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Service Providers' Perspectives on Coping Strategies of Discharged Adolescent Psychiatric Patients

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Walden University
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MA, College of New Rochelle, 2005

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Doctoral Study Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

Using systems theory, the purpose of this qualitative study was to explore the perspectives of service providers about the psychiatric experiences of hospitalized adolescents, their coping strategies and the aftercare services they used following discharge. The goal was to learn about their experiences as they transitioned into mainstream culture. This study was conducted for psychiatric policy makers to assist with implementing therapeutic programs that teach adolescents coping strategies that help them make a smooth transition. The technique used to recruit 21 participants (psychiatrists, psychologists, social workers, psychiatric nurses, and direct care workers) was snowballing. The participants involved in face-to-face or phone interview. The NVivo coding system identified the following four themes from the service providers' responses: (1) Coping strategies is the core of the teaching process for inpatient psychiatric adolescents, (2) The coping strategies learned in the hospital are assessed at discharge, and used for integration and stability in mainstream society, (3) Adolescent patients who correctly used prescribed medication along with other coping strategies in and outside the hospital and were linked to aftercare programs were better able to handle their experiences of stigmatization and integrate into the community, (4) The role of the service providers is vital for ongoing communication among family, adolescent, inpatient hospital, and aftercare personnel. The most common coping strategies taught to adolescents were asking for help, avoiding conflicts, following instructions, and medication compliance. The likelihood of recidivism increased with inconsistencies within these coping strategies. The findings can initiate positive social change by guiding policy makers and service providers with the development of appropriate psychiatric care to accommodate adolescents' needs for a smooth transition back into school, work, and community.

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Dedication

I dedicate this breakthrough effort to my husband Julius Henry for his persistent efforts. He has been the Boulder who took on a clear majority of the domestic, financial, and family responsibilities while I pursue this ultimate educational journey. Thanks for your emotional support when I was deeply frustrated and overwhelmed because of the stressors involved in writing a dissertation and studying for this prestigious degree. Thanks for working two full-time jobs for numerous years. Thanks for driving our son Jahnai, sometimes long distances, to his educational and sporting programs throughout the elementary, middle, high school, and college years. Thanks for your understanding patience while raising our second son Juelz. I appreciate your devotion, encouragement, and inspiration throughout this process. Julius has been my biggest cheerleader, consistently congratulating me at each step of my accomplishments. Whenever I needed a shoulder to lean on, you were an enormous support. Again, recognitions are in order; I highly respect and admire you. I love you.

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Chapter 1: Introduction

Introduction

Service providers are individuals who offer service to others in exchange for payment (http://www.businessdictionary.com/service providers. 2017). They play a critical role in the treatment of adolescents who are suffering from mental illness (M'Carthy & Shera, 2013). Psychiatric service providers work with patients from admissions through post-discharge: psychiatrists, psychologists, social workers, psychiatric nurses, and direct care or mental health workers. The United States mental health workforce consists of core providers: psychology, psychiatry, social work, psychiatric nurses, and family therapy (Robiner, 2006). A broader group of practitioners (service providers) also deserves recognition (Robiner, 2006). Diverse professions provide significant services in a variety of settings, extending the diversity of mental health workforce (Robiner, 2006). Varcarolis (2017) stated that the adolescents usually respect staff members who are consistently fair, nonbiased, nonjudgmental, and patient. Positive staff role models are important for adolescent patients to follow during and after discharge. Positive regard implies respect; it is the ability to view another person as being worthy of caring about, and as someone who has strengths and achievement potential (Varcarolis, 2017). Respect is usually communicated indirectly by actions rather than directly by words (Varcarolis, 2017). A key ingredient in building trust is genuineness, or self-awareness of one's feelings as they arise within a relationship and the ability to communicate when appropriate (Varcarolis, 2017). While integrating back into society, compliance, coping strategies, and aftercare services are important tools for adolescents to use. Evaluation of

conformance at regular intervals should be an important aspect of mental health care for adolescents (Taddeo, Egedy, & Frappier, 2008).

While the overall treatment process may bring significant improvements to the condition of patients, reintegration into society may not be a fluid experience for this vulnerable population (Loch, 2014; Reinharz, Lesage, & Contandriopoulos, 2000). For service providers, the patients' needs are a priority in psychiatric care (Bonham, 2010). Bonham (2010) argued that adolescents are in an exploratory stage where they are discovering their autonomy as well as adapting to physical and psychological changes at this pivotal stage in their lives. Unsuccessful programs, unprofessional staff members, and negative peer pressure increase the difficulties of adolescent psychiatric patients transitioning back into mainstream society.

The stigma of being in a long-term psychiatric ward—from 90 to 120 days (Glick, Shaferstein, & Schwartz, 2011) and isolated from society often create embarrassment and shame (Loch, 2014). Few adolescents who have experienced long-term psychiatric care as inpatients successfully integrate into mainstream society (Loch, 2014). This integration process is a product of ongoing effective therapeutic programs, coping skills (following instructions, avoiding conflict, and seeking help), local education, and communication between the psychiatric institution and the community. Adolescents who conformed to procedures, followed treatment programs, established goals and family participation increased the rates of successful integration into school and community (Contreras, Molina, & Cano, 2011). Cutcliffe et al. (2012) stated that readiness is crucial for a positive transition into the communal environment; readiness means less anxiety for discharged patients.

Based on the framework of Finegood et al.'s (2012) systems theory, the purpose of this qualitative case study was to explore the perspectives of service providers about the psychiatric experiences of hospitalized adolescents, their coping strategies and aftercare services, following discharge from long-term psychiatric care . Stiffman et al. (2001) identified the critical role of service providers' perspectives in the mental health care of adolescents. The authors suggested more research on service providers' perspectives in predicting the use of services (Stiffman et al., 2001). Based on this study, an engaged and fluid system of care could be designed from inpatient to outpatient experiences, so that the adolescent may successfully integrate into society.

This study also examined the gap in literature as it pertains to service providers and their perceptions of adolescents in long-term psychiatric care. Das-Munshi et al. (2016) indicated that the perspectives of service providers are needed to identify discrepancies in the care provided across primary and secondary care. The authors wrote that "data linkages between primary and secondary care should be explored in future work" (Das-Munshi et al., 2016, p. 636). My research study has implications for positive social change to assist policy makers and service providers with implementing therapeutic programs that adequately equip adolescents with coping strategies and effective aftercare planning following discharge from a psychiatric institution.

Background

Service providers play an intrinsic part in teaching adolescent psychiatric patients coping skills that they use both inside and outside the psychiatric institution. Service providers implement individually focused mental health promotion efforts; they attempt to help adolescents negotiate stressful transitions and create programs

that modify the school environment within the institution and later, when the patients are discharged (Durlak & Wells, 2017). Service providers teach adolescents coping strategies via implementation of structured individual and group counseling. These therapeutic sessions were designed to teach interpersonal, vocational and life coping strategies. Prevention programs were designed to prevent behavioral and social problems in adolescents (Durlak & Wells, 2017). Rewards, consequences, and the ability to identify target task were effective ways to assist the adolescents in using the coping skills they learned. Several examples of target tasks were resisting negative peer pressure, assertiveness defined (self-advocating), accepting no for an answer, asking for help, avoiding conflict, and following instructions. Massimo, Rossoni, Mattei, Bonassi, and Caprino (2016) confirmed that adolescent patients are generally underrepresented when it comes to studies focused on improving the patient's quality of life. There is minimal research about the coping strategies gained by adolescents from service providers during their long-term stay in a psychiatric institution. This study lessened the gap with additional research. Durlak and Wells (2017) noted that priorities for research studies included the following: clearer specification of service providers intervention procedures, program goals, assessment of program implementation, more follow-up studies, and determining how the characteristics of the intervention and the participants related to different outcomes.

The social challenges that adolescents encounter pre-and post-psychiatric discharge included stigma, racism, nonsupportive family and peers, gang recruitment, drug use, lack of coping skills, noncompliance with prescribed medication, limited medical insurance, and not seeking aftercare services. These factors often lead to high recidivism. Broken homes, large families, low incomes, deprived neighborhoods, drug

abuse, adolescents with protected and or unprotected criminal records linked to recidivism (Contreras et al., 2011). Research by Ignatious (2015) showed that African American adolescent males who received mental health treatment experience stigma, fear of embarrassment, and mistrust of mental health providers. Some service providers' negative biases toward African-American males impeded their progression in the therapeutic milieu. Inpatient experiences were critical for recovery as documented by Ignatious (2015). Jones et al. (2015) also confirmed the detrimental impact of negative primary care experiences. Research by Ignatious (2015) indicated alcohol, smoking, and the use of illicit drugs among adolescent psychiatric patients was high and, when compared to the general population, resulted in the prevalence of risky behaviors among adolescents with psychiatric disorders (Mangerud, Bjerkseset, Holmen, Lyndersen & Indredavik, 2014). A study conducted by Zhu, Yu, Zang, Bao, Jiang, Chen and Zhen (2016) stated that there is significant evidence of peer victimization and its association with adolescent behavioral problems. They alluded to the fact that adolescents' exposure to peer maladaptive behavior also resulted in impulsivity in adolescents and deviant peer affiliation (Zhu, et. al., 2016). Stigma was a relevant factor for clients returning home after a long-term stay in a psychiatric hospital. Patients negatively internalized this stigma. Wright, Avirappattu, and Lafuze (1999) conducted a qualitative study with long-term psychiatric patients in Indianapolis and found that stigma eventually led to decreased feelings of control and mastery of their lives due to its ramifications. The mentally ill have been ostracized and alienated by society. The aforementioned factors place tremendous pressure on psychiatric nurses and those within the institution that provided care for the adolescents. Nurses have responsibilities within the mental institution where they

deliver direct and indirect care with adolescents (Mendes, Souza, and Mendes, 2012). (Direct care includes face-to-face interactions whereas indirect care involves paperwork and discussions about the adolescent patients.) Psychiatric nurses were inundated with program issues, crisis interventions, and other nursing duties (Mendes et al. 2012). Also, organizational problems and lack of managerial support led to a strain in the staff-patient relationship. This trickle down and/or cause-and-effect process was an unfortunate experience for the adolescent clients (Pelto-Piri, 2012).

As stated by Loch, 2014, service providers and hospital administrators collectively made it a point to oversee inpatient services that were implemented for the adolescents; the goal was a successful learning experience. This study narrowed the gap in literature by delving into service providers' perspectives regarding the coping mechanisms taught to adolescent patients during and after long-term placement.

Problem Statement

It was not known how the experiences of the adolescents during and post-hospitalization facilitate the integration of the adolescent into mainstream culture. Service providers' perspectives were more valuable in predicting the use of services and resources by adolescents having mental health problems (Stiffman et al., 2001).

A study conducted by Tossone, Jefferis, Bhatta, Johnson, and Seifert (2014) stated that readmission is a factor in pediatric psychiatric inpatient admissions. The average adolescent psychiatric inpatient readmission rate ranges from 30% to 60%, (James et al., 2010). At least one-third of adolescents were more likely to be hospitalized within the first 3 months to 2 years after the first admission (Blader, 2004). Patients with a history of victimization, suicidal behavior, learning problems,

problems with peers, and a history of violence were at increased odds of returning to the institution according to the Psychiatric Intake Response Center (Arnold, Goldson, Ruggierro, Reboussin, Sergent, & Hickman, 2003). Family settings and personal variables, such as fragmented homes, large families, low earnings, underprivileged neighborhoods, drug exploitation, and criminal records were linked to high levels of recidivism for adolescents (Contreras et al., 2011). In turn, exploration of the service providers' perspectives on coping strategies and aftercare programs helped reduce recidivism. Additionally, adolescents were at a lower risk for recidivism when they adhered to rules, were in high compliance with treatment programs, had high family involvement, and established objectives (Contreras et al., 2011). This information assisted service providers and policymakers to develop a more effective system of care for psychiatric institutions and aftercare programs that support the integration of the adolescent into society.

A major issue for the psychiatric adolescent patients was the duration of care; because it eliminated insurance coverage for aftercare services. Institutions were also primarily concerned with direct inpatient care funded through national insurance and or Medicaid for most patients. Most insurance companies pay only for an allotted duration of stay. Therefore, the directive of admissions administrators to social workers was to ensure a timely discharge. This protocol increased recidivism because there was insufficient time for the patient to experience a holistic therapeutic program. The length of stay (LOS) has repeatedly been an indicator of efficiency for inpatient care. Effective treatment increases the longer the adoescent patient stays at the hospital (Brownnell, Ross, 1995; Cahssin, 1983; Bradbury & Steen, 2000).

Recidivism was a key financial component for institutions because every re-admit marks additional revenue for the hospital. Each time an adolescent is admitted to a psychiatric hospital money are acquired through insurances and government funding for treatment and professional services. Aftercare services (therapist, psychiatrist, group homes, outpatient therapy, medication compliance, drug re-habilitation facilities, advocates, family involvement, independent living, halfway houses, probation officers) were vital for the ongoing therapy for the patient. Often, psychiatric adolescents do not feel a sense of belonging or stability because of frequent movement from homes, group homes, hospitals, institutions, agencies, district schools, and communities.

A common concern for service providers and families was discharging the maladaptive adolescent back into a hostile environment (Loch, 2014). This situation was a factor related to an acute diagnosis (Loch, 2014). Adolescent patients who returned to the community found it difficult to attend school, find employment and appropriately function in the community. Adolescents who resided in neighborhoods in which crime, drugs, violence, and gangs were rampant remained in a vulnerable state and could fall victim to a culture that has destructive influences. The following issues were all linked to recidivism: broken homes, large families, low incomes, disadvantaged neighborhoods, drug use, and criminal records (Contreras et al., 2011).

Timlin, Riala, and Kyngas (2013) wrote that adolescents with mental illness who were institutionalized created a challenge for treatment teams, for example, noncompliance and disruptive behavior. Research indicated that medication adherence helped foster a positive relationship between the adolescents and support groups (Sturgis & Brunton-Smith, 2009). Psychiatric treatment is a process that may

require a lifetime of medication compliance as well as psychotherapy and other forms of treatment to sustain the patients' quality of life (Munson, Floersch, & Townsend, 2010).

Findings related to the rehabilitation of individuals discharged from long-term psychiatric hospitalization were varied and few. This study explored the perspectives of service providers who had worked closely with adolescents' during and after discharge.

Purpose of the Study

Yin (2003) stated that case studies are experimental in nature. They explore existing occurrences within the framework of a phenomenon. The purpose of this qualitative case study was to explore the perspectives of service providers about the psychiatric experiences of the adolescents, including coping strategies and aftercare services used by adolescents, following long-term psychiatric discharge. This research used the framework of Finegood et al.'s (2012) systems theory.

This case study asked questions about how and what based on life events. Balkin and Roland (2007) affirmed the role of the service providers in the stabilization of patients and achievement of their therapeutic goals. Adolescents who mastered skills, such as problem identification and coping strategies, were more prepared for success upon discharge. Also, adolescents who adhered to a clinically designed outpatient plan were further ready for mainstream society.

Progress takes place when the adolescent can clearly identify her or his symptomology and shows commitment to their aftercare once discharged. When an adolescent complies with this process, it is easier for them to become stable and integrate into mainstream society.

Thus, the input of the service providers allowed for a comprehensive understanding of the processes related to the psychiatric adolescents assimilating into the community. This study explored the service providers' perspective on coping strategies of discharged adolescent psychiatric patients and aftercare programs. The results of this study will inform policy makers on practices that reduce the likelihood of recidivism. Psychiatric hospitals' group and individual counseling that teach adolescents coping strategies coupled with outpatient services foster successful integration and continuous stable functioning in the mainstream culture. Cargo, Grams, Ward, and Green (2003) research is concerned with active community participation and a positive approach to adolescents' health by focusing on their empowerment potential.

Research Questions

This study answered the following questions from the perspective of the service providers:

RQ1. What are the perceptions of service providers about the coping skills learned by adolescents who have experienced long-term inpatient psychiatric care?

RQ2. According to service providers what is the role of the inpatient psychiatric hospitalization and aftercare experiences of adolescents in the acquisition of coping strategies?

RQ3. According to service providers how do adolescents who have experienced long-term inpatient care use coping skills to integrate into mainstream society?

Theoretical Foundation

Systems theory was the framework for this study. Von Bertalany (1956) discovered the phenomenon of systems. He proposed that systems are open concepts that interact with the ecology and what knowledge is to be acquired. This concept of systems theory is the basis of evaluating qualitative mathematical measurements resulting in the continual evolution of behavioral health. It includes the human body, environment, technology, and sociology in which they exist.

The complexity of systems theory involves a scientific base that has influenced public health (Elkins & Gorman 2015). This field is progressing in that policy makers are developing new modalities to address this scientifically driven concept (Elkins & Gorman, 2015). Simply put, systems theory is a set of connected things based on careful examination of facts.

In this qualitative case study, systems theory was relevant because fundamentally it is an innovative approach whereby parts of a model fit together to develop a probable outcome (Peters, 2014). In the health care sector, such as a psychiatric hospital, a systems model helps make clear the interconnections between the needs of the adolescent and the support systems that must be in place for successful treatment outcomes. Additionally, this information as ascertained from the service providers' perspectives helped develop policy-based interventions that successfully affected coping strategies that adolescents acquired for a successful transition to mainstream society. Systems thinking proposes to increase the quality of perceptions by considering the entire system of care for the adolescents experiencing the psychiatric hospitalization, its parts, and the interactions within and between levels (Peters, 2014).

Nature of the Study

Qualitative inquiry was the methodology for this study because the theoretical foundation in a qualitative research is based on the understanding of human behavior from the informants' perspective. Therefore, the qualitative exploration was most applicable for this study (Creswell, 2007). This qualitative study sought to understand the factors related to the experiences of adolescents experiencing long-term psychiatric hospitalization from the service providers' perspectives. Quantitative research, on the other hand, is concerned with verifiable facts about social phenomena and assume a fixed and measurable data. Next, in a quantitative study, the researcher's primary objective is to answer a hypothesis (Creswell, 2007) and data collection in a quantitative inquiry implies an analysis of numerical comparisons and statistical instances (Minchiello, 1990). Also, the quantitative method involves evaluation or testing of a hypothesis. In conclusion, the quantitative technique was not appropriate for this research study.

Systems theory was the theoretical foundation of this study. Systems theory was appropriate because it evaluates the health care sector (Elkins & Gorman, 2015). The rationale for using the systems theory was that the reintegration of adolescents into the society was facilitated by the inpatient and outpatient support systems. The process concluded that adolescents provided with the essential care prepared them for life upon discharge, beginning with their experiences in the psychiatric hospital. The improvement in the quality of the system of care increased the potential in adolescents to become functional members of the society.

This qualitative research used handwritten notes as the data collection strategy and interviewed 21 service providers regarding coping strategies and aftercare

programs for adolescent psychiatric patients. Themes were generated based on the service providers' responses.

This study used the intrinsic case study method, is a type of case study with the focus of the study on the case because it holds intrinsic or unusual interest (Stake, 1995). According to Creswell (2007), the use of an intrinsic case study emphasizes the case itself in order to uncover relative conditions with the belief that they are extremely relevant to the researchers' study. In a qualitative case study, the researcher studies individuals or groups over an extended period to gather an in-depth perspective.

This study described and explored factors related to the experiences, coping strategies and aftercare services from the perspectives of service providers who work with these adolescents who have experienced long-term psychiatric hospitalization. Service providers included psychiatrists, psychologists, nurses, social workers, therapists, and direct care or mental health workers, as well as those that worked with adolescents in their aftercare process. A qualitative case study was appropriate for this exploration.

The purpose of this qualitative case study was to explore the perspectives of service providers about the experiences of the hospitalized adolescents and their use of coping strategies and aftercare services following discharge after long-term psychiatric care. The framework for this research was Finegood et al.'s (2012) systems theory. The therapeutic services that the adolescent receives in the mental health institution, as well as the aftercare services, are critical for rehabilitation and reintegration into the community. The information derived from this study is expected to help policymakers and service providers develop an appropriate long-term

adolescent psychiatric and aftercare system that addresses coping strategies and reintegration into the community.

Chapter 3 will further discuss the methodology as well as the selected participants. This research answered the following questions with a focus on the perspectives of the service providers:

RQ 1. What are the perceptions of service providers about the coping skills learned by adolescents who have experienced long-term inpatient psychiatric care?

RQ 2. According to service providers what is the role of the inpatient psychiatric hospitalization and aftercare experiences for adolescents in the acquisition of coping strategies?

RQ 3. According to service providers how do adolescents who have experienced long-term inpatient care use coping skills to integrate into mainstream society?

Definitions

In this research, the following terms were used as defined below:

Adolescents: A young person who is developing into an adult (http://m-w.com/dictionary/adolescent). Relating to the period of development from the onset of puberty (physiological sexual development) to maturity (American Heritage College Dictionary, 1993). Adolescence typically describes the years between age 13 and 19 and can be considered the transitional stage from childhood to adulthood. However, the physical and psychological changes that occur in adolescence can start earlier, during the preteen or "tween" years (ages 9 through 12). Adolescence can be a time of both disorientation and discovery. This transitional period can bring up issues of

independence and self-identity; many adolescents and their peers face tough choices regarding school work and sexuality, drugs, alcohol, and social life. Peer, romantic interest, appearance tend to naturally increase in importance for some time during an adolescent's journey toward adulthood (www.psychologytoday, 2017).

Coping: This is the process of changing the source of stress. It also marks the ways in which individuals manage their emotions that elicit stress (Folkman & Lazarus, 1985). Some adolescents are more successful than others in coping with stress. Active coping responses to stress tend to be more successful than passive ones. Adolescents may turn to maladaptive coping strategies such as substance abuse and self-harm in response to the challenges they may face. Common problems encountered by counselors when working with adolescent include depression, anxiety, suicidal ideation and behavior, early signs of developing psychosis, post-traumatic stress disorder, attention deficit hyperactivity disorder and autism spectrum disorder. It is useful for counselors to be aware of the symptoms of the psychological disorder so that they can recognize these indications and refer the adolescents to specialists when necessary (Gelard, Gelard, & Yin Foo, 2016). Adolescents' coping styles include the following: (1) Solving the problem: Behaviors such as seeking social support, focusing on finding a solution, seeking a relaxing diversion, investing in close friends, seeking to belong, working hard to achieve and being positive. In this style of coping the individual works on the problem while remaining optimistic, fit, relax, and socially connected. (2) Reference to others: Turning to others such as peers or professionals for social and spiritual support. (3) Non-productive coping: Worrying, seeking to belong, dreaming, not managing, ignoring the problem, keeping things to oneself and self-blame (Gelard et al., 2016).

Long-term hospitalization: Long-term psychiatric hospitalization is from 90 to 120 days as defined by (Glick et al., 2011). During a long-term psychiatric stay, sometimes the separation is very difficult for both the patient and the family. Family members are encouraged to participate in family meetings, support groups and educational settings that provide more information about the patient's illness or addiction. Treatment professionals also work to communicate realistic expectations for the treatment process. Sometimes people expect their family member is going to get cured. But the main task of a long-term care psychiatric facility is to further heal or the process of healing. Every patient should leave with a detailed plan that will act as their guide to navigating life after treatment, and ideally, family members should have input into it (www.menningerclinic.com ,2017).

Integration: In the context of this research, integration means an individual with assimilation skills as it relates to the environment and community. (Mallik, Reeves, & Dellario, 1998). Kuehnel and Liberman (1988) report that both skills development and environmental supports are necessary for the achievement of community integration and that the ongoing assessment of functional status is central to determining the frequency, intensity, and duration of psychiatric rehabilitation services.

Psychiatric discharge: This is the condition when an inpatient gets moved from the mental institution to a less restrictive environment that is accommodating to the type of care and support that the patient requires (Centers for Medical and Medicaid Services, 2014). Inpatient psychiatric discharge planning steps require developing a follow-up plan with the patient and all service providers. Include follow-

up psychiatric treatment and medication in the follow-up plan (Centers for Medical and Medicaid Services, 2014).

Service providers: These are individuals who offer service to others in exchange for payment (http://www.businessdictionary.com. 2017). US mental health workforce consists of individuals from core disciplines such as psychology, psychiatry, social work, psychiatric nurses, and family therapy (Robiner, 2006). Mental health service providers are defined by Baylor College of Medicine as assessment, diagnosis, treatment, or counseling in a professional relationship to assist an individual or group in alleviating mental or emotional illnesses, symptoms, conditions, or disorders (www.bcm.edu/pdf/e_mentalhealth_release, 9.12.05.pdf). The law defines mental health service providers as individuals, license or unlicensed, who perform or purport to perform mental health services, including "a licensed social worker, chemical dependency counselor, license professional counselor, license marriage and family counselor, member of the clergy, physician who practices medicine, psychologist offering psychological services and nurses who provide mental health services to patients" (www.bcm.edu/pdf/e_mentalhealth_release, 9.12.05.pdf).

Assumptions

There were four assumptions about this body of research. Methodological assumption consisted of the assumption made by the researcher regarding the methods used in the process of qualitative research (Creswell, 2007). The qualitative case study method was best suited for this study since it accommodates an in-depth account of the service providers' perspective via interviews about adolescent coping strategies

during and post-hospitalization. The qualitative methodology as it relates to the data collection was enough to answer the research questions of this study.

The second assumption was that the coping strategies adolescents acquired upon discharge from the psychiatric institution affected their integration into society. Research supports this assumption.

According to the third assumption, service providers were knowledgeable about the adolescent's coping skills learned during psychiatric hospitalization. Also, they were aware of what services were most therapeutic for the adolescents. I used an inclusionary criterion confirming that the participating service providers have worked in the psychiatric facility with the adolescents.

The last assumption was that the service providers interviewed reported the most pertinent and truthful information regarding the adolescent. I used IRB human subject's protections and appropriate interview procedures to ensure that the service providers rights were not violated. For example, participants were ensured confidentiality. I also, evaluated probes, interview and research questions to discover relevant information.

Scope

The extent of this research study was to explore the service providers' perspectives on coping strategies of adolescent clients learned during and applied upon discharge from long-term psychiatric care, as well as the effects of the coping strategies on the adolescent's integration into mainstream society. To narrow the scope, this researcher solicited 19 service providers from the tri-state vicinity of New York, New Jersey, Connecticut, 1 service provider from South Carolina and another service provider from Florida.

Delimitations for this study focused on service providers who worked with adolescents in long-term psychiatric care. Due to heavy caseloads and high turnover rates of staff members within the mental health field, participants were not always readily available. Service providers that scheduled time during or after work without interrupting their daily work output were selected as participants for this study.

Limitations

The first limitation of this study was that the target participants for this research were service providers who work with or have worked with adolescents in a psychiatric institution. Thus, the views obtained by this researcher were not the actual experiences of adolescents and coping strategies learned by adolescents from their personal perspectives. Nevertheless, the service providers' perspectives were important because they played a key role in helping adolescents cope during long-term psychiatric hospitalization and transitioning into the community. The second limitation was that there were few studies about adolescents' coping skills in psychiatric institutions and aftercare programs; there was even less research on the service providers' perspective on the adolescent patients' psychiatric behavior.

