Referral to an acute child and adolescent inpatient unit: The experiences and views of community mental health referrers

Abstract

Admission to an acute mental health inpatient unit is a significant event for a young person. The interface between inpatient and community teams negotiating the admission and later discharge can be fraught. In order to understand how to improve the transition between inpatient and community care, we interviewed 48 community clinicians about their experiences of engaging with an acute child and adolescent mental health inpatient unit. Through thematic analysis, we identified management of risk was a central issue. Participants wanted more time in hospital, and more communication and collaboration. They expressed appreciation, but some gave intense descriptions of dissatisfaction. The analysis suggests avenues to improve communication and experience, recognizing the (felt) power differential between inpatient and referring community clinicians. Managing the power dynamics requires inpatient clinicians to use active inquiry to bring forward community clinicians' views, and be mindful of the risk of community clinicians experiencing communication as criticism.

Key words: hospital-based care, inter-professional relations,

Introduction

Effective integration of hospital and community care matters. Young people are vulnerable and at risk at both admission and discharge (Forster, Murff, Peterson, Gandhi, & Bates, 2003; Kingdon et al., 2010; Kjelsberg, 2000). Evidence is increasing of the role of effective teamwork and communication in patient outcomes (Leonard & Frankel, 2011; Weller, Boyd, & Cumin, 2014). We also need to make effective use of the intensive resource invested in inpatient care. The changing role of the inpatient unit means significance of the inpatient/outpatient interface in inpatient care is increasing. Evidence based community treatments have been developed for young people presenting with psychiatric emergencies (Henggeler et al., 1999), Anorexia Nervosa (Lock, 2015), psychotic illness (Mihalopoulos, Harris, Henry, Harrigan, & McGorry, 2009), repeated suicidal behavior (Mehlum et al., 2014; Rossouw & Fonagy, 2012) and general CAMHS presentations (Duffy & Skeldon, 2013). This means that the role of the inpatient unit in adolescent mental health care is changing from providing extended residential treatment to providing crisis support to community treatment. Decreasing length of stay is leading to increasing numbers of transitions (Case, Olfson, Marcus, & Siegel, 2007; Meagher, Rajan, Wyshak, & Goldstein, 2013).

Transitions between health care services are a point of risk. Both admission and discharge have been identified as events with risk for errors for general hospitals (Gleason et al., 2010; Kripalani, Jackson, Schnipper, & Coleman, 2007). Discharge information and patient related communication were key issues of concern identified by German referrers to an adult mental health unit (Spiessl, Semsch, Cording, & Klein, 2001). Many young people fail to make the transition from community child and adolescent mental health services to adult services and are lost to care. Some of this is attributed to communication problems and cultural differences between services (McLaren et al., 2013; Paul et al., 2013; Singh et al., 2010). The therapeutic alliance, which has a significant contribution to psychotherapy outcomes, is interrupted by the change in clinicians (Horvath, Del Re, Fluckiger, & Symonds, 2011; Martin, Garske, & Davis, 2000).

Inpatient and outpatient clinicians struggle to work cooperatively across widely different contexts. This is not documented in the literature but could be predicted by the growing literature describing factors which support effective communication and collaboration. These include physical proximity (Baggs & Schmitt, 1997; Conn, Reeves, Dainty, Kenaszchuk, & Zwarenstein, 2012; Oandasan et al., 2009), opportunistic communication (Conn et al., 2009; Reeves & Lewin, 2004), shared culture (Hall, 2005), integrated governance (Jackson, Nicholson, Doust, Cheung, & O'Donnell, 2008), shared models, integrated knowledge and mutual trust (Evans & Baker, 2012; Korner et al., 2016; Salas, Sims, & Burke, 2005) and clarity in expectations (Jackson et al., 2008). These factors are not likely to be found across an inpatient unit and a range of geographically widely spread community teams working in different contexts and governed by different District Health Boards (Ko, Murphy, & Bindman, 2015).

