



The experiential impact of hospitalisation in early psychosis: Service-user accounts of inpatient environments



Kelly Fenton^{a,b}, Michael Larkin^{a,*}, Zoë V.R. Boden^a, Jessica Thompson^{a,d},
Garth Hickman^{a,c}, Elizabeth Newton^{a,c}

^a University of Birmingham, UK

^b Birmingham and Solihull Mental Health Foundation Trust, UK

^c Coventry and Warwickshire Partnership Trust, UK

^d St. Andrews Healthcare, Birmingham, UK

ARTICLE INFO

Article history:

Received 15 April 2014

Received in revised form

22 September 2014

Accepted 25 September 2014

Keywords:

Psychiatric inpatient unit

Psychosis

Early intervention

Schizophrenia

Emerging adulthood

ABSTRACT

Early Intervention in Psychosis services aim to keep young people out of hospital, but this is not always possible. This research used in-depth interviews to explore the experience of hospitalisation amongst young people with psychosis. Findings describe fear and confusion at admission, conflicting experiences of the inpatient unit as both safe and containing, and unsafe and chaotic, and the difficult process of maintaining identity in light of the admission. We discuss the need to move from construing psychiatric hospitals as places for 'passive seclusion', to developing more permeable and welcoming environments that can play an active role in recovery.

© 2014 Published by Elsevier Ltd.

1. Introduction

It is a central tenet of phenomenological philosophy that the relationship between person and world is reciprocal and mutually-constitutive (e.g. see [Larkin and Thompson, 2011](#)). This idea emerges in various forms in many other domains, such as phenomenological psychology, ethnography, cultural psychology, cultural geography, person-environment psychology, human systems approaches, and health geography. In the latter domain (e.g. see [Cummins et al., 2007](#)), the mutually-constitutive relationship between people and their context has been of particular interest due to a growing consensus about the impact of designed and built environments, and the human systems which shape and interact with them, upon health and wellbeing. In this paper, we explore a particular example of the relationship between environment, systems, and experience - hospitalisation during first-episode psychosis - from a phenomenological psychological perspective.

A first episode of psychosis (FEP) typically occurs in early adulthood, at a time of important psychosocial development. In the UK, Early Intervention Services (EIS) offer biopsychosocial interventions to young people with psychosis during the 'critical

period' after first onset, aiming to avoid hospitalisation and foster recovery ([McGorry and Jackson, 1999](#)). However, at times of acute distress and risk, young people with psychosis are still likely to be admitted to hospital. Sometimes hospitalisation is in response to a crisis that occurs despite established EIS support, and sometimes crises may precede (and trigger) a referral to EIS. Psychiatric hospitalisation can be distressing and even traumatising for mental health service-users (see [Berry et al., 2013](#)). Little is known about its impact on young people with early psychosis, who are likely to have been hospitalised in a crisis, and who may either have believed that hospitalisation was unlikely (given the ethos of EIS) or for whom hospitalisation may have signified first contact with mental health services. This research focuses on understanding the experience of hospitalisation for these young people.

1.1. Experiences of inpatient mental health care

Inpatient care environments have been seen as less central to mental health care than they once were, given the shift to community care ([Healthcare Commission, 2008](#)). However, they remain very important for acute care and are recognised as being under-resourced for the demands placed on them ([Lelliott et al., 2006](#)). It is worth noting that many of these environments were not designed for acute psychiatric care ([Jones, 2004](#); [Von Sommeruga Howard, 2004](#)), and that many of those which were designed for this purpose, appear

* Correspondence to: School of Psychology, University of Birmingham, Edgbaston, Birmingham, B15 2TT. Tel.: +44 0121 414 6036.

E-mail address: m.larkin@bham.ac.uk (M. Larkin).

to have been conceived with relatively limited anticipation of the impact of the environment upon its users (Von Sommaruga Howard, 2004). Curtis et al. (2009) point out that such environments have a dual effect, protecting people from social stigma, but also cutting them off from social support. Similarly, psychiatric hospitals function as a form of social control: the unique dilemma of this healthcare environment is that staff are asked “to treat people in hospital who do not want to be there, whilst constantly discharging those who would like to stay” (Turner, 2005, p. 318). Hospitalisation has featured extensively in the growing literature on psychiatric care generated by survivors and user-researchers. For example, Woodlen (2011) has written extensively about the dehumanising effects of inpatient environments. As a former patient, she has experienced the ways in which “Inpatient psychiatric staff, on a daily—if not hourly—basis, violate the social contract that exists between human beings,” and yet, as a former employee, can also recall how her own prior assumptions appear to her as “ignorant, narrow-minded and judgmental” (2011). Typically, inpatient environments are characterised in survivors’ accounts as exclusively medical, overly coercive, and unempathic (Keyes, 2013). Despite this consensus, very little of this user experience literature focuses specifically upon first admissions and/or early psychosis. Most accounts that do include reflections on these issues are written from considerable retrospective distance. For example, participants in Rose (2001) and Rose et al.’s (1998) two influential reports on user experience of mental health services in London (1998 and 2001) have mean ages in the mid-40s. This may be a reflection of the time which recovery journeys can take, and also the life stage at which it can feel safe or important to share such accounts publically (e.g. see Sen et al., 2009). Thus, there is an important role for more focused, formal and anonymised forms of experiential enquiry alongside these accounts.

