The experience of adolescent inpatient care and the anticipated transition to the community:

Young people's perspectives

Freya Gill, Stephen Butler and Nancy Pistrang

University College London

Contact details of authors:

Department of Clinical, Educational and Health Psychology, University College London,

Gower Street, London WC1E 6BT, UK. Email: freya.gill.11@ucl.ac.uk,

stephen.butler@ucl.ac.uk, n.pistrang@ucl.ac.uk

Corresponding author: Nancy Pistrang

The authors have no conflicts of interest to declare.

**Abstract**

This study explored adolescents' perspectives of inpatient mental health care, focusing on aspects of the inpatient environment they anticipated would help or hinder their transition back home. Semi-structured interviews were conducted with 12 adolescent inpatients; transcripts were analysed thematically. Participants experienced inpatient treatment as offering a mix of benefits (e.g., supportive relationships) and drawbacks (e.g., living in a "fake world"). They anticipated the transition home as providing opportunities for personal growth and consolidation of new coping skills, but also posing challenges concerning re-entering the "real world" after the experience of being "wrapped in cotton wool". Self-determination theory and attachment theory offer two potential frameworks for understanding these opportunities and challenges. Inpatient care has the potential to foster key mechanisms for adaptive development, creating a platform for developing positive future behaviours. Community teams should work closely with inpatient units to support the generalisation of the young person's newly acquired coping skills.

**Keywords**

## Introduction

Adolescent inpatient treatment aims to reduce risk, or severity, of long-term psychopathology through the provision of an intensive therapeutic environment (Hanssen-Bauer et al., 2011). Ongoing debate exists about the advantages (e.g., 24-hour assessment and support) and disadvantages (e.g., high costs) of inpatient treatment (Green, 2006), which is arguably complicated further for the adolescent population. Firstly, significant events, such as hospitalisation, can disrupt the negotiation of key tasks (e.g., increasing autonomy, relationship development) inherent to the transition to adulthood (Erikson, 1968). Secondly, stigma surrounding mental health issues is common in this age group (YoungMinds, 2010), and has been reported as particularly prominent within the adolescent inpatient population (Martin et al., 2007).

Despite government initiatives emphasising the importance of listening to service-users' accounts (e.g., Every Child Matters, DfES, 2004), few studies have elicited adolescents' views of inpatient care. Overall, these studies present a mixed picture. For example, surveys report that young people value the availability of staff and relationships with fellow inpatients (e.g., Tas, Guvenir & Cevrim, 2010), yet also find many aspects unhelpful, such as boredom and the emphasis on "problems" (Street & Svanberg, 2003). Qualitative studies also indicate mixed experiences. The development of coping strategies and the experience of 'containment' have been reported as benefits of inpatient treatment (Hepper, Weaver & Rose, 2005); however, two recent qualitative studies reported mostly negative experiences, including feelings of restriction and disconnection from friends and family (Haynes, Eivors & Crossley, 2011; Polvere, 2011).

Whilst the small body of qualitative research on inpatient treatment has begun to provide a nuanced account of adolescents' experiences, an important area that has not been

addressed is the transition from inpatient care to the community following discharge. The extent to which the adolescent successfully reintegrates into their home environment following intensive therapeutic treatment is likely to have far-reaching implications in terms of their subsequent development and recovery (Green & Jones, 1998). Risk of readmission is high and the type of aftercare has been found to be a strong predictor of readmission (Fontanella, 2008). Moreover, findings from a large-scale UK follow-up study revealed that a quarter of adolescent inpatients had not received any of the services recommended at discharge (Green et al., 2007). Understanding the transition back to the community and how the young person will generalise and sustain the inpatient treatment gains is therefore crucial.

This qualitative study aimed to extend previous research by focusing not only on adolescents' perceptions of the benefits and drawbacks of inpatient care, but on their expectations about the transition back home. Specifically, it focused on adolescents' perceptions of the aspects of inpatient treatment that would help or hinder this transition.

## Method

### Methodological approach

A qualitative approach was chosen because it enables complex aspects of human experience to be studied, including individual beliefs and interpretations of events (Barker, Pistrang & Elliott, 2016). Semi-structured interviews were conducted in order to capture the potential complexity and variability of participants' experiences.