The inpatient/outpatient interface is asymmetrical. Inpatient clinicians negotiate this interface daily and it is relevant for all of their patients. In contrast, community clinicians negotiate it with only the small proportion of their patients they refer for admission. Thus in order to improve the functioning of the interface, it is most efficient to educate the inpatient clinicians about the perspective of the community clinicians. There is also a perceived power differential in favor of the inpatient clinicians. This is set up by the apparent control they have over inpatient bed days (Lee, 2010) and exacerbated by the differences in clinical responsibility at admission and discharge. At the point of seeking admission, community clinicians are in a position of vulnerability, asking for help in a context of crisis or failure to progress community care. At discharge, they are re-engaging where there is still significant risk (Kingdon et al., 2010; Kjelsberg, 2000), and they are dependent on the inpatient clinicians for current clinical assessment of the young person.

The role of power in inter-professional relations is largely overlooked, but is important in this context (Paradis & Whitehead, 2015). Where there is a perceived power imbalance, the party who experiences having less power is: (i) more likely to attempt to anticipate the needs of the other party; (ii) less likely to bring forward their concerns; and (iii) more likely to experience dissatisfaction or criticism (Anderson & Berdahl, 2002; Lee, 2010). If outpatient clinicians work harder to anticipate the needs of the inpatient clinicians than vice versa, they may be in less immediate need of information about the inpatient clinicians’ perspective. If they are less likely to bring forward their concerns, then their views need to be proactively sought.

Because of such asymmetries in power, information and frequency of using the interface, it is appropriate for inpatient clinicians to take the lead in optimizing the functioning of the interface. Thus the aim of this study is to bring forward the perspective of the referring clinicians in order to develop strategies to improve the functioning of the interface. The focus is on the tensions between inpatient and community clinicians, and does not provide a service evaluation. We have identified three frameworks which are helpful in understanding these: communication challenges, inter-group dynamics and power dynamics.

Context of the study

Mental health care in New Zealand is largely publicly funded. The supra-regional IPU has 20 child and adolescent beds serving a population of about 2.2 million people living mostly in the main metropolitan area, but also up to six hours' drive away. There are over 20 referring teams with over 350 admissions annually, mostly adolescents with para-suicidal behaviour or psychosis. Conduct Disorder, Substance Abuse and sequelae of trauma are common co-morbidities. Admissions can be planned, but most are accepted acutely at any time. During office hours, admission to hospital is accessed following a community assessment and a discussion with a senior clinician within the inpatient team. Out of hours, admission is via the local crisis team and the child and adolescent psychiatrist on call for the metropolitan region. Processes for discharge include a planning meeting with family, young person and clinicians from community and inpatient teams. Documents accompanying discharge include a brief letter with medical handover information and a written plan developed with the young person outlining strategies to identify and address warning signs. Shared access to computerized hospital record systems mean the inpatient clinical notes are visible to some referring teams. They can be printed and faxed to the others.

The philosophical approach of the unit includes (i) a recovery perspective (Barber, 2012), (ii) a strengths-based approach (Rapp, 1998), (iii) minimizing the use of restraint and seclusion, (iv) tolerance of a level of risk in order to minimize dependence and promote autonomy (Deci & Ryan, 2008) and (v) prioritizing family involvement. This approach has been associated with reduction in the average length of stay to 10 days. The associated reduction in occupancy meant space was almost always available for admissions at the time of the study. Feedback from families, by postal questionnaire, with the offer of a follow up interview, is generally positive, but received from only 10-15% of eligible families. Referrers have expressed both appreciation and dissatisfaction via informal channels, specific communications and interface meetings. This study aimed to more formally assess their experiences, perspectives and needs.

The first author, Josephine Stanton, is the Clinical Director of the unit. The other two authors and have no role in the unit outside the study.

