“No one knows I exist”: A qualitative study exploring the experiences of young people and staff in UK mental health hospitals

Abstract

Supporting youth mental health is a priority, currently one in 10 young people experience a mental health disorder. Accordingly, integrated youth health services are a focus for service development both in the United Kingdom and internationally. Less attention is given to inpatient settings and the experiences of young people who use them. This, in-depth, qualitative study aimed to understand the experiences of people aged 16 to 25 years, admitted to inpatient mental health settings, and the experiences of staff caring for them. Individual interviews with seven inpatient young people and three focus groups with staff (N =27) were conducted. An Interpretative Phenomenological Analysis (IPA) methodology with a polyvocal design was used. Young people reported how the impact of restriction, lack of inclusion, information, and transparency, affected their experiences. Relationships with other young people and staff were important while shared experiences were especially salient. Staff identified difficulties of working within a system divided into separate services while attempting to work flexibly with young people. Future practice needs to enhance relational, inclusive and flexible working practices to optimise care delivery.

Key words

Youth mental health, polyvocal, inpatient care, health experiences, Integrated Youth Health Services, Interpretative Phenomenological Analysis.

Practitioner Points

Young people aged 16 to 25 who are admitted to inpatient mental health wards want to be more included in decision-making.

Shared experiences can play a significant role in developing and enhancing relationships with both peers and staff.

Health professionals across both child and adult services require more cohesion and closer working practices. There is an identified need for greater flexibility between mental health services when considering the transition of a young person from one service to another.

Introduction

Mental ill-health currently accounts for 15-20% of the global burden of disease for young people, with depression and anxiety among the leading causes of illness in this age group (Kieling et al., 2024; WHO, 2024). Mental ill-health among children and young people is a global concern, with 8.8% of children and more than 10% of individuals aged 5 to 24 years living with a diagnosable mental disorder (Kieling et al., 2024; Piao et al., 2022). The consequences of this are profound, since these conditions detrimentally affect young people, their families, their communities, and economies at both local and national levels: what McGorry et al. (2022:2) describes as a “public health crisis". In response, and with the acknowledged failings of current mental health services, especially in the United Kingdom (UK), integrated youth health services (IYHS) are now identified as a priority for both UK and international policy (Darzi, 2024; NHS England, 2019).

The current UK goal is to provide comprehensive coordinated care from 0-25 years of age (NHS England, 2024; NHS England, 2019). Historically however, access to mental health services in the UK has been arbitrarily determined by age. Once an individual reaches 16-18 years of age they are expected to ‘transition’ from child to adult mental health services. Inpatient mental health services do not typically follow integrated or collaborative care models as exemplified in other areas of child health (Hope et al., 2023). This transition is often poorly planned, leading to gaps and missed opportunities in the provision of care (Hill et al., 2019; Mulvale et al., 2016). With nearly one million children in England being referred between 2022-23, approximately 8% of children in England (Office of the Childrens Commissioner, 2024), the impact of poorly coordinated and inaccessible services is a serious concern (Darzi, 2024).

International evidence suggests that the provision of integrated youth-specific services offer a novel and more appropriate approach to mental health services delivery (Hetrick et al., 2017; Maxwell et al., 2019). However, there are no robust controlled trials demonstrating the efficacy and impact of IYHS for service delivery (Healthy London Partnership, 2019). To date, IYHS in the UK have predominantly been delivered through community mental health teams with the most vulnerable young people being admitted to mental health hospitals (Hannigan et al., 2019). There are approximately 3500 young people admitted to CAMHS units each year in the UK, these are most often those young people with complex emotional and social needs involving self-harm, emotional dysregulation, psychosis and eating disorders (Clark & MacLennan, 2023). Fazel et al., (2021) suggest that a model that strengthens integration between paediatric services and mental health services is vital since many children with complex and chronic illnesses also experience mental disorders. Of particular note is that in the UK there is an increasing number of admissions for young people with a diagnosis of an eating disorder (Office of the Childrens Commissioner, 2023), suggesting that there may be a compelling reason to consider integrated youth health models for inpatient mental health units, especially where young people are at risk of being in a difficult liminal position between child and adult mental health services (Ragnhildstveit et al., 2024).

