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Research Project Portfolio

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A Mental Health Crisis: Experiences of Young People, Parents and Carers, and Professionals

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Thesis submitted in part fulfilment of the requirements for the degree of Doctorate in Clinical Psychology to the University of Nottingham

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Portfolio Abstract

With a shift away from inpatient care for young people, the delivery of effective community-based crisis care has become a priority. There is a lack of conceptual clarity regarding what constitutes a mental health crisis which has significant implications on the accessibility of crisis services. There is also a paucity of research exploring the experiences of mental health crisis for young people. The aim of this research is to explore the conceptualisation and experience of mental health crisis for young people from the perspectives of young people, parents and carers, and crisis professionals.

A qualitative approach was used. Participants were recruited from CAMHS teams across two regions. Semi-structured interviews with crisis professionals (*n*=5), parents and carers (*n*=4), and young people (*n*=1) were conducted either remotely or in-person. Reflexive Thematic Analysis was used to analyse the data.

Four themes relating to the conceptualisation and experiences of mental health crisis for YP were identified: (1) Early triggers: viewing the crisis in context, (2) The battle for support, (3) The tipping point: a time of high risk, and (4) The aftermath: containing the crisis.

The current study offers new perspectives on the conceptualisation and experience of mental health crisis for YP. To the best of our knowledge, this is the first study to explore multiple perspectives and direct experiences of mental health crisis for YP. Findings demonstrate YP and parents/caregivers conceptualise crisis differently to professionals, which often impacts accessibility to services. Most professionals conceptualised crisis as a time of 'high-risk' behaviours, whereas YP and parents/carers tended to consider the risks incidents happening in response to the crisis, which occurred due to wider relational and contextual factors. The relational themes of connection, communication, responsiveness, and availability were present throughout the crisis experience for YP. These findings should be considered by clinicians and service managers in the development of crisis prevention initiatives and considering designs of crisis services to support YP and families.

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Statement of Contribution

I, Danielle Hills, declare this research portfolio is the product of my own original work conducted since I commenced the Trent Doctorate in Clinical Psychology Programme in September 2020. The original research idea and design was conceptualised by me with support from Dr Sarah Wilde and Dr Mark Hudson. I completed the application for ethical approval and completed the subsequent amendments. All ethics applications were supported by Dr Mark Hudson as Chief Investigator, with additional suggestions from Dr Sarah Wilde. Under supervision from Dr Mark Hudson and Dr Sarah Wilde, I developed and wrote a research protocol, parts of which are now included in the final thesis. I wrote a review of the relevant literature. I completed recruitment with the support of Barbara McGrath, Dr Mark Hudson, Dr Sarah Wilde, and towards the end of the recruitment process Dr Anna Tickle supported with recruitment decisions. I completed data collection and data analysis, with support from Dr Mark Hudson and Dr Anna Tickle. Finally, I completed the report write up with support from all my supervisors through written feedback and supervision.

JOURNAL PAPER

A Mental Health Crisis: Experiences of Young People, Parents and Carers, and Professionals

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A Mental Health Crisis: Experiences of Young People, Parents and Carers, and Professionals

Short title: *Mental health crisis for young people*

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Abstract:
Introduction: *With a shift away from inpatient care for young people, the delivery of community-based crisis care has become a priority. There is a lack of conceptual clarity regarding what constitutes a mental health crisis which has significant implications on the accessibility of crisis services. There is also a paucity of research exploring the experiences of mental health crisis for young people. The aim of this research is to explore the conceptualisation and experience of mental health crisis for young people from the perspectives of young people, parents and carers, and professionals.*
Methods: *A qualitative approach was used. Participants were recruited from CAMHS teams across two regions. Semi-structured interviews with professionals (n=5), parents and carers (n=4), and young people (n=1) were conducted either remotely or in-person. Reflexive Thematic Analysis was used for analysis.*
Results: *Four themes relating to the conceptualisation and experiences of mental health crisis for YP were identified: (1) Early triggers: viewing the crisis in context, (2) The battle for support, (3) The tipping point: a time of high risk, and (4) The aftermath: containing the crisis.*
Conclusions: *Findings demonstrate YP and parents/caregivers conceptualise crisis differently to professionals, which often impacts accessibility to services. Most professionals conceptualised crisis as a time of 'high-risk' behaviours, whereas YP and parents/carers tended to consider the risks incidents happening in response to the crisis, which occurred due to wider relational and contextual factors. The relational themes of connection, communication, responsiveness, and availability were present throughout the crisis experience for YP.*

Keywords: mental health crisis, young people, parents, professionals, experiences, thematic analysis

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Research data are not shared.

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The authors declare no conflicts of interest.

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Practitioner Points

- Mental health crisis for YP was conceptualised as multi-faceted and findings suggest that whilst risk occurs in crisis, it is important to view the crisis in the context of the YP's lives, hence a holistic case formulation approach to guide crisis interventions may be beneficial.
- Findings demonstrate YP and parents/caregivers conceptualise crisis differently to professionals, which often impacts accessibility to services.
- The relational themes of connection, communication, responsiveness, and availability were present throughout the crisis experience for YP.

Introduction

The prevalence of mental health difficulties in Young People (YP) has increased significantly since 2017, with an estimated one in five YP now experiencing a probable mental health difficulty, which has increased from one in eight YP in 2017 (Newlove-Delgado et al., 2023; National Health Service [NHS] Digital, 2018)[1]. Whilst Child and Adolescent Mental Health Services (CAMHS) have been adapting in an attempt to meet the changing demands, the Future in Mind report (Department of Health, 2015) has demonstrated there remains a large unmet need. The Education Policy Institute (2020) identified 26% of referrals to CAMHS were declined due to eligibility thresholds. There is a discrepancy between YP meeting clinical criteria for mental health difficulties and the point at which support is offered (Prior, 2012). A review by the Care Quality Commission [CQC] found referrals for YP to mental health services were often rejected due to high thresholds and YP received support only when in crisis (CQC, 2018). A 47% increase in referrals to CAMHS crisis teams was found between 2019 and 2021 (Lewis, 2021). Similarly, during the COVID-19 pandemic, an increase in YP experiencing mental health crises was reported in several countries (Edwards et al., 2023)[2].

In the United Kingdom and internationally, urgent and emergency mental health care has become a policy priority (World Health Organisation [WHO], 2021; NHS England, 2019)[3]. The increase in demand for access to mental health care for YP places significant pressure on inpatient units and Accident and Emergency Departments (A&E) (NHS England, 2019). Consequently, there has been a drive to re-configure community-based support with the aim of reducing the number of inpatient admissions (Kwok et al., 2016; Munton et al., 2011). More recently, The NHS Long Term Plan (NHS England, 2019) states "expanding timely, age-appropriate crisis services will improve the experience of children and young people and reduce pressures on accident and emergency departments" (p.50).

However, lack of conceptual clarity around the term 'mental health crisis' poses challenges in the accessibility of services and delivery of care [4]. For instance, parents who accessed a crisis line felt dismissed by call handlers due to different perceptions of what was deemed a crisis between professionals and carers (Walter et al., 2006). In order to understand how individuals, conceptualise mental health crisis, it is important to understand their experiences of being in a mental health crisis. Due limited resources and funding, mental health organisations are expected to increase their capacity with less access to resource creating a larger gap between mental health policy and actual service delivery (Cummins, 2018). There are various definitions of mental health crisis proposed by services emphasising risk of harm, functional disruption, pathology, and deterioration of serious mental illness (Gullslett et al., 2016; Johnson, 2013).

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[1] See extended introduction 1.1.1 for further discussion on prevalence rates
[2] See extended introduction 1.1.2 for information about mental health crises for YP
[3] See extended introduction 1.1.3 for relevant policy
[4] See extended introduction 1.2 for further information on the conceptualisation of mental health crisis

Additionally, the theoretical underpinning of the concept of crisis has often been overlooked in mental health literature and policy (Johnson, 2013; Tobitt & Kamboj, 2011). Crisis Theory[5] proposes a crisis can be understood as a response to acute stress, where there is a natural disturbance to a person or system's state of equilibrium (Caplan, 1964). Caplan (1964) stipulates a crisis is not the precipitant, but it is a response. Distress arises as usual coping mechanisms become ineffective and crisis is a window where novel coping strategies can be introduced by professionals, who can promote psychological growth (Caplan, 1964). There is an ongoing debate around the extent to which Crisis Theory is applicable to current mental health services and its influence on mental health crisis policy (Ball et al., 2005; Bridgett & Polak, 2003; Tobitt & Kamboj, 2011). Crisis Theory was originally based on non-clinical populations and, arguably, has limited applicability to interventions delivered by crisis workers (Ball et al., 2005; Tobitt & Kamboj, 2011). Given the discrepancies in defining a mental health crisis, the development of an inclusive understanding of mental health crisis was identified as an urgent priority to inform service provision and development (Tobitt & Kamboj, 2011).

There have been numerous research studies that have explored the experiences of mental health crises for adult service users (Collom et al., 2019; Gullslett et al., 2016; McGrath & Reavey, 2015). Adults described crises as devastating 'full-human experiences', with themes including loss of self-worth, inability to cope, loss of structure and a lack of connectedness (Gullslett et al., 2016). Adults reported experiencing barriers to accessing care and how a lack of continuity of care exacerbated their mental health crisis, due to not feeling understood and heard (Middleton et al., 2008)[6]. Service users identified building trusting relationships was a crucial contributor to recovery from a mental health crisis (Prytherch et al., 2020). With a shift to more community-based crisis care, studies have explored the experience of carers of individuals who have experienced a mental health crisis (see Broady & Stone, 2015)[7]. Although the positive contributions of community-based crisis care were noted, it was highlighted this type of care increased the burden of caregiving (Broady & Stone, 2015) and triggered a complex emotional response (Albert & Simpson, 2015). Caregivers identified the discrepancies in the definition of mental health crisis has been a barrier to accessing support, which contributed to perceptions of not feeling heard and higher levels of stress (Albert & Simpson, 2015; Olasoji et al., 2017). Higher levels of family stress have been associated with episodes of relapse in individuals with mental health conditions (Fadden, 1998). To fully understand the experiences of mental health crises, there is a need to explore multiple perspectives, including carers.

Research has predominantly focused on the experience of mental health crises for adults, and there is a paucity of research relating to the experience of mental health crises for YP (Edwards et al., 2023). Recently, two systematic reviews have examined how crisis care is provided for YP (see Evans et al.,

[5] See extended introduction 1.3.1 for further information on Crisis Theory

[6] See extended introduction 1.2.1 for information on adults direct experiences of mental health crisis

[7] See extended introduction 1.2.2 for further information on parents and carers experiences of supporting someone in a mental health crisis

2023; Vusio et al., 2019)[8]. Vusio et al. (2019) explored YP and parents experiences of accessing crisis services and interventions during a crisis. Parents and YP reported a preference to community-based care, however both parents and YP reported significant barriers to help-seeking during a crisis and parents reported high-levels of parental burden (Vusio et al., 2019). However, there were only a small number of studies examining satisfaction and acceptability of crisis care for YP. In addition, a systematic review by Edwards et al. (2023) identified YP experience barriers to accessing support, which included: stigma, a sense of powerlessness at the point of referral, and feeling out of control (Narendorf et al., 2017; Pycroft et al., 2015). These findings have been corroborated by Sukhera et al. (2017), who studied YP and parents' experiences of crisis services in Canada. However, Sukhera et al. (2017) only examined the experience of YP aged 16-25 years old, hence focusing on the experiences of YP in crisis as they transition into adulthood, which may not be applicable to the needs of younger adolescents accessing crisis services.

In comparison to other stages in the life cycle, adolescence has been identified as a time where mental health difficulties are common, with 20% of adolescents expected to experience mental health problems (Gulliver et al., 2010; WHO, 2021). Adolescence is recognised as a key developmental period, particularly in the creation and maintenance of health-related behaviours and outcomes across the lifespan (Kessler et al., 2005). Most of the literature exploring experiences of being in a mental health crisis has primarily focused on adults and has excluded YP, due to YP being recognised as having distinct needs. These needs include: developmental transitions; legal and statutory considerations; reduced psychological maturity; a greater role of parents/caregivers; differences in service provision and the involvement of multiple systems, such as schools (The Healthy London Partnership, 2016)[9]. Due to these distinct needs, attachment and systemic ideas are often inform assessments and interventions with young people, with a focus on family functioning, attunement/connection, and communication (Becker-Weidman & Hughes, 2008; Riedinger et al., 2017)[10]. Research examining crisis care for YP highlighted the need for more experiential research focused on understanding the experience of mental health crises for YP to inform re-configurations of service provision (Vusio et al., 2019). To fully explore the conceptualisation and experience of mental health crises for YP, it is important to consider the views of YP, parents/carers, and professionals[11]. This study aimed to explore the conceptualisation and experience of a mental health crisis for YP from the perspectives of YP, parents/carers and professionals. To the best of our knowledge, this was the first study to explore the experiences of mental health crises for YP from multiple perspectives.

[8] See extended introduction 1.2.3 for further information on crisis care for YP

[9] See extended introduction 1.4 for further information on adolescent development

[10] See extended introduction 1.3.2 and 1.3.3 for further information on systemic and attachment theory

[11] See extended introduction 1.5 for extended rationale for the study

Methods

Design

An experiential qualitative design, grounded in critical realism, was adopted with the aim of exploring participants' understanding and experiences of mental health crises in YP[12]. Critical realists[13] have argued there is reality in the world, but data provided does not offer a direct reflection of reality (Willig, 2013). Rather, what can be accessed are 'situated realities', which have been shaped by cultural and social contexts (Willig, 2013; Braun & Clarke, 2013). Hence, this study aimed to understand the experiences of YP in mental health crisis through multiple perspectives, so it was assumed there would be multiple situated realities, and these would be influenced by the contexts in which they occurred.

Participants and Recruitment

Participants were recruited via purposive sampling[14]. The sample consisted of CAMHS crisis professionals, parents/carers, and YP. YP and parents/carers were recruited via CAMHS community teams and CAMHS crisis professionals were recruited through CAMHS crisis teams across two regions. CAMHS crisis professionals were eligible to participate if they were a healthcare professional, currently working in a CAMHS crisis team, and had been in the role for at least three-months. Parents/carers were eligible to participate if they were the primary caregiver of a YP aged 13-17 who had previously been open to the CAMHS crisis team and been discharged in the past 12-months; the young person had to be allocated to a community CAMHS clinician. A primary caregiver was defined as the caregiver who provides the care for the YP on a day-to-day basis (Umemura et al., 2013). YP were eligible to participate if they were aged 13-17, had previously been open to a CAMHS crisis team and been discharged in the last 12-months, and had an allocated CAMHS community clinician. The YP, parents/carers, and professionals did not have to be linked cases. In terms of exclusion criteria, CAMHS crisis professionals were unable to participate if they were not employed by a CAMHS crisis team. YP and parents/carers were unable to participate if there were significant ongoing safeguarding concerns (e.g., Child Protection Plans) or if the young person was in an 'active' mental health crisis[15].

A total of ten participants were recruited (five CAMHS crisis professionals, four parents/carers, and one young person)[16]. The study aimed to recruit an equal number of participants in each group, however the recruitment target was not met in the groups for YP and parents/carers[17]. For the CAMHS crisis professionals, the team manager emailed out the study information sheet and those interested in participating contacted the first author directly. For the recruitment of YP and parents/carers, an email was sent to all clinicians including eligibility criteria and the participant information sheet.

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[12] See extended section 2.1. for further information on qualitative methodology

[13] See extended section 2.2. for epistemological position

[14] See extended section 2.3.1. for further information on sampling strategy

[15] See extended section 2.3.2. for further information on rationale for inclusion and exclusion criteria

[16] See extended section 2.3.3 for information on determining sample size

[17] See extended section 2.4. for further information on recruitment procedure and decision-making around recruitment

Clinicians then approached participants and requested a completed contact details form, which was sent to the first author. The first author provided a follow-up telephone call and obtained written consent.

Data Collection[18]

A semi-structured interview schedule was developed with open-ended prompts focusing on how participants experienced mental health crisis for YP[19]. Online video interviews (*n*=7) and face-to-face interviews (*n*=3) were conducted. Demographic information was collected verbally at the start of the interview. The interviews were audio-recorded and transcribed verbatim by an automated transcription service. Interviews ranged from 22-minutes to 51-minutes, with a combined total of six hours and 27-minutes. All participants were offered a 15-minute de-brief after the interview, which was not recorded, and they were sent an age-appropriate de-brief sheet.

Data Analysis

The data was analysed using reflexive Thematic Analysis (TA)[20]. Reflexive TA was chosen as it allows the researchers to explore patterns associated with meaning across a dataset, which meant patterns could be identified across all three groups of participants in this study (Braun & Clarke, 2022). There is a paucity of literature around experiences of mental health crisis in YP, however some assumptions can be drawn from relevant theory. Hence, a mixed-inductive deductive approach was taken to TA (Fereday & Muir-Cochrane, 2006) to offer new insights whilst considering the assumptions already held within this area. Reflexive TA's theoretical flexibility meant the researchers had freedom to flexibly use concepts from existing theories (Braun & Clarke, 2022). Concepts from Crisis Theory (Caplan, 1964), systemic family therapy principles (Vetere & Dallos, 2003), and attachment theory (Ainsworth et al., 1979; Bowlby, 1969) were used as theoretical lenses to inform deductive coding. Analysis was primarily at a semantic level but shifted through coding to a more latent orientation.

In practice[21], for data familiarisation the first author re-listened to the audio files and corrected any typographical errors in the transcriptions. For active engagement during this phase, the first author made analytic field notes throughout this process. During the first round of coding, the first author coded primarily inductively, however she acknowledged she was unable to complete a purely inductive analysis due to prior knowledge from working in CAMHS crisis teams. The second round of coding was undertaken deductively. As coding is a recursive process, the third round of coding included reading analytic notes made earlier and refining codes, which were discussed with the second and third author (Braun & Clarke, 2022; Trainor & Bunden, 2020). Coding initially produced several hundred codes. These codes were then put into a spreadsheet (one database per transcript) along with the corresponding line number for the data extract. During this process, codes with similar meaning

[18] See extended section 2.5. for further information on data collection

[19] See extended section 2.6. for information on expert involvement in the research design

[20] See extended section 2.7. for further information on choosing a qualitative methodology

[21] See extended section 2.8. for further information of how the researcher engaged with data analysis

were condensed and clustered. Initial theme generation involved clustering similar codes together. This resulted in 23 clusters. By reviewing each cluster of meaning and re-arranging codes, six tentative themes were developed through this analytic process and a visual map was drawn (Braun & Clarke, 2022). This was reduced to four themes by refinement through reconnecting with the data extracts which were coded (Braun & Clarke, 2022). In the phase of refining, defining, and naming themes, thorough discussion with the second and fourth author supported the consideration of the boundaries and naming of the themes. The first author created a final visual thematic map which supported the refinement by portraying the relationship between the codes, sub-themes, and themes (Braun & Clarke, 2022). Finally, to ensure a coherent story was captured by the themes, the first author reviewed the entire data set and selected data extracts to illustrate participants' experiences.

Reflexivity [22]

Researcher subjectivity is a resource in reflexive TA and can strengthen the quality of the research through aiding the researcher to explore how they interacted with the data (Braun & Clarke, 2019).The first author maintained a reflexive audio diary[23] throughout the research process and kept relevant field notes as an audit trail which provided opportunities for her to consider her role and influence in the research process (Braun & Clarke, 2019). There was an awareness during all phases of the research the first author had experience of working in CAMHS crisis team as a professional. Through awareness of the researcher's own experiences, this influenced how the research was formed and how meanings were co-constructed throughout data analysis (Trainor & Bundon, 2021). Supervision sessions for the first author were held with the second, third and fourth authors. This provided opportunities for reflecting on assumptions which may have been brought to the data analysis, how these might have influenced the engagement with the data, and how conclusions about the analysis were reached and incorporated in the process of interpretation (Morrow, 2005).

Ethics[24]

This study was approved by West Scotland Research Ethics Committee (REC Reference: 22/WS/0008). No incentives were provided for participating in this research.

[22] See extended sections 2.9. and 2.10. for further information on reflexivity

[23] See extended section 5 for critical reflection on audio diary

[24] See extended section 2.11. for information on ethical considerations and extended section 2.12. for information on dissemination

Results[25]

Summary of Participant Characteristics

Parents/carers and professionals were aged between 16 to 47 years old, with all participants identifying as female. When considering parents/carers relationship to the YP, all participants reported they were mothers. In terms of CAMHS crisis professionals, two participants were mental health nurses, one participant was a healthcare assistant, one participant was a Consultant Psychiatrist, and one participant was a social worker (See Table 1. for participant demographics).

Table 1

Participant demographics

Pseudonym	Age	Gender	Ethnic Background	Group
Kathryn	27	Female	British	Professionals
Aniya	41	Female	Indian	Professionals
Hazel	37	Female	British	Professionals
Charlotte	31	Female	British	Professionals
Laura	28	Female	British	Professionals
Trisha	42	Female	British	Parent
Carmel	47	Female	British	Parent
Tilly	36	Female	British	Parent
Samantha	31	Female	British	Parent
Maisie	16	Female	British	Young Person

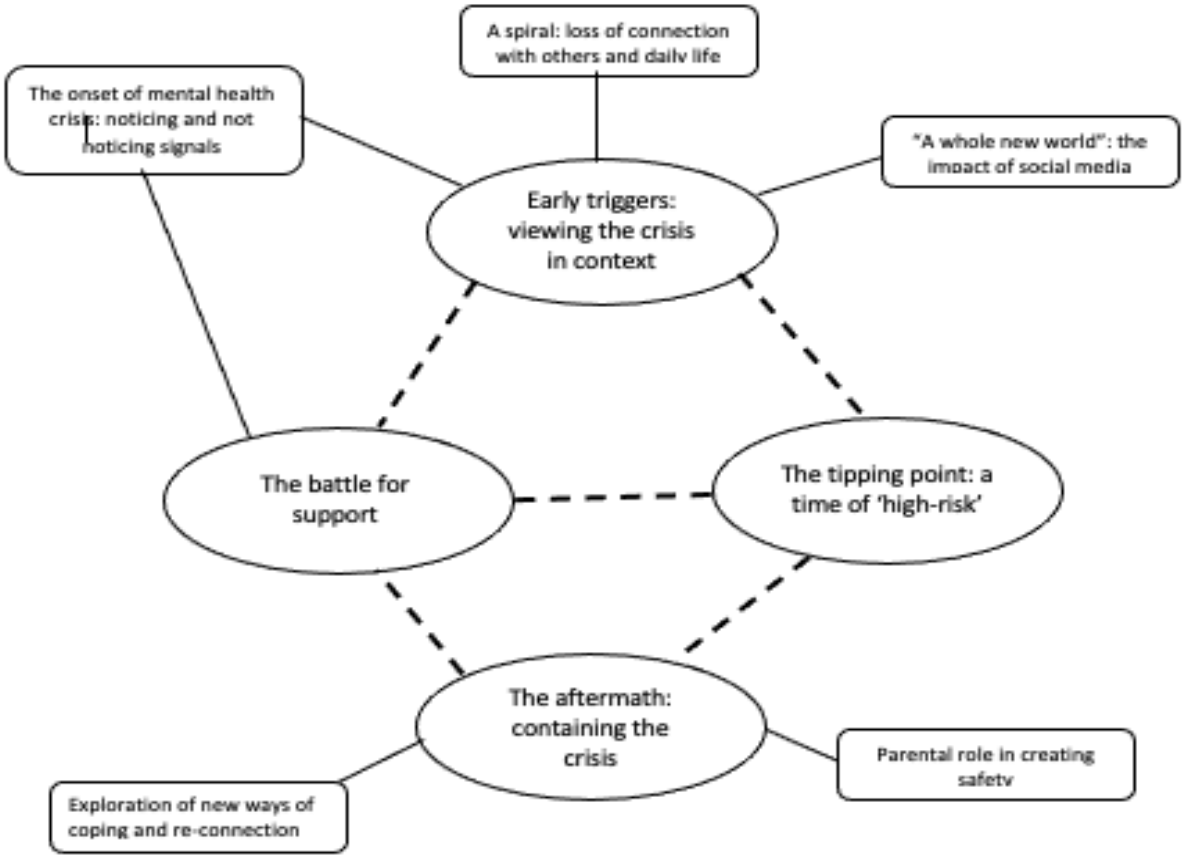
Themes and Sub-themes

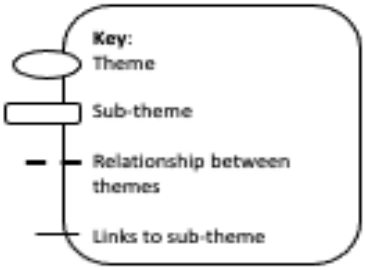
The conceptualisation of YP's mental health crises was multi-faceted and subjective. Four themes were constructed: (1) Early triggers: viewing the crisis in context, (2) The battle for support, (3) The tipping point: a time of high risk, and (4) The aftermath: containing the crisis (See Figure 1. for thematic map).