Inpatient services are frequently constructed as a topic of concern in mental health research and policy, often in response to service-users’ reports. Reviewing the literature, Quirk and Lelliott (2001) conclude that service-users experience wards as unsafe, boring, and lacking in amenities. We can situate these concerns in the wider context of findings on the relationship between environment and wellbeing. While it can sometimes be difficult to tease out relationships between specific environmental features and specific health consequences (Cummins et al., 2007), and may even be difficult to make sense of such relationships when they emerge (e.g. see Weich et al., 2002), the general patterns in the literature are clearly relevant to this setting. For example, Evans (2003) shows three important features of the psychosocial environment with positive benefits for wellbeing: the affordance of personal control over one’s own experience; access to supportive relationships, and opportunities for restorative engagement with the natural world (see also Jackson, 2003). All three of these levels of interaction between person and world are under threat in typical acute care settings. Encouragingly, positive attempts to address these threats, through anticipatory design of the physical and systemic environment, appear to improve people’s experiences of these settings (e.g. see Curtis et al., 2007). The overarching concerns about acute care environments are summarised very clearly in the literature on therapeutic landscapes and psychologically-informed environments, where writers have emphasised the mutually-constitutive relationship between the environment, what happens in that environment, and our experience of it. That is, on the one hand, “Place becomes meaning-filled through experiencing agents” (Fenner, 2011, p. 852), and on the other hand, certain kinds of meaning and experience are afforded by certain kinds of places and spaces (Nova, 2005).

Advocates of psychologically-informed environments (Johnson and Haigh, 2011) extend this rationale to argue that the physical and social organisation of healthcare environments should thus be informed by a set of common psychological principles, in order to

ensure that the environment does foster the appropriate behaviours and interactions from those who interact with it. The recommendations made in both of these fields highlight that acute care remains some distance from the ideal (Muijen, 2002) and that it has progressed very little on those issues which are most important to user experience (Lloyd-Evans et al., 2010; Csipke et al., 2014), such as improved communication and empathy, more personal one-to-one care, and fewer restrictions on personal freedom.

The breadth of such concerns perhaps serves to emphasise the importance of understanding the needs of particular populations in relation to inpatient care. A younger population, who may be using adult mental health services for the first time, may be particularly impacted by hospitalisation. One concern is the context of the psychiatric hospital as a site of inevitable stigmatisation (McGrath and Reavey, 2013), which may have particularly strong consequences for young adults at an important stage of identity development (something also a concern for parents of service-users with early psychosis; Hickman et al., in submission). Warner et al. (1989) highlight that self-esteem was particularly low among those who perceived high levels of stigma attached to their mental health issues. Roe (2003) suggests that some forms of treatment, including hospitalisation, convey a powerful negative statement about competence and thus challenge an individuals’ self-esteem; adolescent service-users in a psychiatric facility have been shown to report more negative self-descriptions than controls (Bers et al., 1993). In addition, hospitalisation is linked to post-traumatic stress disorder (PTSD): Morrison et al. (1999) found 44% of people admitted to an inpatient psychiatric unit subsequently exhibited PTSD symptoms. Trauma can compound the difficulties associated with psychosis and hamper recovery and the work of EIS. Traumatic aspects of hospitalisation, for example restraint and exposure to violence, should be minimised (Craig and Power, 2010).

1.2. First person accounts of psychosis

Quirk and Lelliott (2001) argue that there is a need for qualitative research to explore the meanings of hospitalisation. This study uses the qualitative psychological approach Interpretative Phenomenological Analysis (IPA; Smith et al., 2009). IPA is concerned with understanding the perspective of the ‘person-in-context.’ It draws on hermeneutic phenomenology to focus researchers’ attention on identifying and interpreting the ‘perspectival’ qualities of each participant’s relationship to the ‘things that matter’ to them and which constitute their world (Larkin and Thompson, 2011). Thus, the approach is committed to the examination of how people make sense of major life experiences, in detail and depth. IPA has been employed to investigate a variety of experiences within psychosis (e.g. Newton et al., 2007). In one relevant example, Perry et al. (2007) investigated experiences of ‘hope’ in FEP. They report that hospitalisation was associated with hopelessness, being treated without respect, not having control, and having a lack of information. This study aimed to extend these limited findings by directly exploring what it was like for young adults to be hospitalised for early psychosis.

2. Method

2.1. Context

This paper reports upon one part of a larger ‘multiple-perspective design’ study (Larkin et al., 2013), which uses semi-structured interviews and IPA to explore three different perspectives of hospitalisation for early psychosis: parents (Hickman et al., in submission), staff (Thompson et al., in submission), and in this

paper, the experiences of service-users. All three studies were conducted in one NHS Trust, in the Midlands, UK, which has three EIS teams and two inpatient hospitals. Once completed, studies were fed into a service-development project (Larkin et al., in submission), which involved sharing findings with approximately 150 service-users, inpatient and community staff, managers, and relatives.

2.2. Participants

Sample sizes in IPA are typically small in order to meet IPA's commitment to idiography and context-sensitivity. At the time of recruitment, potential participants were under the care of EIS, and were approached via their care co-ordinators. Participants were excluded if they were actively experiencing psychosis, unable to speak English, or unable to consent as outlined in the Mental Capacity Act (2005). Ten people were approached to take part in the research and six consented (see Table 1). IPA samples aim for a degree of homogeneity, and all participants had recently experienced FEP (ICD-10; F20), which emerged between 12 and 18 months prior to interview, and all had been hospitalised at least once.

2.3. Data-collection

Data-collection was via semi-structured interviews. A schedule of open-ended questions was developed by the research team around five main areas (what hospital was like, how time was spent, the family experience, the discharge experience, and helpful/unhelpful aspects). Prompts were used to explore the participants' stories and to follow-up interesting areas. Two participants had experienced multiple hospitalisations and they were asked to focus on the most recent. Interviews were conducted by the first author (a Clinical Psychology trainee, who was not employed by the Trust) in participants' homes. Interviews lasted between 30 and 90 min, and were audio-recorded, transcribed verbatim and anonymised.

Table 1
Participants.