### Recruitment and participants

The research took place at three adolescent psychiatric inpatient units in London. Seven units were originally identified, based on their delivery of generic, as opposed to disorder-specific, adolescent inpatient care. Three units declined to take part in the study because of competing demands on the young people's time, including involvement in other research projects; one unit did not respond.

The units differed in their treatment approach, with unit 'A' offering more of a therapeutic environment and longer admissions (three months average stay) compared to units 'B' and 'C', which offered more crisis-led services with shorter admissions (one month average stay).

Current inpatients were eligible if they met the following criteria:

1. Aged 13-18 years.

2. A minimum of two months admission (in order to ensure sufficient experience of inpatient stay).

3. No symptoms of active psychosis and no significant learning disability or developmental disorder.

Eligible adolescents were identified by members of the care team at the respective inpatient unit. Where possible a purposive sampling strategy was employed in order to recruit a heterogeneous sample. Recruitment ceased when little new information emerged from the interviews and a rich data set capturing the young people's experiences had been obtained (Strauss & Corbin, 1998). Written information about the study and consent forms were given to each participant, and a separate information sheet and consent form was given to their parents/carers.

Of 19 eligible adolescents, four declined to take part; the main reason given was not feeling sufficiently emotionally stable to talk about their experiences. Of the 15 who consented to participate, three were discharged before interviews were undertaken.

Table 1 presents characteristics of the 12 participants. The mean age was 16 years 3 months; seven (58%) were from a White ethnic background, three (25%) Black and two (17%) Asian. Eight had more than one mental health diagnosis and three had experienced a previous inpatient admission. The mean length of stay was just under three-and-a-half months (mode: two months).

[Insert Table 1 here]

**Ethics**

Ethical approval was obtained from an NHS Research Ethics Committee.

**Data collection**

A semi-structured interview schedule was developed based on published guidelines on qualitative methodology (Smith, Flowers, & Larkin, 2009). The schedule was used flexibly; open, non-directive questions were used to limit the influence of the interviewer. The context surrounding admission to the inpatient unit was explored first, followed by the experience of staying on the unit and how this compared to home life, with a particular focus on relationships, education and independent living skills. Next, issues relating to stigma were explored, before finally focusing on expectations of leaving the unit and of how things would be in the future.

Each interview lasted approximately one hour and took place at the inpatient unit in a quiet interview room. Where possible, it was conducted towards the end of the participant's stay when a discharge date had been set. Participants were given a £10 gift voucher to thank them for their time.

**Data analysis**

Interviews were audio-recorded and transcribed verbatim. Braun and Clarke's (2006) method of thematic analysis was used to systematically identify ideas and patterns of responses within and across participants accounts. This involved an iterative process of developing codes to describe the ideas expressed, grouping these codes to generate initial themes, analysing and synthesising the data to form main themes, and selecting quotations from the transcripts to illustrate each theme. Decisions about the final set of themes were informed by the frequency of relevant material both across the data set and within individual transcripts. Although most themes were supported by data from all participants, some applied

to only a subset of participants; in the latter case, a theme was included if it captured a central aspect of those participants' experiences.

The study was guided by established quality criteria for qualitative research in order to ensure that it was conducted in a systematic and rigorous way (Barker & Pistrang, 2005). Generated themes and interpretations were grounded in the data, which was achieved by sticking closely to the transcripts during the coding and development of initial themes. In order to avoid relying on a single researcher's interpretation of the data, a consensus approach was taken. This involved the first author taking the lead in the analysis, with the second and third authors reading a subset of transcripts; discussions about different ways of conceptualising and synthesising the data took place throughout the analysis, and modifications to the labels and clustering of themes were made before reaching agreement on the final set of themes. The first author also attempted to 'bracket' the assumptions (Tufford, 2012) she had developed through clinical experience in adolescent inpatient units and intensive community settings, in order to reduce the effect this could have on the findings.

## Results

Five superordinate themes were identified, each with component themes (Table 2). The first two superordinate themes summarise the perceived benefits and drawbacks of the inpatient environment; the third captures the personal changes the young people experienced; the final two focus on the anticipated transition from the unit to "normal life".