While most research focuses on community service delivery for this age group, much less is known about the lived experiences of young people aged 16 to 25 admitted to mental health hospital inpatient wards. Previous research on inpatient experiences, based on children up to

18 years, provides evidence that this group are often excluded from discussions about their care where many may report not feeling listened to, describing how they frequently struggle to access appropriate support after discharge (NSPCC, 2024; Reavey et al., 2017; Wallstrom et al., 2021). Combined with service level and systemic barriers in today's health care systems, this situation has created multiple challenges to effective access and engagement with services (Anderson et al., 2017)

The aim of this study was to explore both the perspectives of young people aged 16 to 25 admitted to mental health hospitals and the views of health professionals providing care for this group.

Materials and Methods

Methodological framework

Interpretive Phenomenological Analysis (IPA) (Smith et al., 2022) is an increasingly popular method amongst heath researchers, with the suitability for IPA relating to the bio-psycho-social theory of healthcare and for IPA to allow an ascription of meaning to their interactions, especially within the health environment (Biggerstaff and Thompson, 2008). The aim of IPA is to facilitate an understanding of participants' major life experiences (Smith et al., 2022; Tuffour, 2017) through exploration, description, and interpretation. We adopted a multiperspective IPA design (Larkin et al. 2019), involving both service-user participants and healthcare staff to explore each aspect of the dyad group.

Sampling

A convenience sample of participants aged between 16 and 25 were invited by clinical staff from three NHS trusts in the West Midlands, UK. Participants were recruited from adult wards where those from 18 to 25 were eligible for inclusion, and children's wards where patients aged 16 to 17 were eligible to participate. Eligible participants were provided with information about the study, and, if agreeable, were then contacted by the research team. In addition, inpatient ward managers of child and adult wards from these three NHS Trusts were approached to support the recruitment of interested staff to focus groups. Following IPA principles, sampling was broadly homogenous, providing a sample that can give sufficient perspective, the emphasis being on quality of the in-depth interview rather than quantity (Smith et al., 2022).

Data collection

Eligible participants were young people aged between 16 and 25 years admitted to a mental health hospital inpatient ward for any reason. People with significant cognitive impairment which impeded their capacity to consent were excluded. Health care staff needed to have had experience of working with this age group (young adults 16 – 25 years) to be eligible. Health staff included registered Nurses, Doctors, Psychologists, Occupational Therapists and supporting healthcare staff, often called Healthcare Assistants. Interviews with young people were conducted face-to-face, on the wards in pre-booked private meeting rooms, by the first author (WM) using a semi-structured interview schedule. Focus groups with staff were conducted in pre-booked meeting rooms. The interview schedule was informed by an earlier published review (Murcott, 2016). This schedule supported the interviewer to elicit lengthy dialogue and clarity as to the individual accounts, open ended questions; Socratic dialogue, clarifications and freedom to explore were all employed to encourage depth from all participants. Written and signed consent was obtained prior to the interviews and verbal consent audio recorded at interview.