Pseudonym	Age	Gender	Ethnicity	Number of admissions	Length of most recent admission
David	27	Male	White-British	1	8 days
Jason	20	Male	White-British	3	3 months
Karen	27	Female	White-European	1	4 days
Luke	18	Male	White-African Caribbean	3	5 days
Mark	22	Male	White-British	1	5 days
Simon	33	Male	White-British	1	21 days

Table 2
Analytic process.

1. Open and free coding to identify both initial areas of interest and possible preconceptions.
2. IPA analysis 'proper' begins at the level of the individual case, with close, line-by-line analysis (i.e. *coding*) of the experiential claims, concerns, and understandings of each participant (e.g. see Larkin et al., 2006).
3. Identification of the emergent patterns (i.e. *themes*) within this experiential material emphasising both convergence and divergence, commonality and nuance (e.g. see Eatough and Smith, 2008); usually first for single cases, and then subsequently across multiple cases.
4. Development of a 'dialogue' between the researchers, their coded data, and their psychological knowledge, about what it might mean for participants to have these concerns, in this context (e.g. see Larkin et al., 2006; Smith, 2004), leading in turn to the development of a more interpretative account.
5. Development of a *structure*, frame or *gestalt*, which illustrates the relationships between themes.
6. *Organisation* of all of this material in a format which allows for coded data to be traced right through the analysis - from initial codes on the transcript, through initial clustering and thematic development, into the final structure of themes.
7. Use of *supervision or collaboration, to audit*, to help test and develop the coherence and plausibility of the interpretation and explore reflexivity.
8. Development of a *narrative*, evidenced by detailed commentary on data extracts, which takes the reader through this interpretation, usually theme-by-theme, and often supported by some form of *visual guide* (simple heuristic, diagram or table). (from Smith et al., 2009, p. 79–80).

2.4. Data analysis

Analysis in IPA is described as an 'iterative and inductive cycle' (Smith, 2007) that focuses on participants' attempts to make sense of their experiences. Analysis followed the strategies outlined by Smith et al. (2009) (see Table 2 and Larkin and Thompson, 2011) emphasising the focus of coding upon experiential claims and concerns). All interviews were initially coded line-by-line by the first author in order to identify and contextualise the claims and concerns of participants. Thus, codes identified meanings in the accounts. Themes were then developed by identifying meanings which were shared across the accounts. This is a systematic process which begins by clustering together all coded extracts of data, based on their common features, claims or concerns. Clusters were then evaluated, and sorted again, into a smaller number of emerging themes. For credibility checking and triangulation, a subset of the data was also coded by members of the research team. All developing clusters and themes were discussed and developed within the team. The validity of this analysis is also supported by the feedback from the subsequent service-development project, where service-users expressed strong recognition of the themes presented here.

3. Results

Four over-arching super-ordinate themes were found, entitled: Confusion and uncertainty; Feeling safe; Feeling chaotic and unsafe; and Maintaining identity.

3.1. Confusion and uncertainty

Participants provided rich accounts of feeling confused, paranoid and fearful when first encountering the hospitalisation process. When being transported from general hospital to psychiatric hospital, Mark asked staff, 'so, where are you taking me?', but was not answered. His experience seemed to reflect the lack of explanation echoed by other participants.

The process of hospitalisation was opaque. Karen described being in a police cell and feeling 'terrible, and majorly confused.' Simon was also detained by police and had no sense of what was happening when he was locked in a cell. In the absence of any explanation, Simon made sense of his situation as being under-attack and in danger. He described the fear and confusion he felt on the way to the hospital:

"I just thought, 'I'm gonna die.' I was in the back of the van going somewhere and I didn't know where I was going - that was when I became quite panicky and obviously I got took to the [unit] which I didn't know was the [unit]. I hadn't got a clue, all I knew was that

the police was the highest authority at the time and they were taking me somewhere else."

The uncertainty, powerlessness and feeling that events had their own momentum are tangible. It is impossible to know what information was given to Karen, Simon, and the others, but it is striking that all but one of the six participants described being unclear about what was happening. It appears their distress was exacerbated by a lack of information. This seems to be a particularly salient issue for younger service-users, and those being admitted for the first time, given their intense distress, and the wider context of uncertainty about what this might mean.

Medication was also a cause of uncertainty. Simon's experience of receiving medication in the police station and on the unit was confusing:

"You don't know what's going on [laughing]. I must have been on quite a few different things when I went in there, it just seemed like they give me everything you know, or they tried to".

The perceived absence of explanation and information may have been caused by participants' distress and psychotic symptoms, but this seems unlikely because, despite their confusion, they provided detailed accounts of their experiences. Participants recalled being told they were 'ill', but rarely about potential consequences. This lack of clarity also characterised their recalled interactions with a range of professionals prior to and during admission. Four participants were describing their first admission to a psychiatric hospital, and they appeared to have no knowledge to help them understand what to expect.

3.2. Feeling safe

Participants experienced their hospital stay in ways that were sometimes contradictory. Hospitalisation involved feeling safe and cared for, but also feeling bored. The hospital was construed as a place of respite, away from the stresses of normal life – but also away from its comforts, connections and diversions.

Participants experienced some positive aspects of hospitalisation, particularly in relation to feeling that some staff were caring and supportive. Luke talked about staff being 'really nice', 'easy to approach' and people he 'could talk to'. Karen described how the most helpful thing about the unit was having staff to talk to when she wanted. David felt he was well supported and that staff listened to him, describing how the staff kept 'communication open'. Simon found it easier to relate to certain staff (those who posed a less 'serious threat'), and he attributed the 'genuine' caring characteristics of female staff to the fact that they were mothers:

"Some of the women in there, they had their own kids and everything, that- and you just felt like they really did care, you know they really did, it was good in that way."