[25] See extended section 3 for further information on themes and subthemes

Figure 1

Thematic Map





1.Early triggers: viewing the crisis in context

Participants identified early warning signs and contributory factors either went noticed or unnoticed as signals of mental health crisis. The early signs of a mental health crisis were conceptualised in the context of wider influential factors from a young person's life.

1a. "A whole new world": the impact of social media. All professionals and parents expressed how they feel social media has made it easier for YP to gain awareness about methods to harm themselves. Parents and professionals suggested YP learn harmful ways of managing through social media and their peers. Hence, suggesting when YP enter a state of disequilibrium they may try and draw on their own coping mechanisms and learn coping mechanisms from their peers. For example, Kathryn acknowledged:

"So when I was 12-13 years old I had no idea about taking an overdose or self-harming um whereas the kids these days they do from social media. They have learnt this is the way to manage."

Although there is increased awareness of social media, some parents identified the challenges of monitoring social media usage despite recognising the concerns surrounding peer influence on mental health via social media. For instance, Carmel said her daughter *"just sits up there on her phone really and it's hard to know for sure what she is watching or doing but it's got to have an impact surely".* For some parents, there is a lack of understanding of this aspect of their child's world whilst recognising peers as an increasingly important attachment figure.

Cyber-bullying was identified as a factor that negatively impacted YP's self-worth and confidence contributing to a mental health crisis. Cyber-bullying was linked to an impact on YP's views of their own identity that is portrayed online, but also their sense of identity in real-life. As Laura identified:

"…a lot of young people obviously wanting to fit in so put stuff up online and people saying nasty things online. You know, and some like rumours and things like it's hard to get away from with this online stuff.".

Therefore, some YP are facing a pressure to fit in, which can impact their sense of self, as they may be striving for a sense of belonging through social media. Interestingly, there was a perceived notion bullying is easier online, which creates issues as it was felt to be harder to resolve, intervene or for the YP to distance themselves from. It was felt this trigger was harder to offer support around in a crisis leaving families and professionals feeling stuck.

1b. A spiral: Loss of connection with others and daily life Crises were often described in the context of others noticing withdrawal by YP from structures in their lives, importantly, not only the outer structures in one's life, but also daily routines one tends to use to organise their life. This may be an indication of a YP starting to enter a spiral into a state of disequilibrium whereby

YP are employing withdrawal as a coping mechanism for crisis (Caplan, 1964). For instance, Kathryn noticed commonly YP would *"reduce sort of like social activities in terms of like spending time with their family and like communal areas of the home,so isolating themselves a little bit more"*, which resulted in a lack of social connection, particularly with family members. The reduction in proximity to their caregiver was seen as a worrying signal for a deterioration in mental health. Some parents noticed YP avoiding self-care. For example, Tilly said noticing her daughter *"not wanting to go in the shower. Hmm. Not wanting to do like a skin care"* indicated to her, as a parent, that this was the start of a crisis.

Whilst most participants discussed how YP tended to experience withdrawal in a loss of connection from structures in their lives, such as family and friends, only some participants reflected on the function of withdrawal. For example, Maisie, a young person, spoke about the impact of the loss of connection with others had on her emotions. She said:

"Like in the period of time I was just really quiet and I wasn't talking to anyone and if anyone asked, I wouldn't speak about it. And, then it started to just get... I'd get more panicky or more stronger feelings... it was overwhelming".

When isolation occurred this contributed to a 'bottling-up' of thoughts and feelings which resulted in YP feeling overwhelmed. Therefore, losing connections within life may be linked to withdrawal from structures in life and resulted in a spiral of intertwined social, emotional and cognitive factors. Loss of connection with others was seen as protective in the short-term, as Maisie identified: *"It just made… I made myself more isolated so I didn't have to speak about how I was feeling."* Also, opening up and talking at this stage in a crisis felt hard for YP so withdrawing functioned as an avoidance strategy to verbally communicate, whilst their non-verbal behaviour communicated to others they were struggling. However, parents also noticed a loss of connection with their child when they are withdrawing from others. For instance, Trisha spoke about her relationship with her daughter and described feeling *"so distant. It feels you feel like you've lost them".* This may suggest a lack of opportunity for attunement between parent/carer and their child resulting in a breakdown in communication longer-term due to disconnection. Therefore, there is likely to be changes in the sub-systems within family units during the build-up to a crisis which may contribute to feelings of dysfunction and stuckness. Hence, the relationship between withdrawal and a loss of connection appears to be circular.

1c. The onset of mental health crisis: noticing and not noticing signals. The onset of mental health crises either went noticed or un-noticed. Some professionals noticed some YP experience chronic noticeable signs of deteriorating mental health and will not define this as a crisis until a risk incident has occurred. However, some YP will attend the CAMHS crisis team after the first noticeable sign of mood difficulties indicating that signs of crisis are subjective. For instance, Laura stated:

"Yeah, yeah, because especially if they've been experiencing low mood for a long time and not think they are in crisis until they make an attempt. For

some, some young people, they come to us like weeks after they first started feeling low in mood."

Whilst mental health crisis is subjective, the way it is conceptualised by services and professionals may impact narratives YP draw on to define the onset of their emotional experiences. For those that did not notice signs of crisis, parents discussed how YP can hide signs of crisis, therefore meaning it is hard for them to notice and this inadvertently places responsibility on the child to communicate verbally their feelings for others to notice their emotional world. Carmel discussed how her daughter hid signs from her due to fears of judgement and invalidation, therefore suggesting open communication was not possible which may have resulted in changes in the parent-child dyadic relationship. For example:

"That she don't like to tell me because she's worried what I think okay and what I say, but I always say the wrong things and that when anything to her about it.. she tells me I don't understand."

Open communication was not necessarily possible due to parental fears about being able to tolerate and contain their child's emotional response and worries from the child about being understood. Some professionals experienced early warning signs of a crisis from young people as very subtle changes which may impede access to services. This implied that due to the subtlety of these signs, they can often go un-noticed until it is more severe, or lots have cumulatively built-up. Whilst this indicates that there may be signs of a crisis that build-up, it is often too late, and the crisis has worsened by the time others and services notice. For instance, Kathryn discussed:

"… changing all those sort of things are usually very low level and I think that's why obviously people don't notice them until they start to build up or it's become… It's sort of a little bit too late and sort of everything's dropped off."

Furthermore, Trisha reflected on how she initially took the position of no noticeable signs of crisis, however in hindsight reflected that in fact there were a numerous signs that her daughter was struggling. For instance, she said: *"I didn't notice anything when she did the first suicide attempt. Nothing at all. And there were a number of signs she was going to."* Therefore, this indicates there may always be signs of the onset of mental health crisis for YP however these may go un-noticed initially until they become more observable i.e risk incidents. Hence, subtle signs of the onset of mental health crisis may not be recognised or noticed due to disconnection. This implies that YP's difficulties may need to be overtly obvious to be acknowledged and noticed, therefore an escalation to risky behaviours may occur to get their needs met and recognised by others, including services.

2. The battle for support

A young person and parents described experiences of seeking help and support, however many experienced barriers to accessing this. Parents and a young person spoke about how long waiting times and being refused access to services results in an escalation of risk behaviours and their presentation. It was

recognised that some parents and the young person defined mental health crisis as the point at which they ask for help, which was impacted by whether the onset of crisis signals are noticed or not-noticed. Often, parents described feeling alone due to resources not being available at the time in need.

Although, Maisie, a YP, defined crisis as "*a time where you reach for help"*. Crisis appeared to be a time where additional resource is required to resolve the crisis. Although, parents and a young person felt that at different points throughout the crisis they had attempted to seek help, but this was not received or delivered. For instance, Carmel felt that due to the struggles of getting help for her daughter, this escalated to a crisis situation:

"Well, at the minute, no, I don't I don't think there is nothing. My experience with mental health is it is very hard to get help and then bang you end up in crisis with them. There is nothing out there"

Some parents described the "battle" as becoming more intense when they noticed their child was in crisis, however, often spoke about trying to access other services prior to crisis. Whereas, the YP, Maisie, identified that being in crisis equated to readiness to access help. Therefore, there are differing conceptualisations of crisis between YP and parents. In addition, parents reflected multiple experiences during crisis of being told the YP does not meet the service's access criteria. For instance, Trisha was informed that despite feeling like her child was in crisis, she was told *"she [her child] wasn't deemed in need as much as some other children…like we were in crisis"*. This demonstrates a difference in perceptions of what crisis is between parents and professionals and how decisions to offer support are limited by definitions of 'crisis'.

Whilst YP often struggled to get into services, professionals also recognised that support was not offered at the point of need. For instance, Aniya explained that *"you see anxiety results in the self-harming behaviour and I think when they don't get the right support at the right time*." Also, Charlotte described her job role as "*you know it's all about putting out fires rather than starting from this small prevention elements*." Therefore, this indicates that support tends to be delivered when it is reactive to a crisis situation, rather than during the escalation or at preventative levels.

3. The tipping point: A time of 'high risk'

Thoughts of not wanting to be alive and making attempts to end one's life were a dominant aspect of the recognised crisis which tipped people into services. At times, professionals viewed this specific risk point as the crisis, which appeared to be influenced by their experiences of YP coming to their team after showing suicidal or para-suicidal thoughts and behaviour. For instance, Laura explained *"So anyone that like presents at A&E with like suicidal thoughts and then young people that have maybe taken overdoses or attempted to end their life. I would sort of define that as a crisis.*" Most professionals relied on levels of high-risk to determine a 'crisis', which was often expressed through an observable behaviour.

Some parents and the YP reflected on observable behaviours that happened at the 'peak' of the crisis. For instance, Carmel spoke about the experience for her daughter where she said:

"A mental health crisis to me, for a young person, is a point where, when they're like that is when they are at rock bottom. They can't do anything, they can't get out of it. And they just they talk. Hmm. Stuck in a rut"

For parents, crisis was a time not necessarily conceptualised by risk but conceptualised by feelings of stuckness and complete lack of functioning, which are shown through observable and overt signs.

The young person elaborated further by describing cognitive processes alongside the observable behaviour whereby they reached a point where the difficulties feel insuperable, resulting in them feeling overwhelmed which may affect the way they view themselves, others and the world. For instance, Maisie identified that shortly before making an attempt on their life *"it's more in your head to be fair, or just your feelings feel like there's just a lot happening at the time, too much to cope with".* This indicates that whilst there may be a high-risk behaviour this was understood by parents and the YP as a response to the 'crisis' rather than the crisis itself.

Kathryn identified how often YP feel unable to cope as they *"don't know how to communicate their feelings or how to tolerate those intense feelings of grief or sadness. So they have this thought that I'd be better off dead and they act on it".* This implies that YP may lack the resources to cope with what they are thinking and feeling so view ending their life as a way out of painful and overwhelming experiences. Also, during this point, some parents and professionals identified that YP's thoughts or attempts to end their lives may serve as result or response to the crisis episode. Interestingly, due to these risky observable behaviours this is when the crisis becomes most visible to others surrounding the YP which may be why crisis is conceptualised at this point by professionals. For instance, Kathryn said:

"And I think that's when it starts to breach into more crisis situations when we see this sort of escalation in self harm starts becoming more severe sort of plans to end their life and thoughts about how, when, and trying to end their life like overdose and stuff".

4. The aftermath: containing the crisis

After the 'tipping point', participants referred to a period where the primary aim was to contain the crisis and prevent further crises from happening, which was conceptualised as part of the crisis experience. These attempts to 'contain' the crisis focused on practical solutions to create safety which were offered by professionals and primarily implemented by parents to YP.

4a: Parental role in creating safety. Professionals indicated safety planning interventions as a primary tool they advise to support after a crisis in an attempt to continue to keep YP safe. Kathryn described safety planning as:

"…advising them to lock all medication away any sharp objects that can do severe damage, locking razors away, and ingestible. Harmful substances, hazardous substances."

Safety planning is an intervention which advises practical changes to one's environment which is dependent on which risks are identified with the aim of creating a safe environment. Some professionals referred to the creation of safety as minimising the risk. For instance, Hazel described the purpose of safety planning *"as removing medications and um you know depending on their reason for attending um you know according to the risk to remove the risk".*

Professionals referred to parents as *"the lifeline"* (Charlotte) when considering how safety plans are implemented to create safety. However, some parents described after coming home from hospital with a safety plan, they felt this is when crisis started for them. Tilly explained her fear when walking into her child's room, for instance *"I go to see if they are alive or dead and says that is, that's what crisis is for a parent, that's what that parent goes through on a daily basis after the hospital".*

The fear of death of the child after the safety planning process was prominent in other interviews with parents. For example, Carmel described the emotional impact of the responsibility of safety planning: "*I felt trapped. I couldn't go out. I couldn't leave her remove all the tablets and the knives. It's scary."*

4b: Exploration of new ways of coping and re-connection. Participants identified cognitive strategies which support YP to cope with their emotions and experiences. Professionals and the YP referred to a time of reflection after crisis which enabled them to take different perspectives on contributory factors to their crisis. For instance, Maisie explained *"…Like the reflection. And speaking about it because it helps you realise that you're not really on your own and there's other things that you can do*". This was further corroborated by Charlotte:

"Um, perspective shifting a little bit, shifting their perspective can help just bring them down a little bit and think more logically. They think it's not actually as bad as they thought it was. Or it's something that can be fixed with the right support, making you feel heard and supported"

Participants indicated that when YP can take different perspectives and think more rationally, this indicates a sign of recovery. Participants also noticed post the 'tipping point' was a time for re-connection with one another. Trisha reflected *"Just that they will eventually come back to you. Yeah, because it feels so distant. It feels you feel like you've lost them"*, therefore during crisis there were less opportunities for connection. However, Trisha reflected that *"talking helped bring us back together"*. The majority of participants referred to

improving communication as a key factor in containing the crisis and supporting YP to cope with difficult experiences. For example, Hazel described working on communication by trialling new ways of communicating:

"So sometimes we talk about sending an emoji, if they're young person is feeling, you know, suicidal if it, it's too much to sort of verbally communicate that, then you can communicate it through an emoji or like having a card system, traffic light system."

Hence, supporting YP and parents to develop ways of communicating to aid attunement, connection and enable signs of struggling to become noticed. Maisie noticed her relationship with her mother has changed now *"because the more I talk about it, the more they realise."* Crisis was recognised by most participants as a time for introducing novel understandings, ways of thinking and was referred to as *"very eye opening"* (Kathryn), therefore crisis can be a time for growth and a catalyst for change.

Discussion[26]

The present study aimed to explore the conceptualisation and experiences of mental health crisis for YP from the perspectives of YP, parents/carers and professionals. Four themes were identified (1) Early triggers: viewing the crisis in context, (2) The battle for support, (3) The tipping point: a time of high risk, and (4) The aftermath: containing the crisis.

Findings highlighted crisis was conceptualised for all participants in a temporal manner, which is also outlined in Caplan's Crisis Theory (Caplan, 1964). The parents and the young person conceptualised crisis differently to professionals. Parents and the young person conceptualised crisis as starting before any risk incidents, whereas professionals commonly conceptualised crisis with risk-focused discourse. Systematic reviews exploring YP's experiences of help-seeking identified there were many barriers to accessing support at the time of need (Anderson et al., 2017). This study has demonstrated that the differences in conceptualisation of crisis has resulted in difficulties in accessing crisis services and escalating distress, which is likely to impact further help-seeking. This was corroborated by Walter et al. (2006) who noted parents felt dismissed when calling the crisis line to access support as they felt professionals had a difference in understanding of crisis. It could be argued that the system lacked attunement to YP's needs, in the context of attachment theory (Ainsworth et al., 1978; Slater, 2007).

Parents are often viewed as key facilitators to accessing support for YP (Evans et al., 2023). In the current study, some parents noticed signs of crisis and others did not. The notion that crisis is not always noticeable was corroborated by Ball et al. (2005) who explored adults direct experiences of crisis and some participants felt crisis was gradual whereas some felt it was sudden. When signs of crisis were noticed, it was recognised the impact of social media and loss of connection with themselves, and daily routines were

[26] See extended section 4 for extended discussion

crucial indicators of a crisis. The themes of loss of connection with themselves and changes to daily routines were cited in adult literature (Gulslett et al., 2016). For adults, this was often referred to in the context of a loss of control of their lives and was seen as an individualistic coping mechanism (Ball et al., 2005; Gulsett et al., 2016). Whereas parents and YP both reflected on the impact of the loss of connection on the parent-child relationship. As YP started to withdraw, parents described feeling distant from their child, which impacted their sense of connection and communication with one another. From an attachment lens, this could have resulted in a lack of opportunities for connection and attunement, hence this could explain why early warning signals went un-noticed for some families (Bowlby, 1969).

The importance of viewing the crisis in the context of daily life for YP was crucial to gain a thorough understanding of the early signals of crisis. One key factor was the negative impact of social media, which is rarely cited in the adult literature as a contributory factor, potentially due to generational differences (Nesi, 2020). This often means parents may feel ill-equipped to support their child through cyber-bullying online and may be unaware of what YP are accessing online (Nesi, 2020). The impact of social changes in the adolescent period has been recognised as a key change during this age-range. Cyber-bullying has been found to increase suicidal behaviours and depressive symptoms for YP across a three-year cohort study (Maurya et al., 2022). However, it was also noted that YP may use social media as a form of distraction and to try and reduce feelings of isolation (Hinduja & Patchin, 2010). This is corroborated by Caplan's Crisis Theory (1964) which stipulates that when person enters a state of disequilibrium they may reach for usual coping mechanisms, which the use of social media could be one, however this also means YP may observe other harmful coping mechanisms of social media platforms.

Due to the difference in conceptualisation, support was often not offered at the right time and parents and the young person reported this contributed to an escalation to a high-risk point due to lack of responsiveness and availability of support. These findings are consistent with previous studies which reported that due to financial difficulties, awareness of pathways, and high thresholds YP often do not reach the right service at the right time which results in an escalation to crisis point (Evans et al., 2023). The current study reported the 'tipping point' was where professionals conceptualised a crisis and this was only when a risk incident occurred. This is similar to studies of the direct experiences of adult crisis team workers, where there was a risk-focused discourse when determining eligibility to services (Tobitt & Kamboj, 2011). However, the young person and parents understood this time as a response to the crisis rather than the crisis itself. It could be argued that the systems that support YP in crisis are often in crisis themselves as they were described by CAMHS crisis workers as 'reactive' in comparison to 'preventative'.

After the tipping point, all participants recognised attempts to contain the crisis and prevent future crises by trying to create safety, learn new skills and re-connect with one another. The stage of 'containing the crisis' was consistent with existing theory re-establishing a state of homeostasis and the view that

crisis is a time for introducing novel coping mechanisms for people to learn (Caplan, 1964). However, rather than locating the responsibility to learn new ways of coping in the young person, it was identified that to support YP to recover from a crisis parents/carers also need to be heavily involved. This is also consistent when considering the developmental stage of adolescence and the importance of the involvement of caregivers. Similar to adult caregiver's experiences, parents noted the significant emotional impact of being responsible for someone's safety when they are suicidal or self-harming (Albert & Simpson, 2015; Olasoji et al., 2017). Whilst professionals experienced safety planning by removing environmental risks as creating safety, this resulted in parents feeling unsafe and uncontained due to fears of death of their child. Hence, more support may need to be considered for parents/caregivers to contain them to support them in containing their child to ensure family system stability and prevent crisis re-presentation (Colapinto, 1988).

Strengths and Limitations

To the best of our knowledge this is the first qualitative study to explore the direct experiences of being in a mental health crisis for YP from multiple perspectives, which is an under-researched area due to YP often being excluded from research in this area. Through exploring direct experiences from multiple perspectives, this study provides a detailed understanding of the conceptualisation of mental health crisis for YP and highlights the impact of multi-faceted conceptualisation on the accessibility to crisis services.

A key limitation of the current study was recruitment as only one young person was recruited. Therefore, the authors were cautious in regards to the claims made throughout the analysis of the young person interview in terms of answering the research question. The sample size could be considered problematic due to the limited recruitment of young people. However, the research aimed to explore patterns of meaning across the dataset focused on exploring mental health crisis for young people. Due to exploring patterns of meaning, the researchers considered information power and reflected on the richness of the data which was felt sufficient to answer the research aims (Maltreud et al., 2016). Due to recruiting one young person, it was recognised the perspectives shared may have contributed less to the development of the themes and was considered in the analysis. The recruitment plan relied on stakeholders to identify YP who meet the eligibility criteria and due to varying demands on the stakeholders, this may have impacted the recruitment target being met. Recruitment difficulties are common in qualitative research, particularly with young adults and exploring sensitive topics, such as mental health crisis (Bonisteel et al., 2021). As one young person was recruited to this study and the recruitment target was not met, future research may want to consider novel research methodologies to aid the recruitment of YP. For instance, involving YP as co-researchers to reduce power dynamics, capture the voice of the young person, and support recruitment to the study (McPartlan., 2024). A further limitation is only parents and YP under CAMHS teams were sampled. It was highlighted that there are significant difficulties in getting support from NHS services and YP often reach out to charities, emergency services and primary care (Edwards et al, 2023). Hence, there is a potential limitation as this study only captured the experiences of mental health crisis

from the perspectives of those under NHS mental health services. This study has not captured those who have not received support or have accessed other forms of crisis support.