Data analysis

All interviews and focus groups were digitally recorded, anonymised and transcribed in full. The research examined two distinct groups of participants: young people in receipt of care, and professionals/staff members involved in the delivery of care. This multi-perspective design meant that analysis was first conducted for each case (participant), before each set of cases (the group dyad of young people or the group dyad of staff focus groups), was examined across cases and between dyads. During each stage of analysis, emerging Personal Experiential Statements (PETs) and Group Experiential Statements (GETs) were discussed between authors (WM DB SW and AT) and consensus agreed. The first author conducted the interviews, transcripts and analysis and kept a reflective diary throughout the process. This later process assisted in gaining greater understanding of the impact of existing professional knowledge between the interviewer and the interviewee. Interviewer WM is a mental health nurse, with experience of both CAMHS and AMHS inpatient settings, but had limited knowledge of the inpatient environments where this research was conducted and no prior knowledge of the participants. IPA, an interpretative paradigm, foregrounds the lived experience of research participants, whereby the researchers took a subjective stance to gain understanding from participant's perspectives (Smith et al., 2022). The participants were recognised as experts in their own experiences, concentrating on the lived experiences. Reflexivity is a key part of IPA (Langdridge, 2007), whereby the researchers also need to consider their own world view and how this may impact on the research process, particularly as this assists against bias impacting the findings while being mindful of the emphasis on 'truthfulness' in qualitative data (Tuffour, 2017).

Ethics

The interviewer (WM) was aware that conducting interviews and focus groups to gain qualitative data might pose a potential risk to participants due to the sensitive nature of mental health care. All participants were provided with details of the study, including Participant Information Leaflets (PILs) written, and signed, consent forms and gave permission for digital audio recordings. Ethical approval was granted by the University of Warwick and the West Midlands and Black Country Research Ethics Committee (REC reference 217781)

Results

Participants

Seven young people who had been admitted to inpatient mental health wards participated in one-to-one interviews, three had been admitted to children's wards and four to adult wards. Twenty staff contributed to three focus groups, two on adult wards, one children's ward, providing a combined total of more than ten hours of in-depth qualitative interview data. Tables 1 and 2 provide anonymised details of the study participants.

Pseudonym	**Age**	**Gender**	**Setting**	**Number of admissions**
Lila	17	Female	CAMHS	Multiple admissions
Tracy	16	Female	CAMHS	Second
Becky	16	Female	CAMHS	Second
Darren	24	Male	AMHS	First
Jodie	20	Female	AMHS	First
Jenny	25	Female	AMHS	Multiple admissions
Gemma	21	Female	AMHS	First

Table 1. Patient participants

	Number in group	Ward type	Group members
Focus group 1	4 nursing staff	female AMHS ward	Ward manager, two registered nurses and a health care assistant
Focus Group 2	8 doctors	across AMHS wards	All working below grade of consultant
Focus Group 3	8 nurses and doctors	CAMHS wards	senior nurses, ward managers and registered nurses

Table 2 Focus Group Participants

Summary of Findings

The main themes derived from patient participants were identified as:

- The importance of interpersonal connections
- Making sense of the admission
- Power dynamics and compromises to autonomy.

Health professional themes were:

- The system, and supporting
- Failing young people.

Table 3. shows the three group experiential themes (GETs) and sub themes identified for patient participants and health professional participants that highlight the importance of the overarching core theme (in bold).

Group Experiential Themes (GETs): Young People	**Group Experiential Themes (GETs): Staff**
The importance of personal connections Wanting to be known by staff and peers The importance of shared stories	**The system** The system as being difficult to navigate
Making sense of, and understanding the admission Time and space Fitting into the age range Transition between services	**Working together** Co-location and service integration A suitable age range and the divide between services
Power dynamics and compromises to autonomy The importance of empowerment and disempowerment Punishment, criminalisation and violence	

Table 3: Summary of Group Experiential Themes and subthemes.

Group Experiential Theme, GET: The importance of connections

‘The importance of connections’ was identified as being meaningful for all participants. This umbrella GET includes the themes of ‘wanting to be known’ and ‘the importance of shared stories’.

Wanting to be known by staff and peers

Interpersonal connections were an important aspect for all the young people during their admission. Despite the proximity to staff and others, young people reported finding themselves in situations where they felt unable to talk to others, or worried about who they could talk to:

> Gemma (Adult Patient, AP): I remember saying to my mum like the two [people] I’ve got on with left and I don’t know who I’m going to talk to now.