To a degree, we could consider this to be an unintended affordance of the environment: many of the staff were also parents, and both they (see Thompson et al., in submission) and the service-users noticed that a set of parent-child scripts were activated. In some respects, such scripts might be helpful (e.g. as here, invoking nurture and care), and in others we could speculate that they may not (e.g. there is the potential for the 'parent' role to undermine independence, or overlook individuality). Simon described feeling 'looked after,' and missed the staff once he left (he went back to visit the staff and say thank you). Although Mark also felt looked after, he did not feel actively cared for by staff and felt his individuality was overlooked:

"The carers were good in terms of - well most of them - were good in terms of- of erm- that they provided your basic needs and

everything [...] but there was no personal care, in that they just treated every patient there the same."

Mark makes a distinction between being looked after and being treated as a person. The importance of personal connections with others (staff and/or service-users) was illustrated by many participants, and although examples were rare, these connections were greatly valued.

Much of the positive talk about hospitalisation focused on escape and rest. David described the ward as 'respite' – a place away from everyday life where he could begin to understand his experiences. Luke talked about the unit as a place of escape from 'normal' life where there was 'family stress' and 'it was a bit manic':

"Just getting away from normal life and having a chill out time, like little holiday, that was helpful, erm just having your own space definitely, not sharing with anyone [...] that definitely helped."

The experience of feeling safe and cared for is important because it illustrates that there were positive aspects to hospitalisation, although these formed relatively small parts of the service-users' accounts. Participants deeply valued their scarce recollections of 'someone who made a difference', but they also emphasised that for the most part, they felt isolated and bored.

3.3. Feeling chaotic and unsafe

While the inpatient unit could provide a feeling of safety, the overarching tone of the young people's experience was one of being overwhelmed. Mark says, "I would classify my whole experience in there as quite horrific [...] it was just horrible being in there". Participants found the units both chaotic and prison-like.

Adult inpatient units were difficult for the young people to understand. Luke described 'chaotic' nights when he was unable to talk to staff as he needed. David worried about the number of service-users on the unit, saying he would 'freak out, as it feels they are coming for you'. David also talked about feeling overwhelmed and frightened by the unexplained activity around him:

"Being somewhere where you don't know and you've just got there and you've got people rushing by you at first - it was only because I was there for a month that I got to know people and so I got to know why they were running around me."

In addition, participants experienced the ward as like being 'in prison', 'on lock-down', and 'cut off from the world'. This conveys a sense of confinement, restriction and segregation. Viewing hospital as a prison evokes images of being trapped and having limited agency. David talked about being discharged from hospital by saying that 'two doctors had to pass [me] out,' conjuring images of the military; although he was also the only participant who saw the restrictions as necessary for service-users' safety. Jason felt staff "were needlessly strict in the rules - not, not letting me out". He felt unfairly treated, and that rules were maintained through assertion rather than explanation:

"When someone else was watching the golf on one of the TVs, I went into the women's lounge as no one was using it and er, I was forcefully removed from it, but you know, no one else was using it, well no one had used it for a few days until now, and I was dragged across the entire hospital."

This incident left Jason feeling confused and humiliated in front of other service-users. Furthermore, not having an explanation for his treatment meant that Jason viewed staff as unpredictable, which exacerbated his sense of chaos.

Participants' experience of the unit as chaotic and restrictive contrasted with the value they were also able to take from the

environment, as a place of safety and respite. It is reasonable to speculate that some aspects of the restrictive nature of inpatient environments might be experienced as particularly negative for young adults precisely because they are at a stage of life where they are only just beginning to achieve independence from institutional spaces and structures (e.g. schools) in their day-to-day lives. With the onset of a crisis, these newly acquired rights are retracted by hospitalisation, potentially leading some young service-users to view the hospital as ‘a prison’ and to feel confused as to why they are being ‘punished’ in this way. Typically, inpatient spaces are designed to be hard-wearing, impersonal and multi-functional. Observationally, we noted that many aspects of the physical spaces on the wards (e.g. texture and type of flooring; lack of pattern or colour in the fabrics; lack of variation between spaces) served to emphasise their institutional character.

It is also important to emphasise that the chaotic aspects of the environment were largely located, by our participants, in other people’s acute distress and/or agitated behaviour. This has been well established as a common concern during psychiatric hospitalisation (e.g. see [Lloyd-Evans et al., 2010](#)). For younger people, who are encountering this environment for the first time, and who may lack the life experience that prepares them for understanding other people’s acute distress, we can surmise that this must be particularly discomforting.

3.4. Maintaining identity

Participants’ accounts of their hospitalisation were characterised by their efforts to make sense of what had happened. This was largely identity work – hospitalisation presented a challenge to their identities – and it involved situating the event in terms of a wider process of recovery, or as a staging-point on a journey through services. Participants reflected on what they had learned about themselves, and drew particularly on the importance of interactions with other service-users, and the value of family support.

On admission, the self was experienced as alien (*‘I wasn’t myself’*) or impaired (*‘not 100%’, ‘something was missing’*). However, most of the young people differentiated themselves from the other service-users who were *‘weirdos’, ‘nasty’, ‘scary’* or *‘not very pleasant to be around’* and who could be *‘aggressive’*. Karen and Mark described trying to *‘stay away from’* other service-users, and Jason described himself as *‘not a real patient’*. Positioning other service-users in this way suggests that participants saw themselves as *‘outsiders’*, perhaps in part because of their young age and the early stage of their psychosis.

Simon made sense of his encounters with other service-users by drawing favourable comparisons and seeing himself as *‘not the worst case’*. Similarly, Jason minimised his behaviour by describing himself as *‘aggressive, but not violent at all’*. There was recognition from both Simon and Jason that they were experiencing a different sense of themselves at that time and that their behaviour was difficult to understand, but that the inpatient environment brought them into contact with others who were *‘worse’* than, and different from, them.