Significance

The potential contributions of this study are that it will advance knowledge in the social sciences and the understanding that if mental health institutions have effective therapeutic programming that teaches coping strategies to adolescents, their integration into mainstream culture will be more successful. There is a need to conduct extensive research to outline the service providers' perspectives on issues to determine the quality of care within psychiatric hospitals. Policymakers could benefit

from this study by conducting a reevaluation of the system of services that their institution provides to adolescents before and following discharge.

Summary

This study guided by the systems theory to understand service provider's perspectives on coping strategies for adolescent patients learned during hospitalization and coping strategies applied following long-term psychiatric discharge. The goal of the service providers was to educate the patients about their condition and teach them how to cope with their illness. Service providers also arranged for aftercare that will continue to support the adolescents in their transition into the community and, in turn, reduce recidivism. The multidisciplinary team arranged services that prepared the adolescent for medication management, daily living skills, therapeutic and crisis intervention. Thus, the role of the service providers was essential. Twenty-one participants answered interview questions relating to the research questions. I generated themes based on the service providers responses. Information derived from this study will assist in the development of appropriate psychiatric care to accommodate the adolescents' necessary requirements for a smooth transition into the mainstream population. There is a plethora of information on adult psychiatric patients from the service providers' perspective; however, there is a need for more empirical research on psychiatric care conducted at the level of adolescents (Pelto-Piri et al., 2012).

In Chapter 2, a review of the literature included research related to the topic of this study. The review included adolescents' rehabilitation offered by mental health organizations, aftercare services and coping strategies for the clients. Chapter 3 entails a comprehensive breakdown of the research procedures. Chapter 4 will comprise of

results pertaining to the research questions. Lastly, Chapter 5 summarizes findings, limitations, recommendations, and implications of this study.

Chapter 2: Literature Review

Introduction

The purpose of this qualitative case study was to explore the perspectives of service providers about the psychiatric experiences of hospitalized adolescents, their coping strategies and the aftercare services they used following discharge from long-term psychiatric care. The framework of the study was Finegood et al.'s (2012) systems theory. The population for this research was adolescents because existing mental health research has overlooked their vulnerabilities. Initially, Remschmidt and Belfer (2005) reported that that the severity of mental health problems among adolescents had not been recognized by the government, not only in the North America but even globally. Since the release of the report along with the plans, the mental health community has made significant progress in supporting adolescents' rights for care as mandated by the United Nations (Remschmidt & Belfer, 2005). However, Ptakowski (2010) argued that this issue remains a challenge for legislators, policymakers, and other advocates who remain unaware.

The systems theory is used in this research. The theory has been used in the public health arena where the parts of a system fit together to produce an outcome (Peters 2014). The theory is relevant to the psychiatric hospital system of care to help explain the interconnections between the needs, experiences, and the support systems that must be in place for adolescents' successful treatment outcomes. Significant and innovative opportunities may arise to improve the conditions of the targeted population.

Literature Search Strategy

For articles and other materials pertinent to the study, the following EBSCOhost (Elton B. Stephens Company) databases were used: Academic Search Complete, PsycARTICLES, PsycINFO, and SocINDEX. The number of research articles available for *adolescents* were 360,384 and were generated from articles and books, respectively. *Systems theory within health care* yielded 84 journals. The utilization of keywords such as *psychiatric hospitalization* produced seven items and the search of the literature based on *adolescent psychiatry rehabilitation of adolescents* produced 13 articles. *Integration of adolescents* yielded 98 articles, *adolescents psychiatric care* yielded 480 articles, and *perceptions of service providers* yielded 1,666. *Coping skills and psychiatric hospitalization, as well as inpatient coping skills training*, did not yield any articles. Keywords such as *aftercare coping skills training* yielded two items and *coping skills, and integration* had 388 articles and journals. A search for words such as *psychiatric treatment outcomes* there were 847 articles and journals. The search of the literature of *service providers in psychiatric care* had nine journal articles, one of which was not dated material. The researcher retrieved information about *service providers in psychiatric care,* with one out of nine articles dated 2014 and was appropriate to the literature review.

The studies provided was either dated, conducted in other countries or had little correlation to this research topic. There were no articles that referred to adolescents in psychiatric care on how they coped and integrated into the mainstream. This research study will fill the gap of knowledge by delving into the service providers perspective as it relates to the coping mechanism taught to the adolescent patients during and after long-term placement.

Theoretical Foundation

System theory is the chosen theoretical foundation for this study. To interpret the phenomenon of service provider's perspectives about the psychiatric experiences of the adolescents, coping strategies and aftercare services used by adolescents following long-term psychiatric discharge, a compilation of theories are applied.

A holistic approach is used to understand the underlying issues and solutions to the problem. Finegood et al. (2012) described systems theory as a complex scientific framework which employs large amounts of data to produce a depiction and development of a scientific system. The approach of systems thinking initiated by searching the causes and solutions of a complex problem by looking at the structure and function of the system. As opposed to traditional science, systems theory is more integrative and solution-oriented.

Systems theory has a direct correlation to the proactivity of public health in such a way that allows effective programs and policies to be developed in an institution by applying a holistic approach. Systems theory in public health relates to this current study by providing evidence for policy makers on the organizational level to generate programs within the hospital setting that will create a therapeutic environment for adolescents. Using such a holistic approach will thus allow the patients' needs to be met. The patients ultimately will gain the coping skills that will prepare them for a positive transition into society.

Outlined by Green and Fielding (2011) in an article written to display the disparities of developed versus developing countries and the responses to the public health system, these researchers stated that the United States health system exemplifies what developing countries should not do while making policies involving governmental health care. Identifying suitable treatment models for adolescent

inpatients “should become a routine part of hospital programs aimed at improving the patient’s quality of life” (Massimo et al. 2016, p. 16). They argue that the expenditure of monies allocated for health systems in this country have been misused. It is noted by public health experts that if a country wants to improve their public health system, it must invest in public and primary health. Despite this recommendation to invest, it is apparent that primary health care is not prioritized in underserved areas of the United States. Knowledge of the public health sector and the improvements of governing bodies are essential to meet local needs for both developing and developed countries (Fielding, Teutsch, & Koh, 2012).

Also, systems theory, in the context of this research, can be understood as the underpinnings of the health care system to achieve homeostasis (Noyes, Brenner, Fox, & Guerin, 2014). Health care systems are not progressive thus creating ineffective discharge. Systems theory uses evidence-based models to expose the systems as part of a whole. For the basis of this study, systems theory is utilized to look at the discharge process as well. The design of health systems and lack of communication creates a paradigm that makes the transition from the hospital to home a difficult integration process. Based on this theory about health care, researchers indicate that a positive relationship between the health care staff and the families of patients results in exceptional healthcare plans (Noyes et al., 2014).

Among the applied methods of systems theory in complex systems and public health, agent-based modeling is one of the most used (Finegood et al., 2012). This modeling system works by studying the behavior of agents within the system and looking as to how it affects the overall picture. Valente (2010) stated that this kind of modeling is ideal for representing the behavior of each in a detailed population.

Relating to the overall system, Gibbons (2007) showed how agent-based models are used to investigate the impact of network structures on distribution and implementation of information and policies throughout the health care system. Through this approach, issues of heterogeneous participators are addressed and interactions between policy and those who determine the scientific models to implement programs for an institution are explored (Elkins & Gorman, 2015).

Going back to Noyes et al.'s (2014) findings, they have identified five health system levels to evaluate successful transitions for children and adolescents from the hospital to home. These levels are (a) governmental policy, culture, leadership, and economics that may affect the transitioning from the hospital to home and or family; (b) legal and governance framework applied to children and families, care organization and delivery; (c) the hospital's care from which the child is discharged to families and homes; (d) primary care environment to which the child is discharged to the community itself; and (e) the family as a whole or parent's, guardian's, siblings and extended family. This current study using the service providers perspectives will be able to provide information about those levels of care that will deliver successful outcomes.

As previously stated, my research and Noyes et al. highlighted the importance of prevailing governing policies and framework. These policies and implementations relate to creating a system that will improve factors and construct an environment on the organizational level that will aim for parts of the system to respond accordingly and make essential changes that make this system function.

Lastly, the research also revealed that the continuum of governing policies should also work as a complete entity from the policy makers to the hospital staff to

create a cohesive environment in which the transition into the community is healthy for both the patient and their families. This health care system approach will model cohesion in the hospital and what the organization embodies (Noyes et al.,2014). This is important because creating a cohesive environment between inpatient to outpatient experiences for the discharged adolescent will ensure a successful transition into the community. A cohesive environment includes communication between family, community, hospital and school personnel; on and off unit therapeutic programs and the training of coping strategies for adolescents implemented by the hospital's service providers.

Literature Review

Empirical Foundation

Empirical foundation is a compilation of research articles and peer review journals pertaining to research that supports adolescents in psychiatric care, service providers interactions with these adolescents, implementation of coping strategies and aftercare services.

Psychiatric adolescents not properly equipped with coping strategies often return to the psychiatric facility. Readmissions are generally due to mental illness, poor social support, and poverty (Joynt & Ashish, 2012). Another factor leading to recidivism is poor aftercare services most presently a lack of communication between service providers, community resources, family and or guardian. The Psychiatric Intake Response Center (PIRC) also provides linkage to services in the community and specialized programs. A lack of post-discharge services is a risk factor for adolescents psychiatric repeated admissions, James et al. (2010), Blader, (2004). Adolescent inpatient psychiatric hospital experiences include the learning of specific

coping skills, staff to patients' interactions and peer interpersonal relationships. Outpatient experiences are pertinent to the success of a smooth transition into society. It is of great importance that community resources continue the training of the patients regarding when and how to use their coping skills effectively. Most of the adolescent psychiatric population readmitted to the institution are from the group and or foster homes. Structural factors play a significant part in increasing the risk of psychiatric re- hospitalization. Those living in foster care and congregate care are also more likely to be re-hospitalized (Romansky, Lyons, Lehner, West, 2003). Reasons for the "revolving door" are due to a lack of financial resources for a continuum of treatment and the inability to cope with mainstream culture. Broken homes, large families, low incomes, and deprived neighborhoods linked to recidivism (Contreras et al., 2011). This continuum of care is critical to prevent recidivism, or a readmission into the hospital. Most adolescent patients remain in a psychiatric institution, incarcerated, drug rehabilitation program and or half-way house. Readmission is often associated with severity of psychiatric illnesses, ineffective patient care, duration of hospital stays or failure in discharge planning, lack of adherence to outpatient care and follow-up processes. Other reasons for readmissions correlate to deprived community resources, lack of employment and inconsistent residency (AHRQ, 2014; Jones and Lien, 2002). Some researchers refer to re-hospitalization as the 'revolving door' (Machado, Leonidas, Santos, & Souza, 2012). The revolving door considered as the readmission process in which adolescents are discharged due to stabilization and return to the hospital because of their psychiatric condition changes, reoccurs or worsens. According to Arnold et al. (2003), 40% of all adolescents admitted to psychiatric inpatient hospitals are readmitted within the first year of discharge.

Therefore, the service providers perspectives on the preparedness of long-term psychiatric adolescents' integration are essential for this process and to assist in the reduction of recidivism.

Adolescents, at times, are court-ordered by the adolescent justice system to be admitted or readmitted to psychiatric hospitals as a plea for committing petty crimes. Judges feel that they can rehabilitate in a psychiatric setting as opposed to an adolescent detention center. In the hospital, they will receive individual therapy, group counseling, and medication treatment for their anger, criminal act and or violent behavioral issues.

Another factor associated with readmission is the quality of care provided by the hospital. Vigod, Paul, Kurdyak, Nathan, Kinwah, Lin, Taylor, (2014) conducted a study that evaluated the quality of long-term care as a correlation of readmission to the psychiatric hospital. Poor quality of care often leads to readmission.

In an observation, Vigod et al. (2014) posited that policymakers and administrators influence recidivism by allowing for easy return. Admissions and Readmissions of psychiatric patients generate revenues for hospital corporations. The money that hospitals get per patient determines the services rendered, programs implemented, and the type of insurance coverage offered. As discussed earlier in this current research, the optimum length of stay for patients in hospitals remains a debate.

The experiences of long-term adolescent patients in psychiatric institutions are influenced by various factors that derive from an individual basis. Govender and Penn-Kekana (2008) argue that the gap between the health service provider and patient regarding social background, gender and ethnicity is vital in the interaction between the two. This gap, therefore, is critical to the success or failure of the

treatment. Thus, before investigating and discussing the effects of system-level parameters, it is necessary to understand the conditions from the lowest levels so that the literary gaps on why adolescents struggle to cope with mental ailments can be fulfilled. The following sections describe how certain categories may influence the investigation of the topic.

Demographic Risk Factors

Race. Race may influence the psychiatric diagnosis and prognosis of adolescents. From a previous research study, having a diagnosis such as chemical dependency has a high population of White American adolescents whereas, adolescents with behavioral disorders are Black Americans (Mason & Gibbs, 1992). Eack and Newhill (2012) point out that this reveals a disproportionate issue among minorities in the mental health sector. They added that African Americans are the largest group receiving mental health services, and Hispanics are the second largest. They also revealed that for two years after discharge, African Americans experienced heightened psychotic symptomology as opposed to their counterparts. Significantly; White Americans were also more likely to seek aftercare services than African Americans and Hispanics (Eack & Newhill, 2012). Lastly, Lapointe, Garcia, Taubert, and Sleet (2010) found from their research on 664 adolescents that those with frequent readmissions to the hospital were generally of African American descent. These findings on the effects of racial factors should be considered by the policy makers when discussing the vision of service providers and adolescents.

Gender. Gender can also affect the quality of care on the psychiatric ward. The staff's attitude towards a sex can also influence the ways in which they are cared for due to biases that the staff may have (Horsfall, 1999; Krumm, Kiian, Becker,

2006). One important research study by Hingley and Goodwin (1994) focused on women in psychiatric hospitals and their perception of the way they look. From their findings on heterogeneous psychiatric wards, there is pressure for women to look their best as reflected in society. Therefore, women prefer to be in a single-sex unit where there is less pressure to look desirable. Men, however, do not seem to share the same philosophy and place less emphasis on their appearance. In long-term psychiatric care, patients were asked if this was an issue for them. Half of the females preferred single-sex units, and one-third of the men preferred single-sex wards. Although further research contended that most patients on the psychiatric ward enjoyed the contact they had with the opposite sex, 80% of patients with acute psychiatric symptoms who were not concerned with their appearances preferred single-sex wards (Hingley & Goodwin, 1994).

Sexual orientation. Coping with the acceptance of the adolescents' sexual orientation is a major factor for adolescents. Prejudice, ridicule, and discrimination towards the adolescents' sexual preference are coupled by the ignorance to the lesbian, gay, bisexual and transgender (LGBT) population within the society. These prejudices play an integral role in gender identity for adolescents at this critical juncture of life. Issues are amplified when dealing with sexual differences for adolescents with mental illness. Adolescents who are not confident with their sexual preference can become morbidly indulged and potentially dangerous, sometimes being fatal in a psychiatric setting (Davis, 2016).

Acute and severe diagnosis. The difference in the conditions between adolescents who suffer from severe mental illness and those who have acute ailments should also be considered. Patients suffering from severe mental illness require

rehabilitation and aftercare services (Rossler, 2006). The goal of psychiatric rehabilitation is to assist mentally ill clients in the development of intellectual, emotional, and social support systems that they need to integrate successfully into the community. Also, rehabilitation will provide support for clients so that they require the least amount of professional guidance upon the completion of treatment (Rossler, 2006).

The ultimate objective for rehabilitation provided by the service providers is for psychiatric adolescents to integrate into the mainstream culture and avoid recidivism. After long-term stays in psychiatric institutions, deinstitutionalization is not an option for severely mentally ill patients (Borgesius & Brunenberg, 1999). Long-term psychiatric care for adolescents with acute symptomology remain hospitalized because they might harm themselves or pose a danger to others in the community. In contrast, patients with less severe symptomology can remain hospitalized up to 14 days before being discharged (Borgesius & Brunenberg, 1999).

Social Challenges

This section discusses the social challenges encountered by adolescents from psychiatric treatments as they are discharged and transitioned back to real life environment outside of hospitalization. This integration is critical for the current research as it looks to identify the literary gap when it comes to the perspectives of the service providers in the mainstreaming process undertaken by adolescents. The systems model is applicable because it will help us understand the interconnections between the needs, experiences of the adolescent and the support systems that must be in place for successful treatment outcomes.

Studies such as that by Cutcliffe et al. (2012) refer to post-discharge as high risk. They state that a patient discharged from a psychiatric hospital, experiences disbelief and shock. These feelings attested to the fact that upon discharge, patients would ask questions such as “How will I survive?”, “Am I ready to integrate into the community?”, “Will I be safe?”, “Will I make suicide attempts?” etc. By understanding the factors that relate to these challenges, adjustments from the upper levels of the mental health system can expedite and ease the discharge process.

Stigma. Stigma is a relevant factor for clients returning home after a long-term stay in a psychiatric hospital. Patients experience the stigma and internalize it when they are not stigmatized. They feel as if their mental illness defines them. Wright, Avirappattu, and Lafuze (1999), found in their qualitative study of long-term psychiatric patients from Central State Hospital in Indianapolis that stigma eventually led to decreased feelings of control and mastery of their lives. They perceived that the stigmatization they were experiencing was responsible for their unsuccessful transition into the community. As a result, they began to suffer from extremely low self-esteem. The clients were projecting negative aspects of their mental health issues, which can lead to negative behavior and ineffective coping skills.

Kunitoh (2013) found in his study that institutionalized long-term patients reported higher social skills upon discharge, which gives hope that even long-stay patients could improve their social skills even after deinstitutionalization. Cutcliffe et al. (2012) attested that preparedness is the key to successful integration into the community and therefore, less anxiety for the patients discharged.

Family, peers, and gangs. Namysloaska and Siewierska (2008) discussed that the inclusion of the family was a deterrent to recidivism. This involvement prompted

them to believe that the incorporation of the family leads to positive outcomes. These outcomes may occur because the client and his or her family can resolve issues, become more informed about the client's mental illness, get information on how to comply with outpatient services and understand the importance of medication management. Therapeutic family models within the adolescent psychiatric unit are beneficial to the adolescent in numerous ways (Namysłowska & Siewierska, 2008).

The role of peer relationships is also critical in the development of the adolescent patient. While peer interactions can enhance the wellness of a growing child, these associations may have a negative impact on the behavioral problem. Deviant peer influences might offset desired positive effects. Peer pressure raises the need to understand this issue better in applying public health policies (Gifford-Smith, Dodge, Dishion, & McCord, 2005).

When adolescents returned to their communities, the stigma of being labeled "crazy," as discussed in the previous section, becomes an issue especially for those who have been in long-term psychiatric care. They may feel isolated and apprehensive about integrating into the community. Developing trust with peers in the community is uncommon due to the patient being shuttled back and forth between home and the institution. Outpatient services will address these issues and assist the client on ways to cope with these debilitating feelings.

Throughout this process, the effects of involvement in gangs become more problematic. Gangs serve as support systems for youngsters although their behavior is usually criminal by nature. They organize and provide the family structure that some individuals lack within their biological family. Gangs give adolescents false hope and security, and they usually target adolescents with low or no self-esteem or conscience

(Morch & Andersen, 2012). Being a witness to violence in the home or the streets is another indication that an individual might become involved in gang activity. Adolescents may also be born into gangs, their parent(s) or guardian(s) may be a gang member, and the child could simply be in the gang due to familial affiliation (McGloin & Piquero, 2009). Due to this inheritance, the vicious cycle of gang involvement is difficult to break. In the case of a child involved in a gang, this scenario may potentially threaten the complete recovery during the mental health treatment process. Adolescent gang susceptibility is a critical concern for discharge planning of psychiatric institutions.

Drug use. Illicit drug exploitation by psychiatric adolescents negatively impacts the healing process. Drug abuse is a factor that contributes to the psychiatric hospitalization of adolescents. The literature states that with proper support within the school system, these behaviors could deter the onset and relapse of drug abuse (McNeely & Falci, 2004). The support team includes peers, social workers, guidance counselors, teachers, administrators and safety officers. The literature on this issue is mixed; some researchers believe that although schools can assist adolescents to prevent such behaviors, they may not be able to control these problems with adolescents once they have already begun (McNeely & Falci, 2004). Sometimes adolescents become hospitalized for using drugs for the first time. Each adolescent reacts differently to drug abuse and may become psychotic, based on the physiological and biological makeup of the individual.

Suicide risk. One pertinent variable found in the literature is that some patients discharged from hospitals are at risk for suicide. Researchers discovered that there was a direct correlation between shorter lengths of stay and the likelihood of

committing suicide (Ho, 2006). From the study of Cutcliffe et al. (2012), patients admitted to mental health facilities for anxiety, stress, fear and were at risk for suicide upon discharge from the psychiatric institution. The participants for this study were 18 years of age and older who had a history of suicidal behavior and had become stable during their inpatient stay in the psychiatric hospital. The patients felt discomfort and anxiety after discharge because they were now responsible for caring for themselves while being integrating back into society (Cutcliffe et al. 2012). There is a need for hospitals to develop programs that address this issue.

In addition to adolescents who threatened to commit suicide, there were adolescents sent to psychiatric hospitals due to "cutting." Cutting is a disorder usually marked by an individual who is depressed. Some adolescents cut themselves for various reasons. Some adolescents report that they like the way it feels and looks. Researchers state that it is a cry for help and embodies an attention-seeking behavior (Davis, 2016; Masterson, 2010; Greydanus, 2011).

Psychotropic medications along with ongoing therapy are a successful treatment modality for youngsters who cut themselves. Antidepressant medications may be beneficial for adolescents who mutilate (Derouin and Bravender, 2004). Psychiatric staff complete room searches every shift to find items that can be used by cutters. In the psychiatric unit, those who cut themselves are on "eye contact." Eye contact is a term used to describe when a mental health associate must be in full view and arm's length of the adolescent. These techniques are required to deter the patient from cutting. Thus, the role of the service providers in monitoring and providing surveillance to inhibit these behaviors assumes critical importance.

Inpatient Experiences

Jones et al. (2015) emphasize the need for future research on the impact of primary care experiences. Positive experiences are important for the adolescent patient and are a key ingredient in building trust (Varicorlis, 2017). The inpatient experiences impact psychiatric outcomes (Ignatious, 2015). Thus, the systems model will help us understand the interconnections between the needs of the adolescent and the support systems that impact treatment outcomes.

Experience on the psychiatric ward. The adolescent's experience on the psychiatric ward can be perplexing. While it can produce positive outcomes, the adolescent does not view it as such initially. Patients stigmatized by the negative experiences cited by others and the connotations that if someone hospitalized for being mentally ill, then that individual is branded "crazy" by society. They look at the locked doors, quiet rooms and medication as the drawback of the hospital experience (Raney & Siegel, 1994).

Past studies showed that a shorter length of stay on psychiatric wards linked to psychopathology (Cohen & Casimir, 1989; Kirshner & Johnston, 1985). Outside of the US, Rocca et al. (2010) from Turin, Italy supported the correlation between length of stay and the severity of psychopathology. From data in Canada, Stewart, Kam, and Baiden (2013) noted that boys with a diagnosis of schizophrenia, mood disorders, eating disorders, personality disorders and intellectual disability are likely to stay longer. Individuals with higher levels of education stayed shorter and discharged against medical advice with a diagnosis of adjustment disorders. On the contrary, those with schizophrenia, mood disorders, and intellectual disabilities are predicted to experience frequent readmission. Thus, this study which focuses on this vulnerable

population is important; which are adolescents with long-term inpatient psychiatric experiences.

Recent studies about this correlation between adolescent stay in the psychiatric hospital and readmission, show a lack in the US. In 2008, Auffarth, Busse, Dietrich and Emrich when comparing the average inpatient stay for mental health patients found it to be significantly shorter in the USA than that of Germany. The researchers highlighted that this discrepancy might have been due to cultural differences. This current research considers this lack of study about this topic within the USA for possible investigation.

In implementing methods of system levels, inpatient psychiatric hospitals provide services that assist the clients with coping strategies and preparation for outpatient treatment. One positive strategy is to have flexible rules and teach the adolescents problem-solving skills through consistent therapy. Additional strategies would be to provide a rationale for procedures, use effective programs, disciplinary actions and policies administered by hospital staff that will lead to fewer anxiety issues for the involved patients (Moses, 2010). For adolescents to successfully cope with the stress they experience on the ward, two important goals need to be met: (a) they must exercise their ability to identify the problem clearly and (b) they must appropriately diffuse the incident by using coping skills learned previously or from the program implemented by the hospital.

Parent surveys reveal that some adolescents favored their experiences, particularly their interactions with staff and peers (Landers & Zhou, 2011). Their ability to compare situations without the propensity of being judged was one of the main components of these peer relationships. From the same survey findings, the

adolescents offered each other social, emotional, and instrumental support as well. This type of support rendered to adolescents who share the same experiences to facilitate social interactions as well as positive personal change (Landers & Zhou, 2011).

The study of Haynes, Eivors, Crossley, (2011) found that adolescents felt scrutinized and frustrated when admitted to a psychiatric ward for the first time. They felt a negative sense of self-worth and had the impression that the hospitalization was a mark against their social status. Overall, transitioning to the ward is a delicate situation for an adolescent patient.

Group Homes

Over the past 20 years, group homes for adolescents have been a substantial movement (Lorandos, 2014). Adolescents sent to group homes for being orphans, uncontrollable behaviors, committing crimes or misdemeanors. Currently, there has been a rise in the number of youngsters who are court mandated to group homes as an alternative to jail or juvenile hall. Lorandos (2014) stated that the group home offers an ongoing therapeutic alliance with the individual in hopes that rehabilitation occurs. The group home residents who repeatedly use drugs, act out violently, run away, hallucinate, hurt themselves, or believe their safety is in danger are admitted to a psychiatric hospital for stabilization. Once stable, the adolescents may return to the group home. There is an extremely high recidivism rate among adolescents who enter the hospital from group homes (Lorandos, 2014).

Coping Strategies

Hunter, Grealish, and Dowling (2010) stated that when adolescents have experienced long-term psychiatric hospitalizations, coping strategies determine their

success or failure. The framework of the systems theory (a set of connected things based on careful examination of facts) applies because of the interconnection of service providers teaching the adolescent coping strategies during and post hospitalization.