Methods

Ethics permission was sought from the research committees of the seven District Health Boards governing the referring CAMHS services and received from six. Josephine Stanton approached clinical leaders and managers of referring services in these six areas and requested that they send the participant information sheet, and the list of interview questions, to all clinicians inviting them to participate. Because of her quasi-insider status and prominent position, extra measures were taken to maintain the anonymity of the participants within the research team. The second author, Viktor Lahdenpera, made all subsequent contacts with services and participants. Josephine Stanton was not aware of the identity of the participants, ensured by strategies such as her not seeing whole transcripts, but only parts of transcripts grouped by topic. Participants were informed of this approach. We have also limited the demographic and professional information obtained and reported on in order to protect anonymity and support participation.

There are several hundred community child and adolescent clinicians working in the area. The number who have engaged with the IPU is not known. We included all clinicians who consented and were available for an interview. The interviewer, Viktor Lahdenpera, visited services, interviewing participants face to face (or in two cases by phone) individually or in small groups. He used the semi-structured interview guide which had been previously sent to all potential participants. It included specific questions as to what participants valued, found unhelpful, and would like to see with respect to each aspect of inpatient care, including admission, treatment while in hospital and discharge. In total, he interviewed 48 clinicians over 24 interviews, ranging in length from 50 minutes to one hour and 45 minutes. Of the 48 participants, nine were from services in the metropolitan area and 39 from smaller centres. Six were psychiatrists or other doctors. Others included nurses, psychologists, occupational therapists, social workers and cultural workers. Six identified as Maori, with a range of other ethnicities, mostly New Zealand European. Numbers of admissions each clinician had been involved with varied widely.

Interviews were transcribed and returned to participants for checking. Analysis followed broad guidelines for thematic analysis (Braun & Clarke, 2006) conducted in an experiential, realist framework. Both Josephine Stanton and Viktor Lahdenpera initially read through the transcribed data (Viktor Lahdenpera in full transcripts; Josephine Stanton in topic-based data clusters), making notes and identifying potential patterns in items of interest. We then each independently (i) coded the data using NVIVO, (ii) compared codes, (iii) developed an initial summary and (iv) returned to the data to confirm, or disconfirm, the thematic analysis we were developing, and select suitable quotations. Differences were addressed through an iterative review process back and forth between codes and raw data, to reach collective agreement around key and most relevant patterns in participants' experiences. As is typical for thematic analysis (Braun & Clarke, 2006), we went through several iterations before settling on a final thematic structure. This version of thematic analysis does not advocate coding and analysis based around consensus coding or measures of inter-rater reliability (some others do). The third author, Virginia Braun, whose expertise is in qualitative research, participated in each iteration of the analysis: she read some raw and coded data, and discussed developing themes with the other authors at each point; Virginia Braun did not read the whole data set.

Because clinicians from Auckland, where the unit was located, psychiatrists and Maori clinicians were numerically small groups, but with potentially different perspectives, their transcripts were reviewed separately, as well as part of the whole group. The only consistent differences which were found were those relating to travel for clinicians from the non-metropolitan areas. Numbers of participants endorsing a particular view are represented only in terms of trends, as the sample was not statistically representative and numbers of patients each clinician had referred to hospital varied widely. Extracts of transcripts presented in the results are intended, not just as exemplars of the theme, but also to show breadth and diversity, and to give voice to the issues raised.

Results

In the analysis we sought to understand what referrers valued in the functioning of the IPU and potential for improvement. The central issue identified by participants was management of risk. We identified three other themes related to participants wanting more communication, more time in hospital, and more collaboration. Although most expressed appreciation for IPU staff and service there was also an intensely described thread of dissatisfaction; we highlight this after the four themes, under ‘points of tension’.

Risk reduced or shared

Risk in the context of suicidality or psychosis was the commonest reason for seeking admission. Participants talked of wanting containment of the risk and for the decision to discharge to be based on significant reduction of risk.

> *… inpatient unit is one of the only places that can contain the level of risk and anxiety for community teams if things are that level*

> *It's really to stabilize them and get over that real risky stuff.*

Some talked of the admission as an opportunity to contain risk while new treatment was tried, the young person recovered or there was work done in the community: *giving us some time to plan things out in the community while our young person is in a facility where we know that they're safe*.