Mark described fears of *‘being classified in the same way as them’* and concerns that others’ psychosis might somehow contaminate him:

“The people there they were so, so heavily you know in psychosis it was very disturbing to be around them and feel like I’m in the same place as these people, and you feel like you are being classified in the same way as them and it scares you a bit as you almost feel like somehow being around them is going to make you worse.”

Participants also emphasised the importance of maintaining relational links to the *‘outside’* in order to facilitate the process of

‘getting better’. Simon described how it was after his friend’s visits that *‘it started to sink in, and I think that’s when it got better’*. Mark too talked about the influence of people from outside, and how those interactions helped his recovery:

“My Dad, when he would come to visit me, he would just sit there with me and talk to me as if I was normal and I found that a lot more therapeutic- and he continued to visit me every day when I was in there which really helped, and I recognised the fact that I was going to have to make myself venture out.”

Relationships within the unit were also important for David and Luke. David described how being able to *‘mix’* with the other service-users had helped him explain what had happened to him, whilst Luke talked about the importance of being able to *‘help’* others. Thus, under the right conditions, interactions on the unit also had positive outcomes. Whilst we must acknowledge that psychiatric hospitalisation can be a threat to *anyone’s* identity, we must also emphasise the centrality of this concern in the accounts of these young people. Emerging adulthood is a time of crucial psychosocial development, individuation, memory formation, and identity construction ([Harrop and Trower, 2003](#)). Both psychosis itself and intense exposure to its potential consequences (via hospitalisation in an environment peopled by older and more experienced adults in distress), present substantive threats to this process, as we can see in the accounts above.

4. Discussion

This research aimed to understand what it was like for young people to be hospitalised during early psychosis. The analysis highlights the service-users’ lack of knowledge about what hospital might be like; the importance, and absence, of clear information about what was happening during the transition to hospital; the sense of hospital as a safe, but separate place and the conflict between this perceived safety and the wider experience of wards as chaotic and unsafe; and finally, the importance of positive, meaningful relationships (with staff, family, friends and service-users) in fostering the idea of recovery as a slow, but active process. Some of these findings resonate with generic studies of inpatient experiences, whilst other aspects highlight the particular concerns of young people with early psychosis.

The experience of psychiatric hospitalisation as distressing (e.g. confusing, overwhelming) has been highlighted across the literature (see [Glasby and Lester, 2005](#); [Quirk and Lelliott, 2001](#)). This is also true of the finding that service-users valued feeling cared for by, and connecting with, staff when they have the time and motivation to do so (e.g. [Goodwin Holmes et al., 1999](#)). Parents ([Hickman et al., in submission](#)) and inpatient staff ([Thompson et al., in submission](#)) in the companion studies from our research team’s multiple-perspective project also expressed the importance of making and maintaining connections during hospitalisation – staff feel frustrated by the limited time they can spend with service-users, parents feel excluded and bewildered, and service-users acknowledge the importance of relationships with both parents and staff for their recovery. While the wider literature frequently emphasises the importance of fostering positive relationships between service-users and staff, it provides fewer details regarding relationships with other service-users, friends and family, which are particularly important in adolescence.

In the context of younger people with early psychosis, these issues bear further discussion. A sense of connectedness is associated with wellbeing ([Baumeister and Leary, 1995](#)), and good interpersonal relationships can be central to both “the creation and amelioration of mental health problems” ([Pilgrim et al., 2009](#), p235). FEP typically occurs in late adolescence or early adulthood, disrupting psychosocial

development and interrupting the development of close relationships outside of the family, often with long-term consequences (Mackrell and Lavender, 2004; Macdonald et al., 2005). Hospitalisation adds further disruption to be overcome. Perceived stigma, and the restrictions on movement in and out of the inpatient environment, may cut young people off from relationships that are important for their wellbeing, support and identities.

Given that 60–70% of people hospitalised for early psychosis will return to their families after discharge (Stirling et al., 1991), and most are in 'emerging adulthood' (Arnett, 2007) and still being parented, opportunities for 'normal' contact with supportive family members should be facilitated during hospitalisation (see Hickman et al., in submission, for the parents' perspective). Under the right conditions, opportunities to share experiences with other young people with psychosis can also be destigmatising and reassuring (Newton et al., 2007), and current NICE guidance (National Institute for Clinical Excellence, 2014) suggests that peer-support interventions should be considered. Across all three dimensions (friends, parents, fellow service-users), participants described interpersonal connections which made a positive difference for their insight and recovery. The critical issue for inpatient care is how to facilitate such interactions when the environment itself is perceived as cut-off, closed and chaotic. The answer may lie in the concept of 'permeability' (Quirk et al., 2006), which underpins an approach to the design and management of psychiatric healthcare environments making them more diffuse, less 'separate', and more therapeutic (Curtis et al., 2009; Duff, 2012; McGrath and Reavey, 2013). Such an approach would certainly be consistent with some of the principles of 'enabling' or 'psychologically-informed' environments (Johnson and Haigh, 2011).

The prison imagery used in this study echoes previous findings (Myers et al., 1990; Perry et al., 2007). Images of the psychiatric hospital as both *prison* and *refuge* are underpinned by an extensive historical and conceptual literature (see Curtis et al., 2009). One hypothesis for the contradiction of experiencing both constraint and safety is that the inpatient environment provides both physical and psychological containment, with the positive, psychological aspects of containment provided by the restrictions of the physical environment. Alternatively, wards may be construed as 'heterotopias' (McGrath and Reavey, 2013), which feel safe because they permit expressions of distress without drawing excess attention to it – but which are chaotic precisely because of this permissiveness. Yet, inpatient services can be more permeable and diffuse than has traditionally been the case, with wards unlocked and 'recovery activities' and 'recovery spaces' distributed across a wider, external environment (Curtis et al., 2009). This is likely to be important for maintaining connections between the young person and their support network. Perkins et al. (2012) similarly outline an educational (rather than medical) approach which provides 'recovery colleges' in place of wards, and Johnson et al. (2007) describe community-based alternatives to standard inpatient care. These developments in 'blurring the edges' of the hospital seem to connect to the Italian tradition of psychiatric care (Burti, 2001) and the Soteria movement (Mosher, 1999). Extending the permeability of inpatient services, with the aim of improving their acceptability, will require something of a revolution in the delivery of acute care: currently, around 90% of acute services operate on the standard model (Lloyd-Evans et al., 2010).

