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Young Persons' Experiences of Inpatient Care for Self-Harm: A Qualitative Exploration

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Abstract

In the UK, self-harm is a major healthcare problem. Self-harm is an especially common behaviour in young people admitted to psychiatric inpatient care and is one of the primary reasons for presenting to hospital. The management and treatment of self-harming behaviours can be challenging, and few treatment guidelines are available for inpatient settings. Poor understanding of self-harm and how to manage it effectively is likely to lead to staff feeling hopeless and helpless, but also to reduced support for the young people under their care. The current study constitutes an attempt to build on what is known by exploring young people's reports on their experiences of inpatient treatment when presenting with self-harm. A grounded theory methodology was used to analyse the data. There were two key study aims which were: to obtain young people's reports on their experiences of inpatient care when presenting with self-harm; and to integrate these views into a grounded theory that would serve as a model for understanding features of young persons' experiences of inpatient care when presenting with self-harm. Semi-structured interviews were conducted at two NHS mental health inpatient units. Participants were a convenience sample of 10 young people, aged between 12 and 18 years. Analysis of these interviews was done in accordance with grounded theory. Two core concepts of humanness and restriction emerged from the data which contribute to the construction of meaning and understanding. Service implications and recommendations highlight the need for improved understanding, maintaining relationships and continued connection during admissions. The methodology contributed to developing a rich and detailed understanding of young persons' experiences of inpatient care when presenting with self-harm.

Keywords: Self-harm, inpatient care, adolescents, mental health, grounded theory, lived experience, qualitative research

Introduction

In the UK and indeed globally, self-harm is a significant healthcare issue, particularly among young people admitted to psychiatric inpatient care (Majid et al., 2016). Defined as intentional self-injury or self-poisoning without suicidal intent, self-harm is associated with psychological distress, emotional dysregulation, and emerging psychiatric conditions (Gratz, 2003; Hawton & Rodham, 2006). Rates of self-harm among adolescents, a developmental stage marked by identity formation and heightened sensitivity to social and emotional stressors, have increased over the past two decades (Majid et al., 2016; Holley et al., 2012). A

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2023 systematic review estimated that the lifetime prevalence of non-suicidal self-injury (NSSI) among adolescents is approximately 16%, with higher rates among women (Farkas et al., 2023). Estimates suggest that many cases go unrecorded, especially those that do not lead to hospital attendance, indicating that official figures likely underestimate the true prevalence (Steeg et al., 2018). In England, it is estimated that annually around 200,000 adolescents engage in self-harm without presenting to clinical services, while over 21,000 attend hospital due to self-harm (Geulayov et al., 2021). Self-harm is strongly associated with a heightened risk of later suicide (Hawton et al., 2003), and the 12-month suicide rate following hospital-presenting self-harm in 10-18-year-olds is 30 times higher than the general population (Geulayov et al., 2021). It is often accompanied by complex emotional, psychological, and social difficulties. Among young people, self-harming behaviour is one of the most common reasons for admission to psychiatric inpatient care (Ougrin et al., 2012). Yet there is a notable lack of guidance and research around the most effective ways to support these individuals within inpatient settings (Doyle et al., 2017). Inpatient admissions are sometimes perceived as restrictive or disempowering, and without clear, trauma-informed or collaborative care plans, they may inadvertently reinforce feelings of loss of control or hopelessness (Arnold, 1995; Rouski, et al., 2017).

Despite increasing emphasis on patient-centred care, relatively few studies have explored young people's own experiences of psychiatric inpatient treatment for self-harm. Their experiences are often shaped by complex interactions between their needs, staff responses, and the institutional environment. Existing literature, where available, tends to focus on adults, general psychiatric care, or clinical interventions rather than the lived experience of adolescent inpatients (Clarke et al., 2001; Crawford & Rose, 2014). A small number of qualitative studies have highlighted themes such as being misunderstood, lacking autonomy, and struggling with the restrictive environment of the ward (Lindgren et al., 2004; Horrocks et al., 2005; Smith-Gowling et al., 2018). However, these insights are limited, and there is a need to give voice directly to young people themselves as a lack of guidance can contribute to staff feeling helpless or ill-equipped to manage these behaviours, which may in turn affect the quality of care provided (Rouski et al., 2017).