A few people, in contrast to the dominant view, questioned that inpatient admission would reduce the young person's risk, but spoke of an admission enabling them to share the responsibility for the risk with the inpatient team: *maybe at times been more to treat our anxiety than the patient, if I'm honest*.

Hospitalization was generally therefore perceived as an important opportunity for containment or reduction of risk, particularly for patients whose needs exceeded resources available within community settings. However, a few people did raise a concern that a hospital stay could exacerbate risk, citing risk of peer contagion, reinforcing dysfunctional behaviour and developing a dependence on hospital.

> *…meeting like-minded young people, other young people, actually exacerbated the stuff.*

> *This belief that hospital is a safe place, I don't quite hold on to. I think sometimes it can escalate the difficulties, that children, young people and families just think of hospital as soon as there's a risk rather than looking at ways to manage it themselves. So, at times, I feel it can escalate the issue if it's not really thought about why we're admitting.*

This view was, however, the minority, and hospitalization was generally understood as beneficial in terms of risk reduction, both to the patient and for the clinicians involved.

Communication

Overall, participants seemed to see communication from the IPU as limited and in need of improvement. A desire for *more* communication was expressed widely. Participants spoke of wanting to know more about the observations made in hospital, treatments used, inpatient clinicians' impressions and formulations and plans about discharge. There was also interest in a better *quality* of communication. As well as regular updates, participants wanted an ease of connection with inpatient clinicians and to have them listen to community clinicians.

Within a theme of better communication, views on what actually comprised quality or better communication varied. Each of the specific communication strategies already used by the IPU (availability of full inpatient clinical notes, plans for identifying and addressing early warning signs, notes from weekly review meetings, telephone conferences, emails etc) was valued by some participants, but described as unhelpful by others. Face to face communication was seen as the ideal, but challenging in terms of travelling time, especially for rural clinicians.

> *We have instigated more recently actually going to* [IPU] *if we've got somebody that's high risk or that we've had a discharge that maybe has failed previously, actually going up in person … just to try and make sure that we get it right.*

One aspect of communication that many participants emphasised was *notice* about discharge: *it would be helpful if someone was likely to be discharged in a very short time frame, for me or for our team to be notified of that as soon as possible*. Having relevant handover information available to the community clinicians on the day of discharge was similarly described as very important - *It's not helpful at all … if it's too late*. Ideally handover information would comprise "*an integrated summary"* of observations, assessments and progress from the admission with diagnosis, formulation and a collaboratively developed plan for community treatment: *I just think you need one document, one discharge summary which has everything in it.*

Effective and informative communication, particularly prior to, and at, discharge, was therefore a key need for the community clinicians, but what the data suggest is that *discussion* about communication needs is important, as there is no universal agreement, and it may need tailoring to each situation.

It’s valuable, we want more

Inpatient stay as a valuable opportunity was another key theme.

> *It’s a great opportunity for the child to be out of his (sic) normal day to day set. Think about therapeutic advantages because this is where the child can actually be disengaged with his (sic) friends and his (sic) family which are, in a lot of cases, the offending agent and the child can be exposed to different modelling in a 24/7 setting which is really intense*.

Participants described valuing observation, assessment and treatment. However, there was some patterning around the value of inpatient care related to diagnosis. Participants described the most satisfaction with the admission of young people with acute psychosis, variable satisfaction with those with complex presentations, and the least satisfaction around young people with chronic suicidal ideation who had short stays.

Linking to the previous theme of risk, several spoke about “*stabilizing*” the young person, so acute mood or psychotic symptoms were resolved and distress reduced to the point where they could be treated in the community. As well as containment of risk (highlighted above), increasing understanding of, and information about, the young person and family were valued: *Sometimes it’s useful to get a second opinion or to get 24 hour assessment when you can’t get that information, or you need it quicker than you can get*

Participants also indicated a diverse range of less tangible benefits of admission, such as family support, breathing space, something different from community treatment and an opportunity to socialize with other young people with similar issues:

