promoted other face to face interventions to keep the CYP in contact with their family such as visiting and the Visitors' Suite:

*"A young person's requests to have home leave next week to attend a friend's birthday party. The MDT members are hopeful that this can go ahead. The Consultant Psychiatrist states that he doesn't want the young person to be admitted for long and wants to encourage leave with her parents. He also states that the young person is close with her sibling and does not want them to be away from each other for long. The MDT discuss whether the young person is ready to have overnight leave and agree that she is."*

*The Consultant Clinical Psychologist suggests the young person go on leave this afternoon after parents have family therapy at the unit and come back for the CTP review tomorrow. She explains that the assessment of the overnight leave could be added to tomorrow's review. The MDT agree that this is a good suggestion. A Community Mental Health Nurse informs the MDT that she spoke with the parents yesterday and states that they do not want their child to have*

*leave, they are not ready for it yet and wish to use the flat first. The MDT recommend the parents stay in the Visitors' Suite with their child this week."*  
(Fieldnote, MDT Meeting)

### **6.3.10 CYP's experiences of home leave**

At the time of interviewing Jenny, she stated that she had recently started to have home leave for the first time since she was admitted to the unit and enjoyed the comforts of her home compared to the ward environment such as having more privacy and being supervised less. Jenny reported gradually building up home leave starting with 24 hours leave initially, with a further 48 hours leave planned the following week. She also informed me that she was able to go off the unit for periods with her family, and within the hospital grounds escorted by staff members:

*"Int: Do you have time off the ward?"*

*I do yeah, I go home. I had one overnight leave last week and I'm going for two overnight this week... we're just trying.*

*Int: When was the last time you went on leave?*

*Last Friday.*

*Int: How was it?*

*It was really good, it's just nice to have a different atmosphere and to sleep in a nice bed without someone checking on you every 15 minutes, so it was just nice to have a shower without being checked on and being able to just use a razor to shave your legs without someone literally hawk eye watching you... ..it was just nice to have a bit of privacy really." (Interview, Jenny)*

Heidi who was recently admitted to the ward and had not been home yet at the time of the interview, explored with me ways in which she could have more contact with her mother. Heidi informed me that she was planning to request to have home leave from the unit as part of her upcoming ward round request:

*"Int: How could you have more contact with your mum?"*

*I think leave maybe.*

*Int: Mmm-hmm.*

*I'm going to ask for it on the next ward round.*

*Int: Ok, is it a request?*

*Yeah. It's like, you write it down on a piece of paper and then give it to the staff and then they go into a big meeting and depending on what you've asked, if you ask, 'Can I have 24 hours leave?' they'll discuss it and then get back to you." (Interview, Heidi)*

When discussing home leave with staff members, some informed me that the process of home leave was encouraged soon after a CYP's admission to the unit. This was not always possible however, due to factors such as the level of risk and severity of physical and mental health issues. When discussing home leave with Joanna, she informed me that she was unable to go home for a few weeks after first being admitted due to her clinical risk at the time. She also reported feeling happy when going home and described to me how she initially perceived her home environment to appear differently after spending a long period of time on the unit without going home:

*"Int: When you did have leave, what was it like going home?*

*Oh, it was amazing... ...I was so happy, my parents were so happy to see me and it was like Christmas... ...every time I went home because it was just, like, 'Oh my God,' everything is so different as well when you walk in. Obviously, you're used to seeing your bedroom. When you walk into your house it's like 'this has changed so much'. It hasn't, but to you it has because you've been so like isolated... for a long time." (Interview, Joanna)*

### **6.3.11 Health impacting home leave**

As indicated to in the previous chapter, a barrier to some CYP in touch with their family outside of the unit was due to their deteriorated mental state and physical health issues. When discussing barriers to CYP going home from the unit in interviews with staff members, I was informed that some patients were unable to go home as it would not have been safe due to their physical or mental health. In these circumstances, the promotion of visiting on the unit between CYP and caregivers was encouraged by unit staff:

*“Some young people are not actually allowed off the ward because perhaps they’re not physically well enough at the moment and their mental health isn’t the best so safety wise, they need to remain on the unit. So, then we provide rooms so it’s quite private, they can have a visit but they’ve still got staff in the vicinity to have that support if they needed it.” (Interview, Senior Staff Nurse)*

Although most CYP were able to go on home leave over the course of their admission to the unit, some were unable to have home leave or go off the ward with their families due to the severity of their physical and mental health issues. When discussing Steven’s care and treatment in a weekly ward meeting, the MDT were unable to agree him having home leave due to the severe deterioration of his mental state, despite him requesting to have home leave as part of his ward round request:

*“A Senior Staff Nurse provides the MDT with an overview of Steven’s presentation. She states that he is still being nursed on 1:1 observation due to psychosis presentation. The Consultant Psychiatrist states that Steven is very unwell at present, and that he has had very few lucid moments.*

*A Senior Staff Nurse states that Steven has asked for 3 days leave on his ward round request sheet. The MDT concur that Steven is too unwell at present to have home leave but suggest offering the Visitors’ Suite to his parents when it is available.” (Fieldnote, MDT Meeting)*

The physical complications associated with Anorexia Nervosa prevented some CYP from having leave from the ward on occasions. Certain medical complications as a direct result of ongoing weight loss and malnutrition such as hypotension, required nursing staff to undertake more frequent physical observations with CYP. For one CYP who experienced these complications and was unable to go home, the MDT discussed potential ways of supporting her to spend time with her family, despite being unable to go home:

*“The MDT discuss the young person’s physical deterioration over the past week. The young person has requested to go home on leave, or to spend time off the ward with her mum. The Consultant Psychiatrist states that the young person is too physically unwell to have home leave at present. The Consultant Clinical Psychologist states to the MDT that they need to give the young person opportunities to do normal things off the ward. A Staff Nurse suggests using a*

*wheelchair with the young person so her mother could take her for a therapeutic trip to the local Costa. MDT agree with this.” (Fieldnote, MDT Meeting)*

#### **6.3.12 Compliance with Care and Treatment Plan impacting home leave**

Having contact off the ward with family for some CYP such as going off the ward for a certain period or planned overnight home leave, was sometimes dependent on their ongoing compliance with their individual care and treatment plan. In some cases, CYP who had requested to go on home leave, had this granted by the MDT on the basis that they were compliant with certain aspects of their CTP such as gaining weight or periods of incident free behaviour. On occasions, CYP who were due to go on home leave had this revoked by the MDT due to breaching certain conditions of their CTP.

Jessica, whose mental health declined throughout her admission, frequently displayed high risk-taking behaviours such as self-harm. When discussing her care and contact with her family in a meeting, the MDT concluded that her current mental state had deteriorated too severely to allow her to go home:

*“A Staff Nurse informs the MDT that there have been multiple incidents of self-harm. The MDT conclude that home leave for Jessica is not currently possible due to her level of risk and continuing to be on 1:1 observation at present.” (Fieldnote, MDT Meeting)*

When exploring Jessica having home leave with her mother who I happened to interview around the same time as the MDT ward round meeting, explained to me that despite leave from the unit not being possible, they were still able to frequently visit her:

*“Int: Has Jessica had any home leave yet from this unit?”*

*No, because it’s not safe. They [unit staff] suggested we will get there... ...I know we will get there, and we will eventually get her out, but they won’t even give her flat leave now, it was not allowed on Friday. So for now we’ve just been visiting her in the evenings.” (Interview, Parent)*

Throughout the data collection period, several CYP diagnosed with eating disorders appeared to have their requests for home leave granted by the MDT on the basis



that they would continue adhere to their CTP and gain weight through following an individualised meal plan set by the dietician.

*“A Staff Nurse reports that a young person has been positively engaging with her care and treatment plan and individual meal plan, but she was upset about not being able to go on leave previously due to weight loss. The Consultant Psychiatrist states that if the young person gains weight when she returns to the ward, and the community CAMHS team can continue to support her leave, she can go home for 48 hours over the weekend.” (Fieldnote, MDT Meeting)*

When discussing home leave with Sarah’s parents, they informed me that there were occasions throughout her admission where home leave had been revoked due to not gaining enough weight in between weigh-in periods. They also informed that they were fortunate to live close to the unit so therefore they were able to frequently visit the unit and were allowed to take their daughter out in the car whilst she was unable to go home:

*“Int: Are you able to take your daughter off the hospital grounds when you visit?”*

*“R1: Well, depending on what her weight was really..., she had a week where she was on 1:1 where she was not allowed off. Other times we haven’t been because of her weight, she hadn’t put on enough weight between weigh-ins.*

*R2: Luckily it isn’t very far to drive. Sometimes we just come out and do a little drive in the evening and go down and see the sea and stuff. So, at least there is places to go.” (Interview, Parents)*

When discussing home leave with Joanna, she informed me that she had been put on a meal plan provided by the dietician as part of her treatment for Anorexia Nervosa. She described how she found it difficult to follow her meal plan on occasions and therefore was unable to go home due to losing weight:

*“Int: What do you dislike about being here?”*

*When you’re not allowed to go home.*

*Int: Why are you not allowed to go home?*

*If you don’t gain weight in my case, or if you do something you’re not supposed to do, something like that. They wanted me to go home but the doctor said until*

*I eat and drink something and show them that I can do it, I can manage on leave, I won't be going home.” (Interview, Joanna)*

In summary theme two reviewed the physical methods enabling CYP to keep in touch with their family when in hospital for care of their mental health. This began with discussing the health care organisation's regulations on visitation. It then focussed on the experiences of CYP and caregivers' experiences of visiting. This theme also explored staff members flexibility around visiting, whilst acknowledging some of the challenges associated with visiting such as parents work commitments and visiting hours clashing with the allocated time for CYP to use their mobile phones. This theme then provided an overview with the various visiting rooms available at the unit.

Distance as a barrier to keeping CYP and their parents in touch was then explored, with CYP and parents giving accounts of the challenges with frequently travelling to the unit due to the vast distances required. The focus of this theme then turned to exploring the Visitors' Suite, which supported parents with contact with their child. This was especially useful for caregivers who were travelling to the unit from a distance. It also explored how the Visitors' Suite was an intervention used when preparing CYP for home leave and to eventually be discharged from the unit.

Finally, this theme explored another physical method of keeping young CYP and their family connected through having leave from the unit. This began with exploring how home leave was discussed between the MDT, before explaining the process of CYP having gradual periods of leave. CYP's accounts of home leave were explored, including the mental and physical health barriers some experienced associated with home leave.

#### **6.4 Theme three – The emotional, employment and financial impact on families**

A potential barrier associated with CYP keeping in touch with their family throughout their admission to the CAMHS inpatient unit was the impact on the family. During the interviews, both staff and caregivers gave accounts of the emotional toll an admission had on parents and wider members of the family, in addition to the financial and employment implications experienced by parents. To support caregivers at the beginning of their child's admission to the unit, an informal

intervention called a 'Welcome Meeting' was usually offered to parents shortly after the admission.

#### **6.4.1 Welcome meetings**

This meeting usually consisted of a nurse, a member of the therapies team, and caregivers, which occurred a short period of time after a CYP had been admitted to the unit. Its purpose was to keep the family involved by having an informal discussion about any queries they had regarding their child's admission and to share information. Reference to the welcome meeting was first highlighted in the organisation's Information Booklet for patients and carers under a 'Family Involvement' section:

*"...we understand that family and carer involvement is very important to supporting your recovery and this is a central part of the work we do here at [organisation]. Your family and carers will be invited to a 'Welcome Meeting' with staff. Every effort will be made to ensure that this meeting is held within the first 3 days of your admission. This is an opportunity for parents and carers to share information with staff and ask any questions that they may have about your admission." (Information Booklet, 2019 page 13)*

When discussing the welcome meetings with ward staff, some staff provided an overview of what a typical meeting involved, which included timescales and some of the topics that would be covered in the meeting between staff, and caregivers:

*"If they're admitted, they should have a welcome meeting. That needs to be offered within a certain timeframe, I think it's between 24-48 hours. We contact the family to arrange a welcome meeting... .. it's about bringing them to the unit and giving them a full overview of our model of working, the purpose of admission, what we hope to achieve, what the parents hope to achieve, and making sure that the parents have got realistic expectations as well." (Interview, Senior Staff Nurse)*

Another staff member who was a social care practitioner, also discussed welcome meetings with me in our interview and highlighted its value of contributing to an important aspect of a CYP's, maintaining family involvement from the outset of admission:

*"It's a way of maintaining that kind of family liaison, family communication. They're [caregivers] told that their input into their young person's care is vital, it's really important. They are such a huge resource to the young person, and that we as a unit want to work with them to facilitate that process." (Interview, Social Worker)*

Many staff acknowledged that an inpatient admission can be particularly difficult time for families and their anxieties may be heightened, especially if it is the first time, they have experienced their child being admitted to the unit. Staff reported that the welcome meeting was beneficial in relieving some of the parent's anxieties around the admission:

*"...from the initial assessment, it's not just the young person who's often heightened, it's also the family who are also heightened in anxiety... ..they're not taking everything in because it can be quite disorientating for them, a Tier 4 CAMHS admission." (Interview, Social Worker)*

On occasions during MDT meetings, welcome meetings were discussed and one set of parents who were reportedly to have been anxious about their daughter's admission to the unit, stated to staff that they found the welcome meeting helpful:

*A Staff Nurse states that parents had a welcome meeting this morning and then came back in the evening to visit their daughter. The Staff Nurse reports that the parents stated they found the welcome meeting helpful and gave good feedback about staff saying they were professional and wanted to thank staff for taking care of their daughter." (Fieldnote, MDT Meeting)*

Despite efforts being made by unit staff to ensure all families were offered Welcome Meetings within the first 3 days of admission, this did not always occur. In one instance, a family were not offered a Welcome Meeting by the unit staff until a month after their daughter had been admitted:

*"An Education Worker states that the parents feel like they have been 'left in the dark' as they have been waiting four weeks for a welcome meeting. The Consultant Clinical Psychologist states that welcome meetings with families are supposed to occur 72 hours after admission. Ward Manager states she will*

*email ward staff to remind them to arrange timely welcome meetings with parents.” (Fieldnote, MDT Meeting)*

The emotional toll of an inpatient CAMHS admission was felt and described by parents, with a mother describing how she and her husband were struggling to cope with their daughter being in hospital:

*“My husband and I, either one of us has been here daily, but the family, we’re all struggling. Nobody’s sleeping, I’m off work. We forget everything... ..we’re in a bubble, keeping ourselves going. We’ve got friends and family around but we don’t really want to see them. It’s just us stuck, trying to manage. We just think about Jessica all the time and I know people say you can get a bit of rest but you don’t sleep. You don’t stop thinking about them and you worry that things are getting worse, I haven’t had anything positive yet to focus on so it’s really hard.” (Interview, Parent)*

The impact of an admission siblings was also highlighted during an interview with a member of the therapies team. The therapist described how in some cases, siblings have struggled to understand and process their brother or sisters’ admission:

*“I’m really mindful it’s not just mum and dad. There’s siblings, you know. How do siblings make sense of big or little brother or sister is now in a hospital because of mental health... ..we’ve had conversations with siblings where they’ve said “Am I going to catch this? Is my brother or sister safe to come home?”. I’m mindful of the impact of what they’ve witnessed and experienced.” (Interview, Therapist)*

During the interview with Jessica’s mother, she described how she and her husband tried to protect their other daughter who was already under pressure and stress from upcoming exams. The parents decided not to inform her of the extent or seriousness of Jessica’s deteriorated mental health:

*“Her older sisters in the middle of her A levels so we protected her quite a lot. She doesn’t know everything that’s been happening here. She doesn’t know about the extent of more suicide attempts and self-harm because we’re going to save that until after the exams are over. She just knows that things aren’t good.” (Interview, Parent)*

#### **6.4.2 Caregivers taking time off work**

Caregivers also reported having to take time off work throughout their child's admission due to stress or to be available to support their child when having home leave from the unit:

*"It's draining you know, I work full time, and I've had some time off myself earlier this year for a couple of weeks, because of the stress of the situation and it's taken its toll. Between work and visiting, it's tiring. But, as parents, we do what's right, not what's easy." (Interview, Parent)*

The mother of Jessica described how she was unable to work due to stress, and how she and her husband were anticipating taking a period of time off work to care for their daughter post discharge. She also disclosed her concerns about how they would manage with providing around the clock care for their daughter:

*"I'm off work at the moment. My husband's going to take time off when she comes out. His company are very supportive but he's working while he can and he finds work a distraction for him, helps him a little bit, although he's very overtired, I think he's doing too much. I'd like him to take some time off now but he's saving it for a couple of weeks when she comes out. I'm just worried that we'll be giving 24 hour care ourselves and I don't know how we'll sustain that." (Interview, Parent)*

Not all parents were able to take time off work to be able to look after their child, however. In a CTP meeting I attended, there were discussions between the patient, patient's mother and MDT members about arranging increased periods of home leave from the unit. The mother stated concerns about continuing to request time off from her employer after a long period of absence:

*"The Consultant Psychiatrist asks the patient and his mother how the recent 24 hours leave went. The mother explains that it is difficult to judge how things have been over the past 24 hours when comparing it to the unit and states, "It isn't like the real world being in here". The Consultant Psychiatrist agrees with this statement. Young person states he would like to try more home leave. Mum explains that she is back in work but on a phased return as she has been off sick from work for 6 months.*

*The Consultant Psychiatrist states that trying more leave is important, and that he recommends 48 hours leave as soon as possible. Mum states she is young person's sole carer and asks the MDT how to accommodate the leaves around work. Mum [visibly upset] states she is on phased return and cannot keep asking for days off. Mum states that she needs to think about this. MDT recommend arranging home leaves over the weekend." (Fieldnote, CTP Meeting)*

Some staff were empathetic towards parents' employment and financial needs. One therapist described to me some of the employment issues that some parents face which may impact their ability to frequently visit the unit. She also reported that parents' employment concerns were sometimes misunderstood by staff members as parents not visiting as much as they had expected:

*"I'm mindful that some parents are really pushing their employers because they may have had to have time off to care for their son or daughter. You know, we all work and come April 1st we know how much annual leave we've got. And in the back of our heads, if need be, we know how the [name of organisation] is going to support us for our sick leave or maternity or bereavement. We have that knowledge and these parents are juggling those life experiences as well. So, that might hinder, and I think sometimes then that can be open to misinterpretation – 'Oh, they're not coming to visit.' – yeah, but what hurdles are there that hinder that? Is it because of work commitments because they're on their last warning that if you take any more leave your employment is at risk? Then you've got to think of what a lack of finance would do within that family home ... ..so, it's about being empathetic to that as well." (Interview, Therapist)*

#### **6.4.3 Financial impact on caregivers**

An adolescents admission to a CAMHS inpatient unit also had financial implications for caregivers. The cost of travelling to the unit when visiting or reducing the amount of hours worked due to caring responsibilities impacted caregivers financially. Nia's parents who owned a business, described how they had experienced a loss of income over the course of their daughter's three-month admission to the unit:

*"Int: How has it been for you with work?"*

*Yes it has been slightly stressful. We're self-employed, we've kind of rescheduled and delayed orders and things and everyone has been incredibly understanding luckily. It has resulted in a drop in income but not to any kind of worrying extent yet, so I think we've been able to kind of absorb it.” (Interview, Parent)*

Due to the large geographical area covered by the unit, some caregivers were required to travel long distances by either car or public transport. Another parent described how due to the vast distance between their home and the unit, along with one parent reducing work hours, the family had experienced some financial hardship throughout their daughter’s multiple admissions over a period of eight months:

*Int: Has there been any financial difficulties with regards to travelling?*

*Yeah, the whole situation is a challenge in that sense. Because of the care and responsibilities, and also the emotional side of things. Her mother’s not been able to work anywhere near as much as normal. She tends to just work a Saturday or a Sunday at the moment so the income is reduced in the family. It’s hard on the outgoings in terms of travel obviously increased. We’ve probably done close to 7000 miles back and forth since Emma has been admitted.” (Interview, Parent)*

Joanna, whose parents relied on public transport described how on a previous admission to the unit there had been challenges with her parents and older sister travelling in the evenings to the unit on occasions due to a lack of finances within the family:

*“Int: Have your parents ever struggled to get here?*

*At night yeah, because of money... ...it’s quite a lot of money to come on the train and then going back and even if three people are coming, that’s quite a lot of money, you know, they have struggled.” (Interview, Joanna)*

When discussing families’ financial and travel needs with one of the staff members, they informed me that there were families who struggled with the financial aspect of keeping in touch with their child:



*“...especially families who may be living in quite deprived areas, if they don’t drive and have some financial concerns where they’re not able to buy their train tickets, or their taxi.” (Interview, Staff Nurse)*

To support caregivers with the financial costs of travelling to the unit, I was informed that the staff regularly promoted caregivers completing expenses claim forms to try to reimburse some of the travel cost when visiting the unit.

#### **6.4.4 Travel reimbursement challenges**

I had been informed that some caregivers were eligible to apply for a specific fund to have travel costs reimbursed. When discussing this with various staff members in interviews and through observing meetings, I had been made aware that the process for reimbursing travel expenses was made through the unit’s social worker, along with some of the issues associated with families claiming travel expenses such as reimbursement delays:

*“We do have an expenses form that families can fill out in order to get the expenses of travelling back, the nursing team don’t organise that, it goes through the social worker. But sometimes families have had problems in actually getting that sorted so that can be a problem for them as well...  
...sometimes there’s a delay and so the financial difficulty can bring up difficulties actually getting here in the first place.” (Interview, Senior Staff Nurse)*

During an MDT meeting I attended, there were ongoing discussions between professionals about a CYP’s parent visiting. This meeting highlighted the financial constraints some parents were under and the challenges associated with claiming for travel expenses, with there seemingly being specific criteria that needed to be met in order for caregivers to be able to claim:

*“The Senior Staff Nurse states that the parents can only visit every few days for a couple hours, and that they struggle with transport. The Consultant Clinical Psychologist states that not knowing when his parents are going to visit is going to make the young person feel worse. The Family Therapists states that there is a process of reclaiming for travel expenses and that the parents need this explaining to them. She also states however that it is an online process, and it is complicated.*

*An email is read out by the Senior Staff Nurse from the Social Worker explaining to the MDT that the young person's parents are on Universal Credit, and they struggle with frequently paying for a 1 hour 30-minute train journey to the unit. The Social Worker's email also states that the parents can apply for discretionary funding to help with travel expenses but explains that some local authorities do not provide reimbursement if the hospital visit is not for their own care. The Social Worker also explains through the email that she will contact the parents to inform them about the potential funds available for travelling."*  
(Fieldnote, MDT Meeting)

During interviews with social care staff, the topic of reimbursing travel expenses was highlighted when discussing caregivers travelling to the unit. During this discussion, the social care worker reported that the reimbursement process was difficult, and clarified some of the criteria for claiming for expenses:

*"Int: What support is there for families who struggle financially?*

*We always advise that families can apply for a discretionary fund, its an online process that they can fill out. The difficulties that we do have with travel expenses is, families are only entitled to travel expenses if they visit in hospital for an appointment.*

*Int: For their child?*

*Yes. We record the visiting but obviously we're not the decision-makers in this, because a lot of the time they could be visiting the family therapist, or the psychotherapist for their own appointment, but it may be that not all of the visiting costs are going to be covered by the fund. So, I would love to say that that is in place, most parents don't apply for the fund, and the ones that do sometimes have difficulty getting the money back for their expenses.*

*But what we have done for a few families is, we've discussed this with the local authority if there's an allocated social worker, and we've ensured that the local authority have made an agreement to cover some of the transport expenses. Because without it they're not able to come down to see their child, and that is so much part of the recovery process, is to maintain that communication and that link. So, it's not as easy as it should be."* (Interview, Social Worker)

As previously mentioned by some staff members in interviews and MDT meetings, the process of claiming for travel expenses seemed to be complicated. When discussing this with one of the unit's therapists, she indicated to me that despite her being proficient in IT systems, she struggled with the online expenses reimbursement system and reported to me that parents have found the system difficult too:

*"There is a scheme I've looked into myself, and I find it quite complicated to access. Previously there used to be a system where parents could go over to the main hospital site here and reclaim their travel expenses. But that system changed and it's an online system, and I think of myself as being quite IT savvy, but when I've looked at the system I've found it quite complicated, and I do wonder if our families when they're under pressure, stressed already, would be able to navigate that for themselves... ..when I've talked to families about it, it does seem to be a barrier to them claiming back their travel cost, even if they can." (Interview, Therapist)*

When discussing being reimbursed for travel expenses with a parent, I was reminded of the impact of the rising cost of living on families. Despite the difficult process of claiming for travel expenses, fortunately some were able to receive funding:

*"I had a letter from [unit] saying there was this DAF fund, discretionary assistance fund. I didn't think anything of it at first. But I thought hang on a minute, I'm putting in a tank of petrol plus whatever I'm spending on food for Kayleigh so we followed up again and we have had some payments to cover some of the travel that will apply retrospectively. It's money we didn't think was going to be there to help, and it relieves some of that financial concern." (Interview, Parent)*

Another parent who had managed to have some travel expenses reimbursed, explained how the funding had been helpful in relieving some of his daughter's anxieties who had been worrying about the financial impact that the admission had been causing the family:

*"The other thing is Emma, she'd not daft, she knows petrol costs money, she knows the amount of driving that's been taking place back and forth. She*

*knows we've not been working as much, so her mind is processing all of that and is worried about the financial impact that she's causing and that's not helpful for her. So, we've been able to say, "Actually, we've applied for this. It's all being taken care of" and that I think has helped reassure Emma as well."*  
(Interview, Parent)

Although another parent who had previously informed me that there had been a decrease in income within the family due his wife being off sick from work, tried to claim for travel expenses but discovered that it appeared to be a means tested system and was unable to claim due to his salary being over a certain threshold:

*"Int: Has anyone from the unit spoken to you about help or support with that [travel reimbursement]?"*

*"We looked on the [regional government] website and effectively, it's means tested and if you're receiving benefits. Now, I work full time and I have a reasonable job, a reasonable income... ..we didn't meet the threshold and that was one of those things. Fortunately, we've got savings and we can prioritise where we're spending money, you know, our priority is Sarah and that's where we're spending our money and that's fine."* (Interview, Parent)

In summary theme three explored the impact a CYP's admission to the unit had on caregivers and wider members of their family. This began with discussing the unit's post admission welcome meetings, an intervention aimed at reducing parents stress and anxieties around their child's admission, which some parents reported as finding helpful. Following this the emotional impact an admission to a CAMHS inpatient unit had on siblings and parents was explored, with accounts from parents reporting that they had struggled to adjust to the admission. The effects of the admission on parents' employment were highlighted, with some parents taking periods of sick leave from work due to ill health. In addition, some parents struggled to take time off work in order to support their after their child on home leave. Finally, the financial hardship that some parents experienced due to their child's admission was also explored, with some parents working reduced hours and the cost of frequently travelling to the unit when visiting their child. The challenges associated with reclaiming travel expenses were also explored, with this appearing to be a complex, means-tested system.

## **6.5 Chapter Summary**

In conclusion, this chapter reviewed data generated from interviews with CYP, parents, carers and various health, social and education practitioners. In addition, it reviewed fieldnotes generated from observations of ward-based events such as MDT and CTP meetings, and documentary data in the form of the health care organisation's policy and procedure documents. From the data generated, exploring CYP's connections to their family produced three themes.

Theme one focused on how CYP remotely connected with their family when they were an inpatient at the unit. Through the use of mobile phones CYP were able to contact their parents by texting, phoning and video calling them. CYP and their parents appeared to take issue with some of the restrictions associated with the unit's mobile phone policy such as the time constraints around its usage and lack of private spaces to make phone calls. The ward's telephone was explored as primary remote communication method for some CYP, particularly those who did not have access to a mobile phone. Despite staff members flexibility around this intervention, the restrictions around its use was an issue for CYP and parents.

The telephone contact between caregivers and staff members was also explored in this theme, which included nursing staff contacting caregivers to update them on aspects of their child's care. Telephone calls between parents and staff also occurred through parents calling the ward for updates and to pass on messages to their child. Staff members were not always able to give accurate updates however, and cited reasons such as the high changeover of nurses and shift patterns may have led to information to parents being miscommunicated at times.

Theme two focussed on the physical methods enabling CYP to remain in contact with their family. This began with discussing visitation at the unit and explored CYP's, parents and staff members experiences of visiting. Although there were protected times where visiting was restricted such as meals and school, staff appeared to be as flexible as possible with visiting around these times. Certain barriers to visiting were highlighted, such as parents own work commitments and some of the time allocated for visiting and mobile phone use clashing with one another. In addition, the provision of adequate visiting spaces was discussed.

The physical distance some families lived from the unit was highlighted by CYP parents as a barrier frequently keeping in touch, with accounts from parents and CYP acknowledging the vast distances that some families were required to travel. The unit's Visitors' Suite was highlighted as a helpful intervention in supporting CYP and parents keeping in touch. This intervention was highlighted as being especially helpful to families who lived far away from the unit. CYP having leave for a specified time to go home was a physical way keeping in touch with their family, and the process of gradually having more leave until being discharged was described. This theme also recognised that some CYP's opportunities for home leave were impacted by the severity of their physical and mental health issues.

Theme three highlighted how caregivers were impacted by a CYP's admission to a CAMHS unit. This began with a description of the unit's welcome meetings, an informal intervention aimed at maintaining parent's involvement in their child's care. This meeting also appeared to relieve caregivers concerns and anxieties regarding their child's admission. Following this the impact a CAMHS admission had on caregivers' and siblings' wellbeing was explored, with some parents struggling to adjust to the admission and how they tried to safeguard their other children by withholding certain information from them. Parents employment concerns were explored in this theme, with some parents taking sick leave from work due to stress and struggling to take additional time off work to care for their child. Finally, the financial implications an admission to the unit had on family were explored, with some experiencing a loss of income throughout their child's admission to the unit. In addition, some caregivers struggled with paying for the cost of frequently travelling to the unit when visiting their child. The challenges surrounding parents being reimbursed for travel expenses was explored, and despite some parents successfully claiming for travel expenses, the process of claiming appeared to be complicated.

## **Chapter seven - Connections to Education**

### **7.1 Introduction**

The previous two chapters focussed on exploring CYP's connections to their friends and caregivers. This chapter will explore the ways in which CYP accessed their education when admitted to hospital for care and treatment of their mental health. This will begin with discussing the organisation's local policy and procedure documents relating to CYP's education. An overview of the Learning Centre will be provided and the various levels of education provision are discussed, along with its differences compared to typical mainstream schools. Following this, the process of assessing CYP's education needs upon admission to the unit are explored.

Later in this chapter the communication and liaison between the Learning Centre and mainstream schools will be discussed. CYP's experiences of keeping up with their education whilst in the Learning Centre are discussed, including those CYP who were in post-16 education and were either still or no longer attending their mainstream school. Finally, some of the limitations of the education provision at the Learning Centre will be explored.

### **7.2 Theme one – inpatient education and reduced opportunities**

#### **7.2.1 Education policies and procedures**

In the list of organisational policy and procedure documents that I was provided with, there appeared to be a lack of documents specifically relating to the facilitation of CYP's education at the unit. Reference to supporting CYP with keeping up with their education was addressed in the Information Booklet for CYP and caregivers when providing details of the unit's internal Learning Centre, more commonly referred to as the 'unit school'. This informed CYP and caregivers that in addition to providing a full timetable to CYP, efforts were made by the unit's educational department to liaise with the CYP's mainstream school, to establish links to ensure the continuation of their studies:

*“All young people of school age are required to attend the Learning Centre based within [the unit]. The Learning Centre offers a full timetable during normal school hours and term times. It includes individual study on core subjects and group sessions which can include cookery, yoga and music. Links are made, with permission from parents, with the young person's main*

*educational establishment to ensure continuity of studies.” (Information Booklet, Page 6)*

### **7.2.2 Overview of Learning Centre**

Located on the upper floor of the hospital building and situated away from the two hospital wards was the Learning Centre. The structural layout of the Learning Centre consisted of a main classroom, art room, kitchen and a third larger classroom which was used for group work and group therapy sessions with patients. Overall management of the Learning Centre was overseen by a Headteacher, and the day to day running of lessons were managed by a mixture of specialist Teachers, Learning Support Assistants (LSA) and health care support workers who were there to supervise and support CYP.