[Insert Table 2 here]

## 1: Feeling understood by others

A central experience reported by all participants was the importance of feeling understood by the other young people and staff in the inpatient unit.

### *Theme 1.1. A shared experience*

Having a shared experience with fellow inpatients led to a sense of validation and belonging. This contrasted with young people's experiences in the community, where the majority had felt judged and criticised for having difficulties:

> *When I talk to [a fellow inpatient] about my experiences I feel that they know what I'm taking about and that they've been through a similar sort of situation.* (P8)

> *If people don't understand what we've been through they will judge.* (P9)

However, some also described challenges that arose from living with other young people with difficulties, including witnessing others' distress, and the risk of "*triggering each other off*" (P6).

### Theme 1.2. "I can always talk to someone"

Most participants highly valued having people around "24/7" (P4) to talk to. They appreciated the staff's persistent approach in supporting them and "*not giving up on me*" (P1). This contrasted with their experience of feeling isolated prior to admission:

> *I didn't really have anyone to talk to. I couldn't even talk to my mum. I couldn't even talk to my friends.* (P5)

However, for some participants, the "24/7" support felt too much, particularly at times when they wanted to be on their own:

> *No one has time to spend alone, because as you can see all these doors are locked. You can't go into your bedroom… the only place you could possibly have all by yourself is the loo.* (P6)

### Theme 1.3. "A special person"

Most participants talked about developing a significant relationship with either a fellow inpatient or staff member during their time on the unit. This relationship played an important role in their experience of inpatient treatment, with several referring to it as being a "*life saver*" (P8):

> *I became friends with [fellow inpatient] and things have been on an upward cycle since… everybody needs someone like that when they come to an environment like this.* (P3)

## 2: "A fake world"

The young people described the inpatient environment as strikingly different from their home life or "*the outside world*" (P4, P9). Several described it as "*a fake world*" (P3, P4, P7, P10, P11), which had its advantages and disadvantages.

### Theme 2.1. "A substitute family"

Given the intensity of the inpatient environment and the strong interpersonal bonds that had developed, fellow patients and staff were experienced as akin to a family:

> *Staff almost become your parents in the sense that they nag you sometimes and you've got to ask permission for things… And the patients almost become like brothers and sisters.* (P4)

Several participants, however, also spoke about feeling uncomfortable that they had become "too attached" to the other young people and staff, and worried that this would make it harder for them to leave the inpatient unit and return home to their families:

> *I don't want to get comfortable because one day I will have to leave... I don't want to be really attached with this place because I will just get disappointed in the end…* (P9)

### Theme 2.2. Structure and routine

The high level of structure and routine on the unit (e.g. fixed meal times and bedtime) was a novel experience for most participants, who were used to doing "*what I wanted when I wanted*" (P5). Most valued the impact that having a clear and consistent routine had on their psychological wellbeing: it helped keep them distracted from difficult thoughts and feelings:

> *Routine's important, it is necessary for managing yourself… the devil makes work for idle minds, but here you're always two minutes away from something else to keep you busy.* (P1)

However, a minority spoke about how the strict regime felt as though they were being "controlled" by the unit staff. This left a few participants feeling somewhat powerless and confined:

> *[Staff are] telling me what to do and [they're] in charge of my medication and [they're] literally in charge of… they're like in control of your life.* (P6)

### Theme 2.3. "Wrapped in cotton wool"

Feelings of safety and security on the inpatient unit were common amongst the young people, with one describing the experience as if she were "*wrapped in cotton wool*" (P4). With over half of the participants having a history of self-harming behaviours or suicidal ideation, a sense of personal safety was common:

> *We're being watched quite a lot of the time…I think it's quite good because I don't have a chance to hurt myself and I know I'm safe.* (P11)

Several participants experienced the inpatient unit as a non-judgemental environment to practice skills that had been too difficult or frightening to do in the "outside world":

> *I feel like this is my safe zone where I can talk and I won't sound silly…when I say something people won't laugh at me.* (P8)

However, there were some downsides: for example, the focus on safety and risk management was frustrating for some because, as one young person put it, "*a lot of the time you don't want to be safe*" (P12). Several participants also talked about how being in such a safe environment provided limited opportunities to deal with "real life" situations.