‘Not being known’ was strongly felt by most of the young people interviewed, and they considered this as a detrimental aspect to their experiences of care, as ‘Jenny’ identifies:

> Jenny (AP): […] just for some recognition on this ward of who I am, and have faith [that] staff actually know who I am and calling me Katie and Sally and every other name under the sun, it would be nice just to feel that people know who you are […]

The importance of shared stories

Although staff were perceived as trying to connect with the young people in their care, they were dismissed by the young participants because they considered that the health staff were not seen as ‘people’ who they, as ‘patients-as-participants’, felt they could have a shared experience with, Lila, for example observed:

> Lila (Child Patient, CP): […] although the staff are trained and qualified, it’s very different with the understanding because, obviously, they haven’t been through it but I found when you have ex-patients come and visit and talk to the young people, I think that’s quite helpful as well.

Gemma held a similar view to Lila, although Gemma’s opinion changed during her period of admission to the ward. The image of the ‘nurse’ carried with it a sense of being an ‘official’, and Gemma saw this initially as a barrier:

> Gemma (AP): I held back on things because when you first look at them as official bodies with a job title like ‘nurse’, and whatever, the longer you see them and get to know them, the more, you know, they are real people doing a job.

The excerpt below illustrates how a nurse was able to show herself as being ‘a person’ to Gemma. This connection was highlighted by their shared experience:

> Gemma (AP): […] I was talking to one of the nurses, that she had suffered with depression […] I think it is, you know, reassuring that staff have gone through whatever, have got their own experiences to share upon.

GET: Making sense of, and understanding the admission

Time and space

Gemma found that her admission to an adult ward gave her a ‘peaceful’ space. She considered that her admission allowed her to be able to explore negative emotions in a safe environment as a liminal space. This space was not attached to an important area, such as her home, enabling her to leave these emotions behind her:

> Gemma (AP): Because it's not home, I'm not worried about upsetting anyone or anyone overhearing, or you know it's kind of said here and when I leave.

[….]

> Gemma (AP): Yeah, if it was in your living room it would always be this was where I said whatever when I was feeling this, is going to be attached on.

By contrast, Jodie's experiences as an inpatient, were that too much space and lack of activities created an environment of boredom and isolation:

> Jodie (AP): I would say prepare to be bored..

Crucially for the participants, the possibility of being able to take 'leave' from the unit, facilitated by the young person's family, or care givers' proximity to the ward, was frequently prevented by the distance of the unit from the family home:

> Lila (AP): You can't have leave if your parents can't come and take you out, so you're stuck there in this cycle until you get discharged, and that's the first time you've ever had leave […] it's very hard.

Fitting into the age range

Some participants found that residing with people older than their owm age group allowed them to develop relationships, and to understand adults from a perspective they had not previously considered:

> Gemma (AP): Because they're like 20 years ahead of me in life and they are that much more insightful and lived a bit longer, done real jobs, that kind of thing […] you still lived a normal life and that's quite reassuring.

In contrast to Gemma's observation, other participants viewed older patients as people they did not want to engage with, and a possible 'warning' as to what may lie ahead for their own future:

> Jenny (AP): […] I have met so many women in their 40s, 50s, 60s who've been in hospital since they were children, just never got out of the system.

Transition between services

Participants interviewed on the CAMHS units were concerned about what might happen to them after they were discharged. The information young people were given was perceived as being mostly negative. This experience then became an added pressure on them to 'get better' more quickly, if they were to avoid the move to adult care:

> Becky (CP): Well, people [*staff*] have said like "Oh you best try and get it sorted now 'cos it'll be adult services soon".
>
> Lila (CP): […] I have friends who have been in adult services and said it's not the best place to be. They kind of summed it up as get better before you turn 18, otherwise you'll end up in adult services and that's not a place you want to be!