Attendance to the Learning Centre was compulsory for all CYP still in mainstream school and were expected to attend from Monday to Friday from 9:30am to 3:15pm. CYP were provided with a structured weekly timetable/planner which incorporated the school day around mealtimes, breaks and various individual and group-based therapy sessions and activities such as group art therapy, walking, yoga, sports, music and cooking:

*“Int: How often do young people attend the ward school?”*

*Daily, Monday to Friday 9:30 to 3:15, with a variety of things on the timetable to ensure we promote some type of break in between learning as well. Therapists work alongside the timetable, so they would run joint groups, or groups would be run by therapists during the day.” (Interview, Education Team)*

When discussing a typical day at the Learning Centre, a health care support worker reported CYP starting the day off with a group discussion on a specific topic, such as history or the United Nations convention Rights of a Child, before moving on to individualised work for the school day:

*“So they go into school at 9.30, they have like a welcome meeting in the morning, it’s kind of like an ice breaker, they watch something that is relevant to this date in history and they’ll have a little discussion about that. And then they’ll say, “right when you’ve got maths work to do today so you’ll be spending some time with...”, whoever the teacher is. And then the other young person, “right*



*you've got some English work" so it's all individualised for the young people."*  
(Interview, Healthcare Support Worker)

When asked about a typical day at the Learning Centre, CYP also described starting the day with group-based activity such as a discussion, before moving on to individualised work for the day such as maths, before finishing off the school day with a group activity or therapy in the afternoon:

*"Int: Can you describe a typical day to me in the unit school?"*

*We normally go up there in the morning and we normally have the circle time which is where we're in a group and we do some work in a group. Then once that's done we normally go and do what we fancy doing, like getting maths solutions. Then we normally sit down and there's a group then which is normally either therapy group or stuff like that. Then we go back to what work you want to do."* (Interview, Carly)

### **7.2.3 Learning Centre Education Provision**

This section will explore the various provisions of education for CYP who were admitted to hospital for care and treatment of their mental health. When discussing what academic curriculum and subjects CYP were able to study during their stay at the unit, a nursing staff member explained that CYP's learning would reflect what work they were being taught at their mainstream school:

*"Int: Do you know what subjects are taught in the Learning Centre?"*

*As far as I'm aware it's all the core subjects, and any subject that's taught in mainstream school that is on the curriculum will be taught here.*

*Int: Ok*

*So a bit of everything really. It would be dictated by the schools that they've come from. They'll say, "this is what we're doing in school at the moment", and this is what they need to be doing on the unit really."* (Interview, Staff Nurse)

With the Learning Centre providing education to CYP between the ages of 11-18, most of the learning being incorporated was through the UK national curriculum of Key Stages (KS) 3 and 4. When conducting an interview with an education staff member, she was able to provide further details on what education could be

provided for CYP at the unit Learning Centre, which was dependant on their age and current level of study:

*“Int: going back to the unit school, what subjects are taught here?”*

*Because we can have from 11 to 18, we cover Key Stage 3 which is 11 to 14, with the teachers that we have here, as long as the work coming from their school is relevant, but we can provide work also. We could go into many areas but the core subjects are Maths, English and Science.” (Interview, Education Team)*

The education staff member later explained that whilst they can comfortably support CYP who were in Key Stage 3 education, some CYP on the unit were in KS4 education (14-16 years of age). Facilitating education for these CYP was still possible, although this required a more specialist approach to facilitate if it was outside of core subjects:

*“So Key Stage 3, we would cover everything, and it would be supported from the school, so we facilitate all the subjects. Key Stage 4 they need a little bit more specialist, but we have access to specialist teachers, and I can source those generally through the medium of English through a supply company, if they’re doing their GCSE’s, it’s important that they have that. We have Science, Maths, English for Key Stage 4.” (Interview, Education Team)*

The education worker also explained that whilst in theory the Learning Centre was able to support CYP who were doing their A-Levels, this was highlighted as being a significant challenge for the education team:

*“A-level, then you’re talking very specialist, which can be difficult to get hold of, especially in the sciences, someone to come and support those young people. But I just need to say, we didn’t used to have post-16s in education when I first started working here; when I first started working here we had Key Stage 3 and Key Stage 4, that’s what I was employed to do was to support and facilitate the learning for those young people.*

*Then, there was something to do with the Mental Health Act and 16 year olds weren’t allowed to go on adult wards. We started to see an increase in post-16s, post-16s in education generally are independent learners who will be able*

*to use the internet and link with us for some suggestions, we can facilitate that education, but post-16s not in education can be difficult. We've also had post-16s from colleges that are doing courses such as mechanics and plastering, so I've actually sat next to a guy and talked about plastering.*

*So, we will adapt in order to support every young person, and we'll seek specialist teachers from agencies if that is required. We can usually manage Key Stage 3 but need a bit more specialist for Key Stage 4." (Interview, Education Team)*

#### **7.2.4 Assessing CYP's education needs on admission**

Ward staff described the process of identifying a CYP's education needs when they were newly admitted to the unit. This usually began as part of discussions about newly admitted patients between health, social and education staff members in the daily 'pay over' and weekly ward round MDT meetings. An education worker explained this process and how following the meetings, education and nursing staff would often informally meet with the CYP on the ward:

*"On admission the young people are discussed in the pay over in the morning. We like to meet the young person on the ward and introduce ourselves, then when they come up to school which is quite quickly really, some people are admitted and they're up on the same day, we will give them an introduction to our area of work, give them an introduction booklet and just let them settle in for a certain period. We try to find out a little bit about them, build up trust etc. If they've got work to do from their school, then straightaway we will continue with that. We will also contact their parents and have a chat with them about their perspective of their child's education." (Interview, Education Team)*

Nursing staff also described how educational needs were addressed during the admission process and when completing the patient's CTP. The CTP allows for people who are receiving secondary mental health services, the opportunity to set outcomes in eight areas of their lives. In domain B, 'education & training' outcomes to be achieved in relation to education and training and what services are to be provided by who and by when are documented within the plan. A senior staff nurse described to me how she implemented this as part of her role:

*“Yeah, so as part of the care and treatment plan education is one and occupation... ..they’re two of the domains, so we always when they first come on to the ward find out what their goals are, what they’re working towards education-wise. As a nurse, when I first meet them, I’ll sit down with my patient, we’ll go through their care and treatment plan, looking at the mental health measure<sup>4</sup> where we must see to their educational needs.” (Interview, Senior Staff Nurse)*

Staff reported to minimise the potential delays in receiving work from the CYP’s mainstream school and to get a better understanding of where they were at with their education, CYP were encouraged to attend the Learning Centre regardless of whether contact had been made with their mainstream school:

*“Int: Regarding their education, what happens to a young person when they’re first admitted to the unit?”*

*So they would attend school and usually what happens is the teachers get them to do key stage assessments to see where they are and what kind of help and support they need.” (Interview, Healthcare Support Worker)*

### **7.2.5 Differences between Learning Centre and mainstream schools**

A key difference between the Learning Centre and mainstream schools was the shorter school day. Although the school day officially ran from 9:30am to 3:15pm, it was difficult to state exactly how much time patients spent studying in the Learning Centre. The structure of the morning to mid-afternoon school day incorporated lessons around mealtimes and other activities. Considering the time spent having the mid-morning snack, lunch time meal and afternoon snack, therapy sessions, along with the associated rest periods around mealtimes for some CYP, it would be safe to estimate they spent an average of three to four hours of study in total per day at the Learning Centre.

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<sup>4</sup> The Mental Health Measure 2010 is a law about the support that should be available for people with mental health problems in living within the region. Within part 2 of the measure is the right for an individual to have a personalised, comprehensive Care and Treatment Plan to assist their recovery.

When discussing the Learning Centre in interviews with CYP, some highlighted the difference in daily structure and shorter day when compared to their mainstream school which was often a longer and much busier day:

*“Int: How different is the school here than to back home?”*

*Very different. I usually do an eight till four day in my college with quite a busy timetable and not that many frees whereas here you only work a couple of hours obviously because of the food times and you have therapies which obviously you don’t have in normal college.” (Interview, Emma)*

Another stark difference between a mainstream school and the Learning Centre was the vastly smaller number of pupils in attendance and a higher teacher to pupil ratio compared to a mainstream school. According to staff members, the smaller classroom numbers also helped CYP experience a more relaxed environment when attending the Learning Centre:

*“Yeah massively (different) I would say because obviously there’s a better ratio of staff support for young people. It’s much smaller classes, it’s only the young people that are on the ward have access to school. You’ve got a member of staff and about six or seven children. So it can be good for learners here, it’s a lot more relaxed and it’s a very nurturing learning centre environment.” (Interview, Activity Co-ordinator)*

This was echoed by adolescents who informed me that the lower number of pupils attending helped them to feel less intimidated when in the Learning Centre as opposed to a larger classroom found in most mainstream schools:

*“Int: What is the school like here?”*

*“It’s not proper lessons. They’re more relaxed... ..the school here is much better than actual school because it’s a smaller class so it’s not as intimidating. Overall I think it’s just more friendly and nicer people.” (Interview, Heidi)*

The mix of age groups within the classroom was also a key difference between the Learning Centre and mainstream school which some found difficult to come to terms with. Many like Joanna, highlighted the lack of year groups and lesson schedules in the Learning Centre which are common in mainstream schools:

*“Obviously we don’t have year groups but like we’re all a similar age so like 16 do whatever, and then the younger people do another thing, like... It’s not really scheduled.” (Interview, Joanna)*

During Joanna’s admission, there happened to be many CYP who were around the same age as her. However during Emma’s, she appeared to be one of the eldest on the unit and was admitted around the same time as others a lot younger than her. She described finding it difficult to study in the Learning Centre whilst transitioning from GCSE to A Level, especially when she was not around people her age:

*“...because I am an A Level student that transition from GCSE to A Level isn’t easy especially whilst being in a unit like this where you’re not with people of the same age group either which is quite difficult.” (Interview, Emma)*

Whilst the Learning Centre appeared to provide CYP with a relaxed learning environment, staff informed me that some adolescents found the Learning Centre difficult and unsettling due to not being in their usual school environment and away from their peers:

*“It [the Learning Centre] can be very unsettling for some people, because they’re not used to this, they would prefer to be in their classroom and we understand that learning takes place when you have interaction with others. We can’t really set group activities related to particular topics, so it can be very different.” (Interview, Education Team)*

#### **7.2.6 Learning Centre liaising with mainstream school**

A key component in supporting CYP with keeping in touch with their education was through the communication and liaison between education staff at the Learning Centre and mainstream education providers. The liaison between the two departments would usually be prioritised by the unit education staff and connections were established soon after the patient had been admitted to the unit:

*“What our school department does really well is build strong connections with the schools or colleges out in the community. They’ll get in touch with the teacher, or the Headteacher, or the support worker, look at what work that young person needs to be doing, and they’ll get work sent in. So, the young people then have got a focus when they’re in school, and that’s supported within our own school unit.” (Interview, Social Worker)*

When conducting an interview with one of the unit's ward managers, she reported how the Learning Centre staff made links with the CYP's local education provider to get a better understanding of their education needs and ultimately to reintegrate the CYP into their own school when possible:

*"The [Headteacher] would be linking with the local education provider from the initial point of their admission to see exactly where the young person is at in terms of their education, what subjects they're working on, what needs to be prioritised and then get the work from the local education providers that they can continue as best as possible from within our own provision. We would also be looking at getting the young person back into their own subject lessons locally from the earliest possible stage." (Interview, Ward Manager)*

The ward manager also highlighted how the unit tried to make arrangements to have the CYP attend their mainstream school whilst still being an inpatient at the unit. This process will be outlined in further detail later within this chapter in theme two.

### **7.2.7 Experiences of the Learning Centre**

Of the nine adolescents who participated in the interview phase of the study, five were regularly attending the Learning Centre. One had left school and was in employment, one was anticipating enrolling in college in the new academic year, and two were not in education, employment, or training (NEET). Over the course of the data collection period CYP managed to study the core subjects of English, Maths and Science in the Learning Centre, in addition to a range of national curriculum subjects such as geography, history, art and design and music.

CYP reported positive experiences of the Learning Centre and some had managed to keep up with their schoolwork over the course of their admission. Lilly, listed the core subjects she had studied throughout her admission:

*"Int: Have you managed to keep up with your studies?"*

*Yes, quite well really.*

*What subjects are you studying at the moment?"*

*Maths, English, Science and PSE. I think that's all." (Interview, Lilly)*

Another participant, Carly, described how the unit was able to address and support her with her additional learning needs as opposed to her mainstream school:

*“Int: What’s the unit school like?”*

*It’s good. I’m getting help where I need it in the school here. They’re helping me a lot more. I’m dyslexic. I have dyslexia, whereas my other school wasn’t helping me at all with it.” (Interview, Carly )*

### **7.2.8 Post-16 provision and in education prior to admission**

Due to the range of ages of adolescents being admitted to the ward ranging from 11 up to their 18<sup>th</sup> birthday, inevitably there were some who were in post-16 education and were still attending their mainstream school or college prior their admission to the unit. This range of age groups in the Learning Centre was acknowledged by ward staff:

*“We have a broad range of ages of young people, we can have a young person who is 11 or young person who’s doing their A levels, you know.” (Interview, Healthcare Support Worker)*

Some ward staff reported there had been instances of CYP keeping up with their A-level studies whilst on the unit and described the efforts the education staff at the unit made in liaising with their college to obtain suitable work for them to do on the unit:

*“So there are young people here who have done A-levels... ..the ones who are doing their A Levels or those who are in colleges, again we liaise with the college and stuff like that, and try to give them as much work as possible.” (Interview, Staff Nurse)*

However, as mentioned previously in this chapter, education staff reported the challenges and difficulties associated with provision of education for those in post compulsory education such as A-Levels. When interviewing a CYP who was at the time studying for A-Level Sciences, she reported to me the unit managing to source a science teacher for her however she found it difficult to study this subject due to the tutor primarily working with CYP learning at GCSE level:

*“Int: What is the school like here?”*



*Um I think it mainly works with people up to the age of GCSE as they weren't necessarily sure what to do with an A Level student.*

*Int: Oh I see, okay.*

*They were on about getting a science tutor in, which they did but she mainly worked with GCSE so it was harder for her to... she was kind of learning with me as we were going through the biology and chemistry, so it was quite difficult.” (Interview, Emma)*

Parents also reported how they felt the unit was not best equipped to support their child with their education, especially when their child was undertaking A-Level learning. The father of Emma described to me how he felt the unit was more suited to adolescents studying for their GCSE's:

*“The lack of A-level provision at the unit here. It's not a criticism, it's just what it is. It meant that she didn't have tutors that could really help her... ..I think if Emma was doing GCSE's, and she'd been able to continue with a similar structure to what she was studying but it didn't work out in that way. I know there's been some young people who are actually studying for GCSE's and they're sitting their GCSE's at the moment, and without the school facility, that wouldn't have happened, so you know, we can see it's really positive, but as I said, it's capped really at the GCSE level.” (Interview, Parent)*

### **7.2.9 Post-16 and not in education prior to admission**

Over the course of the data collection period there appeared to be a significant number of patients aged 16 and over who were no longer enrolled in mainstream school. Some had either completed their GCSE's or had dropped out of school prior to sitting their exams. Addressing the education needs for CYP beyond age 16 was highlighted in the patient & parent Information Booklet:

*“Young people not in education and over 16 are offered the opportunity to access 'Learn Direct' courses and engage in activities linked to their interests and can be supported to access education or employment on discharge. A Careers Advisor is available if requested.” (Information Booklet 2019, page 6)*

Many staff members acknowledged there being an issue with those who were post 16 and were no longer in school and the difficulty in how this should have been best managed by the unit, particularly when there were such a vast range of age between CYP studying at the Learning Centre:

*“... we’ve got such a mix of inpatients that are both under 16, and post-16, you’ve got one school unit which is trying to accommodate for children who are perhaps studying for their GCSE’s, but also post-16’s who may not be looking to access education in the community. So, it’s quite difficult for them to manage all of that.” (Interview, Social Worker)*

Other staff spoke of how post-16’s lacked motivation for attending the Learning Centre and often refused, especially when they were no longer enrolled in mainstream education and were no longer required to attend compulsory education:

*“... there is sometimes a lack of motivation for kids to attend school when they feel they don’t need to... they don’t have to legally attend school after 16. Quite often the young person will refuse to go up to the Learning Centre, which I think is a real shame because they could be doing work, and I’m thinking about what they do next, not necessarily academic work. It could be about what courses are available to them, special interests they might have, hobbies, they could use their time in other ways, more constructive ways.” (Interview, Therapist)*

Alternative education provisions in more vocational based subjects as opposed to academic subjects were something many post-16 CYP were interested in undertaking according to unit management staff:

*“Int: Does the unit support young people who are in post 16 education?”*

*It does but it can be more tricky. The feedback that I get from a lot of our post 16s is that they feel that an alternative provision would be helpful such as, young people who maybe struggled academically for many years and it maybe one of the red flags for them. Such as the vocational side of things, that is something which has been brought to my attention and I flagged up to [Headteacher’s] attention on numerous occasions.” (Interview, Ward Manager)*

Discussions regarding the provision of vocational learning for occurred over a series of meetings between CYP and staff members within the wider MDT. During the weekly community meeting, CYP collectively highlighted the need for more vocational activities, particularly for those who had finished school or had completed their GCSE's:

*"Young people reported in the weekly community meeting that they would like more activities, specifically for post-16's and for those who have completed their GCSE's. Young people stated they wanted more opportunities to do arts & crafts, karaoke, music and mindfulness." (Fieldnote, MDT Meeting)*

Addressing the requests from CYP in the following weekly MDT meeting, staff members explored how vocational subjects could be incorporated into post-16's weekly timetable more often:

*"Education Worker suggests utilising the multi-purpose room in the Learning Centre specifically for post -16 young people to do activities like yoga, music, arts & crafts during the general school timetable. She states the room is appropriate as it allows the other young people doing school work and exams a quiet place for revision and others who want to be a bit louder, a place to do other activities without disrupting others. MDT members are in agreement and the Consultant Psychiatrist states that the unit is here to accommodate the young people, not for staff and managers." (Fieldnote, MDT Meeting)*

As previously stated in the unit's Information Booklet (2019), "engagement in activities" were promoted by the unit in conjunction with a more formal education. Vocational activities were especially promoted by staff with post-16 CYP who were no longer attending their mainstream school:

*"Some of the other people if they are above over a certain age, if they've left school, we'll make sure we have some sort of other engagement for them, that could be led by the Occupational Therapist (O.T), led by the activity co-ordinator, that will be art and crafts or music. It doesn't have to be schoolwork, but they're doing something engaging. They're socialising, they're learning something." (Interview, Staff Nurse)*

When interviewing the unit's Occupational Therapist (O.T), I was informed of group work she did specifically with post-16's and what groups were provided by wider members of the MDT. She also informed me that there were opportunities for CYP to contact a careers adviser for future career and education plans:

*"I run two groups looking at budgeting and life skills. Budgeting, it's like a transferable skill, going to the shop with the young people to buy ingredients, that kind of thing. I do life skills too, like how to make a meal, cooking a proper meal. But there are other groups too, there is art therapy, a discussion group by psychology. Recently we've just started doing post-16 groups as well for those children that aren't of school age.*

*We also have the careers lady who comes in to speak to post-16s about careers and can get the young people in contact with the right people outside of here, whether it's for an apprenticeships or college."* (Interview, Therapist)

During an interview with a parent, the mother of Kayleigh praised the Learning Centre for managing to keep her daughter occupied and involved in various vocational activities:

*"Int: How is the school here?*

*Yeah, incredible. Yeah.*

*Int: Ok*

*It focused on what Kayleigh needed really because... not everyone's made for school. Kayleigh certainly isn't, especially after the assault, so... ..she got more out of the cooking, the art and the music than she would have got out of RE and her Welsh lesson. So yeah, it was more through the efforts of the school here, they were very good."* (Interview, Parent)

Jenny, who had finished her GCSE's prior to being admitted to the unit, described to me how she enjoyed participating in some of the vocational ward-based activities when discussing the Learning Centre:

*“...they have music, yoga, art therapy and stuff like that. We’ve got music today. A music man comes in with instruments and microphones, that’s quite nice. Then there’s a kitchen as well.*

*Int: Ok*

*Music’s really good. We do singing and piano and you do it as a group You can do recordings as well and then they give it to you to take home with you.*

*Int: You mentioned the kitchen too?*

*We all have a day where we’re allowed to cook. My day’s Thursday. Last week I made chocolate cake but you can make curry, anything you want really.”*

*(Interview, Jenny)*

### **7.2.10 Examinations**

A key aspect education provision at the Learning Centre was the capability for CYP to prepare for upcoming coursework and examinations. CYP and caregivers were informed of this on admission through the units information booklet stating that whilst limited, examinations could be undertaken at the Learning Centre if they were unable to sit them in their mainstream schools:

*“The Learning Centre is a registered examination centre so young people are able to sit examinations for which they have been entered.” (Information Booklet 2019, Page 6)*

When discussing CYP preparing for exams and coursework with a Staff Nurse, I had been informed that CYP had managed to complete exams during an admission to the unit and the exam revision work that tends to be studied in the Learning Centre was usually the same work as what would be studied in mainstream schools:

*“We’ve had quite a lot of young people that have done exams here or in their school. The teachers here are really good at preparing and working alongside the pupil’s school to achieve that. They take their exams with us if needs be and they then will have like test papers, the same ones that they have in their own school, everything would be the same, the coursework that they would follow is exactly the same as what they would if they were in their normal school.” (Interview, Staff Nurse)*

Whilst informing me that the unit was a registered examination centre and describing to me the process of entering a patient for an exam, the headteacher highlighted the potential challenges with a CYP undertaking exams in certain practical based subjects such as science and geography:

*“Int: Do young people manage to prepare for examinations or coursework?”*

*Yes, we’re an exam centre, we can host exams here. The school would be the entering exam centre, and we would transfer the candidate across to us to allow them to sit the exams. We have to meet exam conditions through the Joint Council for Qualifications (JCQ), and for that we would also be able to administer controlled assessments which are part of coursework that needs to be done. The only thing that would be difficult for us to do is practical science work because we don’t have a lab, so we would rely on the schools to do that. We also find geography coursework & fieldwork difficult due to the illness of the young person not being able to leave the ward, there would be a certain thing they would have to do that their teacher from their school would have organised.*

*So, we can facilitate exams, we can look at catching up with coursework, and completing controlled assessments under exam conditions. We also have had the government tests which are annual tests, during this time of year, and we can administer those in exam conditions and return them back to their schools, if they’re well enough to do it.” (Interview, Education Team)*

When interviewing the CYP, some informed me that they had managed to complete their exams at the Learning Centre:

*“Int: So, you said you were doing art in mainstream school. Were you able to continue that in this school?”*

*Yeah, in fact it was better in this school. I got two or three art qualifications from this school so that’s really good.” (Interview, Heidi)*

Kayleigh informed me that on a previous admission to the unit she had managed to complete a hairdressing exam by completing the theoretical work in the Learning Centre and having time off the unit to complete the practical assessments at a local work placement:

*“When I was here last, I was still doing my level one hairdressing, so they had the examiner come into here and do the tasks with me and I was allowed to work one day a week to do the practical work.” (Interview, Kayleigh)*

When discussing her upcoming exams in our interview, Sarah informed me that she was unsure whether she would be sitting them in her mainstream school or at the Learning Centre. She did not appear to be concerned by this uncertainty however as she had been reassured by one of the unit teachers that she could still sit them at the Learning Centre if she was unable to attend her mainstream school when they were due:

*“Int: Are you due to sit any exams this school year?”*

*Yes I think I’d probably just do it, the same as if you’re here, or there, even.*

*You can do them here, can you?*

*Yes.*

*Int: Have the teachers explained that to you?*

*Yes hopefully I’ll be able to do them in my school, but otherwise, I’ll have to do them here.” (Interview, Sarah)*

Not all CYP were able to complete their exams however, Lilly reported in our interview that she had recently missed a practical exam due to being admitted to the unit when she was due to sit the exam:

*“Int: Have you managed to prepare for any exams, or coursework?”*

*I missed my science because I’ve been here.*

*Int: What was that like?*

*It was hard, because I didn’t really want to miss it... ..but I had no choice, really.” (Interview, Lilly)*

However, when the issue of Lilly’s examinations were discussed in MDT meetings, the unfortunate missed opportunity to sit her exam was addressed by arrangements being made for Lilly to resit her science exam later in the academic year.

### 7.2.11 Limitations of Learning Centre education provision

As previously mentioned when discussing the various education provisions that were available to CYP within Learning Centre, education staff informed me that the focus appeared to be on providing teaching support for KS3 national curriculum core subjects such as maths, English and science. I was also informed that other subjects were facilitated with the support from the CYPs mainstream school. Nia reported that due to the main focussing being on core subjects, she felt her learning in other subjects had been neglected:

*“Int: What do you think the barriers or issues are to keeping up with your studies when you’re in hospital?”*

*Well they only have like, provision to do the core subjects so like other subjects that you choose for GCSE, I think they slightly get neglected. Like I haven’t done any history or RE. I’ve done a bit of art with the art teacher but nothing other than that.” (Interview, Nia)*

Education staff acknowledged that practical based subjects such as geography and science were difficult to support due this requiring CYP to go off the ward and due to a lack of practical facilities available in the Learning Centre such as a laboratory and equipment. This appeared to be an issue for some CYP with the limitation of subjects that they could be supported with when studying in the Learning Centre:

*“The teachers aren’t really trained to do certain subjects so there’s an English teacher, there’s a maths teacher but there’s no a childcare teacher, science teacher, PE teacher, any of the other subjects. When I was trying to do my childcare course I found it very difficult because the teachers didn’t know what they were doing. So... I just didn’t do it.” (Interview, Kayleigh)*

When discussing the subjects she had previously been studying, Sarah described to me what she had been learning before attending the Learning Centre and how she was unable to keep up with her studies in one her subjects, Design and Technology (DT) due to the practical requirements these courses:

*“Int: What subjects were you studying?”*

*Triple science, partially geography, and design and technology (DT). I took it but I haven’t really had time to do any of it, because you need to actually be*



*making stuff and they don't have laser cutters and things here. So you can't really do it." (Interview, Sarah)*

When discussing education provisions with staff members they had informed me of some of the limitations of what could be studied within the Learning Centre. One staff member was keen to remind me that the Learning Centre was situated within a hospital, and whether a full curriculum with young people could be supported:

*"... this is a Learning Centre within a hospital, so it's not possible to offer a full curriculum. They [Learning Centre] can't follow every curriculum closely with every child, because they're catering for 11 to 18s. I don't know if that's even possible to be honest." (Interview, Therapist)*

When discussing their daughter being unable to keep up with her science coursework, the parents of Sarah described her daughter being disappointed. They did however acknowledge and comment that this would have been difficult for the unit to achieve logistically:

*R1: "I think she is disappointed that she hasn't done the coursework with the Sciences because it is the more interesting stuff... ...you are doing the experiments.*

*R2: Yeah... having that practical, lab work... ... that is something you can never get back is it... I don't think they do any of that here, do they?*

*R1: No.*

*R2: It would be quite tricky to do that here." (Interview, Parent)*

Another barrier to some CYP's education was those whose first language was not English and in particular, CYP who studied through the medium of the Welsh language. Of the five who participated in the study who were still in mainstream school and regularly attended the Learning Centre, three studied through the Welsh medium. Sarah, who had been an inpatient at the unit for nearly three months by the time the interview was conducted, described how she had to adapt her learning to English as her first language was Welsh and no Welsh tutors were available at the Learning Centre:

*"Int: What's the school like here?*

*Because I speak Welsh in my school, it's a bit strange then doing everything in English, because they can't find a Welsh teacher. So I've had to move over to doing everything in English since I've been here, so it's a bit of a pain really.*

*Int: Okay. So they haven't even managed to get a teacher in then?*

*No, because they're all in the Welsh schools, so there isn't anybody free.*

*Int: How have you felt about that, doing English work?*

*It was strange to start off with, but because I speak English at home anyway, sometimes I do things in Welsh, but then if I want help, then I have to translate them back again. So it's a bit awkward, really." (Interview, Sarah)*

Nia who came from a Welsh medium school, described how her Welsh speaking had become 'rusty' due to only speaking it in her mainstream school and being unable to study it at the Learning Centre. She was also concerned about it deteriorating further the longer she was in hospital:

*"I feel like my Welsh is probably quite rusty because I don't speak it at home. It's only in school.*

*Int: Did you have any concerns about your Welsh speaking when you first came to this unit?*

*Not really at first... but I think if I carry on for much longer then it will start to deteriorate. I don't know what they would be able to do... ...nobody really speaks Welsh." (Interview, Nia)*

The number of CYP being admitted to the unit from Welsh medium schools and the limited availability of Welsh language tutors was also recognised by the education staff at the unit:

*"At the moment we can't support people who are working through the medium of Welsh, but it is an issue that is being looked at. We have access to a Welsh learning support assistant who can translate and work with that young person, she did come over here once when we required her a while back. We understand there's quite a lot who come from Welsh medium schools and are doing particular subjects, and we have access to agencies who quite often can't supply that particular type of person. That's an area we need to develop and*

*have a bank of teachers that we can refer to, but they're very rare at the moment.” (Interview, Education Team)*

When discussing their daughter studying through the medium of Welsh, the parents of Sarah described how they made the unit staff aware of their daughter's Welsh language needs upon her admission and how the unit staff were going to address this:

*“Int: How different is the school here to Sarah's school back at home?”*

*R1: The main difference is that she goes to a Welsh medium school and they don't have any Welsh speakers here at the school or they couldn't get anyone in either. So, she's sort of carried on teaching herself.*

*Int: Were there any discussions with staff at all around her learning through Welsh?*

*R1 : They did say, didn't they? We made them aware.*

*R2: Yes she was hoping they might be able to get somebody in. But that didn't happen...*

*R1: They did say she could have done a Facetime or something with her Welsh teacher, but that didn't come off for whatever reason. Sarah thought when it was mentioned, she knew it wouldn't happen.*

*Int: Oh, right.*

*R1: Yeah, so there were a few things that have been mentioned that might have been setup which weren't.” (Joint Interview, Parent)*

Despite the parents addressing their daughter's language needs on admission and staff stating they could accommodate this expectation, in reality this specific need went unmet.

### **7.2.12 Summary**

In summary, this theme has explored CYP's education needs whilst they were in hospital receiving care and treatment for their mental health. It has highlighted the lack of local policy and procedure documents in this area, whilst providing an overview of the unit and the education provision that was available to CYP. Some of the key differences between the Learning Centre and mainstream schools have

been discussed, along with the communication and liaising between the two education departments to ensure CYP are provided with their schoolwork. CYP's experiences of their education in the Learning Centre have been explored, including CYP who were undertaking exams and in post 16 education. Finally, some of the limitations of education provision at the Learning Centre have been outlined.

### **7.3 Theme two - Interface between Learning Centre and mainstream School**

#### **7.3.1 Introduction**

This theme will explore the role mainstream schools played in supporting CYP with keeping up with their education whilst in hospital for care and treatment of their mental health. This will be achieved through exploring some of the methods mainstream schools used to facilitate supporting CYP with their studies. Following this an important aspect and key component of inpatient education will be explored, the process of reintegration back into mainstream school and the support provided from community CAMHS teams.

#### **7.3.2 Mainstream schools providing work**

As mentioned in the previous theme, after being contacted by the Learning Centre's education team, the school was usually responsible for arranging work to be sent into the Learning Centre. This work had been prepared by the mainstream school and was usually sent through email, by mailing it to the unit, or given to parents to bring in when they visited their child. In some mainstream schools however, interactive methods were being utilised to keep CYP in touch with their education such specific online learning platforms. By remotely logging into these websites from the Learning Centre, the platforms gave CYP the opportunity to access lessons their peers would have been studying in mainstream school:

*"Int: How do you promote young people keeping in touch with their education studies?"*

*We keep in touch through email with their teachers directly... ..the main thing that's happening at the moment is a lot of schools are using what's called Moodle, or Google Classroom, or social media, in order to keep young people up to speed. They can put lessons on there so we can access those lessons directly, we would encourage them to look at their school emails as well, because some teachers email work or messages about work to their pupils*

*directly. So, it's very important that we've got enough computers, and we give them enough access to that aspect of school life... ..we encourage them to straightaway show us their school website and show us if they've got any links. If they can't remember their password for some reason, we'll go back to the school and get that password and encourage them to log on."* (Interview, Education Team)

The education worker also described an interactive method that some mainstream schools had started to implement which involved creating podcasts of lessons for CYP to access remotely:

*"We have had some schools now going a bit further, making podcasts of lessons, and I would really like to see more schools doing that type of thing, because it allows that young person to feel like they're in that lesson. I think that's the way to go forward."* (Interview, Education Team)

When discussing this further however, the education worker highlighted that this relatively new interactive method involved certain schools within the region and that there was a large financial element involved when providing this bespoke education for an individual:

*"Int: Is this something that is pretty new then?"*

*It's the first time this year that we've had a podcast of a lesson, I know there are some isolated schools that are going for a Skype type of method where they can watch that lesson. We've also had somebody who is using InterHigh, which is an interactive lesson, at certain times they would log on, like a distance learning system I should imagine, where the tutor was available and gave a lesson through that. But that was a specific young person who had been offered it due to not being able to attend school, so there was a big cost around that for her school."* (Interview, Education Team)

### **7.3.3 Slow links with mainstream schools**

A barrier for some CYP accessing their education whilst being an inpatient was the mainstream school that they were associated with at home. When interviewing a management staff member at the unit, I was informed that some mainstream schools were more consistent than others at maintaining contact with the Learning Centre

and at attending key meetings regarding the planning of CYP's care such as CTP review meetings:

*"Some schools are not as good at keeping in touch with the Learning Centre as they could be... ...some are better than others at attending reviews and being available for meetings, and it's probably down to resources, time, distance if it's [in the West of the region]. Yes, the distance they live away is probably going to show up as being an issue." (Interview, Ward Manager)*

An activity co-ordinator who worked closely with the education team, highlighted whether or not a CYP received timely work from their mainstream school could have been dependant on their mainstream school:

*"Int: what you think the barriers or issues are to young people keeping in touch with their studies when they're on the unit?"*

*"Well, I think a main barrier... ...it all depends how good the school is that they've come from because they're the ones that are providing the work. So if the host school isn't providing them with the appropriate work, then you've got difficulties." (Interview, Activity Co-ordinator)*

When discussing the issues of mainstream schools with caregivers, they described problems with communication and delays in their daughter receiving mock examination papers to practice at the Learning Centre:

*"R1: I think it is just the communication with Sarah's (mainstream) school. Because the teachers here (Learning Centre) are having to get in touch with other teachers... ...it is always difficult getting in touch with teachers in a big school when they are teaching themselves.*

*R2: Yes. That is probably more of an issue. The links from her school.*

*R1: There wasn't a continuous flow of work was there?*

*R2: No. I think there have been a few hiccups. It took a little while to get the papers coming from her school efficiently." (Joint Interview, Parent)*

#### **7.3.4 Mainstream school reintegration**

For CYP who had been attending their mainstream school prior to being admitted to the unit, some were able to gradually transition back to attending their mainstream

school during their admission. Reintegration to mainstream schools often occurred when a CYP had been on the unit for some time and was working towards being discharged from the unit.