Empowerment is regularly espoused as a major element of successful service delivery and is central to recovery in mental health (Clearly and Dowling, 2009). Youth Matters (Department for Education and Skills 2006) is one of the government's coping strategies for empowering adolescents to shape the services they need, to promote their involvement and to support better choices. It also promotes a single point of contact for adolescents experiencing difficulties (Hunter et al. 2010). Grealish (2010) reports that adolescents with psychosis view empowerment as crucial to their recovery, quality of life and being in control of their illness and life. However, Grealish (2010) also reports adolescents felt disempowered by clinicians who did not communicate effectively, listen to their needs or effectively help them control and manage symptoms. These findings are supported by previous studies into adolescents, experiences with mental health services, in particular, work by Fraser and Blishsen (2007) and Worrall-Davies and Marino-Francis (2008). Barker and Whitehill (1997) maintain that empowerment depends on a number of key values that improve the person's situation and show that a better lifestyle is possible in their model, collaboration and participation are vital, with self-determination the ultimate goal, resulting in enhancement of the person's capacities. Focusing on a greater sense of empowerment may enable change by causing the individual to experience a sense of hope, excitement, and direction (Mason et al 2007). During the process of empowerment, adolescents with psychosis may discover the cause of their problems,

which may help them to cope and take action (Zimmerman 2000). However, adolescents cannot be empowered to contribute to their mental health treatment if the staff does not have effective communication skills (Cortes, Mulvaney-Day, Fortuna, 2009). Another important consideration is that an empowered adolescent may have little power in the political sense, but may have an understanding of the choices and decisions available to them in different situations. This does not mean that they will always make the right choices but they will be in a better position to respond to or disengage from services. There are a number of factors that encourage or limit empowerment that needs to be appreciated to understand the concept in relation to adolescents with psychosis. These are likely to include an adolescent's self-efficacy, coping strategies, and problem-solving skills.

The systems model can help explain the outcomes. That is, if the system of care is available to aid and enhance the development of coping strategies during primary and secondary care, the adolescents are more than likely to successfully integrate into the community. When clinicians listen to and value adolescents' thoughts, the latter develop a sense of autonomy and believe that with the proper outpatient services, they will become a successful part of society. Hunter et al. (2010) expressed theories for clinicians to follow to treat adolescents' suffering with mental illness properly. The two strategies are (a) for the clients to use their coping skills independently to manage their maladaptive behavior(s) and (b) to give clients choices for them to utilize while making decisions regarding their actions (Hunter et. al, 2010). This quote is referring to adolescent patients utilizing their coping strategies learned via service providers to assist the adolescents with maintaining appropriate behavior and making proper choices in mainstream settings.

The coping strategies learned in mental health facilities would build positive self-esteem within the adolescents and deter re-hospitalization. Hunter et al. (2010) and Simon and Savina (2010) studied the phenomenon that one of the hospital's goals is to treat the psychosis and then bring the client to a state of stability. Thus, it implied that meeting the goal of stabilization as an outpatient is not necessarily the hospital's priority. Clemens, Welfare, and Williams (2010) argued that the process of reintegrating back into school upon discharge from the hospital is a significant challenge for the adolescent. The Becker and Luthar (2002) study revealed that psychological issues such as behavioral, mood swings, hallucinating and suicidal ideations might drastically affect the client's ability to transition into the school community.

The research on reintegration into the school community after long-term psychiatric care is limited, according to Simon and Savina (2010). A study was conducted of the outcomes of all children and adolescents ($N = 114$) with serious emotional disturbance who had been placed by school districts in residential treatment facilities for educational purposes over a three-year period. Both cost and outcome analyses were conducted. Cost analyses indicated a total annual expenditure more than $5 million, or $80,000 per adolescent per length of stay. Outcome analyses, consisting of ratings of outcomes and outcome interviews with special education directors, revealed that 63% of the adolescents had either made no or minimal progress, had been discharged with a negative outcome or had run away. Positive outcomes were achieved in only 25% of the cases, measured by the students' return to school or placement into a vocational training program. Another 11% of the adolescent were making substantial progress. Analyses of the

relationships between outcomes and cost revealed no relationship. However, positive outcomes were associated with shorter lengths of stay. Further, students in the positive outcome categories had more severe functioning deficits at intake than students in the negative outcome categories. The availability of community-based services for the student and family was the single most likely reason reported by special education directors for positive discharge status (Hoagwood & Cunningham,1993). The process for re-entering school upon discharge from a psychiatric hospital should mirror the procedures that adolescents experience upon discharge from a non-psychiatric hospital (Clemens et al., 2010). The overall success of a smooth transition back into the school community is a function of effective communication between the service providers of the discharging institution, school personnel and parents or guardian.

Based on longitudinal studies, adolescents who have been in an inpatient psychiatric hospital are more likely than their peers to have troubles in school and a distressed adulthood. They also are more likely to participate in criminal behavior (Best, Hauser, Gralinski-Bakker, Allen, & Crowell, 2004). The ideal situation for adolescents who have been in long-term psychiatric care would be to have a social or community-based service provider facilitate their re-entry into school. School transitioning is a limited service that is usually left for the parents to accomplish alone. At times, parents are not knowledgeable about the procedures for gaining aftercare for their children who have been in a psychiatric hospital setting.

Again, applying methods of system levels, psychiatric hospitals provide services that support the adolescent patients with coping skills and preparation for outpatient treatment. One positive strategy is to have flexible rules and teach the

adolescents problem-solving skills through reliable counseling services. Additional strategies would be to provide a basis for procedures, use effective programs, disciplinary actions and policies implemented by the hospital's service providers that will lead to fewer anxiety challenges for the psychiatric adolescent patients (Moses, 2010). For adolescents to positively manage the pressures they experience on the ward, two imperative goals need to be met: (a) they must exercise their capability to recognize the issue clearly and (b) they must properly diffuse the incident by using coping strategies previously learned in a psychiatric institution. If the system of care works cohesively to identify, teach, and enhance the use of these coping strategies the patients will experience positive treatment outcomes. Therefore, the identification of the system of care from the perspectives of service providers is important (Das-Munshi et al., 2016).

In the Clemens, et al. (2010) qualitative study, the family, mental health, and academics of the adolescents are necessary variables assessed when he or she is making a transition from the hospital to school. Also, communication between the hospital staff and the school itself is essential. The implementation of the client's individual education plans (IEP) provided by the school district is pertinent for a smooth reentry into the classroom environment.

For a successful integration into the community, a strong relationship must exist between the adolescent and their parents or guardian; it also requires communication between the psychiatric institutions, schools and places of public gathering in the community (for example churches, recreational and counseling centers). Providers are liaisons between psychiatrist, hospital staff and families to assist the clients' successful integration into the community. Youngsters also need

outpatient services that will assist in medication management and therapeutic intervention as well as counseling. These support systems must be in place for the adolescent to integrate into society. Coping skills such as "asking for help, avoiding conflict, resisting negative peer pressure, following instructions and assertiveness defined" will assist with the mainstream process.

Medication

Medication compliance is a vital and essential component for the adolescents to learn before and after discharge. Their discharge may be affected if they are not compliant and aftercare services must provide the support and care.

The use of psychotropic medication for adolescents in state custody suffering from psychosis is growing steadily, according to the American Academy of Child and Adolescent Psychiatry (AACAP, 2012). Adolescents with emotional disturbances, mood disorders, and impulsive conditions use several prescribed medications for these conditions. Medication use is prevalent in state child care agencies, group homes, and psychiatric hospitals. Medications such as Clonidine and Guanfacine, antipsychotic and anticonvulsant medications and mood stabilizers are the ones used in psychiatric hospitals.

However, for this ongoing practice, the AACAP also recognizes that there are concerns about psychotropic prescribing practices particularly in safety and the quality post-treatment for both children and adolescents. As a regulation, AACAP recommends improvements and observed practices from the three categories of clinical practice; psychotropic medication monitoring, oversight, and research (AACAP, 2015).

Medical Coverage

In states, such as California, clients with private insurance stay an average of 8 days longer than those with public insurance (Mason & Gibbs, 1992). Some researchers argue that a diagnosis is not a criterion for hospitalization. Hospitalization is influenced by the type of insurance (Kirk & Kutchins, 1988). The affective disorder is the most common diagnosis of adolescents in California with private and public insurance (Mason & Gibbs, 1992).

The California study by Mason and Gibbs (1992) evaluated that a job with insurance benefits is given based on earnings. During that period, the results revealed that the median income for White families was $37,700; for Black families, the median income was $25,200; and for Hispanic families, it was $21,900 (California State Census Data Center, 1987). For the updated data in 2012, the relative rankings were almost unchanged with White families earning $69,150, Black making $42,339, and Hispanic taking in $45,680 (United States Census Bureau, 2016). Mason and Gibb's report cited that the higher the income, the better the health insurance, and the adolescent will optimize on inpatient and outpatient services. Thus, service providers perspectives on the length of stay needed for successful reintegration into the community is an important disclosure for the process.

Service Providers

Service providers are individuals who offer service to others in exchange for payment (http://www.businessdictionary.com/service providers. 2017). The following professionals provide mental health services to the adolescent population: Psychiatrists, psychologists, psychiatric nurses, social workers, family therapists, and direct care or mental health workers. Next are job descriptions and educational requirements of each professional service provider:

Psychiatrist – is a medical doctor (an M.D. or D.O.) who specializes in mental health, including substance use disorders. Psychiatrists are qualified to assess both the mental and physical aspects of psychological problems (http://www.pschiatry.org 2017). People seek psychiatric help for many reasons. The problems can be sudden such as a panic attack, frightening, hallucinations, thoughts of suicide, or hearing "voices". Or they may be more long-term, such as feelings of sadness, hopelessness, or anxiousness that never seem to subside or problems functioning causing everyday life to feel distorted or out of control (http://www.pschiatry.org 2017).

Psychologist -- someone who studies the human mind and human emotions and behavior, and how different situations effect people (www.dictionary.cambridge.org 2017). A psychologist is a person who has at least an undergraduate degree in psychology, which is the study of the human brain in terms of human behavior and personality (http://www.study.com 2017). Psychologist work in a variety of settings with individual patients, businesses, hospitals, clinics, schools, prisons, communities, government, the military, and many other capacities. Most psychologist jobs require advance degrees, such as master's or doctorate (http://www.study.com 2017).

Psychiatric nurse – the branch of nursing concerned with the prevention, care, and cure of mental disorder and their sequelae (a pathological condition resulting from a disease, a secondary consequence). It uses theories of human behavior as its scientific framework (http://www.everynurse.org. 2015). Some other activities of the psychiatric nurse include providing a safe therapeutic milieu or environment; working with patients or clients on the real day to day problems they

face; identifying and caring for the physical aspects of the patients problems including drug therapy reaction; assuming the role of social agent or parent for the patient in various recreational, occupational, and social situations; conduct psychotherapy; and providing leadership and clinical assistance for other nurses and health care workers (http://www.everynurse.org. 2015). Psychiatric nurses work in many settings; their responsibilities vary with the settings and with the level of expertise, experience, and training of the individual nurse (http://www.everynurse.org. 2015). Psychiatric nursing is also called mental health nursing (Mosby's Medical Dictionary, 9th edition. 2009, Elsevier.). To become a psychiatric nurse requires a blend of education and experience. The first step toward pursuing a career as a psychiatric nurse is obtaining the proper education. You first need to earn a bachelors or master's degree in nursing. While doing so you should also concentrate on taking several mental health courses. Once you earn your nursing degree, you will also need to pass the proper licensure examination to become a registered nurse or advance practice nurse (http://www.everynurse.org. 2015).

Social worker – There are many forms of social work and so a simple and concrete definition of social work is not easy to come by in a sentence or two. Instead, social work is a vast discipline that encompasses many modalities and methodologies. These far-flung occupations include everything from humanitarian rescue missions, to helping families gain access to government assistance, to the counseling of those who are near death and their love ones. A simple social work definition simply does not do justice to the myriad ways that social work touches the lives of people every day. The one thing this vast array of occupations has in common is that social work strives to better the lives of people whether at the individual, family, group, or societal level

(http://www.humanservice.edu.org. 2015). One aspect that all social work has in common is the intake or initial examination of both a client and their situation. This occurs at many levels from the intuitive to the thorough analysis of data that a client will provide. In the case of social work in a medical or counseling environment, this can take the form of diagnosis of mental conditions that are noticeable in the way the client presents. This can also take the form of a careful evaluation of a client's economic background in the case of a Family Support Worker trying to determine the eligibility of a family for government assistance period. The initial evaluation of client during the intake process is the first point of contact that allows the social worker to get their bearings to better serve the client. Being able to effectively diagnose the needs of a given situation is a critical skill in social work (http://www.humanservice.edu.org. 2015). Social work can also take on the form of acting in a counseling capacity. This can be as a mental health counselor (commonly called Licensed Clinical Social Worker or LCSW), a substance abuse or addictions counselor. In these forms, the goal of the social worker is to empower the client to be able to see their own inner strengths and build upon them so that they can overcome the challenges they are facing in their lives. All social work requires a high degree of empathy and excellent communication skills. However, the counseling sub-discipline of social work relies upon these even more heavily than other fields within social work (http://www.humanservice.edu.org. 2015). Social Workers at the entry level positions are required to hold at least a bachelor's degree in Social Work. Often states require that social workers obtain a master's in social work or a relevant doctoral degree for advance social work licensure (http://www.socialworklicensemap.com. 2017).

Family therapist – steps toward becoming a family therapist include earning a bachelor's degree, completing a master's degree program, acquiring clinical experience, passing the licensing exam, and completing continuing education requirements to maintain licensure (http://www.study.com. 2017). Family therapist help enhance communication and understanding among family members to remedy such problems as alcohol and drug abuse or marital stress. Treatment usually takes place over the course of 12 to 50 sessions and combines individual and family therapy. Family therapist work at mental health centers, hospitals, treatment centers, government departments and post-secondary institutions. They deal with clients who suffer from severe familial conflicts, so the job is stressful and demanding. Some therapist travel to patient's homes to administer treatment (http://www.study.com. 2017).

Direct care workers – assist individuals with their daily living, providing safety and comfort. Aiding people with a basic task such as bathing, dressing, grooming, and eating. Helping with home management tasks such as preparing meals, grocery shopping and cleaning (http://www.jobhero.com. 2017). Mental Health Workers (MHW) also called Psychiatric Technicians, provide basic care, therapy and assistance to patients with mental illness or developmental disability. Mental Health Workers generally work in a psychiatric hospital and residential mental health facilities. Mental Health Workers intake new patients and collaborate with other staff members to identify the issues patients are facing. They work together to develop treatment plans and strategies to best meet their needs. Mental Health Workers provide medication and other treatment to patients, under the instruction of doctors or nurses (http://www.jobhero.com. 2017). They must also be prepared to intervene in a

crisis and may need to restrain patients who may become physically violent. The Mental Health Worker must constantly supervise patients to ensure their safety and well-being. They observe patient behavior and keep meticulous records, reporting any changes in behavior or health to medical staff. MHW's plan and lead individual, family, couples, or group therapy to address patient issues. MHW's also develop and lead focused group activities. Direct Care and Mental Health Workers educational requirements consist of high school diploma, strong written and verbal communication skills, computer literacy and ability to conduct data entry, and working knowledge of clinical diagnoses for mental health population (http://www.jobhero.com 2017).

According to the World Health Organization's (WHO) Health assembly, employees represent half of the world's population and are the major contributors to global economic development (Stahl, Aborg, Tommingas, Parmsud, & Kjellberg, 2015). Because of the responsibilities placed on the service providers and related stress, access to health services is a factor determining service providers' health, in addition to workplace hazards and social and individual factors (Stahl et al., 2015). Occupational health services (OHS) have a key role in supporting the health and work ability of service providers in many settings (Hallonen, Atkins, Hakulinen, Pesonen, Uitti, 2017). Employers are a pre-requisite for effective OHS and healthy service providers (Peltomaki & Husman 2002; Saaranen, Tossavainen, Turunen 2005).

In the research article Pinto, Rochat, Hennink, Zertuche, and Spelke (2016) stated that the interviewed participants (service providers) emphasized that continuity of care was an extremely important component of care, and there is certain information you get from seeing a patient "over and over" again. Patients repeatedly

meeting with the same service providers is critical in developing a positive rapport. Thomas, Williams, Ritchie, and Zwi (2015) in their qualitative research article on service providers roles and responsibilities identified these four themes: Informal and formal ways of working, cultivating effective relationships, demonstrating cultural sensitivity, and forging strong leadership (Thomas et al., 2015). Many participants (service providers) felt that communicating informally facilitated collaboration and relevant information about shared patients was exchanged opportunistically. Service providers in the focus groups noted that clients were comfortable with the informal setting in the community and that communication was sometimes easier outside the formal or structured setting (Thomas et al., 2015). While it was agreed that these informal methods were important and practical, it was also agreed that some health care service providers were maybe "left out of the loop", particularly if they were not co-located or did not have access to the patient record or email related to the care plan. Some service providers agreed that having an identified case manager and formal meetings would be useful in sharing information and planning the care of children (Thomas et al., 2015). Regarding cultivating effective relationships; there was general agreement from service providers that effective relationships were central to partnerships. For most service providers, partnerships meant teamwork, collaborating to achieve common goals, and cultivating equal relationships (Thomas et al., 2015). When working in an effective relationship with colleagues, health care workers felt supported and able to improve their own skills and knowledge. There was an agreement that effective relationships "cast a wider net" improving access to early intervention services for more children who would benefit from a broad range of services, with better health outcomes as a result (Thomas et al.,

2015). Most service providers commented on those personal traits that supported effective relationships including willingness, persistence, commitment to problem-solving, a non-judgmental attitude and listening skills.

Most service providers in the focus groups said that it was the person rather than the position that was important (Thomas et al., 2015). Some service providers commented that working collaboratively requires time and commitment, and with potentially ineffective team dynamics, there could be "more pain than gain" in the end. Some participants express lack of clarity about the inter-professional relationships between services including the roles and responsibilities held by different health care service providers (Thomas et al., 2015).

Demonstrating cultural sensitivity was deemed important by the service providers. Examples of partnership with the community included the adoption of a culturally appropriate model of care that recognized the widespread ethnic value of a comprehensive approach to health and wellness, allowing more time for consultations, more time for listening and more opportunity for follow-up than would normally occur in the outpatient setting (Thomas et al., 2015). Culturally sensitive consultation with the community was a corner stone of this model and helped ensure that service was accepted and utilized. This occurred through established meetings with community representatives (Thomas et al., 2015). Service providers discussed additional strategies, which help ensure that staff worked in a culturally acceptable way with families and the communities. These included a comprehensive orientation period, which provided a range of information about the way the team "does business", consistent supervision, support, modeling and mentoring. Some service providers raised the importance of trust and confidentiality while working in a small

community and that attention was required to ensure that breaches were avoided (Thomas et al., 2015).

The last theme, forging strong leadership was identified by many participants as being important in the conception of the service, adoption of a culturally appropriate model and in consolidating the values or philosophy of the department. Leadership was having not only the responsibility and the vision but also the authority and the resources to implement this vision in the short and long-term plans. Support for leaders from top tier managers was felt to be an enabling factor in the collaboration between services (Thomas et al., 2015). Several participants noticed that partnerships are very political and that problems between services can impact negatively on grassroots service providers who can feel like the "meat in the sandwich". Managers commented on complex funding arrangements that were short term, irregular, confusing, difficult, and time-consuming to secure. This was a significant barrier to on-going collaboration with other services and the community (Thomas et al., 2015).

While managers describe formal meetings between relevant services as a way of forging partnerships between services, there was a general feeling that meetings took up a lot of time and were often fraught with conflicting agenda, and lack of shared vision and long-term objectives. Some service providers indicated that meeting across services were often characterized by inadequate leadership from higher levels but that there had not been a recognized need to address this. One service provider expressed it concisely, "so, its structure, leadership, money and time". "That's all you need" (Thomas et al., 2015).

Summary

The experiences and coping strategies of long-term adolescent clients in psychiatric care are influenced by demographic factors, social challenges, and inpatient experiences. These variables assist in understanding the level of recidivism. The level of recidivism, however, is an unforeseen phenomenon that can be evaluated on an individual basis. Several studies support the incidence of high rates of repeated hospitalization. This research study will fill the gap in the knowledge by delving into the service providers' perspective as it relates to the coping strategies taught to the adolescent patients during and post long-term psychiatric hospitalization. This gap has been acknowledged by Stiffman et al. (2001) who ask for more research considering the service providers perspectives in predicting the use of services as well as the perspectives of service providers to identify discrepancies in across primary and secondary care (Das-Munshi et al., 2016). Massimo, Rossoni, Mattei, Bonassi, and Caprino (2016) also indicated that research on improving the quality of life of adolescent patients is generally underrepresented.

Adolescence is a discovery period as well as an exciting time that paradoxically can be a time of turmoil. Some children whose experiences plagued with trauma may develop depression, bipolar depression, suicidal ideations, behavioral problems, and many other psychoses. Suggestions from researchers include hospitals having a multidisciplinary team that assists in formulating an aftercare discharge plan. This multidisciplinary team of nurses, social workers, psychiatrists, psychologists, and direct care or mental health workers should assist in implementing the outpatient services for this fragile population.

The quality of mental health care is dependent on policymakers and the input of full-time certified service providers who can meet the therapeutic requirements of

the adolescent patient. Consistent therapy, medication compliance, follow-up appointments and aftercare services are significant deterrents of recidivism. It is not known how the experiences of the adolescents during and post-hospitalization facilitate the integration of the adolescent into the mainstream culture. And these experiences of the service provider perspectives are more valuable in predicting the use of services and resources by adolescents having mental health problems (Stiffman et al., 2001). I will explore the perspectives of service providers about the psychiatric experiences of the adolescents, coping strategies and aftercare services used by adolescents following long-term psychiatric discharge.

Further explorations of the research methods are detailed in Chapter 3.

Chapter 3: Research Method

Introduction

The purpose of this qualitative case study was to explore the perspectives of service providers about the psychiatric experiences of hospitalized adolescents, their coping strategies and the aftercare services they used following discharge from long-term psychiatric care. The framework of the study was Finegood et al.'s (2012) systems theory.

The input of service providers allowed for a comprehensive understanding of the process of integration of adolescents back into society. This research study explored this phenomenon and will bring awareness to the institutions' coping strategies (ask for help, follow instructions, medication compliance, avoid conflict) instilled in the adolescents that will, in turn, provide them with an opportunity to be successful in the mainstream culture. Aftercare programs provided adolescents with therapeutic services such as counseling and crisis intervention and encouraged support for their families.

This chapter includes a brief introduction to the role of the researcher and an in-depth discussion on the methodology of the study. It concludes with issues of trustworthiness that strengthen and validate this qualitative study. The following research questions were also developed to reinforce, support and validate my research.

RQ1. What are the perceptions of service providers about the coping skills learned by adolescents who have experienced long-term inpatient psychiatric care?

RQ2. According to service providers what is the role of the inpatient psychiatric hospitalization and aftercare experience of adolescents in the acquisition of coping strategies?

RQ3. According to service providers how do adolescents who have experienced long-term inpatient care use coping skills to integrate into mainstream society?

Research Design and Rationale

This study utilized the qualitative case study design. Although the research conducted by Baxter and Jackson (2008) is dated, it provided an extensive look at the intrinsic value of using a qualitative case study as a research methodology. Baxter and Jackson (2008) claimed that a qualitative case study is a valuable method for health science research; it can be used to develop a theory, evaluate programs, and develop interventions. This study on service providers' perspectives identified elements in the system that will facilitate adolescents' transition into the community following discharge after long-term treatment. The premise was that effective therapeutic programs in the psychiatric institution would promote a healthy, uneventful transition back into society.

Within the tradition of the research approach, both Yin (2003) and Stake (1995) base the approach to the case study design on a constructivist paradigm. A constructivist claim that the truth is relative and is dependent on one's perspective (Baxter & Jackson, 2008). (Stiffman et al. 2001) have confirmed the importance of the service providers perspectives and the knowledge of the mental health resources. Within the tradition of the qualitative case study design, the perspectives of service providers supported the importance of this paradigm relating to the individual

(adolescents) coping strategies and how it relates to integration into the society as their coping skills were a supportive factor for this transition.

Yin (2003) stated that the qualitative case studies allow the researcher to explore individuals or organizations through complex interventions, relationships, communities, and programs. Qualitative case studies support the breakdown and then the reconstruction of adolescents psychiatric coping strategies and aftercare services. Case studies provide an understanding of interventions that are feasible and flexible (Baxter & Jackson, 2008). This researcher researched an understanding of adolescents and the coping skills acquired during their stay in a psychiatric institution. Open-ended and probing questions guided the participants to gather the most pertinent and in-depth responses to support the phenomenon. Yin (2003) stated that in case studies the questions should not be broad to avoid losing sight of the intended research.

Role of the Researcher

This researcher's role was to develop themes generated from the interviews that explained the experiences and coping strategies of adolescent clients who have experienced long-term psychiatric care. How the coping strategies learned during hospitalization affects their integration into society is also an extension of the phenomenon. Also, this researcher evaluated generated themes from the results of the NVivo coding system.

This researcher worked in a residential treatment setting with adolescents as a direct care or mental health worker, a psychiatric hospital as a psychological test administrator as well as a school psychologist in the public-school system. Within these varying positions, this researcher witnessed many positive rapports that developed between the adolescents and the service providers through consistent

counseling, therapeutic programs, and appropriate role modeling by the service providers. Because of the relationships between the service providers and the adolescents the service providers perspectives were key as it relates to the coping mechanism taught to the adolescent patients during and post long-term placement.

I followed the procedure and guidelines for all relevant permissions required by the Walden University Institutional Review Board (IRB). The IRB authorizations was attained and accessed for their insight. During the progression of my academic experience at Walden University, I have completed the National Institutes of Health (NIH), a web-based training certification course on "Protecting Human Research Participants". This process highly prepared me on how to interview participants while keeping in mind the American Psychological Association (APA) guidelines and Ethical Principles for the Treatment of Human Participants.

Under the guidelines of the Institutional Review Board (IRB), adolescents are a "protected population"; therefore, I interviewed service providers who have worked with or who currently work with adolescents in the mental health capacity. Through consistent time spent on observation, the service providers developed an understanding with the adolescents and therefore acquired pertinent information that was critical to my research. Furthermore, Stiffman et al. (2001) demonstrated through structural equation modeling that the client model only (when the clients were asked about the use of services) explained 24% of the variance in the use of services whereas the provider model (when service providers were asked about the use of services) accounted for 55% of the variance in the use of services.

This researcher did not have any professional or personal relationships with the participants. There was no conflict of interest within the study. This researcher has

worked with adolescents in the past; however, there were no biases due to the environment in which the interviews took place and the responses submitted. The questions and answers procedure happened in a natural environment; there were no correlations between the researcher's work environment and the environment of the interviewees'.

Methodology

Participant Selection Logic

The participants were five different types of service providers, who provided information about the adolescents they serve at the psychiatric institution. This researcher contacted twenty-one service providers from five categories who agreed to participate. Thus, twenty-one participants provided five different perspectives. Participation in this study was voluntary. The recruitment process of participants included presenting the study and its components by word of mouth, provided service providers with the pertinent documentation from the IRB, met with the partakers and a face-to-face or phone interview. Additionally; this researcher placed flyers around psychiatric institutions and recruited participants in that manner.