Participants considered that CAMHS reduced their sense of personal responsibility, whereas the perception of adult services was that a person is completely responsible and accountable for their own actions:

> Lila (CP): I think because staff think "Oh, you're in your teenage years, you should take responsibility for yourself", but when you have mental illness, you're more vulnerable and I don't think […] we shouldn't be treated as adults so much.

GET: The theme of power dynamics and compromises to autonomy

Participants reported how they experienced feelings of either being empowered through support and care or disempowered through restriction, coercion and compulsory actions relating to the care they received.

The importance of empowerment and disempowerment

Gemma not only did not know what would happen to her as ‘no one really said “this is what happens”, but also reported she did not understand why nursing staff did what they did:

> If they sat you down and said what we’re doing and why we’re doing it blah blah blah that would make it a bit more normal […] it was kind of explained a couple of days after when I was like “Oh there’s people shining lights on me at 2.00 am”.

Gemma described her freedom prior to her admission, contrasting her former lived-world experience of being an independent person being able to “come and go and do whatever”, clashing with the more constricting clinical rules of the ward:

> Coming here I found it difficult because there are so many rules, you can’t have your phone charger for health and safety; it felt a bit like Big Brother.

Punishment, criminalisation and violence

Young people in the study appeared to draw parallels with other institutions associated with exclusion, such as prison, and hell:

> Gemma (AP): It was hell there, a living hell.
>
> Darren (AP): I don’t call this place home. I call it hell […] I feel like I’m in hell.
>
> Tracy (CP): I felt like some kind of criminal.

Physical contact was described, both where it related to physical restraint, and, by contrast, participants’ need for positive physical contact. The young people who described their experiences of restraint held very strong views concerning their criticisms of restraint, its application and the reasons for use:

> Tracy (CP): They honestly would restrain you over the tiniest, pettiest little things, like I had a paperclip in my hand once and they immediately just like try to restrain it off me. Sometimes it was needed but it was just constant.

Jenny also saw restraint as a form of ‘physical violence’, thus implying that there was a much more personal and negative intention from the perpetrator of the violence towards herself, as the victim.:

> Jenny (AP): It’s just physical violence, I mean restraint but restraint not being used properly […], some staff are caring even if they are restraining you, they remain caring and supportive, some staff take it on and see it as though they’re bullying you and they’re sort of enjoying the satisfaction of bullying you and hurting you and again it just depends on what staff you have on what ward and it varied completely throughout the Trust, so I’ve had some amazing staff members and I’ve had some terrible ones.

Group experiential themes for health professionals.

GET: The system

The system is difficult to navigate

Focus Group 1 (FG1, composed of nurses and health care assistants on an Adult Ward (AW, see Table 2)) were in agreement during their discussion that their experiences of the working practices were difficult for a young person to comprehend. This group of participants (N = 4) recognised that a young person may have difficulty in understanding the reasons for this new-found loss/lack of autonomy in their life:

> Female Staff Nurse: They don’t, they can’t grasp that, especially when they are unwell.

While FG1 were unanimous in agreeing that they realised that the system was difficult for a young person to understand, participants in FG2 (AW), comprising 8 Adult Mental Health Service (AMHS) doctors, debated the difficulties of how they, as professionals, needed to be able to help a young person, a point which is discussed further below:

> Male Doctor (AW): How are we going to help these people? Well, we’re probably not, is the answer really.

This view, i.e. of not feeling able to help the young people in their care, stems from the professional group’s concerns about how the young person navigated their own care. Whereas in FG1 (AW), this other group noted that the young person was often thought to have difficulty in understanding what happens to them:

> Female nurse: They don’t understand how the system actually works […] they don’t actually understand, like, why they can’t leave.

In Focus Group 3 (FG3 Child Ward (CW)), comprising of 8 CAMHS allied professionals’ group, interviewees considered that the young person’s way of navigating the system was being ‘primed’ by ward staff, and other sources, such as peers and social media, to deliberately misunderstand adult services:

> Female nurse: I think because they’ve heard what they’re like! I mean, like even in the media or from people who work in these services I can imagine that there’s probably been times where people have heard the words, “You don’t want to go to Adult Services”.