Future Research and Clinical Practice Implications

Due to the high thresholds as a result of the conceptualisation of crisis, systems that support YP in crisis can often be experienced as less responsive and available (Evans et al., 2023). Hence, from an attachment perspective being passed around and not understood by caregivers and caregiving agencies is significant as it may suggest that the crisis may occur between the system and individual in the form of lack of responsiveness and availability (Bucci et al., 2014). From this study, it is apparent that YP and families feel in crisis before encountering crisis services and it is often the risk incidents which prompt access to crisis services. It is evident clearer pathways for community-based preventative support are required for YP to avoid an escalation to 'the tipping point', which often involves high-risk behaviours. Therefore, services should consider their referral criteria to ensure it is not only primarily focused on 'risk' and focuses on the underlying need of the young person to ensure they are being understood. From this study, the responsiveness of services was named a crucial part of the crisis experience of young people. Services may need to consider their out-of-hour provisions of care, such as crisis lines, and how these interact with wider agencies to provide timely access to crisis care, as stated in the NHS Long Term Plan (2019). Additionally, reviewing service thresholds may pose an opportunity to devise a co-produced training for crisis workers around the conceptualisation of mental health crisis for young people, and the importance that risk is not the sole factor for offering a crisis service or intervention.

As communication and connection were prominent themes when considering early warning signs of a crisis and recovery from crisis, a more relationally informed approach to crisis care for YP may be beneficial. During moments of crisis, there may be times of misattunement between parent and child. This can be due to high stress (internal and external factors), fears for safety of themselves or the young person, and reduced moments of connection, which have all been identified as being present at times of crises for families. Hence, misattunement to emotional cues of a young person during this time could be considered an understandable factor in a crisis experience. Signs of withdrawal and loss of connection were stipulated as noticeable signs a YP may be tipping into a crisis, which was found to often result in parents/caregivers feeling distant from their child. It can be hypothesised that both states of the young person being withdrawn and the parent feeling distant are both highly emotional states and could result in disconnection (Griffiths et al., 2019). Therefore, psychological and social interventions which promote connection are crucial when safety planning with young people and families and Mentalisation-Based Approaches (e.g., see Griffiths et al., 2019) may support connection and understanding of emotional signals. In addition, mental health crisis for YP was conceptualised as multi-faceted and findings suggest that whilst risk occurs in crisis, it is important to view the crisis in the context of the YP's lives, hence a holistic case formulation approach to guide crisis interventions may be more beneficial.

Additionally, safety plans were referred to by all participants as an intervention used in mental health crisis for YP to contain the crisis. Due to themes around noticing/not noticing crisis signals and also the identification of caregivers battling for support, professionals who work with young people at early intervention stages could use a safety planning intervention as a tool to try and prevent future crises rather than the tool being used in a reactive manner. This may provide support for parents/caregivers in knowing where to access support and open communication around early warning signals which may aid parents/caregivers to identify different emotional cues from their child and what responses are helpful. Additionally, Caplan's (1964) Crisis Theory stipulated that when entering a state of disequilibrium, individuals may draw upon 'usual' ways of coping. Therefore, if safety plans and ways of coping with emotions are introduced at an early intervention stage, this may support young people at not escalating to the point of crisis. Importantly, there were mixed emotions expressed towards the implementation of safety plans, particularly due to the fear parents experienced post-crisis. Therefore, brief interventions based on relational principles of communication, connection and noticing/responding to emotional cues for parents/caregivers alongside support for young people may support parents/caregivers in implementing safety plans and containing further crises. Future research could explore the experiences of safety planning for YP and parents/caregivers. Lastly, all participants noted the accessibility of services was often problematic and crisis professionals had to then take a 'reactive' approach. Therefore, further studies exploring help-seeking in YP, awareness of services, and the mechanisms for seeking help could be explored to assess whether this reduces the numbers of YP presenting in crisis.

Conclusion

The current study offers new perspectives on the conceptualisation and experience of mental health crisis for YP. To the best of our knowledge, this is the first study to explore multiple perspectives and direct experiences of mental health crisis for YP. Findings demonstrate YP and parents/caregivers conceptualise crisis differently to professionals, which often impacts accessibility to services. Whilst it is recognised during the period of adolescence there are many social changes, the findings emphasise the importance of the consideration of social media in the context of mental health crises for YP. Most professionals conceptualised crisis as a time of 'high-risk' behaviours, whereas YP and parents/carers tended to consider the risks incidents happening in response to the crisis, which occurred due to wider relational and contextual factors. The relational themes of connection, communication, responsiveness, and availability were present throughout the crisis experience for YP. The findings demonstrate the importance of the involvement of parents/caregivers in supporting YP to recover from crises. These findings should be considered by clinicians and service managers in the development of crisis prevention initiatives and considering designs of crisis services to support YP and families.

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EXTENDED PAPER

1. Extended Introduction

1.1.The landscape of Child and Adolescent Mental Health

1.1.1. General prevalence rates of mental health difficulties

It is estimated adolescents constitute a quarter of the population worldwide and this is expected to increase substantially in the upcoming decades (Magadi, 2017; Weiss & Ferrand., 2019). When exploring burdens of disease and mortality, over half of mental health conditions are expected to emerge in the developmental period of adolescence (Kessler et al., 2007). Globally, mental health difficulties are increasing for children and adolescents (Polanczyk et al., 2015). For instance, it was found that for 10–19-year-olds one-in-seven will experience mental health difficulties during the adolescent period world-wide, which equates to 13% of the global burden of ill-health (World Health Organisation [WHO], 2021). Research has demonstrated mental health difficulties experienced in adolescence can contribute to challenges with physical health, life satisfaction, participation in the work force, and educational attainment in young adulthood and adulthood (Patel et al., 2007; Roza et al., 2003). Therefore, adolescence is a crucial developmental period and the exploration of mental health difficulties in adolescence is pivotal to inform national policies focused around improving the health of YP.

In the United Kingdom (U.K.) for children and YP aged seven to 16-years-old, 18% have a probable mental health condition, with this rising to 22% for YP aged 17 to 24-years-old (Newlove-Delgado et al., 2022). In 2023, one in five YP aged eight to 25-years-old in the U.K. were found to have a possible mental health condition, which has risen from one in eight YP aged five to 19-years in 2017 (Newlove-Delgado et al., 2023). The reported increase in prevalence rates may indicate a true representation of an increase in mental health conditions for YP; however, the observed increase could also be attributed to changes in diagnostic classifications, increased awareness, and help-seeking behaviours (Collishaw, 2015). For children aged eight to 16-years-old, the rates of possible mental health conditions remained the same for males and females (Newlove-Delgado et al., 2023; Vizard et al., 2018). In addition, approximately half of older adolescents with a mental health difficulty reported self-harming or attempting to end their life (Vizard et al., 2021). In 15–19-year-olds, suicide was found to be the fourth most common cause of death across both sexes and is recorded as a global public health priority (Hughes et al., 2023; WHO, 2021). This demonstrates the urgency of accessibility to appropriate mental health care for

YP. As a result, WHO has recommended the development of a national suicide prevention strategy which aims to offer support to those at-risk of or attempted suicide (WHO, 2021). However, the precision of global health prevalence rates for suicide is challenging to record, hence rates could be higher. The recording relies heavily on data provided on death certificates being coded accurately and there is significant variability in the consistency of this recording across the world, potentially due to associated stigma (WHO, 2021).

Whilst evidence demonstrated mental health difficulties experienced by YP was already deteriorating pre-pandemic, there were concerns raised the COVID-19 pandemic significantly impacted the health and wellbeing of YP (Newlove-Delgado et al., 2022). For example, 40% of YP self-reported a decline in their mental health and wellbeing because of the pandemic (Waite et al., 2021). However, at the time there was a lack of longitudinal data exploring the patterns regarding the impact of the pandemic over time. YP were significantly impacted due to factors such as, limited direct contact with peers and school closures (Larsen et al., 2022). During the COVID-19 pandemic, a study examined admissions to the Emergency Departments and found that in the first two months of the pandemic there was a reduction in psychiatric presentations to emergency departments for YP (Ougrin et al., 2022). It is hypothesised that due to significant restrictions to reduce the spread of COVID-19, the usual methods of help-seeking were affected in the early phases of the pandemic (Ougrin et al., 2022). Although, data has shown an increase in attendances to the paediatric emergency department for YP who have self-harmed, specifically in 2021 when COVID-19 restrictions were eased during periods of time (Wong et al., 2023). The Children's Commissioner report identified "949,200 YP were open to mental health services in the U.K. between 2022-2023, which equates to 8% of the 11.9 million YP in the country" (Children's Commissioner, 2024). This report also highlighted 28% of referrals to CAMHS remained on the treatment waiting list at the end of the financial year and 39% of referrals to CAMHS were closed before being seen (Children's Commissioner, 2024). These figures further emphasise the treatment gap between YP and families recognising they need support and support being delivered.

1.1.2. Mental Health Crisis for YP

Prevalence rates for mental health crises occurring for YP are variable due to the lack of consensus of the conceptualisation of mental health crisis (Vusio et al., 2020). For instance, in terms of accessing crisis services for YP, parents/carers reported feeling dismissed by crisis line services, due a difference in opinion on what was defined as a mental health crisis between parents/carers and the call handlers (Walter et al., 2006). Also, some crisis services eligibility criteria were determined by the 'level of suicidality' (Walter et al., 2006). For instance, for children aged 12-15 years old, evidence has shown a treatment gap in CAMHS in the U.K of up to 55% (Knapp et al., 2016). There are a significant number of YP in the U.K presenting with mental health crises associated with risks of harm to self-and/or others (Edwards et al., 2023; Evans et al., 2023). Presentations of YP in mental health crisis to primary and secondary care settings has increased (Morgan et al., 2017; Pittsenbarger & Mannix, 2014). Due to stretched resources, YP often present to Emergency Departments when experiencing a mental health crisis (CQC, 2018). A factor potentially contributing to the use of Emergency Departments is the lack of knowledge of where to go in a mental health crisis (East of England Clinical Network, 2017). Also, in the U.K., YP with mild to moderate mental health difficulties were often declined support from specialist mental health services so turned to Emergency Departments when support was required in a mental health crisis (CQC, 2018).

If mental health crises cannot be managed in the community, this can result in YP being admitted to inpatient psychiatric units (Clisu et al., 2022). Whilst some benefits to inpatient admissions for YP have been identified for managing high acuity, there have also been significant challenges identified (Clisu et al., 2022; Hartley et al., 2022). For instance, out-of-area placements, lengthy admissions, an impact on psychosocial development, impact on peer and family relationships, risks of YP learning new harmful behaviours, and significant costs to providers of healthcare (Clisu et al., 2022; Edwards et al., 2015; Green et al., 2007). Demand for beds has also outweighed capacity frequently meaning YP have been placed in general medical hospitals for long-periods of times and placed on adult psychiatric wards, resulting in YP not accessing appropriate

care to meet their needs (Gowers & Cotgrove, 2003; O'Herlihy et al., 2003; Worrall et al., 2009). Hence, it is recommended that where inpatient admissions are required the least restrictive option of care should be used and, where possible, inpatient admissions should be avoided (NHS England, 2022). As a result, a significant focus on options for out-patient crisis care has been a priority (See Clisu et al., 2022; Kwok et al., 2016; Shepperd et al., 2009; Vusio et al., 2020). Hence, in the U.K. there has been an emphasis for each area to have a dedicated Children and YP crisis service which can exist alongside community CAMHS. However, there is a paucity of research and a lack of consensus about the effectiveness, organisation of such services, and experience of using crisis services for YP (Evans et al., 2023; National Assembly for Wales Children Young People and Education Committee, 2018).

1.1.3. Relevant Policy Drivers

Mental health crisis care for YP is an urgent and current policy priority. Broadly, the Comprehensive Mental Health Action Plan 2013-2030 emphasises a need for a shift away from long-stay inpatient care to community care (WHO, 2021). The plan stipulates "80% of countries will have doubled number of community-based mental health facilities by 2030" (WHO, 2021, p.10). The action plan promotes a focus on YP's mental health in regards to building an understanding of YP's needs, and a focus on early intervention/prevention support (WHO., 2021). In addition, there is also a commitment to reduce the rates of suicide internationally by one-third by 2030 (WHO,2021). There is an international driver to re-configure services to further develop community care as an alternative to inpatient care and to understand needs of YP who experience mental health difficulties to provide appropriate support.

In the U.K., there are several policy drivers related to mental health crisis care demonstrating crisis care is a priority (Edwards et al., 2023). Firstly, the NHS Long Term Plan (2019) emphasises improving crisis care for YP and stipulates a necessary expansion of community services for YP. For example, a key point in the NHS Long Term Plan (2019) is that "children and young people experiencing a mental health crisis will be able to access the support they need" (p.50). However, there is a paucity of literature exploring what YP's

needs are during a crisis, therefore it would be important to understand how YP experience a mental health crisis currently to aid access to services and inform the ways in which services are designed (Evans et al., 2023). A clear understanding of a definition of mental health crisis for young people is required due to YP and their families feeling like they have a different conceptualisation of crisis to professionals which has resulted in requests for support being declined, which can inadvertently perpetuate the feeling of 'being in crisis' (Vusio et al., 2019; CQC, 2018). As a result of high thresholds and limited resources, it has been reported that mental health difficulties which could have been managed at an earlier intervention level escalate to a crisis point due to support not being provided at the right time (CQC, 2018). Therefore, in order to provide focused support at the right time and to understand how to prevent needs escalating to a crisis, there is a need to explore direct experiences of being in a mental health crisis.

Secondly, The Future in Mind Plan (2015) stipulated there should be "improved care for children and young people in crisis so they are treated in the right place at the right time and as close to home as possible" (Department of Health, p.17). The mandate demonstrated the importance to provide sufficient community care to YP in crisis. Also, by understanding how YP experience mental health crisis, this allows for further clarity on the point at which crisis care should be provided. Thirdly, the Five Year Forward View (NHS, 2014) further highlighted the importance of responsive mental health crisis care and recognised the negative impact delayed crisis care can have on acute services. As a result, an expansion of crisis care services for adults was stipulated and a relevant equivalent was recommended as a requirement for children and YP (NHS, 2014). Alongside the Future in Mind Plan (Department of Health, 2015), the Five Year Forward (NHS, 2014) emphasised the importance of prevention/early intervention of mental health crisis for all ages.

Lastly, in response to concerns related to crisis services and the significant changes required, the Crisis Care Concordant (HM Government, 2014) which is a document signed by multiple agencies involved in the provision of crisis care (e.g., paramedics, children's services etc.) The aim of the

concordant is to improve the outcomes of crisis care for people of all-ages by proposing actions and recommendations that should be implemented by all local areas that signed the concordant (HM Government, 2014). In the concordant, the distinct needs of YP are recognised and the consideration of the involvement of parents/carers early on in care planning for YP in crisis is emphasised where this is appropriate (HM Government, 2014). The concordant focuses on a 'crisis point' and then sets out recommendations for prevention of mental health crises (HM Government, 2014).

1.2 Conceptualisation of mental health crisis

There is significant variability in the conceptualisation of mental health crisis. Broadly, definitions of mental health crisis for often emphasise an acute situation which requires immediate management for safety (Murphy et al., 2015). Additionally, many crisis services include risk-focused criterion to meet eligibility thresholds for crisis service input (Paton et al., 2016). Due to certain factors being emphasised in definitions of crisis, this can impact the accessibility and the design of crisis services. Hence, it remains crucial to explore the direct experiences of individuals experiencing mental health crisis to inform and gain an understanding of how mental health crises are conceptualised.

1.2.1 Adults' experiences of mental health crisis

Whilst there is a paucity of literature focused on exploring the experiences of mental health crisis for YP, there are a number of studies on the direct experiences of mental health crisis for adults. Adults who deemed themselves as being in a mental health crisis were often either denied support or received support that did not meet their needs due to differences in perceptions of 'mental health crisis' (CQC, 2015). Hence, this highlights the importance of service criteria being aligned with people's experiences to provide timely crisis care. In addition, the CQC reflected despite the implementation of the Crisis Care Concordat (HM Government, 2014) there remains a significant postcode lottery in the provision of services for adults in crisis. This may in part be due to the lack of consensus around how mental health crises are conceptualised.

A systematic review conducted by Winness et al. (2010) explored the 'positive' experiences of adults accessing and using Crisis Resolution Home Treatment Teams (CRHTTs). Findings demonstrated that an intensive level of care provided in the person's own environment aided recovery as service users were seen as 'normal' human beings, which helped people feel a sense of safety and control (Kalucy *et al*., 2004; Winness *et al*., 2010). By being able to access a service 24/7 and having care within the home context, service users reported feeling more empowered to seek help and embed coping skills into their lives at their pace (Goldsack *et al*., 2005; Winness *et al*., 2010). Hence, adults identified mental health as an experience which needed to be understood in the context of their daily lives. The shift in care provided from hospital and clinic-based environments to home environments was found to strengthen the sense of further agency and control for service users and emphasised the importance of viewing their problems in the context of their lives (Winness et al., 2010). However, in Winness et al's. (2010) systematic review only 16 studies were identified. Hence, there is a lack of research focused on direct experiences of the meaning of being in a mental health crisis for service uses and professionals understanding of this experience.

Mental health crises are considered as complex experiences characterised by a lack of control, loss of connection with life and loneliness (Gulslett et al., 2016; Klevan et al., 2017). During a crisis individuals have reported suicidal ideation or thoughts to harm themselves as when feeling emotional pain this was perceived as a coping mechanism or an escape from the crisis (Klevan et al., 2017; Gulslett et al., 2016). Hence, the increase in risk was seen as a response to the mental health crisis. The relationship to help and help-seeking was identified as complex due to individuals reporting they sought compassion at a time of crisis, however due to their mental states during a crisis, they did not feel worthy of a compassionate response (Klevan et al., 2017). Therefore, highlighting mental health crises are often characterised by existential and identity concerns rather than purely associated with increased risks. In addition, the development of self-awareness and social re-engagement were recognised as key factors to supporting someone out of a

crisis (Gulslett et al., 2016). A mental health crisis was seen as an iterative process, and not just viewed as a single event (Gulslett et al., 2016).

For individuals experiencing severe and persistent mental illness, Ball et al. (2005) developed a model to explain the experiences of mental health crisis as they felt that original crisis theories did not apply to this population. Service users with severe and persistent mental illness described their crisis experience as a worsening of psychiatric illness symptoms which resulted in them feeling overwhelmed and out of control (Ball et al., 2005). During a mental health crisis for this population, help was typically sought by a third-party and was often sought after the crisis event (Ball et al., 2005). From this understanding, mental health crisis for adults with severe and persistent mental illness may require a more assertive outreach approach and may rely on support networks and professionals to identify the mental health crisis. Whilst mental health crisis was understood in the context of a pathological narrative, it was hypothesised that individuals experiencing severe and persistent mental illness may have significant experiences of their symptoms being medicalised which may have resulted in this understanding of crisis (Ball et al., 2005; Baker, 1996).

Mental health crises for adults have been recognised as being complex and multi-layered (Winness et al., 2010; Borg et al., 2011). Borg et al. (2011) emphasised mental health crises were found to be experienced by families rather than individualistic experiences. Individuals highlighted a tension between keeping the crisis to themselves or sharing their difficulties with family members due to not wanting to burden others with their difficulties but also recognising crisis is a time for growth and openness may support this (Borg et al., 2011). It was recognised that crisis staff have a key role in the provision of family interventions and support service users with navigating the involvement of others in their care (Borg et al., 2011). Whilst there is a strong drive to shift from hospital-based to home-based care, there is limited attention given to family members experiences and roles during a mental health crisis (Borg et al., 2011).

1.2.2 Parents/carers experiences of supporting someone in a mental health crisis

The NHS Long Term Plan (2019) identified an 'NHS Commitment to Carers' with a pledge to increase the support and recognition of carers. A carer is defined as "…anyone, including children and adults who looks after a family member, partner or friend who needs help because of their illness, frailty, disability, a mental health problem or an addiction and cannot cope without their support. The care they give is unpaid." (NHS England, 2019). Caregivers provide vital emotional, social, financial, and physical support (Kamil & Velligan., 2019). In addition, carers of individuals experiencing mental health difficulties experienced poorer physical and mental health outcomes in comparison to other carers (Broady & Stone, 2015). Rowe (2012) stated that when caring for people who are experiencing severe mental illness, the therapeutic relationship between healthcare staff and carers is crucial. However ,they found some carers reported some staff had negative attitudes towards them and there was limited involvement/information sharing with carers (Rowe, 2012). In addition, carers of adults with severe mental illness described struggling to cope with the unexpected demands of caring for their loved one (Rowe, 2012). Hence, whilst the importance of carers is recognised, there is often limited understanding of their needs and consideration of ways of involving carers in their loved one's care.

As mental health crisis care is transitioning to a more community-based model, the role of carers is considered vital in providing effective care for individuals (Klevan et al., 2016). Caregivers were found to offer support in implementing recommended coping strategies, which is often helpful in preventing future crises (Klevan et al., 2016). Therefore, demonstrating the importance of the working relationship between professionals and carers. If individuals have a support network around them, this is often viewed as a protective factor when assessing individuals in mental health crisis, as they often play a crucial role in recovery (Tew, 2013). However, due to a discrepancy in understandings of crisis, carers reported a 'double deprivation' due to feeling abandoned from healthcare staff due to limited support, whilst also trying to protect close support networks from witnessing the crisis (Albert & Simpson,

2015). Carers identified feelings of loneliness, loss and uncertainty whilst supporting their loved one in a mental health crisis (Klevan et al., 2016). Also, a tension between carers being able to share their difficulties with others due to recognition this could open doors for support whilst also a sense of shame that carers struggle with which impedes the ability to share what they are going through (Borg et al., 2010). Hence, exploration of the context around a carer and getting to know the carer as an individual is a crucial aspect of crisis work. Klevan et al. (2016) identified the personal experiences of carers can impact their perceptions of care for their loved one and influence how they support their loved one during a crisis, which can impact what care by professionals is delivered.

Particularly for YP, parents are often seen as their main caregiver and act as a facilitator for accessing crisis services (Evans et al., 2023). Parents/carers identified that due to limited information about where to access support, they often turned to Accident & Emergency (A&E) departments during a mental health crisis for their young person (East of England Clinical Networks, 2017) . However, follow-up care after attendance at A&E was experienced as limited and sparse for most families (Bolger et al., 2004). In addition, when parents and carers were asked what response they require during a crisis for their child, they identified needing access to timely advice and input 24/7 (East of England Clinical Networks, 2017). However, a recent systematic review demonstrated significant variability in the models of crisis care available to children and YP (Evans et al., 2023). One commonly used model of out-of-hours crisis support is mental health crisis lines (Evans et al., 2023). However, one study exploring caregiver's experiences of using crisis lines indicated a discrepancy between the support needed for caregivers and the advice provided by crisis line staff (Walter et al., 2006). For instance, the use of mental health crisis helplines was considered unhelpful if an immediate response was required or if the crisis focused primarily on behaviours of concern as parents were advised to contact the police (Walter et al., 2006). However, where advice and support were offered on crisis lines or YP were able to access an assessment in a different venue, crisis lines were considered a helpful means of accessing appropriate support (Walter et al., 2006). More importantly,

caregivers of YP have identified that professionals often struggle to recognise a mental health crisis for a YP can result in parents feeling uncontained (East of England Clinical Networks, 2017). Therefore, it is equally important to consider caregivers perspectives alongside YP's to explore a holistic understanding of experiences of mental health crisis for YP.