> *On several occasions, I've had young people who've been admitted who have been presenting with quite complex and dual type diagnosis presentations. It was very, very influential in that young person's care to have that admission…*
>
> *… it stabilised that young person, to give them time to reflect over what's been going on for themselves. That's when you know it's made a significant contribution in their lives.*
>
> *My clients have always found it extremely supportive in lots of ways …. There's always good reports, positive stuff happening.*

In fitting with the theme that admission is beneficial, participants with few exceptions talked of wanting *longer* admissions:

> *For us, it's a major decision as clinicians to send somebody … Our expectation will be for anybody we sent up to* [the hospital], *we would value a longer stay there. If it was only two or three days, we're not getting that value*.
>
> *…the service that we're looking for is far more intense and longer in duration*
>
> *I would like them to do a period of observation so they can do a proper diagnosis. You can't do that in a day or two*.

Hospitalisation was identified, therefore, as offering a wide range of benefits that went beyond the immediate symptom reduction, and *more* was often seen as *better*.

Experts in this together

Participants spoke a lot about collaboration between community and inpatient clinicians, but often the collaborative potential was not realized. Many identified wanting to be more involved. *What would be helpful is, if we were more a part of the decision making process.* Participants talked of wanting community team goals to guide interventions during the admission, and expressed concern about inpatient staff changing plans without consultation. *they do not actually do what we request of the admission.*

There was, again variability in the type of relationship seen as ideal. Some wanted expert guidance: *we send them to* [hospital] *for a specialist work up in terms of diagnosis and some guidance in terms of where to from here*. Others wanted a sharing of ideas: *We're more trying to invite them to have a dialogue than to actually have them tell us what to do*.

Differences between the clinical opinions of the inpatient team and the community team were both valued and seen as problematic. Participants described valuing difference in terms of *a "second opinion" or* "*another set of eyes"*. They also valued assessment data which could not be accessed in the community, such as 24/7 observations when the patient was substance-free. But some pointed out the 'artificial' nature of the inpatient environment, without the stressors of everyday life in the community, as a limit to the usefulness of solely inpatient-based assessments.

Participants valued treatment decisions based on observations in hospital which were congruent with what they saw in the community. *If they see the symptomatology that we see, then it is helpful.*

Participants wanted differences in clinical opinions to be kept between professionals, and not discussed with families. They described wanting a management plan for ongoing care to be developed collaboratively with inpatient and community clinicians, prior to options being discussed with young people and their families. They felt inpatient clinicians should reinforce the messages the community clinicians were giving: *We want the information to be aligned with both teams, not just their opinion.*

This theme highlighted the importance of an open, collaborative style of communication and working, which integrated the community clinicians' expertise alongside that which the IPU offered – and which relied on professional respect and participation. The risks of the absence of these are illustrated in our final discussion around points of tension.

Points of tension

A substantial minority of participants described negative experiences of engaging with the IPU. These related to both clinical (for instance, describing negligible positive impact of admission) and administrative practice, and to how their professional expertise was treated.

Participants recounted episodes where they felt practice by the IPU had been poor:

> *…the worst one I've had was a girl that was in the car on the way home and I didn't need even know she was in [hospital] and they just rang and said that they were discharging her*

> *I don't think there's ever, in my opinion, there is ever, ever a situation where it's acceptable to put a child under the age of 18 on a bus on their own*.

> *Unhelpful is when they trespass the families and just have a blanket, 'You are too difficult so go away'*

Several participants described single adverse experiences of the IPU, some dating back many years.

> *…someone was actually really quite rude on the phone to me*.

> *I remember one, but that's over a period of five years, that was discharged while she was still quite a high risk.*

> *I remember one time and it's in old case, … but some of the remarks were a bit derogatory of our intervention here*

Inpatient clinicians' decision-making processes for discharge were strongly criticized by participants with terms like "*bizarre" and "arbitrary"* being used. Some felt inpatient clinicians should manage challenging behavior, such as causing property damage or assaulting staff, rather than discharging the young person, a practice they perceived to happen. Similarly, some felt the risks of 'peer contagion' should be managed in order to keep patients in the unit longer:

> *I do not accept any more the deliberation around 'we have so many borderliners here now that we couldn't keep her any more, it was bad for her to be here'. Again, that is not my problem.*

Another practice that was criticized was inpatient clinicians' perceived prioritizing the views of family in a discharge decision: *discharging some who's really unwell just cos the family want it*.