Alternatives to inpatient care (such as soteria, day care, partial hospitalisation, crisis houses, and home treatment teams) are available, and could segue neatly with other progressive initiatives (outreach services, self-management programs, recovery colleges, peer support, and user-led care). A recent evaluation of several residential alternatives to standard inpatient care (Morant et al., 2012) suggest that these are more acceptable to service-users, and either better than, or comparable to, standard care on most other important outcomes. An earlier review (Lloyd-Evans et al., 2009)

concluded that there was no evidence to indicate that alternative models were less effective than standard care, but made the observation that some approaches had failed to break through to mainstream practice, despite multiple attempts. They conclude that community-based crisis/respite houses could provide a positive alternative for some service-users, and might also relieve some pressure on standard acute units. It is not clear how much these different approaches to acute care environments also adopt different approaches to the design and use of space, and if so, what the consequences might be for user experience. From the point of view of young people's experience, it would seem to be particularly important that such spaces can be experienced as safe (perhaps by keeping young people apart from the most distressed or agitated service-users, as recommended by Lloyd-Evans et al., 2010), comfortable (perhaps by using interior design features to disrupt the institutional character of the space) and supportive (through enabling more one-to-one contact, and through making the environment accessible and welcoming to family and friends). On the basis of our own exploratory study, we recommend that further consideration is given to the needs of young adults with first episode psychosis in inpatient care. In the context of the wider literature, we can be more emphatic: services which are more focused upon young adults (e.g. see O'toole et al., 2004; Boydell et al., 2010), and which are delivered via systems and environments which are more permeable and flexible (e.g. see Wood et al., 2013), are likely to be more acceptable, less threatening and more engaging for both young people and their families.

4.1. Implications: from passive seclusion to active recovery

In the immediate clinical context, it is clear that young people are not well prepared for potential hospitalisation, or for what happens during the process. EIS could provide pre-crisis information packs, or arrange visits to local inpatient units, in order to explain what might happen and what to expect. Inpatient units should provide welcome packs for new patients with accessible information (Healthcare Commission, 2008) and could also provide a few essential items for the first few days. Hospitalisation is sometimes the entry point to services; establishing trust and successfully engaging with the service-user is important for future relationships with services. Staffing policies and activity patterns that give staff the time to connect with new patients are likely to be beneficial. Therapeutic practices that involve service-users in setting short-term goals for their recovery ('by the time I leave I would like to be able to do x', or 'to feel better about y', etc.) would allow staff to focus one-to-one time on supporting service-users in making active progress towards recovery. This would also help to clarify the purpose of the hospital stay, which can, as Curtis et al. (2009) point out, be unclear.

4.2. Summary

For young service-users experiencing early psychosis, relationships are important – with parents, but also with fellow service-users (provided these are managed safely) and friends (who are important in adolescence). A welcoming, permeable institution with good strategies for communicating its activities and purposes is likely to foster such relationships more effectively.

Acknowledgements

Thanks to Terry Twomey, Janet Kenworthy-Harvey, Donna Luck and all of the participants in both the research and service-development project.