This study aimed to explore young people's lived experiences of care after being admitted to inpatient psychiatric care following incidents of self-harm. The study uses a constructivist grounded theory approach (Charmaz, 2006), which facilitates the co-construction of meaning between researcher and participant, enabling the emergence of concepts that are grounded in the data while acknowledging the context and reflexivity involved in the research process. By focusing on young people's narratives, this study aims to develop a theoretical model of the key factors shaping their experiences in inpatient settings. In doing so, it seeks to contribute to a better understanding of what helps or hinders recovery, and to inform the design and delivery of more responsive, compassionate, and effective mental health services for this vulnerable group. Semi-structured interviews were conducted with young people at two NHS inpatient units specialising in mental health care for adolescents.

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Rationale and Objectives

There is a striking lack of published research exploring young persons' experiences of inpatient treatment when presenting with self-harm. Government policy has increasingly stressed the importance of involving young people in their own care and service development (DoH, 2015; Francis, 2013). This research attempts to not only contribute to what is known on the subject of young people's experiences of inpatient care when presenting with self-harm, but also to remain positioned in accordance with government priorities regarding mental health service provision. Capturing their voices is not only ethically sound but essential for developing services that are safe, effective, and person-centred. This study attempts to fill this gap by offering a theory grounded in the lived experiences of adolescents. The objectives of this study are:

1. To obtain young people's reports on their experiences of inpatient care when presenting with self-harm.
2. To integrate these views into a grounded theory that conceptualises the key factors shaping those experiences.

The theory will provide knowledge that could be used to inform clinical practice. Improved understanding of the young persons' experience of inpatient treatment will support the development of effective treatment guidelines, policy development and service planning.

Method

This study aimed to understand how young people experienced inpatient care during admissions for self-harm. A qualitative approach was chosen to enable a rich, in-depth exploration of their perspectives. The research was guided by constructivist grounded theory (Charmaz, 2006), which provided a framework for developing concepts that were closely tied to the participants' accounts, while recognising the researcher's active role in interpreting the data.

Philosophy of the Approach

This study is grounded in constructivist grounded theory, underpinned by an interpretivist paradigm. This perspective prioritises understanding the lived experiences of participants through their own narratives and meanings (Charmaz, 2006). This study is grounded in the view that reality is shaped through relationships and context, rather than being something fixed or objective. Knowledge is seen as situated, emerging from the interaction between participant and researcher, and shaped by their respective histories and perspectives (Guba & Lincoln, 1994; Schwandt, 1998). Rather than searching for a single truth, this approach values the different ways people make sense of their experiences. The researcher is part of that meaning-making process, and their background and assumptions are recognised as influencing how the analysis unfolds. This stance is particularly relevant when working with sensitive material such as self-harm, where emotional, relational, and social contexts are central to understanding participants' accounts.

Grounded Theory

Grounded theory involves the systematic collection and analysis of data, with concepts and categories developed through ongoing engagement with participants' accounts (Glaser & Strauss, 1967). In this study, data collection and analysis were guided by

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constructivist grounded theory, following the approach outlined by Charmaz (2006). This framework allows for a flexible and reflective engagement with the data, where meaning develops through the interaction between participants' accounts and the researcher's interpretations. It also takes into account how the researcher's perspective and professional context shape the analytic process. Unlike earlier grounded theory models that emphasise objectivity and theoretical neutrality, the constructivist approach values subjectivity and reflexivity, allowing for a more situated understanding of the topic under investigation (Ramalho et al., 2015). This was particularly appropriate for the current study, given the limited existing research on young people's experiences of inpatient care for self-harm. The use of grounded theory allowed the analytic process to be shaped by participants' narratives rather than by predefined frameworks (Corbin & Strauss, 2008). A preliminary literature review was conducted to identify relevant areas of focus and to inform the development of interview prompts, without limiting the potential for new insights (Giles et al., 2013). Data collection and analysis occurred concurrently, with categories revised and refined as the study progressed. New interviews were informed by emerging ideas, supporting depth and responsiveness in the analytic process. The study continued until categories were sufficiently developed and no substantially new themes were arising (Charmaz, 2006). A reflexive log was kept throughout the study to record key decisions during analysis and track how interpretations evolved over time. This helped to clarify the reasoning behind analytical choices and contributed to the study's overall transparency (Pidgeon & Henwood, 1996).