The planning of CYP potentially attending their mainstream schools in the future was often discussed each week in MDT meetings between professionals as part of wider discussions on CYP having home leave from the unit:

*“The planning for Sarah’s home leave is discussed. The Consultant Psychiatrist states he would like Sarah to have 24 hours leave and to attend her school for one session, even if this is just for the social aspect. Education worker states that Sarah has exams coming up this summer.” (Fieldnote, MDT Meeting)*

Following these initial discussions regarding CYP reintegrated into their mainstream school, arrangements were often discussed in liaison with mainstream school teachers, and in partnership with the CYP, caregivers, and unit staff members in MDT and CTP ‘review’ meetings:

*“Int: Do young people attend their own school back home?”*

*Yes, if they’re on a transition pathway and they’re spending 48 hours to 72 hours at home, generally it can start off with an hour or two, go to breaktime just to be in the building, meet your peers, have a catchup, and then maybe the next day or whatever the young person is able to start incorporating some lessons. The young person very much leads that in what they feel able to manage. So, it’s very much done in partnership.” (Interview, Education Team)*

### **7.3.5 Experiences of mainstream school reintegration**

Over the course of their admission to the unit, some CYP reported that they had managed to begin attending their mainstream school. Nia reported to me how despite her education started to return to normal, she struggled with seeing her friends:

*“Int: Have you kept in touch with your school?”*

*Yeah, a little bit, I first went to school about a week or two ago and in a way, it was quite nice to go back to normality, but it was also quite difficult as well. It was quite stressful seeing everyone.” (Interview, Nia)*

Lilly, who was further along the care pathway and was working towards being discharged from the unit, described to me how she gradually spent more days per week at her mainstream school:

*"I go there on certain days, like three times a week probably. I had to gradually build it up."*

*Int: Okay, so it wasn't something that happened straightaway?*

*No, over time. First I went once a week first and then increased it slowly."*  
*(Interview, Lilly)*

The stress experienced by some CYP when going back to their mainstream school was acknowledged by staff at the unit. A Senior Staff Nurse recognised this in our interview and reported on how different the environment of the Learning Centre is logistically. She also highlighted how the education team at the unit liaised with mainstream schools in CTP reviews to support the CYP when returning to their mainstream school and described strategies such as being accompanied by a close friend:

*"Int: Do young people attend their own schools?"*

*Yeah, that's all part of the working towards going back into the community, so often if young people have been here for like a couple of months, that can be a really scary thing for them to contemplate going back to school, so sometimes they start going back one day a week or one class a week. Often during the CTP reviews, education would speak with the young person's school to look at their timetable and establish a fairly comfortable class for the young person to go back to for that one time."* *(Interview, Senior Staff Nurse)*

The gradual reintegration to mainstream school did not always go as planned by the MDT however and in some cases, there was too much reintegration. In one MDT meeting it was reported that a CYP had planned to go to her mainstream school for 30 minutes to see her friends for the first time since being admitted whilst she was on home leave from the unit, but ended up staying longer than had been planned and attended additional lessons:



*“A Staff Nurse reports that Jessica is currently on home leave, and the plan was for her to gradually attend her own school.*

*An education worker states that when Jessica last went on leave from the unit, she took on too much at once at her own school. She was due to attend her mainstream school just to see her friends but ended up staying for half a day. Jessica stated to a Nurse that this felt overwhelming, and that she realises she needs to take small steps.” (Fieldnote, MDT Meeting)*

In some cases, staff members undertook individualised work with CYP specifically around reintegration into mainstream school. One therapist described to me a piece of ongoing roleplay she was doing with a patient to support them with the anxieties they had about returning to their mainstream school:

*“I often role play with a child, we will do visualisation techniques (like) “Ok, allow me to be you walking through those school gates, tell me what I’m going to see... .. who are you going to meet? How long are you going to be there?” I want to hear what you’ve told your mates. “Where have you been?” You know, because some kids will say they’ve told them they’re in the general hospital or, “sorry I’ve been travelling the world”. I’ve heard phenomenal stories.”*  
*(Interview, Therapist)*

### **7.3.6 Community teams supporting reintegration**

During weekly MDT discussions, the availability of various community CAMHS teams to support CYP returning to mainstream school was often discussed. When exploring support for CYP transitioning to mainstream school from the Learning Centre, the head teacher explained that the community CAMHS teams were relied upon by the unit:

*“...we’ve got different areas where we have [different community teams] working through certain health boards. They can meet people in schools but I don’t think they transport. They can liaise with the school in the community because that would be something we would find difficult to do due to staffing. We haven’t got the ability to transport or support [CYP] in the school environment. So, we would rely on the community teams.” (Interview, Education Team)*

The education worker later explained however that the support for adolescents from community teams with mainstream school reintegration often depended on where they lived, due to various community teams having different remits with their service provision:

*“...it depends on the remit of the community team. [community team] generally support people in school by having meetings with the school. [another community team], link with colleges and schools and take on that responsibility. But [West community team] don’t actually do anything, they’re very different to all of the other teams.*

*In fact every team is a little bit different in what they can offer. So, we would encourage parents to keep in touch with the school, and we would organise a meeting with the school, or somebody to meet the young person at reception so they didn’t feel they were just walking into a class, and work with the school regarding the anxiety they might be feeling around those situations.” (Interview, Education Team)*

### **7.3.7 Summary**

In summary, this theme has explored CYP’s mainstream schools within the context of when they were inpatients receiving care and treatment for their mental health. This theme has highlighted the various online, interactive and distance learning methods some mainstream schools utilised to support CYP with accessing their studies. It has also reported the lack of communication some mainstream schools have with the Learning Centre, and the inefficiency of sending work through to CYP. Finally, the careful planning of CYP transitioning back to mainstream schools has been discussed, along with the support some community teams were able to provide depending on their remit and service provision. The final theme within this chapter will discuss the potential physical health and mental health issues have on CYP’s education when they are in hospital for care and treatment of their mental health.

## **7.4 Theme three – Impact of health on education**

This theme will explore some of the physical health and mental health barriers to CYP’s education whilst they were inpatients in a mental health hospital. This will begin with exploring how some CYP’s access to education was affected due to some of the physical and cognitive effects on them due to various mental health conditions, along with the side effects of medication used as treatment for the conditions.

Following this the experiences of CYP who were concerned over missing school will be discussed, and how CYP were encouraged to recover before considering their educational needs. Finally, some CYP having to reduce the number of subjects they were studying due to missing school as a way of coping, will be explored.

For some CYP, the severity of the physical and mental health issues they were experiencing affected their ability to attend the Learning Centre. Throughout the data collection period there were instances of CYP being unable to go to school due to physical and mental health reasons. In one MDT meeting, Callum, who had been admitted to the unit with an eating disorder, anorexia nervosa, had his physical health discussed by the MDT and how it impacted him attending the Learning Centre:

*“Callum’s clinical presentation and symptoms of Anorexia Nervosa are discussed. Education Worker states that she has met Callum and that he has been enrolled in the Learning Centre, but at present he is too physically unwell to attend. Due to ongoing rapid weight loss, the MDT agree that Callum will need to have an extended period of bed rest until he is physically able to attend the Learning Centre and, in the meantime, the Education Worker will provide work for Callum to do on the ward.” (Fieldnote, MDT Meeting)*

Steven, who had been admitted multiple times with Psychosis throughout the data collection period, often found it difficult to concentrate on schoolwork at the Learning Centre. When discussing the planning of his care in a weekly meeting, members of the MDT considered the possibility of engaging Steven in vocational activities as opposed to academic work due to his reduced ability to concentrate and disrupted thought patterns:

*“Student Nurse describes Steven’s presentation. She states he attends the Learning Centre, although an Education Worker states that he is unable to sit still and concentrate in school and often sits in the school corridor throwing a ball. A therapist describes Steven as being warm hearted towards other young people on the ward despite psychosis present. Consultant Psychiatrist states he hopes Steven can develop vocational skills on the ward as opposed to academic work. Education worker suggests modifying his timetable to focus on more vocational activities.” (Fieldnote, MDT Meeting)*

During interviews with staff members, some reported that occasionally there were instances whereby CYP were unable to attend the Learning Centre due to physical and mental health related complications:

*“It depends on how able they are. Because sometimes if say they are... like those patients who are psychotic or treatment resistant, the mind is not capable of doing the work... ... some of the people with eating disorders, they again were discouraged from going to school because of their physical state.”*

*(Interview, Medical Team)*

In some instances, CYP were unable to take part in certain physical activities due to the activity potentially impacting their physical health and its complications associated with Anorexia Nervosa. Nia described how she was unable to take part in a recent yoga group activity:

*“... it’s a bit of a shame that I’m not allowed to do that. I think it would be quite a nice one to attend... ... but because they don’t want me to burn calories... they would let me if I chose to have extra food, but I don’t think they think I’m ready for that yet.”* *(Interview, Nia)*

#### **7.4.1 Side effects of medication**

Some CYP reported the side effects of medication they had been prescribed was having an impact on their ability to study in the Learning Centre. When discussing the Learning Centre in our interview, Nia mentioned that if she was struggling to concentrate or felt fatigued due to the medication she had been taking, she would ask to return to the ward:

*“Sometimes it just doesn’t feel right going up [to school] because I just can’t concentrate and I feel tired, which I think might be due to the medication.”*

*(Interview, Nia)*

When discussing how she was coping with her schoolwork in a professionals’ meeting, the MDT discussed reviewing Nia’s medication and its dosage, as she had stated to staff it was impacting her ability to do work:

*“A Consultant Psychiatrist asks the MDT how Nia is doing in the unit classroom. An education worker informs the MDT that Nia is excellent academically, however she appears to have ‘shakes’ in her hands which Nia has stated she*

*believes is due to the medication she is on and is also worried that she is not performing academically compared to what she has been previously. The medical staff attending the meeting state that they will review Nia's medication and its dosage" (Fieldnote MDT Meeting)*

The medication some CYP took as part of treatment for their mental health having an impact on their education was also reported by caregivers. When discussing his daughter keeping up with her studies whilst being an inpatient, one parent informed me that her medication, combined with her illness impacted her ability to focus on her studies:

*"Even if Emma was in the right frame of mind to try and work, because of the illness and the meds she's taking, she's not really in a position to study either. Emma says the medication she's on at the moment makes her sleepy, and her concentration span is lowered. She finds it difficult to really focus on something complex. She used to love to read, a massive reader. She hardly reads at the moment because she can't just concentrate on a book and take it in so she might pick up a few pages and put it back down again, whereas before, she would just devour a book." (Interview, Parent)*

#### **7.4.2 Concerns over missing school**

Several adolescents reported feeling worried or concerned that they had missed time out of their mainstream education. During MDT meetings, the education team attempted to address these concerns by contacting staff at the mainstream schools:

*"An education worker states that Maya is due to attend her mainstream school this week. Maya reported to the education worker that she struggles with missing lessons in her own school and being unable to attend all her lessons. She is also concerned that her GCSE's will start soon and that she is worried about falling behind in English, Maths and Science. The education worker states to the MDT that she will contact Maya's head of school to discuss these concerns." (Fieldnote, MDT Meeting)*

Lilly, who was due to begin GCSEs, described feeling scared about returning to school due to missing time at her own school but was hoping to catch up:

*"Int: Have you kept up with your studies?"*

*I haven't really. I'm quite behind.*

*Int: Ok*

*I think I've fallen behind quite a lot, and I'm just scared to go back now and do my GCSEs, because I think I've missed a lot of schoolwork, really.*

*Int: Are you hopeful about catching up?*

*Yeah, I want to catch up. I know it's going to be hard because I'm really behind." (Interview, Lilly)*

The grandmother of Lilly was more optimistic however, and discussed with me how she believed Lilly would be able to catch up with her studies despite missing some time off school:

*"Int: Has Lilly managed to keep up with her own schoolwork since she's been here?*

*No, which is one of the things which is making her anxious, that she's behind.*

*Int: Ok*

*Although since she's been here I guess she has caught up a little bit. I don't know really. I think if her recovery is able to continue as it is now, I'm fairly optimistic that she will be able to catch up. She's very bright and she's very good at focusing and I think she'll be determined to do well and she will." (Interview, Grandparent)*

#### **7.4.3 A focus on health in addition to education**

When discussing the concerns or worries over missing time from their mainstream school, CYP and caregivers informed me that previous concerns about missed education were not as important now and they described how they felt that they needed to focus on their recovery first, as opposed to education. One father described to me how due to the severity of his daughter's deteriorated physical health, she was unable to attend school for many months. During our interview, he emphasised that it was irrelevant if his daughter did not follow the traditional GCSE to A-Level learning pathway, and that it was important for her to do what was right for her at the right time:

*“Without being too dramatic or blunt, the way I see it is without her coming here, she’d probably be dead. Her physical health was extremely poor when she was in hospital and they were very worried about her physical state, that’s why she was brought here under a section. If she’s missed school, if she doesn’t follow the path she was probably going to follow before, it doesn’t matter. Education is something that people can go to at any time. If it’s right for her to pick it back up, and that’s what she wants to do, then fine. She’s a very driven student. She still talks about her aspirations to work in medicine... ..it’s about finding what’s right for her, you know, and time will tell. The fact that she hasn’t followed the traditional GCSE A-level path is irrelevant really.”*

*(Interview, Parent)*

The traditional compulsory education pathway was also discussed in interviews. When discussing her GCSE’s and how she had missed some of her mainstream education, Jenny informed me that she was not as worried as she had been previously, and could take GCSEs in the future:

*“I was worried, but then I understand you can redo your GCSEs at any age. It’s just everyone thinks you’re meant to have them when you’re this age, like it doesn’t really matter what age you have them.”* *(Interview, Jenny)*

One mother also reported to me having previously felt worried about her daughter having missed school. She described a change in her outlook towards this however and was more focussed on her daughters recovery before pursuing her exams. The mother also mentioned to me in our interview that there had been discussions about her daughter potentially dropping some of her studies whilst she continued her recovery to focus on a select few:

*“It would have worried me a year ago that she wouldn’t be in school. I don’t really care now. I just want my daughter to be happy again. She’s very bright and I have come to terms with the fact that she may not do exams until she’s ready, until she’s well and if it means she does them at a very different stage, that’s fine.”* *(Interview, Parent)*

In many instances there had been discussions between patients, caregivers and MDT members about reducing the number of subjects a CYP was studying due to missing school due to their physical and mental health. In some cases, CYP went

back a whole academic year. Caregivers described how their child had purposely planned to go back a year in school due to missing several months of mainstream education whilst being an inpatient at the unit:

*“Emma wanted to go back to college. We were arranging some college attendance... ..but realistically, when you’ve missed months of A-level study, you can’t really catch up or drop into the odd lesson. So, Emma has pretty much written off this academic year for herself. She does want to return to study, she’s planning for that.” (Interview, Parent)*

When interviewing Emma, she discussed with me her plans to re-sit the current school year and how she had planned to recommence her studies the following academic year:

*“A lot’s happened since I’ve been admitted so I’m going to restart my A Level in September so... I’ll be a year behind my friends so I will be working on different time scales which will be difficult.” (Interview, Emma)*

Emma also described to me how through planning to re-sit to academic year, her worries and anxieties around potentially falling behind with her studies were eased:

*“When I was first admitted I was really worried about my education because I haven’t attended college properly since October, so I was worried that I was falling behind and I was missing mock exams and that I was going to have to redo the year. I just didn’t see how I was going to catch up at all so I thought it was better that I just redid the year in September so that’s definitely eased my worries because I was falling behind.” (Interview, Emma)*

On occasions CYP reduced the number of subjects they were studying due to the additional stress and anxiety it caused them. A staff member reported to me that often CYP will maintain some form of education by reducing the overall number of subjects, and to focus on core subjects that they know they will perform well in:

*“Int: Have young people had to reduce the number of subjects that they have been studying?”*

*Yes, that’s quite common, we get a lot of young people who come through who want to maintain their education. They’re still very much focused on getting an*



*education but realise that maybe the amount of subjects is quite distressing for them at times, they're not managing the stress that it's causing. They might be feeling anxious about a certain subject, they might not have completed enough, so it could be a suggestion that they perform better in a number of core subjects rather than trying to get too many GCSEs, and getting lower grades etc.*

*So, we can have discussions with them on what subjects they like, what subjects they would prefer, and they feel they're able to continue with, and then discuss that with the school. Quite frequently they will go back on a reduced timetable, but they maintain their education.” (Interview, Social Worker)*

When interviewing the education staff however, one staff member highlighted to me that not all CYP reduced the number of subjects they were studying. Some managed to catch up with their coursework and achieved successful gradings in certain assessments, despite missing many months of schooling:

*“Some people do have to reduce their subjects, which would be done in their best interest, in conjunction with them and their parents. Some people come here and haven't done coursework for six months and have caught up completely, so they haven't had to drop anything at all.” (Interview, Education Team)*

#### **7.4.4 Summary**

This theme has explored some of the physical health and mental health barriers to CYP's education whilst they were receiving care and treatment for their mental health as inpatients in a CAMHS mental health hospital. Firstly, the physical and mental health symptoms impacting CYP accessing their education was discussed, along with some of the side effects of mental health medication. Following this caregivers and family members experiences of CYP missing school was discussed, and how there was an emphasis on CYP recovering from their illnesses before considering their educational needs. Finally, CYP reducing the number of subjects they were studying as a way of coping with the additional stress and anxiety over their education was explored.

## **7.5 Chapter Summary**

In conclusion, this chapter has included data generated from interviews with CYP, caregivers, a variety of ward staff and documentary data such as local policies and fieldnotes of direct observations of MDT meetings.

The first theme in this chapter began with an overview of the provision of education offered to CYP in the Learning Centre, which included KS3 and limited KS4 provision. Following this the process of identifying CYP's learning needs were discussed. Next an overview of the Learning Centre was provided, and a comparison was made between the Learning Centre and mainstream schools in terms of timetables, class sizes and the mixture of age groups. Following this the experiences of CYP accessing the Learning Centre were discussed and the education for CYP aged 16 and above who were both in and not in education was explored. A key component of CYP's education was then discussed, examinations. Finally, the limitations of the Learning Centre were then explored.

The next theme explored CYP's mainstream schools whilst they were in hospital. It reported how mainstream schools liaised with Learning Centre staff to provide CYP with work they would be receiving in mainstream school and highlighted online and distance learning methods some schools were adopting to support CYP with their studies. However, this theme also found that some mainstream schools were more consistent than others with regards to arranging sending in work and attending key meetings at the unit. This theme also explored CYP's reintegration into mainstream school. The planning process of reintegration was described and included patients' experiences of school reintegration and explored how some CMHT's supported CYP reintegration although this was dependent on remit and service provision.

The final theme in this chapter explored some of the health barriers to CYP accessing education at the Learning Centre. This included the symptoms of CYP's physical and mental ill-health impacting their education, and associated side effects of medication. This theme highlighted how this impacted some CYP missing school, and how there was a willingness to support CYP with their recovery of their mental health before addressing their educational needs.

## **Chapter eight – Discussion**

### **8.1 Introduction**

This study adds to the growing body of literature concerning CYP staying in hospital for care and treatment of their mental health. The study aimed to explore the opportunities and barriers to CYP's connections to their friends, family and education during periods of inpatient mental health care. In this final chapter an overview and recap of the study is provided and discussions pertaining to the main findings that have emerged from the study in relation to existing literature on CYP's experiences of inpatient mental health care in relation to contact with their friends, family and education are included.

The discussion highlights the study's unique contributions to research into CYP's mental health during inpatient mental health care. This is the first study to explore connections to friends, family and education for adolescents who were patients at an inpatient mental health unit within the region. The utilisation and application of mixed research methods to collect data in this study and data collection involving CYP who were current inpatients, their caregivers and a variety of health, social and education staff to describe the experiences of each individual has not been previously undertaken in the NHS in the region. The implications for further research are provided, study limitations explored and plans for dissemination are described.

### **8.2 Study overview**

This section will provide an overview of the study and its aims and objectives which were previously referred to in Chapter three. The overarching research question was: *“What are the interventions and the processes that promote or hinder young people's connections to their education, friends and families during inpatient mental health care?”* and the study had the following four main objectives:

1. To explore how health care, social care and teaching practitioners facilitate connections to education, friends and families when young people are in hospital receiving mental health care.
2. To examine CYP's and caregivers' experiences of maintaining connections during admission to inpatient mental health care.
3. Assess the suitability of standardised tools to measure outcomes related to education, friends and families for young people in a mental health hospital.

4. Identify candidate interventions and processes helping young people maintain their connections during periods of inpatient mental health care.

A summary of the study's main findings in relation to study objectives 1 and 2 can be found in the table below and the findings will be discussed in further detail.

Table 8.1- Summary of main findings for objectives 1 and 2

<b>Remote connections</b>	<b>Physical connections</b>	<b>Peers in hospital</b>	<b>Impact on families</b>	<b>Connections to education</b>
<ul style="list-style-type: none"> <li>➤ Mobile phones</li> <li>➤ Internet/Social media</li> <li>➤ Ward telephone</li> <li>➤ Letters/cards</li> </ul>	<ul style="list-style-type: none"> <li>➤ Visitation</li> <li>➤ Home leave</li> <li>➤ Geographical/physical distance</li> <li>➤ Visitors' Suite</li> </ul>	<ul style="list-style-type: none"> <li>➤ Formation of new friendships</li> <li>➤ Group activities/therapy</li> <li>➤ Challenges of living in hospital with other CYP</li> </ul>	<ul style="list-style-type: none"> <li>➤ Emotional</li> <li>➤ Financial</li> <li>➤ Employment</li> </ul>	<ul style="list-style-type: none"> <li>➤ Inpatient education and reduced opportunities</li> <li>➤ Interface between inpatient school and school of origin</li> <li>➤ Impact of health on education</li> </ul>

### 8.3 Remote connections

#### 8.3.1 Remote connections with friends and family – Mobile phones

The findings suggest a primary form of remote communication for CYP to keep in touch with friends and family was through using personal mobile phones, with seven of the nine interviewed informing me that they had access to a mobile phone during their admission. The provision of mobile phones for CYP in inpatient CAMHS is suggested in the most recent inpatient CAMHS service standards, with recommendations that CYP have access to mobile phones, computers and other electronic devices subject to risk assessment and in line with local policy (QNIC, 2021). The health care organisation had its own specific policy with regards to patients' access to mobile phones, which allowed access for one hour between 6-7pm in the evenings. The time constraints on the access to mobile phones was an issue for some CYP, who reported that they felt the one hour per day was not enough time to speak to their friends and family, particularly if they wanted to contact more than one family member during the hour or if their friends and family were unavailable. Parents reported finding it difficult having to get used to the small

window of opportunity to contact their child during the evening and this was especially difficult if parents had other commitments such as work or caring for other siblings. Caregivers also described feeling surprised their children had coped well with the reduced access to mobile phones, with one parent reporting that his daughter's prolonged mobile phone use directly impacted her mental health. Interestingly, some CYP interviewed reported not being affected by the restricted access to their mobile phones, and preferred face to face contact with their friends and family when they visited or went on home leave. Additionally, staff members highlighted that in some cases CYP were relieved to have had their access to their mobile phone reduced due to previous experiences of cyberbullying.

Although a key form of communication for CYP in this study was through using mobile phones, a concern amongst CYP and parents regarding its use was the perceived lack of privacy to speak with friends and family. The organisation's policy on mobile phones ensured they had to be used in the main communal lounge under supervision from staff members. This resulted in many CYP relying on text messaging or using instant messaging applications such as WhatsApp to contact their friends and family as opposed to calling them, as they did not feel comfortable having conversations in shared communal spaces.

Access to items such as mobile phones has also been reported in previous studies (Moses, 2011), where CYP reported access was too limited and rigidly enforced by unit staff. In Bravander's (2017) study, the limits placed on mobile phones were understood to be one of the least helpful aspects of the inpatient experience for CYP. The ability by which CYP were easily able to make phone calls was also highlighted as practical solution for CYP to maintain contact with their family in another study (Stanton et al, 2020).

### **8.3.2 Remote connections with friends and family - Access to the internet and social media**

Findings suggest that whilst CYP used their mobile phones for the purpose of calling and text messaging friends and family, CYP in this study also accessed the internet and social media applications through their mobile phones to contact their family and friends. This appeared to be one of the most prominent forms of remote contact between CYP and their friends and family and there appears to be a dearth of both

research and recommendations from policy documents in this area within the UK adolescent inpatient mental health literature.

Over the past decade, there has been a rapid increase in CYP's internet and social media use (Glazzard and Stones, 2020). Research has indicated that over a third of UK 15 year olds are classed as 'extreme internet users' and a third had used the internet by age 6 (Frith, 2017). CYP in the UK use social media extensively, with 91% of those aged 16-24 using the internet to access social media (Royal Society for Public Health (RSPH, 2017) and nearly 95% of 15-year-olds access social media applications either before or after school daily (Frith, 2017).

The internet and social media are important aspects of CYP lives which have increasingly become a part of clinical practice with CYP (Stanton et al, 2015). In the current study, mobile technology such as the internet and social media applications brought new ways in which CYP were able to connect with others. However, this also brought significant challenges for CYP, parents and staff members regarding its safety and how staff members safely managed CYP's internet and social media access on the unit.

As indicated earlier in this chapter, CAMHS inpatient service standards acknowledge CYP having access to mobile phones and other electronic devices which provide access to the internet and social media. Further recommendations include inpatient units having a local policy on mobile phones and that the use of such devices respects the privacy and dignity of other patients, and to have procedures in place should this be breached (QNIC, 2019). Within the health care organisation's policy on CYP using mobile phones was a section specifically relating to CYP's access to the internet and social media. Access to such media was not permitted unless a contract had been signed between the CYP and their caregivers. Details regarding the key components of the contract were previously outlined in Chapter five.

The findings suggest there were instances of CYP keeping in touch with friends and family in a positive manner through using social media and social networking applications on their mobile phones and other electronic devices. The most accessed social media applications appeared to be 'apps' which had implemented an instant messaging service such as WhatsApp, Facebook Messenger, Instagram and Snapchat. There is some evidence to suggest that social media can be a useful

platform for CYP to make or sustain social connections with others (RSPH, 2017) and strong adolescent friendships can be enhanced by social media interactions (Lenhart, 2015) particularly if friendships are affected by geographical restrictions (Glazzard and Stones, 2020).

Whilst CYP informed me that they had kept in touch with friends through social media and social networking platforms, some parents perceived this type of contact to be superficial and not as valuable as face-to-face interactions. Parents also commented on the negative influence they perceived social media applications such as Instagram were having on their child, with one parent whose daughter was admitted with an eating disorder, describing how her mood would be affected after spending long periods on Instagram comparing her body image with that of female fitness models.

Through interviews with caregivers and ward staff and through observing MDT meetings, it was evident that some CYP were accessing online content through websites and social media that were deemed to be harmful to their physical and mental health. This included CYP accessing websites on self-harm and the promotion of harmful behaviours associated with eating disorders such as 'pro-ana', 'pro-mia' and 'pro-ed' (Yeshua-Katz and Martins, 2013). CYP accessing internet webpages which may include a higher risk of harm to them such as content that endorses eating disorders, self-harm and suicide has been reported in other studies. Findings from a UK study indicated that of girls aged 13-16, 14% reported accessing anorexic or bulimic content, 9% self-harm websites and 8% reported viewing websites discussing suicide (O'Neill and Dinh, 2015). Research on CYP accessing the internet and social media within an adolescent inpatient setting is scarce, although a survey from one study in Ireland has reported CYP in both inpatient and outpatient settings accessed more harmful content when compared with those under community mental health services (Mullen et al, 2018).

The findings also suggest that there were challenges encountered by staff members when trying to safely manage CYP's internet and social media usage on the unit. When interviewed, some staff members reported that their 'hands were tied' when it came to managing CYP's social media and internet usage. It has been reported that the rapidly changing access to and evolving content of the internet may leave

clinicians feeling unprepared regarding this aspect of CYP's lives (Rafla et al, 2014). Whilst staff members acknowledged the positive aspects of CYP's access to the internet and social media, they also described sitting with CYP in key working sessions and discussing the potential harms. A similar approach to managing internet and mobile phone use has been previously demonstrated by another UK CAMHS inpatient unit which was regarded as an example of good practice. By taking an open approach to the use of the internet and staff being honest with CYP about its potential risks, this unit aimed to adapt the culture to empower CYP so that they benefitted from access to the internet (QNIC, 2016).

### **8.3.3 Remote connections with friends and family - Ward mobile phone**

Another means for CYP to remotely communicate with friends and family was through the ward's mobile phone, which was available for CYP to use for either one 15-minute phone call or 3x5 minute phone calls. The ward mobile phone appeared to be particularly important for the two CYP interviewed who did not have access to a personal mobile phone. Caregivers also reported the ward mobile phone as a helpful intervention and described feeling reassured that their child had regular access to a telephone. Initially the ward mobile phone appeared to have restricted access, although the findings from interviews with CYP, caregivers and ward staff indicate that in practice, staff were flexible when providing this and CYP were able to use it to call family members outside of the allocated time for mobile phones. This flexible approach from staff members regarding the ward phone contrasts the rigidity of staff members' approaches found in other studies (Moses, 2011), where participants reported being unable to use a ward telephone to contact their parents regularly. The provision of a telephone on the ward that adolescents could use to contact friends and family was also seen as important in other work (Claveirole, 2005 and Mental Welfare Commission, 2009), where most reported being able to make a private phone call if they needed to.

### **8.3.4 Remote connections with friends and family - Letter and card writing**

A subtle but rare method of remote communication for CYP keeping in touch with friends and family was through writing letters, cards and receiving post. This helped CYP maintain a sense of what was going on back home and helped them to stay informed about important events that they had missed out on such as attending friend's birthdays and celebrating their own birthday. Although according to staff



members writing letters and cards only occurred on a handful of occasions and was not routinely discussed in MDT meetings, it was the education staff in particular who described promoting letter writing with CYP. These findings are supported by another study which found that CYP valued their friendships at home, which they tried to maintain through writing letters (Painter, 2008). A reason for the limited occurrence of letter writing on the unit and in previous literature could be the emergence of more accessible forms of digital communication over the past decade.

## **8.4 Physical connections**

### **8.4.1 Physical connections with friends and family - Visiting**

The findings in this study suggest that a key method of face-to-face contact between CYP and their friends and family during their admission was through visitation on the ward. The health care organisation had a specific local policy on visiting, which stated that visiting was allowed between the hours of 6-8pm in the evenings and midday-8pm on weekends. This policy was in line with previous CAMHS inpatient service standards recommending that inpatient mental health hospitals should have unit-level policies and procedures on visiting (Solomon et al, 2011). The organisation's earlier policy document on visiting implied that only family could visit and made no mention of friends being able to visit. This appeared to change in a more recent visiting policy which formally recognised friends visiting along with family, and the policy stated that informal visiting at the unit was actively encouraged.