Some participants described feeling judged or undermined by inpatient clinicians. When clinicians bringing a child to the IPU had to wait, this was described as not only poor practice, but indicating a lack of respect for community clinicians. A few felt IPU clinicians viewed them as inferior and not equal participants in the clinical process.

> *They do not invite you to have an opinion or they do not invite you to participate in the discussion. … the decisions of the cause have already been made and now it's about making these stupid farmers down there in* [Place X] *understand …*

Although most expressed satisfaction with the process of negotiating the admission, others described it as adversarial, experiencing answering questions about a clinical presention as "*jumping through hoops"*: *it's almost like every step of the process somebody's challenging the idea that we want to hospitalize the child*. This was experienced as professionally disrespectful, given that they described seeking admission as a "*last resort"*, with hospital "*being the place where you send somebody if you have tried everything else"*. Short length of stay was experienced as undermining community clinicians’ judgment in their decision to admit, with emphasis given to the point that *“we don’t admit for nothing”* .

Our discussion of points of tension, which cuts across the other themes already discussed (risk containment, benefits, communication and shared expertise), illustrates the ways even one-off negative encounters with the unit may impact community clinician perceptions over many years, and demonstrates the complexities that need to be negotiated at this interface.

Discussion

Participants described what they saw as ideal for an inpatient service. This included: (i) admitting all patients unable to be managed in the community; (ii) providing assessment; (iii) keeping patients safe; (iv) reducing risk via individual and family treatment and (v) contributing to ongoing community work. The inpatient clinicians would use enriched assessment information from 24/7 observation to offer a second opinion, which would augment but not conflict with, the community team’s understanding and plan. Treatment and discharge planning would be collaborative and focused on meeting community team goals. Discharge planning would happen with ample notice, when community team goals were met or, at least, addressed in some way. The inpatient team would effectively manage challenges such as “peer contagion” and violence against property and people. A comprehensive discharge summary would available on the day of discharge, outlining the observations and assessments from the admission as well as collaboratively-developed ongoing treatment plans.

There is evidence supporting aspects of this picture as an ideal to be strived for, particularly with respect to communication and collaboration (Ko et al., 2015; Leonard & Frankel, 2011; Weller et al., 2014). The finding that participants varied widely in how much they valued the different genres of communication is consistent with studies of communication within hospitals (Conn et al., 2009). The complexity of the knowledge acquired in a 24/7 multi-disciplinary environment also indicates the need for a range of genres (James, Andershed, Gustavsson, & Ternestedt, 2010). Written communication is probably most appropriate for the sort of “medical” information GP’s want from a specialist medical referral (Tattersall et al., 1995). But participants in this study described interest in the depth and richness available from a 24/7 assessment. Face to face communication is ideal, particularly if available in an opportunistic way in the context of a social relationship (Conn et al., 2012). Circumstances are against this sort of communication in this context, but opportunities should not be missed and could be created by IPU clinicians for informal telephone conversations, outside of formal meetings and in addition to the range of electronic and written information.

The differences in satisfaction described with respect to admissions for suicidal adolescents with those with psychotic illness may be at least partly explained by the differences in effectiveness of treatments available. There are a range of treatments for psychosis with established effectiveness (Lehman et al., 2004). But there is limited effectiveness demonstrated for interventions to decrease risk in self harming adolescents in any setting (Brent et al., 2013). Specifically, the effectiveness of inpatient care in reducing risk is not established (Gould, Greenberg, Velting, & Shaffer, 2003). The finding that suicidal ideation appears to develop following engaging in treatment and fail to remit with treatment (Nock et al., 2013), indicate that we have much to learn in this area.