Implementing Grounded Theory

The analysis in this study was guided by Charmaz's (2014) constructivist grounded theory, as represented in Figure 1. This framework offered a structure for engaging with the data while remaining open to what emerged from participants' accounts. Semi-structured interviews were selected to allow for both consistency across the sample and the flexibility to follow individual narratives in more depth (Willig, 2008). Each interview was audio-recorded and fully transcribed to retain the depth of what participants shared. Analysis began with open coding, where transcripts were reviewed line by line and segments were labelled using words that closely reflected how participants expressed their experiences (Charmaz, 2006). Using constant comparison (Glaser & Strauss, 1967), early codes were explored across cases to begin shaping categories that reflected shared or contrasting experiences. These groupings were gradually developed into broader concepts that represented recurring patterns in the data. As analysis progressed, theoretical sampling was introduced to guide the focus of subsequent interviews. New data collection was shaped by the emerging categories, allowing areas of interest to be explored in more detail (Charmaz, 2006). Axial coding was used to examine how different categories related to one another (Strauss & Corbin, 1998), while focused coding supported the refinement of key themes. The process continued until theoretical saturation was reached, that is, when further interviews no longer contributed substantially new insights. At that point, the core categories had been fully developed and integrated into a working theoretical model grounded in participants' lived experiences. Throughout this process, memo writing was used to record analytic decisions, insights, and theoretical developments. These memos became a central part of the analytic trail, enhancing transparency and helping shape the final model (Charmaz, 2006).

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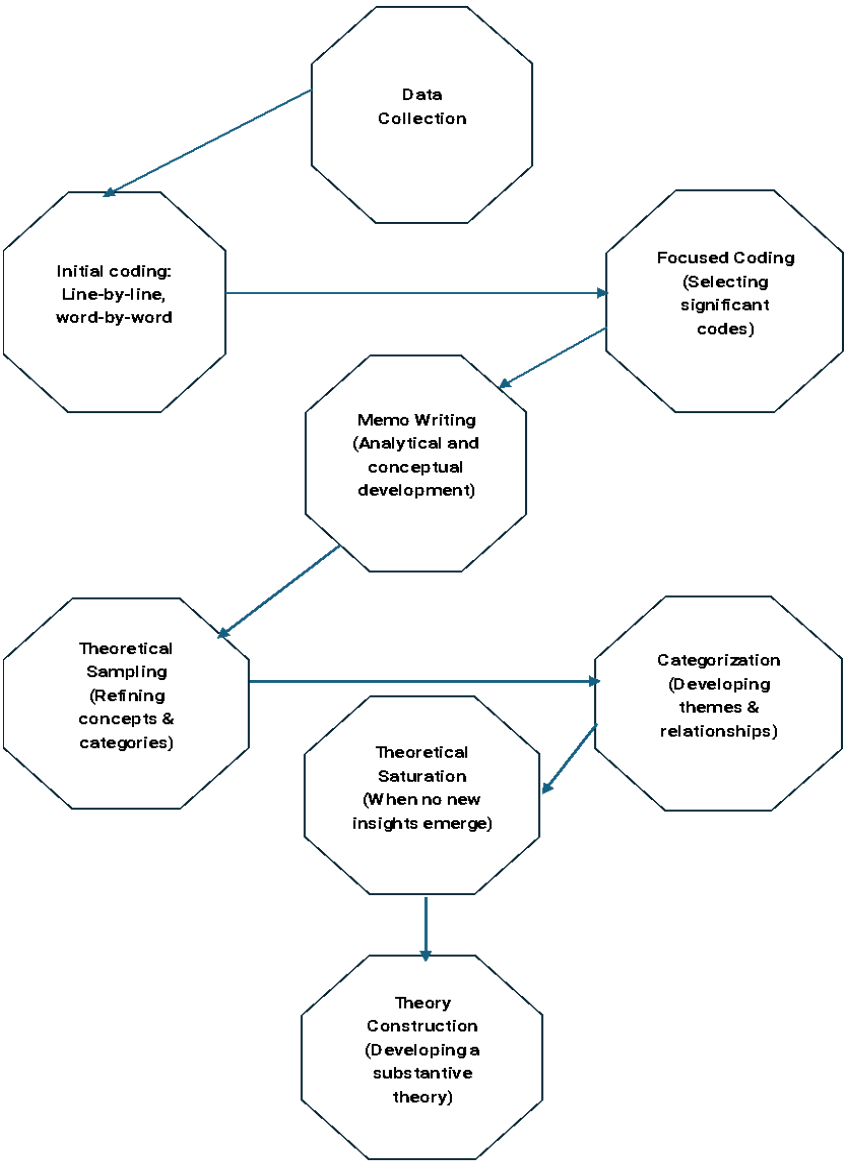
Reflexivity remained a core feature of the study. The researcher maintained a reflexive journal throughout the project to document assumptions, positionality, and interpretive decisions (Cope, 2014). This supported critical awareness and contributed to the overall trustworthiness of the findings. To strengthen credibility, member checking and peer debriefing were integrated into the process (Lincoln et al., 2011). Young people were given the option to review their transcripts, and one participant requested and received the final write-up. Findings and developing categories were also shared and discussed in regular supervision and peer research meetings. The coherence of the emerging theory was assessed by how well the categories connected to form a meaningful, explanatory model (Strauss & Corbin, 1998). While grounded in this specific population and context, the resulting framework was developed with the hope that it might also resonate with similar settings. Throughout, care was taken to present findings in a clear and accessible way, with the intention of reaching practitioners as well as academic audiences (Elliott et al., 1999).