Visiting was viewed as an important aspect of facilitating contact between CYP and their families in other reports and studies. In previous literature, CYP reported wanting to keep in touch with their families through interventions such as visiting (Offord et al, 2006 and Mental Welfare Commission, 2009). In a report investigating UK CAMHS inpatient units, some units actively encouraged family contact and promoted a flexible approach towards visiting, despite there being core visiting times (Mental Welfare Commission, 2009). However, findings from another study indicated that not all inpatient units' practices were as accommodating, and lack of visiting space combined with inflexible visiting hours made connecting with family and friends outside of the unit difficult (Offord et al, 2006).

In more recent studies, CYP receiving support from the family during hospitalisation through visiting was experienced by most participants (Schneidtinger and Haslinger-

Baumann, 2019). Although the visiting hours were not documented, regular visits to the ward by family members were highlighted as being highly positive by CYP and helped them to feel strengthened and 'bolstered' by family members frequently visiting between the allocated visiting hours (Schneidtinger and Haslinger-Baumann, 2019). The supporting of long visiting hours was identified as a practical solution in supporting CYP to stay connected to their families (Stanton et al, 2020).

These findings are consistent with the present study, which found that the promotion of families and friends visiting by staff members, the flexible approach regarding visiting in addition to allowing longer visiting hours at weekends, were seen as helpful aspects of the inpatient experience assisting CYP to stay connected physically to their friends and family during admission.

Visiting between CYP and their friends and family took place in a variety of locations within the unit. Locations included 'informal' areas such as the unit's reception area and atrium, to specific rooms for the purpose of facilitating visiting. The visiting rooms were always clean, tidy and some had a selection of books and toys for younger siblings. The provision of visiting spaces by the organisation was in line with current service standards for inpatient CAMHS which recommend a suitable location or designated private space be provided for CYP to receive visitors such as friends and family, including age-appropriate facilities such as books and toys (QNIC, 2021).

An unanticipated finding that was consistent across interviews with all three subgroups of people surprising the researcher, was that not all CYP in the sample interviewed reported having friends or a friendship group outside of hospital. During interviews with CYP, whilst most informed the researcher that they had received a visit from a family member, only three out of the sample of nine interviewed stated that had received a visit from a friend. When asked, some CYP informed me that they did not have many, if any, friends outside of hospital and therefore did not expect to receive any visits from friends during their admission. Some CYP identified their siblings as the closest they had to a friend. This was evident for some during the questionnaire phase of the study, where there was incomplete data for the friend's section of the IPPA-R questionnaire, or it was completed by CYP in relation to a sibling and not a friend.

The findings also suggest that some CYP only felt comfortable with their family visiting and informed their friends that they were not allowed to attend the unit despite the policy allowing this. This reflects similar findings in a previous study which reported that CYP expressed discomfort with their friends seeing them in a mental health hospital (Moses, 2011). Another perceived barrier to friends visiting appeared to be the organisation's policy. Visits to the ward needed to be supervised by an adult if the person visiting was under 18, to ensure the safeguarding of patients. However, CYP reported this as a barrier to seeing their friends and stated their peers would not visit due to the need to be supervised. Certain rules on friends visiting in another study, were seen as contributing to CYP feeling disconnected from their friends and made existing friendships difficult to sustain (Painter, 2008).

#### **8.4.2 Physical connections with friends and family – Geographical distance**

The findings suggest that a significant physical barrier to some CYP maintaining contact with their friends and family was the geographical distance between the inpatient unit and their homes. With only two Tier 4 CAMHS inpatient units located within the region, it was seemingly inevitable that some friends and families would find difficulties in frequently travelling to the unit for visits and meetings, particularly as the hospital covered a large catchment area from which CYP may be admitted.

The unit's location was a particular concern, especially for nearly half of the sample of CYP interviewed  $n=4$  who lived a significant distance of more than an hour's drive from the unit by car. When additional time was factored in for visiting, families would frequently spend up to 5 hours for a single evening, combining travelling and visiting the unit. The location of the hospital was also a concern for the friends and families who lived in rural locations within the region. This was further compounded as some caregivers did not drive and therefore relied on public transport. Public transport systems for those living in rural areas within the region were reported as being notoriously disconnected in places.

The barrier of physical distance was felt by CYP and parents who reported in interviews and MDT meetings how it affected them. Some CYP reported that they would have liked to have had more visits from their friends and family but recognised the difficulties with them being located at a distance from the unit. In some cases, CYP reported feeling sad because their family lived a long distance from the unit and they were unable to see their friends. Parents noted that although their child and

their friends were at an age where legally they were able to drive, this was not applicable to all CYP and many did not have access to their own car.

In some situations, there was potentially added pressure on parents to facilitate friends visiting the unit. This was also reported in a study by Painter (2008), which found that it was parents who ended up having to provide lifts so friends could visit. Despite providing lifts for CYP friends to and from the unit, parents in the current study described feeling uncomfortable about the thought of having to ask other parents to help with providing lifts to the unit.

The challenges faced by friends and families traveling a long distance to the inpatient unit in this study is supported by the findings in other studies which recognised the distance between home and admission to hospital as an issue (Buston, 2002; Svanberg and Street, 2003; Claveriole, 2005; Painter, 2008; Tulloch et al, 2008 and Frith, 2017). Studies have found that CYP were admitted to inpatient units at a distance from their family home, making frequent contact between CYP and their family difficult (Tulloch et al, 2008). When CYP were asked, over 69% of the sample n=109 in one study reported that they had been placed too far away from their homes (Svanberg and Street, 2003). Staff members in the current study recognised that distance may have been a barrier for CYP to see friends and family due to the large catchment area from which CYP could potentially be admitted and particularly if patients were sent further afield when the unit was full. An unsuspected finding in relation to geographical distance was the potential for video technology to be utilised to facilitate virtual meetings between CYP and caregivers. Utilising such technology in the conference room would also provide CYP with the privacy they lacked in ward communal areas.

#### **8.4.3 Physical connections with friends and family – Visitors' Suite**

The findings suggest a facility which appeared to be of benefit to families to stay connected to their child on a physical level was the accommodation provided through the Visitors' Suite, more commonly referred to as the 'unit flat'. The Visitors' Suite had multiple purposes, from being used as a method to facilitate 'formal' treatment and interventions such as family meals and medication management, to more 'informal' uses where CYP would spend time in the flat with caregivers who were visiting and gave them an opportunity to provide their child with care in a quiet setting.

As noted from the findings from interviews with both parents and unit staff members, this intervention was particularly important for families who lived a significant distance from the unit and was described by one staff member as a 'lifeline' for parents. This was also noted in the organisation's specific policy on the Visitors' Suite which highlighted its benefits, especially for families that lived in areas which were difficult to reach such as in rural locations. The Visitors' Suite gave families the opportunity to stay overnight and was frequently booked throughout the week and on weekends. The importance of CYP maintaining contact with family and friends is recognised in government guidance documents, recommending that consideration be made for the provision of overnight accommodation (DoH, 2017). The provision of this intervention for families by the organisation was also in line with national commissioning services policy documents stating that if deemed clinically appropriate, accessible overnight accommodation should be provided to caregivers (NHS Commissioning Board, 2013).

The provision of onsite accommodation for families highlighted in this study is supported by recent research involving an adolescent psychiatric inpatient unit which also emphasised the importance of a facility such as on-site accommodation in assisting families to stay connected to their child (Stanton et al, 2020). CYP in this study described feeling well connected to their families throughout the admission, with some CYP reporting an increased sense of connection. Providing families with practical support such as onsite accommodation was seen as particularly helpful in this study (Stanton et al, 2020).

In another study by Kyriakopoulos et al (2015), the inpatient unit's 'flat' was seen as a contributing factor to easing parents' anxieties about separation from their child. Parents were able to stay in the accommodation for several days post their child's admission to the unit to help with the transition to hospital (Kyriakopoulos et al, 2015).

Not all UK CAMHS inpatient units have access to on-site accommodation however, with just three of the 31 NHS inpatient units surveyed in the study, reporting that a specific room for friends and family to stay overnight could be provided (Tulloch et al, 2008). Where inpatient units were unable to provide on-site accommodation, unit

staff have reported arrangements could have been made for parents to stay in local accommodation such as hotels nearby (O'Herlihy et al, 2001).

#### **8.4.4 Physical connections with friends and family – Ward leave**

The findings in this study suggest another approach in which CYP physically kept in touch with their friends and family was through having time off the ward, with 8 out of the cohort of 9 CYP interviewed reporting that they had been on leave from the unit at least once over the course of their admission. CYP either did this informally such as having trips out with family, or more formally by having pre-arranged periods of leave from the hospital to go home. Interestingly, for some in the sample of CYP interviewed, this was a preferred method of keeping in touch with friends and family, as opposed to remote methods such as mobile phones and social media. Despite there appearing to be no official policy on CYP having leave from hospital, it was clearly mentioned in the organisation's information booklets for CYP and caregivers which stated that patients would be sent home on short periods of home leave as part of the unit's assessment process.

CYP having time off the unit has been reported in another study (Stanton et al, 2020). In that study a practical solution to keep families connected was staff promoting CYP and their families to have time out off the ward and encouraging them to go on outings. These interventions were highlighted as contributing to CYP perceiving they felt closer to their family members throughout their admission (Stanton et al, 2020).

CYP going on leave was an important aspect of the unit's assessment process and was promoted by staff members throughout the CYP's admission. Leave was gradually built up over time in preparation for discharging CYP from the unit. This was found in another study where CYP going home on leave was built up gradually as part of the discharge process. Participants described first trying some leave to go home and see friends, then gradually building this up to staying overnight (Salamone-Violi et al, 2015). Findings in this study also indicated that the way in which discharge was planned and delivered influenced CYP's perceptions of the usefulness of the inpatient experience. CYP who were perceived to have had a positive discharge were more likely to engage with community support, whereas CYP who had an abrupt discharge, found it scary and rejecting (Salamone-Violi et al, 2015).

## **8.5 Peers in hospital**

This section will discuss the findings of the study pertaining to CYP being in hospital with other patients. It will discuss the formation of new friendships during admission, which occurred through participating in events such as unit activities and having a shared experience of mental health issues. This section will also discuss the findings pertaining to the difficulties CYP encountered when living in hospital with other CYP and the formation of unhelpful peer relationships.

### **8.5.1 Relationships with peers in hospital – The formation of new friendships**

It was evident that some CYP formed friendships with their peers in hospital, with over half of the sample of CYP interviewed  $n=4$  out of 9 reporting that they had made at least one friendship with a peer on the unit and some of these friendships extended beyond discharge. Whilst for some CYP these were completely new friendships, for others they were reformed friendships with CYP who they had met in hospital on a previous admission to the unit. Making friendships with peers in hospital appeared to help CYP's sense of feelings of loneliness and isolation. In addition, caregivers commented that they felt reassured knowing their child was having contact with peers.

### **8.5.2 Relationships with peers in hospital - Unit activities**

The promotion and facilitation of ward-based group activities by staff members potentially supported the formation of friendships between CYP on the ward. Regular activities such as sports games, music, cooking and arts and crafts, in addition to the ward communal lounge, naturally provided spaces for interactions and socialisation between patients. This was also linked to CYP having shared and hobbies in common which helped them to connect. The inclusion of unit-based activities is suggested by UK CAMHS inpatient service standards, which recommend every CYP has a seven-day recreational timetable of activities to promote social inclusion, in which unit staff encourage CYP to engage (QNIC, 2021). The lack of unit activities such as cooking, arts and crafts and outdoor-based activities in some inpatient units were perceived by patients as a negative aspect of the inpatient experience (Salamone-Violi et al, 2015). Clinicians have noted the shared spaces on inpatient units surround adolescents with peers with similar mental health problems and support the transition from being isolated (Hayes et al, 2019).

### **8.5.3 Relationships with peers in hospital - Shared and similar experiences of mental health**

It was also evident from the findings that some CYP felt they could relate to their peers in hospital with regards to their mental health through having a greater understanding and similar experiences of mental health difficulties. This was further described by patients, staff members and parents who all suggested that CYP and their peers in hospital understand each other through having shared experiences and were able to connect on a level where friends outside of hospital may not. Other staff noted the acceptance between CYP in hospital and describe the relief CYP experience knowing there were others who may have had similar experiences.

The shared experiences and understanding CYP had with their peers in hospital has also been highlighted further in more recent studies (Salamone-Violi et al 2015; Gill et al 2016; Schneidtinger and Haslinger-Baumann 2019; Hayes et al, 2019; Hayes et al, 2020 and Stanton et al, 2020). The connection between peers on the ward was found to be an aspect of making the inpatient experience positive (Salamone-Violi et al, 2015). In addition to feeling connected to peers, CYP have described a general sense of companionship with their peers (Stanton et al, 2020) and feeling understood due to having similar experiences (Salamone-Violi et al, 2015 and Stanton et al, 2020). In Hayes et al's (2020) paper on the perspectives of adolescents and caregivers, being understood, building trust, and being around others who were in similar situations were found to be key aspects in building friendships. (Hayes et al, 2020). Feeling understood by others and having a shared experience with fellow inpatients regarding mental health difficulties has also led to a sense of belonging and validation (Gill et al, 2016). The findings of the current study specifically regarding staff promoting peer to peer connections contrast the findings in another qualitative study (Reavey et al, 2017) which highlighted that certain positive aspects of peer relationships such as learning and sharing similar experiences were neglected by some staff due to the perceived concern over risk (Reavey et al, 2017).

### **8.5.4 Relationships with peers in hospital – The difficulties of living in hospital with other CYP**

Whilst the current study found that there were positive interactions between CYP on the unit and relationships that were perceived to be of benefit, the findings also suggest that CYP found challenges and faced difficulties throughout their admission



when living in hospital with other CYP. Participants reported factors such as the age range of CYP within the unit, witnessing distress in others and CYP 'triggering' negative emotions with each other was often upsetting and a challenge to live with.

The negative experiences associated with living with other CYP in hospital has been reported by patients, caregivers and staff members in previous research. There were similarities in the findings of a recent study which highlighted the negative influence patients had on each other, which was particularly affecting CYP of a younger age (Schneidtinger and Haslinger-Baumann, 2019). Clinicians have highlighted negative relationships may occur from CYP sharing distressing personal information and therefore need to be considered and monitored (Hayes et al, 2019). CYP have reported finding others annoying and talked of being influenced negatively (Stanton et al, 2020). Similar to the findings of the current study, CYP have commented on the challenges that arose from living in hospital with other CYP as a result from witnessing distress in others (Gill et al, 2016). The difficulties experienced by CYP living with other CYP and the concept of 'triggering' has been reported in other studies (Gill et al, 2016 and Reavey et al, 2017).

#### **8.5.5 Relationships with peers in hospital - CYP forming unhelpful peer relationships**

The findings indicate that there were instances of CYP forming relationships with hospital peers which members of the MDT and caregivers deemed to be unhelpful to CYP's recovery. This was generally described by the MDT as CYP who were participating in various incidents on the ward as a group, CYP encouraging others to participate in risk taking behaviours such as deliberate self-harm and CYP acquiring unhelpful behaviours from other patients. This was particularly evident in CYP with eating disorders which will be discussed further later in this chapter.

Caregivers also reported that their child had learned behaviours from other patients and expressed this as a concern in interviews. They recognised that whilst the inpatient environment provided their child a high level of safety, they reported understanding that the unit was not free from risk and that there was a risk of their child learning behaviours from other CYP.

The findings of the current study are consistent with prior research, with previous studies describing occasions where CYP have formed new, unhelpful friendships with peers in hospital and have acquired self-harming behaviours from others. This

has been conceptualised in a previous evidence synthesis as 'Contagion', and in relation to deliberate self-harm, was defined as two or more acts of deliberate self-harming behaviour that involved two or more CYP occurring on the same day or over consecutive days (Hannigan et al, 2015). In the areas of suicide and deliberate self-harm, a previous study has shown that health care professionals and parents have had particular concerns with CYP acquiring unhelpful behaviours (Claveirole, 2005). A more recent study reported that exposure to self-harm within the inpatient environment was extremely challenging for CYP and described them learning from and copying each other (Smith-Gowling et al, 2018). Whilst recognising the importance of making new friendships, caregivers have also commented on feeling worried about the intensity of their child's relationships with their peers (Hayes et al, 2020). In the current study, staff informed me that whilst they recognised the issue of CYP learning and acquiring unhealthy behaviours from their peers in hospital, they tried to manage this through logistical interventions within the ward environment such as observation and splitting up CYP at mealtimes and during group activities.

#### **8.5.6 Relationships with peers in hospital – CYP comparing themselves to others**

The findings of this study suggest that CYP in hospital found a support network through relationships with other CYP. This was particularly evident with CYP who were admitted for difficulties regarding their eating, with ward staff reporting that on occasions CYP would be a supportive network for each other and help each other through their recovery from the eating disorder. Similar findings were reported in a study which highlighted that CYP developed positive coping strategies to manage their mental health difficulties through learning how other CYP cope with their mental health (Offord et al, 2006).

However, the findings also indicated that there were instances of CYP who were admitted to the unit who were comparing, competing with, or mirroring the behaviours of other patients who were also diagnosed with similar mental health issues such as eating disorders. These behaviours included the refusal of food, noncompliance with rest periods post mealtimes, and increased exercise on the ward. Ward staff reported previous instances of patients with eating disorders trying to compete to be the 'best anorexic', a term which has been previously referred to in

another study where a participant described recovering from Anorexia Nervosa at the same rate as her peers with the same illness (Offord et al, 2006).

The issue of CYP comparing themselves to other CYP and learning behaviours was a concern also voiced by caregivers. Caregivers reported realising that although their child may have wanted to meet other CYP who had similar experiences regarding their mental health such as anorexia, they reported feeling nervous about their child potentially learning these behaviours associated with eating disorders from other patients which they perceived as unhelpful.

These findings are supported by other studies which reported that CYP with eating disorders made comparisons and were competing with and copying one another (Colton and Pistrang, 2004; Claveirole 2005 and Offord et al, 2006). It was reported in one study that a combination of a desire to fit-in with the inpatient peer group and that the patients were vulnerable to peer influence, meant that additional eating disorder behaviours were learned by CYP (Offord et al, 2006). This resulted in CYP reducing their dietary intake or increasing their exercise such as taking longer routes when walking around the ward (Offord et al, 2006). CYP with eating disorders were also found to quickly mimic the behaviours of others with eating disorders and competed to be thin (Colton and Pistrang, 2004).

## **8.6 Impact on families**

### **8.6.1 Impact of admission on family - Emotional toll on caregivers and siblings**

It was evident from interviews of the emotional impact the CYP's admission to the unit had on caregivers. Caregivers described feeling stressed and anxious when referring to previous events leading to their child's admission, in addition to experiences of their child's current admission and reported how it affected their partners and other children. Caregivers described feeling physically and mentally fatigued, reporting issues such as a lack of sleep and forgetfulness. These findings are similar to that reported in a recent qualitative study of the experience of parents whose child had been admitted to an adolescent inpatient mental health unit, which reported that parents experienced a high level of emotional suffering in addition to feelings of guilt and stigma (Merayo-Sereno et al, 2021). Both parents and staff also described the impact of the admission on CYP's siblings. In some instances, parents tried to protect their other children by limiting the amount of information given to them

about their sibling's admission and the severity of mental health issues and risk taking behaviours such as self-harm and suicide attempts. Staff members also spoke about the impact on siblings, and therapists described responding to siblings' worries about mental health issues in therapy sessions.

To support caregivers and help alleviate some of the potential stress and anxieties they had around their child's admission to hospital, some families were having family therapy interventions at the unit. The MDT also offered appointments for 'Welcome Meetings' to caregivers on the unit with a nurse and therapist. Although on some occasions these meetings did not occur until weeks after the CYP's admission to the unit, they generally occurred within the first 72 hours of admission.

The content of the Welcome Meetings were individual and specific to each family, but the organisations information booklet provided some details on the welcome meetings, stating that it was an opportunity for caregivers to ask staff members questions about the admission and to share information. Additionally interviews with various staff members indicated that the Welcome Meetings were an opportunity to work with family members and inform them that their involvement in the planning of the CYP care was vitally important.

The equivalent of the unit's Welcome Meetings are also recommended by Tier 4 CAMHS inpatient service standards which advocate ensuring that CYP and caregivers are supported throughout the process of admission. With CYP's consent, it is recommended that caregivers are offered individual time with staff members within 48 hours of the CYP's admission to discuss concerns, family history and their own needs (QNIC, 2021). Additionally, providing families with meetings is recommended in policy and guidance documents, with Tier 4 CAMHS national commissioning services recommending the provision of meetings being offered to families within the first week of admission (NHS Commissioning Board, 2013). Staff members recognised that some families may feel anxious or disorientated when their child is admitted to hospital and informed me that the Welcome Meeting was a way to help support families shortly after admission.

#### **8.6.2 Impact of admission on family – Caregivers employment concerns**

The findings also suggested caregivers faced challenges regarding their employment whilst their child was admitted to hospital. Some caregivers had taken time off work

due to stress or were anticipating taking time off working to care for their child. This was particularly evident for families during CYP's build up to and eventually being discharged from the unit. In some cases, parents took time off work either unplanned through sickness or some were fortunate to take planned time off such as annual leave. These findings are consistent with research by Merayo-Serenio et al (2021), which found that parents had taken sick leave from work due to the impact of their child's admission on their own mental health (Merayo-Serenio et al, 2021). However, unfortunately this was not applicable for all parents, and some expressed concerns in meetings about continuing to take time off work and how their employer would react to this. To support caregivers with concerns around their employment and to mitigate the impact of having time off work when supporting their child during the process of discharge, unit staff attempted to organise periods of leave over the weekend.

### **8.6.3 Impact of admission on parents - Financial impact on families**

The financial implications associated with CYP's admission to the inpatient unit experienced by caregivers was also reported in this study. The cost of frequently travelling to the unit, along with parents working reduced hours due to caring responsibilities for their child, meant that unfortunately some families experienced financial hardship which was particularly evident with the CYP who had longer admissions to the hospital. Parents who were self-employed reported having to delay orders with their business and were fortunate enough to absorb the loss of income through savings. Other parents who were employed, reported a reduced income within the family due to having to reduce the number of hours they were able to work, combined with having to frequently drive a significant distance to visit their child. The financial aspect of the admission was also felt by CYP, who recognised that their parents have struggled with getting to the unit frequently due to the cost of travelling by car and public transport.

Previous research and reports have described the financial impact involved with CYP being admitted to inpatient units in areas that were difficult to access (Buston, 2002; Svanberg and Street, 2003, Tulloch et, 2008 and Mental Welfare Commission, 2009), with parents reporting that travel costs caused financial problems (Tulloch et al, 2008). In one study a CYP reported that her mother was unable to visit her frequently due to the cost of fuel (Svanberg and Street, 2003). In another study,

participants reported being concerned that the inpatient unit was located too far away for their parents to travel, with one parent having to reduce the frequency of travelling to the inpatient unit and limit visiting their child to just weekends, again due to being unable to afford the cost of fuel (Buston, 2002). In a more recent study, admission was shown to be costly for caregivers with them paying up to £2,000 in travel costs to the inpatient unit (Green et al, 2007).

The findings of this study indicating that there is a financial impact on families is further supported by a more recent five-year survey of Tier 4 CAMHS inpatient units in the north of the UK. This survey reported that some families went into debt or increased pre-existing debt due to the high cost associated with travelling across the region to the inpatient units (Scottish Government, 2017).

The current study also found that in some situations families were eligible to be reimbursed for the cost of travelling to the unit. Caregivers who were able to receive some financial support reported how receiving these payments to cover travel costs helped relieve both their financial concerns and their child's worries about their finances. However, the findings also indicate that some families appeared to face challenges when claiming expenses for travelling and the process appeared to be a complex and means tested system. Parents who did receive travel reimbursement, reported receiving state welfare support to be applicable to make a reimbursement claim and others reported being ineligible due to their salary being over a certain threshold.

In some instances, inpatient units have had access to financial support to help families receiving welfare benefits to visit, especially if they were required to travel a distance (Mental Welfare Commission, 2009). Although data on the provision of reimbursement for travel and subsistence costs for parents visiting CAMHS inpatient units appears to be limited, one survey provided an example of a family receiving £3,000 over a 6-month period (Scottish Government, 2017).

## **8.7 Connections to education**

### **8.7.1 Inpatient education and reduced opportunities**

This section will discuss the study's findings in relation to CYP's education whilst they were inpatients at the unit. This will begin with a brief overview of the layout of the Learning Centre, its associated facilities and then highlights key findings across

the following three sections: inpatient education and reduced opportunities, interface between the Learning Centre and school of origin, and impact of health on education.

In England and Wales, Local Authorities (LA) have a legal requirement to arrange education for any person of compulsory school age, who is prevented from attending mainstream school due to illness (Welsh Government 2010b and DfE, 2013).

Education within a CAMHS hospital may be provided by a local authority or by an independent school provider (DoH 2017). Hospital education is defined in legislation as, “education provided at a community special school or foundation special school established in a hospital, or under any arrangements made by the local authority under part 19 of the Education Act (1996), where the child is being provided with such education by reason of a decision made by a medical practitioner” (Education Act, 1996).

### **8.7.2 Learning Centre layout and facilities**

As previous outlined in chapter four, the Learning Centre was a self-contained area away from the unit’s two main wards but still situated within the hospital building. It was made up of three classrooms which ranged in size, a kitchen area and offices. The Learning Centre staff members consisted of a Headteacher, specialist teachers and learning support assistants. The Learning Centre could facilitate up to 15 CYP at a time, although throughout the period of data collection anywhere between 5-10 CYP attended the school at various times.

Education in the current study was provided on-site, which is typical of tier 4 inpatient units (DoH, 2017). The model for delivering education was within the two methods highlighted in a previous study (Hannigan et al, 2015), where inpatient schools were either integrated into the unit or away from the unit but still within the confines of the hospital grounds (Tulloch et al, 2008). The inpatient unit delivered education through the first method which has been reported as the most common method of education delivery (DfE, 2018).

The findings highlighted key differences between the Learning Centre and a typical mainstream school such as smaller classroom sizes, shorter school day, mix of age groups and higher teacher to pupil ratio. Of the CYP included in this study who were regularly attending the Learning Centre, it was estimated they spent an average of 3-

4 hours per day in the Learning Centre, Monday to Friday. This appears to be consistent with a report into education in UK CAMHS inpatient units which found that overall, most pupils from the 61 inpatient units surveyed received 16 hours of education per week (DfE, 2018). Inpatient service standards recommend a minimum of one qualified teacher to every four pupils per lesson (QNIC, 2021). This was also consistent with the current study, which found that there were sufficient qualified teachers and learning support assistants available in relation to the number of pupils in attendance.

### **8.7.3 Inpatient education provision**

The need for CYP to continue their education whilst in hospital for care and treatment of their mental health is a key CAMHS inpatient service standard (QNIC, 2021). The findings pertaining to education provision at the unit indicate that CYP were able to study a range of national curriculum subjects. This was especially prevalent for CYP in KS3 education aged 11-13 who described studying 'core' National Curriculum Subjects such as Maths, English and Science. Furthermore, CYP reported studying additional subjects such as Geography, Art, History and PSE. Education provision for post 16's both in and not in education appeared to be less developed however and will be discussed in further detail later in this chapter.

Limited studies and reports have explored the education curriculum within inpatient CAMHS. In a previous study by O'Herlihy et al, (2001), all units surveyed met the key stage demands of all age groups of CYP within the units, but 56% of the unit schools surveyed (35 out of 62) were unable to provide any additional education other than the national curriculum (O'Herlihy et al, 2001). The findings in the current study regarding education provision are similar to a more recent report published on behalf of the DfE (2018) on the provision of inpatient education in Tier 4 CAMHS. This survey included some details on the education provided at various inpatient units in the UK. Amongst the 62 of the 107 units surveyed with a 58% response rate, 90% provided Maths, 92% English and 82% Science. In addition to Maths, English and Science, units reported providing a range of other subjects including Art, Personal Social Health and Citizenship Education (PSHCE/PSHE), Physical Education (PE), ICT, Music, History, and Geography (DfE, 2018). Although the report provided no details regarding what subjects were specifically taught at each KS, the most common format (92%) was learning in mixed key stage groups (DfE,



2018). This is also consistent with the current study where classrooms consisted of CYP learning at different key stages based on their age.

#### **8.7.4 Subjects limited to 'core' National Curriculum subjects for KS4 and KS5**

Although CYP aged 11-13 and in KS3 education were able to study a range of national curriculum subjects at the Learning Centre, there appeared to be a different experience for older patients in education KS4 and 5. The findings suggest that in some instances, the Learning Centre found challenges delivering age-appropriate education to CYP aged 14-16 and above. Education for CYP of this age appeared to be limited to the 'core' National Curriculum subjects of Maths, English and Science. There were other limitations to education provision regarding undertaking practical assessments for subjects such as Science and Geography, as the Learning Centre was not equipped to facilitate these subjects and relied on mainstream schools. There were also issues regarding CYP undertaking examinations which will be discussed in more detail further in this chapter.

Recommendations from inpatient service standards are that CYP are taught the core National Curriculum subjects of Maths, English and Science (QNIC, 2021). Further recommendations are that inpatient units provide a broad and balanced curriculum which is appropriate, flexible and suited to the needs of the student (QNIC, 2021). In the case of the current study, these inpatient guidelines appear to be only applicable to CYP who were studying KS3 education. Furthermore, it has been highlighted that smaller inpatient units may face problems with providing CYP with specialist teaching for GCSE level (DoH, 2017). Similar findings in a qualitative study of adolescent mental health inpatient care reported that whilst the hospital school helped some CYP to get back into a routine regarding their schoolwork as they felt they had lost competence, other adolescents expressed concerns that the inpatient school was not pushing them enough academically (Stanton et al, 2020).

#### **8.7.5 Provision for post 16s**

It has been recommended by inpatient CAMHS service standards that young people should be able to continue their education where the unit caters for CYP over the age of 16 (QNIC, 2021). As the age of CYP admitted to the unit covered 16 and 17 year olds, some were still in post 16 education prior to their admission. Ward staff described education provision for these CYP and reported those who were in college or sixth form prior to being admitted were able to continue their education providing

the Learning Centre was receiving work from the college or school. However, education provision for post 16s appeared to be limited at the Learning Centre. This challenge was recognised by the education staff who stated that they try to seek specialist teachers from agencies. In practice, however, it was very difficult to acquire specialised tutors to support CYP with their A Level learning. This appeared to be detrimental for some CYP and in one instance, a CYP reported struggling to continue with her A-Levels due to the Learning Centre teachers and additional tutor only having experience up to GCSE level. This was also described by caregivers who reported that unfortunately despite their best efforts, the unit was not best equipped to support CYP in post-16 education.

Findings from this study regarding education provision for post 16's appears to be consistent with other studies. It has been suggested that education provision for those older than 16 in inpatient CAMHS appears to be less developed in the UK (Hannigan et al, 2015). A previous study found that access to education was more difficult for hospitalised adolescents who were above the age of 16. CYP reported a lack of age-appropriate work and that there was very limited support available for older patients (Svanberg and Street, 2003).

In a legal context, under the Education Act (1996) Local authorities have a power and not a duty, to arrange education provision for those aged 16 to 18. (DfE, 2013). For CYP aged 16 and 17 in hospital however, there is no national principle to provide access to further education (Care Quality Commission (CQC), 2018). It has been noted that it may be possible for CYP to continue their education while they are in hospital, depending on the nature of the education or training they are undertaking, although the decision on funding further education for post 16's is dependent on the LA in where the individual resides (CQC, 2018).

Education staff in this study further highlighted that students studying their A Levels were an exception compared to other age groups as they were more likely to be independent learners and use the internet to support their learning. Despite the challenges of providing sufficient education to post 16's, it appeared that some CYP were still able to continue with their studies in some format.

The findings of the study showed that there were also some CYP who were aged 16 and above who were not in education, employment or training (NEET), but continued

to attend the Learning Centre. Not all CYP post 16 regularly attended however, and on occasions staff members cited a lack of motivation from CYP to attend the Learning Centre if they were above the compulsory age of attendance. Despite there being no national obligation for hospitals to provide further education for post 16's (CQC, 2018), the Learning Centre staff attempted to engage these CYP in a range of vocational courses and skills, careers advice and activities. This was outlined in the unit's information booklet for CYP and caregivers and incorporating more vocational activities into the school timetable was often discussed between professionals in weekly MDT meetings.

Other studies have found that one of the leading reasons for CYP not receiving full time education whilst at inpatient units schools was due to being outside of the compulsory age to attend school. A survey of education provision in UK inpatient units found this was the second most prevalent reason (24% of units) behind CYP's medical needs (DfE, 2018).

#### **8.7.6 Limitations regarding the provision of additional languages**

There were other limitations of education provision within the Learning Centre, and this was particularly relevant to CYP whose first language was not English. In the context of the current study, it was mainly the Welsh language that was the first language for some CYP. Of the 9 CYP interviewed for the study, three primarily learned through the medium of the Welsh language.