## 3: Feeling stronger

All the young people felt they had developed more confidence in themselves and their abilities to cope with their difficulties.

### Theme 3.1. "I've been transformed"

Participants felt they had developed a better understanding of their difficulties, which had helped them build a more positive self-concept. One highlighted the enormity of change she had witnessed in herself:

> *All these little things all kind of add up to one big change… I feel like I've been*
> *transformed in a way, like upgraded to a new me.* (P8)

Others felt they had developed a more balanced perspective of themselves that incorporated both their strengths and weaknesses. A common view was that they had begun to recognise their vulnerabilities. None felt that their experience of staying on an inpatient unit had altered their perception of themselves in a negative way.

### Theme 3.2. The bigger picture

The young people spoke about developing a shift in, or new, perspective as a consequence of their inpatient experience, for example, a sense of hope about the future that "*no matter how hard things will get it does eventually get better*" (P3). Several described how issues that previously bothered them now appeared insignificant, and that their inpatient stay had given them a "wake up call" about what was important in life:

> *[The inpatient experience] makes things in the outside world seem a lot more*
> *insignificant. So like, 'Oh my gosh, what am I going to wear to that party?'… It's like,*
> *does it really matter?!* (P3)

### Theme 3.3. Can I do it for myself?

Several participants described having learnt strategies to manage their difficulties, with one referring to her newly acquired coping strategies as "*survival skills*" (P8). However, for some young people, the inpatient environment was experienced as reinforcing their dependence on others:

> *I was quite an independent person… but here you got to rely on people because*
> *everything you do has got to be checked with staff members.* (P4)

This increased reliance on others left some feeling unconfident about how they would manage on their own when they did not have the support of the staff at the unit.

## 4: Road to recovery

Most participants had been given their discharge date, and had begun to imagine what it would be like to leave the inpatient unit and be back in the community.

### Theme 4.1. I still have problems

Although the majority of participants described significant improvements in their emotional wellbeing, all believed they would be leaving the unit with some ongoing difficulties. However, most suggested that their difficulties would be more manageable and have less of a detrimental impact on their lives:

> *I'll struggle in some areas [of emotional wellbeing] but I think they'll be a lot easier to get out of.* (P10)

One participant, however, felt that she was *"not mentally better"* and that *"some things have gotten worse since I've been in here"*. (P7)

### Theme 4.2. "One step at a time"

In light of anticipating continued difficulties after discharge, a common aim in thinking about leaving was to take things slowly, *"one step at a time"* (P1, P3, P8). Yet most also described a conflict between taking things "one step at a time" but also wanting to *"pick up where I left off"* (P3):

> *Before I was the sort of person that would jump straight into something... Now I'm thinking maybe I should take baby steps…it would be much easier than taking a big long jump and then breaking down again.* (P8)

### Theme 4.3. I need others to help me

Young people identified the need for others to support them when they were discharged from the inpatient unit, including their family, friends, and community mental health teams. All reported feeling more confident in their family's understanding of their difficulties as a consequence of the support they had received at the unit:

> *Your family can pick up on difficulties quicker because they now know you better.* (P3)

A comfort to many was *"knowing that I've got a good support network out there waiting for me"* (P4). This was particularly important given the "24/7" support that they had

become used to receiving at the unit. Several talked about wanting to replicate the support they had received in the inpatient unit when they left, for example finding youth-based groups in the community.

### Theme 4.4. "Back to square one"

A key fear for all the young people was becoming unwell again, being readmitted to the unit and going "*back to square one*" (P1, P5, P7). The prospect of returning to the inpatient unit symbolised a personal failure:

> *I: What's your biggest fear?*
> *P: That things will deteriorate and I'll end up back here. I'd see that as such defeat because you've battled for such a long time to get out and then you just end up back, it's like you're starting back from square one.* (P3)

Some young people went on further to say that they wanted to completely forget about their inpatient experience and almost "*pretend as if it never happened*" (P5). In contrast, a small number of participants worried that they would miss their experience of the unit so much that they would engage in behaviours that would result in their returning to the unit (e.g. suicide attempt). One young person had already pre-empted this concern by establishing a plan for keeping in touch with staff members on the unit.