Instrumentation

Creswell (2009) suggested that issues may arise during a study. These issues can include but are not limited to access to the participants, a collection of information, and the researcher may experience ethical issues. The Walden IRB determined the researcher's qualitative case study is ethical. The protocol approved by the ethical principles of the American Psychological Association (APA) were utilized. Before the researcher proceeded an assessment of the questions were conducted, so there is no potential of causing any psychological harm to the participants.

Table 1 provided information about the questions and probes that guided the service providers interviewed. The researcher was the sole data collector. The frequency of interviews depended on the service providers work schedule and availability. The computer software program NVivo coded the results. The program has seven text search tools including keyword search, section retrieval, along with query by example, a search tool that learns from the user and a cluster-exacting tool. It is also a flexible program for coding retrieval.

Procedures

Participants solicited by the researcher comprised of service providers from psychiatric institutions. The participants must have worked in long-term adolescent care at the psychiatric institution. The make-up of the participants included mental health service providers such as; direct care workers, social workers, psychiatric nurses, psychologists, and psychiatrists. This diverse set of participants provided multiple and varied sources of information needed for a case study.

Participants signed informed consent forms and read a detailed explanation about the confidential study. The signed consent forms provided this researcher with information regarding the service providers credentials and years of experience in the mental health care sector. The participants answered the research questions, sub-questions, and probing questions. The participants provided the best source of information based on their experiences of the adolescents' hospitalization and coping strategies learned by the psychiatric adolescent during and post long-term psychiatric hospitalization. The open-ended questions assisted the researcher in compiling a reference point to the exploration of the study (see Appendix B). The questions focused on the adolescents' experience in the psychiatric institution and the coping

strategies they cultured in the context of the therapeutic environment. The data was coded using NVivo software for qualitative data. NVivo computer coding system manufactured by QSR International is a deep level data analysis tool used in qualitative research; it collects and organizes data on small or large volumes of data (www.qsrinternational.com/nvivo/nvivo-products/nvivo-11-for-windows). Validation checks such as reflexivity, thick, rich descriptions, member checking, and peer review was used.

The procedures for the recruitment and participation process was obtained by first gaining approval (approval # 12-21-17-0058255) from the Institutional Review Board (IRB). The recruitment procedure is called "snowballing." "Snowballing" is a word-of-mouth process (Biernacki & Waldorf, 1981). Snowball sampling utilized individuals who have similar interests to inform each other. Participation was voluntary, and the service providers were informed that they could withdraw from the study at any time. The researcher interviewed the service providers individually.

Method of Inquiry

This qualitative case study focused on the perspectives of the service providers about the psychiatric experiences of the adolescents, coping strategies and aftercare services used by adolescents following long-term psychiatric discharge. The multiple data points provided by twenty-one different service providers whose professional titles were direct care workers, social workers, psychologist, psychiatric nurses and psychiatrist. The quantitative strategy cannot answer these research questions.

The quantitative methodology assumes a fixed and measurable reality that involves the collection of data in a numerical form (Minichiello, 1990). The quantitative method discovers the factors of a social phenomenon and reports the

results via graphs and tables of raw data using mathematical explanations to validate the topic of research. The quantitative methodology utilizes closed questions, rating scales and other mathematical units of measurement. The conceptual process of a quantitative study uncovers facts about a social phenomenon by assuming a fixed and measurable reality (Minichiello, 1990). This study did not involve numerical data of outcomes and associated statistical analysis. This study intended to instead understand the psychiatric experiences and coping strategies of adolescents during and post long-term psychiatric care from the service providers perspectives. For such an understanding, the quantitative method was not appropriate for this research.

Conversely, the qualitative research method studies human behavior and habits (McLeod, 2011). A qualitative study asked how, what and why individuals behave in a specific manner. This qualitative research method utilizes interviews to explore processes that are difficult to replicate. Creswell, (2007) alluded that qualitative research is a necessity in making societal changes. This previous statement was a direct correlation to this body of research because the researcher explored coping strategies and how it can affect an adolescent's transition into society which supports the social change theory.

Phenomenology, narrative research, ethnography, grounded theory, and case study were the five approaches of qualitative inquiry and research design (Creswell, 2007). Phenomenology is a form of inquiry that relates to the individual and their experiences that shape their behavior. However, this study explored the essence of the lived experiences of the adolescents directly; rather, this research explored the perceptions of the service providers who have worked with this group (Creswell, 2007).

The second form of qualitative inquiry was the narrative research strategy. With narrative research, the focus is on exploring the life of an individual with stories used to depict the individual experiences. This research did not develop a narrative of the individual's life; thus, this strategy was not appropriate (Creswell, 2007).

The third form of qualitative inquiry was ethnography. Ethnographic research requires the researcher to spend several hours in the field collecting data based on their observations to produce detailed and pertinent information related to sharing patterns of a cultural group (Yin, 2002). This research did not describe how a culture-sharing group works, but rather focused on developing a detailed analysis of one or more cases.

The fourth form of qualitative inquiry was grounded theory. Grounded theory involves data collection via video, text, and observations, with the data inserted into conceptual categories for the researchers to generate a theory. This research did not generate a theory but used multiple sources to develop detailed analyses of cases (Creswell, 2007).

The final and selected form of qualitative inquiry and research design was the case study method. The qualitative case study data collection involved an array of procedures as the researcher builds an in-depth picture of the case (Creswell, 2007). These procedures included direct observation, interviews, documents, and participant observation (Yin, 2002). The case study technique was the most effective process to interpret interviews, handwritten notes, and captured perspectives of service providers.

In this case study, the qualitative research tradition led to the description of the experience of multiple individuals. The general theme(s) generated were based on the

findings that will support the nature of this qualitative study. According to Yin (2002), a case study as a research strategy comprises of and evaluates phenomena that may have several outcomes based on data retrieval and logic. Evaluation of a case study has five different applications. The most important factor is to describe, illustrate, and explore meta-evaluation (Yin, 2002). Case study as a research methodology is a way of investigating an empirical topic by following a set of pre-specified procedures (Yin, 2002).

Within this case study, the researcher conducted in-depth interviews and utilized the journaling technique. Journaling assisted the researcher in having documentation of the participants' responses during the interview. Clandinin and Connely, (2000) suggested that collecting field texts through a wide array of sources. The sources included; autobiographies, journaling, researcher field notes, letters, conversations, interviews, stories of families, documents, photographs and personal artifacts.

Creswell (2007) stated that the important point is to describe the meaning of the phenomenon for a small number of individuals who have experienced it. Adolescents aged 13–18 who have experienced long-term psychiatric care and either returned to hospitals or integrated successfully into the community were the central focus of the service providers' response in their interviews. The rationale for selecting the intrinsic case study was the explorative nature of this study and how it relates to a system (adolescent patients in a psychiatric setting). Creswell (2007) stated that the intrinsic case study is when the researcher has a clearly defined case, and the focus is the case set in an unusual context. This study described and explored the perspectives of the service providers about the psychiatric experiences of the adolescents, coping

strategies and aftercare services used by adolescents following long-term psychiatric discharge. The service providers that work with these adolescents were psychiatrists, psychologists, psychiatric nurses, social workers, therapists, and direct care or mental health workers as well as those professionals that work with the adolescents in the aftercare process. Again, the intrinsic qualitative case study was appropriate for this study because there is a lack of research on the phenomenon that this researcher intends to explore.

Sampling

A small sample size from each category of service providers, twenty-one in total, provided an understanding of the experiences of those adolescents in long-term psychiatric hospitalizations via service providers. According to Creswell (2007), saturation occurs when participants' responses replicate existing themes. Saturation occurred with participants 11-15.

Qualitative researchers typically use purposive sampling however due to the nature of this study criterion sampling was the best approach. This concept uses characteristics of subgroups (Patton, 1990) such as service providers who have been in contact with hospitalized psychiatric adolescents for a minimum of 6 months. Criterion sampling involves the participants who have similar experiences telling their story about the main theme and the calculated phenomenon (Creswell, 2009).

Data Collection

The following interview protocol was used for asking questions during a qualitative interview. This protocol included the following components:

- Heading (place, interviewer, interviewee)

- Directions for the interviewer to follow so that standard procedure is used from one interview to another.
- Probing questions (questions that the interviewer asks the participants which will elicit a response in relation to the interview questions).
- Spaces in between questions to record responses.
- Researcher records information from interviews by making handwritten notes.
- Secondary material or second-hand accounts of the subjects (service providers perspectives on adolescents).
- Documentation on the reliability and validity of the data source and participants interviewed. The data collection process involved a thorough face-to-face or telephone interview (see Appendix B). These interviews were used to explore the psychiatric adolescents' experiences. McCracken (1988) concluded in his study that the process of a qualitative study should contain at least five individuals and the researcher will utilize in-depth interviews that will support the findings. A thematic analysis (NVivo) was conducted to identify common themes and emerging theories. Extensive interviews were the major components of this qualitative study. These interviews provided detailed psychiatric experiences of adolescents based on the participants' responses.

Participants

The diverse set of service providers provided the multiple data points for this study. Direct care workers, psychiatric nurses, social workers, psychologist, and psychiatrist were the service providers who provided information about the

adolescents they serve at a psychiatric institution. Again, this researcher contacted the service providers who agreed to participate voluntarily. Participants signed a written explanation of the study, informed consent and confidentiality forms. The researcher read interview and probing questions to the participants. Also, the participants provided the best source of information based on their experiences of the adolescents' psychiatric hospitalization and coping skills upon discharge. The open-ended questions assisted the researcher in compiling the themes of the study. The questions related to the adolescents' experience in the psychiatric institution, the coping strategies in which they learned in the context of the therapeutic environment and aftercare services.

Data Security

The research results were placed in a locked box in the researcher's home office. The researcher will maintain the documentation of this study for five years as per Institution Review Board. All names were concealed to ensure confidentiality. Again, a confidential agreement was signed to ensure that the respondents' answers are valid, and the adolescents' privacy protected.

Data Analysis Plan

With the themes formed from the interview process, this researcher evaluated the clusters of meaning (Creswell, 2009). The significant statements and results of the face-to-face interviews and; telephone interviews revealed the experiences of the participants working with adolescents in psychiatric hospital settings. Then the researcher generated the textual descriptions by evaluating the data and writing a report of what the participants experienced while working with the psychiatric adolescent patients. The data was coded using the NVivo software that allowed the

researcher to eliminate any biases and objectively evaluate the data. The NVivo software also allowed the researcher to organize and identify themes in this study. Further information regarding security discussed under the Issues of Trustworthiness section.

Issues of Trustworthiness

Reflexivity

The use of journaling (reflexivity) after each interview to capture the researcher's observations was helpful in identifying researcher bias and preconceived notions in the research process. Sullivan (2002) stated that reflexivity is used to control the researcher's biases. Reflexivity also moderates the researcher's judgment and the absence of perceptions, interest, while refraining from limiting the researcher from interpreting data without bias (Sullivan, 2002).

Thick and rich descriptions

Thick (detailed description) and rich descriptions are described by Lincoln and Guba (1985) as a means of achieving validity. Thick descriptions provide enough context so that a person outside the culture can make meaning of the behavior (Geertz, 1973). In this qualitative case study, the researcher described the responses in sufficient detail. These quotes thoroughly described the research context and assumptions that are central to this study.

Member checking

Member checking was an additional form of credibility within this research study. Lincoln and Guba (1985), described this technique as the most critical validation of a research study. The process of member checking requested the participants to express their views on the interpretations of findings within the study

(Ely, Anzul, Friedman, Garner, & Steinmetz, 1991; Erlandson, Harris, Skipper, & Allen, 1993; Glesne & Peshkin, 1992; Lincoln & Guba, 1985; Merriam, 1988; Miles & Huberman, 1994). It allowed the participant the opportunity to determine if the information is correct and intended. Also, it gives the participants the opportunity to make changes to the reported information. In this process, the respondents assessed the accuracy of the data before confirmation of the data (Cohen & Crabtree, 2006). Lastly, it is also a tool within the research process that gives the research study, supportive information from the respondents. Due to the abundance of participants (twenty-one) the member checking method of synthesized analyzed data was most fitting for this research. Debriefing took place with the participants to maintain continuity with ethical procedures put forth by this researcher.

Peer Review

The study utilized the validation strategy of peer review. This process noted by Creswell and Miller (2000) is when the researcher consults an expert within the same field of psychology who judges the quality of the research study. This researcher approached a colleague from the dissertation course who completed the qualitative research methods class to examine, evaluate and constructively critique this entire dissertation exploration. The peer reviewer determined the themes were like those extracted by the researcher. The peer reviewer ensured the validation of this researcher's study and contributed to the reliability of the case study. The peer reviewer stated they were no themes overlooked within the study.

Ethical Procedures

This researcher followed the ethical principles and guidelines of the American Psychological Association (APA) standards and Belmont Report for the protection of

human subjects of research. The basic ethical principles were informed consent which is respect for persons, subjects must enter the research voluntarily with adequate information, maximize possible benefits, minimize possible harm, subjects can decline to continue at any point of the research, every person should be treated fairly and equitably while bearing the risk and benefits (http://www.apa.org./ethics/code 2017). After gaining approval from the IRB, the researcher collected data via interviews designed for the service providers. The researcher questioned service providers who have worked with adolescents regarding the adolescents' psychiatric experiences, coping strategies and aftercare services used by adolescents following long-term psychiatric discharge. Names of adolescent psychiatric patients encrypted to ensure confidentiality. The researcher extracted data from twenty-one participants. No participants withdrew from the study, therefore possible supplementary participants were not used.

Summary

Chapter 3 described the methodology of the research study. The qualitative method was chosen for this case study versus the quantitative method. Other approaches described but not selected were phenomenology, narrative research, ethnography, and grounded theory. Through exploration, perspectives of the service providers created a vivid picture of the adolescents' psychiatric experiences, coping strategies learned and applied during and post hospitalization. The results of this qualitative case study will be used to inform psychiatric hospital administration of effective implementation of coping strategies programs and aftercare services that will assist adolescents for a smooth transition into the community.

The succeeding chapter, Chapter 4, will discuss the results of this qualitative case study based on, the interviews, themes generated from the responses of the service providers and NVivo codes.

Chapter 4: Results

Introduction

The purpose of this qualitative case study was to explore the perspectives of service providers about the psychiatric experiences of hospitalized adolescents, their coping strategies and the aftercare services they used following discharge from long-term psychiatric care. The framework of the study was Finegood et al.'s (2012) systems theory. Systems theory is a set of connected parts based on careful examination of facts. In this qualitative case study, systems theory was relevant because, fundamentally, it is an innovative approach whereby parts of a model fit together to develop a probable outcome (Peters, 2014). In the health care sector, such as a psychiatric hospital, a systems model helps explain the interconnections between the needs of the adolescent and the support systems that must be in place for successful treatment outcomes. Furthermore, this information, as established from the service providers' perspectives, can help in the development of policy-based interventions that may improve the coping strategies that adolescents attain for a successful transition to mainstream society. Systems thinking proposes to increase the quality of perceptions by considering the entire system of care for adolescents experiencing psychiatric hospitalization, its parts, and the interactions within and between levels (Peters, 2014).

The interview questions and probing questions were incorporated to answer the following research questions:

RQ1. What are the perceptions of service providers about the coping skills learned by adolescents who have experienced long-term inpatient psychiatric care?

RQ2. According to service providers what is the role of the inpatient psychiatric hospitalization and aftercare experience of adolescents in the acquisition of coping strategies?

RQ3. According to service providers how do adolescents who have experienced long-term inpatient care use coping skills to integrate into mainstream society?

This chapter covers the following topics: the setting, the demographics of the participants, data collection, data analysis (triangulation and NVivo), evidence of trustworthiness (including member checking and peer review), results of the interviews, and a summary.

Setting

The interview process took 30-60 minutes. I interviewed at least one service provider from each group of psychiatric professionals for differentiation in saturation. The interviews were conducted face to face at the participants' professional office or home, face to face at the researher's house and most of the interviews via phone at the participants' convenience. The location and or background scenery was calm and private. The climate of the environment is important to note for confidentiality and an atmosphere that is comfortable for the participants to feel hassle-free.

Demographics

For this qualitative case study, the researcher solicited participants using the snowballing technique known as "word of mouth." The researcher and informed service providers asked colleagues, friends, family, present and former co-workers about being interviewed for this research study. The name of the service providers, adolescent subjects and workplaces are encrypted for confidentiality. Charted below

is a brief synopsis of the participants interviewed. The service providers interviewed are listed in sequence from highest educational level to the lowest educational level generally speaking.

Table 1

Participant Characteristics

Participant	Title	Years of experience	Age in years	Race/Gender	Pages of Interview Transcript
Participant 1	Psychiatrist	33	>65	White male	3
Participant 2	Psychiatrist	40	>65	White male	3
Participant 3	Psychiatrist	17	45	White female	3
Participant 4	Psychologist	14	44	Black female	3
Participant 5	Psychologist	38	>65	White male	3
Participant 6	Psychologist	16	47	Black female	2
Participant 7	Psychologist	7	35	White female	3
Participant 8	Psychologist	41	>65	White female	3
Participant 9	Social Worker	17	44	Black female	3
Participant 10	Social Worker	20	45	Black female	3
Participant 11	Social Worker	26	50	Black female	2
Participant 12	Social Worker	40	>65	Black female	3
Participant 13	Social Worker	35	>65	White female	3
Participant 14	Social Worker	15	50	Hispanic female	2
Participant 15	Social Worker	18	55	Black female	2
Participant 16	Psychiatric Nurse	22	52	Black female	2
Participant 17	Psychiatric Nurse	25	51	Black male	2

Participant 18	Direct Care Worker	24	47	Black male	3
Participant 19	Direct Care Worker	7	26	Black female	2
Participant 20	Direct Care Worker	40	65	Black male	3
Participant 21	Direct Care Worker	10	39	Black male	2

Data Collection

The variation from the plan presented in Chapter 3 was a drastic increase from 5–21 participants and the number of participants from each category of service providers. The 21 service providers outlined above included three psychiatrist, five psychologists, seven social workers, two psychiatric nurses and four direct care workers. The data collection process involved a thorough face-to-face or telephone interview. The researcher recorded information from the interviews by making handwritten notes. The interviews provided detailed psychiatric experiences relating to this qualitative research study. Interviews 11–15 ensured saturation through frequent report of supportive quality data. Because saturation was achieved prior to the previously determined sample size, data collection was concluded with the information from 21 service providers. A thematic analysis (NVivo) was also conducted to assist in identifying common codes, categories and emerging theories from the participants' responses.

Data Analysis

For case studies, the researcher collects qualitative data, analyses it for themes or perspectives, and reports 4 to 5 themes, this approach is a basic qualitative analysis (Creswell 2009). In appendix C there is a codes-to-theory model indicating the open codes, axial codes and themes. Open coding (see appendix D for Code Book) is

generating categories of information (Creswell, 2009). Axial coding in qualitative research is the breakdown of core themes during data analysis and relating data together to reveal codes, categories and subcategories grounded within participants' voices within the researcher's collected data. In other words, axial coding is one way to construct linkages between data (http://www.methods.sagepub.com 2017)

The data analysis for this case study began with a reading of the transcripts from the interviews followed by sectioning raw data (open codes), concisely narrowing these sections into subcategories (axial coding) and ultimately the theming process that identified phrases and/or sentences relevant to the study in relation to the research questions. In the results segment, data was transcribed by establishing the theme(s) for each research questions, data also organized by putting all the service providers in a large group and finally supplemental coping strategies beneficial for the psychiatric adolescents.

Triangulation

Triangulation was the method used for this qualitative case study to check and establish validity by analyzing three research question(s) from multiple perspectives and to arrive at consistency across data sources or approaches, the convergence of evidence (Yin, 2003). According to Yin, 2003 there are four types of triangulation. The first is data triangulation - acquiring different sources of information to increase validity of a study; for example, in-depth interviews. The second is investigator triangulation - using several different researchers/investigators in the analysis process. the third is theory triangulation – multiple perspectives to interpret a single set of data. The last is methodological triangulation – multiple methods to study a single problem or a program. Data and theory triangulation were the underpinnings of this qualitative

case study. Data triangulation through the interview responses of five diverse type of psychiatric adolescent service providers. Theory triangulation via 21 perspectives about the interview questions that form the themes for the three research questions.

NVivo Coding System

Transferability demonstrates one's ability to apply the findings to other contexts (Lincoln & Guba, 1985). Because of obvious association of the findings, this researcher was able to easily correlate the themes generated by the NVivo coding system. Lincoln and Guba (1985) also states that other techniques for establishing credibility are confidence in the truth of the findings. The service providers interviewed are certified, qualified, experienced and well-trained professionals therefore there is reliability, integrity and trustworthiness in the applicability of the participants' responses. NVivo computer coding system manufactured by QSR International is a deep level data analysis tool used in qualitative research; it collects and organizes data on small or large volumes of information (http://www.qsrinternational.com/nvivo/nvivo-products/nvivo-11-for-windows). NVivo was used to confirm the codes and themes generated by the research and interview questions.

Evidence of Trustworthiness

The validation strategies used to ensure trustworthiness are credibility, transferability, reflexivity (journaling), member checking, peer review, ethical procedures, thick and rich descriptions of context, dependability, and confirmability.

Credibility

Lincoln and Guba (1985) states that techniques for establishing credibility are confidence in the truth of the findings. The participants for this study were competent,

experienced and highly skilled professionals so there was dependability, consistency, and trustworthiness in the applicability of the service providers responses. The participants demographics included an average of 24 years of experience, residence in suburbs or inner cities, cultural diversity, young adult to the elderly, male and female. The participants' knowledge and years of practice allowed for credibility and an abundance of specific and comprehensive information. The different participants allowed for variation but resulted in comparable, similar and identical responses that created the themes to validate this case study. Member checking was implemented as an extra form of credibility within this qualitative study.

Transferability

Transferability demonstrates one's ability to apply the findings to other contexts (Lincoln & Guba, 1985). Because of the clear association of the results, this researcher was able to effortlessly compare and relate the information generated by the participants responses and NVivo coding system to the themes developed for this case study. Each participant described in detail consistent experiences thus transferability and dependability strategies were obvious. For example, the participants mentioned in different ways that the coping strategies learned on the hospitals' units transfer to life in the mainstream society.

Reflexivity

The use of journaling (reflexivity) was incorporated after each interview to capture the researcher's observations. This technique helped in identifying researcher bias and preconceived notions in the research process. Reflexivity also moderates the researcher's judgment and the absence of perceptions, interest, while refraining from limiting the researcher from interpreting data without bias (Sullivan, 2002).

Member Checking

This researcher conducted member checking during and or at the ending of the interviews. Member checking was done to get feedback on the other participants' responses to the interview questions. The actual participant being interviewed would comment on the previous participant(s) answers to the interview questions. Member checking is a form of credibility used within this research study. Lincoln and Guba (1985), describes this technique as the most critical validation of a research study. The process of member checking requests the participants to express their views on the interpretations of findings within the study (Ely, Anzul, Friedman, Garner, & Steinmetz, 1991; Erlandson, Harris, Skipper, & Allen, 1993; Glesne & Peshkin, 1992; Lincoln & Guba, 1985; Merriam, 1988; Miles & Huberman, 1994). Member checking allowed the participant the opportunity to determine if the information is correct and intended. Also, it gives the participants the opportunity to make changes to the reported information. In this process, the respondents assessed the accuracy of the data. During face to face interviews this interviewer discussed the responses in comparison to what the previous participant(s) stated to ensure that the research study was consistent and valid. Member checking performed via telephone was conducted at the end of the responses of services providers. During member checking all the participants stated that the most common coping strategies for adolescents are asking for help, avoiding conflict, medication compliance, and following instructions. Most of the participants mentioned that during the adolescents' hospitalization if the patients accomplish those ideal coping strategies mentioned in the previous sentence then the adolescents are prepared for discharge and integration into the mainstream society. Also, consistent family and social worker involvement after discharge is

critical for connecting the adolescent to aftercare counseling and reducing recidivism. A psychologist participant alluded that sometimes not all family involvement is positive and a dysfunctional and non-supportive family can have an adverse effect on the adolescent. All the member checking participants agreed with this statement.

Peer Review

The validation strategy of peer review noted by Creswell and Miller (2000) is when the researcher consults an expert within the same field of psychology who judges the quality of the research study. This researcher used a Walden University doctoral clinical psychology candidate student who has completed the qualitative research methods class to examine, evaluate and constructively critique this entire dissertation exploration. The peer reviewer read through each participant responses to all the interview questions and concurred with the themes extracted by the researcher and determined no themes were overlooked within the study. This peer review process ensured the validation of this researcher's qualitative study and contributed to the reliability of the research. The peer reviewer expressed that the themes were clear and consistent across the participants responses. She indicated that responses were all parallel with what is validated within the study of service providers about the coping skills learned by adolescents. According to Research Question 1: What are the perceptions of service providers about coping skills learned by adolescents who have experienced long-term inpatient psychiatric care? She stated that the coping strategies that are most effective are those that were taught in psychotherapy and during the adolescents' stay in the psychiatric hospital. These coping strategies practiced through programs implemented by the treatment team of service providers carried over to aftercare services and are beneficial to the continuum of care for adolescents.

Research Question 2: According to service providers what is the role of the inpatient psychiatric hospitalization and aftercare experience of adolescents in the acquisition of coping strategies? The peer reviewer stated that aftercare programming is applied and projected based on the adolescent individual needs. These services are put in place by the designated social worker. Aftercare services include counseling, family support, and communication between the hospitals' service providers and the outpatient service providers about the follow-up treatment needs for the adolescents. These needs include (but are not limited to) psychiatrist for medication compliance and psychologists or social workers for psychotherapy. She also concluded that service providers are involved to create a liaison between the adolescent, hospital, school and family. Research Question 3: According to service providers how do adolescents who have experienced long term inpatient care use coping skills to integrate into mainstream society? The peer reviewer reiterated that adolescents who have experienced long-term inpatient care use coping skills such as asking for help, following instructions, avoiding conflict, accepting no for an answer, not harming oneself and others, journaling and resisting peer pressure. These coping strategies are all applicable to the success of the adolescents' integration into mainstream society. Thus, the peer reviewer supported and agreed with the themes generated from this qualitative study.

Ethical Procedures

Debriefing took place with the participants to maintain continuity with ethical procedures. The basic ethical principles are informed consent which is respect for persons, subjects must enter the research voluntarily with adequate information, maximize possible benefits, minimize possible harm, subjects can decline to continue

at any point of the research, every person should be treated fairly and equitably while bearing the risk and benefits (http://www.answer.com. 2017; www.apa.org. 2017). The researcher interviewed service providers who have worked with adolescents regarding the adolescents' psychiatric experiences, coping strategies and aftercare services used by adolescents following long-term psychiatric discharge. Names of adolescent psychiatric patients, respondents and the agency where the service providers were or are employed was encrypted to ensure confidentially.