References

- Arnett, J.J., 2007. Emerging adulthood: What is it and what is it good for? *Child Development Perspectives* 1 (2), 68–73.
- Baumeister, R.F., Leary, M.R., 1995. The need to belong: desire for interpersonal attachments as a fundamental human motivation. *Psychol. Bull.* 117, 497–529.
- Bers, S., Blatt, S.J., Sayward, H.K., Johnston, R.S., 1993. Normal and pathological aspects of self-descriptions and their change over long-term treatment. *Psychosomatic Psychol.* 10, 17–37.
- Berry, K., Ford, S., Jellicoe-Jones, L., Haddock, G., 2013. PTSD symptoms associated with the experiences of psychosis and hospitalisation: a review of the literature. *Clin. Psychol. Rev.* 33, 526–538.
- Boydell, K.M., Stasiulis, E., Volpe, T., Gladstone, B., 2010. A descriptive review of qualitative studies in first episode psychosis. *Early Intervention Psychiatry* 4, 7–24.
- Burt, L., 2001. Italian psychiatric reform 20 plus years after. *Acta Psychiatr. Scand.* 104 (Suppl. 410), 41–46.
- Cispke, E., Flach, C., McCrone, P., Rose, D., Tilley, J., Wykes, T., Craig, T., 2014. Inpatient care 50 years after the process of deinstitutionalisation. *Soc. Psychiatry Psychiatr. Epidemiol.* 49 (4), 665–671.
- Craig, T., Power, P., 2010. Inpatient provision in early psychosis. In: French, P., Smith, J., Shiers, D., Reed, M., Rayne, M. (Eds.), *Promoting Recovery in Early Psychosis. A Practice Manual*. Wiley-Blackwell, Chichester.
- Cummins, S., Curtis, S., Diez-Roux, A.V., Macintyre, S., 2007. Understanding and representing 'place' in health research: a relational approach. *Soc. Sci. Med.* 65, 1825–1838.
- Curtis, S., Gesler, W., Fabian, K., Francis, S., Priebe, S., 2007. Therapeutic landscapes in hospital design: a qualitative assessment by staff and service-users of the design of a new mental health inpatient unit. *Environ. Plan. C: Govern. Policy* 25, 591–610.
- Curtis, S., Gesler, W., Priebe, S., Francis, S., 2009. New spaces of inpatient care for people with mental illness: a complex 'rebirth' of the clinic? *Health Place* 15 (1), 340–348.
- Duff, C., 2012. Exploring the role of 'enabling places' in promoting recovery from mental illness: a qualitative test of a relational model. *Health Place* 18, 1388–1395.
- Eatough, V., Smith, J.A., 2008. Interpretative phenomenological analysis. In: Willig, C., Stainton Rogers, W. (Eds.), *Handbook of Qualitative Psychology*. Sage, London.
- Evans, G.W., 2003. The built environment and mental health. *J. Urban Health* 80, 536–555.
- Fenner, P., 2011. Place, matter and meaning: extending the relationship in psychological therapies. *Health Place* 17, 851–857.
- Glasby, J., Lester, H., 2005. On the inside: a narrative review of mental health inpatient services. *Br. J. Soc. Work* 35 (6), 863–879.
- Goodwin, I., Holmes, G., Newnes, C., Waltho, D., 1999. A qualitative analysis of the views of in-patient mental health service users. *J. Mental Health* 8 (1), 43–54.
- Harrop, C.E., Trower, P., 2003. *Why does Schizophrenia Develop at Late Adolescence?*. Wiley, Chichester.
- Healthcare Commission, 2008. *The Pathway to Recovery. A Review of NHS Acute Inpatient Mental Health Services*. Commission for Healthcare Audit and Inspection, London.
- Hickman, G., Newton, E., Larkin, M., Fenton, K., Thompson, J., Boden, Z., 2014. The Experiential Impact of Hospitalisation in Early Psychosis: Parents' accounts (in submission).
- Jackson, L.E., 2003. The relationship of urban design to human health and condition. *Landscape Urban Plan.* 64, 191–200.
- Johnson, R., Haigh, R., 2011. Social psychiatry and social policy for the 21st century: new concepts for new needs – the 'Enabling Environments' initiative. *Mental Health and Social Inclusion* Vol. 15 (1), 17–23.
- Johnson, S., Lloyd-Evans, B., Gilbert, H., Slade, M., 2007. Acute in-patient psychiatry: residential alternatives to hospital. *Psychiatr. Bull.* 31, 262–264.
- Jones, K., 2004. The historical context of psychiatric environments. In: Campling, P., Davies, S., Farquharson, G. (Eds.), *From Toxic Institutions to Therapeutic Environments: Residential Settings in Mental Health Services*. The Royal College of Psychiatrists, London, pp. 3–11.
- Keyes, J. (2013). Inpatient Hospitalization: An Inside Perspective. Contribution to the *Mad in America* blog. Posted 30th November 2013 (accessed 14.07.14.). (<http://www.madinamerica.com/2013/11/inpatient-hospitalization-inside-perspective/>).
- Larkin, M., Newton, E., Boden, Z., 2014. On the brink of genuinely collaborative care: reflections on the use of an adapted form of 'experience-based design' as mechanism for translating qualitative research into service development (in submission).
- Larkin, M., Thompson, A., 2011. Interpretative phenomenological analysis. In: Harper, D., Thompson, A. (Eds.), *Qualitative Research Methods in Mental Health and Psychotherapy: An Introduction for Students and Practitioners*. Wiley, Oxford.
- Larkin, M., Flowers, P. & Shaw, R. (2013). The use of multiple perspective designs in experiential qualitative research. Invited talk at NIHR School for Primary Care Research, University of Bristol, 13th Feb 2013. Available at: (<http://ipacommde.signdata.tumblr.com/post/49364708258/the-use-of-multiple-perspective-designs-in-experiential>) accessed July 2013.
- Larkin, M., Watts, S., Clifton, E., 2006. Giving voice and making sense in Interpretative Phenomenological Analysis. *Qual. Res. Psychol.* 3:2, 102–120.
- Lelliott, P., Bennett, H., McGeorge, M., Turner, T., 2006. Accreditation of acute inpatient mental health services. *Psychiatr. Bull.* 30, 361–363.
- Lloyd-Evans, B., Slade, M., Jagielska, D., Johnson, S., 2009. Residential alternatives to acute psychiatric admission: systematic review. *Br. J. Psychiatry* 195, 109–117.
- Lloyd-Evans, B., Johnson, S., Slade, M., Barrett, B., Byford, S., Gilbert, H., Leese, M., Morant, N., Osborn, D., Skinner, R., Malone, N., Thornicroft, G., 2010. In-patient alternatives to traditional mental health acute in-patient care, Report for the National Service Delivery and Organisation. HMSO, London.
- Macdonald, E., Sauer, K., Howie, L., Albiston, D., 2005. What happens to social relationships in early psychosis? A phenomenological study of young people's experiences. *J. Mental Health* 14 (2), 129–143.
- Mackrell, L., Lavender, T., 2004. Peer relationships in adolescents experiencing a first episode of psychosis. *J. Mental Health* 13 (5), 467–479.
- McGrath, P., 2013. Heterotopias of control: placing the material in experiences of mental health service use and community living. *Health Place* 22, 123–131. (Online advance available at) <http://dx.doi.org/10.1016/j.healthplace.2013.03.010>.
- Morant, N., Lloyd-Evans, B., Gilbert, H., Slade, M., Osborn, D., Johnson, S., 2012. Implementing successful residential alternatives to acute in-patient psychiatric services: lessons from a multi-centre study of alternatives in England. *Epidemiol. Psychiatr. Sci.* 21, 175–185.
- Morrison, A., Bowe, S., Larkin, W., Nothard, S., 1999. The psychological impact of psychiatric admission: some preliminary findings. *J. Nerv. Mental Dis.* 187 (4), 250–253.
- Mosher, L.R., 1999. Soteria and other alternatives to acute psychiatric hospitalization. *J. Nerv. Mental Dis.* 187, 142–149.
- Muijen, M., 2002. Acute wards: problems and solutions. *Psychiatr. Bull.* 26, 342–343.
- Myers, D. H., Leahy, A., Shoen, H., Ryder, J., 1990. The patients' view of life in a psychiatric hospital. A questionnaire study and associated methodological considerations. *Br. J. Psychiatry* 156, 853–860.
- National Institute for Clinical Excellence, 2014. *Psychosis and schizophrenia in adults: Treatment and Management (NICE clinical guidance 178)*. National Institute for Health and Care Excellence, London.
- Newton, E., Larkin, M., Melhuish, R., Wykes, T., 2007. More than just a place to talk: young people's experiences of group psychological therapy as an early intervention for auditory hallucinations. *Psychol. Psychother.: Theory Res. Pract.* 8, 127–149.
- Nova, N., 2005. A review of how space affords socio-cognitive processes during collaboration. *PsychNology J.* 3 (2), 118–148.
- O'toole, M.S., Ohlsen, R.L., Taylor, T.M., Purvis, R., Walters, J., Pilowsky, L.S., 2004. Treating first episode psychosis – the service users' perspective: a focus group evaluation. *J. Psychiatr. Mental Health Nurs.* 11, 319–326.
- Perkins, R., Repper, J., Rinaldi, M., & Brown, H. (2012). *Implementing Recovery through Organisational Change Briefing Paper 1*. Recovery Colleges. London: Centre for Mental Health.
- Perry, B.M., Taylor, D., Shaw, S.K., 2007. "You've got to have a positive state of mind": an interpretive phenomenological analysis of hope and first episode psychoses. *J. Mental Health* 16 (6), 781–793.
- Pilgrim, D., Rogers, A., Bentall, R., 2009. The centrality of personal relationships in the creation and amelioration of mental health problems: the current interdisciplinary case. *Health* 13 (2), 235–254.
- Quirk, A., Lelliott, P., 2001. What do we know about life on acute psychiatric wards in the UK? A review of the research evidence. *Soc. Sci. Med.* 53 (12), 1565–1574.
- Quirk, A., Lelliott, P., Seale, C., 2006. The permeable institution: an ethnographic study of three acute psychiatric wards in London. *Soc. Sci. Med.* 63 (8), 2105–2117.
- Roe, D., 2003. A prospective study on the relationship between self-esteem and functioning during the first year after being hospitalized for psychosis. *J. Nerv. Mental Dis.* 191, 45–49.
- Rose, D., Ford, R., Gawith, L., Lindley, P., 1998. In *Our Experience: User-Focused Monitoring of Mental Health Services in KCW HA*. SCMH, London (and the KCW UFM User Group).
- Rose, D., 2001. *Users' Voices: The Perspectives of Mental Health Service Users on Community and Hospital Care*. The Sainsbury Centre for Mental Health, London.
- Sen, D., Morgan, S., Carson, J., 2009. Recovery heroes: a profile of Dolly Sen. *A Life Day* 13 (2), 6–8.
- Smith, J.A., 2004. Reflecting on the development of interpretative phenomenological analysis and its contribution to qualitative research in psychology. *Qualitative Research in Psychology* 1, 39–54.
- Smith, J.A., 2007. Hermeneutics, human sciences and health: linking theory and practice. *Int. J. Qual. Stud. Health Well-being* 2, 3–11.
- Smith, J.A., Flowers, P., Larkin, M., 2009. *Interpretative Phenomenological Analysis: Theory, Methods and Research*. Sage, London.
- Stirling, J., Tantum, D., Thonks, P., Newby, D., Montague, L., 1991. Expressed emotion and early onset schizophrenia. *Psychol. Med.* 21, 675–685.
- The recognition and management of early psychosis. In: McGorry, P.D., Jackson, H.J. (Eds.), *A Preventive Approach*. Cambridge University Press, Cambridge, UK.
- Thompson, J., Boden, Z., Larkin, M., Hickman, G., Fenton, K., Newton, E., 2014. Inpatient staff accounts of caring for young people with early psychosis (in submission).
- Turner, T., 2005. From toxic institutions to therapeutic environments: residential settings in mental health services. *Psychiatr. Med.* 29, 318.