## 5: Getting back to normal life

An important goal for all the young people following discharge was to get back to "normality" and "*do things that normal teenagers do*" (P3).

### Theme 5.1. "Culture shock"

All participants expressed concern about leaving the unit, reporting it would be hard to adjust, given the significant differences between the unit and their homes. Several felt unprepared for what they would have to face in the "real world", anticipating it would be a "*culture shock*" (P3, P4, P6).

Some talked about the safety of the unit as a double-edged sword: it provided a high level of security whilst on the unit, yet gave a "*false sense of security*" (P6) about the "real world", where they would be exposed to difficulties that they would not be prepared for.

A small number of young people expressed concerns about how they would cope without some of the key benefits of the inpatient experience, for example always having people around to talk to, and how this would have a negative impact on their wellbeing:

> *[When] I go back I've got no one who's really close to me… You go from here where you see young people every single day, to back home and it's just you basically…then you're gonna start feeling a bit crap.* (P7)

### Theme 5.2. Will I be seen as normal?

All the young people desperately wanted to be seen as "normal" by their friends and others in their community when they were discharged from the unit. The level of desperation was highlighted by one participant's "bargaining" to be "normal": *"[I will] chop off my right arm to be normal"* (P6). The young people worried about whether their experience of being on a psychiatric inpatient unit had negatively changed others' perceptions of them:

> *People might get worried in the sense that I'm not the same person anymore, that I'm different. But I don't want to be perceived as that. I just want to be normal.* (P1)

Most participants expected they would have to answer a lot of difficult questions when they returned to school, and that they would be "*talked about behind my back*" (P9). All worried about the stigma attached to mental health problems, particularly amongst school peers, and expected they would be labelled as "mental" or "psycho" if people found out that they had been on an inpatient unit:

> *[My friend] told another person who she wasn't meant to tell and that person was like 'Oh, my God! She's gone psycho!… dadedada!'* (P7)

However, the young people themselves had changed their views about mental health and inpatient units. Prior to their admission, several identified with the stereotypes of "madness", expecting lots of "*crazy people to run around screaming*" (P5). Through their

experiences they had learnt that people with mental health problems are "like everybody else", which had not only impacted on their overall view of mental health, but also helped them to re-evaluate their beliefs about their own problems:

> *You come here and realise [a mental health problem] is not a bad thing, it can happen to anybody. And that makes it feel less harsh on yourself... it doesn't make me a freak, it doesn't make me any less of a person than anyone else who doesn't have a mental health disorder.* (P3)

## Discussion

The young people in this study described their experience of inpatient care as offering a mix of benefits (e.g., supportive relationships, structure and routine) and drawbacks (e.g., living in a "fake world", lack of autonomy). They saw the transition back home as providing both opportunities and challenges: opportunities for personal growth and consolidation of the skills they had learnt to cope with their difficulties, while feeling unprepared to re-enter the "real world" after the experience of being "wrapped in cotton wool" on the unit, as well as concerned about how they would be perceived by others. They appeared acutely aware of the complexities surrounding the intensive therapeutic nature of the inpatient unit and how this might both facilitate and hinder their transition back into the community.

The young people's accounts suggest that inpatient treatment may be a double-edged sword. Consistent with previous research (e.g., Tas et al., 2010), the adolescents' descriptions indicate that the optimal inpatient environment is one that provides high levels of safety and containment, coupled with a consistent and predictable routine. On the one hand, these conditions fostered positive self-concepts and confidence in coping with difficulties, which then enabled the young people to begin to think constructively about how they would adjust to life back at home. On the other hand, the young people also anticipated that the high level of support and their strong attachments to 'unit life' would make the transition back home challenging, given that the same levels of resources and therapeutic understanding are not

typically available in the home environment. In this way, their accounts are consistent with the argument that the relatively controlled and dissimilar nature of the inpatient environment has the potential to render the young person unprepared to re-enter the community (Pumariega, 2007).