Thick and Rich Descriptions

Thick and rich descriptions are described by Lincoln and Guba (1985) as a means of achieving validity. In this qualitative case study, the researcher described the responses and perspectives from many service providers in sufficient detail. These quotes will be able to thoroughly describe the research context and assumptions that are central to this qualitative study. Fifty-five pages of broad, deep, specific and expressive information was gathered from the participants interviewed. The three psychiatrists interview responses totaled nine pages, five psychologist responses totaled 14 pages, seven social workers 18 pages, two psychiatric nurses 4 pages and four direct care workers 10 pages.

Dependability

NVivo computer coding system manufactured by QSR International is a deep level information analysis tool used in qualitative research; it collects and categorizes information on small or large volumes of information (http://www.qsrinternational.com/nvivo/nvivo-products/nvivo-11-for-windows). The themes, axial and open codes produced by this research exploration are reliable, consistent and dependable because of the participants' credibility, thick and rich

descriptions of responses to interview questions, member checking, peer review, and the researcher conforming to ethical procedures. Also, the computer coding system NVivo is a well-known dependable tool used to assist in processing and confirming the responses by the service providers and the themes generated by the researcher.

Confirmability

Confirmability is the capacity to authenticate the internal coherence of data, findings, interpretations, and recommendations (Lincoln and Guba, 1985). The participants were credible based on knowledge, years of experience and professional credentials. Each respondent described in detail consistent experiences therefore transferability and dependability strategies were prevalent. Again, the participants' responses were consistent in providing the content of this qualitative research study. Due to the abundance of participants (21), debriefing and the member checking method of synthesized analyzed data was applied to verify the participants answers, position and accuracy of the interviews and research questions. The participants' responses pertaining to adolescents' readmission to psychiatric hospitals were generally a result of the patients' unsuccessful adherence to therapeutic programs within the psychiatric institution and associated aftercare protocol. Again, the documentation of the researcher's interview responses and themes generated from this case study were read-through and confirmed by peer review. A recommendation for future exploration would be to bring forth information based on the confirmability of this study in determining policy revisions concerning the coping strategies taught to adolescents in psychiatric hospitals. Another recommendation based on the data and themes produced by this study is to continuously explore the perspectives of service

providers about the benefits and importance of coping strategies, how to improve integration and aftercare services for psychiatric adolescents.

Results

Research Question 1

This section will describe the results organized by research question, theme(s), relevant participant quotes, axial codes, participants as a larger group, and supplemental coping strategies.

RQ1: What are the perceptions of service providers about the coping skills learned by adolescents who have experienced long-term inpatient psychiatric care?

Main theme. Coping strategies is the core of the teaching process for inpatient psychiatric adolescents.

***RQ1/Quotes*.** A psychiatrist participant stated that the coping strategies taught within the hospital is to teach adolescents to realize when a crisis is happening, so they can recognize it and seek assistance. This participant also mentioned "adolescents must know when to remove themselves from potentially dangerous situations". Typical scenarios include avoiding a fight and or a verbal confrontation that can escalate to a physical altercation, choosing your peers wisely, not following peers that are involved in negative behavior which in-turn prolongs their stay at the psychiatric institution. Some examples of negative conduct are bullying, smoking, stealing, destroying property, disrespecting peers and or service providers, running away from the hospital, self-injurious behavior, colluding others to fight, gang or drug activities and medication non-compliance. To extend self-injurious behavior, a psychiatric nurse participant shared that the direct care staff is trained to treat patients according to their diagnosis. If a patient is depressed, self-injurious or suicidal a direct

care staff must supervise that patient closely until a doctor's order is obtained for "eye contact". On "eye contact" a service provider usually a direct care worker is assigned per work shift to be one on one with in arms-length of the patient every day for 24 hours or while awake until the doctor's order is lifted.

Another psychiatrist participant mentioned "being educated about their medication and its side effects is empowering for the adolescent". A patient can be intrigued by this learning process and continue to educate themselves on this subject and later pursue a career in this field or similar profession. He also stated that the treatment team (psychiatrist, psychologist, social worker, psychiatric nurse, direct care worker) meet once a week to designate, add or minus specific coping strategies for each adolescent patient. The direct care workers daily notes are critical because documented are the behaviors and the specific coping strategies utilize by the adolescent patient. Also documented by the direct care workers are recommendations for new coping objectives and adjustment(s) to the old coping goals. According to a psychiatric nurse participant the direct care worker is the most important service provider because of numerous amounts of time spent supervising, conversing, role modeling, redirecting, de-escalating, rewarding and applying consequences for the adolescents' negative behavior (point system). If the direct care worker is considerate, has a calm but firm demeanor, implements the structured program organized by the treatment team and is fair in her or his approach she or he over time will develop a positive rapport with the adolescent. These direct care workers are key in terms of keeping the adolescent patients safe, stable, comfortable and determining coping strategies for the patients. Some coping strategies mentioned by the nurse are waking up on time, listening to music, going for a walk, asking to speak to a hospital staff that

they have develop a constructive rapport with, following procedures, taking prescribed medication, asking for help, displaying appropriate behavior while attending individual and group psychotherapy, the dining hall, recreational facilities, social hour and complying with curfew for bed or room time.

The third psychiatrist interviewed stated that goals group usually supervised by a social worker and direct care worker is where the education of coping strategies take place. In goals group adolescents breakdown and recite the meaning of specific coping strategies, role-play scenarios using coping strategies and are verbally praised for maintaining positive behavior and appropriate usage of coping strategies throughout the day.

A social worker participant reported that in addition to therapy for the adolescent patients it is important to also teach the parents during consistent counseling sessions strategies to cope with the stressors of having a psychiatric family member. Often, the parents are uneducated, unaware and not informed on programs that assist them on how to deal with and or get help for their adolescent child. Reported by a psychologist participant is another effective teaching tool where the patients self-assess their behaviors and design their own coping strategies under the supervision of a therapist. This learning process helps the adolescents to be aware of their behaviors and take responsibility for their actions.

- ***Axial coding.*** Axial coding was used to link data from the service providers interview responses to reveal shared categories or statements that shaped the theme for RQ1. The most common coping strategies identified are: Asking for help, (e.g., “seeking help from staff”)

- Following instructions, (e.g., “following rules”, “complying everyday with the inpatient program activities”)
- Medication compliance, (e.g., “taking medication on a regular basis”)
- Avoiding verbal and physical conflicts, (e.g., “avoiding combative behaviors” “avoiding confrontations”)

The context for learning the coping strategies is also important. Service providers reported that specific coping strategies are taught to adolescents (a) based on their diagnosis and or treatment needs, (b) adolescents practiced and rehearse when and how to use coping strategies during on-unit programing, individual and group counseling with service providers, (c) positive family involvements are critical to reinforce and support coping strategies.

Coping strategies across service providers. The following coping strategies were identified across service providers for RQ1:

- showing appreciation (P3,16);
- journaling (P16-18);
- not harming self, peers and others (P2-5,7,10-12,21);
- drawing (P16-18);
- counseling with advocate service providers (P1-9,12-15,18-21);
- asking for help (P1-5,8-16,18-20);
- resisting peer pressure (P2,20,21);
- assertiveness defined (P6,9);
- taking a time-out (P5,9,10,16);
- avoiding conflict (P1-18,20,21);
- accepting no for an answer (P2,11,12,14,17,18);
- following instructions (P1-18,20,21);
- respecting self, staff and peers (P2,3,6,10);
- making an apology (P4,14);
- disagreeing appropriately (P13,21);
- medication compliance (P1-5,8-16,19);
- expressing feelings appropriately (P6,7,12,14,21);
- listening to music (P1,3,4,6,17,18);
- accepting consequences (P6,9,11,17);
- family involvement (P1-15,17-21);

- peer mediation (P3,5);
- therapeutic walks (P3,4,5,18);
- and seeking positive attention (P8,13).

The education and or utilization of these therapeutic coping strategies are listed and defined in admission packets(P8), rehearsed and role played in individual or group counseling sessions supervised by the therapists and or direct care workers (P1-6,8,9,11-21), displayed by attending, participating and behaving in program activities (P1-6,8,9,11-21), and practiced, redirected and rewarded through a point system (P4,11,15,17,19). These coping strategies according to service providers will assist the adolescent patients with maintaining appropriate conduct in a psychiatric setting.

Supplemental Coping Strategies for RQ1

The following participants mentioned additional noteworthy therapeutic coping strategies that should be taught and or implemented by their institution hence beneficial for the psychiatric adolescent patients.

Psychiatrist participant. Simple manners such as "you are welcome, excuse me, please and thank you" are coping gestures that hospitals' inpatient programs need to teach a lot more. Adolescents need to display these motions on a steady basis. Often psychiatric and mainstream adolescents demonstrate impolite behavior by interrupting adults without saying excuse me and then pausing to be acknowledge. Too many of today's adolescents believe they are entitled to most things versus being patient and working hard to achieve their goals.

Psychologist participant. Making an apology is a coping strategy she declared would be beneficial to the adolescent patients and should be officially added to the list of coping strategies. Frequently confrontations would be resolved if a

sincere apology was made by a patient and accepted by the other. In addition to "making an apology" a jury of adolescent patients supervised by service providers to assist in developing other coping strategies to help diffuse conflicts between peers. The patients would have to maintain appropriate behavior for a week to partake in this judging process.

Social worker participant. A coping strategy she believes should be added and emphasize by facilities is dealing with anxiety. Patients become anxious when receiving consequences for their inappropriate actions and have a hard time accepting responsibility for their behaviors. Taking deep breaths to help relax, isolating self by taking a time-out, getting advice from a service provider in general and about what he or she should do next time are coping measures for this situation.

Research Question #2

RQ2: According to service providers what is the role of the inpatient psychiatric hospitalization and aftercare experiences for adolescents in the acquisition of coping strategies?

Main theme. The same coping strategies learned in the hospital are the same coping strategies assessed for discharge, used for integration and maintenance in the mainstream society.

RQ2/quotes. A psychiatric nurse participant stated, "the success of the adolescents' on unit program and their treatment plans are designed to correlate and be transferrable to life outside of the hospital". If the adolescent patients conduct her or his self appropriately and comply with the hospitals' behavior modification programs, they will develop naturally with coping strategies and be better prepared for life in the mainstream culture thus decreasing recidivism. In addition, the nurse

stated that coping skills are implemented to “mimic” real life situations. Simple target tasks such as following instructions, journaling, drawing, the appropriate time to listen to music, accepting no for an answer and when to separate yourself from stressful situations are lifetime strategies that can be used effectively every day. A psychologist participant stated, “the coping skills taught at the inpatient as well as outpatient psychiatric facilities are the same and endless”. Because the coping therapy in and outside the institutions are alike the adolescents rely on aftercare services for continued guidance, support and treatment.

A direct care worker participant reported that if adolescent patients maintain appropriate behavior while socializing with peers, attending academic programs, recreation, and handling day to day issues they automatically have a better chance at mixing into a regular setting. Most compliant adolescents earn weekend and or holiday(s) home visits with approved family members. If the adolescent has multiple practical visits, the social worker along with other service providers can start the discharge process in conjunction with suitable aftercare services. Sadly, few well behaved adolescent patients have no functional family members to visit.

A psychiatrist participant reported that the same coping strategies learned on the hospital unit are the same coping strategies evaluated for patient discharge, assimilation and longevity in the mainstream population. The same psychiatrist also reported that adolescents’ psychiatric programs differs from institution to institution but the main goals for the patients are the same. For example, patient safety, family support, maintaining appropriate behavior and consistently taking medication if required are fundamentals for psychiatric facilities. The adolescent patients are taught coping strategies that should ultimately prepare them for successful discharge. Coping

strategies are memorized, practiced during therapy group and while the adolescent patients are involved in daily routine activities. These same coping strategies prepare the adolescent patient for discharge and carryover into the mainstream world. Another psychiatrist participant specified that proper training of coping strategies during all day program activities, individual and group therapy for the patients is the most important factor; if the adolescent is not armed with the proper coping information on how to preserve in the mainstream culture, progression will never be achieved for this population. This therapeutic method for individuals with mental health challenges is a life-long coping process.

Axial coding. Service providers strive to stabilize adolescents by teaching coping strategies during routine counseling and therefore rehabilitate the inpatient for long term success in mainstream society. The most common roles identified are:

- The social worker is the main service provider that remains in contact with the adolescent after discharge, e.g., "aftercare and or outpatient plan is packaged and communicated by the social worker", "after discharge the longer weekly meetings continue the stronger the association between social worker and adolescent", "therapists involved after discharge is either a psychologist or family therapist but mostly a social worker"
- Verbal praise, incentives and point sheets are the types of feedback provided when the adolescents use their coping strategies, e.g., "service providers should verbally praise the adolescent patients whenever they use their coping strategies", "patients earn points for attendance, participation and behavior written on their daily point sheets for on and off unit activities", "on the patients' point sheets points are frequently awarded and

signed by service providers for patients using coping strategies; except the issuing nurse on duty is the only person that can sign for the patients taking their medication", "coping strategies are taught everyday via a point system regulated mostly by the direct care workers; bonus and positive points for compliance with program procedures and negative points for inappropriate behaviors are earned through this point system; the point system allows the patient to earn points when they follow their daily living skills; these skills are taking a shower, displaying appropriate behavior, completing school work and complying with bed time", "point sheets are signed and points tallied in a book at night by the direct care workers", "incentives to motivate the adolescents to participate in groups and activities involves a point system where the patient spends their points weekly purchasing items at an adolescent friendly point store; items in the store are scented lotions, shampoo, deodorant, perfumes, colognes, radios, puzzles, toy cars, board games, stuff animals, slippers, socks, pajamas, t-shirts, shorts, sweatpants and books; this behavior reinforcement program is effective most of the time, however some patients still refuse to comply", "psychiatrist, nurse, therapist and direct care worker must brainstorm and implement a rewarding therapeutic plan for the adolescents that adhere to taking medication; rewards include but are not limited to radio time, a specific amount of time in another peer's room, candy, a walk, board and video games", "accepting consequences is an important coping strategy for hospitals using a point system for privileges and penalties; often patients lose a few points for misbehaving, then becoming

highly agitated and or destructive; consequentially losing major points and their status level".

- Outpatient counseling, family involvement and medication management are the aftercare therapeutic support systems in place for the adolescents that reinforce coping strategies, e.g., "it is a necessity for more availability of family inclusion and teen day programs which is vital for continued treatment of coping skills and to assist with successful integration into society", "mastered coping strategies along with required medication, dedicated therapist and family members are tools that will help the adolescents with maintaining on the psychiatric ward, attending outpatient services and transitioning to mainstream population".

Role of hospitalization and experiences. The following interview responses are connected across service provider participants for RQ2:

- The mannerisms displayed by the adolescent patients on the psychiatric unit are the same behaviors demonstrated in the mainstream environment (P1-21).
- Each patient is assigned specific coping strategies designed by the service providers according to the adolescent diagnosis and or treatment needs (P1-6,8-20).
- The social workers and the direct care workers are most equipped to develop these coping goals. Social workers because of immediate access to background, current and future pertinent information regarding the adolescent (P10) and the direct care workers beneficially develop a bond

since they spend the most time observing, supervising, redirecting and disciplining the patient (P17).

- The discharged adolescent patients who did not comply with the prescribed medication and inpatient therapeutic programing were not successful in the aftercare process and or mainstream society and subsequently returned to some fashion of a psychiatric setting (P1-15,17-21).
- Also, crucial to the aftercare procedure is the therapist remaining in contact with the adolescent (P1-9,11-20) and family to insure outpatient services and support (P1-21).
- The adolescents with severely maladaptive behaviors and or dual diagnosis require taking medication, inpatient therapy and the structure of a psychiatric facility for their stabilization (P13,15,20).

Supplemental Coping Strategies for RQ2

Psychologist participant. Being patient is a coping strategy she declared should be added to the official list of coping strategies. Psychiatric adolescents are demanding and focus on immediate gratification instead of persevering and preparing for the future.

Social worker participant. Being that many of the psychiatric inpatients are from New York city, she thought that implementing a gardening team would be an effective and therapeutic coping strategy and an incentive for the adolescents belonging to a higher-level status. During the spring season showing the patients the correct tool to use and how to dig the right size hole for the flowers and plants is aspiring for the adolescents. Watching their garden mature with the additions of

mulch, decorative rocks and fake animal predators to deter shrubbery destructive animals is attractive, therapeutic and pleasing to the soul.

Social worker participant. A coping strategy she stated adolescents would benefit from is regular family meetings involving the patient, therapist and parent. The meetings do not have to be face to face, as it may be difficult for the parent to acquire transportation to meet on a regular basis; therefore, over the phone counseling is sufficient.

Milieu manager/Direct care worker participant. Regularly scheduled nature walks for psychiatric adolescents is a coping strategy activity that would be beneficial for psychiatric institutions located in rural or suburban areas. The natural wooded environment (birds chirping, deer, bushes, trees) is visually fulfilling and has a soothing effect on the soul. The walking exercise is important for fitness, health and mental wellness. This exposure of countryside and therapeutic movement is a coping strategy that the adolescent can utilize in mainstream society for life.

Research Question #3

RQ3: According to service providers how do adolescents who have experienced long-term inpatient care use coping skills to integrate into mainstream society?

Main themes. Adolescent patients who correctly used prescribed medication along with other coping strategies in and outside the hospital and were linked to aftercare programs were better able to handle their experiences of stigmatization and continue in an appropriate manner in the workplace, school, and community environment. Correspondingly, the role of the service providers is vital concerning

on-going communication amongst family, adolescent, inpatient hospital and aftercare personnel.

RQ3/quotes. A psychiatrist participant responded, “adolescents who experience unsuccessful integration into mainstream are those adolescents who are not connected with aftercare counseling services and a psychiatrist to prescribe and manage medication. In turn, recidivism usually occurs for these adolescents”. The therapist continued involvement is key in acquiring information on aftercare programs that will support adolescent via talk therapy and schedule routine visits with the psychiatrist. These visits are important for medication evaluation and prescriptions because medication non-compliance after discharge is one of the major factors of recidivism. A social worker participant reinforced the importance of outpatient facilities by revealing that most recidivism was due to lack of aftercare programs and the depletion of services such as independent living. She mentioned that minimal funding and unfair distribution of money by government entities negatively affects psychiatric care by diminishing incentive programs which reward the adolescents for positive use of coping strategies and maintaining appropriate behavior. Because of this financial neglect, countless psychiatric programs which treat adolescents offer inadequate services. During independent living therapeutic meetings take place to assist the clients with job situations, daily life coping skills, education, career goals and discharge planning. A direct care worker participant explained that independent living is organized, managed and an extension of group home settings. Once the group home residents become eighteen, the social worker begins the discharge process by first enquiring about living arrangements with a family member. If this situation is not feasible then independent living programs is the next step for the

adolescents to ease their way back into the community and be productive members of society.

A social worker participant responded, “the main challenges for the adolescents transitioning from psychiatric hospital to the mainstream community, school or work is that they hold the stigma of being hospitalized, transported to school in a small special bus, stigma of being placed in a special self-contained classroom and returning to a community where there is a lack of coping programs”. Although these different therapeutic treatments are designed for the betterment of the adolescent, the unalike and unnormal circumstances can trigger a negative impact emotionally and psychologically therefore inappropriately conducting themselves as labelled. Another social worker participant responded, “the challenges with most adolescents are lack of family support, medication non-compliance and poor aftercare counseling services”. Family involvement is important for mainstream adolescents and even more important for the psychiatric adolescents. Because of adolescent pressure psychologically, hormonally and physiologically coupled with psychiatric stressors a committed caring family member positively role-modeling is paramount for the adolescent.

A direct care worker responded that therapist are the service providers that remain in contact with the adolescent after discharge. A psychiatric nurse participant responded, “after discharging the adolescent, weekly communication between the social worker, patient and family should be on-going about the type of care the adolescent is receiving. The probability of recidivism increases as soon as this communication procedure is terminated”. The main reason for lack of communication concerning the discharged patient is the therapist high, demanding and challenging

caseloads. Furthermore, the extraordinary high turnover ratio amongst service providers causes an increase in an already difficult workload therefore at times leading to a chaotic and an imbalanced work environment.

A direct care participant responded, “the goal of the hospital is to arm the adolescent patients with coping strategies that will successfully prepare them for discharge, assimilation into the normal environment and reduce recidivism. The inpatient program provided directly correlates with the success of the adolescents integration into mainstream society. If the psychiatric patient followed staff instructions, attended and participated in all on-unit individual and group activities then this conforming behavior will transfer outside the hospital and lessen the adolescent chances of returning to the hospital. Another direct care worker responded, “therapists and direct care workers are assigned to ensure that there is always someone readily available to counsel patients”. Due to the challenges the psychiatric adolescents face, they are easily frustrated and require frequent counseling and or a staff member to listen to them. A social worker participant shared that an effective coping strategy that was most successful allowed adolescents to just express themselves and have their therapist listen and be a “sound board” for them. She also mentioned that from her observations and experiences of what makes adolescents most frustrated is when those who can help them refuse to listen. To support this process, the milieu manager (supervisor of direct care workers) on duty assigns a direct care worker to several patients ensuring that all the psychiatric adolescents have a contact to talk to on every shift. This is a proactive measure to de-escalate the patients and to prevent a possible crisis.

Axial coding. The characteristics exhibited by the adolescent patients in the psychiatric hospital were the identical behaviors displayed in the mainstream setting. The challenges for adolescents integrating into mainstream school, work and community are:

- Stigmatization, e.g., "patients act according to their placement", "patients display negative emotions because of classification", "the stigmatization feeling is a common challenge for the adolescent patient and at some point during the beginning stage of the patients' stay at the hospital, most adolescents make the statement "I am not crazy", "I am not retarded" and or "I don't need medication", "to help the patient with these feelings, private individualized counseling with a service provider is effective", "therapist informs the patients that their continuous disruptive behavior they displayed falls under the category of psychiatric behavior and reaffirm the adolescents that they are not "crazy", "medication along with this type of talk therapy helps to keep the adolescents calm"
- Lack of family involvement, e.g., "unfortunately most family members are not consistently present during hospital visiting hours", "family support is key when treating psychiatric adolescents"
- Non-compliance with prescribed medication, e.g., "patients fake taking their meds and hide it in their pockets", "it is common practice for reluctant patients to "cheek" their medication (hiding it in the mouth)", "the nurse must check under the tongue and have the patients open their mouth wide to assure swallowing of the prescribed drugs", "the responsibilities of the nurses are to follow, report and carryout the

psychiatrist orders, insure the adolescent patients receive and take their correct medication including proper dosage and to observe the patients for damaging side-effects", "to eliminate confusion and increase compliance one patient at a time accompanied by a direct care staff member at the disbursement window of the medication room", "medication compliance is essential when treating adolescents with mental illness about 70 to 75% of clients return to some type of psychiatric setting because of the adolescent not adhering to the medication process",

- Adolescents returning to a drug and gang inflicted community, e.g., "some parents, relatives and peers are drug dealers and gang members", "patients returning to the hospital from home visits are thoroughly searched for weapons and drug paraphernalia"
- Lack of aftercare services or not attending aftercare counseling e.g., "if there is no aftercare process then patients returning to the hospital after discharge is likely", "for the discharge patient continuous therapy should take place outside the hospital and the treatment team must develop a plan for the adolescent to partake in"
- Little or no communication between service providers, family and adolescent, e.g., "more communication between discharging institution and school personnel increases mainstream stability", "it is very helpful when the family is involved in this aftercare process and there is weekly communication between the discharging hospital and an assigned community service provider usually a social worker, family therapist and or psychologist", "there is a greater chance for recidivism when there is a

breakdown in communication between the service providers, family and patient"

Larger Group. In relation to RQ3, the participants' responses revealed that coping strategies learned and utilized by adolescent patients were determinants that would potentially lead to the success or failure of their integration into society.

- Social workers and or psychologists lead the remainder of the treatment team (psychiatrist, nurses, direct care workers) in the discharge planning meeting for the psychiatric adolescent patient. If necessary, adjustments to prescribed medication and coping strategies are made that will benefit the adolescent for assimilation into the mainstream community (P8).
- The structure of how the therapeutic programing within the institution afforded and assisted the adolescent in making a smooth transition into society and with the tenacity to comply with aftercare services. Basically, if the adolescent patient mostly attended all activity groups, perform daily routine tasks including taking medication, follow service providers' procedures, and maintaining appropriate behavior throughout the hospital length of stay then these coping practices help with integration into mainstream society (P1-15,17-21).
- Most of the participants stated that working with adolescents in long term psychiatric care is difficult as well as challenging and the major goal is to rehabilitate the inpatient for long-term success in the mainstream world (P1).

- The challenges are that adolescents are in a transitional stage physiologically and mentally (P1).
- High turnover rates of service providers (P5).
- Stigmatization (P1,2,3,6,7,11,18).
- Minimal funding for adolescent psychiatric inpatient and aftercare programs (P8,9,11).
- Therapist inconsistencies regarding contact after discharge (P4).
- Dual diagnosis patients (P13,15,20).
- Drugs and gang inflicted communities (P2,3,9,10,19,21).
- Non-compliance with medication (P1-5, 8-16,19).
- Dysfunctional family (P5,9,10,19).
- Lack of family involvement (P1-21).
- Involved family not complying with treatment (P2,7).
- Adolescent patient and or family refusing to accept diagnosis (P8).

Supplemental Coping Strategies for RQ3

Psychologist participant. Appropriately dealing with postponement and cancelation of discharge is a coping strategy that needs to be taught prior to the scenario and added to the list of coping strategies. When the social worker on the case is not present at the actual time of discharge there is confusion which creates frustration for all personnel involved. Frequently, the discharge process takes place after 5pm when the adolescent's social worker is off-duty. This leaves mainly the direct care worker to de-escalate the agitated or depressed patient. Often the direct

care worker is not informed of the precise particulars pertaining to the rearrangement or termination of discharge.

Social Worker participant. A coping strategy she cited for possible implementation in and outside of psychiatric institutions is money management. Adolescents educated about the importance of saving money for the future is a monetary coping strategy. Adolescents are fixated with purchasing expensive sneakers (Air Jordan's and or Lebron's) instead of buying a cheaper pair of sneakers and saving half the money for the future.

Social Worker participant. Service providers teaching coping strategies to the parents and adolescents to co-exist is a treatment that need to happen a lot more frequently. Because of parents work hours and transportation issues (not having a car or money for train, bus, uber or taxi-cab) the parents aren't likely to make the schedule meetings**.**

Summary

The research and interview questions guided the data analysis to generate commonalities within the study. NVivo (qualitative study coding system) was also utilized to code results which assisted in the confirmation of themes. A common response by service providers interviewed was that coping strategies taught in psychiatric hospitals were learned and practice by adolescences who conformed to the program. This optimistic behavior assisted with integration. Adolescent patients linked to therapists and aftercare and or outpatient programs positively increase stability in the normal mainstream setting therefore reducing recidivism. There were no discrepant cases, the information obtained were consistent among all participants.