Participants in FG3 (CW) discussed that they were ‘compromised’ by the systems processes; the system itself dictating the boundaries of care, and how they could best deliver ‘treatment’.

This situation then affected their sense of how they might be able to organise the transfer of care between the different services for their patients:

> Female manager (CW): […] when we've got young people in our service that are coming up to an 18th birthday trying to plan ahead for continuing care is really hard, […] You can't really have a lot of pre-planning because they're not accepting referrals into Adult Services until quite close to that birthday.

Thus, any treatment that the team considered they were able to provide was time limited, meaning that often treatments for the young person were not always completed in the time the team had available. This perceived lack of adequate time created challenges among the health professionals involved as to how they might work with their 16- to 18-year-old patients; from working with increased 'risk' to 'stretching the boundaries' of transition to create a longer admission.

> Male deputy ward manager (CW): […] for her, we knew that was never gonna happen because her birthday was too soon […] we kind of, bent over backwards, you know, tried to as much as we could do to keep her here as long as possible […] whereas really if she'd been 16, we'd have done things completely differently.

Observations such as these illuminate new perspectives on the challenges faced by mental health professionals prior to, and leading up to, the transition from a children's service. CAMHS staff participating in this study considered that they had needed to compromise some of their usual working practices, due to concerns over the care and treatment of a young person when faced with a largely inflexible transition point, as one senior nurse observed:

> Male senior nurse (CW): […] you're left managing a higher state of risk […] trying to manage risk that is above the threshold […] managing a risk that's higher than with that age group […] what we're used to managing, or what our environment allows us to manage.

Although clearly a phenomenon of importance to CAMHS staff, to the best of our knowledge we believe this to be the first qualitative reporting of staff working with young people over the typical threshold of 18 years old.

GET: Working Together

Co-location and service integration

Both FG1 (AW) and FG3 (CW), described experiences of isolation in their clinical work. FG1 experienced geographical isolation from other services:

> Male ward manager (AW): […] We just, like, literally give them a handover on the phone when they've been discharged.

Participants in FG3 were part of a children's health service. Consequently, interviewees in FG3 stated that they experienced further isolation from other mental health services:

> Male staff nurse (CW): I don't think we could be much more isolated, could we?! I mean, we're literally just a little part on our own, aren't we? I mean, even the rest of the Trust forget about us half the time!

All three health professional focus groups discussed the topic of isolation by explaining how they wanted to become more unified with other services, for both the co-location of services, thus enabling them to work more closely with other professionals.

A suitable age range and the division between services

Some participants in FG2 (AW) expressed uncertainty as to whether a specific 16 to 25 service was necessary. They raised concerns over some 18-year-olds not being developmentally 'ready' for adult services, and the detrimental influence from those adults receiving treatment on adult wards:

> Male doctor (AW): […] they might be 18 but emotionally they're probably 13 so yes they're on a ward with 45-year-olds who smoke, do hard drugs, cannabis and all sorts of things and you know yes they're too old to be on the CAMHS ward, that's completely inappropriate.

CAMHS staff participants within FG3 also raised concerns about using the age of 18 as the 'boundary' between adolescent and adult care:

> Female senior nurse (CW): […] it's such a stark shift. It's, it's for me, it's too big, it's a complete turnaround overnight.

Participants in this group experienced little power to alter or change the process, and this appeared to be a fundamental issue; where the staff group worked developmentally, but the system and processes did not facilitate that:

> Female ward manager (CW): […] so I think the model is not developed, it's not a development model [*the service*] they're thinking about. It's almost a one-size-fits-all.