Attachment theory (Bowlby, 1969/1982, 1988) provides a framework for understanding some of these key characteristics of inpatient care. For example, the round-the-clock availability of staff offers a secure base for the adolescents and enhances their sense of safety and security during a time of crisis and emotional distress. It has been argued that dependency on others is a normative and important aspect of development across the lifespan, and that true independence emerges once an individual is able to depend on close relationship patterns in times of need (Feeney, Van Vleet & Jakubiak, 2015). Whilst the young people raised some concerns about being "too attached" to the unit, it could be proposed that the sensitive and accessible caregiving provided by the inpatient staff offered the characteristics of a secure attachment from which the young people were able to begin to consider moving on and re-establishing their independence in the "outside world". Detailed research would be required, however, to explore these associations further.

The accounts of the young people in this study also connect with the three mechanisms proposed by self-determination theory (Ryan & Deci, 2000) for psychological wellbeing and positive future-orientated behaviours: autonomy, relatedness and competence. Inpatient treatment can be conceptualised as an autonomy paradox for adolescents: it takes control away from the young person in order to provide safety and structure, but in doing so it ultimately facilitates the development of autonomy needed for functioning in post-discharge "real life". In a similar vein, the young people in this study noted how inpatient treatment disrupted established relationships with family and friends, yet also gave them the opportunity to develop new, valued relationships with peers (fellow inpatients) and adults

(staff members). They also spoke about a sense of competence through learning new ways to manage situations, which enabled them to feel "stronger" in coping with their difficulties. In light of their accounts, and given the theory that optimal development is actualised through nurturance of the social environment (Ryan & Deci, 2000), it could be suggested that the inpatient environment can foster several key mechanisms for adaptive development and thus create a platform from which the adolescent can develop positive future behaviours.

**Limitations**

The young people who took part in the study had been selected by unit staff, were willing to talk about and reflect on their experience, and generally found inpatient treatment beneficial; they therefore are unlikely to be typical of all adolescent inpatients. However, even for this subgroup of individuals, who seemed to make use of treatment, the prospect of the transition back home was still daunting.

Generalisability was further compromised by the self-selected nature of the units that took part in the study, as well as most participants coming from only two of the three units that took part. Due to the small sample size, a comparison between the accounts of the young people who stayed in the more therapeutic verses the crisis units could not be undertaken.

Participants were also predominately girls who presented with largely internalised problems (e.g. anxiety, depression). Individuals with internalising problems tend to be more reflective and introspective (McLaughlin & Nolen-Hoeksema, 2011); arguably the findings may have been different if more boys, who characteristically present with externalising problems, had taken part. However, the uneven balance of girls and boys also reflects the gender ratio reported in adolescent units nationally (O'Herlihy et al., 2001).

**Clinical and research implications**

The young people in this study showed a confident ability to reflect on their experiences. Providing adolescents with an opportunity to voice their views enables them to

have an active and valuable role in the planning of their treatment (e.g. Biering, 2010; Every

Child Matters, DfES, 2004). Importantly, it recognises their rights and acknowledges their

developmental need to separate from their family and develop autonomy. It may be beneficial

for inpatient units to foster and encourage adolescents' self-reflective capacity and ability to

think of themselves as active agents within the overall therapeutic model (Hepper et al.,

2005), particularly in relation to their discharge and making sense of their inpatient

experience.

The young people identified the need for continued support by community mental

health teams after discharge. Follow-up provision of services is associated with positive

longer-term outcomes of inpatient treatment (Green et al., 2007), which may be undone when

services are not available. Given the intensive therapeutic nature of the inpatient

environment, and the significant contrasts that the young people reported experiencing at

home, it is paramount that adolescents are supported during the transition and long after their

discharge. Crucially, community teams should work closely with inpatient units to support

the generalisation of the young person's newly acquired coping skills when they return home.

The adolescents also raised concerns about being stigmatised, particularly in a school

context amongst their peers. Providing psychoeducation about mental health problems in

school settings would help to encourage open discussions and reduce stigma. This is

particularly relevant in education settings supporting the adolescent age group, given that the

peak age of onset for developing a mental health disorder is 14 years (Kessler et al., 2005).

Longitudinal studies following up young people after discharge are needed to

establish whether the perceptions reported near discharge remain the same when the young

person is back at home and readjusting to "normal life". Young people's experiences of post-

discharge care – and indeed alternatives to inpatient care, such as community intensive

treatment teams – also require research attention. Finally, future research might explore the

perspectives of parents and other family members, particularly given that families have a

crucial role in facilitating recovery from mental health problems (e.g., Sin, Moone, & Harris,

2008), as well as the views of professionals working with this population.