The seven males and 14 female participants involved in the interview process are from inner cities or suburbs, racially mixed, live in apartments or houses, from different socioeconomic backgrounds and average 24 years' experience. These years of experience allow for credibility in terms of knowledge and a plethora of detailed and situational information. The diversity of the participants allowed for differentiation but resulted in similar and same responses to verify this research study.

Most of the participants identified asking for help, following instructions, avoiding conflict, and medication compliance as important and common coping strategies. Most of the participants stated that each psychiatric adolescent is assigned individualized coping strategies according to their diagnosis by the treatment team of service providers and these coping strategies are taught and learned during daily routine programming, individual and or group counseling. Also, most of the participants identified stigmatization as a common challenge for psychiatric adolescents during the hospitalization, integration and the outpatient process.

All participants mentioned that the same coping strategies learned in the hospital setting are the same coping strategies utilized outside of the hospital. Also, all participants stated that incentives, rewards and or verbal praise is important teaching tool implemented by the service providers and supportive family involvement is critical for the psychiatric adolescent conforming with coping strategies and aftercare services.

The therapists (social workers, psychologists, family therapists) are the key service providers in assigning, adjusting and teaching coping strategies during the adolescent patients' hospitalization, discharge planning, integration and connecting adolescents to aftercare programs.

In Chapter 5 I will analyze and interpret findings. I will also document the limitations, recommendations, and implications of this qualitative research study.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this qualitative case study was to explore the perspectives of service providers about the psychiatric experiences of hospitalized adolescents, their coping strategies and the aftercare services they used following discharge from long-term psychiatric care. The framework of the study was Finegood et al.'s (2012) systems theory. Qualitative research studies use interviews about an issue or case, allow the researcher to use more than one form of data collection. There is no hypothesis to be proven.

The information derived from this research study has implications for positive social change: It can help policymakers and service providers with the development of appropriate psychiatric care to accommodate adolescents' needs during inpatient stays, which, in turn, leads to a smooth transition into the mainstream population and connecting to aftercare services.

Key Findings

As a result of this research study four themes were identified. (a) Coping strategies is the core of the teaching process for inpatient psychiatric adolescents. (b) The same coping strategies learned in the hospital are the same coping strategies assessed for discharge and used for integration and stability in mainstream society. (c) Adolescent patients who correctly used prescribed medication along with other coping strategies in and outside the hospital and were linked to aftercare programs were better able to handle their experiences of stigmatization and continue in an appropriate manner in the workplace, school, and community environment. (d) The

role of the service providers is vital for ongoing communication among family, adolescent, inpatient hospital, and aftercare personnel.

Most participants declared that asking for help, following instructions, medication compliance, and avoiding conflict are the most common coping strategies implemented by service providers and therefore, those that should regularly use by the adolescent psychiatric patients. A majority the participants alluded to the following statements during the interviews.

- Specific coping strategies are assigned to each adolescent according to her or his diagnosis.
- Adolescents practice and rehearse coping strategies during daily inpatient or outpatient programming activities, individual and group counseling.
- Family involvement is important to reinforce and support coping strategies.
- Rewards, a point system and/or verbal praise are feedbacks used to encourage the use of coping strategies.
- Poor teaching of coping strategies by the psychiatric institution, lack of family support, noncompliance with medication is three reasons for frequent recidivism.

Most of the participants also alluded that dealing with adolescents in psychiatric care is challenging and the chief goal is to reeducate the patient for long-term accomplishment in the conventional world. The trying tasks are that adolescents are in a temporary phase physiologically and emotionally, non-compliance with medication, dual diagnosis psychiatric patients, stigmatization, high turnover rates of service providers, minimal funding for adolescent psychiatric inpatient and aftercare

programs, therapist inconsistencies regarding contact with the patient after discharge, adolescents returning to drug and gang inflicted communities, dysfunctional family, lack of family involvement, involved family not complying with treatment, and adolescent patients and or families refusing to accept diagnosis.

After discharge, those adolescents who followed procedures for therapeutic programs within the psychiatric institution were able to apply the coping strategies learned and employ them in the mainstream community. Adolescents who were connected to post-hospital care or outpatient services increase their likelihoods of sustaining in the typical culture and living usual lives.

Interpretation of the Findings

The peer-reviewed literature highlighted the thoroughness, precision and confirmed the following findings of this case study. Through work related association and involvement, the service providers perspectives concerning psychiatric adolescents is key and relevant for this qualitative research. The amount of time expended daily with the adolescents makes the service providers perception the best source of information through the interview process. The service providers interviewed confirmed that the complete method of teaching coping strategies to psychiatric adolescents in the hospital is fundamental for the adolescents' stability, progression and changeover into mainstream society. In relation and according to Arnold et al. (2003), the service providers perspectives on the preparedness of long-term psychiatric adolescents' integration are essential for this process and to assist in the reduction of recidivism.

Hunter, Grealish, and Dowling (2010) stated that when adolescents have experienced long-term psychiatric hospitalizations, coping strategies determine their

success or failure. The findings confirmed that the most common coping strategies taught to adolescent patients are avoiding conflict, medication compliance, ask for help, and following instructions. Other general coping strategies involve taking a walk, listening to music, taking a timeout in a quiet place, journaling, family involvement, drawing, peer and or staff counseling. Coping strategies are taught by service providers to adolescents individually and or in a group setting through reciting the meanings of the coping terms, role playing, and counseling. Point sheets are a popular and effective behavior modification system implemented by hospitals where the service providers sign when the adolescents earn positive points for conforming to coping strategies and negative or no points for inappropriate behavior. Moses (2010) stated that a strategy would be to provide a basis for procedures, use effective programs, disciplinary actions and policies implemented by the hospital's service providers that will lead to fewer anxiety challenges for the psychiatric adolescent patients.

According to service providers, stigma, the influence of negative prime family upbringing experience, drugs, gangs, and impoverished communities has a disadvantageous effect on the psychology and emotion of the adolescent and increases recidivism. In support of the findings related to the negative impact of broken homes, large families, low incomes, deprived neighborhoods, drug abuse, adolescents with protective and or unprotective criminal records linked to recidivism has been established by past research (Contreras et al., 2011). Participants mentioned that most adolescent patients emotionally carried the stigma of being admitted to a psychiatric ward as an association with "crazy". The adolescents and their families are embarrassed, angry and feel a shame because of this negative connotation. Service

providers provide counseling therapy, medication and stabilizing program activities to combat these feelings. The mental health community has made significant progress in supporting the adolescents' rights for care as mandated by the United Nations, (Remschmidt & Belfer, 2005). However, Ptakowski (2010) argued that this issue remains a challenge for legislators, policymakers, and other advocacies who continue to be unaware. To inform the system of care, future studies could relay information from this exploration and help shape policy regulations about the coping strategies imparted to adolescents in psychiatric hospitals. Also, grounded in the information and themes identified by this qualitative research are that the perspectives of service providers can be used to inform methods for assimilation and aftercare programs.

Based on results of this study and empirical foundation (a collection of research articles and peer review journals) that supports adolescents in psychiatric care, service providers relations with these adolescents, application of coping strategies and aftercare facilities; psychiatric adolescents who are non-compliant with medication and or not appropriately armed with coping strategies frequently return to the psychiatric facility. Also, acute and severely diagnosed adolescents require service providers' professionalism for continuous medication evaluation, supervision and to implement programs for structure of a therapeutic inpatient environment. Because of these factors, this type of patients quickly returns to the hospital if discharged. Readmissions are usually due to mental illness, poor social support, and poverty (Joynt & Ashish, 2012). Another reason leading to recidivism is substandard aftercare services most currently an absence of communication between service providers, community resources, family and or guardian. A lack of post-discharge programs is a risk factor for adolescents psychiatric repeated admissions (James et al.,2010; Blader,

2004). According to participants, outpatient experiences are relevant to the accomplishment of an even transition into society. It is critical that community resources continue teaching the patients about when and how to use their learned coping skills effectively.

Most of the adolescent psychiatric population readmitted to the hospitals are from the group and or foster homes. Those living in adoptive and mass care are also more likely to be re-hospitalized (Romansky, Lyons, Lehner, & West, 2003). Structural issues play a substantial part in increasing the risk of psychiatric re-hospitalization. A social worker participant stated that in residential treatment facilities the adolescent may act out to return to the hospital where they feel safe because of the structure of the psychiatric setting, education of coping strategies, constant redirection and support from service providers. Another social worker participant challenged the "rotating door" system between the group homes and psychiatric hospitals. She stated that the back and forth adolescent patients are primarily for monetary gains for these institutions and treatment is secondary. As soon as a prospective discharge date is set for a patient, immediately the director of admissions at that psychiatric facility is communicating with the group home agencies for candidates to fill the vacancy (usually re-admits). In addition, the adolescents coming from a residential treatment facility usually have the lowest paying insurance and allotted an insufficient amount of time at the hospital for proper therapeutic treatment thus perpetuating the recidivism cycle.

Systems theory was the theoretical foundation of this research. Systems theory is fitting because it assesses the health care segment (Elkins & Gorman, 2015). In the health care division, such as a psychiatric hospital, a systems model will help us

recognize the interconnections between the needs of the adolescent and the support systems that must be in place for positive treatment outcomes. The support systems for adolescents established by psychiatrists, psychologists, social workers, psychiatric nurses, and direct care workers include the education system for coping strategies, redirection and supervision by service providers, point system for attending and participating in the hospitals inpatient programs, using verbal praise and rewards for appropriate behavior, family involvement, medication compliance and linkage to aftercare services. This evidence was determined from the interview results of the service providers' perspectives. So, the service providers themselves are also a vital part of the support system.

In this qualitative case study, the systems theory foundation was relevant because primarily the systems theory approach identifies the parts of a model which fit together to deliver a probable outcome (Peters, 2014). For this study, this theoretical foundation provides an insight through the perspectives of the service providers, into the system of care where the coping strategies learned in the hospital setting provides a crucial support system for adolescents' reintegration into mainstream society. Twenty-one participants stated that the same coping strategies learned in the hospital are the same coping strategies assessed for discharge and used for integration into the mainstream society. In the system of care identified in this case study, service providers design therapeutic treatment plans (including coping strategies) and therapists remain in contact with the adolescents to ease the integration process and make sure the adolescents are involved in outpatient services. Also, after discharge the hospital therapist continues communicating with the adolescent patient, family, and other service providers in the school and community, keeping the system

of care active, which is essential for sustainability in the mainstream environment. A breakdown in any part of this systems approach increases recidivism (adolescent returning to the hospital). Furthermore, support regarding this issue will advance and expand the quality and system of care which in turn will increase the ability for adolescents to become productive members of the world.

The support systems for adolescents established by the participants are psychiatrist, psychologist, social workers, nurses, direct care workers, the education of coping strategies and consistent linkage to aftercare services. This evidence determined from the service providers' perspectives can help advance policy-based interventions that may brilliantly affect coping strategies that adolescents acquire for an effective changeover to normal society. Systems thinking proposes to increase the quality of perceptions by considering the entire system of care for the adolescents experiencing the psychiatric hospitalization, its parts, and the interactions within and between levels (Peters, 2014).

Limitations of the Study

Although, the participants signed consent forms and were debriefed trustworthiness must be established. Trustworthiness consist of credibility, transferability, confirmability and dependability. According to the article What is Trustworthiness in Qualitative Research by Connelly (2016), credibility is established by how confident the researcher is in the truth and accuracy of the findings based on the participants' responses and themes generated. Transferability is how the researcher demonstrates that the case study applies thick, rich and accurate descriptions to similar populations, similar situations, similar phenomena and context circumstances. Confirmability is the degree of neutrality in the research study and that the findings

are based on the participants' responses and not any potential biases or personal motivations of the researcher. Confirmability also involves making sure that the researcher bias does not skew the interpretation of what the participants stated. Dependability is that the study could be repeated by other researchers and that the findings would be consistent, and they should have enough information from your research report to replicate the study and obtain similar findings. A qualitative researcher can use inquiry audit to establish dependability by having an outside person review, examine the research process and the data analysis to ensure that the findings are consistent and can be duplicated (retrieved August 25, 2018 from http://www.statisticssolutions.com/what-is -trustworthiness-in-qualitative-research/).

A limitation of this research concerning trustworthiness is hoping that the participants trust this researcher enough to reveal personal information pertaining to their experiences while working with psychiatric adolescents. Another limitation of this study regarding trustworthiness is dependability. It was challenging for the service providers to plan time through or after work without disturbing their day-to-day work productivity. The third limitation of this qualitative case study is that the participants for this qualitative research study are service providers who work with or have worked with adolescents in a psychiatric establishment. Hence, the interpretations attained by this researcher are not the authentic experiences of adolescents and coping strategies learned by adolescents from their individual perspectives. Nonetheless, the service providers' perspectives are imperative because they play a significant part in helping the adolescents cope during long-term psychiatric hospitalization and transitioning into the community. The fourth limitation is that there are scarce research studies about adolescents' coping strategies in

psychiatric institutions and aftercare services; there is even less research on the service providers' perspective on adolescents' psychiatric patients' conduct. This study has helped fill that gap by exploring the perspectives of the service providers. Lastly, the fifth limitation of this research study was that most of the material on this research subject was out-of-date. However, the results of this study provide current information from the service providers perspectives about the system of care which will enable psychiatric adolescents who have experienced long term psychiatric hospitalization to integrate into the mainstream society.

Recommendations

The strength of this research study explores the service providers' perspectives on coping strategies of adolescent patients learned throughout and applied upon release from long-term psychiatric care, as well as the effects of the coping strategies on the adolescent's incorporation into ordinary society. This researcher interviewed service providers from the states of New York, New Jersey, Connecticut, South Carolina and the District Columbia of Washington.

The following immediate recommendations are derived from the key findings of the study: (a) efforts must be made to provide aftercare services and access (b) efforts must continue to connect adolescents to aftercare services (c) all participants should be taught how to ask for help, follow instructions, engage in medication compliance and avoid and deal with conflict (d) efforts should continue for on-going communication between family, adolescent, inpatient hospital and aftercare personnel.

Recommendations are that extensive research needs to be conducted in the areas of the service providers and the adolescent's perspectives on the effects of coping strategies implemented by psychiatric hospitals. There are few researches

presently available that discusses several aspects of the adolescent perspectives on their coping strategies learned in mental health institutions and the treatment they received while in care. Research pertaining to the adolescents' perspectives also discusses the effectiveness of the programs offered as well as the propensity for recidivism. Other, research on adolescents' perspectives allude to the relationship they form in the hospitals with peers, direct care staff, social workers, psychiatric nurses, psychologist and psychiatrist.

There are even less research involving the service providers perspectives regarding psychiatric adolescents. About research on service providers' perspectives, there is a need for more studies on this topic. More extensive research is essential about coping strategies effect on psychiatric adolescent patients returning to the mental health institutions; exploration can help reduce the recidivism rates and bring awareness to policy makers and society. Another recommendation is also for more comparison research involving the perspectives of adolescents and service providers about psychiatric hospital services.

A third recommendation for research alludes to the perspectives of the involved family members of the psychiatric adolescents. The families input concerning all programs of the psychiatric hospital is valuable and empowering for both the family member(s) and adolescents. Again, there is little research on this topic.

The final recommendation involves researching how the government disburse the allocated funds for adolescent psychiatric institutions. This exploration would provide awareness, permit the public to be informed, and an additional form of a checks and balance system. Massimo et al. (2016, p.16) argued that the expenditure of

monies allocated for the health systems in this country have been misused. It is noted by public health experts that if a country wants to improve their public health system, it must invest in public and primary health. Despite this recommendation to invest, it is apparent that primary health care is not prioritized in underserved areas of the United States (Massimo et al. 2016).

Implications

Social Change

The service provider perspectives from this qualitative case study will encourage societal transformation by providing information to adolescents, their families, service providers, and policy makers about the progression of proper psychiatric care needed to accommodate the adolescents' during their hospital stay. The coping strategies taught on the hospitals' units are critical for adolescents assimilating into the mainstream world. The fundamental coping strategies are knowing when to ask for help, following instructions, medication compliance, avoiding verbal and physical altercations. The therapist (usually the social worker) staying in contact with the adolescents after discharge is important for communication with outpatient service providers, family and connecting the adolescent patients to aftercare services. All participants stated that appropriate family support is key in developing the psychiatric adolescent. Aftercare services include the adolescent consistently meeting with a social worker or psychologist for counseling therapy, psychiatrist for medication evaluation and positive family involvement. A breakdown with any of these processes increases recidivism. The additional challenges the adolescents deal with are the factors of stigmatization. These factors are the adolescent being admitted in a psychiatric institution, taking medication, labelled as a

special education student, remaining in a small special education classroom most of the school day, meeting with the school psychologist frequently, and riding a small school bus for special needs students back and forth to school.

Namysloaska and Siewierska (2008) quoted that beneficial family models inside the adolescent psychiatric unit are advantageous to the adolescent in many ways. This involvement encouraged them to believe that the integration of the family leads to positive social outcomes. These results may transpire since the patient and his or her family can resolve problems, become further knowledgeable about the patient's mental illness, get information on how to conform with aftercare programs and appreciate the importance of medication administration. The researchers also discoursed that the inclusion of the family was a deterrent to recidivism (Namysłowska & Siewierska, 2008).

Again, this researchers' intent for social change is to assist policy makers and service providers with implementing therapeutic programs that will adequately equip adolescents with coping strategies and effective aftercare arrangement(s) following discharge from psychiatric institutions.

Methodological Implications

Case study as a research methodology is a means of investigating a practical issue by following a set of pre-specified procedures (Yin, 2002). The conceptual outline in a qualitative research is grounded on the understanding of human actions from the informers' perspective. So, the qualitative exploration is most appropriate for this research study (Creswell, 2007). In addition, and terms of relevance, the qualitative case study method accommodates an in-depth account of the service

providers' perspective about adolescent coping strategies during and post-hospitalization.

Baxter and Jackson (2008) indicated that the qualitative case study is a respected method for health science research to advance a theory, assess programs, and develop interventions. This study on the service providers perspectives will help recognize essentials in the system that will simplify adolescents' integration into the community following long term discharge. The principle is that effective therapeutic programs within the psychiatric establishment would endorse a healthy and smooth transition into the society for adolescents.

Theoretical Implications

The system theory is the theoretical foundation selected to understand the phenomenon of service provider's perspectives about the psychiatric experiences of the adolescents, coping strategies and outpatient programs used by adolescents following long-term psychiatric discharge. Finegood et al. (2012) define systems theory as an intricate scientific framework which employs huge quantities of information to yield a description and development of a scientific system. The method of systems thinking starts by probing the roots and answers of a complex issue by observing the construction and purpose of the system. Systems theory has a straight correlation to the proactivity of civic health in such a way that allows effective programs and guidelines to be developed in an institution by applying a holistic approach. A holistic approach is used to understand the primary issues and resolutions to the problem. Systems theory in public health relates to this present study thru providing evidence for policy makers on the organizational level to create programs within the hospital set that will generate a therapeutic milieu for adolescents. Using

such a holistic approach will consequently allow the adolescent patients' needs to be met. For example, from teaching the adolescents specific skills—medication compliance, conflict management to ensuring the provision of aftercare services and outreach to enhance adolescent access, the system of care can prevent recidivism. The patients eventually will gain the coping strategies that will prepare them for a confident shift into mainstream society.

Empirical Implications

Empirical implications are defined as a conclusion drawn from a concern verifiable by observation (Creswell, 2009). Empirical observation about this qualitative case study research concluded that coping strategies are a necessary tool for psychiatric adolescents from the service providers perspectives. Coping strategies for these adolescents are utilized for inpatient rehabilitation, mainstream integration and the outpatient process. The data collected from the participants interviewed verified that the adolescents who conform with the coping program implemented and taught by service providers in psychiatric hospitals correlate with the adolescents' success outside of the hospital. The information gathered also determined that lack of family support, medication non-compliance and no connection to aftercare services lead to high recidivism rates for the psychiatric adolescent population.

Conclusion

The main purpose of this qualitative research case study was to explore the perspectives of service providers about the psychiatric experiences of the adolescents, coping strategies and aftercare services used by adolescents following long-term psychiatric discharge using the framework of Finegood et al.'s (2012) systems theory. Service providers provide a pertinent role in the overall treatment process for the

adolescents through close professional association. The information attained from the service providers' interview described in detail the entire implementation process of coping strategies, successful transitioning from the hospital to a mainstream environment and the importance of consistently connecting to aftercare programs. The participants also confirmed that compliant adolescents and appropriate family involvement help reduce recidivism. Information resulting from this study will drive social change by supporting governing administration, management, and service providers with the progression of suitable psychiatric care to accommodate the adolescents' needs. This process is necessary for the therapeutic transformation of psychiatric adolescents in terms of coping in the world. Educating and including this systems approach for all categories of children, especially the less fortunate, impoverished, disabled, disadvantaged, abused, and neglected may stimulate positive social change at the level of our civilization. This holistic approach is key in describing the summation of this qualitative research case study.

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Appendix A: Screening

This study will consist of service providers in the mental health field. The screening process involves selecting a participant from each of the following professional category; psychologist, psychiatric nurse, social worker, family worker and direct care or mental health worker. Below are icebreakers and a series of questions relating to adolescent mental health work experience.

Screening Questions

1. What is your name, cell phone number, and email address?
2. What is your profession?
3. How long have you worked with adolescents in psychiatric care?
4. Did you provide services for adolescent directly?
5. From your perspective can you attest that therapeutic programs teach the adolescents ways to cope for integrating into the community.

Answering yes to all 5 of the aforementioned questions will determine if the participant will qualify for this research study. If they are not eligible this researcher will kindly thank them for their time and interest in this study.

Appendix B: Interview Protocol

Table 1

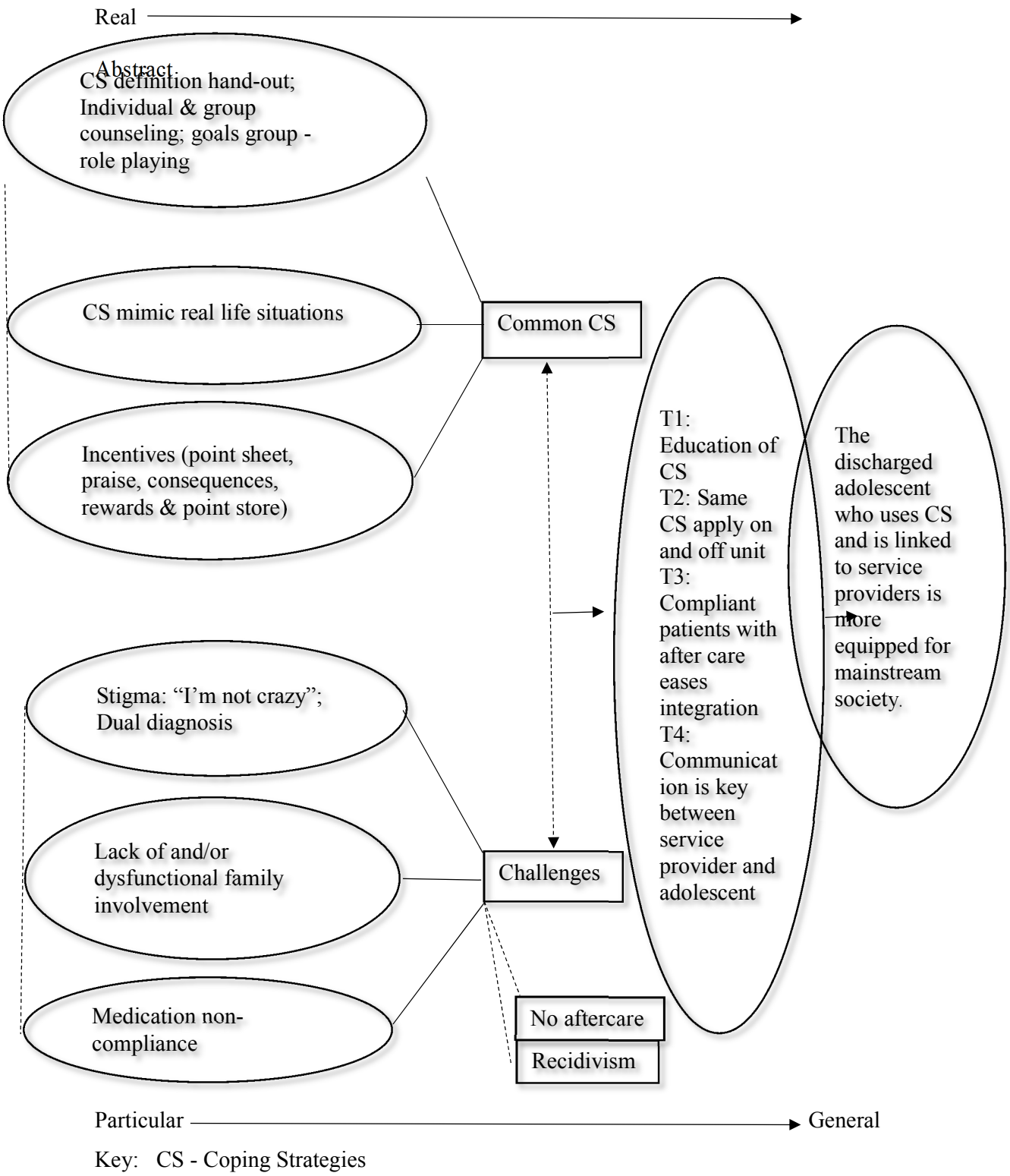
Research, Interview, and Probing questions

Research Questions	What are the perceptions of service providers about the coping skills learned by adolescents who have experienced long-term inpatient psychiatric care?	According to service providers what is the role of the inpatient psychiatric hospitalization and aftercare experiences for adolescents in the acquisition of coping strategies?	According to service providers how do adolescents who have experienced long-term inpatient care use coping skills to integrate into mainstream society?
Interview Questions	-which coping strategies or skills are taught to adolescents during their time in the hospital? -which coping strategies or skills are taught to adolescents during their discharge from the hospital? -what is the most common coping skill(s) used by adolescents? -are specific coping strategies taught to adolescents based on their diagnosis? -which coping skills do you think NEED to be learned by the adolescents in addition to what is	-in your experience, how does the hospital system help adolescents prepare for discharge after long-term psychiatric care? -can you identify the type of staff that remain in contact with the adolescents after discharge? -how often (weekly, monthly, yearly) are the service providers in contact with the adolescent after discharge? -how does the support staff, family, reinforce the use of coping skill(s) by the adolescent during and after discharge? -what is the type of feedback provided	-what do you think are the experiences of the adolescents after discharge from long-term psychiatric care? -what are the challenges for these adolescents when integrating into mainstream school, work, and community? -in your opinion what coping skills are required and used by the adolescents to integrate into a school setting? -in your opinion what coping skills are required and used by the adolescents to integrate into the community?

	being taught by service providers? - how do the adolescents practice and rehearse when and how to use coping strategies? - what are the therapeutic programs accessible for adolescents in long-term inpatient psychiatric care that help to build their coping skills?	when the adolescents use their coping skills? -can you describe the system which assists the adolescents with practicing the coping strategies? -what are the types of aftercare therapeutic support systems in place for the adolescents to reinforce the use of coping strategies? - can you indicate the system of care which must be in place to help the adolescent learn the different coping strategies?	-what do you think are the main reasons for the adolescents that frequently return to psychiatric institutions? -what skills do you think should the adolescents use so that the high rates of recidivism be reduced?
Examples of Probing Questions	What do you remember about a specific individual and an experience and the specific skills involved?	Can you describe the experience and incident further?	Does a certain individual and an incident come to your mind?