Whilst education staff members described difficulties in providing additional tutors and teachers for general subjects studied in English, they reported that they were unable to support CYP learning through the medium of Welsh and recognised it was an area that needed developing. The Learning Centre had on previous occasions provided some support to CYP with translation from Welsh to English through a Welsh learning support assistant. Overall, they recognised the difficulties in acquiring teachers if it was for the purpose of tutoring in the Welsh Language and highlighted lack of resources with regards to Welsh tutors. CYP and parents both described issues regarding the lack of Welsh language provision at the Learning Centre. The lack of Welsh language provision resulted in CYP having to self-translate their work from English to Welsh, and others described their proficiency in both speaking and writing in the Welsh language deteriorating over the course of their admission. Parents reported making the inpatient unit staff members aware of their child's

Welsh language needs on admission and despite the inpatient unit suggesting using interactive methods such as Facetime for their child to remain in contact with her Welsh teacher, in practice this did not materialise.

The Welsh Language (Wales) Measure (2011) is statutory law for the promotion and facilitation of the Welsh language by public bodies and a core principle is to treat the Welsh language no less favourable than English. In a recent government publication categorising schools according to Welsh medium provision, there is no mention of the provision of Welsh language in hospital schools (Welsh Government, 2021b). Current inpatient service standards recommend that CYP have access to teachers of specialist subjects such as language tutors (QNIC, 2021). Whilst the current study found limited support for pupils regarding their Welsh language needs, it appeared to fall short to sufficiently meet their needs.

#### **8.7.7 Examinations**

The study found that the Learning Centre could provide an important aspect of CYP's education which was examinations and CYP and parents were made aware of this on admission when given the unit's information booklet. Examinations were either facilitated by CYP's mainstream school and home leave would be arranged to enable this, or it would be facilitated through holding examinations exclusively in the Learning Centre. I had been informed by an education worker that the Learning Centre was registered as an examination centre, therefore CYP were capable of sitting some public examinations such as GCSE's under strict exam conditions within the Learning Centre classrooms. The process of entering CYP for their examinations was explained, and to ensure the continuity of studies leading up to exams, their work would follow the same curriculum as if they were in their school of origin.

The provision of examinations appeared to be in line with current best practice, with CAMHS inpatient service standards recommending that inpatient units should be part of an education organisation that is a registered examination centre (QNIC, 2021). Some CYP and staff who were interviewed, successfully described adolescents achieving qualifications from examinations they undertook at the Learning Centre. Examinations were limited however, and appeared to mainly be in relation to core national curriculum subjects, although there were some exceptions such as art.

As described above, the Learning Centre was not equipped to facilitate all aspects of a subject, especially if it incorporated practical elements such as Bunsen burners for science and field work for Geography. This also applied to examinations and Learning Centre staff relied on mainstream schools to facilitate these aspects of CYP's education. However, previous policy documents on the design of inpatient CAMHS units recommended overcoming barriers to practical aspects to education such as the safe installation of Bunsen burners (DoH, 2017).

Recent data regarding CYP undertaking their examinations whilst admitted to inpatient CAMHS units appears to be limited. In the research report published by the DfE on the provision of Inpatient Education in inpatient CAMHS (DfE, 2018), there were no references made specifically in relation to the provision of examinations. Although in a previous report by the DoH (2013), it was suggested that effective and efficient liaison between inpatient services, LA's and mainstream schools were crucial in ensuring CYP with health needs were able to undertake public examinations whilst they were still in hospital, (DoH, 2013). One previous study has addressed the issue of CYP taking exams whilst in hospital, and this study found that teachers reported that there were opportunities for CYP to take exams in most of the inpatient units surveyed, with only one unit reporting that there was no provision for examinations (O'Herlihy et al, 2001).

#### **8.7.8 Interface between Learning Centre and school of origin**

The findings indicate that a core aspect enabling CYP to remain in touch with their education was through the liaison between the Learning Centre and their mainstream school. This would happen on the individual's admission and the staff at the Learning Centre would get in touch with their mainstream school to discuss their education needs and to arrange for work to be sent into the Learning Centre. The liaison between unit and mainstream school educational staff is recommended in CAMHS inpatient standards in order to support the continuity of education provision (QNIC, 2021).

UK legislation states that CYP who are unable to attend school due to health needs, such as those in hospital, should receive the same quality and range of education as they would have in their home school (DfE, 2013). Whilst most ward staff reported having good relationships with mainstream schools, some suggested that a barrier for CYP to keeping in touch with their education was the lack of communication from

mainstream schools and getting work sent in. This was reiterated by some caregivers who described a slow process from their child's mainstream school in efficiently providing work.

Similar findings were stated in a UK wide study whereby most CAMHS inpatient units surveyed reported having a good relationship with their respective education authority (Tulloch et al, 2008). Schoolteachers have also been found to have positive relationships with CYP's parents (O'Herlirly et al, 2001). When asked however, parents have highlighted the slow response from mainstream schools and regularly sending schoolwork to inpatient units (Svanberg and Street, 2003).

#### **8.7.9 Reintegration into mainstream school**

The final sub section within this theme pertains to CYP's reintegration into their mainstream school. This was perhaps one of the most prominent methods in which CYP kept in touch with their own school whilst inpatients. The current study found that CYP's reintegration into their mainstream school was a carefully planned process which occurred through discussions and partnership working between health, social and education staff at the unit, CYP, their caregivers and mainstream education professionals. The process of reintegration was planned through MDT meetings and was often in conjunction with CYP having home leave from the unit and their discharge pathway. When asked about their experiences of returning to their school of origin, CYP reported mixed feelings such as welcoming the return of the normality of attending their school, however they also reported feeling stressed, particularly about seeing their peers. This corroborates the findings in another study where adolescents expressed a heightened concern about social situations upon reintegration into mainstream school (Preyde et al, 2018).

In the current study, reintegration into mainstream schools was a planned, gradual process enabling CYP to attend their school of origin at a pace that CYP, caregivers and MDT professionals felt comfortable with. The gradual reintegration into mainstream school was planned through MDT meetings and data extracts from Chapter seven provide examples of MDT members discussing school reintegration. Education staff also reported contributing to discussions regarding school reintegration in MDT meetings by suggesting the time CYP initially spend in their school based upon a modified timetable. This usually began with going to school for a few hours and slowly increasing the rate and duration of attendance to

incorporate lessons. School reintegration did not always go as planned and on occasions too much reintegration occurred leaving CYP feeling overwhelmed by the experience.

Findings also highlighted the various levels of support for CYP from CAMHS CMHT's when transitioning back into school. The level of support to CYP was often dependent on the remit of the CMHT however, with some teams within the region being able to provide more support than others. It was suggested by education workers that due to the uncertainty of support from CMHT's regarding school reintegration, caregivers keep in touch with the school and Learning Centre education staff organise meetings with mainstream schoolteachers to discuss school re-entry.

Returning to school has been seen as a priority for adolescents, with one study finding that adolescents wanted help with returning to school and expected the inpatient Learning Centre to help them achieve this goal (Hayes et al, 2020). However, there have been difficulties when CYP re-enter and reintegrate back into mainstream school and this has been described as a significant barrier to CYP's academic progress when hospitalised (Hannigan et al, 2015). Inpatient service standards recommend that unit staff support CYP with their reintegration if they are returning to their local education facility post discharge (QNIC, 2021). The concept of CYP's school re-entry and reintegration post hospitalisation has also been discussed more recently in what is one of the first pieces of research to propose a series of recommendations by hospitals for schools to consider when CYP return to their mainstream school (Marracinni et al, 2021). This research recommended supporting a gradual return from hospital to mainstream school, and this is supported by findings in the current study.

#### **8.7.10 Health impact on education**

The findings indicate that a significant physical barrier to some CYP accessing their education whilst at the unit was the severity of their physical and mental health needs. The mental health issues of CYP highlighted how symptoms of their condition had a major impact on their ability to learn. The data highlighted such examples with CYP diagnosed with eating disorders such as Anorexia Nervosa, who were on occasions too physically frail to attend the Learning Centre or participate in ward-based activities. Education needs for these CYP were met by education staff

providing work for them to do in their bedrooms. This was in line with policy highlighting that significant health needs are a barrier accessing education (Estyn, 2016) and recommend education provisions be made on the ward where CYP are too ill or frail to attend the inpatient school (DoH, 2017).

Other examples included CYP with diagnoses of serious mental health conditions such as psychosis, who struggled with concentrating and focussing on their schoolwork due to the symptoms associated with the illness such as distorted thought patterns. In cases such as these, the MDT encouraged vocational opportunities as opposed to academic learning. A previous report also found that CYP's health had an impact on their ability to study in the inpatient unit schools, with medical needs being cited in the survey of inpatient units as the main reason (65%) for CYP not attending full time education whilst in inpatient schooling (DfE, 2018).

#### **8.7.11 Medication side effects**

The side effects of some medications appeared to have an impact on CYP's learning and were cited predominantly by patients and their caregivers as a barrier to accessing education for those who were struggling to complete their schoolwork in the Learning Centre. CYP reported common side effects such as fatigue, drowsiness and struggling to concentrate appeared to affect their ability to focus on their schoolwork. To support CYP with this issue, medications and dosages were reviewed by the medical staff routinely in weekly MDT meetings.

#### **8.7.12 Concerns over missing school**

The findings from interviews and observations of MDT meetings indicated that some CYP were able to catch up with their studies and achieved success in coursework, assessments, and exams. However, several CYP were concerned about the time they had missed from their mainstream school and were worried about falling behind with their schoolwork and having to catch up. This appeared to be especially concerning for the CYP who were in year groups that were due to sit compulsory public examinations such as GCSE's. To help alleviate CYP worries over missed school time, the headteacher at the Learning Centre would liaise with the mainstream schoolteachers. In some cases, CYP reduced the number of subjects they were studying to relieve some of the academic pressures or in more rare circumstances, were planning to re-sit the whole academic year. These decisions



were made in partnership between the CYP, their caregivers, inpatient unit education staff and mainstream school staff.

Similar to the current study, hospitalisation was a contributing factor in the impact of the achievements and long-term goals of CYP reported in another study particularly in relation to their education (Haynes et al, 2011). Studies have described how peers were moving on to educational milestones such as completing exams and going into further education such as college or university (Offord et al, 2006, Painter 2008 and Haynes et al, 2011), and how CYP have been concerned about having to catch up (Offord et al, 2006 and Clemens et al, 2010). Despite some CYP in the current study reporting that they were worried about falling behind with their schoolwork and missing examinations, others appeared to be less concerned and referred to future plans of resitting exams. Similar findings were reported where CYP reassured themselves that educational plans could be attended to in the future (Hayes et al, 2011).

An unanticipated finding in relation to the long-term academic goals for CYP were the views and emphasising on personal recovery from mental health difficulties before continuing or recommencing education. This was particularly potent in the views of caregivers, who gave powerful accounts describing the seriousness of their child's physical and mental health difficulties. These statements provided insight into how CYP's education can be affected by their health needs, but also caregivers prioritising their child's wellbeing as opposed to solely focussing on their education.

### **8.8 Summary of main findings for objective 3**

To achieve objective 3, CYP were invited to complete three outcome questionnaires in relation to their mental health, friends, family and education and data on demographics of the sample were collected.

Regarding the gender of the study's sample for the questionnaire phase of the study, the sample was predominantly female  $n=21$  with 5 males  $n=5$ . This was consistent with the number of CYP admitted during the period of fieldwork and the previous three years which indicated females were the more common gender being admitted to the unit. The sample was representative with regards to gender reported in other adolescent inpatient mental health research (Gill et al, 2016, Preyde et al, 2017;2018, Reavey et al, 2017 and Schneidtinger and Haslinger-Baumann, 2019),

and in units across the UK which report more females than males are admitted (NHS Benchmarking Network, 2021). The number of admissions was significantly lower than previous years, likely to be explained by the ward closures as discussed at the end of Chapter four.

The study indicated that despite the small sample size, the two most prominent diagnoses were emotional dysregulation  $n=13$  (50%) and eating disorders  $n=10$  (38.5%). These two diagnoses are common when compared with reports providing information on admissions to UK inpatient units by diagnosis (Children's Commissioner, 2020). Eating disorders account for the highest single group of CYP admitted (20%) with behavioural and emotional disorders accounting for 8% of admissions (Children's Commissioner, 2020).

CYP's age indicated that the most common age of CYP included in the sample were 16 years of age, which is consistent with previous research (Salamone-Violi et al, 2015, Gill et al, 2016 and Reavey et al, 2017). Average length of stay for the sample was 88.6 days. This a longer average length of stay for the total number of participants screened for participation which stood at 77.8 days and contrasted previous years which was around 45 days, which is the average for this region of the UK (NHS Benchmarking Network, 2021). An explanation for the increase in length of stay for the study sample could be that a small number of CYP had considerably longer admissions than others, potentially skewing the data. The average length of stay for the sample is consistent with previous research (Gill et al, 2016 and Reavey et al, 2017) and in inpatient units across the UK which stood at 85 days in the year 2019/2020 (Children's Commissioner, 2020).

Regarding SDQ and its subscales, results indicated that most of the sample scored in the abnormal category for the emotional scale and in the normal category for the conduct problems, hyperactivity and prosocial scales. However, for the peer problems scale, CYP scored similarly across the three bandings. For the total sum of SDQ scores, results indicated that CYP were placed in the 'abnormal' band of the total difficulties scale, suggesting that their emotional health and wellbeing was likely to be under considerable strain. This was to be expected given that the CYP admitted to the unit for severe and complex mental health difficulties.

For the IPPA-R, results indicated that despite the missing data, CYP scored highest in global and trust and communication subscales regarding their mothers, followed by friends/peers and finally their fathers, suggesting they had more positive communication and trust with their mothers. For the alienation subscale, CYP scored highest in regards to friends, followed by fathers and mothers suggesting they were most alienated from their friends. When split into the two categories of either cared for or not cared for by a family member on admission, CYP who were cared for by a family member on admission scored higher in global, trust and communication scales across all three questionnaires. For the alienation subscale, results were similar between both categories.

For the SSES, results indicate that for part A of the questionnaire, the highest scores were found in the Behavioural Engagement subscale suggesting CYP had more behavioural engagement regarding their school. The second highest scores were in Cognitive Engagement, followed closely by Emotional Engagement. These results contrast Part B of the questionnaire where highest scores were found in Emotional Engagement, then Cognitive Engagement and finally Behavioural Engagement. When split into either being in education prior to admission and not in education prior to admission, CYP who were in education prior to admission scored higher scores across all four engagement scales in both parts of the questionnaire.

Whilst part of objective 3 was for CYP to complete the questionnaires, it was also to assess the suitability of them with regards to measuring connections to friends, family and education within adolescents in inpatient mental health care. Reflections on CYP completing the questionnaires discussed at the end of Chapter four indicated that some CYP had difficulties completing the IPPA-R and SSES such as completing the friends section of the IPPA-R in relation to siblings as opposed to friends and the discrepancies between completing the SSES in relation to mainstream schools or the Learning Centre.

This section concludes acknowledging that the SDQ, IPPA-R and SSES may have been the most appropriate candidate questionnaires available to report on CYP's mental health, and their connections to their friends, family and education at the commencement of the study. However, acknowledgement is made that the IPPA-R and SSES may not be appropriate to be used with adolescents in inpatient mental

health care as they were intended to be used in different population groups and are not specifically intended to 'measure' connections to friends, family and education. This highlights the need for appropriate questionnaires to measure connections to friends, family and education with adolescents in inpatient mental health settings.

### **8.9 Summary of candidate interventions objective 4**

Study objective 4 sought to identify candidate interventions to support CYP maintaining their connections to friends, family and education when in hospital for their mental health. The study identified the primary interventions promoting CYP's remote connections to friends and family were through mobile technology such as patients' own mobile phones, with a combination of the internet and social media applications, and the unit's own mobile phone. The ease of access to frequently connect to friends and family through mobile technology by texting, instant messaging, phone and video calling was helpful, although the limited access and harms of the internet and social media on adolescents were apparent. The study found that by staff members adopting a flexible approach with regards to the rules around the mobile phone policy and being open and honest about the potentially negative aspects of the internet and social media, inpatient staff can better support CYP when facing these challenges. The study has also shown that during the development of mobile phone and internet policies and practices, there is a need for inpatient CAMHS to consider the balance of access and potential harms in a flexible, person centred approach.

The key interventions supporting CYP's physical connections to friends and family were through promoting visiting, home leave and the Visitors' Suite. Again, staff being flexible with regards to visiting hours proved to be helpful and the promotion of home leave soon after adolescents are admitted to the unit helped CYP keep in touch in their normal environment. The study has highlighted the significance of a Visitors' Suite in supporting CYP and families for both visiting and how it was particularly important for families travelling from a distance who may require overnight accommodation. It would be ideal for commissioning services to consider having this facility included in the design of and installed in, future inpatient units. The emotional and financial impact on caregivers was apparent, particularly if they struggled with the costs associated with frequently travelling to the unit. Staff facilitating welcome meetings soon after admission appeared to be beneficial for

caregivers. The implementation of dedicated funds to support all caregivers with travel costs, not just those receiving welfare benefits would be helpful for families. If financial resources are a key barrier to implementing this, a more simplified process of accessing funds for families who are able to would be helpful as this appeared to be a complicated system.

In the case of adolescents maintaining connections to their education, the Learning Centre was the overall intervention supporting CYP. To maintain the continuity of CYP's education, education staff within the Learning Centre engaging CYP in schoolwork on admission, in conjunction with the swift liaison with mainstream school staff and facilitating limited examinations ensured the continuity of CYP's education. The careful planning and partnership working between the MDT, patients, caregivers and mainstream school staff, ensured CYP were supported with a smooth, gradual reintegration into their mainstream school. Additionally, supporting CYP who are not in education post 16 with alternative provisions such as vocational activities, planning for college and careers advice was highlighted as helpful aspects of the Learning Centre.

### **8.10 Contribution to knowledge**

This study is the first to explore CYP's connections to their friends, families and education during inpatient mental health care and adds to the growing body of knowledge in the area of adolescent mental health care. It contributes to highlighting the voices, experiences and perspectives of CYP, caregivers and staff in adolescent inpatient mental health settings, an area in which there is currently a dearth of research. In addition, to the researcher's knowledge, this is the first piece of research that has been conducted at the NHS Tier 4 CAMHS inpatient unit since it's construction over a decade ago.

When in an era where internet use and social media have rapidly become part of the everyday lives of CYP, this study is the first of its kind to explore and report findings specifically in relation to the positive and negative aspects of the internet and social media usage with adolescents in inpatient mental health care.

This study has highlighted wider barriers and significant challenges facing families which hinder staying connected such as geographical distance, the burden of travel

and associated costs and the difficulties encountered when applying for financial reimbursement.

This study also provides new research relating to the daily provision, planning and continuity of CYP's education, an aspect of adolescent inpatient mental health services in which there is a particular lack of research. It has also highlighted the implications for CYP accessing inpatient education such as the limited provision of subjects and examinations, lack of tuition in additional languages and post 16 education provision.

It has been noted in this thesis that the period of data collection occurred shortly before the beginning of the Covid-19 global pandemic, when restrictions were placed on hospitals. Regarding the inpatient unit used as the recruitment site for the current study, there were significant restrictions placed on the hospital initially with regards to visitation, home leave and education in line with local infection control guidance (Healthcare Inspectorate Wales (HIW), 2022). The coronavirus pandemic has magnified the importance of staying connected and has made it more obvious how important it was to maintain connections to friends, family and education, especially when interventions supporting maintaining these connections were unable to be used.

### **8.11 Strengths and limitations**

CYP with experience of using Tiers 3 and 4 CAMHS were consulted during the design of research documents to ensure they were appropriate to be used with CYP in the unit. The study gained ethical approval from an NHS REC through a rigorously controlled process. It is particularly difficult to gain this approval when conducting research involving vulnerable participants or in certain clinical environments such as inpatient mental health settings.

Another strength of this study was its participants, with the inclusion of multiple perspectives from CYP, caregivers and a variety of inpatient professionals in health, social and education services. Previous research has involved perspectives from CYP (Haynes et al, 2011; Gill et al, 2016 and Stanton et al, 2020), caregivers (Hayes et al, 2020) and staff members (Claveirole, 2005 and Hayes et al, 2019;2020) in adolescent inpatient mental health settings. Despite this limited research this study was the first of its kind to have conducted research into CYP's connections to their

friends, family and education from multiple perspectives and methods of data collection in an adolescent inpatient mental health unit.

There were several limitations noted within the study. In relation to the study's methodology, the case study design employed was a single-case holistic design. Utilising a more complex design such as a single-case embedded design involving subunits can often add opportunities for extensive analysis and enhance insights into the single case (Yin, 2018). A way to achieve this would have been to focus on the connections between participants by categorising interviews with CYP, their caregivers, their primary nurse and observations of their individual CTP meetings as 'subunits', and then embedding them into the original, larger case, the inpatient unit (Yin, 2018).

Limitations were noted during data collection. The assessment of CYP's capacity and suitability for participation by the unit's Child and Adolescent psychiatrist meant that there was a potential bias in the CYP who were approached for participation in the study. Additionally, six potential participants were missed for interviewing and completion of questionnaires due to a deterioration in their mental health.

Acknowledgement is made that the researcher who undertook interviews and recording MDT meetings is a mental health nurse with previous experience of working at the CAMHS inpatient unit, therefore participants and the interpretation of data may have been influenced. This was mitigated as the researcher had not met or provided any prior care to the participants before the commencement of the study. The period between working at the unit and undertaking the research also ensured that many staff members were not known to the researcher.

Another potential limitation was the selection of a single research site, as one of only two available CAMHS units within the region. It may be not possible to generalise how other units manage CYP's connections to friends, family and education given that Tier 4 inpatient services vary in the interventions they offer and models of care to which they adhere (McDougall and Cotgrove, 2014). However, there was nothing unusual to note about the inpatient unit and the mental health services it delivered, and it is considered typical of most UK Tier 4 CAMHS GAU's.

Despite attempting to include all genders of adolescent participants, recruitment of an all-female population group into the interview aspect of the study  $n=9$  and that

most of the questionnaire sample  $n=21$  out of a total of 26 were also female, was inevitably a limitation of the study's sample. Additionally, the small sample size of the questionnaire phase of the study brings into question the generalisability of the results and should therefore be treated with caution when being extended to CYP in other clinical settings.

Reflecting on the study it has been noted that both the researcher and CYP were often working within the boundaries, constraints and balance of power with other individuals during both the research process and in clinical practice. For researchers this may often involve tactfully navigating and negotiating access to participants with gatekeepers in order to conduct research procedures. Within social research settings, gatekeepers are essential facilitators for accessing study settings and participants (Andoh-Arthur, 2019) and were identified in the current study as the Senior Nurse and Clinical Director.

As previously alluded to in Chapter three, there were additional challenges to overcome with regards to the fieldwork with the potential for having to be chaperoned during interviews and changes to the research protocol. This had the potential to affect the study research questions, and collection and interpretation of the data. Initially when negotiating with gatekeepers, additional time was allowed for discussions with regards to accessing participants and the nature and purpose of the study was explained in lay terms. Additionally, any reservations about the research from gatekeepers were met positively and with respect. This approach to working with gatekeepers is particularly important when conducting research in institutions or organisations (Buchanan et al, 2013). The balance of power between staff and CYP was also apparent, whereby CYP were required to adhere to certain ward rules and policies such as mobile phone access and visiting which often appeared to be restrictive in nature.



### **8.12 Recommendations for practice**

The following recommendations for practice are made to support CYP to maintain connections to friends, family and education in adolescent inpatient mental health settings. The study showed (a) the importance and value of mobile technology and the need for balance regarding access and safeguarding patients. A recommendation is made that adolescent inpatient mental health services continue to provide CYP with appropriate access to mobile technology in such a way which protects and safeguards the wellbeing of CYP. (b) The study recommends the need for staff in inpatient CAMHS settings to continue to provide appropriate emotional support to caregivers, especially when facing significant barriers to keeping in touch such as geographical distance and the financial aspect associated with travel. (c) The project showed the need for improvement in education provision in adolescent inpatient mental health units, particularly within the context of Welsh language and with a focus on improving education for post 16 adolescents. (d) The research identified the need for further work to be undertaken to bridge the interface between inpatient education and mainstream schools.

### **8.13 Recommendations for future research**

This study has highlighted a series of candidate interventions supporting CYP maintain remote and face to face connections with their friends and family and has explored how CYP's education is maintained during periods of inpatient mental health care. Future research is needed to determine how supportive interventions such as mobile technology, visiting, home leave, the Visitors' Suite and inpatient education are applied and managed in other adolescent inpatient mental health settings across the UK. There is a particular need to know what is best practice in adolescent inpatient mental health settings with regards to balancing CYP keeping in touch with friends and family through using the internet and social media, while promoting its safe use.

The next task of the research is to publish journal articles based on the main findings of the study which is outlined below in a proposed dissemination plan. During this period the planning of the next phase of the research will commence, which will involve liaising and networking with key stakeholders and collaborators such as future potential funding organisations, university colleagues, the Local Health Board R&D department and CAMHS. The next steps include mapping out and developing a

programme of research which will build on the work within this thesis and continue work into the area of CYP mental health care.

### **8.14 Dissemination**

Dissemination will take various formats and include distribution to key stakeholders both at a local and national level.

#### **8.14.1 Publications**

It is anticipated that two articles will be published based on the study aims:

- This will report findings from interviews with CYP, caregivers and health, social and education practitioners and will focus on anonymised data of the opportunities and barriers for CYP maintaining contact with their friends and family.
- This will report findings from interviews with CYP, caregivers and health, social and education practitioners and will focus on the opportunities and barriers for CYP maintaining their education.

Targeted journals include: *Journal of Child and Adolescent Psychiatric Nursing*, *Journal of Adolescence* and *Journal of Psychiatric and Mental Health Nursing*.

#### **8.14.2 Presentations and Posters**

Opportunities will be taken to display posters and oral presentations at both local and national level. These will be presented in line with the publications discussed above.

Suggested conferences to present at include:

- Royal College of Nursing (RCN) Annual International Mental Health Nursing Research Conference Autumn 2022.
- University Postgraduate Research Symposium.
- Local Research and Development Conference November 2022.

#### **8.14.3 Stakeholders**

Study information will be disseminated to stakeholders involved and interested in the mental health of CYP at local level.

- A summary of findings will be prepared in the format of an infographic leaflet, including the number of participants who completed interviews and questionnaires and the main findings. These will be sent to the CYP and caregivers who requested them and will be placed on display at the research sites reception area.

- Dissemination through the participating Local Health Board will be via poster format and oral presentation, and a study summary will be posted on the Local Health Board's Research and Development secure Facebook page.
- Presentations will be made to nursing and postgraduate students, lecturers and researchers in the local university.
- A short, summarising report will be prepared and sent to the funding organisations KESS2 and the Local Health Board.

### **8.15 Conclusion**

This project contributes to an important but neglected area of research with a highly vulnerable group of people, where recent figures suggest one in six CYP aged 5-16 are known to have experienced difficulties with their mental health. For those with the most severe and complex mental health difficulties requiring care in hospital, there are additional challenges regarding their connections to their friends, family and education.

To support CYP to maintain connections to friends, family and education in adolescent inpatient mental health settings, this study shows the importance and value of mobile technology and the need for balance regarding access and safeguarding patients. It highlights the need to provide appropriate emotional support to caregivers, especially when facing significant barriers to keeping in touch such as geographical distance and the associated travel costs. The project shows the need for improvement in education provision in adolescent inpatient mental health units, particularly in the context of Welsh language and post 16 education provision. The research identified the need for further work to be undertaken to bridge the interface between mainstream schools and inpatient education. The project has produced valuable new knowledge with clear implications for CAMHS services and recommendations for future research.

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## Appendix 1 – Systematic Literature Search

The question asked was “What is known about the risks to a young person’s connections to their friends, family and education during periods of inpatient mental healthcare?” A systematic search of the literature was planned to review articles previously published relating to young people’s experiences of their friends, family and education whilst in inpatient mental services. A wide search strategy was incorporated initially to explore background literature relating to the topic. Initial searches for literature were undertaken using Google Scholar to determine search terms. The following three subject headings were then used as a basis for the search strategy: Adolescent, Mental Health and Inpatient. The subject headings were then broken down further into key words and phrases which were applied to the search. For example, ‘Young people’, ‘Psychiatr\*’ and ‘Hospitalization’.

The initial searches from combining Boolean operators ‘AND’ and ‘OR’ with the three main subject headings of adolescent, mental health and inpatient produced tens of thousands of results. Due to the vast number of results found from the original three subject headings and key words, advice was sought from a healthcare subject librarian. Consultations with the librarian resulted in adding a fourth subject heading to the search to encompass the three broad areas of friends, family and education. A list of all subject headings, key words and phrases used in each database can be found in tables below.

The search inclusion criteria were then tightened and restricted to studies published in the English language and limited to studies undertaken in high-income countries with developed healthcare systems such as the UK, Europe, Canada, USA, Australia and New Zealand. A filter was applied to restrict the date of publications from 2014-2021 to search for papers in the subsequent years that have passed since the publication of Hannigan et al’s (2015) evidence synthesis which stopped searching late 2013.

The titles and abstracts were assessed for relevance and retrieved if they met the inclusion and exclusion criteria. Many data bases produced duplicate articles, following which 41 articles were briefly reviewed and 14 were reviewed in detail. The following seven online databases were searched: PsycINFO via Ovid, Medline via Ovid, Embase via Ovid, Ovid Emcare, Cinahl via Ebsco, Scopus and Web of Science. Accounts were created in all databases and the searches were saved to run automatically every month to capture new research that was conducted during the project. A review of the database searches can be found below and a discussion of the articles were presented in Chapter two.

Table A1.1 Number of articles identified from each source



Databases	References Retrieved
PsycINFO (Ovid)	867
Medline (Ovid)	1498
EMBASE (Ovid)	2182
Ovid Emcare	1046
CINAHL (EBSCO)	1006
Scopus	1294
Web Of Science	1136
<b>TOTAL</b>	<b>9029</b>

Table A1.2. Subject headings and key words used in the literature search.