Figure 1

Charmaz (2014) Grounded Theory Process



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Design

The research was conducted within two NHS inpatient units providing care for young people with mental health difficulties. Detailed descriptions of these settings are provided to contextualise the findings and ensure transferability (Guba & Lincoln, 1994). The units, one a 16-bed unit and the other with 9-beds, are located within an NHS Trust in the South of England. The units are geographically separate and have separate and individual management and staff teams. However, the structure and philosophy of the units are consistent with one another, with lead managers overseeing their operational functioning, meeting regularly to ensure parity of provision across services. They have similar and closely aligned treatment protocols and procedures, which mitigate any experiences being influenced too heavily by differences in treatment approaches between the units.

Participants included 10 young people aged 12-18 who were admitted to the inpatient units for self-harm. A purposive sampling strategy was employed to ensure a diverse range of experiences and perspectives were captured (Patton, 2002). The following inclusion criteria were applied:

- Young people aged 12 -18 years
- Currently a voluntary or compulsory admission to psychiatric hospital
- Presenting with self-harm as defined in the research study
- At least one week presence on the unit
- A level of cognitive ability and verbal communication to be able to give informed consent and understand what was being asked of them so as to participate in the research process voluntarily

The following were exclusion criteria:

- Significant cognitive impairment
- Florid and acute psychosis
- Inability to consent to participating in the research

Table 1 is a summary of the participants' age, Mental Health Act status, presentation according to their medical records and when the interview was conducted after admission. The study involved a diverse group of 10 young people. These participants varied in terms of their backgrounds, experiences, and the nature and frequency of their self-harm behaviours. This diversity provided a rich dataset from which to develop a comprehensive theoretical model.

Table 1

Summary Descriptors of Young People Participating in the Research

	Age	Status	Presentation	Interview
Young person A	15	Voluntary	Emerging EUPD, anxiety and depression. Query Autism.	2 weeks post admission.
Young person B	16	Detained	Emerging EUPD.	1 week post admission.

Young person C	17	Detained	Anorexia Nervosa, anxiety and depression.	3 months post admission.
Young person D	17	Detained	Depression and self-harm	5 months post admission.
Young person E	17	Voluntary	Emerging EUPD	4 weeks post admission.
Young person F	17	Voluntary	Severe anxiety and depression	4 weeks post admission.
Young Person G	15	Voluntary	Emerging EUPD	3 months post admission.
Young person H	16	Detained	Body dysmorphia	3 weeks post admission.
Young person I	17	Voluntary	Bipolar mood disorder	4 weeks post admission.
Young person J	17	Voluntary	Emerging EUPD	3 weeks post admission.

Semi-structured interviews were conducted to gather in-depth data on participants' experiences. The interview guide was designed to be flexible, allowing participants to share their stories in their own words while ensuring that key topics were covered (Willig, 2008). These interviews were carried out in private rooms within the inpatient units to promote comfort and confidentiality. Recordings were made with participants' consent, and all interviews were transcribed verbatim. The data were analysed using grounded theory methods, starting with open coding and progressing through axial and selective coding to develop a set of interconnected conceptual categories. A constant comparative approach was adopted throughout, allowing the analysis to evolve alongside the data and supporting the emergence of a theory grounded in participants' experiences (Charmaz, 2006).