Note. Interview questions for service providers on coping strategies for adolescents' experiencing long-term psychiatric hospitalization.

Appendix C: Codes-to-Theory Model



Key: CS - Coping Strategies

Common CS - following instructions, ask for help, medication compliance, & avoiding conflict

Appendix D: Code Book

Hierarchical Nodes (convergence)	Number of Sources Coded	Number of Coding References	Number of Interviewee
Nodes\\10% of adolescents have mental health issues	1	1	10
Nodes\\adolescents' psychiatric therapeutic programming differs institution to institution, goals similar	1	1	3
Nodes\\adolescents with psychiatric illnesses do not think further than today, do not plan for tomorrow	1	1	17
Nodes\\adolescents with psychosis from vast number of situations	1	1	1
Nodes\\adolescents with psychosis from vast number of situations\bullying	1	1	1
Nodes\\adolescents with psychosis from vast number of situations\drug abuse	1	1	1
Nodes\\adolescents with psychosis from vast number of situations\living arrangements	1	1	1
Nodes\\adolescents with psychosis from vast number of situations\living arrangements\foster home	1	1	1
Nodes\\adolescents with psychosis from vast number of situations\living arrangements\group home	1	1	1
Nodes\\adolescents with psychosis from vast number of situations\living arrangements\home	1	1	1
Nodes\\adolescents with psychosis from vast number of situations\mental abuse	1	1	1
Nodes\\adolescents with psychosis from vast number of situations\parental drug abuse	1	1	1
Nodes\\adolescents with psychosis from vast number of situations\physical abuse	1	1	1
Nodes\\adolescents with psychosis from vast number of situations\sexual exploitation	1	1	1
Nodes\\aftercare	1	1	2
Nodes\\aftercare, integrating coping strategies	2	2	2, 4
Nodes\\aftercare, integrating coping strategies\adhering to aftercare coping plan	1	1	11
Nodes\\aftercare, integrating coping strategies\attend counseling meetings with school therapist, psychologist	3	3	2, 4, 9

Nodes\\aftercare, integrating coping strategies\attend educationally and emotionally extra help meetings	2	2	4, 9
Nodes\\aftercare, integrating coping strategies\completing homework	1	1	4
Nodes\\aftercare, integrating coping strategies\following therapist, school instructions, rules, procedures	3	3	4, 6, 9
Nodes\\aftercare, integrating coping strategies\independent living therapeutic meetings	1	1	13
Nodes\\aftercare, integrating coping strategies\phone calls to hospital to service provider developed positive rapport with	1	1	3
Nodes\\aftercare, integrating coping strategies\phone calls to hospital to service provider developed positive rapport with\usually direct care worker because amount of time spent with patient	1	1	3
Nodes\\aftercare\communication between hospital and school necessary for mainstream inclusion	2	3	6, 6, 18
Nodes\\aftercare\communication between social workers and family should be on-going	1	1	16
Nodes\\aftercare\continuous therapy, consistently attend outpatient coping services	9	9	1, 2, 6, 10, 11, 13, 15, 18, 19
Nodes\\aftercare\continuous therapy, consistently attend outpatient coping services\importance of follow-up treatment detrimental to success in mainstream	1	1	10
Nodes\\aftercare\continuous therapy, consistently attend outpatient coping services\the longer meetings continue, the greater chance for successful mainstreaming	1	1	15
Nodes\\aftercare\coping strategies necessary for successful integration into community	10	10	3, 4, 5, 6, 10, 11, 13, 14, 15, 17
Nodes\\aftercare\dedicated therapists help transitioning to mainstream	1	1	15
Nodes\\aftercare\detrimental stage, trying find where fit in society, struggling with physical development	1	1	17
Nodes\\aftercare\developing treatment plans including coping skills is key	1	1	14
Nodes\\aftercare\family support, involvement helpful, parental involvement	5	5	6, 10, 11, 18, 19
Nodes\\aftercare\family support, involvement helpful, parental involvement\parenting workshops	1	1	6
Nodes\\aftercare\follow up with adolescent once discharge	2	2	10, 13

Nodes\\aftercare\follow up with adolescent once discharge\longer therapist remains in contact, stronger association	1	1	13
Nodes\\aftercare\maintain adolescent in least restrictive environment, return to family	1	1	10
Nodes\\aftercare\medication management, compliance	5	5	2, 3, 10, 11, 19
Nodes\\aftercare\must be cohesion with hospital service providers and aftercare services	1	1	17
Nodes\\aftercare\not enough aftercare services available	1	1	1
Nodes\\aftercare\not enough aftercare services available\assist with carryover of coping skills	1	1	1
Nodes\\aftercare\not enough aftercare services available\following service providers' directives key coping component for positive integration	1	1	1
Nodes\\aftercare\patients that do not cope in facilities have difficulty incorporating society	1	1	19
Nodes\\aftercare\programs help with mainstream assimilation	1	1	7
Nodes\\aftercare\referrals to psychiatrist, medication management	1	1	10
Nodes\\aftercare\return to drug-free, safe, adolescent welcoming environment	1	1	3
Nodes\\aftercare\schools support through meetings with students, families and counseling sessions	1	1	7
Nodes\\aftercare\services should encourage exposure various services, contact positive peer role models	1	1	7
Nodes\\aftercare\solid foundation of services, foster care or residential treatment facilities	1	1	10
Nodes\\aftercare\taking advantage of resources depends on skill set	1	1	7
Nodes\\alters coping therapy according to diagnosis, state of mind, emotional level	9	10	2, 2, 5, 6, 8, 11, 12, 13, 14, 18
Nodes\\alters coping therapy according to diagnosis, state of mind, emotional level\acute psychosis programs for inpatient arena	1	1	2
Nodes\\alters coping therapy according to diagnosis, state of mind, emotional level\acute psychosis programs for inpatient arena\goals group supervised by social and direct care worker	1	1	2

Nodes\\alters coping therapy according to diagnosis, state of mind, emotional level\acute psychosis programs for inpatient arena\goals group where education of coping strategies takes place	1	1	2
Nodes\\apply several therapeutic coping models	1	1	12
Nodes\\assess patient, determine psychosis, name it	1	1	1
Nodes\\assess patient, determine psychosis, name it\can be transported to hospital as emergency case	1	1	1
Nodes\\assess patient, determine psychosis, name it\psychiatrist makes referrals based on level of psychosis	1	1	1
Nodes\\assess patient, determine psychosis, name it\referrals inpatient or outpatient services	1	1	1
Nodes\\believes in eclectic approach for each adolescent	1	1	11
Nodes\\better chance in regular setting	1	1	18
Nodes\\better chance in regular setting\coping with day-today issues	1	1	18
Nodes\\better chance in regular setting\maintain appropriate behavior while attending academic programs, recreation	1	1	18
Nodes\\better chance in regular setting\socializing with peers	1	1	18
Nodes\\blend of service providers, exceptional education, therapeutic treatment programs, research resources help patients	1	1	14
Nodes\\challenges	1	1	3
Nodes\\challenges\adolescents returning to community do not apply coping strategies	1	1	3
Nodes\\challenges\constantly attending aftercare difficult for patients and families	1	1	9
Nodes\\challenges\constantly attending aftercare difficult for patients and families\adolescent becomes consumed with social pressures	1	1	9
Nodes\\challenges\constantly attending aftercare difficult for patients and families\adolescent does not view as meaningful coping skill	1	1	9
Nodes\\challenges\dysfunctional home	1	1	10
Nodes\\challenges\dysfunctional home\neighborhoods riddled with drugs, gang activity	1	1	10
Nodes\\challenges\dysfunctional home\parents abusing drugs	1	1	10
Nodes\\challenges\dysfunctional home\parents abusing drugs\court-ordered rehabilitation ordered	1	1	10

Nodes\\challenges\dysfunctional home\parents abusing drugs\if noncompliance, parental rights terminated	1	1	10
Nodes\\challenges\families do not comply with treatment plan	1	1	3
Nodes\\challenges\getting family involvement	3	3	9, 11, 14
Nodes\\challenges\getting family involvement\single parents overwhelmed with other children	1	1	9
Nodes\\challenges\getting family involvement\transportation issues, not likely make meetings	1	1	14
Nodes\\challenges\getting family involvement\work hours, work 2 jobs	2	2	9, 14
Nodes\\challenges\lack of programs, aftercare services treat adolescents with varied difficult life issues	2	2	8, 11
Nodes\\challenges\medication non-compliance, parents refuse regimen	3	3	3, 11, 18
Nodes\\challenges\most families do not model, reinforce appropriate coping strategies	1	1	7
Nodes\\challenges\parents, guardians communicate poorly with social, family worker	1	1	3
Nodes\\challenges\parents, guardians not investing quality time in adolescent's life	1	1	3
Nodes\\challenges\parents, guardians not investing quality time in adolescent's life\educational support	1	1	3
Nodes\\challenges\parents, guardians not investing quality time in adolescent's life\emotional support	1	1	3
Nodes\\challenges\parents, guardians not investing quality time in adolescent's life\hobbies	1	1	3
Nodes\\challenges\parents, guardians not investing quality time in adolescent's life\spending time with hooligans	1	1	3
Nodes\\challenges\poor aftercare services	1	1	11
Nodes\\challenges\stigmatization feeling	3	3	6, 11, 18
Nodes\\challenges\stigmatization feeling\individualized counseling help with feelings	1	1	18
Nodes\\challenges\stigmatization feeling\state not crazy, not retarded, don't need medication	1	1	18
Nodes\\challenges\stigmatization feeling\stigmatization being labelled crazy, refuse services	1	1	6
Nodes\\challenges\stigmatization feeling\stigmatization being labelled crazy, refuse services\social workers formulate coping treatment, education plan	1	1	6

Nodes\\challenges\therapist remain in contact with patient after discharge	1	1	4
Nodes\\challenges\therapist remain in contact with patient after discharge\average communication approximately once a week of a month	1	1	4
Nodes\\challenges\therapist remain in contact with patient after discharge\early termination services due to high caseload	1	1	4
Nodes\\challenges\triggered negatively by going back into drug afflicted neighborhoods	1	1	3
Nodes\\cognitive behavioral coping therapy	1	1	19
Nodes\\coping skills developed to mimic real life situations	1	1	17
Nodes\\coping skills taught at psychiatric facilities endless	1	1	5
Nodes\\coping skills taught in hospital create base for integration, social skills, therapy	1	1	6
Nodes\\coping skills taught in institution not always reflection of treatment plan	1	1	3
Nodes\\coping skills, strategies	1	1	1
Nodes\\coping skills, strategies\accepting diagnosis	1	1	9
Nodes\\coping skills, strategies\accepting no for an answer	5	5	11, 12, 14, 17, 18
Nodes\\coping skills, strategies\anger management	1	1	21
Nodes\\coping skills, strategies\appropriate behavior while attending social hour, dining hall, recreational facilities, psychotherapy	1	1	2
Nodes\\coping skills, strategies\ask for conflict resolution with confrontational peer	1	1	5
Nodes\\coping skills, strategies\ask staff for help, seek assistance, how to get help	10	13	1, 1, 2, 4, 8, 9, 9, 10, 12, 12, 15, 16, 18,
Nodes\\coping skills, strategies\asking to speak to hospital staff	2	2	3, 5
Nodes\\coping skills, strategies\attending group programs	3	3	10, 13, 15
Nodes\\coping skills, strategies\avoid confrontational behavior	1	1	15
Nodes\\coping skills, strategies\avoid negative situations, removing self from potential trouble	3	3	1, 4, 6
Nodes\\coping skills, strategies\avoiding fights, conflicts	9	9	4, 5, 7, 8, 10, 12, 13, 14, 21

Nodes\\coping skills, strategies\being assertive	1	1	13
Nodes\\coping skills, strategies\building confidence	1	1	8
Nodes\\coping skills, strategies\curfew for bed or room	1	1	2
Nodes\\coping skills, strategies\demonstrating compliant behavior	1	1	20
Nodes\\coping skills, strategies\disagreeing appropriately	2	2	13, 21
Nodes\\coping skills, strategies\education about medication, side effects	1	1	1
Nodes\\coping skills, strategies\education, willingness to learn	1	1	2
Nodes\\coping skills, strategies\express themselves, have therapist listen	1	1	12
Nodes\\coping skills, strategies\expressing feelings appropriately	5	5	6, 7, 12, 14, 21
Nodes\\coping skills, strategies\finding adults who will advocate for her	1	1	8
Nodes\\coping skills, strategies\following instructions, directions, procedures	12	12	4, 5, 7, 8, 11, 12, 13, 14, 15, 16, 17, 18
Nodes\\coping skills, strategies\going for a walk	2	2	3, 5
Nodes\\coping skills, strategies\knowing when need help	5	5	1, 2, 11, 12, 20
Nodes\\coping skills, strategies\knowing when need help\most ideal coping skill	1	1	2
Nodes\\coping skills, strategies\knowing when to be assertive	1	1	6
Nodes\\coping skills, strategies\maintain in the milieu	1	1	9
Nodes\\coping skills, strategies\making apology	1	1	14
Nodes\\coping skills, strategies\medication compliance	6	6	4, 9, 10, 11, 14, 16
Nodes\\coping skills, strategies\music common coping strategy	3	3	1, 3, 17
Nodes\\coping skills, strategies\music common coping strategy\appropriate time listen to music	1	1	17
Nodes\\coping skills, strategies\music common coping strategy\even tone helps sooth the soul	1	1	1
Nodes\\coping skills, strategies\music common coping strategy\low volume music has tranquil effect	1	1	1

Nodes\\coping skills, strategies\music common coping strategy\used by patient	1	1	1
Nodes\\coping skills, strategies\music common coping strategy\used by treatment facility	1	1	1
Nodes\\coping skills, strategies\not harming self, others	1	1	12
Nodes\\coping skills, strategies\peer counseling	1	1	3
Nodes\\coping skills, strategies\problem-solving techniques	1	2	7, 7
Nodes\\coping skills, strategies\problem-solving techniques\anything interferes with balance and life	1	1	7
Nodes\\coping skills, strategies\problem-solving techniques\family situations	1	1	7
Nodes\\coping skills, strategies\problem-solving techniques\social situations	1	1	7
Nodes\\coping skills, strategies\proper research, discharge planning	2	2	3, 12
Nodes\\coping skills, strategies\resisting peer pressure	7	7	2, 9, 11, 16, 18, 20, 21
Nodes\\coping skills, strategies\resisting verbal, physical aggressive behavior	1	1	11
Nodes\\coping skills, strategies\respecting self, staff, peers	2	2	2, 6
Nodes\\coping skills, strategies\seeking positive attention	2	2	8, 13
Nodes\\coping skills, strategies\seeking positive relationships	1	1	8
Nodes\\coping skills, strategies\self-esteem, self-worth	3	3	5, 6, 8
Nodes\\coping skills, strategies\self-esteem, self-worth\builds by acknowledging strengths	1	1	5
Nodes\\coping skills, strategies\self-esteem, self-worth\needs to be taught to adolescents	1	1	5
Nodes\\coping skills, strategies\self-esteem, self-worth\understanding, displaying other coping strategies shapes self-confidence	2	2	5, 6
Nodes\\coping skills, strategies\taking deep breaths to relax	1	1	9

Nodes\\coping skills, strategies\time-out in quiet room, taking breathing space, separate self from stressful situations	7	8	5, 9, 9, 10, 14, 15, 16, 17
Nodes\\coping skills, strategies\tolerance of frustration	1	1	7
Nodes\\coping skills, strategies\understand, accept treatment	1	1	2
Nodes\\coping skills, strategies\waking up on time	1	1	2
Nodes\\coping strategies should be modeled by adults in their lives	1	1	7
Nodes\\coping strategies taught by redirecting patients	1	1	14
Nodes\\coping strategies taught, practice during therapy groups	7	7	5, 6, 11, 12, 13, 14, 18
Nodes\\coping strategies taught, practice during therapy groups\coping strategies learned during group and at their convenience	1	1	13
Nodes\\coping strategies taught, practice during therapy groups\most effective way teach coping skills individual therapy	1	1	11
Nodes\\coping strategies taught, practice during therapy groups\therapist's relationship with clients key to learning process	1	1	13
Nodes\\coping strategies, dedicated therapists help adolescents maintaining psychiatric ward	1	1	15
Nodes\\coping therapy most important along with medication compliance	2	2	13, 15
Nodes\\dealing with adolescents developing physiologically, mentally is challenging mission	1	1	1
Nodes\\demographics, participant	1	1	2
Nodes\\demographics, participant\10 years	1	1	15
Nodes\\demographics, participant\18 years	1	1	14
Nodes\\demographics, participant\24-hour emergency screening services	1	1	15
Nodes\\demographics, participant\25 years	1	1	1
Nodes\\demographics, participant\30 years	2	2	9, 13
Nodes\\demographics, participant\40 years with adolescents	1	1	2

Nodes\\demographics, participant\7 years with adolescents	1	1	7
Nodes\\demographics, participant\agencies liaison between service providers and adolescents	1	1	9
Nodes\\demographics, participant\court mandated foster care agency	1	1	18
Nodes\\demographics, participant\decades dealing with adolescents face-to-face, day-to-day	1	1	18
Nodes\\demographics, participant\developing small mental health clinics branches in several counties	1	1	5
Nodes\\demographics, participant\direct care worker	4	4	18, 19, 20, 21
Nodes\\demographics, participant\direct care worker\intake counselor	1	1	19
Nodes\\demographics, participant\direct care worker\milieu mental health manager	1	1	18
Nodes\\demographics, participant\email interview	1	1	7
Nodes\\demographics, participant\face-to-face interview	8	8	1, 4, 5, 11, 12, 13, 14, 21
Nodes\\demographics, participant\in home private practice	1	1	13
Nodes\\demographics, participant\independent living services, like group home	1	1	20
Nodes\\demographics, participant\independent living services, like group home\expectation attend individual and group counseling, chores, meet with probation officer	1	1	20
Nodes\\demographics, participant\inpatient and outpatient settings	9	9	1, 2, 4, 6, 11, 13, 14, 15, 20
Nodes\\demographics, participant\non-for-profit agency	1	1	10
Nodes\\demographics, participant\nurse	2	2	16, 17
Nodes\\demographics, participant\outpatient	2	2	9, 14
Nodes\\demographics, participant\partial care	1	1	15
Nodes\\demographics, participant\phone interview	13	13	2, 3, 5, 6, 8, 9, 10, 15, 16, 17, 18, 19, 20

Nodes\\demographics, participant\private practice	1	1	5
Nodes\\demographics, participant\psychiatrist	3	3	1, 2, 3
Nodes\\demographics, participant\psychologist	5	5	4, 5, 6, 7, 8
Nodes\\demographics, participant\social worker	7	7	9, 10, 11, 12, 13, 14, 15
Nodes\\demographics, participant\women's correctional center	1	1	5
Nodes\\demographics, participant\worked for hospital	10	10	4, 5, 11, 12, 14, 15, 17, 18, 19, 20
Nodes\\demographics, participant\worked for hospital\22 bed intimate setting ensure individualized attention	1	1	14
Nodes\\demographics, participant\worked for hospital\aftercare where coping strategies emphasized	1	1	14
Nodes\\demographics, participant\worked for hospital\inpatient program consists of coping treatment	1	1	15
Nodes\\demographics, participant\worked for hospital\psychiatric	4	4	5, 12, 17, 18
Nodes\\demographics, participant\worked for hospital\psychiatric\state psychiatric hospital	1	1	5
Nodes\\demographics, participant\worked in several agencies	1	1	19
Nodes\\demographics, participant\worked with adolescents suffering from substance abuse, domestic violence	1	1	9
Nodes\\demographics, participant\working with adolescents began 1996	1	1	10
Nodes\\demographics, participant\working with adolescents long time	1	1	3
Nodes\\demographics, participant\works in wellness center	1	1	2
Nodes\\demographics, participant\works with adolescent boys committed crimes, have mental illness	1	1	21
Nodes\\demographics, participant\works with adolescent boys committed crimes, have mental illness\aren't many success stories, usually fail and return to psychiatric setting	1	1	21
Nodes\\demographics, participant\works with adolescent boys committed crimes, have mental illness\basic function consistently coping, avoiding physical battles, attending counseling	1	1	21

Nodes\\demographics, participant\works with adolescent boys committed crimes, have mental illness\coping strategies need to learn numerous	1	1	21
Nodes\\demographics, participant\works with adolescent boys committed crimes, have mental illness\difficult teach coping strategies until harnessed anger, willing to accept treatment	1	1	21
Nodes\\demographics, participant\works with adolescent boys committed crimes, have mental illness\frequent confrontations, security overwhelmed breaking up fights, keeping facility safe	1	1	21
Nodes\\demographics, participant\works with adolescent boys committed crimes, have mental illness\if on certain level positive conforming can hold job, few benefit from privilege	1	1	21
Nodes\\demographics, participant\works with adolescent boys committed crimes, have mental illness\individual and group counseling available, only some clients attend	1	1	21
Nodes\\demographics, participant\works with adolescent boys committed crimes, have mental illness\most challenging aspect learning anger management	1	1	21
Nodes\\demographics, participant\works with adolescent boys committed crimes, have mental illness\rage stems from family issues, abuse, environment not conducive bringing up children	1	1	21
Nodes\\demographics, participant\works with adolescent boys committed crimes, have mental illness\therapy treatment becomes secondary because often violence	1	1	21
Nodes\\discharge planning	2	2	2, 8
Nodes\\discharge planning\as patient nears discharge, aftercare plan packaged by service providers	1	1	2
Nodes\\discharge planning\once coping strategies mastered, time frame set for discharge	1	1	8
Nodes\\discharge planning\service providers discuss coping strategies patient need to improve on	1	1	8
Nodes\\during groups patients discuss mental health issue, how cope daily	1	1	17
Nodes\\effective teaching tool have patient self-assess, design coping strategies	1	1	4
Nodes\\effective therapeutic programs in hospital critical teaching coping strategies	1	1	9
Nodes\\encouraging rapport developed with direct care worker, social worker, psychologist, nurses important to development	1	1	6
Nodes\\ethical, moral responsibility treat, repair adolescent	1	1	1

Nodes\\family support, involvement important	2	2	15, 17
Nodes\\family support, involvement important\involvement, communication huge developing coping strategies for both adolescent and parent	1	1	15
Nodes\\foster home	1	1	10
Nodes\\foster home\adolescent may not like home	1	1	10
Nodes\\foster home\foster parents might not like adolescent	1	1	10
Nodes\\foster home\some are unorganized	1	1	10
Nodes\\foster home\some foster parents abusive, interested in monetary incentive	1	1	10
Nodes\\foster home\the more structured, greater chance for success	1	1	10
Nodes\\fundamentals for psychiatric facilities	1	1	3
Nodes\\fundamentals for psychiatric facilities\consistently taking medication	1	1	3
Nodes\\fundamentals for psychiatric facilities\maintaining appropriate behavior	1	1	3
Nodes\\fundamentals for psychiatric facilities\safety	1	1	3
Nodes\\goal to teach patients coping strategies, prepare assimilation to normal environment	3	3	4, 17, 18
Nodes\\goal to teach patients coping strategies, prepare assimilation to normal environment\maintain in facility	1	1	4
Nodes\\goal to teach patients coping strategies, prepare assimilation to normal environment\maintain outside in society	1	1	4
Nodes\\handout detailed explanation each coping strategy given to patient admittance packet	1	1	8
Nodes\\highest achievement is to return home with biological parents	1	1	10
Nodes\\holistic positive approach	1	1	7
Nodes\\holistic positive approach\all parties should support adolescent through whole day, week	1	1	7
Nodes\\holistic positive approach\includes collaborate hospital service providers, outpatient services, schools, family support, community	1	1	7

Nodes\\hospital provides therapeutic environment	1	1	17
Nodes\\hospital provides therapeutic environment\addresses coping strategies	1	1	17
Nodes\\hospital provides therapeutic environment\addresses developmental growth	1	1	17
Nodes\\hospital stays can vary 6 weeks to 6 months depending on symptomology, diagnosis	1	1	3
Nodes\\hospital therapist main provider responsible keeping adolescents engaged with outpatient services	1	1	4
Nodes\\hospitals can do better preparing patients for community, school, workplace by enforcing consequences for inappropriate behavior	1	1	6
Nodes\\if not armed with proper coping information, progression in mainstream culture not achieved	1	1	1
Nodes\\important explore childhood, family composition and dynamics	1	1	13
Nodes\\incentive, reward program	8	8	4, 6, 14, 15, 16, 17, 18, 19
Nodes\\incentive, reward program\a walk	1	1	18
Nodes\\incentive, reward program\adolescent-friendly point store	1	1	17
Nodes\\incentive, reward program\art therapy	1	1	6
Nodes\\incentive, reward program\basketball, ping pong, table hockey	1	1	6
Nodes\\incentive, reward program\board games	2	2	4, 18
Nodes\\incentive, reward program\candy for taking medication	2	2	4, 18
Nodes\\incentive, reward program\cooking group	1	1	6
Nodes\\incentive, reward program\coping strategies taught everyday via point system	2	2	4, 15
Nodes\\incentive, reward program\earn points when follow daily living skills	1	1	17
Nodes\\incentive, reward program\earn points when follow daily living skills\completing school work	1	1	17
Nodes\\incentive, reward program\earn points when follow daily living skills\complying with bedtime	1	1	17
Nodes\\incentive, reward program\earn points when follow daily living skills\displaying appropriate behavior	1	1	17

Nodes\\incentive, reward program\earn points when follow daily living skills\taking shower	1	1	17
Nodes\\incentive, reward program\effective most of the time	1	1	17
Nodes\\incentive, reward program\more likely to comply when there are incentives for accomplishments	1	1	10
Nodes\\incentive, reward program\movie night	1	1	14
Nodes\\incentive, reward program\negative points for inappropriate behaviors	1	1	15
Nodes\\incentive, reward program\point reward adhere program, school's positive interventions	1	1	19
Nodes\\incentive, reward program\radio time	2	2	6, 18
Nodes\\incentive, reward program\remote control cars	1	1	6
Nodes\\incentive, reward program\some patients refuse to comply	1	1	17
Nodes\\incentive, reward program\time in peer's room	1	1	18
Nodes\\incentive, reward program\verbal acknowledgements	1	1	16
Nodes\\incentive, reward program\video games	2	2	4, 18
Nodes\\incentive, reward program\weekend, holiday home visits	1	1	18
Nodes\\incorporating families in therapy vital help adolescents maintain in hospital, prepare for discharge	1	1	13
Nodes\\length of stay critical in determining what treatment modality works best	1	1	2
Nodes\\length of stay critical in determining what treatment modality works best\some must be observed, evaluated on unit specific amount of time to diagnose, implement treatment plan	1	1	2
Nodes\\length of stay critical in determining what treatment modality works best\some must be observed, evaluated on unit specific amount of time to diagnose, implement treatment plan\beneficial coping skills	1	1	2
Nodes\\length of stay critical in determining what treatment modality works best\some must be observed, evaluated on unit specific amount of time to diagnose, implement treatment plan\counseling sessions	1	1	2
Nodes\\length of stay critical in determining what treatment modality works best\some must be observed, evaluated on unit specific amount of time to diagnose, implement treatment plan\medication evaluation, dosage	1	1	2