Discussion

The research reported here explore the experiences of staff and young people aged 16 to 25 admitted to mental health inpatients wards. Key findings concern the importance of personal connections for both groups of participants, with shared experiences and inclusion being at the forefront for young people. Making sense of, and understanding the admission was largely dependent on the power dynamic between the groups, such as whether the young person felt empowered or disempowered by staff actions, and how the system was navigated by both health professionals and by young people.

Peer relationships were mentioned by patient participants across both child and adult settings as important relational aspects to an in-patient admission. This type of relationship helped the young person gain different perspectives on what they thought about others, and about their own experiences. Reavey et al. (2017) noted the value of young people sharing their thoughts and feelings with each other, in that a 'greater sense of emotional competency' was gained among patients than with staff. For many of the patients as participants in their study this experience occurred informally, through the development of peer relationships, and often continued after discharge. Similarly Walsh and Boyle's (2009) service user led research indicates that coming together in adverse circumstances can provide a sense of camaraderie, which may be more supportive for recovery than the provision of clinical treatment alone. Findings from our research found peer support was equally highly valued by participants since the young people interviewed wanted to relate to other people with similar experiences: this novel finding highlights the importance of sharing and shared experiences, especially within this age group. The young participants appeared to find other young people easier and more accessible to talk to than conversing with staff. The young people also described having clear ideas about the importance of seeing nurses as real people and how shared experiences with the nursing staff helped them make sense of connecting to staff.

Inclusion and exclusion

Participants interviewed for this research reported not wanting to be 'passive' recipients of care, but, instead, hoped for more involvement in their care, to enable them to make more of their own decisions and retain more autonomy. Connecting to others was closely related to, and often contingent on, the inclusion or exclusion experienced by participants during their admission to an in-patient ward.

What is particularly noteworthy in our study is the consistency of this view since this element was perceived as important by all participants interviewed in our study. Involvement in treatment decisions, while associated with offering a more positive experience for young people as in-patients, was only found in two of seventy-two studies included in a recent review (Staniszewska et al., 2019). The findings we report on here, indicate that, despite national UK policy and current best practice guidelines for inclusion in care and much NHS rhetoric about the model of 'shared decision making', the young participants interviewed did not feel included in their own experiences of care. Importantly, participants wanted their experience of care to be, not only for them individually, but expressed how they wanted to be able to contribute to, and participate in, the service design, development and delivery of their care.

Power

Participants across child and adult wards experienced such aspects of their care as 'punishment', using terms such as feeling as if they were being 'cast into hell'. The perception of not having sufficient information about their care, as a form of disempowerment, was a feature common to all patient participants, along with participants' feelings of being excluded from society, being imprisoned for some undefined punishments, and placed in 'hell'. Indeed, the young adult participants' views on social exclusion, from being in 'hell', being in 'prison' and being excluded from their own community of patients, resonate with much of the writings on power and coercion, forming a powerful connection to the negative effects of social exclusion. Social exclusion is a distressing and hurtful experience (Baumeister and Leary, 1995; Eisenberger et al., 2003) and can influence people's behaviour and their ways of coping (Moor et al., 2012). Moor et al. (2012) suggest that, following an experience of exclusion, people have a need to regain this lost control and will also act less cooperatively towards the excluder, thus forming a downward spiral. Adolescents, as part of their social development, are thought to be particularly sensitive to experiences of rejection, whether real or perceived, with stronger negative emotions in adolescents who experience rejection, frequently reported compared to adults (Sebastian et al., 2010). Thus, our findings highlight the importance of the necessity for health professionals to pay attention to the need for inclusion among this patient group.

The system and working together

Hill et al. (2019) found that the perceived lack of knowledge among staff from CAMHS towards adult services was being transferred onto young people and their carers, resulting in many young people having unrealistic expectations of AMHS. It is perhaps not ideal for CAMHS to 'lower' expectations, as found within our research study, since this appears to run the risk of embedding fear, but as Murcott (2014) and Mulvale et al. (2019) observe, it is a matter of today's health services needing to pay greater attention to and develop a better shared understanding of modern services philosophy and future planning. Provision of specialist mental health training, such as with CAMHS, remains inconsistent and is frequently geographically based (Thomas, 2017), thus, we suggest, there is scope for further exploration of pre-registration health professional training and multi-professional integrated training as a conduit for improving knowledge and understanding of care.