Ethical Considerations

- Ethical approval was granted by the relevant institutional ethics committee, and all procedures were conducted in accordance with established ethical standards (British Psychological Society, 2014). The study took careful account of key ethical principles, including informed consent, confidentiality, and the wellbeing of participants.
- Given the dual role of the researcher as both practitioner and researcher, the researcher remained mindful of potential boundary issues and took steps to manage this throughout the project. This included clearly separating clinical and research activities and ensuring that participants understood the researcher's role in each context (Bell & Nutt, 2002).

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- Reflexivity was used to navigate ethical tensions as they arose, particularly where professional responsibilities intersected with research objectives. The researcher kept a reflexive journal to track any dilemmas and support consistent, ethically sound decision-making.
- Throughout the research, safeguarding participants' privacy and emotional safety remained a priority. Private interview settings, anonymised transcripts, and clear data protection protocols were all used to uphold confidentiality. Where young people disclosed distress or potential risk, the researcher followed pre-agreed procedures to ensure appropriate support was offered (Shaw, 2003).
- All participants received written and verbal information about the study's purpose, format, and any potential risks or benefits. Informed consent was obtained from each participant. For those under 16, parental consent was also secured in line with ethical guidance on research involving children and young people (Morrow & Richards, 1996).

Results

The analysis revealed two core concepts that are central to understanding the young people's experiences: Humanness and Restriction. Table 2 represents the Core concepts, categories and subcategories. These concepts encompass various categories and subcategories that illustrate the complexities of inpatient care from the perspectives of the young people. Throughout the study, an important aspect was constantly holding in mind the dignity and welfare of the young people, to treat this as both privilege and an opportunity to improve their experience of inpatient care. A rather poignant quote from the very first interview helped keep the researcher focussed on these ideals.

> *"We are stuck, sometimes against our own will. And in that moment, I'm just thinking, could you just keep quiet, you just don't get it. I feel staff think they understand what's going on inside other people's lives. But they don't even know what it's like to be shoved in a place like this, against your own will sometimes and you can't actually physically leave" (Participant B).*

Table 2

Core Concepts, Categories and Subcategories

Humanness			Restriction		
Connectedness	Interpersonal Factors	Intrapersonal factors	Hospitalisation	Clinical Intervention	Dilemma
• Support • Community care and treatment	• Collaboration • Staff attributes • Expectations	• Emotions • Hope and motivation • Seen and treated as an individual	• Admission • Environment • Triggers	• Planning of care • Techniques and therapeutic process	• Control • Ambivalence

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Humanness refers to the aspects of care that emphasise personal connection, understanding, and empathy. It includes the following subcategories: connectedness, interpersonal factors and intrapersonal factors.

> *"Being in hospital, well, sometimes I don't even feel like a human being anymore. I feel like an animal" (Participant A).*

Connectedness involves the emotional and relational bonds between young people and staff. Participants highlighted the importance of feeling understood and valued by the healthcare professionals caring for them. Positive interactions were characterised by empathy, active listening, and genuine concern, which contributed to a sense of being cared for as a whole person rather than merely a patient. Connectedness included support and community care and treatment.

> *"…once you've been in here for a while, it doesn't even have to take that long, it's really difficult to get back into the community again. It's like you feel disconnected, you think, oh wow there's still a world outside" (Participant B).*

Interpersonal factors encompass the qualities and behaviours of staff that impact the young people's experiences. These include collaboration, staff attributes, and expectations. Effective collaboration between staff and young people was seen as crucial for fostering a supportive environment. Attributes such as patience, kindness, and consistency were particularly valued, while unmet expectations often led to feelings of frustration and disappointment. Interpersonal factors included collaboration, staff attributes and expectations.

> *"There is so much that happens here, but the main thing is how we get along with each other, I mean, like with the staff. It really makes a difference on how my day goes, being treated like a human being" (Participant F).*

Intrapersonal factors relate to the young people's internal experiences, such as emotions, hope, and motivation. Participants described a range of emotions, from anxiety and fear to hope and resilience. Being seen and treated as an individual was essential for fostering positive emotional states and encouraging motivation towards recovery. Intrapersonal factors included emotions, hope and motivation, and being seen and treated as an individual

> *"Even talking about it is a really big thing, like for me, talking to somebody and being open to somebody that I want to self-harm, that's a huge thing. I never used to do that, I think there is so much that happens inside me that is making it difficult to talk about it. I don't know whether that is the same for the others, but I guess we're all different" (Participant F).*

Restriction refers to the elements of inpatient care that impose limits on the young people's autonomy and freedom. This concept includes the subcategories: Hospitalisation, Clinical Intervention and Dilemma.