1.2.3 YP's experiences of crisis services

Despite the national and international focus on mental health crisis care for YP, there is a paucity of studies exploring the experiences of mental health crisis for YP (Edwards et al., 2023). Since alternatives to inpatient care for YP have been considered, several systematic reviews have explored 'crisis care' as a valuable alternative to inpatient care (Hamm et al., 2010; Kwok et al., 2016; Sheppard et al., 2008). For instance, Hamm et al. (2010) explored interventions in the Emergency Department for YP experiencing a mental health crisis. Crisis interventions in the Emergency Department were found to positively impact the flow and efficiency of service users through the department subsequently there was a reduction in the length of stay, reduction in admissions to acute beds, and less frequent visits by service users (Hamm et al., 2010). However, the systematic review only included three studies related to YP and most of the studies only included adults. This is a limitation of this review as YP often have distinct needs from adults, hence interventions that may influence the outcomes for adults may not be the same for YP. Also, it was identified that the studies included in the review provided weak descriptions of the interventions hence identifying key characteristics or mechanisms influencing these outcomes was not possible (Hamm et al., 2010). Furthermore, the outcomes identified from crisis intervention primarily focused on organisational outcomes and there was a lack of person-centred outcomes identified, which may be due to the lack of studies that used experience measures.

A systematic review identified primary models of out-of-hospital care for YP in crisis and compared these with inpatient care (control group) (Shepperd et al., 2008). These included day hospitals, home-based multi-systemic therapy, specialist outpatient care, intensive home treatment, and intensive crisis intervention (Shepperd et al., 2008). One study identified a reduction in

externalising behaviours and a reduction in the number of days off school for YP accessing multi-systemic therapy (Henggeler, 1999). For intensive home treatment, Shepperd et al. (2008) identified YP did not demonstrate any improvement from accessing intensive home treatment in comparison to those who did not receive this intervention. A review of a 'homebuilders' crisis model which provided psychoeducation, skills for communication, support in re-framing 'the problem', and Cognitive Behavioural Therapy (CBT) informed skills demonstrated higher levels of family cohesion in comparison to controls (Evans et al., 2003). However, in the short-term, the control group at six-month follow-up demonstrated improved self-concept whereas the intervention group noted significant improvements in social skills (Evans et al., 2003). Similarly, Shepperd et al. (2008) noted that all studies included were underpowered and studies were of variable methodological quality. Due to this limitation, it was often difficult to ascertain the mechanisms of change included in the interventions and there was recognition that inpatient care is hard to standardise for inclusion in Randomised Controlled Trials due to the nature in which it is delivered by a multi-disciplinary team (Shepperd et al., 2008). A recent systematic review of alternatives to inpatient care identified intensive community care resulted in shorter admissions, reduced costs and increased satisfaction with the care provided (Kwok et al., 2016). However, it was highlighted studies excluded YP who were at severe risk of self-harm or suicide who may be in high need of crisis intervention, hence it is important to explore crisis interventions for this population. In addition, a systematic review by Janssens et al. (2013) focused primarily on the structure of emergency support for high-risk YP experiencing a mental health crisis and emphasised the impact of a poorly delineated definition of mental health crisis had on crisis care delivery. A common finding across the systematic reviews exploring crisis care for YP was the low- quality evidence and the lack of research around the experiences of crisis care for YP (Edwards et al., 2023; Hamm et al., 2010; Sheppard et al., 2008).

When exploring the satisfaction of YP for alternative to inpatient care models, a systematic review found YP wanted to be treated at home and felt their care was improved when professionals took their needs seriously, they felt

fully supported during their crisis experience and there was increased communication across services (Vusio et al., 2019). A systematic review conducted by Edwards et al. (2023) explored facilitators and barriers to accessing crisis care for YP and their experiences of crisis responses from services. In regards to barriers to accessing care, YP reflected on the differing thresholds of crisis service, some specifying YP had to reach the point of feeling suicidal to access help (Walter et al., 2006). In addition, YP felt there was a discrepancy between their definition of crisis and that of triage call handlers, resulting in them feeling let down and dismissed by crisis services (Walter et al., 2006). Therefore, when YP could not access services, they usually turned to A&E for support (CQC, 2018). This highlights the importance of exploring the conceptualisation of mental health crisis experiences of YP as differing definitions is often a barrier to accessing help. Also, YP reflected on their journey to accessing support and identified having to navigate through various webpages and contact numbers before support was offered (Narendorf et al., 2017). Hence, the lack of available information about where to access mental health support appears to contribute to YP presenting in mental health crises services.

When considering what facilitates YP in accessing mental health crisis services, YP identified having a trusted adult outside of the family network who could provide non-judgemental support was key to help-seeking behaviours (Bolger et al., 2004). However, some YP also reported when they were experiencing suicidal ideation and hopelessness, they did not want to seek support from others (Bolger et al., 2004). Therefore, this demonstrates the complexities in YP's crisis experiences and understanding these experiences is crucial to aiding service design and delivery. Also, where YP had pre-existing relationships with professionals, help-seeking behaviour was viewed as feeling more manageable (Walter et al., 2006). Hence, it may be other people in the system that identify a 'mental health crisis' for a young person and seek help on their behalf. When accessing crisis services, YP described wanting to be seen as a human and for their needs to be recognised (East of England Clinical Networks, 2017). For their needs to be understood, YP identified staff training as an area of importance in crisis care as this allowed staff to navigate complex

emotions and ask helpful questions to enable the YP to feel supported (East of England Clinical Networks, 2017).

Overall, the current literature and systematic reviews has focused primarily on the organisation and effectiveness of crisis care for YP, whilst also noting the evidence base was of low-quality. There is a paucity of literature focusing on experiences associated with the care and direct experiences of mental health crisis for YP, which impacts service delivery. Recent systematic reviews have called for further qualitative research and acceptability studies to explore YP's experiences of mental health crisis care (Edwards et al., 2023; Vusio et al., 2019). In particular, there is a focus on the conceptualisation and experience of mental health crisis for YP. It is recognised that poorly delineated definitions of crisis and a paucity of experiential research to explore the conceptualisation of mental health crisis has resulted in YP being unable to utilise services at their time of need (CQC, 2018; East of England Clinical Networks, 2017).

1.3.Theoretical Underpinning

1.3.1 Crisis Theory

Crisis Theory was originally developed in non-clinical settings (Caplan, 1964). Primarily, it is a descriptive theory pertaining to how crises develop, what influences and contributes to the development of a crises, and the nature and course of crises (Caplan, 1964; Hobbs, 1984). The premise of Crisis Theory is human beings and systems are in a state of equilibrium or 'homeostasis'. Caplan (1964) stipulated there are four main phases a person or system goes through as a crisis response. Initially, when an individual experiences psychological distress, they may attempt to deploy usual coping mechanisms (Caplan, 1964). However, a crisis reaction arises, when an individual's coping mechanisms are ineffectual at problem-solving the psychological distress (Caplan, 1964). Due to common coping mechanisms not working, individuals experience an impact on their daily functioning and heightened distress (Caplan, 1964). A state of disequilibrium is experienced by individuals at this point and emergency coping mechanisms are employed and help is sought (Caplan, 1964). When experiencing disequilibrium individuals are unable to

cope with the challenges they are facing and experience exhaustion resulting in a deterioration in their psychological health (Caplan, 1964). Caplan (1964) stipulates triggers/precipitants to crisis situations can arise from internal processes (e.g., the meaning individuals attribute to the life events) and external events (e.g., major life events).

Crisis Theory posits there are key characteristics related to a crisis (Caplan, 1964; Hobbs, 1984). These include: crisis is a temporary state; crisis is short in duration; crisis occurs suddenly; crisis is a time for growth and can be a turning point in individuals lives (Caplan, 1964; Graham & Bancroft, 2006; Hobbs, 1984). Crisis is viewed as a key time to introduce new coping mechanisms to individuals as they may be more open to trying these due to other coping mechanisms not working (Caplan, 1964). Hence, the idea of 'crisis intervention' was derived from Crisis Theory (Caplan, 1964; Hobbs, 1984). Due to the theoretical assumptions of crisis, crisis intervention is expected to be focused on the present moment and remain goal-focused (Hobbs, 1984). The aim of 'crisis intervention' is for a state of equilibrium to be re-established with the recognition that there may still be distress present, hence the aim is to not remove all distress (Hobbs, 1984). However, Crisis Theory does not specify what targets for change should be focused on and does not elaborate fully on the process of crisis resolution, which limits the ability to devise models of care. Crisis Theory is primarily represented in the literature within the United States in comparison to the United Kingdom (Tobitt & Kamboj, 2011).

As Crisis Theory was developed for non-clinical populations, there remains significant debate about the applicability of Crisis Theory to clinical populations, such as psychiatric emergencies (Caplan, 1964; Tobitt & Kamboj, 2011). Some state that individuals with serious mental illnesses experience significant fragility in their coping mechanisms, hence their mental state is continuously fluctuating. In addition, it is recognised that for people experiencing mental illness there are often stable and settled periods and periods of acute distress, hence demonstrating the applicability of Crisis Theory to this population (Bridgett & Polak, 2003).

Crisis Theory has been critiqued due to the lack of recognition of the requirement of social support during a crisis and the assumption that individuals will seek support themselves (Bridgett & Polak, 2003). Hence, Bridgett and Polak (2003) stipulated Crisis Theory is only applicable to mental health crises if viewed in the context of the current social circumstances. In addition, the concepts of equilibrium and disequilibrium have been supported by further research exploring professionals' conceptualisations of mental health crisis for adults (Tobitt & Kamboj, 2011). Crisis workers identified a disruption in functioning as a key aspect of mental health crisis and identified a lack of internal and external coping mechanisms as a contributory factor to functional disruption (Tobitt & Kamboj, 2011). Additionally, Tobitt and Kamboj (2011) found the phases of Crisis Theory as broadly applicable to conceptualisations of mental health crisis for adults from the perspective of professionals.

On the other hand, it has been argued that Crisis Theory has limited applicability to current mental health crisis services due to complexities in current presentations and, more specifically, the proposed temporal aspect of crisis (Brimblecoombe, 2001). In addition, deterioration in functioning was conceptualised as always being linked to risk events, according to crisis professionals, whereas risk discourse is not mentioned in Crisis Theory (Caplan, 1964; Tobitt & Kamboj, 2011). However, it could be argued that risk is alluded to in Crisis Theory due to the recognition individuals may use maladaptive coping mechanisms. Also, crisis professionals did not support the notion of service users experiencing mental health crisis moving through various phases of crisis and acknowledged individuals they work with may not progress through these phases in a linear way (Tobitt & Kamboj, 2011). The learning and time for opportunity from a mental health crisis was not found to also be experienced by adult service users and professionals identified that individuals tended to return to pre-crisis functioning (Tobitt & Kamboj, 2011). However, it is important to note that Tobitt and Kamboj (2011) only examined one team of crisis clinicians' conceptualisations of mental health crisis and across the identified themes in their study there were significant differences between professionals hence, this indicates the variability in the conceptualisation of mental health crisis and understanding of people's

experiences. This can have significant implications for accessing crisis services as professionals often act as gatekeepers for these services.

1.3.2 Attachment Theory

Attachment theory has influenced may areas of practice associated with working with children and YP (Slater, 2007). A key assumption of Attachment Theory is babies seek to form a bond with their primary caregiver for survival and use attachment behaviours (e.g., crying) to ensure their needs are met (Bowlby, 1969). According to Attachment theory, a young person's early life experiences with a primary caregiver can shape the young person's mental representation of themselves in relation to others and the world (Bowlby, 1969). Attachment theory refers to these internal representations as 'internal working models' and recognise they can impact many areas of a child's life (Bowlby, 1969). These internal working models provide foundations for expectations of future relational experiences, which can impact emotional and social functioning (Bowlby, 1969; Danquah & Berry, 2013).

Attachment theory was further developed by Ainsworth et al. (1978) via the 'strange situation procedure', which explored differing attachment patterns and behaviours when infants are separated from their caregiver. During an infant's early life, if interactions are considered 'good enough', a secure attachment is likely to develop between the infant and the primary caregiver. For a secure attachment to develop, the 'good enough' threshold is met if primary caregivers can provide: attunement to the baby's needs and distress; become a secure base to allow for safe exploration; being emotionally and physically available and flexible; interceding when required; being consistent in responses (Ainsworth et al., 1978; Hesse & Main, 2000). Children who have developed a secure attachment to their primary caregiver were found to develop trust in their caregiver and were more able to regulate their emotions, express their thoughts and behaviours in a way that signalled attachment cues to the caregiver, so their needs were met (Schore, 2001). When attachment security was ruptured for securely attached children, parents were found to repair this rupture by attuning to their child's needs and distress, hence re-establishing attachment security (Hughes, 2004).

However, when an infant's early interactions with a primary caregiver are inconsistent and the primary caregiver may appear emotionally unavailable or unresponsive to distress cues, they may develop an insecure attachment (Ainsworth et al., 1978). Due to insensitivity and inconsistency in the response from the caregiver, the infant may learn that showing distress has aversive consequences and may then develop their own coping mechanisms to manage their distress due to lack of attunement (van Ijzendoorn et al., 1995). Children with an insecure anxious-ambivalent attachment may try to keep the caregiver near and avoid separation by using hyper-activating strategies to draw in connection and attention from the caregiver (Ainsworth et al., 1978). In addition, children with an insecure anxious-avoidant attachment may dismiss their own emotional desires, be overly independent, and feel uncomfortable with closeness (Ainsworth et al., 1978). Also, an insecure disorganised attachment style was noticed for children who use both anxious and avoidant attachment strategies and is a common attachment style for children who have experienced severe abuse and neglect (Ainsworth et al., 1978; Main & Solomon, 1990). For children where there is a disorganised attachment style, they may fear being near a primary caregiver whilst also needing and wating the closeness, hence they may demonstrate conflicting behaviour (Cooper et al., 2001). Adolescents may seek out support from their caregiver as required, whilst also using peers as an additional attachment figure (Allen, 2008). Attachment styles can adjust throughout the life span, hence individuals who are securely attached can develop insecure attachments and insecurely attached individuals can develop secure attachments depending on life experiences and relational experiences (Cozzareli et al., 2003).

Attachment theory has been applied to adolescent mental health settings and has been used a lens for understanding the development of adolescent mental health difficulties (Keskin & Cam, 2010). Insecure attachment styles have been associated with higher risks of mental health difficulties (Figueriredo et al., 2006). A higher incidence of anti-social behaviour, depression, anxiety, behavioural difficulties, and suicidality have been identified in those with an insecure attachment style (Keskin & Cam, 2010; Fonagy et al., 1997).

Attachment theory provides indications as to how individuals seek help in moments of distress (Bowlby, 1969). Hence, the application of attachment theory to understand how people may help-seek when experiencing mental health difficulties is crucial. Bucci et al. (2014) identified that service users attachment histories are activated when they present to mental health services and impact interactions with clinical staff. Also, due to the development of therapeutic alliances, professionals can constitute as an attachment figure to their service users (Adshead, 1998). Despite the recognition the influence attachment has on mental illness, access to therapeutic provisions, and outcomes, there has been limited consideration of attachment theory and the design/delivery of services (Bucci et al., 2014; Adshead, 1998). Due to the Attachment Theory providing an influential lens to understanding distress in children and understanding how attachment systems may influence interactions with mental health services, it may a useful theory to explore understandings of mental health crisis for YP. However, attachment theory has been critiqued for primarily exploring dyadic relationships and ignoring any wider attachments in a triadic way (Dallos et al., 2023). Hence, ideas from attachment and systemic therapies are often drawn upon when working with children and YP.

1.3.3 Systemic Family Therapy

Systemic Family Therapy is a well-established therapeutic modality used within children and YP mental health services (Carr, 2019). For YP and their families, Systemic Family Therapy has been recommended as an intervention for a variety of psychological difficulties, including self-harm, high-risk behaviours, eating disorders, depression, and behavioural difficulties (Carr, 2019). However, Systemic Family Therapy research has been critiqued for its lack of outcome studies and the vagueness of interventions reported in research, hence a call for more manualised interventions is required (Cottrell & Boston, 2002). Moreover, Systems Theory (Von Bertalanffy, 1950) underpins Systemic Family Therapy practice and development and is used as a theoretical framework. According to Systems Theory, each part of the system, in regards to individual characteristics, needs to be understood to fully understand a systems behaviour (Von Bertalanffy, 1950). Systems Theory explores the relationships within these different characteristics of a system and explores relationships

between these elements (Von Bertalanffy, 1950). Family units can be viewed as a system and each family unit relates to wider social systems (Vetere & Dallos, 2003).

There are several key ideas and assumptions within Systemic Family Therapy, underpinned by systems theoretical framework. Firstly, a key focus is communication within the family system, including how beliefs, emotions, and thoughts are spoken or remain unspoken between the system (Vetere & Dallos, 2003). Secondly, the stability or instability of a system is crucial to the understanding of how 'problems' are arising and considering varying boundaries of sub-systems within the system (Rivett & Street, 2003). Thirdly, resistance, 'stuckness' and change are viewed as an outcome of the communication strategies used within the system and can be helped or hindered at varying levels of the system (e.g., at an emotional level, beliefs level, behavioural level, societal level) (Vetere & Dallos, 2003). If the system is unable to be flexible and adapt to certain changes, 'symptoms' or 'problems' may occur (Vetere & Dallos, 2003). Lastly, circularity is a central concept of systemic family therapy (Vetere & Dallos, 2003). This moves the assumption of the maintenance of difficulties away from the individual level (linearity) and assumes difficulties are maintained by interactions within the system due to interactional processes within the system (Vetere & Dallos, 2003).

1.4. Adolescent Development

Within the mental health crisis literature, adolescents are recognised as having distinct needs (Edwards et al., 2023). Adolescents have often been excluded from mental health crisis research due to this reason (Vusio et al., 2020b). Adolescence is recognised as a key developmental period, particularly in the creation and maintenance of health-related behaviours and outcomes across the lifespan (Kessler et al., 2005). Broadly, adolescence refers to the unique developmental period between childhood and adulthood (Jaworska et al., 2015). The period of adolescence is characterised by psychological, biological, and social changes and is recognised as a period of adjustment and vulnerability (Steinberg, 2005). There are also cultural differences in how the adolescent period is understood due to differences in cultural expectations and norms for this age range (Jaworska et al., 2015). More recently, due to

prolonged neural changes past 18-years-old, there has been a need to extend the definition of adolescence to capture these important changes to 25-years-old (Jaworska et al., 2015; Steinberg, 2005). This presents challenges for clinical service structures, clinical approaches, and policies that inform clinical work as this is not currently how many mental health services are designed. Also, the developmental, emotional, and social needs of a younger adolescent (e.g., aged 13) are considered as significantly different to that of a young adult (e.g., aged 25), hence demonstrating the vast development the period of adolescence encompasses (Jaworska et al., 2015; Spear, 2000).

Biologically, adolescence is recognised as co-occurring with puberty. During puberty, there is an increase in sex hormones for males and females and often the development of secondary sex characteristics occurs during this developmental period (Spear, 2000). Some studies have demonstrated sex differences in the onset of psychiatric difficulties occurring during adolescence (Dekker et al., 2007; Murray et al., 2022; Rutter et al., 2003). For instance, sex differences in the incidence of depression were identified in the adolescent period, demonstrating a possible increased susceptibility to depression during the period of adolescence (Hankin et al., 1998). Whilst these changes are happening to the body, during puberty there are also changes that occur within the brain. Specifically, there are several structural development changes that occur in the cortical areas associated with motor and sensory processing, with areas such as the pre-frontal cortex developing towards the mid-twenties (Konrad et al., 2013). The brain undergoes a process known as synaptic pruning, whereby the neural connections in the brain are pruned (the grey matter) if they are unused and other connections are strengthened (the white matter) (Blakemore & Choudhury, 2006). Synaptic pruning tends to occur from the back of the brain to the front of the brain, where the pre-frontal cortex is located, across the span of adolescence and young adulthood (Blakemore & Choudhury, 2006). The pre-frontal cortex is associated with higher-order cognitive functions, such as executive function tasks (e.g., weighing up risks, planning, cognitive processes involved in social functioning, and decision-making) (Blakemore, 2019; Konrad et al., 2013). Hence, this may contribute to the increase in risk-taking behaviours seen in the period of adolescence due to

them having to rely on the amygdala for decision-making at times (Johnson et al., 2009).

Alongside the anatomical changes occurring in the brain, there are various social, emotional and cognitive changes that also occur during adolescence. It is recognised adolescents experience changes focused on the executive functioning regions which results in developments in working memory, decision-making, and flexibility around cognition (Jansen & Kiefer, 2020). In addition, it is recognised that adolescents go through several social changes, such as being exposed to new situations, expectations of increased autonomy, susceptibility of peer influences, and experimenting with different aspects of their lives (Eccles & Roeser, 2011; Jansen & Kiefer, 2020). However, whilst young people are seeking autonomy in situations and strive to make autonomous decisions, it is recognised that their primary caregivers play a crucial role in their development through this turbulent phase of development (McCurdy et al., 2020).

Erikson's (1980) theory of psychosocial development has been a largely influential model in understanding developmental stages, particularly the period of adolescence (Côté, 2018; Erikson, 1980). The premise of Erikson's (1980) theory is there are a series of stages across the lifespan and as individuals move through these, they will continue to develop (Gross, 2020). Erikson (1980) argues individuals develop by being faced with and moving through different events, which he termed 'crises' and if these crises remain unresolved the individual may experience challenges in life in other life stages. As stipulated by Erikson's (1980) theory adolescence is a transitional life point which facilitates the transition from being a child to becoming an adult. According to Erikson (1980) this phase of life focuses on tensions between adolescents building a sense of identity, navigating puberty, whilst also ascertaining and confirming to the expectations of those around them (Erikson, 1980; Gross, 2020). If an individual resolves this crisis, they achieve a sense of ego identity through the integration of separate parts of themselves and developing their sense of self (Erikson, 1980). However, if this crisis is not resolved individuals, according to Erikson (1980), experience 'role confusion' regarding the direction of travel for their lives. They may experience low self-esteem and may be more

likely to conform to other people's norms, for instance their peers (Côté, 2018; Maree, 2021). However, this theory has been criticised for the lack of explanatory power related to the mechanisms in which psychosocial crises are resolved and the development of the model was based on examination of western males (Côté, 2018; Maree, 2021). Despite this, Erikson's (1980) theory has been applied to the field of mental health recovery literature and supporting understanding as to how individuals may improve their functioning and aspects to focus on in their recovery (Vogel-Scibilia et al., 2009). Hence, this theory highlights the crucial aspects of development for young people at this developmental stage. Whilst the stage of adolescence provides several opportunities for identity formation and development, there are also significant vulnerabilities for young people at this stage.