### PsycINFO (Ovid)

Search Number	Description	Results
1	(adolescen* or teen* or "young adult*" or "young people" or "young person" or youth).tw	395,929
2	(mental adj (health or illness)).tw	237,134
3	psychiatr*.tw	275,873
4	exp Mental Health/	76,363
5	2 or 3 or 4	466,856
6	1 and 5	60,822
7	exp Adolescent Psychiatry	5635
8	exp Child Psychiatry/	7032
9	camhs.tw	694
10	7 or 8 or 9	10,129
11	6 or 10	65,499
12	exp Hospitalization/	24,876
13	exp Hospital Admission/	5,842
14	(inpatient* or admission* or admit* or discharge* or resident*).tw	203,273
15	(transition adj2 school).tw	2272
16	12 or 13 or 14 or 15	213,798
17	exp Family/	320,315
18	exp Friendship/	10,234
19	exp Peer Relations/	18,003
20	exp Social Support/	39,645
21	exp Education/	453,965
22	(famil* or parent* or carer* or friend*).tw	698,725
23	((education or school) adj2 (reintegration or re-integration or "re integration" or reentry or re-entry or "re entry").tw	270
24	17 or 18 or 19 or 20 or 21 or 22 or 23	1,175,621
25	11 and 16 and 24	3354
26	Limit 25 to (English language and yr="2014-Current")	<b>867</b>

Table A1.3 Medline (Ovid)

Search Number	Description	Results
1	exp Adolescent/	21,462,53
2	exp Young Adult/	967,598
3	(adolescen* or teen* or "young adult*" or "young people" or "young person" or youth).tw	472,679
4	1 or 2 or 3	2,739,538
5	exp Mental Health/	49,588
6	(mental adj (health or illness)).tw	191,671
7	psychiatr*.tw	258,098
8	5 or 6 or 7	428,821
9	4 and 8	105,007
10	exp Adolescent Psychiatry	2964
11	exp Child Psychiatry/	5732
12	camhs.tw	547
13	10 or 11 or 12	7514
14	9 or 13	109,614
15	exp Hospitalization/	270,914
16	exp Patient Admission/	25,830
17	(inpatient* or admission* or admit* or discharge* or resident*).tw	929,721
18	(transition adj2 school).tw	472
19	15 or 16 or 17 or 18	1,065,494
20	exp Family/	345,072
21	exp Friends/	6039
22	exp Peer Group/	23,209
23	exp Social Support/	76,568
24	exp Education/	861,656
25	(famil* or parent* or carer* or friend*).tw	1,611,539
26	((education or school) adj2 (reintegration or re-integration or "re integration" or reentry or re-entry or "re entry").tw	163
27	20 or 21 or 22 or 23 or 24 or 25 or 26	2,584,520
28	14 and 19 and 27	4503
29	Limit 28 to (English language and yr="2014-Current")	<b>1498</b>

Table A1.4 Embase (Ovid)

Search Number	Description	Results
1	(adolescen* or teen* or "young adult*" or "young people" or "young person" or youth).tw	632,156
2	(mental adj (health or illness)).tw	242,826
3	psychiatr*.tw	379,074
4	exp Mental Health/	191,611
5	2 or 3 or 4	650,825
6	1 and 5	66,885
7	exp Child Psychiatry/	25,769
8	camhs.tw	914

9	7 or 8	26,502
10	6 or 9	85,264
11	exp Hospitalization/	446,966
12	exp Hospital Admission/	230,322
13	(inpatient* or admission* or admit* or discharge* or resident*).tw	1,487,820
14	(transition adj2 school).tw	572
15	11 or 12 or 13 or 14	1,857,357
16	exp Family/	602,911
17	exp Friend/	23,722
18	exp Peer Group/	27,253
19	exp Social Support/	101,356
20	exp Education/	1,617,999
21	(famil* or parent* or carer* or friend*).tw	2,090,962
22	((education or school) adj2 (reintegration or re-integration or "re integration" or reentry or re-entry or "re entry").tw	269
24	16 or 17 or 18 or 19 or 20 or 21 or 22	3,824,047
25	10 and 15 and 24	4803
26	Limit 25 to (English language and yr="2014-Current")	<b>2182</b>

Table A1.5 Ovid Emcare

Search Number	Description	Results
1	exp Adolescent/	373,303
2	exp Young Adult/	83,826
3	(adolescen* or teen* or "young adult*" or "young people" or "young person" or youth).tw	257,030
4	1 or 2 or 3	527,026
5	exp Mental Health/	117,253
6	(mental adj (health or illness)).tw	128,872
7	psychiatr*.tw	95,598
8	5 or 6 or 7	242,443
9	4 and 8	40,944
10	exp Child Psychiatry/	5986
11	camhs.tw	432
12	10 or 11	6370
13	9 or 12	44,634
14	exp Hospitalization/	113,236
15	exp Hospital Admission/	80,770
16	(inpatient* or admission* or admit* or discharge* or resident*).tw	365,139
17	(transition adj2 school).tw	514
18	14 or 15 or 16 or 17	466,500
19	exp Family/	229,845
20	exp Friend/	21,019
21	exp Peer Group/	12,929
22	exp Social Support/	52,924

23	exp Education/	654,711
24	(famil* or parent* or carer* or friend*).tw	512,182
25	((education or school) adj2 (reintegration or re-integration or "re integration" or reentry or re-entry or "re entry").tw	123
26	19 or 20 or 21 or 22 or 23 or 24 or 25	1169638
27	13 and 18 and 26	2231
28	Limit 27 to (English language and yr="2014-Current")	<b>1046</b>

Table A1.6 CINAHL (Ebsco)

Search Number	Description	Results
1	(MH "Adolescence+")	569,756
2	(MM "Young Adult")	367
3	TI: adolescen* or teen* or "young adult*" or "young people" or "young person" or youth	157,047
4	AB: adolescen* or teen* or "young adult*" or "young people" or "young person" or youth	179,371
5	1 or 2 or 3 or 4	645,321
6	(MH "Mental Health")	46,469
7	TI: mental N1 (health or illness)	60,110
8	AB: mental N1 (health or illness)	110,594
9	TI: psychiatr*	36,449
10	AB: psychiatr*	57,589
11	6 or 7 or 8 or 9 or 10	219,597
12	5 and 11	41,705
13	(MH "Adolescent Psychiatry")	1,337
14	(MH "Child Psychiatry")	1,971
15	TI: camhs	189
16	AB: camhs	486
17	13 or 14 or 15 or 16	3,066
18	12 or 17	43,376
19	(MH Hospitalization+)	111,898
20	TI: inpatient* or admission* or admit* or discharge* or resident*	72,616
21	AB: inpatient* or admission* or admit* or discharge* or resident*	276,739
22	TI: transition N2 school	347
23	AB: transition N2 school	731
24	19 or 20 or 21 or 22 or 23	392,782
25	(MH "Family+")	253,393
26	(MH "Friendship")	6,912
27	(MH "Peer Group")	14,713
28	(MH "Support, Psychosocial+")	93,859
29	(MH "Education+")	982,804
30	TI: famil* or parent* or carer* or friend*	157,027
31	AB: famil* or parent* or carer* or friend*	381,124

32	TI: (education* or school*) N2 (reintegration or re-integration or “re integration or reentry or re-entry or “re entry”)	74
33	AB: (education* or school*) N2 (reintegration or re-integration or “re integration or reentry or re-entry or “re entry”)	146
34	25 or 26 or 27 or 28 or 29 or 30 or 31 or 32 or 33	1,476,980
35	18 and 24 and 34	<b>1006</b>

Scopus & Web of Science:

Article Title, Abstract, Keyword: (adolescen\* or teen\* or “young adult\*” or “young people” or “young person” or youth) W10 (“mental health” or “mental illness” or psychiatr\* or camhs) AND hospital\* or inpatient\* or admission\* or admit\* or discharge\* or resident\* or transition AND famil\* or parent\* or carer\* or friend\* or peer\* or education or school.

## Appendix 2 – Table of Articles

Author (Date) Country, Title	Aim	Participants (Sample size, Age, Recruitment)	Method (Design, Data Collection and Analysis)	Key findings relevant to review
Blizzard et al (2016)  USA  Caregivers Perspectives During the Post Inpatient Hospital Transition: A Mixed Methods Approach	To examine the psychosocial resources of caregivers of children leaving intensive psychiatric care and participating in a post in-patient transition program, and to describe their reported needs at home and school.	44 Caregivers of adolescents who had been admitted to psychiatric inpatient units.	44 participants recruited across two child and adolescent psychiatric inpatient units across two hospitals (one urban and one suburban).  Mixed methods Concurrent equal status design for MM analysis. Qualitative data analysed using consensual qualitative research methodology.	<b>Education</b> –Parents and families may require information about the resources available for psychosocial support and information on the process of school reintegration.
Gill et al (2016)  England UK  'The experience of adolescent inpatient care and the anticipated transition to the community: Young People's perspectives'	Study aimed to explore adolescents' perceptions of the benefits and drawbacks of inpatient care, but also on their expectations about the transition back home. More specifically, it focused on adolescents' perceptions of the aspects of inpatient treatment that would	Adolescents- 2 male and 10 female participants.  Aged between 13-18 years  Mean age – 16 years 3 months.  Average length of stay – just under 3 and a half months.	12 participants across three adolescent inpatient units in London. Although most participants came from 2 of the 3 units.  Qualitative study using semi-structured interviews.  Thematic analysis	<b>Friends</b> - CYP reported they liked knowing they could always talk to someone. Having a shared experience with fellow inpatients led to a sense of validation and belonging. CYP talked about developing a significant relationship with a fellow inpatient or staff member. However, some spoke of feeling too attached to other patients and staff. CYP described challenges that arose from living with other peoples difficulties, e.g. witnessing other peoples distress and risk of 'Triggering each other off'. <b>Family/Friends</b> – CYP noted how inpatient treatment can disrupt established relationships with family and friends, yet also give them the opportunity to develop

	help or hinder this transition.			new, valued relationships with fellow inpatients and staff.
Author (Date) Country, Title	Aim	Participants (Sample size, Age, Recruitment)	Method (Design, Data Collection and Analysis)	Key findings relevant to review
Hayes et al (2019)  Melbourne, Australia  The unheard voice of the clinician: Perspectives on the key features of an adolescent inpatient model of care.	This study aimed to describe an inpatient model of care in operation, by defining key features from the perspectives of clinicians.	10 clinicians working at a private inpatient unit.  Registered Nurses, Endorsed Enrolled Nurses, Art Therapist, Occupation Therapist, and Psychologist.	Semi structured interviews with 10 clinicians  Thematic analysis	<b>Friends</b> – Patients engaged through shared experiences. Adolescents who may have previously struggled with ‘fitting in’ or felt different with regards to their peer group, suddenly had peers who understood them and people who they could open up to and share their problems with. Clinicians described acceptance between adolescents in the inpatient environment because they understood each other, and that this was different for CYP’s interactions with other groups of people such as their peers from school. Clinicians described the environment as one with no judgement, which provided a platform for CYP people to develop therapeutic relationships. clinicians reported that there were issues with CYP forming unhelpful friendships such as them being disruptive. Clinicians also reported that by becoming concerned with their peers’ problems, this caused a knock-on effect in which CYP often avoided their own issues.
Hayes et al (2020)  Melbourne, Australia  Experiences of an adolescent inpatient model of care: Adolescent and caregiver perspectives.	This study aimed to understand how adolescents and caregivers experience an inpatient model of care and perceive the helpfulness over time.	16 adolescents, 12 caregivers.	Longitudinal prospective qualitative design.  Semi structured interviews.  Thematic analysis and trajectory analysis	<b>Friends</b> - CYP perceived their relationships with peers as helpful due to being around others who were in similar situations to themselves. A key aspect to CYP making new friendships in this study was the feeling of being understood and developing trust with other CYP <b>Family</b> - caregivers reported finding their child’s peer relationships being difficult, with some caregivers feeling rejected. Caregivers also acknowledged the importance of CYP meeting new friends in hospital,

				although in some instances they were concerned about the intensity of these peer relationships <b>Education</b> – Schoolwork was the focus of admission for some CYP. Others wanted structure from the admission and help with returning to their school.
<b>Author (Date) Country, Title</b>	<b>Aim</b>	<b>Participants (Sample size, Age, Recruitment)</b>	<b>Method (Design, Data Collection and Analysis)</b>	<b>Key findings relevant to review</b>
Marraccini et al (2019)  USA  School Reintegration Post-Psychiatric Hospitalization: Protocols and Procedures Across the Nation	To identify the prevalence and scope of school reintegration protocols and procedures in middle and high schools in USA.	133 school psychologists across USA	Self-report questionnaire	<b>Education</b> – Common services available to support CYP upon their return their school may include establishing communication with the hospital, meeting the family prior to the students return, developing an individualised re-entry plan. Support with time management, individual counselling and on-site tutoring. Other practical support for students in some studies included extended time to complete academic deadlines, being flexible with students time of arrival and departure from school, and providing students with a universal pass to see a counsellor.
Marraccini and Pittleman (2021)  USA  Returning to School Following Hospitalization for Suicide-Related Behaviours: Recognizing Student Voice for Improving Practice	To explore the lived experiences of adolescents to help inform practices that support adolescent school re-entry following hospitalization for a suicide-related crisis.	19 adolescents hospitalized for suicide related crisis at a large psychiatric hospital in southeast USA.	Qualitative Design.  Interviews with adolescents.	<b>Education</b> – Findings suggest the need to strengthen social support for CYP returning to school. the importance of emotional support (positive school relationships and a safer psychosocial school climate). Instrumental support (collaborations and communication around re-entry and informational support (clearer procedures around re-entry processes)
Marraccinni et al (2021)	The study aimed to inform recommendations provided by hospitals	133 school professionals	Concurrent Mixed Methods Design.	<b>Education</b> – Schools in rural areas were less likely to have reintegration protocols for returning adolescents. Available interventions and school



USA  School Supports for Reintegration Following a Suicide-Related Crisis: A Mixed Methods Study Informing Hospital Recommendations for Schools During Discharge.	to schools to improve school reintegration practices	Interviews with 19 of the 133 school professionals	Survey with school professionals  In depth interviews with a subset of professionals.	modifications were consistent across rural and urban/suburban schools.  Key recommendations – Consider return to school throughout hospitalization, discuss information sharing with families, discharge summary for schools, a set of recommendations for schools and consider variability across schools.
<b>Author (Date) Country, Title</b>	<b>Aim</b>	<b>Participants (Sample size, Age, Recruitment)</b>	<b>Method (Design, Data Collection and Analysis)</b>	<b>Key findings relevant to review</b>
Preyde et al (2017)  Canada  School Reintegration and Perceived Needs: The Perspectives of Child and Adolescent Patients During Psychiatric Hospitalization	To explore CYP's concerns for school reintegration and to report their perceived needs for support before leaving hospital.	161 CYP in psychiatric inpatient care.  Mean age 15.4  75% female, 57% with a diagnosis of major depression.	Self-report questionnaire completed by CYP.	<b>Education</b> – CYP highlighted concerns around anticipating social situations in school, academic progress and feeling overwhelmed returning to school.  CYP identified need for ongoing support from mental health professionals and school staff, social support from friends and family, and educational assistance and modifications.
Preyde et al (2018)  Canada  Youth's Experiences of School Re-Integration	To explore CYP's perceptions of school reintegration following psychiatric hospitalization.	62 CYP at one Child and adolescent inpatient unit.  Mean age 15.6  68% female.	Survey via telephone n=40 or post discharge survey n=22.  Thematic content analysis	<b>Education</b> – CYP reported problems in managing social situations, academic pressures and their emotions. The need for inpatient care to address school related issues, and the importance of CYP transitioning to school during the discharge process.

Following Psychiatric Hospitalization.				
<b>Author (Date) Country, Title</b>	<b>Aim</b>	<b>Participants (Sample size, Age, Recruitment)</b>	<b>Method (Design, Data Collection and Analysis)</b>	<b>Key findings relevant to review</b>
<p>Reavey et al (2017)</p> <p>England UK</p> <p>The ward as emotional ecology: Adolescent experiences of managing mental health and distress in psychiatric inpatient settings</p>	<p>The study aimed to expand the understanding of adolescents' experiences of the inpatient environment with a particular focus on relationships formed with peers, staff and the ward space.</p>	<p>20 young people, 10 from a supported discharge service and 10 from Treatment as usual. Participants had stayed on at least 1 of 4 adolescent wards. Aged between 14-18 years old. Mean age 16.8. Gender – 40% male 60% female. Length of stay – average of 65.8 days</p>	<p>Qualitative study – mixed visual and interview techniques used A thematic decomposition analysis was conducted on the data and specific themes relevant to satisfaction and engagement with inpatient services was examined in-depth.</p>	<p><b>Friends/peers</b> - 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. Several participants believed they had gained a greater sense of emotional competency via their relationships with other patients. Most participants felt that the safest and most reliable way to express themselves was by utilising supportive relationships and trusted peers. Participants reported triggering each other off. The risk of potentially causing emotional distress in others affected some participants to either purposely hide their feelings, attract attention, or invited further criticisms or scrutiny of their behaviours by other CYP</p>
<p>Merayo-Sereno et al (2021)</p> <p>Spain</p> <p>The experience of parents faced with the admission of their adolescent to a child and adolescent psychiatric inpatient unit. A qualitative study with focus groups.</p>	<p>To examine the experience of parents of adolescents with mental health needs that require psychiatric hospitalization in a child and adolescent unit</p>	<p>22 Caregivers of CYP who are in a child and adolescent mental health unit.</p>	<p>Qualitative cross-sectional research, Grounded Theory.</p> <p>Focus Groups with parents.</p>	<p><b>Friends/peers</b> - implications for CYP when entering their mainstream school. Whilst parents highly valued the support from their child's mainstream school, they reported their child being afraid of being judged negatively with regards to their peers. <b>Family</b> - Visitation between CYP and their caregivers was described as a key time throughout the CYP's stay for caregivers' relationship with their child. However, it was recommended that parents were to work on management strategies with their child during the visit as opposed to spending time with them. This often-left parents feeling this task should have been undertaken by a therapist and not themselves.</p>

Author (Date) Country, Title	Aim	Participants (Sample size, Age, Recruitment)	Method (Design, Data Collection and Analysis)	Key findings relevant to review
<p>Salamone-Violi et al (2015)</p> <p>Australia</p> <p>'I don't want to be here but I feel safe': Referral and admission to a child and adolescent psychiatric inpatient unit: The young person's perspective'.</p>	<p>To identify and understand the experiences of the admission process for young people referred to an inpatient unit in one Australian state, for children up to the age of 18 years who have a psychiatric illness.</p>	<p>11 young people – 6 males, 5 females</p> <p>15-17 years old</p> <p>Length of stay: 4-15 days</p> <p>Diagnosis on discharge: depression, adjustment disorder, suicidal ideation/self-harm and situational crisis.</p>	<p>Qualitative design</p> <p>Open-ended, semi-structured interviews transcribed by interviewer</p> <p>Thematic analysis</p>	<p><b>Friends/peers</b> - Satisfaction with the inpatient experience was influenced by whether or not CYP experiences a sense of connection with staff and other patients. How CYP related to their peers influenced their perception of the appropriateness of their admission. When CYP made a connection with another patient, they described the inpatient experience a positive one.</p> <p><b>Family</b> – participants made positive remarks about the usefulness of family meetings.</p> <p><b>Friends/family</b> - CYP going home on leave was built up gradually as part of the discharge process. Participants described first trying some leave to go home and see friends, then gradually building this up to staying overnight.</p>
<p>Schneidtinger and Haslinger-Baumann (2019)</p> <p>Vienna, Austria</p> <p>The lived experience of adolescent users of mental health services in Vienna, Austria: A qualitative study of personal recovery.</p>	<p>To explore how adolescent users of mental health services in Vienna, Austria experienced personal recovery after a stay in a CAMHS hospital.</p>	<p>10 adolescents, eight females and two males. One CAMHS inpatient unit.</p> <p>15-19 years old.</p>	<p>Qualitative exploratory design</p> <p>Interviews</p> <p>Content analysis</p>	<p><b>Friends/peers</b> - Participants described friendships with fellow patients that were of great importance to them and stated that fellow inpatients were extremely helpful as they perceived they understood each other. Many participants also saw themselves and other inpatients as a community in which they supported each other.</p> <p>Personal recovery was hindered by negative group dynamics. Certain individuals were having a negative influence on others, particularly younger adolescents. CYP participated in internal groupings associated with self-harming such as cutting and anorexia nervosa. Also witnessing psychiatric emergencies was distressing for participants.</p> <p><b>Family</b> - Regular visits to the ward by family members were seen as highly positive for CYP.</p>

				<b>Education</b> – all participants had future plans regarding education or work.
<b>Author (Date) Country, Title</b>	<b>Aim</b>	<b>Participants (Sample size, Age, Recruitment)</b>	<b>Method (Design, Data Collection and Analysis)</b>	<b>Key findings relevant to review</b>
<p>Stanton et al (2020)</p> <p>New Zealand</p> <p>Self-determination theory in acute child and adolescent mental health inpatient care. A qualitative exploratory study.</p>	<p>To understand the experience of inpatient care for young people and families with a specific focus on relatedness, autonomy and competence.</p>	<p>Location – One adolescent inpatient mental health unit with 18 beds in Auckland, NZ.</p> <p>Eligible participants were between 12-20 years of age. Of the 65 eligible, 15 participated. No information on gender ratio, or mean age.</p> <p>Average length of stay is 11 days.</p>	<p>Analysis – General inductive approach, similar to thematic analysis Then a template analysis approach, where the data were analysed specifically using the three needs identified</p> <p>Interviews with 15 adolescents during admission and a follow up telephone interview 2-4 weeks after discharge. 6 of the 15 completed follow up interviews via telephone.</p>	<p>Several young people described the process of admission undermining their experience of competence. But some young people did describe gaining competence during admission. Self-determination theory and 3 categories of relatedness, autonomy and competence were described. Young people described largely positive experiences. They spoke to valuing relatedness with staff, peers and families.</p> <p>Autonomy was described as limited at times, and young people appreciated a sense of choice and being heard.</p> <p><b>Friends/Peers Positive</b> – Relatedness with other young people on the unit was described. Participants described feeling connected to other young people even after they left. There was a general sense of companionship. Young people described other young people has being helpful when orientating them to the unit and encouraging them to join in. An important aspect between young people was having similar/shared experiences.</p> <p><b>Friends/Peers Negative</b> – young people felt isolated from their peers outside the unit and found it hard when other young people were discharged. Some young people described other young people being annoying. Some young people would like to have seen the issue of managing inquiries from peers on returning home addressed while they were on the unit.</p> <p><b>Family positive</b> – Most young people felt connected to their families throughout admission and some felt a sense of increasing their connection with their family.</p>

Stanton et al (2020) (cont)				<p>Practical support for families included onsite accommodation, ease of making phone calls, staff welcoming families with long visiting hours and encouraging family outings.</p> <p>One young person reported finding it more difficult to cope knowing his family understood more about what he was going through.</p> <p>Some young people described not being able to access their phones at night. Young people objected some rules including use of phones.</p> <p><b>Education – Competence</b> – some young people described having lost competence in schoolwork and felt the unit school helped in getting them back into a routine. Other young people found the schooling was not stretching them enough or felt that not enough was done to keep them up with their studies.</p>
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## Appendix 3 - Interview questions CYP



### Interview Schedule – Young People



#### **\*Set of Demographic questions\***

##### **General experience**

How long have you been on the ward?

What has it been like staying here?

Prompt: What are the good and bad bits?

How is it different here to life at home?

##### **Friends (relationships on the ward)**

What has it been like staying in hospital with other young people?

Have you mixed in well with the other young people?

Is there anyone here that you have made friends with?

How confident are you about making new friends?

##### **Friends (relationships back home)**

How are your friends from back home?

Have you managed to keep in touch with them? If so, how have you managed to keep in touch with them?

How often do you keep in touch with your friends?

How do you imagine things will be (with your home friends) when you leave here? Do you think there will be anything different or will things be the same?

What do you think the barriers or issues are to you keeping in touch with your friends whilst you are in hospital?

[Version 1, 11/10/2018] IRAS Number 250127 Young people's social connections during inpatient mental health care

## Family

How are you getting along with your family?

Has this changed at all since being in hospital? If so, how?

Prompt: Do you feel any closer/distanced at all from your family since being in hospital?

How do you manage to keep in touch with your family?

How often do you keep in touch with them?

How do you imagine things will be with your family when you leave hospital?

What do you think the barriers or issues are to you keeping in touch with your family whilst you are in hospital?

## School/Education

What is the school like here?

How is it different to your school back home?

Have you kept in touch with your school? If so, how have you kept in touch with your school?

How have you kept up with your studies?

How have you managed to prepare for exams and coursework?

Are you worried that you have missed some school time? If yes, could you explain what your worries might be?

Have your thoughts about your education/studies changed at all since being in hospital?\*

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Have you had to reduce the amount of subjects you are currently doing?\*

What do you think the barriers or issues are to you keeping up with your studies whilst you are in hospital?

Is there anything else you think I should have asked you relating to you keeping in touch with your friends, family and education?

**\*maybe appropriate for the older aged young people in the study 15+**



## Appendix 4 – Interview questions caregivers



### Interview Schedule – Parents/Carers



#### General experience

What is your name?

And you are the parents/carers of?

Where do you live?

How long has your child been on the ward?

What has it been like keeping in touch with your child?

Prompt: What are the good and bad bits?

How do you think it is different here to your child's life at home?

#### Friends (relationships on the ward)

How do you think it has been for your child staying in hospital with other young people?

Do you think your child has mixed in well with the other young people?

How confident do you think your child is at making new friends?

#### Friends (relationships back home)

How is your ~~childs's~~ relationships with his/her friends from back home?

Has your child managed to keep in touch with them? If so, how has your child managed to keep in touch with them?

How often does your child keep in touch with his/her friends?

What do you think the barriers or issues are to your child keeping in touch with their friends whilst they are in hospital?

[Version 1, 11/10/2018] IRAS Number 250127 Young people's social connections during inpatient mental health care

How do you imagine things will be (with your child's home friends) when they leave here? Do you think there will be anything different or will things be the same?

#### Family

How are you getting along with your child?

Has this changed at all since being in hospital? If so, how?

Prompt: Do you feel any closer/distanced at all from your child since they have been in hospital?

How do you manage to keep in touch with your child?

How often do you keep in touch with your child?

Are you able to visit your child? Stay on the unit? Take your child off the unit?

Are there specific visiting times?

The flat, have you used this? if so what is it like? Is it helpful?

How do you imagine things will be with your family when your child leaves hospital?

What do you think the barriers or issues are to keeping in touch with your child whilst they are in hospital?

#### School/Education

What is the school like here?

How is it different to your child's school back home?

[Version 1, 11/10/2018] IRAS Number 250127 Young people's social connections during inpatient mental health care

Has your child kept in touch with their school? If so, how has your child kept in touch with their school?

How has your child kept up with their studies?

Has your child managed to prepare for exams and coursework?

What do you think the barriers or issues are to your child keeping up with their studies whilst they are in hospital?

Are you worried that your child might have missed some school time? If yes, could you explain what your worries might be?

Do you think your child's thoughts about their education/studies changed at all since being in hospital?

Has your child had to reduce the amount of subjects you they are currently doing?

Is there anything else you think I should have asked you relating to your child keeping in touch with their friends, family and education?

## Appendix 5 – Interview questions ward staff



Interview Schedule - ward professionals



What is your name?

What is your self-identified gender?

What is your profession?

How long have you been qualified?

How long have you worked on the ward in this role?

Could you give me a general overview or purpose of this unit?

Could you give me a general overview of the work the unit does with young people?

Could you give me a general overview of the work you do as a (profession) at this unit?

On average how long are young people admitted to the ward for?

### Friends

How do you promote young people keeping in touch with their friends whilst they are on the ward?  
(Interventions)

What are the visiting times on the ward?

Do young people often make new friends on the ward? If so, how do you promote young people making new friends?

What do you think the barriers or issues are to young people keeping in touch with their friends whilst they are in hospital?

Are there any limits on the number of visitors allowed?

### Family

How do you promote young people keeping in touch with their family whilst they are on the ward?

What work does the unit do with young people's families/carers?

Are most young people offered these interventions?

How often do young people get visits from their families?

What do you think the barriers or issues are to young people keeping in touch with their family whilst they are in hospital?

### Education

[Version 1, 11/10/2018] IRAS Number 250127 Young people's social connections during inpatient mental health care

How do you promote young people keeping in touch with their education whilst they are on the ward?

How often do young people attend school?

What subjects are taught?

What do you think the barriers or issues are to young people keeping up with their studies whilst they are in hospital?

Is there anything else you think I should have asked you relating to young people keeping in touch with their friends, family and education whilst they are in hospital?

## Appendix 6 – The Strengths and Difficulties Questionnaire

### Strengths and Difficulties Questionnaire

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain or the item seems daft! Please give your answers on the basis of how things have been for you over the last six months.

Participant ID .....

Male/Female/Other  
please specify.....

Age.....

Prefer not to say

	Not True	Somewhat True	Certainly True
I try to be nice to other people. I care about their feelings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am restless, I cannot stay still for long	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I get a lot of headaches, stomach-aches or sickness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I usually share with others (food, games, pens etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I get very angry and often lose my temper	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am usually on my own. I generally play alone or keep to myself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I usually do as I am told	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I worry a lot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am helpful if someone is hurt, upset or feeling ill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am constantly fidgeting or squirming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have one good friend or more	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I fight a lot. I can make other people do what I want	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am often unhappy, down-hearted or tearful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other people my age generally like me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am easily distracted, I find it difficult to concentrate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am nervous in new situations. I easily lose confidence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am kind to younger children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am often accused of lying or cheating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other children or young people pick on me or bully me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I often volunteer to help others (parents, teachers, children)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I think before I do things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I take things that are not mine from home, school or elsewhere	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I get on better with adults than with people my own age	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have many fears, I am easily scared	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I finish the work I'm doing. My attention is good	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Today's date .....

**Thank you very much for your help**

© Robert Goodman, 2005

## Appendix 7 – The Inventory of Parent and Peer Attachment Revised

Participant ID.....

Today's Date.....

i

### INVENTORY OF PARENT AND PEER ATTACHMENT (IPPA)

Authors:

© Gay Arnsden, Ph.D. and Mark T. Greenberg, Ph.D.<sup>1</sup>

This questionnaire asks about your relationships with important people in your life; your mother, your father, and your close friends. Please read the directions to each part carefully.

#### Part I

Some of the following statements asks about your feelings about your mother or the person who has acted as your mother. If you have more than one person acting as your mother (e.g. a natural mother and a step-mother) answer the questions for the one you feel has most influenced you.

Please read each statement and circle the ONE number that tells how true the statement is for you now.

	Almost Never or Never True	Not Very Often True	Some- times True	Often True	Almost Always or Always True
1. My mother respects my feeling.	1	2	3	4	5
2. I feel my mother does a good job as my mother.	1	2	3	4	5
3. I wish I had a different mother.	1	2	3	4	5
4. My mother accepts me as I am.	1	2	3	4	5
5. I like to get my mother's point of view on things I'm concerned about.	1	2	3	4	5
6. I feel it's no use letting my feelings show around my mother.	1	2	3	4	5
7. My mother can tell when I'm upset about something.	1	2	3	4	5

	Almost Never or Never True	Not Very Often True	Some- times True	Often True	Almost Always or Always True
8. Talking over my problems with my mother makes me feel ashamed or foolish.	1	2	3	4	5
9. My mother expects too much from me.	1	2	3	4	5
10. I get upset easily around my mother.	1	2	3	4	5
11. I get upset a lot more than my mother knows about.	1	2	3	4	5
12. When we discuss things, my mother cares about my point of view.	1	2	3	4	5
13. My mother trusts my judgment.	1	2	3	4	5
14. My mother has her own problems, so I don't bother her with mine.	1	2	3	4	5
15. My mother helps me to understand myself better.	1	2	3	4	5
16. I tell my mother about my problems and troubles.	1	2	3	4	5
17. I feel angry with my mother.	1	2	3	4	5
18. I don't get much attention from my mother.	1	2	3	4	5
19. My mother helps me to talk about my difficulties.	1	2	3	4	5
20. My mother understands me.	1	2	3	4	5
21. When I am angry about something, my mother tries to be understanding.	1	2	3	4	5
22. I trust my mother.	1	2	3	4	5
23. My mother doesn't understand what I'm going through these days.	1	2	3	4	5
24. I can count on my mother when I need to get something off my chest.	1	2	3	4	5
25. If my mother knows something is bothering me, she asks me about it.	1	2	3	4	5

<sup>1</sup> Address for Dr. Greenberg: Dept. of Human Development, Penn State University, State College, PA 16802.

## Part II

This part asks about your feelings about your father, or the man who has acted as your father. If you have more than one person acting as your father (e.g. natural and step-father) answer the question for the one you feel has most influenced you.

	Almost Never or Never True	Not Very Often True	Some- times True	Often True	Almost Always or Always True		Almost Never or Never True	Not Very Often True	Some- times True	Often True	Almost Always or Always True
1. My father respects my feelings.	1	2	3	4	5	16. I tell my father about my problems and troubles	1	2	3	4	5
2. I feel my father does a good job as my father.	1	2	3	4	5	17. I feel angry with my father	1	2	3	4	5
3. I wish I had a different father.	1	2	3	4	5	18. I don't get much attention from my father.	1	2	3	4	5
4. My father accepts me as I am.	1	2	3	4	5	19. My father helps me to talk about my difficulties.	1	2	3	4	5
5. I like to get my father's point of view on things I'm concerned about.	1	2	3	4	5	20. My father understands me.	1	2	3	4	5
6. I feel it's no use letting my feelings show around my father.	1	2	3	4	5	21. When I am angry about something, my father tries to be understanding.	1	2	3	4	5
7. My father can tell when I'm upset about something.	1	2	3	4	5	22. I trust my father.	1	2	3	4	5
8. Talking over my problems with my father makes me feel ashamed or foolish.	1	2	3	4	5	23. My father doesn't understand what I'm going through these days.	1	2	3	4	5
9. My father expects too much from me.	1	2	3	4	5	24. I can count on my father when I need to get something off my chest.	1	2	3	4	5
10. I get upset easily around my father.	1	2	3	4	5	25. If my father knows something is bothering me, he asks me about it.	1	2	3	4	5
11. I get upset a lot more than my father knows about.	1	2	3	4	5						
12. When we discuss things, my father cares about my point of view.	1	2	3	4	5						
13. My father trusts my judgment.	1	2	3	4	5						
14. My father has his own problems, so I don't bother him with mine.	1	2	3	4	5						
15. My father helps me to understand myself better.	1	2	3	4	5						



## Part III

This part asks about your feelings about your relationships with your close friends.

Please read each statement and circle the ONE number that tells how true the statement is for you now.