> *"It's like being able to have a meal every day in your life and then somebody saying all of a sudden that you're not allowed to have that meal. It feels like your way of life has changed and been ripped away from you" (Participant B).*

Hospitalisation encompasses the process of admission, the environment, and the triggers that exacerbate distress. Many participants found the hospital environment to be both a place of safety and a source of stress, with rigid routines and the presence of other

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distressed individuals sometimes acting as triggers for self-harm. Hospitalisation included admission, environment and triggers.

> *"I feel like it can be useful (to be in hospital) because obviously, if you're not well mentally and you're on your own out of hospital you wouldn't really be able to recover, you would just be doing the same thing" (Participant G).*

Participants described a range of experiences with the clinical interventions offered during their admission. While some found the support helpful, others felt that interventions were too generic or failed to meet their individual needs. Several young people spoke about the importance of care plans that reflected their personal histories and goals. For them, access to the right kind of therapeutic input, not just any intervention, was seen as central to their recovery. Care planning and therapeutic work were most valued when tailored, collaborative, and grounded in trust.

> *"I just wish that, well, I guess different things work for different people and it takes a certain thing to help me and I don't know what that certain thing is, it's a bit strange. I think there are things here I want to do, but sometimes there is just not a good thing that fits, you know?" (Participant G).*

The theme of dilemma reflected the internal tension many young people described between wanting support and resisting the structures of inpatient care. Some participants shared that while they knew they needed help, they also struggled with the loss of control that came with being in hospital. This often played out as a struggle for control, over decisions, routines, or how their distress was understood. Some participants said they were glad to be in a place where they felt safe, but also spoke about feeling restricted or like staff didn't fully understand them.

> *"So, I know I'm in hospital, and I know I need to be here, but I really don't want to be here, and I don't think that there is something that can help me, I feel safe though" (Participant J).*

The themes of Humanness and Restriction emerged as central to how young people experienced inpatient care. Where these aspects were in balance, such as when boundaries were enforced with warmth and understanding, participants often described feeling more at ease and better supported. When restrictions were experienced as overly rigid or staff interactions felt distant, young people often described feeling isolated or lacking a sense of connection. Whether or not the environment felt emotionally safe seemed to depend on how these relational and structural aspects were balanced in everyday care. The model presented in Figure 2 reflects this interplay and may help inform ways to strengthen support for young people in similar inpatient contexts.

Discussion

In line with grounded theory principles, the findings were considered in relation to existing research, with attention to their relevance for clinical practice. The two central themes, Humanness and Restriction, capture a key area of tension described by many young people during their time in inpatient care for self-harm. The theme of Humanness reflects the importance of compassionate, relational care. Participants consistently valued being treated as

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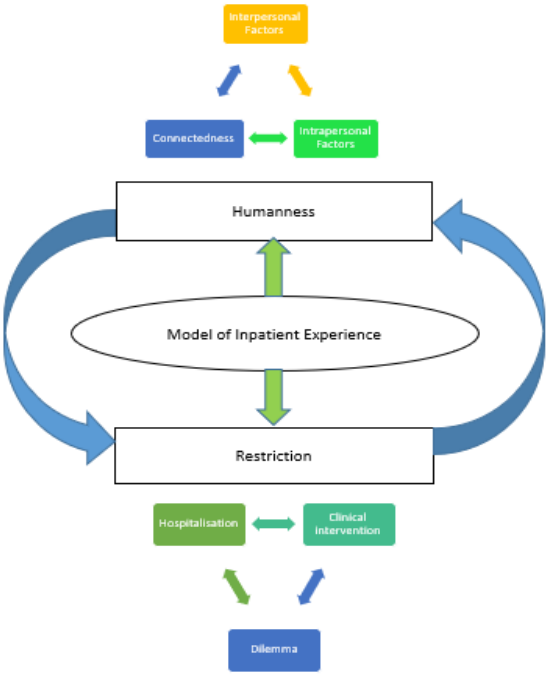
individuals rather than as clinical cases. Their experiences highlighted the emotional impact of being understood, seen, and engaged with by staff. These findings align with previous studies that underscore the importance of therapeutic relationships in inpatient care (Lindgren et al., 2004; Schoppmann et al., 2007). When young people felt that staff communicated clearly, showed empathy, and offered consistency, it contributed to a stronger sense of safety and trust, key ingredients in the recovery process (Horrocks et al., 2005). Participants also described how their interactions with staff influenced their sense of self-worth and hope. Acts of kindness, collaboration, and respect from professionals helped restore their confidence and motivation. These accounts support the principles of person-centred care, which encourage treatment approaches that adapt to individual needs and preferences (Taylor et al., 2009).