1.5 Extended Rationale

The mental health of adolescents is of particular interest internationally and nationally as adolescence is recognised as an important developmental period (World Health Organisation, 2021). Mental health conditions for adolescents can have a significant impact on their emotional, social, and educational functioning and can persist across the lifespan if early intervention is not received (Colizzi et al., 2020; NHS Digital, 2018). YP and families are reporting remaining on waiting lists for longer periods of time and the treatment gap is becoming more apparent as services struggle to meet the required demands due to lack of capacity in services (Children's Commissioner, 2024). In addition, a 47% increase in referrals to CAMHS Crisis Teams were recorded in the U.K (Lewis, 2021). Therefore, the need for urgent and emergency mental health help for YP is increasing. Internationally and nationally, care for people experiencing mental health crises has become a priority (Department of Health, 2015; NHS England, 2019; World Health Organisation, 2021). Whilst the NHS Long Term Plan (NHS England, 2019) requests an improvement in children's crisis care through the provision of timely help, there is limited understanding of the current experience of YP experiencing mental health crises. Despite The Crisis Care Concordat (HM Government, 2014), there is significant variability in service provision and accessibility to urgent mental health care remains a continued concern (Vusio et al., 2020). It is recognised there is a lack of

conceptual clarity surrounding the term ‘mental health crisis’ which may contribute to the variability in the implementation and provision of crisis services, particularly how the 24/7 provision is delivered and brief crisis interventions (Evans et al., 2023). The lack of conceptual clarity could impact the accessibility to crisis services due to differing understandings of what it means to be in a mental health crisis and limited understanding of what support is required. Hence, it is important to explore multiple perspectives to develop an inclusive understanding of mental health crisis as professionals’ understandings may be influenced by service specific guidelines.

Recent systematic reviews (See Edwards et al., 2023; Vusio et al., 2020) have called for further experiential research from a qualitative approach to explore the experience of mental health crisis for YP due to identifying a paucity of studies focusing on adolescents due to their distinct needs. YP exist in multiple systems and parents/carers are often key influential figures at this developmental stage (McCurdy et al., 2020). By exploring the conceptualisation and experience of a mental health crisis for YP from multiple perspectives, this research will further understandings of mental health crises and what it means to be in a mental health crisis for YP. Thus, having implications for service provision with regards to referral criteria, access to services and intervention types offered. Since, Future in Mind (Department of Health, 2015) have emphasised the importance of service user involvement in service design, it is important to gain understandings of the experience of mental health crises for YP from multiple perspectives, such as parents/carer, YP and professionals. As YP crisis services are expanding and being reconfigured to try and improve access and experience, this research could contribute to service design and delivery. Hence, it is anticipated this research may be of interest to commissioning teams, managers, and practitioners and can influence the development of a more inclusive crisis provision for YP.

2. Extended Methodology

2.1 Rationale for Methodology

Broadly, qualitative approaches view words as a form of data, whereas quantitative approaches use numbers as data (Clarke & Braun, 2013). Quantitative approaches aim to identify relationships between different variables to predict or explain the relationship using statistical analysis (Howitt & Cramer, 2007). Whereas qualitative research aims to understand meaning and experiences by generating 'rich' data and values data that is situated in a context (Clarke & Braun, 2013). A qualitative methodology was deemed appropriate for this study. The reason a qualitative approach was chosen was due to the exploratory nature of this research study and as the aim to understand individuals' experiences of mental health crisis and explore patterns of meaning across the three groups.

2.2. Epistemological Position

This research was grounded in critical realism. When considering philosophy of science, critical realism is not tied to any particular methodology (Fletcher, 2017). Critical realism takes an ontological position of realism whilst postulating epistemological assumptions of constructivism and relativism, therefore meaning a reality does exist, but it can only partially be accessed (Bhaskar, 2013; Braun & Clarke, 2022). In terms of understanding reality, Bhakasar (2013) proposed a 'stratified ontology'. Firstly, 'an empirical level' which are observable events which can be noticed by the researcher and are experiences that can be understood through interpretation of human experience to access some form of reality (Fletcher, 2017; Wiltshire & Ronkainen, 2021). Secondly, the 'actual level' whereby experiences occur but are unobserved so may not be captured in the data explicitly (Fletcher, 2017; Wiltshire & Ronkainen, 2021). Lastly, the 'real level' whereby events or experiences at the 'empirical level' occur due to causal mechanisms in the 'real level' meaning aspects at this level are unable to be observed (Fletcher, 2017; Wiltshire & Ronkainen, 2021). By this research being theoretically underpinned by critical realism, reflexive thematic analysis (TA) provides a means of access to situated realities which is situated in and shaped by an individual's cultural and social context (Braun & Clarke, 2022). Therefore, direct understandings of one 'universal reality or truth' are not possible (Fletcher, 2017). This fits with the exploration of mental health crisis for YP through multiple perspectives by

asking participants to share their experiences by identifying patterns of meaning and not acknowledging there is only 'one truth' to be sought. Collecting data underpinned by a critical realist approach assumes the data tells us something about reality but is not a direct mirror of reality (Bhaskar, 2013; Wiltshire & Ronkainen, 2021). So, other forms of evidence (e.g., theory) may need to be applied to articulate the maintaining attributes of reality (Willig, 2012). In essence, this means reality is always accessed through our own individual lenses which are shaped by our social, cultural and historical contexts which allows for exploration of multiple perspectives, in line with this research study (Willig, 2012). Braun and Clarke (2022) argue reflexive TA from a critical realist stance aims to provide "a coherent and compelling interpretation of the data, grounded in, or anchored by, the participants accounts, that speaks to situated realities" (p. 171).

2.3. Participants

2.3.1. Sampling Strategy

This study aimed to recruit equal numbers of participants across the three groups (CAMHS crisis professionals, YP, and parents/carers). The three groups did not have to be linked in any way (e.g., if a young person participated in the study, their parent/carer did not have to also participate). Purposive sampling was adopted as a strategy to recruit potential participants. This is where a particular group of individuals are selected in a non-random manner to generate information-rich data (Palinkas et al., 2015). Purposive sampling was deemed an appropriate sampling strategy as it allowed a particular group of participants, with relevant qualities as defined in the inclusion criteria, to address the research question if they would like to participate (Bernard, 2017; Etikan, 2016).

2.3.2. Rationale for Inclusion and Exclusion Criteria

The inclusion and exclusion criteria for each group are detailed in the journal paper. Below is a further explanation of the rationale for each criterion. The inclusion and exclusion criteria were discussed with the second, third, fourth and fifth author in several research supervisions and refined prior to the recruitment of participants.

Inclusion and Exclusion Criteria for CAMHS Crisis Professionals. In terms of inclusion criteria, CAMHS crisis professionals had to be a healthcare professional who was currently working in a CAMHS crisis team and had to have been in that role for a minimum of three months. The rationale for this criterion was that three months was considered an adequate amount of time for participants to be able to gain some experience of working with YP in crisis. Also, participants had to be able to read and communicate verbally in English. This was required so that individuals could read and understand the information sheet, consent form, and participate in an interview.

In terms of exclusion criteria, participants had to be employed directly by the NHS trusts where staff were recruited from. The rationale was that NHS ethical approval was only sought by trusts listed as recruitment sites. NHS ethical approval was sought as CAMHS crisis teams predominantly sit within NHS services (NHS England, 2019).

***Inclusion and Exclusion Criteria for YP*.** CAMHS community professionals, who were the gatekeepers for recruitment of YP, were made aware of the criteria below and the rationale provided for each criterion. In terms of inclusion criteria, YP had to be aged 13-17, have accessed the CAMHS crisis team and been discharged in the last 12-months. This study was focused on the adolescent age-range and by having accessed the CAMHS crisis team, it meant that at some point a mental health crisis had been identified. The rationale for the time frame of being discharged in the last 12 months was so that the YP were still able to re-call and reflect on their experiences of being in crisis. Initially, when designing the study, the time frame was limited to the YP having been discharged in the past three-months, however due to recruitment difficulties this timeframe was broadened to 12-months[27].

Also, the YP had to be deemed competent to provide informed consent if aged 16-17 or someone with parental responsibility had to be able to provide

[27] See section 2.4.1. for further information on recruitment difficulties

informed consent, if under the age of 16. Due to ethical considerations, the CAMHS community clinician deemed whether those aged 16-17 had the competence to consent to take part in the research as they were best placed to make this decision due to knowing the young person best. Assent was aimed to be obtained from those under the age of 16. Additionally, YP had to be under the care of a named community CAMHS professional at the time of the interview. Due to ethical considerations, it was felt appropriate that the young person had access to direct support at the time of participation in the research in case any concerns arose. Lastly, YP had to be able to read and communicate verbally in English. This was required so that individuals could read and understand the information sheet, consent/assent form, and participate in an interview.

In terms of exclusion criteria, YP were unable to participate if there were significant ongoing safeguarding concerns (e.g., Child Protection Plan) which had been identified. Due to the nature of some of topics which were discussed in the interviews, it was decided it would not be appropriate to include YP where there were significant safeguarding concerns, as this could have adversely impact upon the young person's well-being. Also, if the young person was experiencing an active mental health crisis, they were unable to be recruited. Due to the nature of the research, participation whilst in an 'active' mental health crisis could have adversely impacted upon the young person's well-being. In addition, it could have impacted the person's ability to reflect on the crisis. Lastly, individuals who were under the age of 16 and whose parent/legal guardian did not provide consent were not able to participate. As outlined in the recruitment procedure section, if there was any disagreement between the young person and the parent/legal guardian for those under the age of 16, the young person would not participate.

Inclusion and Exclusion Criteria for Parents/Carers. CAMHS community professionals, who were the gatekeepers for recruitment of parents/carers, were made aware of the criteria below and the subsequent rationales. In terms of inclusion criteria for parents/carers, they had to be the

primary caregiver[28] of a YP who is aged 13-17 who previously had an open referral to the CAMHS crisis team and been discharged in the past 12-months. The young person they were the primary caregiver of also had to be allocated to a named community CAMHS clinician at the time of the interview. This study was focused on the adolescent age-range and by having accessed the CAMHS crisis team at some point a mental health crisis had been identified for the young person. The rationale for the time frame of being discharged in the last 12 months was so that the parent was still able to re-call and reflect on their experiences of their YP being in crisis. Initially, when designing the study, the time frame was 'had to be discharged in the past three-months', however due to recruitment difficulties this timeframe was broadened to 12-months. Additionally, YP had to be under the care of a named community CAMHS professional at the time of the interview. Due to ethical considerations, it was felt appropriate that the YP and family has access to direct support at the time their parent/carer was participating in the research, in case support needs were highlighted in the interview. Lastly, parents/carers had to be able to read and communicate verbally in English. This was required so that individuals could read and understand the information sheet, consent/assent form, and participate in an interview.

In terms of exclusion criteria, parents/carers were unable to participate if they were not the primary caregiver of the young person. To understand the experience of caring for a young person in a mental health crisis, it was important that the parent/carer taking part in the research considered themselves as a primary caregiver so they could reflect on these direct experiences from being with and caring for the young person who experienced the crisis. Parents/carers also could not participate if there were ongoing significant safeguarding concerns (e.g., child protection plan). Due to the nature of some of topics which were discussed in the interviews, it would not have been appropriate to include caregivers where there were significant safeguarding concerns. Lastly, if the young person was in active crisis the

[28] A primary caregiver was self-defined. In essence, it is the person(s) who is primarily responsible for the majority of the young person's care.

parent/carer was unable to participate in the research. Due to the nature of the research, participation whilst in an active mental health crisis could have adversely impacted upon the young person's or caregiver's well-being. In addition, it could have impacted on the person's ability to reflect on the crisis.

2.3.3. Determining Sample Size

In the past, there have been ongoing critical debates around the concept of 'data saturation' in qualitative research (Bowen, 2008; Braun & Clarke, 2021). The term 'data saturation' has been depicted as a 'gold-standard' rationale within health research for determining appropriate sample size (Guest et al., 2017). However, the term 'data saturation' has often been found to be poorly defined and operationalised in qualitative research papers, but researchers have attempted to use it as a concrete device to dictate the appropriateness of the sample size chosen (Clarke & Braun, 2019; Morse, 2015). The claim of 'data saturation' implies that meaning exists within the data and is there to be extracted, therefore it is feasible to reach a point where 'nothing new' can be sought from qualitative data sets (Clarke & Braun, 2019; Sim et al., 2018). This is inherently incongruent with the assumptions of reflexive TA (Braun & Clarke, 2021; Clarke & Braun, 2019). Reflexive TA's assumption about meaning is that it requires interpretation and meaning it is not 'existing' within the data (Clarke & Braun, 2019). Hence, analysis is not finite and new meanings can, in theory, always be sought (Low, 2019). Due to the theoretical incoherence of 'data saturation' as a concept, it was not used in this research study.

Instead, Clarke and Braun (2019) state the sample in qualitative research must be guided by the research question and large enough that patterns can be identified through a meaningful process. In qualitative research, the judgements around sample size are influenced by pragmatic and interpretative judgements (Braun & Clarke, 2013; Sim et al., 2018). Clarke and Braun (2019) advised estimating a provisional sample size range which would aim to generate a multi-faceted story and would allow for patterns of meaning to be identified (Sim et al., 2018). As Braun and Clarke (2019) were aware reviewers often comment on the rationale for sample sizes in reflexive TA, they published some guidance for students, which stated that for professional doctorates the range would often be

between 10-20 interviews. Hence, taking into consideration all the above information, and through discussions in supervision, a total sample size of 15-18 participants was the target sample size range for this research study (5-6 parents/carers, 5-6 YP, and 5-6 CAMHS Crisis Professionals). Due to difficulties with recruitment, the sample size target for YP was not met. However, considering the interviews collected in total was 10, which is the lower range of Braun and Clarke's (2019) criteria, and considering the quality of the data in supervision, this sample size was deemed appropriate to address the aim of this research study.

2.4. Recruitment Procedure

CAMHS community teams and CAMHS crisis teams were notified about the research project via the researcher presenting a summary of the research at team meetings. Topics covered were summary of the recruitment procedure and eligibility criteria.

Recruitment of CAMHS crisis professionals was conducted via email. Two CAMHS Crisis Teams were involved in recruitment of CAMHS crisis professionals. A meeting was held with team managers to provide a summary of the research and what would be required of participants. Team managers were sent the Participant Information Sheet (PIS) (see Appendix A) and were asked to send this to CAMHS crisis professionals in their team to invite them to participate. Those interested were asked to contact the researcher directly via email. The researcher aimed to respond to the participant within seven working days to book in a 20-minute telephone conversation, to go through the PIS and answered any questions. During the appointment, informed consent was sought and the CAMHS crisis professional emailed the written consent form back to the researcher (see Appendix B).

The recruitment of YP, aged 13-17, was via the CAMHS Community professionals, usually the young person's care co-ordinator. For YP aged 16 and above, the CAMHS community professional provided the young person with the age-appropriate PIS (see Appendix C). For YP under the age of 16, prior to providing the young person with the age-appropriate PIS (see Appendix

D), the parent/carer was provided with a PIS (see Appendix E) about the study initially.

If the young person was aged 16 or over, had the competence to provide informed consent, and was interested in hearing more about the study, the CAMHS community professional passed their contact details and details of their named CAMHS professional onto the researcher via the contact details form (see Appendix F). The potential participant was then informed that the researcher would contact them within seven working days to book in a 20-minute appointment. They were given at least 24 hours to consider the information sheet. The researcher then contacted the young person and parent/carer, where appropriate, for a 20-minute telephone call to discuss the PIS, answer questions and obtain written consent (see Appendix B).

If the young person was under the age of 16 and was interested in hearing more about the study, the CAMHS community clinician passed their parent/carer's contact details onto the researcher. The parent/carer was informed that the researcher would contact them within seven working days to book in an initial appointment. They were given at least 24-hours to consider the information sheet. The researcher then contacted the parent/carer and asked the young person to be present during this telephone call. This was planned to be a 20-minute telephone appointment to go through the PIS, answer questions and obtain consent and assent (See Appendix G) for parent/carer consent form for under 16s and Appendix H for assent form).

The recruitment of parent/carers were via the CAMHS community professional. The parents/carers did not need to necessarily be the parents/carers of the YP taking part in the study, although this was allowed within the remit of the study. Hence, the parents/carers and the YP taking part in the study did not need to be linked. The CAMHS community professional provided the parent/carer with the PIS (see Appendix I). If the parent/carer was interested in hearing more information about the study, the CAMHS crisis professional would pass their contact details onto the researcher via the contact details form. The potential participant was informed that the researcher would contact them within seven working days to book in an appointment. They were

given at least 24-hours to consider the information sheet. The researcher then contacted the parent/carer for a 20-minute telephone appointment to go through the PIS, answer questions and obtain consent (See appendix B).

Once informed consent, and where appropriate assent, was provided, a 60-minute interview appointment (45-minute interview with an optional 15-minute de-brief) (See Appendix J) was arranged at a time that was convenient for the participant and researcher. All participants were provided with a 'reminder' via email regarding their upcoming interview appointment two-days prior to the appointment. Participants were able to choose if they would like their interview via Microsoft Teams or in-person. If participants travelled in-person to the interview, they were able to have travel expenses re-imbursed.

2.4.1. Decision-Making around Recruitment

Recruitment commenced in February 2022 and ended in February 2023. However, as noted above, the recruitment target was not met. Issues with recruitment in qualitative studies is not uncommon (Hudson et al., 2017; Jessiman, 2013). Often, challenges with recruitment are only unveiled once significant planning of recruitment has taken place (Bonisteel et al., 2021), like in this study. For the present study, when recruitment difficulties were becoming apparent regarding recruiting parents/carers and YP, the first author took these issues to supervision with the second, fourth and fifth authors. One of the barriers voiced by clinicians identifying suitable cases was that the timeframe of discharge from the crisis team of three months was too limited. It was evident that due to the limited timeframe after crisis it was either felt 'too soon' specifically for the YP, or the family had not yet accessed community support with CAMHS. Hence, an amendment was submitted to broaden this inclusion criteria to 12-months. Also, in supervision, it was reflected that clinicians experienced many demands in their job role, and, at times, there was high staff turnover. Therefore, to support recruitment, regular emails were sent to teams and the first author attended several team meetings to talk about the research project, to try and capture the change in staff and be present to clinicians to ask any questions. This strategy was found to be helpful in supporting clinicians to recruit parents/carers and the YP. Another consideration from the research

team was whether recruiting from third-sector organisations and via social media would be appropriate. However, after extensive discussion, it was decided that this would change the scope of the project and due to ethical concerns regarding the participants well-being, it was not deemed appropriate in the scope of this research project.

2.5. Data Collection

2.5.1. Rationale for use of semi-structured interviews

Semi-structured interviews allowed the researcher to gain an understanding of participants' experiences with some consistency and structure, whilst also being flexible and responsive to the depth of participant's own individual experiences and explore any unanticipated issues (Braun & Clarke, 2013; Willig, 2012). An 'ideal' semi-structured interview has been described as "on target whilst hanging loose" (Rubin & Rubin, 1995), p.42). Face-to-face interviews have been identified as 'gold-standard' in practice (Novick, 2008). It has been argued that in-person interviews allow for both the non-verbal and verbal cues to be considered (Thunberg & Arnell, 2022). Alternatives to in-person interviews, such as telephone interviews, have been criticised due to not being able to observe non-verbal cues, hence they were framed as not being an equivalent replacement but rather merely an alternative (Opdenakker, 2006). However, due to the COVID-19 pandemic, researchers have needed to adapt methodologies to include more 'digital methods' to facilitate social distancing and manage the safety of participants and themselves (Nind et al., 2023) . Whilst 'digital methods' had been considered before this time, they tended to be viewed as an 'alternative' rather than as an equivalent to in-person interviews (Thunberg & Arnell, 2022). However, a review by Thunberg and Arnell (2022) found that when researchers are wanting to explore more sensitive topics or the participants are considered vulnerable, digital methods were experienced positively, as they made it possible for people to give their perspective and gave them a voice to tell their story without the pressures of a face-to-face interview. YP are classified as a 'vulnerable group' (Gubrium & Holstein, 2002). Due to YP being a vulnerable group and mental health crisis is considered a sensitive topic, it was important to give participants a choice in how the interview took

place and offer a digital method as an option. Also, as the research took place in the COVID-19 pandemic, it was important to ensure that both methods were incorporated into the design in case any participants were vulnerable in terms of health or in the case of any further national restrictions.

Focus groups were considered as an alternative data collection method, however, were not chosen due to reasons that were two-fold. First, one group of participants that were interviewed were professionals. Due to their busy schedules, organising focus groups may have posed a significant logistical challenge (Braun & Clarke, 2013). Second, although focus groups have been found to be an effective method of data collection when asking about sensitive topics (E.g.,Krueger & Casey, 2014), detail around individual narratives and the depth that their perspectives can be explored would have been limited by a focus group design (Braun & Clarke, 2013). Hence, one-to-one semi-structured interviews were chosen as the most appropriate method to provide answers to the research questions.

2.5.2. Development of the interview schedule

The interview schedules (See Appendix K) were developed taking into consideration what was already known about the topic area from the adult literature. In supervision with the second and fourth author, several considerations around the design of the interview schedule were discussed. First, a key feature of interactive data collection methods is the ability to build rapport with participants (Braun & Clarke, 2013; Reinharz, 1993), and this has been found to be key in manging power dynamics in research with children (Kirk, 2007). Hence, it was decided that general demographic questions would be asked at the start of the interview as ‘opening questions’ and a closing question was offered at the end to allow participants to raise anything else they felt was important (Braun & Clarke, 2013). Second, Braun and Clarke (2013) stated an important consideration was the order of questions and they advised clustering questions into topic-based areas. Prompts and probes were included at the end of the interview schedule, which could be used at any point during the interview, and it was recognised that probes can take two forms (Braun & Clarke, 2013). First, questions were specified that articulated the type of further

detail that was required (e.g., Tell me about an example of that?) (Brinkmann et al., 2018). Second, it was acknowledged that probing could have also been an 'hmm or yes' or a nod/glance (Braun & Clarke, 2013). The interview schedules were refined during several supervision sessions. However, it was recognised that qualitative semi-structured interview guides are not fixed and could be refined as new issues arose throughout the data collection process (Gubrium et al., 2012). An amendment was submitted to the research ethics committee on 5th September 2022 due to typographical errors in the interview schedules. Demographic information was collected at the start of each interview. Interviews were conducted by the first author only. Interviews were audio-recorded using a dictaphone and were transcribed by an automated transcription service.

2.6. Expert Involvement

During the early phases of the project design, it was a requirement to present the research study design at several panels, which also comprised of members of our Service User and Carer Advisory Panel (SUCAP). In these panels, there were discussions around the language used in the study documents, and the importance of making an engaging PIS for the young people, which helped develop the study documents. Three YP and three parents/carers in the researcher's personal network were consulted to check the readability and suitability of the participant information sheet, consent form and interview schedules. This altered the way that information in the participant information sheet was laid out and the language used on the study documents. For the young person participant information sheet, a BitEmoji was also added of the researcher to improve the design.