**Conclusion**

Concerns about adolescent inpatient treatment have been documented in the literature

for decades (e.g. Green & Jones, 1998; Knitzer, 1982). The findings from the current study,

however, suggest that the inpatient environment has the potential to offer young people some

of the fundamental psychological drivers for adaptive emotional development, for example,

containment of emotional distress and supportive relationships in which they feel understood.

Through this experience, adolescents may be able to develop positive beliefs about

themselves and their own agency, which in turn may facilitate their transition from inpatient

treatment and their capacity to adjust to life in the community.

## Acknowledgements

**References**

Barker, C., & Pistrang, N. (2005). Quality criteria under methodological pluralism: implications for doing and evaluating research. *American Journal of Community Psychology, 35*, 201-212.

Barker, C., Pistrang, N., & Elliott, R. (2016). *Research methods in clinical psychology: An introduction for students and practitioners* (3rd ed.). Chichester: Wiley.

Biering, P. (2010). Child and adolescent experience of and satisfaction with psychiatric care: a critical review of the research literature. *Journal of Psychiatric and Mental Health Nursing, 17,* 65-72.

Bowlby, J. (1969/1982). *Attachment and loss: Vol. 1. Attachment.* New York: Basic Books.

Bowlby, J. (1988). *A secure base.* New York: Basic Books.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*, 77-101.

Department for Education and Skills. (2004). *Every Child Matters: Change for Children*. London: HMSO.

Erikson, E. (1968). *Identity, youth and crisis*. New York: Norton.

Feeney, B. C., Van Vleet, M., & Jakubiak, B.K. (2015). An attachment theoretical perspective on optimal dependence in close relationships. In J.A. Simpson & W.S. Rholes (Eds.), *Attachment Theory and Research: New Directions and Emerging Themes* (pp. 195-233). New York: Guildford Press.

Fontanella, C. A. (2008). The influence of clinical, treatment, and healthcare system characteristics on psychiatric readmission of adolescents. *American Journal of Orthopsychiatry*, *78*, 187-198.

Green, J. (2006). The evolving RCT in mental health – studying complexity and treatment process. *Advances in Psychiatric Treatment*, *12*, 268-279.

Green, J., Jacobs, B., Beecham, J., Dunn, G., Kroll, L., Tobias, C., & Briskman, J. (2007). Inpatient treatment in child and adolescent psychiatry - a prospective study of health gain and costs. *Journal of Child Psychology and Psychiatry*, *48*, 1259-1267.

Green, J., & Jones, D. (1998). Unwanted effects of inpatient treatment: anticipation, prevention, repair. In J. M. Green & B. W. Jacobs (Eds.), *Inpatient child psychiatry: Modern practice research and the future* (pp. 212–220). London: Routledge.

Hanssen-Bauer, K., Heyerdahl, S., Hatling, T., Jensen, G., Olstad, P., Stangeland, T., & Tinderholt, T. (2011). Admissions to acute adolescent psychiatric units: a prospective study of clinical severity and outcome. *International Journal of Mental Health Systems, 5,* 1.

Haynes, C., Eivors, A., & Crossley, J. (2011). 'Living in an alternative reality': adolescents' experiences of psychiatric inpatient care. *Child and Adolescent Mental Health*, *16*, 150-157**.**

Hepper, F., Weaver, T., & Rose, G. (2005). Children's understanding of a psychiatric in-patient admission. *Clinical Child Psychology and Psychiatry, 10*, 557-573.

Kessler, R., Berglund, P., Demler, O., Jin, R., Merikangas, K., & Walters, E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry, 62*, 593-602.

Knitzer, J. (1982). *Unclaimed children: The failure of public responsibility to children and adolescents in need of mental health services*. Washington, DC: Children's Defense Fund.

Martin, J., Pescosolido, B., Olafsdottir, S., & McLeod, J. (2007). The construction of fear: Americans' preferences for social distance from children and adolescents with mental health problems. *Journal of Health and Social Behaviour*, *48*, 50-67.