Nodes\\little funding affects care negatively, diminishes incentive programs	1	1	13
Nodes\\long-term hospitalization allows for continuity to build coping strategies not reinforce in home	1	1	7
Nodes\\most providers make strides rehabilitate, stabilize adolescents by teaching coping strategies	1	1	1
Nodes\\multidisciplinary team	6	6	2, 3, 14, 15, 16, 17
Nodes\\multidisciplinary team\certified adolescent mental health specialist	1	1	15
Nodes\\multidisciplinary team\coping skills evaluated, determine types successful treatments	1	1	17
Nodes\\multidisciplinary team\create outpatient plan	2	2	15, 18
Nodes\\multidisciplinary team\direct care worker	3	3	2, 16, 17
Nodes\\multidisciplinary team\direct care worker\develop positive rapport if considerate, calm, firm, fair, implements treatment plan	1	1	17
Nodes\\multidisciplinary team\direct care worker\inform team patients' day-to-day conduct	1	1	16
Nodes\\multidisciplinary team\direct care worker\key in keeping patients feeling safe, stable, comfortable	1	1	17
Nodes\\multidisciplinary team\direct care worker\most important because amount of time spent	1	1	17
Nodes\\multidisciplinary team\direct care worker\supervising, conversing, role modeling, redirecting, deescalating, apply consequences for negative behavior	1	1	17
Nodes\\multidisciplinary team\direct care worker\trained treat patient according to diagnosis	1	1	17
Nodes\\multidisciplinary team\direct care worker\trained treat patient according to diagnosis\depressed, self-injurious, suicidal supervise on eye contact	1	1	17
Nodes\\multidisciplinary team\discharge planning meetings keep service providers abreast of discharge	1	1	16
Nodes\\multidisciplinary team\evaluate adolescents based on number previous hospitalizations	1	1	3
Nodes\\multidisciplinary team\family therapist	1	1	15
Nodes\\multidisciplinary team\family therapist\liaison between facility and family	1	1	15
Nodes\\multidisciplinary team\formulate treatment plan, design coping plan	2	2	15, 17

Nodes\\multidisciplinary team\formulate treatment plan, design coping plan\design coping plan for each adolescent	1	1	2
Nodes\\multidisciplinary team\formulate treatment plan, design coping plan\goals determined at intake, adjusted when necessary	1	1	17
Nodes\\multidisciplinary team\mental health associates	1	1	2
Nodes\\multidisciplinary team\milieu manager	2	2	16, 17
Nodes\\multidisciplinary team\milieu manager\inform team patients' day-to-day conduct	1	1	16
Nodes\\multidisciplinary team\multidisciplinary team must support adolescent in all systems within mental health field	1	1	2
Nodes\\multidisciplinary team\neuropsychologist	1	1	15
Nodes\\multidisciplinary team\nurse	2	2	2, 16
Nodes\\multidisciplinary team\nurse\determine whether patient hurt himself, someone else	1	1	17
Nodes\\multidisciplinary team\nurse\follow, report, carryout psychiatrist orders	1	1	16
Nodes\\multidisciplinary team\nurse\insure patients receive and take correct medication	1	1	16
Nodes\\multidisciplinary team\nurse\liaison between patient and psychiatrist	1	1	17
Nodes\\multidisciplinary team\nurse\observe patients for side effects	2	2	16, 17
Nodes\\multidisciplinary team\nurse\treatment team discuss patient maintaining, recommend adjust medication	1	1	16
Nodes\\multidisciplinary team\psychiatrist	4	4	2, 15, 16, 17
Nodes\\multidisciplinary team\psychologist	4	4	2, 15, 16, 17
Nodes\\multidisciplinary team\social workers	4	4	2, 15, 16, 17
Nodes\\multidisciplinary team\social workers\communicate with social workers from outpatient clinics, aftercare programs, school	1	1	16
Nodes\\multidisciplinary team\social workers\propose to team tentative date for discharge	1	1	16
Nodes\\multidisciplinary team\social workers\put together discharge packet	1	1	16
Nodes\\multidisciplinary team\stabilize adolescent, prepare for discharge	1	1	15

Nodes\\multidisciplinary team\supervise, implement, teach coping strategies utilized in hospital	1	1	17
Nodes\\multidisciplinary team\team approach effective if each provider carries out duties	1	1	2
Nodes\\multidisciplinary team\treatment meetings discuss patients' behavior	1	1	16
Nodes\\outpatient care	1	1	5
Nodes\\outpatient care\medication compliance by psychiatrist	1	1	5
Nodes\\outpatient care\psychotherapy	1	1	5
Nodes\\patient information	1	1	19
Nodes\\patient information\patient problems treated	2	2	15, 19
Nodes\\patient information\patient problems treated\anxiety	2	2	4, 14
Nodes\\patient information\patient problems treated\autism	1	1	19
Nodes\\patient information\patient problems treated\bipolar	1	1	4
Nodes\\patient information\patient problems treated\chronic mental illnesses	1	1	15
Nodes\\patient information\patient problems treated\chronic mental illnesses\mainstreaming difficult, require close supervision, inpatient treatment	1	1	15
Nodes\\patient information\patient problems treated\crisis situations	1	1	15
Nodes\\patient information\patient problems treated\depression	2	2	4, 14
Nodes\\patient information\patient problems treated\dual diagnosis patients	3	3	13, 15, 20
Nodes\\patient information\patient problems treated\dual diagnosis patients\complain to doctors pain, fabricated illnesses get prescribed medication	1	1	20
Nodes\\patient information\patient problems treated\dual diagnosis patients\drug use and mental illness	3	3	13, 15, 20
Nodes\\patient information\patient problems treated\dual diagnosis patients\medication to help with addiction	1	1	15

Nodes\\patient information\patient problems treated\dual diagnosis patients\mental health issues prevalent due to rising of heroin addiction	1	1	13
Nodes\\patient information\patient problems treated\dual diagnosis patients\patience, 24-hour supervision is necessity	1	1	20
Nodes\\patient information\patient problems treated\dual diagnosis patients\programs being cut, budget reduction, less coverage by insurance	1	1	13
Nodes\\patient information\patient problems treated\dual diagnosis patients\some or most from wealth families	1	1	20
Nodes\\patient information\patient problems treated\dual diagnosis patients\specific coping strategies necessary	1	1	15
Nodes\\patient information\patient problems treated\dual diagnosis patients\steal money from parents, spend hundreds on drug transactions	1	1	20
Nodes\\patient information\patient problems treated\dual diagnosis patients\treatment longer, more involved process, challenging	2	2	13, 20
Nodes\\patient information\patient problems treated\OCD	1	1	14
Nodes\\patient information\patient problems treated\oppositional defiant disorder	2	2	19, 21
Nodes\\patient information\patient problems treated\other psychoses, psychiatric conditions	2	2	4, 14
Nodes\\patient information\patient problems treated\parenting difficulties	1	1	15
Nodes\\patient information\patient problems treated\PTSD	1	1	4
Nodes\\patient information\patient problems treated\schizophrenia	3	3	4., 19, 21
Nodes\\patient information\referred by	1	1	19
Nodes\\patient information\referred by\court stipulated	3	3	14, 20, 21
Nodes\\patient information\referred by\group homes	1	1	10
Nodes\\patient information\referred by\inner city school no therapeutic coping programs	1	1	19
Nodes\\patients consistently comply with treatment plan develop coping strategies prepare for aftercare	1	1	17
Nodes\\patients diagnose severely maladaptive behaviors require extensive inpatient therapy, medication	1	1	18
Nodes\\patients have hard time accepting responsibility for behaviors	1	1	9
Nodes\\peer intervention promotes coping strategies	1	1	6

Nodes\\positive and negative outcomes based on level of symptomology, medication side-affects	1	1	1
Nodes\\practice coping every day when participating in program, interacting and socializing with peers, daily activities	3	3	5, 12, 13
Nodes\\preparation for discharge patient must display cooperative behavior, utilization coping strategies specific length of time	1	1	16
Nodes\\psychotherapy, evidence-based practices best modality integration into mainstream culture	1	1	1
Nodes\\recidivism	3	3	3, 6, 7
Nodes\\recidivism\70-75% return to psychiatric care	1	1	17
Nodes\\recidivism\breakdown of family structure	1	1	19
Nodes\\recidivism\communities challenged with drugs, gangs, negative peer groups	1	1	19
Nodes\\recidivism\consistent inappropriate non-compliant behavior	1	1	9
Nodes\\recidivism\drug relapse	1	1	9
Nodes\\recidivism\facilities poor implementation of coping strategies	1	1	9
Nodes\\recidivism\lack of aftercare programs, services, coping treatment	3	3	13, 14, 20
Nodes\\recidivism\lack of commitment to aftercare services leads to recidivism	1	1	1
Nodes\\recidivism\lack of commitment to aftercare services leads to recidivism\by both patient and service providers	1	1	1
Nodes\\recidivism\lack of commitment to aftercare services leads to recidivism\disservice to patients	1	1	1
Nodes\\recidivism\lack of commitment to aftercare services leads to recidivism\onus on institution for treatment plan	1	1	1
Nodes\\recidivism\lack of commitment to aftercare services leads to recidivism\onus on institution for treatment plan\clear, concise	1	1	1
Nodes\\recidivism\lack of commitment to aftercare services leads to recidivism\onus on institution for treatment plan\continued support from social workers	1	1	1
Nodes\\recidivism\lack of commitment to aftercare services leads to recidivism\onus on institution for treatment plan\include lifetime mental health support systems	1	1	1

Nodes\\recidivism\lack of commitment to aftercare services leads to recidivism\onus on institution for treatment plan\included individual and group therapy	1	1	1
Nodes\\recidivism\lack of commitment to aftercare services leads to recidivism\onus on institution for treatment plan\routine visits to psychiatrist for medication management	1	1	1
Nodes\\recidivism\lack of commitment to aftercare services leads to recidivism\onus on institution for treatment plan\understanding, utilization of coping skills	1	1	1
Nodes\\recidivism\lack of communication between adolescent, family members, hospital, school	1	1	14
Nodes\\recidivism\lack of support of adult, family	2	2	7, 20
Nodes\\recidivism\may miss structure of facility, act-out to return	1	1	10
Nodes\\recidivism\medication re-evaluation	1	1	9
Nodes\\recidivism\patients with severely maladaptive behavior discharged return quickly	1	1	18
Nodes\\recidivism\poor integration	1	1	14
Nodes\\recidivism\refusal to take medication, not connected with psychiatrist manage medication	3	3	1, 3, 20
Nodes\\recidivism\service providers not follow-up with aftercare programs	1	1	6
Nodes\\recidivism\the more negative influences the longer the cycle continues	1	1	7
Nodes\\recidivism\times communication takes place, adolescent still returns	1	1	16
Nodes\\recidivism\usually occurs for those not connected aftercare services	1	1	3
Nodes\\residential home treatment, outpatient, and aftercare process key in continuous therapy	1	1	9
Nodes\\same coping skills learned on unit must be utilized for integration into school	1	1	6
Nodes\\school responsibility create environment	1	1	7
Nodes\\school responsibility create environment\making students aware positive behavior	1	1	7
Nodes\\school responsibility create environment\provides giving positive feedback	1	1	7

Nodes\\school responsibility create environment\supporting maintenance of coping strategies	1	1	7
Nodes\\schooling of coping strategies takes place hospital by direct care workers	1	1	11
Nodes\\service providers contact with discharge patient	1	1	5
Nodes\\service providers contact with discharge patient\inpatient facility rarely in contact with patient after discharge	1	1	9
Nodes\\service providers contact with discharge patient\nurses	1	1	5
Nodes\\service providers contact with discharge patient\often breakdown in communication leads to breakdown in supervision and treatment	1	1	16
Nodes\\service providers contact with discharge patient\overworked, not enough time keep connection with ex-patients	1	1	5
Nodes\\service providers contact with discharge patient\psychologists	1	1	5
Nodes\\service providers contact with discharge patient\remain in contact about 3 weeks after discharge, once a month then discontinuation	3	3	5, 9, 13
Nodes\\service providers contact with discharge patient\social workers	1	1	5
Nodes\\service providers contact with discharge patient\some give personal phone digits, strongly advise against	1	1	5
Nodes\\service providers contact with discharge patient\some service providers disconnect immediately	1	1	5
Nodes\\service providers respecting privacy, demonstrating compassion offers comfortable haven	1	1	14
Nodes\\service providers should be caring, empathetic	1	1	1
Nodes\\severe psychiatric adolescents don't do well in mainstream culture	1	1	9
Nodes\\should be added to list of coping strategies, need teach more frequently	1	1	4
Nodes\\should be added to list of coping strategies, need teach more frequently\accepting consequences	1	1	11
Nodes\\should be added to list of coping strategies, need teach more frequently\appropriately dealing with postponement, cancellation discharge	1	1	8
Nodes\\should be added to list of coping strategies, need teach more frequently\being patient, patients focus on immediate gratification	1	1	6
Nodes\\should be added to list of coping strategies, need teach more frequently\dealing with anxiety	1	1	9

Nodes\\should be added to list of coping strategies, need teach more frequently\hospitals need teach coping gestures more	1	1	3
Nodes\\should be added to list of coping strategies, need teach more frequently\hospitals need teach coping gestures more\excuse me	1	1	3
Nodes\\should be added to list of coping strategies, need teach more frequently\hospitals need teach coping gestures more\need to display on steady basis	1	1	3
Nodes\\should be added to list of coping strategies, need teach more frequently\hospitals need teach coping gestures more\please and thank you	1	1	3
Nodes\\should be added to list of coping strategies, need teach more frequently\hospitals need teach coping gestures more\you are welcome	1	1	2
Nodes\\should be added to list of coping strategies, need teach more frequently\jury of patients supervised by providers assist developing skills diffuse conflicts	1	1	4
Nodes\\should be added to list of coping strategies, need teach more frequently\jury of patients supervised by providers assist developing skills diffuse conflicts\have to maintain appropriate behavior a week to partake	1	1	4
Nodes\\should be added to list of coping strategies, need teach more frequently\making apology, frequently confrontation would be resolved	1	1	4
Nodes\\should be added to list of coping strategies, need teach more frequently\money management, fixated on buying expensive sneaker instead of saving money for future	1	1	10
Nodes\\should be added to list of coping strategies, need teach more frequently\regular family meetings, do not have to be face-to-face	1	1	15
Nodes\\should be added to list of coping strategies, need teach more frequently\regularly scheduled nature walks for rural institutions	1	1	18
Nodes\\should be added to list of coping strategies, need teach more frequently\regularly scheduled nature walks for rural institutions\exercise important for fitness, health, wellness	1	1	18
Nodes\\should be added to list of coping strategies, need teach more frequently\regularly scheduled nature walks for rural institutions\strategy can utilize in mainstream society	1	1	18
Nodes\\should be added to list of coping strategies, need teach more frequently\regularly scheduled nature walks for rural institutions\visually fulfilling, soothing effect	1	1	18
Nodes\\should be added to list of coping strategies, need teach more frequently\teaching coping strategies to parents and adolescents to co-exist	1	1	14
Nodes\\should be more services prepare adolescents integration mainstream society	1	1	6

Nodes\\social worker not present at time of discharge creates confusion, frustration	1	1	8
Nodes\\social worker not present at time of discharge creates confusion, frustration\direct care worker often not informed of discharge particulars	1	1	8
Nodes\\social worker not present at time of discharge creates confusion, frustration\leaves direct care worker de-escalate agitated patient	1	1	8
Nodes\\social workers integral part	7	7	1, 3, 5, 7, 13, 14, 16
Nodes\\social workers integral part\case management	1	1	1
Nodes\\social workers integral part\connecting patients to aftercare resources, coping services	4	4	5, 7, 13, 14
Nodes\\social workers integral part\liaison between psychiatrist, psychologist, administration, family, outpatient aftercare	2	2	1, 14
Nodes\\social workers integral part\liaison between psychiatrist, psychologist, administration, family, outpatient aftercare\compilations of arenas crucial in treatment process	1	1	1
Nodes\\social workers integral part\responsible preparing treatment plan	2	2	3, 14
Nodes\\social workers integral part\responsible preparing treatment plan\notes from direct care workers critical	1	1	3
Nodes\\social workers integral part\responsible preparing treatment plan\notes from direct care workers critical\document behaviors	1	1	3
Nodes\\social workers integral part\responsible preparing treatment plan\notes from direct care workers critical\document coping skills utilized	1	1	3
Nodes\\social workers integral part\responsible preparing treatment plan\notes from direct care workers critical\recommend new coping objectives, adjust old coping goals	1	1	3
Nodes\\some adolescents believe entitled to most things verses working hard to achieve goals	1	1	3
Nodes\\some encounter anxiety when discharge from facility	1	1	3
Nodes\\some hospitals follow up better than others in terms of discharged adolescents	1	1	7
Nodes\\some hospitals follow up better than others in terms of discharged adolescents\communication with family	1	1	7
Nodes\\some hospitals follow up better than others in terms of discharged adolescents\communication with pupil school support team	1	1	7

Nodes\\some hospitals follow up better than others in terms of discharged adolescents\communication with pupil school support team\attending school	1	1	7
Nodes\\some hospitals follow up better than others in terms of discharged adolescents\communication with pupil school support team\completing school work	1	1	7
Nodes\\some hospitals follow up better than others in terms of discharged adolescents\communication with pupil school support team\ensure functioning will in school	1	1	7
Nodes\\some hospitals follow up better than others in terms of discharged adolescents\communication with pupil school support team\positively interacting socially	1	1	7
Nodes\\some hospitals follow up better than others in terms of discharged adolescents\follow-up treatments can be weekly, monthly	1	1	7
Nodes\\sports, Yoga, Pilates integrate mental health, support maintaining coping strategies	1	1	7
Nodes\\state of mental health has changed drastically	1	1	1
Nodes\\state of mental health has changed drastically\adolescents not get care need to transit to mainstream society	1	1	1
Nodes\\state of mental health has changed drastically\untrained staff in different capacities	1	1	1
Nodes\\state of mental health has changed drastically\years ago more long-term treatment facilities, hospitals	1	1	1
Nodes\\structure of successful programs	1	1	3
Nodes\\structure of successful programs\consistently attending group therapy	1	1	3
Nodes\\structure of successful programs\performing daily living skills	1	1	3
Nodes\\structure of successful programs\stress importance practicing coping skills	1	1	3
Nodes\\success happens when mimics coping strategies	1	1	10
Nodes\\success story	1	1	2
Nodes\\success story\boy remained at hospital for at least a year	1	1	16
Nodes\\success story\boy remained at hospital for at least a year\18th birthday started to open up	1	1	16
Nodes\\success story\boy remained at hospital for at least a year\after several years enrollment promoted special assignment sniper	1	1	16

Nodes\\success story\boy remained at hospital for at least a year\explosive, when agitated would destroy hospital's property	1	1	16
Nodes\\success story\boy remained at hospital for at least a year\quiet, stayed to himself, expressionless	1	1	16
Nodes\\success story\boy remained at hospital for at least a year\service provider unsuccessful deescalate him	1	1	16
Nodes\\success story\boy remained at hospital for at least a year\worked with social worker on admission to US Army	1	1	16
Nodes\\success story\dual diagnosis patient	1	1	20
Nodes\\success story\dual diagnosis patient\clean approximately 3 years	1	1	20
Nodes\\success story\dual diagnosis patient\job working as information technology specialist	1	1	20
Nodes\\success story\dual diagnosis patient\mental illness managed by psychiatrist ad social worker	1	1	20
Nodes\\success story\dual diagnosis patient\smooth integration into mainstream after extensive inpatient and outpatient services	1	1	20
Nodes\\success story\family drug dealers and prostitutes	1	1	20
Nodes\\success story\family drug dealers and prostitutes\adolescent boys learned computer programming, have jobs	1	1	20
Nodes\\success story\family drug dealers and prostitutes\all arrested and incarcerated	1	1	20
Nodes\\success story\family drug dealers and prostitutes\judge ordered attend independent living program	1	1	20
Nodes\\success story\family drug dealers and prostitutes\mother, 2 sons drug dealers, when low on drugs mother be call girl	1	1	20
Nodes\\success story\family drug dealers and prostitutes\ordered get job, coping counseling, adhere outpatient service stipulations	1	1	20
Nodes\\success story\female psychiatric adolescent difficult to handle	1	1	2
Nodes\\success story\female psychiatric adolescent difficult to handle\discharged to foster parents because of positive change in behavior, family support	1	1	2
Nodes\\success story\female psychiatric adolescent difficult to handle\hard time accepting no for an answer	1	1	2

Nodes\\success story\female psychiatric adolescent difficult to handle\knowledge of medication, compliant practices, appropriate coping behavior ease process of integration into community, school	1	1	2
Nodes\\success story\female psychiatric adolescent difficult to handle\made great strides after car accident	1	1	2
Nodes\\success story\female psychiatric adolescent difficult to handle\made great strides after car accident\compliant, knowledgeable about medication	1	1	2
Nodes\\success story\female psychiatric adolescent difficult to handle\made great strides after car accident\consistently attended counseling sessions	1	1	2
Nodes\\success story\female psychiatric adolescent difficult to handle\made great strides after car accident\displayed daily utilization of coping strategies	1	1	2
Nodes\\success story\female psychiatric adolescent difficult to handle\non-compliant with medication, attending therapy sessions	1	1	2
Nodes\\success story\female psychiatric adolescent difficult to handle\suffered from depression	1	1	2
Nodes\\success story\few success stories, more stories of depressing nature	1	1	9
Nodes\\success story\former patient hired as direct care worker	1	1	18
Nodes\\success story\former patient hired as direct care worker\because of experiences convincing when counseling	1	1	18
Nodes\\success story\former patient hired as direct care worker\inspiring to patients because was in their shoes	1	1	18
Nodes\\success story\high school female	1	1	8
Nodes\\success story\high school female\associate with thuggish crowd	1	1	8
Nodes\\success story\high school female\embarrassed to return to school	1	1	8
Nodes\\success story\high school female\successful therapy positive strides in interpersonal experiences, ways view herself	1	1	8
Nodes\\success story\high school female\suspended from school, disrespectful behavior toward teachers, principal	1	1	8
Nodes\\success story\high school female\verbal, physical abuse by father	1	1	8
Nodes\\success story\high school female\victim of bullying, unkind song posted on social media	1	1	8
Nodes\\success story\hospitalized adolescent	1	1	11
Nodes\\success story\hospitalized adolescent\been stable at job numerous years	1	1	11

Nodes\\success story\hospitalized adolescent\contacted via social media	1	1	11
Nodes\\success story\hospitalized adolescent\earned associate degree from community college	1	1	11
Nodes\\success story\hospitalized adolescent\expressed she is doing well	1	1	11
Nodes\\success story\hospitalized adolescent\has a family	1	1	11
Nodes\\success story\patient admitted, treated in psychiatric hospital	1	1	9
Nodes\\success story\patient admitted, treated in psychiatric hospital\acquired job, graduated with GED, enrolled in community college	1	1	9
Nodes\\success story\patient admitted, treated in psychiatric hospital\attended program groups, followed regimen of counseling	1	1	9
Nodes\\success story\patient admitted, treated in psychiatric hospital\attending counseling bi-weekly	1	1	9
Nodes\\success story\patient admitted, treated in psychiatric hospital\compliant with medication, service providers	1	1	9
Nodes\\success story\patient admitted, treated in psychiatric hospital\discharged to parents	1	1	9
Nodes\\success story\patient admitted, treated in psychiatric hospital\parents drug abusers, community impoverished	1	1	9
Nodes\\success story\patient admitted, treated in psychiatric hospital\positively integrated into society	1	1	9
Nodes\\success story\patient came to hospital from foster care	1	1	12
Nodes\\success story\patient came to hospital from foster care\after several months therapy, medication developed relationships with peers	1	1	12
Nodes\\success story\patient came to hospital from foster care\after several weeks of therapy began to speak	1	1	12
Nodes\\success story\patient came to hospital from foster care\diagnosed emotionally disturbed, schizophrenic, borderline personality disorder, cutter	1	1	12
Nodes\\success story\patient came to hospital from foster care\expressed concern what would happen once left hospital	1	1	12
Nodes\\success story\patient came to hospital from foster care\prior to foster care raised in house with several dogs	1	1	12
Nodes\\success story\patient came to hospital from foster care\released to foster home backing importance of follow-up treatment, medication compliance	1	1	12
Nodes\\success story\patient came to hospital from foster care\spent most time alone, refuse participate in coping groups	1	1	12
Nodes\\success story\patient came to hospital from foster care\upon arrival nonverbal	1	1	12

Nodes\\success varies depending on family dynamics, diagnosis, support adolescent receives	1	1	7
Nodes\\terms adolescents understand	1	1	8
Nodes\\therapeutic healing begins with family	1	1	5
Nodes\\therapeutic process for mental health life-long coping process	1	1	1
Nodes\\therapeutic services include coping skills learn in, utilized in or outside facilities	1	1	20
Nodes\\therapist design treatment goals, coping tasks	1	1	16
Nodes\\therapist, several direct care workers assigned as advocates for patient	1	1	18
Nodes\\therapist, several direct care workers assigned as advocates for patient\ensure always someone available counsel patients	1	1	18
Nodes\\thought gardening team effective coping strategy, reward	1	1	12
Nodes\\thought gardening team effective coping strategy, reward\showing patients correct tool, how to dig right size hole form plants is aspiring	1	1	12
Nodes\\thought gardening team effective coping strategy, reward\watching garden mature is therapeutic	1	1	12
Nodes\\times emotions impacted negatively when trying utilize coping skills	1	1	3
Nodes\\times emotions impacted negatively when trying utilize coping skills\patient alone in quiet room might hurt themselves	1	1	3
Nodes\\times emotions impacted negatively when trying utilize coping skills\walk might illicit feeling to run away from facility	1	1	3
Nodes\\treatment plans designed be transferrable to life outside hospital	1	1	17
Nodes\\treatment within hospital significant	1	1	2
Nodes\\unsettling for patients, their family acknowledge psychiatric	1	1	14
Nodes\\wish to feel like regular teenager, challenging for emotionally disturbed	1	1	7