2.7. Choosing Reflexive Thematic Analysis

Reflexive thematic analysis is a flexible method which allows researchers to identify patterns of meaning across a dataset (Braun & Clarke, 2019). One of the main premises of the method, and the rationale for including the term 'reflexive', is that researcher plays an active role in the research process through making a series of decisions (e.g., theoretical assumptions, ways of knowingly engaging in the data, and coding process) (Braun & Clarke, 2019). Reflexive thematic analysis is a widely applicable qualitative research method

which is theoretically and analytically flexible (Braun & Clarke, 2022). There are several reasons reflexive thematic analysis was chosen as the most appropriate research method of addressing the aim of this study. Firstly, due to the flexibility of this method it allowed for the researcher to adopt a critical realist epistemological stance. Secondly, as the research was exploring three groups experiences of mental health crisis for YP, this method allows for semantic and latent codes to be used as tools to explore patterns of meaning across the whole dataset. Thirdly, in terms of analytical decisions about the data, reflexive thematic analysis encourages the researcher to make decisions throughout the research process, such as the different types of coding (Braun & Clarke, 2022). Whilst there is a paucity of literature in this area, there were some known assumptions from relevant theory and the adult literature. Reflexive thematic analysis allows for a mixed inductive-deductive approach to be taken to coding, so relevant theory on crisis and YP's mental health can be used to inform interpretation, whilst also allowing the researcher to remain close to the participants' experiences. Hence, the flexible approach allowed for a complex and nuanced analysis of an area where there is a significant lack of literature.

2.7.1. Considering other qualitative approaches

Braun and Clarke (2022) advise against detailing alternative methods that could have been used, rather they recommend placing emphasis on providing a strong rationale for the use of the qualitative approach chosen to address the research question. Braun and Clarke (2022) state that there is rarely one method, especially with research aimed at understanding patterns of meaning, that would be most appropriate. However, the section below documents discussions had in supervision sessions when designing this study and choosing an appropriate methodology. The following methods were considered.

First, Discourse Analysis (DA) was not considered an appropriate methodology as it is concerned with the construction of language, how language is used to construct reality, and the function of language (Georgaca & Avdi, 2011). DA positions language as performative and active as a social practice rather than considering language as participants' direct expression of

feelings and thoughts (Braun & Clarke, 2021). This methodology is more in line with a social constructionist epistemological position (Georgaca & Avdi, 2011). Therefore, as this study was underpinned by a critical realist epistemological position, DA was not considered appropriate. When designing research, it is important to consider the methodological integrity, including the researcher's approaches to the inquiry, for coherence (Levitt et al., 2013). As the aims of the study were to explore conceptualisations and personal experiences of mental health crisis for YP from different perspectives. DA was not considered appropriate as the study did not aim to understand how the use of language constructs meaning around mental health crisis.

Secondly, grounded theory was considered however the type of research questions asked in this approach tend to focus on social process and meaning with the aim of developing a theory from the analysis (Charmaz, 2014). Often in grounded theory, the research will not review the literature prior to commencing data collection with the aim of maintaining independence from the data, which is a key concept (Charmaz, 2006). Hence, grounded theory was not used as the researcher had already conducted a significant literature search and due to the limited extant literature, the researcher aimed to understand experiences rather than develop a grounded theory about mental health crisis.

Thirdly, Interpretative Phenomenological Analysis (IPA) was also considered. Whilst IPA is similar to thematic analysis in regards to exploring patterns of meaning within a data set, IPA tends to be theoretically and epistemologically driven by an interpretive phenomenological position (Braun & Clarke, 2006). Hence, IPA emphasises that people make sense of the world through their interpretations of it (Smith et al., 2017). So, in IPA the researcher makes sense of individual's experiences whilst the individual is also interpreting their own experiences, otherwise known as double hermeneutics (Smith et al., 2017). Initially, within IPA, researchers would complete an inductive analysis to examine the unique features of a case', before moving to the broader dataset (Braun & Clarke, 2021, p. 42).

IPA was not considered the most appropriate methodology to address the research aim because the study was positioned from a critical realist epistemological position. Also, the study aimed to identify patterns of meaning and themes across the whole data set. It was not felt that to address the research question an understanding of the 'unique features of a case' was required. (Braun & Clarke, 2021, p. 42). In addition, as the study aimed to interview three different groups of participants it could be possible that some diversity in experiences of mental health crisis may occur, hence a reflexive thematic analysis approach was felt most appropriate to capture this (Braun & Clarke, 2021; Fassinger, 2005). In terms of the study, it aimed to explore mental health crisis for YP from multiple perspectives, so, if IPA were to be used it would possibly be analysing multiple hermeneutics which would be complex (Braun & Clarke, 2021; Montague et al., 2020).

Lastly, Narrative Analysis (Bamberg, 2012) was strongly considered. Narrative Analysis focuses on how individuals create and tell stories to make sense of their experiences within their lives (Bamberg, 2012). However, Narrative Analysis was not chosen as a methodology as the aim of this research was to explore patterns of meaning across the dataset and was focused on exploring a shared concept of 'mental health crisis', hence a focus on the shared experiences. Whereas, Narrative Analysis tends to focus on exploration more deeply of singular stories and focuses on how individuals narrate those stories rather than exploring the meaning of the experiences.

2.8. Data Analysis

The section below provides further details on how the researcher engaged with the data analysis process.

2.8.1. Phase One: Familiarisation of the dataset

In the familiarisation phase, it is important for the researcher to immerse themselves in the dataset and critically engage with the information as data (Braun & Clarke, 2022). Although the interviews were completed by the first author, they were transcribed by an automated transcription service. The first author felt it was important to re-listen to the audio files and correct

typographical errors, which aided them to become familiar with the dataset. This process was undertaken from starting with the CAMHS crisis professional's interviews, moving onto the parents/carers and then to the young person. Then, the first author re-read all the transcripts in reverse, so started by reading the young person's interview, then the parents/carers, and then the CAMHS crisis professionals. It was felt this aided with the process of immersion in the data set. The first author held in mind that Braun and Clarke (2022) advised the process of immersion should be so deep that if the dataset were to get stolen or lost, it would be possible to describe broadly the content of the data.

As the researcher's engagement progressed deeper, the researcher was able to start to critically engage with the dataset (Braun & Clarke, 2022). The researcher began asking deeper questions of the data to start to make sense of meaning (e.g., Why might the parent be making sense of mental health crisis in this way (and not in a different way)?; What kinds of ideas does my interpretation of the professionals account rely on? How is mental health crisis characterised here?) (Braun & Clark, 2022). Field notes (1 page per interview) were kept during this process as a way of capturing the first author's critical engagement as an analytic tool. Also, the first author then made field notes on the dataset as a whole, to capture ideas about potential patterns of meaning and any key reflexive points i.e emotions or responses to particular parts of the dataset.

2.8.2. Phase Two: Doing Coding

Coding is an active process where the researcher systematically engages with the data and a code is an output of that process (Braun & Clarke, 2022). Codes are used as tools and devices to develop and broaden the researcher's analytic insights (Braun & Clarke, 2022). During coding, researcher subjectivity is key as it is a process of interpretation, and the researcher must make series of active decisions in the coding process (Braun & Clarke, 2022). The first consideration was the orientation of coding. It was felt that a mixed inductive and deductive orientation best suited the study. Whilst acknowledging that the study would primarily take an inductive approach, some deductive coding was used to broaden our interpretation through using existing theory and

concepts as a lens to view the data through rather than a rigid framework to apply codes to the dataset (e.g., codebook thematic analysis). Essentially, this means that there were two ways in this research in which meaning could be noticed, either from a deductive lens (theory/researcher driven) or inductively (data-driven) (Braun & Clarke, 2022). Some argue that an inductive approach should be 'pure' (Fine, 1992). However, this has been disputed as, considering reflexivity, what we bring to the data (e.g., perspectives and theoretical knowledge) shapes our meaning making, so engagement with the data is never purely inductive (Braun & Clarke, 2022). Inductive coding stays close to the data and meanings derived directly from this as a starting point (Braun & Clarke, 2022). In a deductive orientation, existing theory and concepts can be used as a lens to view and make sense of the data through (Braun & Clarke, 2022). Reflexive TA can also be deductively informed if the researcher notices theoretical ideas, obviously this is dependent on the researcher's reflexivity during the early phases of coding, and how they start to interpret the data around these concepts.

The second consideration was the level at which meaning was coded. The levels are twofold. Firstly, semantic coding is more descriptive and participant-driven way of exploring meaning at the surface of the data (Braun & Clarke, 2022). These tend to capture overt meanings expressed and remain close to the language used by the participants (Braun & Clarke, 2022). Secondly, latent codes are more conceptual, researcher-driven ways of focusing on implicit meaning and moving beyond what is stated (Braun & Clarke, 2022). Both depths of coding are not dichotomous, rather they are on a continuum (Braun & Clarke, 2022). In this research study, coding was primarily semantic until the latter stages where some latent-level codes were developed at times in the dataset where appropriate, which is common in a reflexive thematic analysis approach as the researcher becomes more familiar with the process (Braun & Clarke, 2022).

In terms of the process of coding, this was completed on Microsoft Word using the comments function. In the first round of coding, which was completed primarily semantically and inductively, the researcher started working through

each interview one by one. As the coding progressed, the researcher noticed coding became more latent at different points. Prior to coding each interview, the field notes were explored from the familiarisation phase to assist with reflexivity and provide context. During the middle of the first round of coding, the researcher felt that they had ‘over-coded’, and so they discussed this in supervision. When continuing to code, the researcher was guided by the principle that codes should be informative in terms of capturing what was in the data and the analytic interpretation of it (Braun & Clarke, 2013) and aimed towards keeping a focus on the research question, which helped in the coding process. An example excerpt of inductive coding can be found in Appendix L. The second round of coding was deductive. During this process, the data was made sense of through the lenses identified in Table 2. The researcher used these concepts to interpret the data to enrich the understanding of mental health crisis, rather than a rigid framework as noted above. The decision to focus on these lenses was decided after thorough discussion in supervision and informed by searching relevant literature in the topic area of child mental health and crisis. An example excerpt of deductive coding can be found in Appendix M.

The final round of coding involved going back through all the transcripts and analytic notes made and refining the codes. As recommended by Braun and Clarke (2022), the researcher conducted this round of coding in reverse order. This served the function of disrupting the flow which had become familiar with the aim of trying to protect against the dataset becoming unevenly coded, as the latter stages of coding in a round tend to be more defined (Braun & Clarke, 2022). The code labels from each document were then compiled into Microsoft Excel, with one participant per sheet. Whilst coding is never ‘complete’, the researcher decided to use the ‘taking away the data’ exercise to examine whether the code labels captured ‘enough meaning’ and whether the code labels were nuanced enough (Braun & Clarke, 2022). This exercise involved looking at the list of code labels and asking whether the code labels indicate a summary of the diverse meanings in the dataset and whether they provided detail on the analytic stance taken. This helped the researcher identify that the codes were refined to a ‘good enough’ level and they were able to

move on to the next phase. Although, it was also acknowledged that coding is a recursive process so the coding process could be revisited (Braun & Clarke, 2013).

Table 2

Deductive Lens

Theory	Concept(s)	Explanation of Theory/Concepts
Crisis Intervention Theory (Caplan, 1964)	Homeostasis and state of equilibrium	Humans operate in a state of homeostasis, particularly in regard to emotions (Caplan, 1964). A crisis is determined when the state of equilibrium is interrupted or upset in regards to emotions (Caplan, 1964).
	Crisis is temporal	Crisis is a temporary state, usually four to six weeks (Caplan, 1964). The nature of a crisis occurs suddenly and unexpectedly (Caplan, 1964).
	Disequilibrium	This describes a state whereby individuals try to deploy usual coping mechanisms, however these no longer are effective (Caplan, 1964). They experience significant distress and experience a significant impact on their daily functioning (Caplan, 1964).
	Crisis as a time of growth	Due to old coping mechanisms no longer working, crisis is seen as a period where novel coping mechanisms can be implemented to help individuals grow and move forward in their lives (Caplan, 1964).
Attachment Theory (Bowlby, 1969, Ainsworth et al., 1978)	Internal Working Models	A young person's early life experiences with a primary caregiver can shape the young person's mental representation of themselves in relation to others and the world (Bowlby, 1969). These internal working models provide foundations for expectations of future relational experiences, which can impact emotional and social functioning (Bowlby, 1969; Danquah & Berry, 2013).
	Attunement	Attunement refers to a primary caregiver's ability to understand, respond and connect to a child's needs in a 'good enough' manner (Ainsworth et al., 1978; Hesse & Main, 2000). By a 'good enough' manner, there is an

Theory	Concept(s)	Explanation of Theory/Concepts
		understanding that the caregiver may not always get it 'right' the first time but attuning to the child's needs in a consistent manner (Ainsworth et al., 1978). Attunement aids development of a young person's sense of self and self-awareness (Shore, 2001).
	Attachment Styles	See secure, insecure-avoidance, insecure-ambivalent, and disorganised attachment styles described in detail in Section 1.3.2.
Systemic Family Therapy Principles (Vetere & Dallos, 2003)	Communication	All behaviour is viewed as a form of communication and behaviour is often seen as the 'symptom' (Vetere & Dallos, 2003; Minuchin, 1974). A key principle is exploring patterns of communication within the family system and understanding what is voiced and not voiced within a system (Watzlawick et al., 1974; Vetere & Dallos, 2003). This includes patterns of communication around thoughts, emotions, beliefs and responses to behaviour (Vetere & Dallos, 2003).
	System Stability/Instability	Systems can become organised in many ways with varying boundaries and hierarchies, which can create sub-systems (Minuchin, 1974). Family instability can occur when the current organisational structure in a family is not meeting the developmental needs of all family members (Colapinto, 1988). Also, interactions within a family can serve the function of maintaining a problem (Jackson, 1957). For instance, difficulties in behaviour of a child could serve to distract parents from their own difficulties or bring parents together in mutual difficulties (Vetere & Dallos, 2003).
	Circularity	Due to the interconnectedness of a system, the cause of a problem is viewed as circular rather than a linear cause-effect relationship (Vetere & Dallos, 2003). There is a focus on 'feedback loops' whereby reciprocity is recognised within the system as an event/action in one area can impact another area (Vetere & Dallos, 2003). Circular questions are often used within family therapy to elicit feedback loops (Vetere & Dallos, 2003).

2.8.3.Phase Three: Generating Initial Themes

The aim of this phase was to work from smaller units (codes) to move towards considering patterns of meaning across the data set in the form of themes (Braun & Clarke, 2019). Themes have a central organising concept which is a core shared idea (Braun & Clarke, 2019). In the past, qualitative researchers have stated that themes 'emerge' from the data set, however as analysis is a process where the researcher actively engages with the data, themes are developed and generated and do not already exist within the data as this statement implies (Braun & Clarke, 2023; 2019). Once codes were loaded into a spreadsheet (one per participant), it revealed several hundreds of codes across the dataset. The researcher then began to cluster codes with similar meaning on a blank spreadsheet. The clustering process was iterative and codes were moved around several times to where the researcher saw fit. As codes are used as tools of analysis, codes are supposed to provide evidence for themes (Braun & Clarke, 2023). Codes were clustered into 23 clusters (See Appendix N). These clusters were then reviewed to develop tentative candidate themes and subsequent sub-themes. These were discussed in supervision with the second and third author. A visual map was drawn which helped the first author reflect on whether the themes were 'too thin' and whether the themes were distinct enough through supervision these were altered as the analysis developed (see Appendix O).

2.8.4. Phase Four: Developing and Reviewing Themes

This phase involved two steps of re-engagement. First, with the initial coded data extracts and second, with the entire dataset (Braun & Clarke, 2022). In order to develop a nuanced and rich analysis, it was important to re-consider the pattern development in phase three and to ensure the development of rich themes which have scope (Braun & Clarke, 2022). As reflexive TA is recursive, this phase involved moving between the data and thematic map to ensure that the researcher had not moved too far away from the data and to consider whether the story being told addressed the research question (Braun & Clarke, 2022). Themes are "good if they are distinct but also work together as a whole" (Braun & Clarke, 2012, p.65). The first author reviewed each theme on the current thematic map and asked four questions of each theme, after considering

it in the context of the coded data extracts. These four questions were guided by Braun and Clarke (2022, p.99): “(1) Can I identify boundaries of this theme?, (2) Are there enough (meaningful) data to evidence this theme? (3) Are the data contained within each theme too diverse and wide ranging?, (4) Does this theme convey something important?”. Through discussion with the first author and reflection on these questions in relation to the current thematic map in supervision, the themes were refined, and four overall themes were developed. The reason for these changes were that one of the themes was not distinct enough from the other, and one of the other themes did not have enough meaningful data to evidence. After considering these changes, the first author then reviewed them whilst re-engaging with the entire dataset by re-reading the entire dataset to check for any missing codes and whether the developed themes fitted with the scope of the dataset (Trainor & Bundon, 2021).

2.8.5. Phase Five: Refining, Defining and Naming Themes

The first author re-drew the thematic map to capture the changes from the phase above. They then proceeded to write a definition for each theme, as Braun and Clarke (2022) noted that this can be a useful way of seeing if the analysis needed re-working and refining. The researcher then discussed these in supervision with the second and fourth author which enabled them to clearly articulate what the story was and what was/was not part of each theme (Braun et al., 2016). Theme names were then created to capture the meaning.

2.8.6. Phase Six: Writing Up

A report, in the form of this thesis, has been written up which aimed to tell a coherent narrative of the stories of our participants. Braun and Clarke (2022) recognise that analysis is still ongoing whilst the report is being written up as authors figure out how to tell the whole story of analysis. Data extracts were selected to evidence the themes. Decisions around what data extracts to select were made based on extracts which evidenced the fit between the theme and interpretation and that which evidenced the analytic claims made (Braun & Clarke, 2022).

2.9. Quality Monitoring

Quality appraisal is important in qualitative research and concepts such as rigour and credibility are useful in exploring this which involves transparency in the research process (Spencer & Ritchie, 2012). When conducting qualitative research, reflexive practice is essential in gaining an awareness of the impact the researcher's own assumptions may have on the findings of the research (Braun & Clarke, 2022). Also, Braun and Clarke (2019) argue that themes do not 'emerge' from qualitative data, but rather codes and themes are generated through an active process of a researcher, with their pre-conceived ideas, engaging with the data. As a result, it is important that the researcher is aware of their own biases, and so in the current study the researcher has kept a reflective audio diary throughout the research process to aid reflexivity and document an audit trail (Braun & Clarke, 2006; 2022). The reflexive audio diary brought into the spotlight aspects such as reflections on designing the research, the researcher's ideas, discussions in supervision, reflections on the recruitment process, and any emotional reactions had by the researcher. The purpose of the reflexive journal is to allow the researcher to note responses to aspects of the research process, but also go beyond this by interrogating those assumptions and reflections to deepen the researcher's reflexivity (Braun & Clarke, 2022; Morrow, 2005).

Another strategy that was used was consulting with the research team regularly throughout the research process. Supervision records with the second, third and fourth authors have been kept to document discussions had throughout the research process and document decisions made. Supervision sessions were used to reflect on the first author's responses to different parts of the research process and any assumptions or emotional responses that arose. In line with Morrow's (2005) suggestion, supervisors provided alternative or contrary interpretations to the researcher, and these were discussed in supervision sessions, in particular in the data analysis phase. For instance, a participant had discussed noticing their young person was on their phone a lot in their room and the researcher had coded this as withdrawal from social

situations, however upon further discussion, and reflection on the data excerpt the withdrawal could have been understood in the context of seeking further connection with peers for a sense of belonging.

To monitor the quality of the research, the first author used the Critical Appraisal Skills Programme (CASP) Qualitative Checklist (2019). This aided the first author to consider the quality of the research throughout the research process by reflecting on the ten questions in the CASP regarding methodological aspects of the study. The CASP was chosen as it has been found to be a good measure of transparency in the reporting standards and research process (Long et al., 2020). Whilst the first author did complete the CASP checklist (2018) for this research study (See Appendix P), it was noted that this may be influenced by positive bias. Hence, a colleague who had experience in qualitative methodologies also completed the CASP tool (see Appendix Q).

2.10. Researcher Positionality

Unlike in quantitative approaches, reflexive TA views researcher subjectivity as a resource rather than a source of bias and something to be viewed as problematic (Braun & Clarke, 2021 Gough & Madill, 2012). It is important for qualitative researchers to consider their positionality, and the complexity of this, in relation to the process of qualitative research (Hill & Dao, 2020). It is important to acknowledge that reflexivity is never ‘complete’ and continues to be an ongoing process (Braun & Clarke). However, due to the first author being new to qualitative research, this more structured activity provided a useful starting point. The first author discussed the below statement in her research supervision to deepen her thinking and the extract below has been included to demonstrate an example of the start of the first researcher’s reflexive journey in 2020/2021.

“I am a 26-year-old, White British, female who is currently undertaking my Doctorate in Clinical Psychology. This research is being undertaken in partial fulfilment of gaining this qualification. Prior to commencing my training, I worked as an assistant psychologist in a CAMHS crisis team which is what

initiated my interest in this research area. At the time of commencing the research, I was not working in this setting. Although, having worked in a CAMHS crisis team, I am aware that I might find myself falling into a clinical interviewing position when interviewing YP or parents/carers which may impact the responses provided by participants. I am also aware that due to my experience of working in a CAMHS crisis team, I need to hold in mind that this may impact my ability to be curious due to being aware of 'professional' language used and how it would be important to not assume I understood what the professionals meant in these moments to not close down my curiosity. Although, I have undertaken specific modules in my undergraduate degree on qualitative research, this was a brief introduction to each qualitative method. This was the first time I had undertaken qualitative research myself and was going to be writing research at a 'doctoral level' which contributed to fears and anxieties of 'doing it right'. I was aware that due to being on the Doctorate in Clinical Psychology and having supervisors associated with this course, my research question has been influenced by my disciplinary background."

2.11. Ethical Issues

2.11.1. Formal Ethical Approval

An application to conduct research in NHS organisations was completed via the Integrated Research Application System (IRAS) which included submission of the application form, research protocol, study documents, and insurance/indemnity documents. Ethical approval was granted on 2nd February 2022 by the West of Scotland Research Ethics Committee (REC). After REC approval, further approval was granted from NHS Research and Development Departments. An amendment was submitted and was classified as a non-substantial amendment. The amendment was approved on 29th April 2022 and consisted of altering the time frame around when the young person could have been discharged from the crisis team from three months to 12-months, to broaden the pool of participants for recruitment. A further amendment was submitted as a non-notifiable amendment regarding some typographical errors on the interview schedule. This study was conducted in accordance with the ethical principles that have their origin in the principles of Good Clinical Practice

(GCP) (Health Research Authority, 2020) and Code of Human Research Ethics (The British Psychological Society, 2021). For copies of relevant ethical approval documents, see Appendix R.