McLaughlin, K., & Nolen-Hoeksema, S. (2011). Rumination as a transdiagnostic factor in depression and anxiety. *Behaviour Research and Therapy, 49*, 186-193.

O'Herlihy, A., Worrall, A., Banerjee, S., Jaffa, T., Hill, P., Mears, A., … Lelliot P. (2001). *National In-patient Child and Adolescent Psychiatry Study (NICAPS)*. Royal College of Psychiatrists, London.

Polvere, L. (2011). Youth perspectives on restrictive mental health placement: Unearthing a counter narrative. *Journal of Adolescent Research, 26*, 318-343.

Pumariega, A. (2007). Residential treatment for children and youth: time for reconsideration and reform. *The American J*our*nal of Orthopsychiatry*, *77*, 343-345.

Ryan, R.M., & Deci, E.L. (2000). Self-determination theory and the facilitation of intrinsic motivation, social development, and well-being. *American Psychologist, 55*, 68-78.

Sin, J., Moone, N., & Harris, P. (2008). Siblings of individuals with first-episode psychosis: understanding their experiences and needs. *Journal of Psychosocial Nursing and Mental Health Services*, *46*, 33-40.

Smith, J., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research*. London: Sage.

Strauss, A. & Corbin, J. (1998). *Basics of qualitative research: Techniques and procedures for developing grounded theory* (2nd ed). Newbury Park, CA: Sage.

Street, C., & Svanberg, J. (2003). *Where next? New directions in in-patient mental health services for young people. Report 2. Issues emerging: views from young people, parents and staff*. London: YoungMinds.

Tas, V., Guvenir, T., & Cevrim, E. (2010). Patients' and their parents' satisfaction levels about the treatment in a child and adolescent mental health inpatient unit. *Journal of Psychiatric and Mental Health Nursing*, *17*, 769-774.

Tufford, L. (2012). Bracketing in qualitative research. *Qualitative Social Work*, *11*, 80-96.

YoungMinds. (2010). *See beyond our labels: YoungMinds briefing on young people's views about mental health*. London: YoungMinds.

Table 1: Characteristics of participants

| Participant number | Gender | Age (years, months) | Mental health diagnosis | Length of stay (months) | Inpatient unit |
|---|---|---|---|---|---|
| 1 | Male | 17, 11 | Paranoid Schizophrenia | 3 | A |
| 2 | Male | 15, 7 | Bipolar Disorder | 4 | A |
| 3 | Female | 16,5 | Anorexia Nervosa | 8 | A |
| 4 | Female | 15, 7 | Attachment Disorder, emotion dysregulation | 6 | C |
| 5 | Female | 16, 7 | Psychosis, Asperger's Syndrome | 3 | A |
| 6 | Female | 17, 6 | Emotion dysregulation, Depression | 2 ½ | B |
| 7 | Female | 17, 5 | PTSD, OCD, Emerging Borderline Personality Disorder | 4 | B |
| 8 | Female | 14, 3 | Depression, Anxiety, PTSD | 2 | A |
| 9 | Female | 16, 3 | Anorexia Nervosa | 2 | A |
| 10 | Female | 14, 11 | PTSD, emotion dysregulation | 2 ½ | B |
| 11 | Female | 16, 6 | Anxiety, emotion dysregulation | 2 ½ | A |
| 12 | Female | 17, 6 | Emerging Borderline Personality Disorder | 2 | B |

Table 2: Summary of themes

| Superordinate themes | Themes |
| --- | --- |
| 1. Feeling understood by others | 1.1: A shared experience |
| | 1.2: "I can always talk to someone" |
| | 1.3: "A special person" |
| | |
| 2. "A fake world" | 2.1: "A substitute family" |
| | 2.2: Structure and routine |
| | 2.3: "Wrapped in cotton wool" |
| | |
| 3. Feeling stronger | 3.1: "I've been transformed" |
| | 3.2: The bigger picture |
| | 3.3: Can I do it for myself? |
| | |
| 4. Road to recovery | 4.1: I still have problems |
| | 4.2: "One step at a time" |
| | 4.3: I need others to help me |
| | 4.4: "Back to square one" |
| | |
| 5. Getting back to normal life | 5.1: "Culture shock" |
| | 5.2: Will I be seen as normal? |