	Almost Never or Never True	Not Very Often True	Some- times True	Often True	Almost Always or Always True
1. I like to get my friend's point of view on things I'm concerned about.	1	2	3	4	5
2. My friends can tell when I'm upset about something.	1	2	3	4	5
3. When we discuss things, my friends care about my point of view.	1	2	3	4	5
4. Talking over my problems with friends makes me feel ashamed or foolish.	1	2	3	4	5
5. I wish I had different friends.	1	2	3	4	5
6. My friends understand me.	1	2	3	4	5
7. My friends encourage me to talk about my difficulties.	1	2	3	4	5
8. My friends accept me as I am.	1	2	3	4	5
9. I feel the need to be in touch with my friends more often.	1	2	3	4	5
10. My friends don't understand what I'm going through these days.	1	2	3	4	5
11. I feel alone or apart when I am with my friends.	1	2	3	4	5
12. My friends listen to what I have to say.	1	2	3	4	5
13. I feel my friends are good friends.	1	2	3	4	5
14. My friends are fairly easy to talk to.	1	2	3	4	5
15. When I am angry about something, my friends try to be understanding.	1	2	3	4	5
16. My friends help me to understand myself better.	1	2	3	4	5
17. My friends care about how I am feeling.	1	2	3	4	5

	Almost Never or Never True	Not Very Often True	Some- times True	Often True	Almost Always or Always True
18. I feel angry with my friends.	1	2	3	4	5
19. I can count on my friends when I need to get something off my chest.	1	2	3	4	5
20. I trust my friends.	1	2	3	4	5
21. My friends respect my feelings.	1	2	3	4	5
22. I get upset a lot more than my friends know about.	1	2	3	4	5
23. It seems as if my friends are irritated with me for no reason.	1	2	3	4	5
24. I can tell my friends about my problems and troubles.	1	2	3	4	5
25. If my friends know something is bothering me, they ask me about it.	1	2	3	4	5

## Appendix 8 – The Student School Engagement Survey



NCSE | National Center for School Engagement

Participant ID Number: \_\_\_\_\_

Date completed: \_\_\_\_\_

Age: \_\_\_\_\_

Gender: Male/Female/Other please specify: \_\_\_\_\_

/Prefer not to say

### Student Engagement Survey (A)

We would like to find out a little more about you and how you feel about school. Your answers to the following questions will help us to do this. It will take you about 15 minutes to complete this survey. If you are unsure of how to answer a question, please answer it as best you can and then write a comment in the margin. All the information you provide is confidential. It will only be used to help us learn about how to keep children interested in completing school.

1. Your ethnicity (please check all that apply): ☐ White (British/Welsh/English/Scottish/Northern Irish) ☐ Black/Black British (African/Caribbean) ☐ Asian/ Asian British (Bangladeshi, Indian, Pakistani, Chinese) ☐ Mixed/ Multiple Ethnic Groups (White and Black African, White and Asian, White and Black Caribbean, Any other mixed background) ☐ Gypsy/Irish Traveler/Romany ☐ Other, please describe \_\_\_\_\_ ☐ Prefer not to say

2. Your primary language: \_\_\_\_\_ Second language: \_\_\_\_\_

3. How much do you agree with each of the following statements?	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
I come to class prepared.					
I treat my classmates with respect.					
I complete my work on time.					
I treat my teachers with respect.					
I follow the rules at school.					

<b>4. How often are the following statements true for you?</b>	<b>Never/ Almost Never</b>	<b>Rarely</b>	<b>Sometimes</b>	<b>Often</b>	<b>Always/ Almost Always</b>
I feel excited by the work in school.					
I am interested in the work I get to do in my classes.					
I talk with people outside of school about what I am learning.					
I check my schoolwork for mistakes.					
I learn a lot from my classes.					

<b>5. How often are the following statements true for you?</b>	<b>Never/ Almost Never</b>	<b>Rarely</b>	<b>Sometimes</b>	<b>Often</b>	<b>Always/ Almost Always</b>
I enjoy the work I do in class.					
I feel I can go to my teachers with the things that I need to talk about.					
My classroom is a fun place to be.					
Most of my teachers praise me when I work hard.					
Most of my teachers understand me.					



**THANK YOU FOR COMPLETING THIS SURVEY!**



**Student Engagement Survey (B)**

We would like to find out a little more about you and how you feel about school. Your answers to the following questions will help us to do this. It will take you about 15 minutes to complete this survey. If you are unsure of how to answer a question, please answer it as best you can and then write a comment in the margin. All the information you provide is confidential. It will only be used to help us learn about how to keep children interested in completing school.

<b>1. How important do you think...</b>	<b>Very important</b>	<b>Quite important</b>	<b>Fairly important</b>	<b>Slightly important</b>	<b>Not at all important</b>
It is to get good grades?					
The things you are learning in school are going to be to you later in life?					
It is to attend school every day?					

<b>2. How much do you agree with each of the following statements?</b>	<b>Strongly agree</b>	<b>Agree</b>	<b>Disagree</b>	<b>Strongly disagree</b>
I feel close to people at my school.				
I feel like I belong in my school.				
I am happy to be at my school.				
The teachers at my school treat students fairly.				
I feel safe in my school.				
I like most of my teachers at school.				
I am getting a good education at my school.				
The discipline at my school is fair.				
Most of my classes are boring.				
Most of my teachers care about how I'm doing.				
I learn a lot from my classes.				

There is an adult at school that I can talk to about my problems.				
I respect most of my teachers.				
Most of my teachers understand me.				
When I first walked into my school I thought it was good.				
When I first walked into my school I thought it was friendly.				
When I first walked into my school I thought it was clean.				
I come to class prepared				
I treat my classmates with respect.				
I complete my work on time.				
I treat my teachers with respect.				
I try my best on homework.				

<b>3. How often are the following statements true for you?</b>	<b>Always/ Almost Always</b>	<b>Often</b>	<b>Sometimes</b>	<b>Rarely</b>	<b>Never/ Almost Never</b>
I follow the rules at school.					
I get in trouble at school.					
I feel excited by the work in school.					
I am interested in the work I get to do in my classes.					
My classroom is a fun place to be.					
I study at home even when I don't have a test.					
I talk with people outside of school about what I am learning in class.					
I check my schoolwork for mistakes.					
If I don't understand what I read, I go back and read it over again.					

Most of my teachers praise me when I work hard.					
I try my best at school.					
I get good grades in school.					
I enjoy the work I do in class.					
I feel I can go to my teacher(s) with the things that I need to talk about.					

4. How many friends do you have at this school?

\_\_\_\_\_ 0

\_\_\_\_\_ 1-5

\_\_\_\_\_ 6-10

\_\_\_\_\_ more than 10

5. How many friends do you have that do not go to this school?

\_\_\_\_\_ 0

\_\_\_\_\_ 1-5

\_\_\_\_\_ 6-10

\_\_\_\_\_ more than 10

6. What activities have you been involved in at this school?

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**DIRECTIONS:** For each of the following questions, choose how many times these things happened to you in the LAST 30 DAYS.

**1. Other students picked on me.**

☐ Never ☐ 1 or 2 times ☐ 3 or 4 times ☐ 5 or 6 times ☐ 7 or more

**2. Other students made fun of me.**

☐ Never ☐ 1 or 2 times ☐ 3 or 4 times ☐ 5 or 6 times ☐ 7 or more

**3. Other students called me names.**

☐ Never ☐ 1 or 2 times ☐ 3 or 4 times ☐ 5 or 6 times ☐ 7 or more

**4. I got hit and pushed by other students.**

☐ Never ☐ 1 or 2 times ☐ 3 or 4 times ☐ 5 or 6 times ☐ 7 or more

**5. Other students excluded me from their clique of friends.**

☐ Never ☐ 1 or 2 times ☐ 3 or 4 times ☐ 5 or 6 times ☐ 7 or more

**6. Other students excluded me from their activities.**

☐ Never ☐ 1 or 2 times ☐ 3 or 4 times ☐ 5 or 6 times ☐ 7 or more

**7. Other students said bad things about me to other students at school.**

☐ Never ☐ 1 or 2 times ☐ 3 or 4 times ☐ 5 or 6 times ☐ 7 or more

**8. For how long have any of these things happened to you?**

☐ Never

☐ Less than a week

☐ It lasted less than a month

☐ It lasted almost all term

☐ It lasted about a year

☐ It has gone on for several years

**9. How did you feel when these things were happening to you in school (check as many of these that reflect how you felt)**

- ☐ I worried a lot about going to school.
- ☐ I was afraid to go to school.
- ☐ I was afraid while I was in school.
- ☐ I missed school because I was afraid.
- ☐ I felt physically sick.
- ☐ I felt bad about myself.
- ☐ I felt embarrassed and ashamed.
- ☐ I was angry at myself.
- ☐ I wanted to hurt the people who did these things.
- ☐ I felt alone
- ☐ I was very nervous.
- ☐ I would break out in a cold sweat while in school.
- ☐ I avoided places in school where I would be alone.
- ☐ I avoided going to the bathroom.
- ☐ I was unable to concentrate on my school work.
- ☐ I did badly on tests.



**THANK YOU FOR COMPLETING THIS SURVEY!**





## Appendix 9 – Letter of favourable opinion and HRA and HCRW Approval Letter



Gwasanaeth Moeseg Ymchwil  
Research Ethics Service



Wales Research Ethics Committee 5  
Bangor

Mailing address:  
Health and Care Research Wales  
Castlebridge 4  
15-19 Cowbridge Road East  
Cardiff, CF11 9AB

telephone: 07825 244673  
email: [WalesREC5@wales.nhs.uk](mailto:WalesREC5@wales.nhs.uk)  
website: [www.hra.nhs.uk](http://www.hra.nhs.uk)

**Please note:**  
**This is the favourable opinion of the REC only and does not allow you to start your study at NHS sites until you receive HRA /HCRW Approval**

04 December 2018

Mr Gavin John  
School of Healthcare Sciences  
College of Biomedical and Life Sciences  
Cardiff University, 12th Floor Eastgate House, 35-43 Newport Road, Cardiff.  
CF24 0AB

Dear Mr John

**Study title:** Keeping in Touch: opportunities and barriers for young people maintaining connections to families, friends and education during periods of inpatient mental health care using case study methodology.  
**REC reference:** 18/WA/0374  
**Protocol number:** SPON1674-17-18  
**IRAS project ID:** 250127

Thank you for your letter of 03 December 2018. I can confirm the REC has received the documents listed below and that these comply with the approval conditions detailed in our letter dated 26 November 2018

### Documents received

The documents received were as follows:

Document	Version	Date
Covering letter on headed paper [Responses to REC]		03 December 2018
Participant consent form [Parent/Carer Consent form 11-15 yrs Interviews, Observations and Medical Notes]	2	30 November 2018
Participant consent form [Consent Form 16-18 yrs Interviews, Observations and Medical Notes]	2	30 November 2018
Participant consent form [Parent/Carer Consent Form 11-15 yrs Questionnaires]	2	30 November 2018
Participant consent form [Consent Form 16-18 yrs Questionnaires]	2	30 November 2018

Participant information sheet (PIS) [PIS 11-15 yrs Interviews, Obs, Medical Notes]	2	30 November 2018
Participant information sheet (PIS) [PIS 16-18 yrs Interviews, Obs and Medical Notes]	2	30 November 2018
Participant information sheet (PIS) [PIS Questionnaires 11-18 yrs]	2	30 November 2018
Research protocol or project proposal [Research Protocol]	2	30 November 2018
Validated questionnaire [Strengths and Difficulties Questionnaire]		
Validated questionnaire [Student School Engagement Survey A]		
Validated questionnaire [Student School Engagement Survey B]		

### Approved documents

The final list of approved documentation for the study is therefore as follows:

Document	Version	Date
Copies of advertisement materials for research participants [Leaflet for young people v1 11.10.2018]	1	11 October 2018
Covering letter on headed paper [Responses to REC]	-	03 December 2018
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Sponsor Insurance Letter]		16 July 2018
Interview schedules or topic guides for participants [Interview schedule Young People]	1	11 October 2018
Interview schedules or topic guides for participants [Interview Schedule Parents/Carers]	1	11 October 2018
Interview schedules or topic guides for participants [Interview Schedule Ward Professionals]	1	11 October 2018
IRAS Application Form [IRAS_Form_10102018]	-	10 October 2018
Letter from funder [Funding Agreement]	-	10 January 2018
Letter from sponsor [Sponsor Letter]	-	26 September 2018
Participant consent form [Parent/Carer Consent form 11-15 yrs Interviews, Observations and Medical Notes]	2	30 November 2018
Participant consent form [Consent Form 16-18 yrs Interviews, Observations and Medical Notes]	2	30 November 2018
Participant consent form [Parent/Carer Consent Form 11-15 yrs Questionnaires]	2	30 November 2018
Participant consent form [Consent Form 16-18 yrs Questionnaires]	2	30 November 2018
Participant information sheet (PIS) [PIS 11-15 yrs Interviews, Obs, Medical Notes]	2	30 November 2018
Participant information sheet (PIS) [PIS 16-18 yrs Interviews, Obs and Medical Notes]	2	30 November 2018
Participant information sheet (PIS) [PIS Questionnaires 11-18 yrs]	2	30 November 2018
Research protocol or project proposal [Research Protocol]	2	30 November 2018
Summary CV for Chief Investigator (CI) [Student CV]	-	11 October 2018
Summary CV for student [Student CV]	-	11 October 2018
Summary CV for supervisor (student research) [Supervisors CV Ben Hannigan]	-	19 September 2018
Summary CV for supervisor (student research) [Supervisors CV Nicola Evans]	-	20 September 2018
Summary CV for supervisor (student research) [Supervisors CV Rebecca Playle]	-	21 September 2018
Validated questionnaire [Inventory of Parent and Peer Attachment Questionnaire]	-	-
Validated questionnaire [Strengths and Difficulties Questionnaire]	-	-
Validated questionnaire [Student School Engagement Survey A]	-	-
Validated questionnaire [Student School Engagement Survey B]	-	-

You should ensure that the sponsor has a copy of the final documentation for the study. It is the sponsor's responsibility to ensure that the documentation is made available to R&D offices at all participating sites.

18/WA/0374	Please quote this number on all correspondence
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Yours sincerely,

Research Ethics Service Administrative Assistant

e-mail: [WalesREC5@wales.nhs.uk](mailto:WalesREC5@wales.nhs.uk)

### Wales Research Ethics Committee 5

#### Attendance at Committee meeting 15 November 2018

##### Committee Members

Name	Profession	Capacity	Present
[REDACTED]	Consultant Physician	Expert	Yes
[REDACTED]	Research Nurse	Expert	Yes
[REDACTED]	Consultant Neurologist	Expert	Yes
[REDACTED]	Retired College Vice-Principal	Lay +	No
[REDACTED]	Retired Teacher	Lay +	Yes
[REDACTED]	Student	Lay +	No
[REDACTED]	Clinical Studies Officer	Expert	Yes
[REDACTED]	Reader, Senior MRI Physicist	Lay +	No
[REDACTED]	Consultant ENT Surgeon	Expert	Yes
[REDACTED]	Matron, Emergency Department	Expert	Yes
[REDACTED]	Lecturer, Clinical Psychologist	Expert	No
[REDACTED]	Consultant Anaesthetist (Vice-Chair)	Expert	Yes
[REDACTED]	General Practitioner (Chairman)	Expert	Yes
[REDACTED]	Retired Lecturer, College Principal	Lay +	Yes

##### In attendance

Name	Position (or reason for attending)
[REDACTED]	Senior Research Ethics Service Manager
[REDACTED]	RES Administrative Assistant



Ymchwil Iechyd  
a Gofal Cymru  
Health and Care  
Research Wales



Mr Gavin John  
PhD Student  
Cardiff University  
School of Healthcare Sciences  
College of Biomedical and Life Sciences  
Cardiff University, 12th Floor Eastgate House, 35-43  
Newport Road, Cardiff.  
CF24 0AB

Email:  
[Research-permissions@wales.nhs.uk](mailto:Research-permissions@wales.nhs.uk)

05 December 2018

Dear Mr John

**HRA and Health and Care  
Research Wales (HCRW)  
Approval Letter**

<b>Study title:</b>	Keeping in Touch: opportunities and barriers for young people maintaining connections to families, friends and education during periods of inpatient mental health care using case study methodology.
<b>IRAS project ID:</b>	250127
<b>Protocol number:</b>	SPON1674-17-18
<b>REC reference:</b>	18/WA/0374
<b>Sponsor</b>	Cardiff University

I am pleased to confirm that [HRA and Health and Care Research Wales \(HCRW\) Approval](#) has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

**How should I continue to work with participating NHS organisations in England and Wales?**  
You should now provide a copy of this letter to all participating NHS organisations in England and Wales, as well as any documentation that has been updated as a result of the assessment.

Following the arranging of capacity and capability, participating NHS organisations should **formally confirm** their capacity and capability to undertake the study. How this will be confirmed is detailed in the "*summary of assessment*" section towards the end of this letter.

You should provide, if you have not already done so, detailed instructions to each organisation as to how you will notify them that research activities may commence at site following their confirmation of capacity and capability (e.g. provision by you of a 'green light' email, formal notification following a site

IRAS project ID	250127
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initiation visit, activities may commence immediately following confirmation by participating organisation, etc.).

It is important that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details of the research management function for each organisation can be accessed [here](#).

#### **How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?**

HRA and HCRW Approval does not apply to NHS/HSC organisations within the devolved administrations of Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) has been sent to the coordinating centre of each participating nation. You should work with the relevant national coordinating functions to ensure any nation specific checks are complete, and with each site so that they are able to give management permission for the study to begin.

Please see [IRAS Help](#) for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

#### **How should I work with participating non-NHS organisations?**

HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to [obtain local agreement](#) in accordance with their procedures.

#### **What are my notification responsibilities during the study?**

The document "*After Ethical Review – guidance for sponsors and investigators*", issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:


- Registration of research
- Notifying amendments
- Notifying the end of the study

The [HRA website](#) also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

#### **I am a participating NHS organisation in England or Wales. What should I do once I receive this letter?**

You should work with the applicant and sponsor to complete any outstanding arrangements so you are able to confirm capacity and capability in line with the information provided in this letter.

The sponsor contact for this application is as follows:

Name:   
 Tel: 02920879131  
 Email: [resgov@cardiff.ac.uk](mailto:resgov@cardiff.ac.uk)

IRAS project ID	250127
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**Who should I contact for further information?**

Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is 250127. Please quote this on all correspondence.

Yours sincerely



Permissions Service Coordinator

Email: [Research-permissions@wales.nhs.uk](mailto:Research-permissions@wales.nhs.uk)

List of Documents



The final document set assessed and approved by HRA and HCRW Approval is listed below.

Document	Version	Date
Copies of advertisement materials for research participants [Leaflet for young people v1 11.10.2018]	1	11 October 2018
Covering letter on headed paper [Responses to REC]		03 December 2018
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Sponsor Insurance Letter]		16 July 2018
HRA Schedule of Events		16 November 2018
HRA Statement of Activities		16 November 2018
Interview schedules or topic guides for participants [Interview schedule Young People]	1	11 October 2018
Interview schedules or topic guides for participants [Interview Schedule Parents/Carers]	1	11 October 2018
Interview schedules or topic guides for participants [Interview Schedule Ward Professionals]	1	11 October 2018
IRAS Application Form [IRAS_Form_10102018]		10 October 2018
Letter from funder [Funding Agreement]		10 January 2018
Letter from sponsor [Sponsor Letter]		26 September 2018
Participant consent form [Parent/Carer Consent form 11-15 yrs Interviews, Observations and Medical Notes]	2	30 November 2018
Participant consent form [Consent Form 16-18 yrs Interviews, Observations and Medical Notes]	2	30 November 2018
Participant consent form [Parent/Carer Consent Form 11-15 yrs Questionnaires]	2	30 November 2018
Participant consent form [Consent Form 16-18 yrs Questionnaires]	2	30 November 2018
Participant information sheet (PIS) [PIS 16-18 yrs Interviews, Obs and Medical Notes]	2	30 November 2018
Participant information sheet (PIS) [PIS Questionnaires 11-18 yrs]	2	30 November 2018
Participant information sheet (PIS) [PIS 11-15 yrs Interviews, Obs, Medical Notes]	2	30 November 2018
Research protocol or project proposal [Research Protocol]	2	30 November 2018
Summary CV for Chief Investigator (CI) [Student CV]		11 October 2018
Summary CV for student [Student CV]		11 October 2018
Summary CV for supervisor (student research) [Supervisors CV Ben Hannigan]		19 September 2018
Summary CV for supervisor (student research) [Supervisors CV Nicola Evans]		20 September 2018
Summary CV for supervisor (student research) [Supervisors CV Rebecca Playle]		21 September 2018
Validated questionnaire [Strengths and Difficulties Questionnaire]		
Validated questionnaire [Student School Engagement Survey A]		
Validated questionnaire [Student School Engagement Survey B]		
Validated questionnaire [Inventory of Parent and Peer Attachment Questionnaire]		

### Summary of assessment

The following information provides assurance to you, the sponsor and the NHS in England and Wales that the study, as assessed for HRA and HCRW Approval, is compliant with relevant standards. It also provides information and clarification, where appropriate, to participating NHS organisations in England and Wales to assist in assessing, arranging and confirming capacity and capability.

### Assessment criteria

Section	Assessment Criteria	Compliant with Standards	Comments
1.1	IRAS application completed correctly	Yes	No comments
2.1	Participant information/consent documents and consent process	Yes	No comments
3.1	Protocol assessment	Yes	No comments
4.1	Allocation of responsibilities and rights are agreed and documented	Yes	A statement of activities has been submitted and the sponsor is not requesting and does not expect any other site agreement to be used.
4.2	Insurance/indemnity arrangements assessed	Yes	
4.3	Financial arrangements assessed	Yes	Funding has been secured from Knowledge Economy Skills Scholarships (KESS2) and [REDACTED]. A letter from funder has been provided.
5.1	Compliance with the Data Protection Act and data security issues assessed	Yes	No comments
5.2	CTIMPS – Arrangements for compliance with the Clinical Trials Regulations assessed	Not Applicable	No comments
5.3	Compliance with any applicable laws or regulations	Yes	No comments



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Section	Assessment Criteria	Compliant with Standards	Comments
6.1	NHS Research Ethics Committee favourable opinion received for applicable studies	Yes	No comments
6.2	CTIMPS – Clinical Trials Authorisation (CTA) letter received	Not Applicable	No comments
6.3	Devices – MHRA notice of no objection received	Not Applicable	No comments
6.4	Other regulatory approvals and authorisations received	Not Applicable	No comments

### Participating NHS Organisations in England and Wales

*This provides detail on the types of participating NHS organisations in the study and a statement as to whether the activities at all organisations are the same or different.*

This is a single site study taking place in Wales. All research activities are taking place at site.

If chief investigators, sponsors or principal investigators are asked to complete site level forms for participating NHS organisations in England and Wales which are not provided in IRAS, the HRA or HCRW websites, the chief investigator, sponsor or principal investigator should notify the HRA immediately at [hra.approval@nhs.net](mailto:hra.approval@nhs.net) or HCRW at [Research-permissions@wales.nhs.uk](mailto:Research-permissions@wales.nhs.uk). We will work with these organisations to achieve a consistent approach to information provision.

### Principal Investigator Suitability

*This confirms whether the sponsor position on whether a PI, LC or neither should be in place is correct for each type of participating NHS organisation in England and Wales, and the minimum expectations for education, training and experience that PIs should meet (where applicable).*

Local collaborator required and a Letter of Access.

GCP training is not a generic training expectation, in line with the [HRA/HCRW/MHRA statement on training expectations](#).

### HR Good Practice Resource Pack Expectations

*This confirms the HR Good Practice Resource Pack expectations for the study and the pre-engagement checks that should and should not be undertaken*

No Honorary Research Contracts, Letters of Access or pre-engagement checks are expected for local staff employed by the participating NHS organisations. Where arrangements are not already in place, research staff not employed by the NHS host organisation undertaking any of the research activities listed in the research application would be expected to obtain a Letter of Access based on standard DBS checks and occupational health clearance.

### Other Information to Aid Study Set-up

*This details any other information that may be helpful to sponsors and participating NHS organisations in England and Wales to aid study set-up.*

The applicant has indicated that they do not intend to apply for inclusion on the NIHR CRN Portfolio.

## Appendix 10 – Participant inclusion/exclusion criteria



Appendix 10: Inclusion and Exclusion Criteria: Children and Young People Interviews, Questionnaires and Observations

Inclusion Criteria	Exclusion Criteria
Young people receiving inpatient care aged 11-18.	Young people not receiving inpatient care aged 11-18.
Comfortable talking about their experiences of their friends, family and education.	Not comfortable talking about their experiences of their friends, family and education.
Able to converse in English	
Able to provide informed assent (if aged 11-15) and parent/carer is also willing to provide consent.	Unable to provide informed assent (if aged 11-15) and parent/carer is also not willing to provide consent.
Able to provide informed consent (if aged 16-18).	Unable to provide informed consent (if aged 16-18).
Willing to participate in the study.	Does not wish to participate in the study.
Questionnaire Only	Participation is likely to pose a risk to the participant, researcher or others.
Able to understand the questionnaires.	Questionnaire Only
Willing to complete three outcome questionnaires relating to friends, family and education.	Unable to understand the questionnaires.
	Not willing to complete three outcome questionnaires relating to friends, family and education.

Taken from Research Protocol [Version 2, 30/11/2018] IRAS Number 250127 Young people's social connections during inpatient mental health care

#### Inclusion and Exclusion Criteria: Caregiver interviews and Observations of Patient Review Meetings

Comfortable taking about their experiences of their child or cared for young persons, friends, family and education.	Not comfortable taking about their experiences of their child or cared for young persons, friends, family and education.
Able to converse in English	Unable to converse in English
Able to provide informed consent.	Unable to provide informed consent.
Willing to participate in the study.	Not willing to participate in the study.
A parent/carer of a young person on the ward.	Not a parent/carer of a young person on the ward.

#### Inclusion and exclusion criteria: Health, social and education practitioners

Inclusion Criteria	Exclusion Criteria
Employed as a registered or non-registered health care practitioner, social care or education practitioner at the unit and works with young people admitted to the unit.	Not employed as a registered or non-registered health care practitioner, social care or education practitioner at the unit and works with young people admitted to the unit.
Willing to participate in the study.	Does not wish to participate in the study.
Able to provide informed consent.	Unable to provide informed consent.

## Appendix 11 – Study leaflet

### **Who am I and what is the study about?**

Hello I'm Gavin and I am a mental health nurse and research student. I would like to tell you a bit about what I am doing on the ward.

The study aims to explore how children and young people keep in touch with their:

- friends
- family
- education

when they are in hospital.



### **How will the study be carried out?**

The study is hoped to be carried out by the researcher having **talks** with:

- Ward professionals
- Young people on the ward and their parents/carers.
- Young people completing 3 **questionnaires**
- **Observing** ward meetings
- **Reading** medical notes

### **What are the benefits of taking part in the study?**

We hope that taking part in the study will give you an opportunity to:

- open up and talk about any issues you have with keeping in touch with your friends, family and education.
- We hope that the results of this study will help us understand what helps you to keep in touch with your friends, family and education and to improve these connections.

You will also receive a gift voucher for taking part.

### **Are there any risks in taking part in the study?**

There are no major risks of taking part but it will require some of your time (up to an hour for the interview and up to an hour to complete the questionnaires). If you do feel upset or distressed at any point, please be assured the experienced team of ward staff are here to support you.



### **Do I have to take part in the study?**

It is up to you to decide whether or not to take part. If you do decide to take part you will be given an information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time without giving a reason.

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### **Who can I contact to take part in the study?**

You can contact the Lead Researcher Gavin John.

Or

You can ask your nurse/key worker.

**Young People's Social Connections during inpatient mental health care research study (PhD Student Research Project)**



Ysgoloniaethau Sgiliau Economi Gwybodaeth  
Knowledge Economy Skills Scholarships

**Thank you for taking the time to read this leaflet and for considering taking part in this study.**

**For further information please contact:**

**Gavin John**

**PhD student,**

**Cardiff University**

**johnGE@cardiff.ac.uk**



**Information for Young people, families and carers**



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## Appendix 12 – Participant Information Sheet (PIS) CYP interviews and observations



### **Participant Information Sheet (young people) – Interviews, Observations and Medical Notes**

**Study title:** Young people's social connections during inpatient mental health care

**Funder:** Health Board and Knowledge Economy Skills Scholarships (KES2).

#### **Introduction**

My name is Gavin and I am a research student at Cardiff University. I am researching young people's social connections during inpatient mental health care. I am inviting you to take part in this research study. To help you decide whether to take part I've put together this information sheet.

Before you decide, it is important for you to understand why the study is being done and what it will involve for you. Please take time to read the following information carefully and discuss it with others such as your family, doctor or nurse if you wish.

Please ask if there is anything that is not clear or if you would like more information. My contact details are available at the bottom of this information sheet.

#### **What is the purpose of the study?**

The purpose of this study is to gain a better understanding of how children and young people stay connected to their friends, family and education when they are in hospital for care for their mental health. This will be done by gathering the views and experiences of young people, family members and staff.

#### **Why you?**

You have been invited to join this study because you are staying at an adolescent mental health unit. I would like to hear your views and experiences of keeping in touch with your friends, family, and education when you are staying in hospital.

#### **Do I have to take part?**

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form which you will also keep. If you decide to take part, you are still free to withdraw at any time without giving a reason and the future care you receive will not be affected. If you do not decide to take part at all, your future care will not be affected in any way.

#### **What will happen to me if I take part?**

If you decide to take part, I will ask you to take part in a short interview to talk about your experience on the adolescent unit and about how you keep in touch with your friends, family and education. The discussion should last for approximately 60 minutes and will take place in

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a quiet room on the ward. The interview will be audio recorded, and the recording will be kept securely in a password-protected computer. The content of the interview will be typed word-for-word into a document by a Cardiff University approved transcription service, with your personal and other identifying data removed.

We would also like to ask your permission to read information about your connections to family, friends and education contained in your medical notes and to observe meetings held to discuss your care on the ward.

#### **What are the possible benefits of taking part?**

Taking part in the interview may be helpful as an opportunity to talk about keeping in touch with your friends, family and education. The results of this study will help us understand what helps young people keep in touch and how connections can be improved. We also hope this study will help adolescent services provide the right support for young people in the future. For completing the interview, you will receive a £10 gift voucher.

#### **What are the possible risks and disadvantages of taking part?**

Please be assured the staff are here to support you and we will contact your primary nurse or allocated key worker if you become upset or distressed. If you are finding it difficult to talk in the interview we can take a break or stop the discussion and re-schedule to continue at a later date if you wish.

#### **What will happen if I don't want to carry on with the study?**

If you choose to take part in the study you are free to withdraw at any time without giving a reason. This will not affect the care you receive in any way. However, as your information needs to be managed in specific ways in order for the research to be reliable, we'll need to keep any data recorded about you up until the point you chose to leave the study. If you choose to leave the study, Cardiff University will keep the information about you which has already been collected, but we will make sure that this is the minimum amount.

#### **What if I have a problem or complaint?**

If you have a concern about any part of this study, you should ask to speak to the researcher Gavin who will do his best to answer your questions. If you remain unhappy and wish to make a complaint, you can do this through contacting Concerns team (Telephone Number: , email: ). If you wish to express concern to someone not involved in the project, you should contact Dr Kate Button Director of Research Governance at Cardiff University, School of Healthcare Sciences. You can write to Dr Button at the School of Healthcare Sciences, Cardiff University, Eastgate House, 35-43 Newport Road, Cardiff CF24 0AB, or contact her by either telephone on 02920 687734 or by Email: [buttonk@cardiff.ac.uk](mailto:buttonk@cardiff.ac.uk)

#### **Will my participation in this study be kept confidential?**

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Yes, we will follow the law (Data Protection Act, 2018) by making sure that your information is kept private, secure and confidential. Quotations from your interview, and notes from your records and care planning meetings, will be used in a research report and in academic publications and presentations. To help reduce the chances of anyone identifying you I will use a false name and will remove, or amend, identifiable information when writing about you.

All data will be securely stored in accordance with the Data Protection Act 2018. Electronic data (audio recordings, etc.) will be saved on a password-encrypted laptop, in folders only accessible by me and my supervisors. Any paper documents will be locked in filing cabinets on University security controlled premises (an office and a building that both require key- card access). Any identifiable data will be kept for 15 years after the completion of the research and then destroyed.

Cardiff University is the Data Controller for this study and is committed to respecting and protecting your personal data in accordance with Data Protection legislation. The University has a Data Protection Officer who can be contacted at [inforequest@cardiff.ac.uk](mailto:inforequest@cardiff.ac.uk). Further information about Data Protection, including your rights and details about how to contact the Information Commissioner's Office should you wish to complain, can be found on the Cardiff University website: <https://www.cardiff.ac.uk/public-information/policies-and-procedures/data-protection>

I will not tell anyone (including your care team at the adolescent unit) what you talked about in the interview, unless you tell me something that is a safety concern (such as you tell me that you or someone else is at risk of harm).

#### **Will my GP be informed that I am taking part in the study?**

Yes, with your permission, we will inform your G.P. of your participation in the study.

#### **What will happen to the results of the study?**

I will write a report, and publish a series of articles, which will include what you and other young people have said. However, I will not include your or anyone else's names, or any information that could identify you.