2.11.2. Informed Consent and Participant Information

All participants provided written informed consent. The process for obtaining informed consent or assent, and parental informed consent was in accordance with the Research Ethics Committee guidance, and GCP. The investigator and the participant or other legally authorised representative both signed and dated the consent form before the participant could participate in the study. The participants received a copy of the signed and dated forms. For interviews conducted virtually, the participant could either print out the consent form and fill it in with pen then scan it back in or take a photo and send it back into the researcher. Alternatively, they could type their name in capital letters and date the form and this was taken as consent. The original copy was retained in the study records. For informed consent which was being provided for YP who were under 16-years-old, the person who provided consent must have held parental responsibility. Only one person with parental responsibility needed to consent on behalf of the young person. An age appropriate Participant Information Sheet was provided for those under 16-years-old. In the event of any disagreement between a young person and their parent or legal guardian about participation, the young person would not have been entered into the study.

2.11.3. Working with YP in Research

Research has shown that there can be power imbalances between YP participants and adult researchers due to the adult-centricity of most societies which place adults in authoritarian positions (Punch, 2002). This can impact a young person's ability to speak freely and honestly within research (Alderson, 2001). In addition, when YP under the age of 16 are participants, it tends to be the parent/carers who are gate-keepers (Harden et al., 2000). Therefore, the researcher planned to ask YP who were under 16-years-old to sign an assent form as a way of demonstrating willingness to take part in the study, alongside

their parent /guardian's informed consent, which was aimed at minimising power imbalances.

2.11.4. Participant Withdrawal

Participants had the right to withdraw consent at any point up to one week following the interview, without giving a reason for doing so. Any data collected was be destroyed and not used. The rationale for this time-frame was that afterwards, the interviews would have been transcribed and data analysis would have started. If participants withdrew after this time period, the researcher would no longer collect any information about the participant. The researcher planned keep the information about the participant which has already been obtained as the researcher was not allowed to tamper with study records. No participant withdrew from the research study.

2.11.5. Adverse Effects of Participation

The occurrence of an adverse event as a result of participation within this study was not expected. Although, it was acknowledged that individuals may become distressed when talking about their past experiences. Participants were provided a de-brief after the interview. The researcher had any concerns that the participant is at risk to themselves, others or from others, the researcher breached confidentiality and reported this to the appropriate persons, in line with local safeguarding procedures. There was a follow-up plan in place where the researcher could access supervision from their research supervisors for support if an issue arose. If immediate emergency support is required for any participant, the researcher planned to contact the emergency services. If there are concerns regarding any information around professional conduct, appropriate local policies planned to be implemented. This was made clear on all study documents and the participants were reminded prior to the interview starting. In addition, for all YP taking part in the study, their CAMHS clinician was notified that they have participated but was not informed about the content of the interview, unless concerns were raised. On one occasion, the researcher raised some concerns regarding risk, and this was escalated through appropriate procedures identified above.

2.11.6. Adverse Effects for the Researcher

The occurrence of an adverse event to the researcher within this study was expected to be minimal. The researcher was supported in supervision with their researcher supervisor. Where face-to-face interviews were conducted, relevant lone working policies were adhered to.

2.11.6. Confidentiality

Participants will have been informed on the information sheets about the exceptions to confidentiality limits and were reminded at the start of the interview. Participants were informed that their data remained confidential and pseudonyms would be used in the write-up.

2.11.7. Data Protection

All study staff and investigators endeavoured to protect the rights of the study's participants to privacy and informed consent and adhered to the Data Protection Act (2018). Where participant information is held as a paper copy this was anonymised and stored securely in a locked filing cabinet. Any identifiable information such as signed consent forms was stored separately to the anonymised information. Where information was collected in electronic forms, such as audio-recorded interviews, the interviews were recorded onto a dictaphone and then kept as password-protected files on a secure drive. The recordings were sent to the University of Nottingham Automated Transcription service for transcription. The recordings were erased as soon as they were transcribed and checked. To ensure that the data protection rights of participants are upheld, only the investigator, research tutors and administrative staff for the Trent DClinPsy programme will have access to participant information.

2.12. Dissemination of Results

The results of this study will be disseminated in various ways in the hope that the study can be used by professionals working with young people, services, and to inform future research. It is aimed that the journal paper will be submitted to a peer-reviewed journal for publication. A conference poster has also been prepared and relevant conferences will be explored.

All participants have requested a copy of the findings to be disseminated via email. They will be given the opportunity to ask any questions via follow-up emails. This summary of findings will be designed with each audience in mind and will be written age-appropriately. The research will also be presented at CAMHS meetings in relevant local services who supported recruitment and wider CAMHS Crisis teams where appropriate.

3. Extended Results

This section expands further on the themes and sub-themes noted in the journal paper and provides additional illustrative quotes, where necessary.

Theme 1.Early triggers: Viewing the crisis in context

1a: "A whole new world": the impact of social media. Professionals shared concerns regarding how the use of social media for young people is normalised, with little recognition of the impact the use of social media can have on the mental health of YP. For instance, Kathryn identified *"I think people just assumed that that's a trend [the use of social media]"* and due to this assumption, there can be a lack of focus from adults on exploring what YP are viewing on social media and the impact this has on them. Professionals spoke about how social media has influenced those in the same peer group to harm themselves. For example, Trisha noted *"that was when she took the second overdose. She said a friend had took an overdose and texted her".* Therefore, this demonstrates the impact strong peer attachments can have on learning unhelpful or helpful coping mechanisms, to cope with a deterioration in mental health, at the time of adolescence. Also, Kathryn provided an example whereby *"…social media influence…we've had a couple of cases where there's one child who seems to have a very similar episode when her friend does…".*

In addition, participants identified cyber-bullying as contributory contextual factor to mental health crisis in YP. Due to the way social media

functions and the perceived increases in usage of social media, it was suggested that bullying is now easier online and the online images individuals portray can impact one's sense of self. For instance, Aniya stated:

"And I think nowadays with social media and all of the pressures that children are subjected to, it's so much easier to do that [bullying] and it is harder to get away from or intervene. The bullying they can, you know, just let it all through Instagram or whatever. And I think sometimes it's about how they feel about themselves, their own self esteem issues around body image from social media."

Professionals highlighted how in current generations social media encourages social comparison. Throughout interviews with professionals, they hinted at a generational difference in terms of the influence of social media for the current generation now being ubiquitous. For instance, Aniya said:

"you know with social media and things like that like Tik Tok and Instagram and everything everyone wants to look good in the pictures. So I think that has changed because 15 years ago I don't think there was so much social media as compared to what it is now"

Professionals reflected on the pressure YP face in terms of content shown on social media and the impact this can have in shaping one's view of themselves. Also, these generational differences in understanding social media may impact how equipped professionals/parents may feel in supporting YP with issues related to social media, possibly resulting in stuckness in mitigating the crisis trigger.

1b: Loss of connection with others and daily life. Parents used the level of loss of connection to understand their child's emotional state and as a gauge as to how much their child was struggling. For example, Tilly said: "*Obviously if she's not wanting to be with her friends or go out, then I know that she's feeling really, really low…".* It appeared the level was used to determine the severity of the situation. For instance, Tilly also noted *"So when [YP name]*

stays in the bedroom a lot. I know that she's probably more in crisis" (166-169). Hence, the level of the loss of connection was used as a signal to conceptualise the severity of the mental health crisis.

Some professionals and parents articulated how withdrawal from social activities impacted the YP's tolerance to manage stressors. Kathryn discussed the vicious cycle activated by a loss of connection. For example:

"So, their tolerance to sort of like a little argument with their friend is lower. So, then they fall out with friends more often and all those things start to act like impact on them. And then if they've got these thoughts in their head sort of the like you know if they've got self- worth problems. And it sort of reinforces all of that while I'm falling out with my friends all the time, so no one must like me, and it sort of very easily snowballs in that sort of negative thinking."

Participants identified the link between how withdrawal from the social world, resulted in a loss of connection with others, which subsequently reinforced negative self-beliefs, and is likely to impact one's beliefs about going out in the social world. One parent spoke about the impact of COVID-19 and how this contributed to a loss of connection and routine and made the thought of going out harder and escalated the crisis, hence focusing on the individual response to loss of connection. Trisha explained:

"…especially with COVID and everything like that. We've been locked, locked up for so long and then it was a bit of anxiety about going out and meeting people and talking."

Parents spoke about how the loss of connection and loss of daily routines may have been due to YP not wanting to speak about their difficulties. For instance, Samantha explained that for her daughter *"there were big changes, she would be going in her room and shutting the door, spose this mean she didn't need to talk and didn't need to go out".* Although, there was also recognition that being in their own space may function as a '*safe zone' (Hazel).* Hence, aligning with the notion that losing connections with others and

activities for daily life may be protective in the short-term but can also create a sense of isolation in the longer-term and reduce opportunities for attunement due to lack of connections with caregivers.

Also, it was identified that caring for a child in crisis can result in parents feeling like they have lost connections with their own networks, which results in significant loneliness in this situation. For example, Tilly explained the emotional impact of caring for her child in a mental health crisis:

"Just I think it's hard when your child's going through something like this because you do feel very isolated. You do feel very alone."

The isolation parents feel when their child is going through a mental health crisis may reduce their ability to emotionally contain their child due to a lack of their own resources to draw on when in a crisis.

1c: The onset of mental health crisis: noticing and not noticing signals. Professionals,YP, and some parents tended to align with the notion that there are noticeable signs to a mental health crisis which gradually worsen. For instance, Maisie identified *'it seems to all build up overtime and then you don't really know how to get out of it after it's a bit too much'.* (95). Hence, indicating that the onset of a mental health crisis is gradual and can be observed by the build-up of early warning signs. Also, Kathryn articulated that noticing changes in a child, particularly a reduction in usual activities, over-time can indicate a crisis, such as *'I think the early sort of warning signs [of a crisis] are things just slowly dropping off' (263).*

However, parents noticed some contextual signs that they felt indicated a deterioration in mental health but did not ever foresee this escalating to the point of their child wanting to end their life. Hence, these early warning signals were not seen as 'crisis'. For example, Samantha said:

"Obviously over the past year I had seen everything go downhill. So yeah, but I just never thought anything like the overdose and stuff would ever come from

that never thought it, but you kind of notice you know things are a bit off, but not to that point that they don't want to be alive, I cannot imagine it."

Some parents described no noticeable signs and indicated a strong feeling of shock at their child being in crisis. For instance, Carmel reflected on her daughter's experience of crisis and how throughout she felt *"… I still haven't seen any signs. It's very difficult because they I think they seem to keep it to themselves and it comes out of the blue"*. Some parents considered crisis a sudden event. It appeared that some parents conceptualised 'signs' in terms of how well the YP could communicate their difficulties rather than through observable behaviour. Parents alluded to children not wanting to show overt signs of being in a mental health crisis due to perceived stigma or not wanting to become a burden. For example, Samantha described feeling kept in the dark and stated:

" So it was more her hiding everything from me and others. So I think that's where it got tougher because she didn't want people to think she had something wrong with her. Or something like that"

Also, when signs of crisis are hidden or not communicated, this possibly affects parent's ability to attune with their child and further breakdowns in communication. Carmel discussed how her daughter hid signs from her due to fears of judgement and invalidation, therefore suggesting open communication was not possible which may have resulted in changes in the parent-child dyadic relationship. For example:

"That she don't like to tell me because she's worried what I think okay and what I say, but I always say the wrong things and that when anything to her about it.. she tells me I don't understand."

Theme 2: The battle for support

Parents articulated several points throughout their journey into a crisis where they tried to seek support, but this was not delivered either at the appropriate level or at the time of need, implying a lack of attunement between the system

and service users, hence their needs being noticed by the system. Parents and a young person spoke about how long waiting times and being refused access to services results in an escalation of risk behaviours and their presentation. It was recognised that some parents and the young person defined mental health crisis as the point at which they ask for help, which was impacted by whether the onset of crisis signals are noticed or not-noticed. Often, parents described feeling alone due to resources not being available at the time in need. For instance, Trisha reflected seeking support with what she felt was before a crisis episode:

“Because I've got to a point where we were waiting for 3 years for CAMHS after going through the motions and then we'll wait when we are in CAMHS.”

Similarly, some parents discussed how they felt that not receiving the right support in a timely manner or being denied support actually contributed to their child’s crisis. There was expressed disappointment and frustration at the complexity of accessing support and feeling uncertain about who to go to for what help, with a recognition that this requires families and YP to know what help is required and from whom. Hence, a lack of containment provided by the system resulted in a lack of containment for parents. For example, Carmel said:

“You're on your own, you feel like you're on your own and you see where you went at doctors and that and they… they didn't help, they said that comes at after we went to see if we could have medication and they said no to it will be CAMHS it do that. So it's like pushing you to somebody else all the time, but you're not getting anywhere which leads to the crisis getting worse.”

As Carmel expressed there is a significant emotional impact of being declined support or not feeling like support is available. Due to this, families and YP were left with feelings of desperation of trying to get services to listen and input. Hence, feelings of being let down but also a lack of containment by services escalated the crisis. For instance, Trisha said:

“I was in floods of tears. I just said I don't know what to do. I said she's self-harming, she's bulimic, she's tried to take her own life and it was getting to that again. I was really desperate and that's how I felt myself and I could see she felt like that too. I was like, will somebody help me because it's not alright. I got told to then get into CAMHS, but if there's a four month waiting list, it says she's not going to hear for four months. And here we are things just kept getting worse”

Some professionals also spoke about how a contributor to going into crisis for YP was not *“getting appropriate mental health support when they need it”.* Also, it was discussed that at times even though professionals may not feel a YP is in crisis, they feel they have to offer support due to the CAMHS system being in crisis. For instance, Hazel spoke about how families and YP had been declined support for a long time, so when they contact crisis services it makes it harder to decline support, emphasising the emotional impact driving decision-making and the large remit of crisis services:

“we sometimes don’t feel they aren’t in crisis but they have struggled for so long and not received the support, you know long term help isn’t going to be available for ages so we may as well pick them up and do something before things escalate to what I would say is crisis level, but yeah it blurs the boundaries and doesn’t feel great”

Therefore, being rejected from multiple services and long waiting lists are recognised as factors which contribute to crisis presentations due to feelings of being passed around. It was recognised by some parents that limited resources in the form of services contributed to escalations in YP’s crises and risk behaviours. For instance, Tilly described a time where her daughter called a support line:

“she'd rung once to do weird like this suicide line thing, and then they put her on hold for 15 minutes before speaking to her and then yeah the crisis just got worse There's just not enough services. There's not enough, there's not enough people, so we don’t reach out”.

Hence, the responsiveness to crisis signals by services and those around YP impacts how contained individuals feel and may impact help-seeking behaviours.

Theme 3: The tipping point: A time of 'high-risk'

There was a common understanding across participants that there was a point in crisis where struggles felt too overwhelming and resulted in a YP trying to seek a way out. As Maisie described *"I think you try and get out of it in an unhealthy way which then leads to the crisis getting just to a point where its loads worse".* There was recognition that what may be considered 'risky behaviour' is how some YP manage problems that were becoming unmanageable, resulting in them experiencing low self-worth and feeling ill-equipped to manage what they are facing. Hence, the risk behaviour was viewed as a response to the overarching mental health crisis. For instance, Hazel spoke about a sense of internalised pressure but also how YP are involved in many systems which place pressure on YP such as schools. She said:

"You know, perform academically and things like that. I think they they do put in lots of pressure on themselves despite all of these stressors that are ongoing and then don't know how to cope with it all so that's where risk comes in. And I think that sort of tips them into the crisis."

In terms of seeking a way out, sometimes it was identified YP used self-harm to provide short-term relief to problems that felt insuperable. For instance, Trisha described her daughter feeling self-harm was the only way to become calm in this moment as she said her daughter:

'"just got herself really, really worked up and panicky and she said the only way she felt that she could calm herself down was to cut herself"

In addition, Carmel discussed the emotional experience of a parent hearing that self-harm was perceived to provide short-term relief for her daughter:

“But then I know like some people do it as a relief or. And she said to me, it just makes me feel better. And obviously that made me sad, like having to cut yourself to feel better or to let some relief”

When considering how a YP may reach this peak in a crisis, some participants noted that it was important to consider the developmental stage of YP. For instance, Kathryn described teenagers as being impulsive due to their developmental stage and also wider factors, such as trauma can impact impulsivity. She described a situation to evidence an example whereby:

“somebody's taking an overdose and they've said that the reason for doing it was because their boyfriend or girlfriend had just broken up with them or they had a fallout with their friends. So it's a very reactive impulse to a situation”

Hence, what can seem a quick reaction to a relational trigger may also illustrate that in the moment the YP felt unable to tolerate the feelings or communicate how they were feeling. This is further illustrated by Trisha who explained her daughter made an attempt on their life due to not feeling able to express her emotions:

“Just not being able to cope, I think, and they feel, although we've got a brilliant relationship and you'll tell me stuff about like sex, boyfriend, stuff like that. But when I think they have these emotions and they don't know how to get the feelings out”

Theme 4: The aftermath: containing the crisis

All participants reflected on the aspects that they feel contributed to the YP’s recovery after the ‘tipping point’. Underpinning all these elements was a recognition that the crisis was contained which supported the YP’s recovery.

4a: Parental role in creating safety

Professionals stipulated safety planning created safety for YP and their families. For instance, Kathryn described:

“Getting rid of that immediate risk is really comforting for a lot of people, and actually, because there's no immediate risk or that they can grab to harm themselves, it gives them a chance to actually work on how do I distract myself to return to normal?”

This implies safety planning which reduces risks from the environment gives YP a chance to implement other coping skills, hence may prevent harm. The safety plan was also viewed by professionals as a way to support families in returning to a state of equilibrium. After the safety planning process, parents reflected on how the intervention heightened their awareness of risks in the house environment. For example, Tilly shared her experience of when she came home from the hospital with her daughter:

“What's in the house? Is there anything that can get arounds on?...It got to like the very keep your eyes open. Think about what's happening. Like I said, look at, look at the dangers in the house. Just to basically to keep her safe as possible.”

Therefore, safety was created by aiding parental awareness of risks so parents could be more attuned to the environment. Physical parental presence and supervision was highlighted as a key factor in safety planning. Parents described they increased their supervision due to fears around safety. For example, Tilly described that *“I've got to sit with her for a couple of hours in the bedroom until she falls asleep before I can go back to sleep as I was scared.”*. Hence, whilst safety is created to contain the crisis for the YP, this is driven by fear for parents which may result in them feeling unsafe.

4b: Exploration of new ways of coping and re-connection.

Professionals described using cognitive strategies to support YP with challenging situations they are facing, and these strategies are used instead of risky behaviours. Professionals felt a sign of recovery from crisis was YP being open to learning novel coping skills and implementing these independently. For instance, Laura provided an example:

"*Recovery, they just, I would say that they sort of like think about things a bit more logically. So in fact obviously when they're there they're like really highly anxious or low in mood. They like over analyse everything so much all the time that like obviously there's like lose sleep and stuff over it. But ,then after not having chats and stuff about things and trying to get in there some new thinking styles, they'll sort of. They'll come up with like their own examples of like, ohh, so, you know, someone didn't text me back before and that would cause me to like, think they don't like me anymore. They don't want to be my friend or that kind of thing. But then they'll be like, ohh that that happened recently, and I was actually able to say to myself, no, they're probably just busy. They usually text me back."*

All participants reflected on different ways YP and families re-connect to support recovery from a crisis. Some parents identified increasing their parental presence helped them re-connect with their child, and subsequently improved the pattern of communication from their children. For instance, Tilly described her experience with her child:

"Just to like, be supportive, take your time. Don't jump in all blazing... We kind of like have to go back in a way, to them being toddlers and go back to the nurturing stage of parenting by being there from supporting them…you have got to take a step back and you've got to keep calm yourself. You've got to be there from show them that you are on their side then they will talk"

Samantha reported being advised by professionals *"all you can do is just be there for her",* as this would aid recovery by increasing parental presence.

The importance of having a network and someone to connect with if things were feeling worse was also recognised as a key factor for containment of the crisis for parents. For instance, Trisha noticed:

"But if I needed to speak to it was just nice to know that it didn't matter how little. Yeah. And problem it was. It made you feel that you could ring them and

having that phone number, it was like a lifeline. Yeah. Because you feel so desperate so it helped me help her"

Hence, by offering a resource to parents which helped them connect with professionals this inadvertently helped parents support their young person which may aid containment. One professional recognised that by connecting families to a network/system this aided feelings of containment which helped manage the crises. For example, Kathryn stated *"just multidisciplinary work and like with different agencies, a lot of liaison withs social care and family service, schools, all those kind of services sort of get that safety net around them and essentially offers containment to help recovery."*

4. Extended Discussion

4.1 Further Points for Discussion

Mental health crisis for YP is conceptualised in the context of their everyday lives and is multi-faceted. For YP crisis was conceptualised by all participants in a temporal manner, similar to that of Caplan (1964). As viewed by some parents and the YP, the onset of crisis was usually before services were involved. Similarly to adults, the onset of crisis was conceptualised in terms of as a loss of connection with others and with their routines (see Ball et al., 2005). Social connection is associated with positive health outcomes for YP and is considered an essential human function (Birrell et al., 2025). Whilst it is acknowledged that mental health difficulties can contribute to loneliness due to low self-worth and self-esteem, loneliness can also worsen mental health difficulties, hence the relationship is bi-directional (Birrell et al., 2025). This was corroborated by the current study as participants identified the link between how withdrawal from the social world, resulted in a loss of connection with others, which subsequently reinforced negative self-beliefs, and is likely to impact one's beliefs about going out in the social world. Hence, perpetuating and escalating the mental health crisis for YP. One participant also spoke about the impact of COVID-19 and felt this escalated their child to crisis, which is corroborated by studies which demonstrate YP were disproportionately impacted by the COVID-19 pandemic (Newlove-Delgado et al., 2022). Due to parents worries about their child isolating, some parents also lost their own connections due to wanting to increase their parental presence. Hence, in line with Caplan's (1964) crisis

theory, it could be argued both parents and YP were in a state of disequilibrium. In addition, from a systemic lens, this could be understood as contributing to family instability which occur when the current organisational structure in a family is not meeting the developmental needs of all family members (Colapinto, 1988). As YP withdraw, parents may try to increase their parental presence, however this results in them losing their own routines and support network resulting in them having less resources to draw upon for support. Hence, this could perpetuate and escalate the crisis as it is likely the parents may feel uncontained.

In addition, professionals and parents acknowledged the impact of social media on YP's mental health and how this can function in a mental health crisis for YP in different ways. There are often conflicting views within the literature around the use of social media and the impact on YP's mental health (Arango et al., 2023). For some YP they view social media as a 'distraction tool' and as a way to feel connected to others (O'Reiley, 2019). Interpersonal connectedness has been found to positively mediate the relationship between pre-disposing factors and suicidal behaviours (Arango et al., 2023). YP may view social media as a way to seek connectedness. However, in this current study, parents and professionals spoke about lacking the knowledge and awareness, due to generational differences, of how to use and support a YP with social media. Professionals reflected on experiences of YP learning new ways to harm themselves online and impact of cyber-bullying. From Erikson's Theory of Psychosocial Development (1980), adolescence is a time whereby peers are viewed as another attachment figure and adolescents are trying to manage an identity conflict. Social media is a way YP connect with their peers, and this method of connecting may not necessarily be fully understood by parents/professionals due to generational differences. Hence, views around the impact of social media on YP in a mental health crisis may not be congruent between YP and parents/professionals. For instance, mental health professionals, particularly psychiatrists, have voiced significant concerns over social media usage and reported that for YP's safety time should be restricted (Lee et al, 2015). Reid and Weigle (2014) stipulated that mental health professionals need to feel equipped to educate, assess and support YP with social media. This current study demonstrates that social media is a

contemporary issue and trend, which is rarely reflected on in the adult literature around mental health crises, hence may be a unique contributory factor for YP and needs to be further understood.