Participants in this study described a range of ways an inpatient stay could contribute to managing risk in the community, such as additional and different assessment and therapeutic interventions, consultation, acknowledging ongoing risk in the context of the best available care and offering respite to the community clinicians, young person and family. While these can be important contributions, many young people will continue to be at risk over extended periods and this risk is held by the community clinicians.

Participants' request for an increased length of stay is supported empirically for both adolescents (Green et al., 2007) and adults (Figueroa, Harman, & Engberg, 2004; Lin et al., 2006). But a recent Cochrane review identified adverse outcomes in terms of social and occupational functioning associated with length of stay of over 28 days (Babalola, Gormez, Alwan, Johnstone, & Sampson, 2014). Short length of stay is standard care for adults with Borderline Personality Disorder (Helleman, Goossens, Kaasenbrood, & van Achterberg, 2014). Given the difference in treatment effectiveness it may be that longer inpatient stays are of more benefit to people with psychotic illness than those with borderline presentations. Surprisingly, studies in the

US looking at variables associated with length of hospital stay in children and adolescents have identified non-clinical variables such as region, variability in providers and source of funding, to be the only significant predictors of length of stay (Leon, Snowden, Bryant, & Lyons, 2006; Rothbard, Lee, & Noll, 2012).

More may not necessarily be better. Perceived disadvantages of inpatient care, include loss (or disruption) of community networks, difficulties transferring therapeutic gain, and risk of dependency on the inpatient environment (Duffy & Skeldon, 2013). Some young people have reported abuse in hospital (Kaplan, Busner, Chibnall, & Kang, 2001). An inpatient admission is a more visible event than community clinic appointments, with increased risk for stigma (Moses, 2015). Young people have reported favouring home-based treatment over hospital admission (Plaistow et al., 2014), finding aspects of admission stressful (Causey, McKay, Rosenthal, & Darnell, 1998) and experiencing being “triggered” by behavior of other young people (Gill, Butler, & Pistrang, 2016) .

Young people with suicidal presentations may be more at risk of harm in hospital than those with psychotic illness. An inpatient setting may be associated with increased “acting out” for adolescents with features of Borderline Personality Disorder. Participants described concern about this. Laurenssen et al. (Laurenssen et al., 2014) and attributed the increase in acting out they observed to the intensity of contact among the patients leading to “(hyper)activation of the attachment system” (p 6) and large team size impairing the consistency of communication the adolescents experienced from the staff. Increased risk-taking by adolescents in the context of peers (Steinberg, 2008) may also play a role. The evidence for contagion of depression among peers raises a potential risk of hospitalization (Bastiampillai, Allison, & Chan, 2013), but some adolescents have described contact with peers as extremely helpful during a psychiatric admission (Moses, 2011).

More detailed understanding of what it is that participants are wanting more of could indicate areas in which the inpatient unit is under-performing or possibilities for quality improvement. It is also possible that the participants are indicating a shortfall in our health system and what is needed is a creative alternative to hospital. Adult patients have described to prefer alternatives to hospital (Gilburt, Rose, & Slade, 2008).

Inpatient treatment is a complex intervention with wide ranging effects, many of which are independent of actions of clinicians (Craig et al., 2008). These can be powerful. An example is when a young person who makes a suicide attempt in the context of being rejected by a romantic partner who then comes to hospital and recommits to a relationship. Less dramatic, but probably more durable is when family and friends are alerted to the suffering of the young person by the public nature of the hospital admission, express their support and the young person experiences an increased awareness of how loved and valued they are in their network. A context where there is such complexity and variability in what can be provided by an inpatient admission and intermittent delivery of marked positive change provides considerable risk of unrealistic expectations. Managing these is important as they can result in false hope and disappointment which can contribute to the negative feelings reported by the participants (Snyder, Rand, King, Feldman, & Woodward, 2002).

The intense negative experiences participants described are not surprising given the challenges, but risk undermining the morale of community clinicians and the mutual trust identified as important to effective teamwork (Salas et al., 2005). Cognitive functioning is also found to be more optimal in the context of positive, rather than negative emotions (Fredrickson, 2001).