Figure 2

The model of young persons' experiences of inpatient care when presenting with self-harm.



The theme of Restriction highlighted how the inpatient setting, while intended to be protective, could also feel limiting or distressing for some young people. Although the structure and supervision offered a sense of safety, participants also spoke about feelings of frustration, confinement, and a loss of control. Some described how strict routines or exposure to others in acute distress added to their own emotional strain, experiences that reflect earlier concerns raised in the literature (Smith-Gowling et al., 2018). This mix of safety and discomfort captures the difficult balance often present in adolescent inpatient care. While a number of participants found certain therapeutic interventions helpful, others felt their care lacked personal relevance or failed to connect with their individual needs. These varied responses point to the importance of more adaptable, person-centred approaches, and of involving young people more actively in decisions about their care (Hume & Platt, 2007). The conflicting feelings expressed, of being both supported and restricted, reflect the

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emotional complexity of inpatient treatment for self-harm, and are consistent with earlier studies highlighting ambivalence in this context (Schoppmann et al., 2007).

Conclusion

This study offers insight into how young people experience inpatient care when presenting with self-harm, with a focus on the core themes of Humanness and Restriction. The accounts shared by participants emphasise the emotional and relational dimensions of care, highlighting the importance of staff interactions, empathy, and being treated as an individual with unique needs. At the same time, the findings draw attention to the restrictive features of inpatient care, such as rigid routines, loss of autonomy, and exposure to distressing environments, which, for some participants, exacerbated feelings of frustration or led to further distress. These experiences illustrate the complex and, at times, contradictory nature of inpatient care for young people who self-harm. Taken together, the study underlines the need for services that are not only safe but also relational, individualised, and responsive. Improving inpatient experiences for young people requires staff to build meaningful therapeutic relationships, promote collaboration, and adapt care in ways that acknowledge both the risks and strengths of each young person.

Strengths & Limitations

One of the study's key strengths was its attention to the voices of young people with lived experience of inpatient care for self-harm, an area that has received limited direct attention in the literature. The use of constructivist grounded theory allowed themes to develop from the ways participants described their experiences, rather than applying a pre-existing framework. The researcher's background in similar clinical settings helped provide context to the interviews and contributed to the interpretation of the data. This familiarity also helped support rapport-building and sensitive exploration during the research process. That said, there are also limitations to consider. The sample was drawn from a single geographic region and involved a relatively small number of participants, which may limit the broader applicability of the findings. Although care was taken to include diverse perspectives, the group may not fully represent the range of experiences across different services or cultural backgrounds.

Implications

The findings from this study suggest that inpatient services need to place greater emphasis on consistent and compassionate care that takes time to understand each young person's perspective. Establishing strong therapeutic relationships was central to participants' sense of safety and support, and this highlights the importance of relational work even within structured or risk-managed environments. Training for staff should include a focus on empathy, careful communication, and attunement, particularly in how everyday interactions, tone, and language can shape a young person's experience of care. Making room for genuine conversation and curiosity during care may help young people feel more recognised and less disconnected during their admission. While some restrictions are needed for safety, it is important to reflect on how these boundaries might impact a young person's sense of agency

and emotional stability. Supporting young people to take part in decisions about their care could ease the distress that often comes from overly rigid routines or one-size-fits-all approaches. Finally, inpatient teams may benefit from protected time for reflection and supervision, which can support staff to remain responsive and connected to the needs of the young people in their care—especially in high-pressure or resource-limited settings.

Recommendations for Further Research

It may be helpful for future studies to include young people from varied cultural contexts or different types of services, to build on these findings and consider how experiences may differ. Studies that compare perspectives across different inpatient settings may offer further insights into how care environments shape young people's emotional and relational experiences. There is also scope for longitudinal research that follows young people beyond discharge to understand how inpatient care influences their longer-term recovery and engagement with services. This could help clarify which aspects of care are most meaningful and sustainable over time. Collaborative research involving young people in the design and delivery of services could further enhance our understanding of inpatient care. Such approaches would support co-production and ensure that future service developments are grounded in the lived experiences of those most directly affected.

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