#### **Who is organising and funding the study?**

The study is part of Gavin John's Doctor of Philosophy (PhD) degree. This adolescent unit has agreed to take part in the study. The study is sponsored by Cardiff University and is being funded by and Knowledge Economy Skills Scholarships (KES2).

#### **Who has reviewed the study?**

This study has been given favourable opinion by [Name] NHS Research Ethics Committee and has been approved by R&D Office.





**Contact for Further Information:** Gavin John, Lead Researcher. School of Healthcare Sciences, College of Biomedical and Life Sciences, Cardiff University, 12<sup>th</sup> Floor Eastgate House, 35-43 Newport Road, Cardiff, CF24 0AB. Email - JohnGE@cardiff.ac.uk

Professor Ben Hannigan, Academic Supervisor. School of Healthcare Sciences, College of Biomedical and Life Sciences, Cardiff University, 12<sup>th</sup> Floor Eastgate House, 35-43 Newport Road, Cardiff, CF24 0AB.

Dr Nicola Evans, Academic Supervisor. School of Healthcare Sciences, College of Biomedical and Life Sciences, Cardiff University, 13<sup>th</sup> Floor Eastgate House, 35-43 Newport Road, Cardiff, CF24 0AB.

Dr Rebecca Playle, Academic Supervisor. Health Services Research Statistics Group, Centre for Trials Research, College of Biomedical & Life Sciences, Cardiff University, 4th Floor, Neuadd Meirionnydd, Heath Park, Cardiff, CF14 4YS.

**Thank you for taking the time to read this information sheet and for considering taking part in this study.**

## Appendix 13 – Participant Information Sheet (PIS) caregiver interviews and observations



### Participant Information Sheet (Parent or Carer) - Interviews

#### **Study title: Young people's social connections during inpatient mental health care**

**Funder:** Health Board and Knowledge Economy Skills Scholarships (KES\$2).

My name is Gavin and I am a research student at Cardiff University. I am researching young people's social connections during inpatient mental health care. I am inviting you to take part in this research study. To help you decide whether to take part I've put together this information sheet.

Before you decide, it is important for you to understand why the study is being done and what it will involve for you. Please take time to read the following information carefully and discuss it with others if you wish.

Please ask if there is anything that is not clear or if you would like more information. My contact details are available at the bottom of this information sheet.

#### **What is the purpose of the study?**

The purpose of this study is to gain a better understanding of how children and young people stay connected to their friends, family and education when they are in hospital for care for their mental health. This will be done by gathering the views and experiences of young people, family members and staff.

#### **Why you?**

You have been invited to join this study because your child is staying at an adolescent mental health unit. I would like to hear your views and experiences of keeping in touch with your child when they have been staying in hospital.

#### **Do I have to take part?**

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form which you will also keep. If you decide to take part you are still free to withdraw at any time without giving a reason.

#### **What will happen to me if I take part?**

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If you decide to take part, I will ask you to take part in a short interview to talk about your experiences of keeping in touch with your child who is on the adolescent unit. The discussion should last for approximately 60 minutes and will take place in a quiet room. The interview will be audio recorded, and the recording will be kept securely in a password-protected computer. The content of the interview will be typed word-for-word into a document by a Cardiff University approved transcription service, with your personal and other identifying data removed.

#### **What are the possible benefits of taking part?**

Taking part in the interview may be helpful as an opportunity to talk about keeping in touch with your child. The results of this study will help us understand what helps young people keep in touch and how connections can be improved. We also hope this study will help adolescent services provide the right support for young people in the future.

#### **What are the possible risks and disadvantages of taking part?**

If you become upset or find it difficult to talk in the interview we can take a break or stop the discussion. Please be assured the staff are here to support you if you become distressed.

#### **What will happen if I don't want to carry on with the study?**

If you choose to take part in this part of the study you are free to withdraw at any time without giving a reason. If you decide to leave the study then this will have no adverse consequences for you but we will need to keep any data you have provided up until the point you left the study (please see the Cardiff University Privacy Notice below for further information on how we will handle and store your data).

#### **What if I have a problem or complaint?**

If you have a concern about any part of this study, you should ask to speak to the researcher Gavin who will do his best to answer your questions. If you remain unhappy and wish to make a complaint, you can do this through contacting Owm Taf University Health Board's Concerns team (Telephone Number: 0300 060 0600, email: [concerns@owmtaf.ac.uk](mailto:concerns@owmtaf.ac.uk)). If you wish to express concern to someone not involved in the project, you should contact Dr Kate Button Director of Research Governance at Cardiff University, School of Healthcare Sciences. You can write to Dr Button at the School of Healthcare Sciences, Cardiff University, Eastgate House, 35-43 Newport Road, Cardiff CF24 0AB, or contact her by either telephone on 02920 687734 or by Email: [buttonk@cardiff.ac.uk](mailto:buttonk@cardiff.ac.uk)

#### **Will my participation in this study be kept confidential?**

Yes, we will follow the law (Data Protection Act, 2018) by making sure that your information is kept private, secure and confidential. Quotations from your interview will be used in a research report and in academic publications and presentations. To help reduce the chance of anyone identifying you or your child, I will use a false name and will remove, or amend, identifiable information when writing about you or your child.

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### Cardiff University Privacy Notice

Cardiff University is the Sponsor for this study based in the United Kingdom. They will be using information from you and your child/the young person you are responsible for and will act as the Data Controller for this study. This means that the University is responsible for looking after your information and using it properly. Cardiff University will keep identifiable information about you for 15 years after the study has finished.

Under data protection law, the University has to specify the legal basis that we are relying on to process your personal data. In providing your personal data for this research we will process it on the basis that doing so is necessary for our public task for scientific and historical research purposes in accordance with the necessary safeguards, and is in the public interest. The University is a public research institution established by royal charter to advance knowledge and education through its teaching and research activities. The charter can be found on the Cardiff University website.

Your rights to access, change or move your information are limited, as your information needs to be managed in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, Cardiff University will keep the information about you which has already obtained. To safeguard your rights, Cardiff University will use the minimum personally-identifiable information possible.

Cardiff University is the Data Controller and is committed to respecting and protecting your personal data in accordance with your expectations and Data Protection legislation. The University has a Data Protection Officer who can be contacted at [inforequest@cardiff.ac.uk](mailto:inforequest@cardiff.ac.uk). Further information about Data Protection, including your rights and details about how to contact the Information Commissioner's Office should you wish to complain, can be found at the following: <https://www.cardiff.ac.uk/public-information/policies-and-procedures/data-protection>

All data will be securely stored in accordance with the Data Protection Act 2018. Electronic data (audio recordings, etc.) will be saved on a password-encrypted laptop, in folders only accessible by me and my supervisors. Any paper documents will be locked in a filing cabinet/s on University security controlled premises (an office and a building that both require key-card access). Any identifiable data will be kept for 15 years after the completion of the research and then destroyed.

I will not tell anyone what you talked about in the interview, unless you tell me something that is a safety concern (such as you tell me that you or someone else is at risk of harm).

### What will happen to the results of the study?

I will write a report, and publish a series of articles, which will include what you and other parent's/carers have said. However, I will not include your or anyone else's names, or any information that could identify you.

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### **Who is organising and funding the study?**

The study is part of Gavin John's Doctor of Philosophy (PhD) degree. This adolescent unit has agreed to take part in the study. The study is sponsored by Cardiff University and is being funded by Health Board and Knowledge Economy Skills Scholarships (KES2).

### **Who has reviewed the study?**

This study has been given favourable opinion by [Name] NHS Research Ethics Committee and also approved by the R&D Office.

### **Contact for Further Information:**

Gavin John, Lead Researcher. School of Healthcare Sciences, College of Biomedical and Life Sciences, Cardiff University, 12<sup>th</sup> Floor Eastgate House, 35-43 Newport Road, Cardiff, CF24 0AB. Email - JohnGE@cardiff.ac.uk

Professor Ben Hannigan, Academic Supervisor. School of Healthcare Sciences, College of Biomedical and Life Sciences, Cardiff University, 12<sup>th</sup> Floor Eastgate House, 35-43 Newport Road, Cardiff, CF24 0AB.

Dr Nicola Evans, Academic Supervisor. School of Healthcare Sciences, College of Biomedical and Life Sciences, Cardiff University, 13<sup>th</sup> Floor Eastgate House, 35-43 Newport Road, Cardiff, CF24 0AB.

Dr Rebecca Playle, Academic Supervisor. Health Services Research Statistics Group, Centre for Trials Research, College of Biomedical and Life Sciences, Cardiff University, 4<sup>th</sup> Floor, Neuadd Meirionnydd, Health Park, Cardiff, CF14 4YS.

**Thank you for taking the time to read this information sheet and for considering taking part in this study.**

## Appendix 14 – Participant Information Sheet (PIS) ward staff interviews and observations



### Participant Information Sheet (Ward Professionals) – Interviews and Observations

**Study title:** Young people's social connections during inpatient mental health care

**Funder:** Health Board and Knowledge Economy Skills Scholarships (KES2).

My name is Gavin and I am a research student at Cardiff University. I am researching young people's social connections during inpatient mental health care. I am inviting you to take part in this research study. To help you decide whether to take part I've put together this information sheet.

Before you decide, it is important for you to understand why the study is being done and what it will involve for you. Please take time to read the following information carefully and discuss it with others if you wish.

Please ask if there is anything that is not clear or if you would like more information. My contact details are available at the bottom of this information sheet.

#### What is the purpose of the study?

The purpose of this study is to gain a better understanding of how children and young people stay connected to their friends, family and education when they are in hospital for care for their mental health. This will be done by gathering the views and experiences of young people, family members and staff.

#### Why you?

You have been invited to join this study because you work with children staying at an adolescent mental health unit. I would like to hear your views and experiences of interventions that promote young people's connections to their friends, family and education when they have been staying in hospital.

#### Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form which you will also keep. If you decide to take part you are still free to withdraw at any time without giving a reason.

#### What will happen to me if I take part?

If you decide to take part, I will ask you to take part in a short interview to talk about your experiences of how young people maintain social and educational connections

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when in hospital for their mental health. The discussion should last for approximately 60 minutes and will take place in a quiet room. The interview will be audio recorded, and the recording will be kept securely in a password-protected computer. The content of the interview will be typed word-for-word into a document by a Cardiff University approved transcription service, with your personal and other identifying data removed.

We would also like to ask your permission to observe care planning and ward round meetings on the ward that discuss young people's care and to take notes of these meetings.

#### **What are the possible benefits of taking part?**

Taking part in the interview may be helpful as an opportunity to talk about how young people keep in touch with their family, friends and education. The results of this study will help us understand what helps young people keep in touch and how connections can be improved. We also hope this study will help adolescent services provide the right support for young people in the future.

#### **What are the possible risks and disadvantages of taking part?**

There are no foreseeable risks of taking part, although the interview will require approximately 60 minutes of your time.

#### **What will happen if I don't want to carry on with the study?**

If you choose to take part in this part of the study you are free to withdraw at any time without giving a reason. If you decide to leave the study then this will have no adverse consequences for you but we will need to keep any data you have provided up until the point you left the study (please see the Cardiff University Privacy Notice below for further information on how we will handle and store your data).

#### **What if I have a problem or complaint?**

If you have a concern about any part of this study, you should ask to speak to the researcher Gavin who will do his best to answer your questions. If you remain unhappy and wish to make a complaint, you can do this through contacting Concerns team (Telephone Number: 0300 050 0000, email: [concerns@cardiff.ac.uk](mailto:concerns@cardiff.ac.uk)). If you wish to express concern to someone not involved in the project, you should contact Dr Kate Button, Director of Research Governance at Cardiff University, School of Healthcare Sciences. You can write to Dr Button at the School of Healthcare Sciences, Cardiff University, Eastgate House, 35-43 Newport Road, Cardiff CF24 0AB, or contact her by either telephone on 02920 687734 or by Email: [buttonk@cardiff.ac.uk](mailto:buttonk@cardiff.ac.uk)

#### **Will my participation in this study be kept confidential?**

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Yes, we will follow the law (Data Protection Act, 2018) by making sure that your information is kept private, secure and confidential. Quotations from your interview, and notes from the care planning and ward round meetings, will be used in a research report and in academic publications and presentations. To help reduce the chance of anyone identifying you, I will use a false name and will remove, or amend, identifiable information when writing about you.

### Cardiff University Privacy Notice

Cardiff University is the Sponsor for this study based in the United Kingdom. They will be using information from you and will act as the Data Controller for this study. This means that the University is responsible for looking after your information and using it properly. Cardiff University will keep identifiable information about you for 15 years after the study has finished.

Under data protection law, the University has to specify the legal basis that we are relying on to process your personal data. In providing your personal data for this research we will process it on the basis that doing so is necessary for our public task for scientific and historical research purposes in accordance with the necessary safeguards, and is in the public interest. The University is a public research institution established by royal charter to advance knowledge and education through its teaching and research activities. The charter can be found on the Cardiff University website.

Your rights to access, change or move your information are limited, as your information needs to be managed in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, Cardiff University will keep the information about you which has already obtained. To safeguard your rights, Cardiff University will use the minimum personally-identifiable information possible.

Cardiff University is the Data Controller and is committed to respecting and protecting your personal data in accordance with your expectations and Data Protection legislation. The University has a Data Protection Officer who can be contacted at [inforequest@cardiff.ac.uk](mailto:inforequest@cardiff.ac.uk). Further information about Data Protection, including your rights and details about how to contact the Information Commissioner's Office should you wish to complain, can be found at the following: <https://www.cardiff.ac.uk/public-information/policies-and-procedures/data-protection>

All data will be securely stored in accordance with the Data Protection Act 2018. Electronic data (audio recordings, etc.) will be saved on a password-encrypted laptop, in folders only accessible by me and my supervisors. Any paper documents will be locked in a filing cabinets on University security controlled premises (an office and a building that both require key-card access). Any identifiable data will be kept for 15 years after the completion of the research and then destroyed.

[Version 1, 11/10/2018] IRAS Number 250127 Young people's social connections during inpatient mental health care



I will not tell anyone what you talked about in the interview, however in the event that a serious patient's safety issue or practice that is deemed unethical is identified during the interview, this would need to be reported for the health board to take action on, and this could therefore compromise your anonymity.

#### **What will happen to the results of the study?**

I will write a report, and publish a series of articles, which will include what you and other ward professionals have said. However, I will not include your or anyone else's names.

#### **Who is organising and funding the study?**

The study is part of Gavin John's Doctor of Philosophy (PhD) degree. This adolescent unit has agreed to take part in the study. The study has been sponsored by Cardiff University. The study is being funded by Health Board and Knowledge Economy Skills Scholarships (KESS2).

#### **Who has reviewed the study?**

This study has been given favourable opinion by [Name] NHS Research Ethics Committee and also approved by the R&D Office.

#### **Contact for Further Information:**

Gavin John, Lead Researcher. School of Healthcare Sciences, College of Biomedical and Life Sciences, Cardiff University, 12<sup>th</sup> Floor Eastgate House, 35-43 Newport Road, Cardiff, CF24 0AB. Email - JohnGE@cardiff.ac.uk

Professor Ben Hannigan, Academic Supervisor. School of Healthcare Sciences, College of Biomedical and Life Sciences, Cardiff University, 12<sup>th</sup> Floor Eastgate House, 35-43 Newport Road, Cardiff, CF24 0AB.

Dr Nicola Evans, Academic Supervisor. School of Healthcare Sciences, College of Biomedical and Life Sciences, Cardiff University, 13<sup>th</sup> Floor Eastgate House, 35-43 Newport Road, Cardiff, CF24 0AB.

Dr Rebecca Playle, Academic Supervisor. Health Services Research Statistics Group, Centre for Trials Research, College of Biomedical and Life Sciences, Cardiff University, 4<sup>th</sup> Floor, Neuadd Meirionnydd, Health Park, Cardiff, CF14 4YS.

**Thank you for taking the time to read this information sheet and for considering taking part in this study.**

## Appendix 15 – Participant Information Sheet (PIS) CYP questionnaires



### Participant Information Sheet (young people) – Questionnaires

#### Study title: Young people's social connections during inpatient mental health care

**Funder:** Health Board and Knowledge Economy Skills Scholarships (KES2).

#### Introduction

My name is Gavin and I am a research student at Cardiff University. I am researching young people's social connections during inpatient mental health care. I am inviting you to take part in this research study. To help you decide whether to take part I've put together this information sheet.

Before you decide, it is important for you to understand why the study is being done and what it will involve for you. Please take time to read the following information carefully and discuss it with others such as your family, doctor or nurse if you wish.

Please ask if there is anything that is not clear or if you would like more information. My contact details are available at the bottom of this information sheet.

#### What is the purpose of the study?

The purpose of this study is to gain a better understanding of how children and young people stay connected to their friends, family and education when they are in hospital for care for their mental health. This will be done by gathering the views and experiences of young people, family members and staff.

#### Why you?

You have been invited to join this study because you are staying at an adolescent mental health unit. I would like to hear your views and experiences of keeping in touch with your friends, family, and education when you are staying in hospital.

#### Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form which you will also keep. If you decide to take part, you are still free to withdraw at any time without giving a reason and the future care you receive will not be affected. If you do not decide to take part at all, your future care will not be affected in any way.

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### **What will happen to me if I take part?**

If you decide to take part, I will invite you to complete three questionnaires which will ask you about your friends, family and education. The questionnaires should take approximately 60 minutes to complete and you can do this in a quiet room on the ward. The questionnaires are anonymous so nobody will be able to tell who the questionnaire has been completed by.

### **What are the possible benefits of taking part?**

The results of this study will help us understand what helps young people keep in touch and how connections can be improved. We also hope this study will help adolescent services provide the right support for young people in the future. For completing the questionnaires, you will receive a £10 gift voucher.

### **What are the possible risks and disadvantages of taking part?**

Please be assured the staff are here to support you and we will contact your primary nurse or allocated key worker if you become upset or distressed. If you are finding it difficult to complete the questionnaires we can take a break or stop and re-schedule to continue at a later date if you wish.

### **What will happen if I don't want to carry on with the study?**

If you choose to take part in the study you are free to withdraw at any time without giving a reason. This will not affect the care you receive in any way. However, as your information needs to be managed in specific ways in order for the research to be reliable, we'll need to keep any questionnaires you completed up until the point you chose to leave the study. If you choose to leave the study, Cardiff University will keep the information about you which has already been collected, but we will make sure that this is the minimum amount.

### **What if I have a problem or complaint?**

If you have a concern about any part of this study, you should ask to speak to the researcher Gavin who will do his best to answer your questions. If you remain unhappy and wish to make a complaint, you can do this through contacting Concerns team (Telephone Number:, email:). If you wish to express concern to someone not involved in the project, you should contact Dr Kate Button Director of Research Governance at Cardiff University, School of Healthcare Sciences. You can write to Dr Button at the School of Healthcare Sciences, Cardiff University, Eastgate House, 35-43 Newport Road, Cardiff CF24 0AB, or contact her by either telephone on 02920 687734 or by Email: [buttonk@cardiff.ac.uk](mailto:buttonk@cardiff.ac.uk)

### **Will my participation in this study be kept confidential?**

Yes, we will follow the law (Data Protection Act, 2018) by making sure that your information is kept private, secure and confidential. Answers from your questionnaire scores will be used in a research report and in academic publications and presentations. To help reduce the chances of anyone identifying you I will use a false name and will remove, or amend, identifiable information when writing about you.

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All data will be securely stored in accordance with the Data Protection Act 2018. Electronic data will be saved on a password-encrypted laptop, in folders only accessible by me and my supervisors. Any paper documents will be locked in filing cabinets on University security controlled premises (an office and a building that both require key-card access). Any identifiable data will be kept for 15 years after the completion of the research and then destroyed.

Cardiff University is the Data Controller for this study and is committed to respecting and protecting your personal data in accordance with Data Protection legislation. The University has a Data Protection Officer who can be contacted at [inforequest@cardiff.ac.uk](mailto:inforequest@cardiff.ac.uk). Further information about Data Protection, including your rights and details about how to contact the Information Commissioner's Office should you wish to complain, can be found on the Cardiff University website: <https://www.cardiff.ac.uk/public-information/policies-and-procedures/data-protection>

#### **Will my GP be informed that I am taking part in the study?**

Yes, with your permission, we will inform your G.P. of your participation in the study.

#### **What will happen to the results of the study?**

I will write a report, and publish a series of articles, which will include what you and other young people have said in the questionnaires. However, I will not include your or anyone else's names, or any information that could identify you.

#### **Who is organising and funding the study?**

The study is part of Gavin John's Doctor of Philosophy (PhD) degree. This adolescent unit has agreed to take part in the study. The study is sponsored by Cardiff University and is being funded by Health Board and Knowledge Economy Skills Scholarships (KES2).

#### **Who has reviewed the study?**

This study has been given favourable opinion by [Name] NHS Research Ethics Committee and has been approved by R&D Office.

**Contact for Further Information:** Gavin John, Lead Researcher. School of Healthcare Sciences, College of Biomedical and Life Sciences, Cardiff University, 12<sup>th</sup> Floor Eastgate House, 35-43 Newport Road, Cardiff, CF24 0AB. Email - [JohnGE@cardiff.ac.uk](mailto:JohnGE@cardiff.ac.uk)

Professor Ben Hannigan, Academic Supervisor. School of Healthcare Sciences, College of Biomedical and Life Sciences, Cardiff University, 12<sup>th</sup> Floor Eastgate House, 35-43 Newport Road, Cardiff, CF24 0AB.

Dr Nicola Evans, Academic Supervisor. School of Healthcare Sciences, College of Biomedical and Life Sciences, Cardiff University, 13<sup>th</sup> Floor Eastgate House, 35-43 Newport Road, Cardiff, CF24 0AB.

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Dr Rebecca Playle, Academic Supervisor. Health Services Research Statistics Group, Centre for Trials Research, College of Biomedical & Life Sciences, Cardiff University, 4th Floor, Neuadd Meirionnydd, Heath Park, Cardiff, CF14 4YS.

**Thank you for taking the time to read this information sheet and for considering taking part in this study.**

## Appendix 16 – Assent form for CYP aged 11-15 interviews and observations



Participant Identification Number:

Study Title: Young people's social connections during inpatient mental health care

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### ASSENT FORM For Children Aged 11-15 – Interviews, Observations and Medical Notes

#### Young Person

Version 1 dated 11/10/2018

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Name of Researcher: Gavin John

(to be completed by the child and their parent/carer)

Child (or if unable, parent on their behalf) /young person to circle all they agree with:

Has somebody explained this study to you?	Yes/No
Do you understand what this study is about?	Yes/No
Have you asked all the questions you want?	Yes/No
Have you had your questions answered in a way you understand?	Yes/No
Do you agree to take part in the study?	Yes/No

If any answers are 'no' or you don't want to take part, don't sign your name

[Version 1, 11/10/2018] IRAS Number 250127 Young people's social connections during inpatient mental health care



If you do want to take part, you can write your name below

Your name.....

Date.....

Name of Parent/Carer.....

Sign.....

Date.....

The researcher who explained this project to you needs to sign too:

Print Name.....

Sign.....

Date.....

## Appendix 17 – Caregiver consent form for CYP aged 11-15 interviews and observations



Participant Identification Number:

Study Title: Young people's social connections during inpatient mental health care

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### CONSENT FORM – Interviews, Observations and Medical Notes

Parent/Carer

Version 2 dated 30/11/2018

---

Title of Project: Young people's social connections during inpatient mental health care

Name of Researcher: Gavin John

Please initial  
all boxes

1. I confirm that I have read and understand the information sheet dated 30/11/2018 (version 2) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand that my child's participation is voluntary and that I am free to withdraw my child at any time without giving any reason, without their care being affected. ☐
3. I understand that relevant sections of my child's medical notes and data collected during the study, may be looked at by individuals from Cardiff University or from Research & Development Department, to ensure the study is being conducted in the right manner. I give permission for these individuals to have access to my child's data, including medical notes. ☐
4. I agree for my child to take part in an interview and understand that the interview will be audio recorded. ☐
5. I give permission for my child's medical records to be read by the Cardiff University research team, and for notes relating to my child's connections to family, friends and education to be made from these. ☐

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6. I give permission for my child's care planning review and ward round meetings on the ward to be observed and for notes about these to be made by the Cardiff University research team. ☐
7. I give permission for information about my child and their experiences to be used in a research project and that this information (including direct quotes from my child's interview) may be used in reports, articles and presentations. I understand that my child's identity will not be known as information will be anonymised. ☐
8. I understand that my child's GP will be informed of their participation in this study. ☐
9. I agree for my child to take part in the above study. ☐

_____ Name of Parent/Carer	_____ Date	_____ Signature
_____ Name of Person taking consent	_____ Date	_____ Signature

## Appendix 18 – Consent form for CYP aged 16-18 interviews and observations



Participant Identification Number:

Study Title: Young people's social connections during inpatient mental health care

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### CONSENT FORM – Interviews, Observations and Medical Notes

Young Person

Version 2 dated 30/11/2018

---

Name of Researcher: Gavin John

Please initial  
all boxes

- |  |                          |
|--|--------------------------|
| 1. I confirm that I have read and understand the information sheet dated 30/11/2018 (version 2) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.   | <input type="checkbox"/> |
| 2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my care being affected.   | <input type="checkbox"/> |
| 3. I understand that the data collected in this study, may be looked at by individuals from Cardiff University or from Research & Development Department, to ensure the study is being conducted in the right manner. I give permission for these individuals to have access to my data. | <input type="checkbox"/> |
| 4. I agree to take part in an interview and understand that the interview will be audio recorded.  | <input type="checkbox"/> |
| 5. I give permission for my medical records to be read by the Cardiff University research team, and for notes relating to my connections to family, friends and education to be made from these.   | <input type="checkbox"/> |
| 6. I give permission for my care planning review and ward round meetings on the ward to be observed and for notes about these to be made by the Cardiff University research team.  | <input type="checkbox"/> |

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7. I give permission for information about me and my experiences to be used in a research project and that this information (including direct quotes from my interview) may be used in reports, articles and presentations. I understand that my identity will not be known as information will be anonymised.

☐

8. I understand that my GP will be informed of my participation in this study.

☐

9. I agree to take part in the above study.

☐

\_\_\_\_\_  
Name of Participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Name of Person taking consent

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

## Appendix 19 – Consent form for caregiver interviews and observations



Participant Identification Number:

Study Title: Young people's social connections during inpatient mental health care

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### CONSENT FORM – Interviews

Parent/Carer

Version 1 dated 11/10/2018

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Name of Researcher: Gavin John

Please initial

all boxes

- |  |                          |
|--|--------------------------|
| 1. I confirm that I have read and understand the information sheet dated 11/10/2018 (version 1) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.   | <input type="checkbox"/> |
| 2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason.   | <input type="checkbox"/> |
| 3. I understand that the data collected during the study, may be looked at by individuals from Cardiff University or from Research & Development Department, to ensure the study is being conducted in the right manner. I give permission for these individuals to have access to my data.                    | <input type="checkbox"/> |
| 4. I agree to take part in an interview and understand that the interview will audio recorded.   | <input type="checkbox"/> |
| 5. I give permission for information about me and my experiences to be used in a research project and that this information (including direct quotes from my interview) may be used in reports, articles and presentations. I understand that my identity will not be known as information will be anonymised. | <input type="checkbox"/> |
| 6. I agree to take part in the above study.  | <input type="checkbox"/> |

[Version 1, 11/10/2018] IRAS Number 250127 Young people's social connections during inpatient mental health care



\_\_\_\_\_  
Name of Participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Name of Person taking consent

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

[Version 1, 11/10/2018] IRAS Number 250127 Young people's social connections during inpatient mental health care

## Appendix 20 – Consent form for ward staff interviews and observations



Participant Identification Number:

Study Title: Young people's social connections during inpatient mental health care

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### CONSENT FORM – Interviews and Observations

Ward Professionals

Version 1 dated 11/10/2018

---

Name of Researcher: Gavin John

Please initial

all boxes

1. I confirm that I have read and understand the information sheet dated 11/10/2018 (version 1) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason.
3. I understand that the data collected during the study, may be looked at by individuals from Cardiff University or from Research & Development Department, to ensure the study is being conducted in the right manner. I give permission for these individuals to have access to my data.
4. I agree to take part in an interview and understand that the interview will be audio recorded.
5. I give permission to be observed in care planning review and ward round meetings on the ward and for notes about these to be made by the Cardiff University research team.
6. I give permission for information about me and my experiences to be used in a research project and that this information (including direct quotes from my interview) may be used in reports, articles and presentations. I understand that my identity will not be known as information will be anonymised.

☐☐☐☐☐☐

[Version 1, 11/10/2018] IRAS Number 250127 Young people's social connections during inpatient mental health care

7. I agree to take part in the above study.



\_\_\_\_\_  
 Name of Participant

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Signature

\_\_\_\_\_  
 Name of Person taking consent

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Signature

## Appendix 21 – Assent form for CYP aged 11-15 questionnaires



|

Participant Identification Number:

Study Title: Young people's social connections during inpatient mental health care

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### ASSENT FORM For Children Aged 11-15 - Questionnaires

#### Young Person

Version 1 dated 11/10/2018

---

Name of Researcher: Gavin John

(to be completed by the child and their parent/carer)

Child (or if unable, parent on their behalf) /young person to circle all they agree with:

Has somebody explained this study to you?	Yes/No
Do you understand what this study is about?	Yes/No
Have you asked all the questions you want?	Yes/No
Have you had your questions answered in a way you understand?	Yes/No
Do you agree to take part in the study?	Yes/No

If any answers are 'no' or you don't want to take part, don't sign your name

[Version 1, 11/10/2018] IRAS Number 250127 Young people's social connections during inpatient mental health care





If you do want to take part, you can write your name below

Your name.....

Date.....

Name of Parent/Carer.....

Sign.....

Date.....

The researcher who explained this project to you needs to sign too:

Print Name.....

Sign.....

Date.....

## Appendix 22 – Caregiver consent form for CYP aged 11-15 questionnaires



|

Participant Identification Number:

Study Title: Young people's social connections during inpatient mental health care

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### CONSENT FORM - Questionnaires

Parent/Carer

Version 2 dated 30/11/2018

---

Name of Researcher: Gavin John

Please initial  
all boxes

1. I confirm that I have read and understand the information sheet dated 30/11/2018 (version 2) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
2. I understand that my child's participation is voluntary and that I am free to withdraw my child at any time without giving any reason, without their care being affected.
3. I understand that data collected during the study, may be looked at by individuals from Cardiff University or from Research & Development Department, to ensure the study is being conducted in the right manner. I give permission for these individuals to have access to my child's data.
4. I agree for my child to take part by completing three questionnaires.
5. I give permission for information about the experiences of my child to be used in a research project and that this information (including answers from the questionnaires) may be used in reports, articles and presentations. I understand that my child's identity will not be known as information will be anonymised.
6. I understand that my child's GP will be informed of their participation in this study.
7. I agree for my child to take part in the above study.

☐☐☐☐☐☐☐

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_____	_____	_____
<b>Name of Participant</b>	<b>Date</b>	<b>Signature</b>
_____	_____	_____
<b>Name of Person taking consent</b>	<b>Date</b>	<b>Signature</b>

[Version 2, 30/11/2018] IRAS Number 250127 Young people's social connections during inpatient mental health care

## Appendix 23 – Consent form for CYP aged 16-18 questionnaires



Participant Identification Number:

Study Title: Young people's social connections during inpatient mental health care

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### CONSENT FORM - Questionnaires

Young Person

Version 2 dated 30/11/2018

---

Name of Researcher: Gavin John

Please initial  
all boxes

- |  |                          |
|--|--------------------------|
| 1. I confirm that I have read and understand the information sheet dated 30/11/2018 (version 2) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.   | <input type="checkbox"/> |
| 2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my care being affected.   | <input type="checkbox"/> |
| 3. I understand that the data collected in this study, may be looked at by individuals from Cardiff University or from Health Board's Research & Development Department, to ensure the study is being conducted in the right manner. I give permission for these individuals to have access to my data.        | <input type="checkbox"/> |
| 4. I agree to take part by completing three questionnaires.  | <input type="checkbox"/> |
| 5. I give permission for information about me and my experiences to be used in a research project and that this information (including answers from the questionnaires) may be used in reports, articles and presentations. I understand that my identity will not be known as information will be anonymised. | <input type="checkbox"/> |
| 6. I understand that my GP will be informed of my participation in this study.   | <input type="checkbox"/> |
| 7. I agree to take part in the above study.  | <input type="checkbox"/> |

[Version 2, 30/11/2018] IRAS Number 250127 Young people's social connections during inpatient mental health care



\_\_\_\_\_  
Name of Participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Name of Person taking consent

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

[Version 2, 30/11/2018] IRAS Number 250127 Young people's social connections during inpatient mental health care

## Appendix 24 – Tier 4 CAMHS Referral Pathway