The role of the perceived power imbalance in increasing the susceptibility of community clinicians to experiencing criticism (Lee, 2010) may contribute to the negative experiences. An admission negotiation conversation is a potential example of this. For example, being asked for information that is needed for inpatient but not necessarily to outpatient care, such as, “Is there any history of violence?” or “Who is her legal guardian?” could be experienced as being asked to jump through hoops or as a criticism of the clinical judgment that inpatient care is indicated. The role of a dynamic such as a power imbalance is supported by the significant dissatisfaction described with respect to the intake process for a unit with a high level of bed availability.

Other factors can contribute to understanding the negative experiences. Negative emotions enhance memory which may mean that community clinicians may be more likely to remember negative events (Brierley, Medford, Shaw, & David, 2007). Inter-group dynamics may also contribute to differential recall of negative events in that members of any group are likely to have a bias in favour of the group they belong to (Hewstone, Rubin, & Willis, 2002) and be less likely to help out a member of another group (Sturmer, Snyder, & Omoto, 2005). Research into inter-group dynamics also indicates potential ways forward: a small but significant reduction in inter-group prejudice can be effected by contact and trying to take the perspective of members of the other group appears to be associated with being more willing to help out members of the other group (Bilewicz, 2009; Dovidio, Eller, & Hewstone, 2011; Pettigrew & Tropp, 2006).

Strengths and weaknesses

The study provides rich, experience-based data in an area with little research. The experiences described relate to only one inpatient unit, albeit the only unit for a large catchment area. The high level of availability of beds is an important difference from most contexts, nationally and internationally. The sample was large but as recruitment was not stratified, clinicians from outside the metropolitan were over-represented, perhaps highlighting more strongly issues experienced by those who have to travel considerable distance for admission. The similarity of responses from clinicians in the minority sub-group, Maori, doctors and urban clinicians, indicate there may be considerable uniformity of experience over a range of contexts.

The quasi-insider status of the first author as Clinical Director of the inpatient unit has been helpful in recruiting, and offers an increased understanding of the relevant issues, but also has the potential for bias. The outsider status of the other two authors offered a check for this, with robust discussion around interpretation taking place throughout the analytic process. The presence of strong negative perceptions does indicate that participants felt free to express their views, negative as well as positive.

Implications

Inpatient units may need to change. Given that this study is not looking at patient information which is the primary outcome for inpatient care, it does not comprise an evaluation or guide specific change in inpatient treatment. However, the dissatisfaction expressed indicates areas worthy of further research. The differences in levels of satisfaction associated with different diagnoses suggests research should be focused on diagnostic groups. The three theoretical frameworks of inter-professional communication, inter-group dynamics and power dynamics suggest useful strategies for change.

Multiple forms of communication are needed including creation of opportunities for informal communication. The limited nature of the research base underpinning delivery of inpatient care leaves considerable ambiguity, with a risk of mismatch of expectations held by community clinicians and delivery of care by the inpatient unit. Listening carefully to dissatisfaction experienced by referrers may point to areas where inpatient care can be improved – for example, asking, “Do you think there is something helpful we could be doing that we haven’t done?” Clarification of what an inpatient unit can deliver, and active management of expectations, have the potential to reduce dissatisfaction.

Increasing contact and opportunities for perspective-taking of each other’s services could include creating opportunities for each to spend time observing or working in the other service, increasing opportunities for formal and informal contact. Stressors on both groups contribute to the challenge in the inpatient-outpatient interface. The results of this study shed light on potential ways to ease tensions for better professional relationships and patient care. Issues identified can provide some guidance for informal conversations and could be used as the basis for a survey for eliciting community clinicians' views more widely.

Inpatient clinicians also need to attend to the likely effects of the perceived power differential. They need to be mindful of the pressures on outpatient clinicians and the risk of their experiencing communication as criticism. Inpatient clinicians may also need to use active inquiry to overcome any reluctance of referrers to bring forward concerns. For example, at the point of admission asking, "Am I understanding your concerns?" and at the point of discharge planning, "What are you thinking needs to happen before discharge?"

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