To optimise the design and inform the future delivery of services, these findings provide empirical evidence that mental health professionals desire a sense of achieving a closer working practice, better understanding of, and greater flexibility in service delivery, especially when working with this age range. What is significant here is that these staff experiences cast further light on current working practices that demonstrate that staff are working as flexibly and stretching boundaries as much as possible to mediate against what they see as risks to the young person, such as encouraging CAMHS continuing beyond the transition point of 18 years.

Recommendations

Based on these research findings, we propose that the following youth specific principles (Table 4) may be helpful for enhancing health service delivery for the care of 16- to 25-year-olds, whether admitted to CAMHS, AMHS or a dedicated youth service.

Relational
Health professionals need to understand the importance of relationships especially in this age group, and to be able to facilitate these, to assist young people in developing appropriate relationships with staff and peers
For staff to recognise the potential barriers and facilitators they can harness when developing therapeutic relationships with young people
To recognise that peer relations are important to young people, especially shared experiences
Admission to hospital can be viewed as providing an opportunity to explore new experiences and has the potential to offer a safe therapeutic space
Inclusion
Information about young people’s care needs to be transparent, easy for them to understand, and delivered to young people in a manner that is suitable for each individual (the concept of personal care)
Young people should be included in the decision-making processes for their own care. Young people need to feel recognised as the main stakeholder in their own care and afforded that status

Young people should be offered the opportunity to be included in the governance processes of the service where they are receiving care
Day to day to management processes for the setting should be clear and transparent so that the young person in receipt of care is able to understand these elements of their care.
Working practices
Transition to other mental health services should be carefully considered for each individual
Services should engage with, and work in partnership with, the relevant mental health and non-mental health services

Table 4: Principles of inpatient mental health care for 16- to 25-year-olds

Strengths and limitations

We suggest this is the first study of its kind to explore the experiences of young people aged 16 to 25, while simultaneously also considering the views of the staff who work with this age group, admitted to inpatient mental health services, whether in AMHS or CAMHS setting. This novel and innovative study provides rich data and, offers a deeper understanding of what, how, and why, young people and staff experience admission to a mental health ward.

However, as with all research, there are limitations to this study to consider. All participants were self-selecting; therefore, we were unable to account for diversity amongst the populations or capture views and experiences of other people in other areas/ regions. Participants were recruited from a single geographical area in England; however, we should also point out that this is an area of considerable population, circa 3 million people (WMCA, 2023). To maximise the diversity of experiences wards were selected from three urban Health Trusts.

Conclusion

Young people wanted to be understood, informed, and to feel included by the staff involved in their care. The young people in the study recognised that they were not always included, informed or treated as valued partners in their own care. Meanwhile, the health professionals desired a more flexible and closer working relationship with young people and with greater connections to other health services. We propose findings from this study can be utilised to strengthen the development and design of future mental health services. The reconfiguration of mental health service delivery for young people was a core recommendation over a decade ago (Mental Health Task Force, 2016). Progress appears, disappointingly, limited, with findings from the Darzi report (2024) indicate that many UK hospitals are currently unfit for purpose, along with the 2024-25 NHS operating guidance (2024) confirming a move to support services up to 25 years.

Relevance for clinical practice

We propose that the findings and recommendations from this research can inform and support the provision of more detailed guidance needed to improve and develop health policy and mental health services for young people and professionals working with them. Clinicians and providers may, we suggest, wish to consider using the findings and principles from this research to strengthen delivery of care and inclusive practices for this age group in order to enhance mental health care for both young people and more widely.

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Declaration of Conflicting Interests

The authors declare that there is no conflict of interest

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