- Von Sommeruga Howard, T., 2004. The historical context of psychiatric environments. In: Campling, P., Davies, S., Farquharson, G. (Eds.), *From toxic institutions to therapeutic environments: Residential settings in mental health services*. The Royal College of Psychiatrists, London, pp. 3–11.
- Warner, R., Taylor, D., Powers, M., Hyman, J., 1989. Acceptance of the mental illness label by psychotic patients: effects on function. *Am. J. Orthopsychiatry* 59, 398–409.
- Weich, S., Blanchard, M., Prince, M., Burton, E., Erens, B., Sproston, K., 2002. Mental health and the built environment: cross-sectional survey of individual and contextual risk factors for depression. *Br. J. Psychiatry* 180, 428–433.
- Wood, V.J., Curtis, S.E., Gesler, W., Spencer, I.H., Close, H.J., Mason, J., Reilly, J.G., 2013. Creating 'therapeutic landscapes' for mental health carers in inpatient settings: a dynamic perspective on permeability and inclusivity. *Soc. Sci. Med.* 91, 122–129.
- Wooden, A.C. (2011). Made, Not Born: An End to Inpatient Psychiatric Hospitalization (Part II). Contribution to the Behind Locked Doors blog. Posted 12th January 2011 (accessed 13.07.14.). Available at: (<http://behindthelockeddoors.wordpress.com/2011/01/12/made-not-born-an-end-to-inpatient-psychiatric-hospitalization-part-ii/>).