In regards to experiences of mental health crisis for YP, a young person and some parents conceptualised mental health crisis as a time where support is asked for. However, this was often described as a 'battle'. For instance, research has shown requests for support from YP are often declined due to not meeting eligibility thresholds of support, which can inadvertently perpetuate the feeling of 'being in crisis' or escalate the YP to crisis point where then support is offered (Vusio et al., 2019; CQC, 2018). As a result of high thresholds and limited resources, it has been reported that mental health difficulties which could have been managed at an earlier intervention level escalate to a crisis point due to support not being provided at the right time (CQC, 2018). The current findings of 'battling for support' are not aligned with the current NHS Long Term Plan (2019) which stipulated a need for all children to receive support at the right time from the right person.

All participants spoke about a point in time whereby risk increased and/or their functioning deteriorated significantly to the point where they came into contact with crisis services. Professionals tended to draw on risk-focused narratives and conceptualised the onset of crisis as from the point of the risk incident and YP came into their services, which impacted service accessibility. This finding was similar to that of the adult population as adults who deemed themselves as being in a mental health crisis were often either denied support or received support that did not meet their needs due to differences in perceptions of 'mental health crisis' (CQC, 2015). However, YP and parents described the risk incidents as a consequence to the crisis and a communication of asking for help. When drawing on an attachment lens in an attempt to understand the relational patterns, it could be argued that services are not attune to YP's needs, which often results in YP having to use hyper-activating strategies (i.e risk incidents, significant distress) to get their needs met (Ainsworth et al., 1978).

After YP had tipped into services at a point of high-risk levels, it was evident that there was another phase post-crisis whereby all participants were making attempts to try and contain the YP. Safety planning was discussed by all participants as a tool for creating safety. However, it was striking that this primarily referred to reducing access to way of harming themselves i.e by communicating suicidal thoughts and tended to focus on environmental safety i.e by locking away sharps. Safety plans have been found to be an effective intervention for suicide prevention (Abbott-Smith et al., 2023). However, it is recognised that the benefits of completing a safety plan can be limited when there is a lack of training for staff and when they are not completed collaboratively (Abbott-Smith et al., 2023). When creating safety, there was limited insight post-crisis on how to create emotional safety for YP. There is limited research exploring the key effective mechanisms of safety plan. Additionally, it was found that safety planning interventions rarely evaluate the impact on parents, who tend to hold the primary responsibility for implementing them (Abbott-Smith et al., 2023). This was corroborated by the findings in this study, which found that parents reported a ‘fear of death’ and feelings of fear after safety planning interventions.

4.2 Extended Limitations

There were no males included in the sample and only one participant from another ethnic background from British, therefore the sample may lack diversity. Fathers have commonly been under-represented in child and adolescent mental health research (Cabrera et al., 2018). It would be crucial to explore more diverse samples in future research to ensure the experiences of these groups are fully understood in relation to mental health crisis for YP. In addition, the recruitment target was not met and only one young person was recruited. Whilst there may be concerns around homogeneity in the sample, the sample was selected in an attempt to explore rich patterns of meaning across the dataset focused on the concept of mental health crisis for young people. The researcher was mindful to not overgeneralise any findings in relation to the one young person and if further young people were recruited this could have aided the information power and richness of the analysis to explore wider patterns of meaning. However, to address the current aims of the study and due

to the nature of exploring the patterns of meaning around the shared concept of mental health crisis for YP, it was felt the current sample size was sufficient to proceed with the current analysis.

There are methodological limitations as the research relied on participants recall retrospectively of mental health crises as only one interview was completed at one time point. This could be overcome in future research by exploring the direct experiences of mental health crises longitudinally, however ethical considerations would need to be considered due to differing vulnerabilities during an active mental health crisis.

4.3 Extended Clinical Implications and Future Research Recommendations

A contextual factor which is not frequently mentioned in the adult literature is the impact of social media on YP and how this relates as a contributory factor to mental health crisis. Clinicians should consider how social media is explored within crisis assessments and consider interventions to support parents and YP (i.e digital citizenship sessions) to manage the impact of social media (see Hollis et al., 2017). Moreover, whilst this current study provides novel insights into the conceptualisation and experiences of mental health crisis for YP, further longitudinal research with linked family members may provide further understandings of the support required for families, including siblings, during the crisis period. Clinically, this would support services in identifying specific systemic interventions which can be utilised during a crisis period. The effectiveness and acceptability of such interventions would need to be evaluated.

Additionally, throughout the crisis period the importance of connection, communication, responsiveness, attunement, and containment were recognised. During the start of a crisis signs of disconnection and withdrawal were key indicators that YP were going into crisis. Moreover, parents, YP and professionals indicated responsiveness of services varied until a risk incident happened which then prompted a service response. The recovery from a crisis was considered in terms of how to contain the crisis and keep YP safe. These

themes could be suitable targets for intervention to either manage or prevent YP escalating to crisis point, hence more relational therapeutic modalities could be considered as beneficial. For instance, relational modalities such as Cognitive Analytic Therapy and Psychodynamic Interpersonal Therapy have been adapted as brief interventions after episodes of self-harm (see Ougrin et al., 2008; Guthrie et al., 2003). However, these modalities in brief format have primarily been used with adolescents and young adults, hence these would need to be evaluated in the context of crisis care for YP and families.

5. Critical Reflection

This section provides meaningful reflections throughout the research process from the first author. From here, the first author will refer to themselves in the first person. Prior to writing this section, I listened back to my audio diary as a way of re-capping the research experience. I have synthesised my reflections on this process below.

5.1 Developing the research idea

Before commencing the doctorate, I was motivated to complete my research project with children and YP due to my previous experiences of working in CAMHS teams. I became interested in crisis services when I worked in a CAMHS crisis team. I noticed this area was under-researched and the developments in this area, including the involvement of psychologists, was rapidly changing. As a result, I approached several supervisors on the course who had experience of working with children and YP. When reading around the topic area of mental health crisis, I felt there were many avenues which could have progressed as a research idea due to the paucity of research within this area. The idea of exploring the experiences of mental health crisis for young people was devised through discussions with supervisors, exploration of current policies related to YP, and through exploring relevant literature. We had discussions in supervision around the other aspects of crisis care, such as crisis intervention. However, the common reflection when exploring these ideas of ‘how do YP understand what mental health crisis is? how is it conceptualised?’ kept occurring as a theme in our discussions. Hence, without having the

‘starting point’ of understanding exactly what a mental health crisis for a child is, it felt challenging to consider next steps such as research on crisis intervention and outcomes. We also reflected that other people may identify a ‘crisis’ for YP, hence the exploration of parental and caregiver perspectives was an important aspect when shaping the research idea.

In early supervision discussions and after recognising experiential research may provide advancements in the field and topic area, we considered using a qualitative approach. Reflexive Thematic Analysis was chosen to analyse the data as it aligned with my epistemological position, and the chosen method allowed us to answer the research question. I expressed some worries as I had not completed my own research project using a qualitative approach before. I was aware through discussions with my research supervisor, who was experienced in using reflexive thematic analysis, that there was a lot of flexibility in the reflexive thematic analysis approach. This caused me worry as I was concerned that due to my inexperience in carrying out qualitative research, I needed a more ‘structured and rigid’ approach which I felt may support me in managing the project alongside other demands of the clinical psychology doctorate. However, I recognised this approach was the ‘best fit’ to answer my research question and the flexibility in the approach was of benefit to my research design to allow me to be active in the research process.

To develop the research proposal, I attended several research proposal panels which consisted of experts by experience, academic staff members and other trainee clinical psychologists. I recall feeling concerned after the first panel as feedback was provided regarding whether I should change my population group. The rationales provided were that the topic area of mental health crisis was considered a ‘sensitive’ area and there were concerns about getting ethical approval in a timely manner in the context of the COVID-19 pandemic and associated delays. There were also concerns raised about recruiting children and YP to participate as academic staff recalled prior difficulties in projects in recruiting from this population. Initially, this made me feel deflated. I began to explore alternative research ideas as I was concerned about completing this research project during the COVID-19 pandemic alongside the high demands of

the clinical psychology doctoral programme. However, through discussion with one of my supervisors, we discussed the mitigations that could be put in place and they provided re-assurance that there have been lots of successful theses which have recruited children. This helped me think about some of the assumptions that may arise when doing research with young people (e.g., it is going to be hard, vulnerabilities associated with involving young people, and young people might not engage, 'extra' layers of safeguards included). I thoroughly reflected on whether this contributes to mental health crisis in children being under-researched due to the worries about the sensitivity of the topic and 'cautions' associated with the population group. In the final research proposal panel, I re-presented my idea whilst specifically discussing the safeguards in place, such as recruiting from NHS services, those receiving care, and engaging with gatekeepers, which re-assured the panel that I had thought about and considered these challenges. In this panel, an expert-by-experience raised whether I should also consider the professionals perspective alongside the parent/carer and young person perspectives to gain fuller insights in the nuances of the conceptualisation of mental health crisis. I noticed that I had paid less attention to this perspective when considering the research idea, possibly due to having worked in the field. I reflected that this was an area I was familiar with clinically which had benefits of having some knowledge of the field and systems that aim to support young people in crisis. However, it also had challenges for me as a researcher, such as needing to consider my position, role, and how my previous knowledge in the topic area may result in me holding assumptions about the area (e.g., that most professionals held similar views about what a crisis is because they work in similar service settings). In supervision, I explored extant literature which enabled me to realise that the addition of the professional perspective to this research project would provide opportunities for wider perspectives on the experience of mental health crisis for YP and would be of benefit clinically and theoretically. As a previous professional in this field, I learnt it was important for me to be aware of my positionality in the research, but also how through using reflexive thematic analysis, I played an influential role in the co-construction of data and direction of the research.

5.2 Ethics Application

When preparing the ethics application, I was mindful of the challenges and concerns that were raised in the research proposal panels regarding involving young people in research. I decided to speak to other trainees who had completed projects with YP and explore other theses online who had conducted research with YP to see what safeguards had been implemented. Over several supervision sessions, we reflected on whether to recruit YP who were not under services or whether to recruit from services only. We made the decision to recruit YP who were under services due to the scope and timescales of the research project. We felt we were able to implement robust safety measures from those already in contact with services in comparison to those who were not. When preparing the application, I ensured I was thorough in implementing de-brief systems, preparing risk-sharing information emails, and researched appropriate signposting for YP. I found that through developing these safeguards in my research project, it was helpful that I had clinical experience in working with YP. However, I reflected in my audio diary that this is also where I began considering my role as a 'researcher' and the boundaries of this role, in comparison to being in a therapeutic setting with a young person in crisis. As well as navigating the challenges of conducting research with young people, I was also trying to design a research project in the midst of a pandemic. As the previous cohort had already overcome several hurdles surrounding designing research in the heights of the pandemic, they were able to share their ideas and support with introducing new ways and systems of working. However, I was mindful that the situation at the time was ever-changing and new restrictions could be brought in at any moment. I was carefully trying to consider all eventualities and plan for each way my research project could be conducted. For instance, considering online interviews, navigating digital consent forms, and considering how to involve those who may not have access to computers. This contributed to feelings of stress and pressure as I had also heard about the long delays in ethical approval which arose during COVID. However, upon reflection, I also felt that it made me think creatively as a researcher by considering digital ways of working and the ethical issues associated with this, which enabled me to develop my skills of working online with service users.

Before the ethical review panel, I felt very nervous as I was concerned the panel may raise further challenges around investigating a topic of sensitive nature with YP. However, the ethics board gave favourable opinion and commented positively on my knowledge and understanding of working with YP. This was a moment which I felt developed my confidence as a researcher. As I had not conducted doctoral research before, I was always doubting myself through the planning process about whether I was 'doing it right'. The moment of receiving favourable opinion highlighted to me that I was able to confidently defend the decisions I had made in the research design and the rationale for such decisions.

5.3 Recruitment and Data Collection

Whilst the recruitment of YP was something I had discussed at length in my supervision, it was also the stage of the research project I was most concerned about. I was pleased my ethical approval came through promptly and I began recruiting early. As professionals in services were the gatekeepers to my research project, I spent time meeting them, presenting in team meetings, and speaking with service managers. I quite quickly recruited professionals to be involved. However, the challenge arose when trying to recruit YP and parents/carers. A difficulty reported by clinicians, who were gatekeepers, was the timeframe of 'three months of being discharged from a service' was too short due to lengthy waiting lists in CAMHS. After discussion with my field supervisor, we also reflected that this timeframe was also still quite close to the crisis itself. After reading other qualitative studies and reflecting on an appropriate timeframe, we changed this to 12-months and an amendment was submitted. This meant a pause in recruitment until the amendment was approved which contributed to high levels of stress as I was concerned about the delays already occurring with recruitment. As a result of my heightened anxiety, during this period I began to reflect on whether I should change my research idea completely. However, I was reminded of my passion in this area which enabled me to re-focus on the current project and begin to problem-solve arising recruitment challenges.

I also experienced a change of supervisor at the point of recruitment which brought about different ideas and reflections on my project in research supervision. We reflected on my recruitment challenges and considered whether, if the change in inclusion criteria is not helpful, I could recruit from charities to remove the gatekeeping responsibilities of clinicians. Whilst these ideas could have been possible, I reflected on my concerns in supervision about not having the higher level of appropriate safeguards in place and the challenges that could arise, for instance if a young person was in crisis and not under a service during an interview. Due to the timeframes and scope of the project, by having YP being cared for by clinicians allowed me to separate my role as a researcher and as a clinician as the care responsibilities remained with the CAMHS team. However, I feel including a sample of gatekeepers in designing the recruitment aspect of my study may have been beneficial in understanding and thinking about any potential obstacles.

As the recruitment of professionals for this study was relatively quick, I began preparing for my first interview. Due to the nature of crisis work and shift patterns, often interviews would be moved or changed hence taking a flexible approach was important and doing interviews online made this easier. After my first interview with a professional, I acknowledged in supervision that there was often a lot of professional jargon utilised which I did not explore initially. However, in subsequent interviews, I was able to take a more curious stance which led to a deeper understanding of the subjective nature of certain concepts (e.g., risk, taking a referral, distress tolerance) that are referred to so regularly in crisis work.

Due to the time which passed between finishing the interviews with professionals and commencing interviews with parents and young people, I felt more nervous. I reflected on concerns around balancing ‘being an interviewer’ and ‘being a professional’ and whether I would deviate too far from the semi-structured interview guide. During the time of interviewing, supervision was crucial in supporting me to develop my skills and style as an interviewer. Supervision sessions also allowed me to reflect on my emotional responses towards some of the emotive topics which were raised during the interviews and

reflect on how I was going to manage those emotions before proceeding into further interviews. Whilst conducting the interviews, I continued trying to recruit by sending further reminder emails, going to team meetings, speaking with gatekeepers, and presenting my research to service managers. I began discussing in supervision about when to stop trying to recruit, given the timeframes of completing my thesis. I expressed concerns that I had not managed to reach my recruitment target. I reflected on how this was a sensitive topic which included all three groups (YP, parents/carers, and professionals) which to our knowledge had not been completed before. My supervisors suggested that I considered closing the recruitment to my study and move on to the next phase. I expressed my concerns about not reaching recruitment targets for parents/carers and YP. However, my supervisor explained that these are just targets and high-quality thematic analysis can be completed on the data I had. We also reflected that this is an area of research that YP have often been excluded from, therefore the inclusion of all three groups was important despite not reaching recruitment targets.

5.4 Data Analysis

When commencing my data analysis, I scheduled several supervision sessions to ensure I had the appropriate support throughout the process. A common theme through my initial discussions in supervision were focused on ‘how’ to do the data analysis. Over time, I recognised that due to being a novice qualitative researcher, there was part of me that wanted a manual to tell me exactly how to do a reflexive thematic analysis. However, I knew from everything I had read about reflexive thematic analysis that a manual with specified steps would not produce a high-quality analysis and reflexivity would be limited.

In the familiarisation phase, I found making the corrections from the automated transcription service very valuable as I was able to re-listen to the participants voices and make connections in the data. I kept field notes by hand and made these whilst familiarising myself with the data. Due to experiencing episodes of ill-health throughout the initial phases of my analysis, these notes were invaluable. The field notes helped me immerse and re-immerse into the

data when I had to step away from the data and come back to it. When I was coming to the end of the familiarisation phase, I made notes on the data set to aid the familiarisation process. I had a particularly strong emotional response to the fear of death parents reported after the involvement of professionals. I reflected on my assumptions surrounding the process of safety planning and how I had anticipated this would help people feel safer and supported. Through supervision and my reflexive diary, I was able to acknowledge the beliefs I held and how through acknowledging, engaging, and challenging these beliefs throughout the process of developing the current narratives that run through my analysis. The reflexive diary supported me in developing a deeper awareness of my beliefs and assumptions and helped me understand what brought, as a curious researcher, to the analysis.

In the 'doing coding' phase, I completed several rounds of coding. After my coding the first interview, I recognised I was over-coding and looking at the interview became very overwhelming due to each line being coded. I feel this happened due to lacking confidence and due to worries I was going to miss something in the data. My supervisors advised me to put my research aim on a post-it note to enable me to focus on what data was pertinent to answering my research aim. Also, I joined a webinar run by Braun and Clarke with the hope of being able to understand the coding process further. Through doing this, I learnt that when coding not everything will be relevant which allowed me to feel comfortable in letting go of pieces of data. I continued to use supervision sessions to gain deeper insights into my positionality as a researcher, recognise what interested me in parts of the dataset, and my emotional responses. I found supervision an invaluable space throughout the course of my analysis. A challenge of the coding process was knowing when to stop the rounds of coding and a constant thought of 'is this good enough?'. Whilst there was no guidance or standard to aid this decision, I did use the 'taking away the data exercise'. This is where I looked over all my codes and from doing this exercise, I checked I was able to understand my data due to the clarity the codes provided. The exercise also helped me in ensuring I could make sense of the meaning in my data through only the codes. I noticed where my coding had been weak (e.g.,

risk) and helped me consider where my codes needed further refinement to capture the interpretation and meaning.

Regarding generating initial themes, I was apprehensive about starting to develop themes as it felt daunting to start lifting my analysis from codes to a more interpretative level. I considered whether I was going to engage in this process by hand or electronically. I found during my coding, I was often working in different settings, and this helped me in continuing to engage with the data, hence I chose to generate themes using electronic methods. However, I found it helpful to draw my thematic map by hand. When looking at all the coding clusters, I felt quite overwhelmed, and I was noticing I began questioning myself. For example, I kept asking myself 'am I including what is relevant? How will I know? Am I doing it right?' which contributed to a feeling of pressure. I used supervision to explore these anxieties and to check I was not just describing the data but that I was interpreting what was being said. My supervisors advised generating themes is an iterative process which helped reduce a sense of pressure and normalised my continual changes of moving themes around. I found talking about my data in supervision helped me recognise what patterns of meaning I was beginning to develop.

When developing and reviewing themes, drawing out the thematic map by hand was helpful in being able to develop the story I was attempting to tell. I took a cue card per theme and wrote about each theme on the cue card. This process enabled me to see where themes were distinct. In regard to refining, defining and naming themes, I noticed in discussions about my data I was trying to be mindful about how I reflected experiences of all three groups in the story I was trying to tell from the data. I still had fears of whether I was missing out 'important and relevant' aspects which pulled me into considering whether I needed more sub-themes. However, I was advised by my supervisors that relying on too many sub-themes can distract from the actual theme itself and lead to summaries of topics being developed resulting in a 'fragmented and detached' analysis.

The writing-up of my analysis helped me further refine my themes and consider the story I was trying to tell from my data. The different expertise from my supervisors helped in exploring my analytic stance and lifting my analysis to a more interpretative analysis. I found it challenging trying to decide what to include in my journal paper and in my extended paper as it all felt important to include. I spent a significant amount of time moving different quotes around and re-writing my themes. The write-up phase of my project was longer than expected due to episodes of ill-health. As I came towards the end of my write-up, I held concerns around 'missing something' or whether I had 'not analysed in enough depth' due to what I perceived as my 'disjointed' research journey because of episodes of ill-health. When receiving feedback from different supervisors, each had different thoughts on where things could be improved or how to write each section. This helped me remember that this part of the process is ongoing, and my analysis was completed at a certain moment in time, but if others look at my data, they may come up with something different. I learnt to be mindful that the write-up phase is ongoing as analysis of the data is completed at a certain moment in time. As I gained confidence as a qualitative researcher, I recognised that other researchers may notice different things in my data set but that this does not mean that what I have done is 'wrong'. Also, when considering my episodes of ill-health and the impact on the research process, I reflected on how valuable I found my field notes in being able to re-immerse myself after periods of time off in the data set and I feel if I did not have these, my research journey may have been different.

5.5. Concluding Reflections

As this project comes to an end, I recognise I have developed as a researcher and clinician. I have learnt a lot from engaging in discussions and getting feedback from my supervisors. Whilst this project had several challenges, and this was the first piece of research I had conducted at doctoral level; I feel my confidence in conducting qualitative research has grown immensely. I am keen to continue to engage in research projects post-qualifying and still feel passionate about contributing to the area of mental health crisis care for YP.

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Appendices
Appendix A

CAMHS Crisis Professional Participant Information Sheet

CAMHS Crisis Professional Participant Information Sheet
(Final Version 1.1: 28/01/2022, IRAS ID: 307581)
Name of Researcher: Danielle Hills
Chief Investigator: Dr Mark Hudson

Study Title

A Mental Health Crisis: Experiences of Young People (YP), Parents and Carers, and Professionals.

Introduction

I am a Trainee Clinical Psychologist based at the University of Nottingham completing a Professional Doctorate in Clinical Psychology. I would like to invite you to take part in my research study. Before you decide, I would like you to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully. Please feel free to talk to others about the study if you wish. If anything is not clear, please ask me.

What is the purpose of the study?

Mental health crisis care for children and young people is a current focus within the NHS and is currently developing. The purpose of this study is to understand the experience of being in a mental health crisis for young people from the perspectives of young people, professionals and parents/carers. Through exploring multiple perspectives, we would like to gain an understanding of how mental health crises are conceptualised and the experience of being in a mental health crisis for young people. This study is being undertaken as a thesis for part of a Doctorate in Clinical Psychology.

Why have I been invited?

You are being invited to take part because you are a health professional working currently in a CAMHS Crisis Team in the United Kingdom. We are inviting 4-5 other participants like you to take part.

What will happen to me if I take part?

If you decide after reading this information sheet that you are interested in taking part in this research, please email the Principal Investigator, (see contact details below). the investigator will liaise with you via e-mail to book in an initial appointment. You will be given at least 24 hours to consider the information sheet. Initially, you will be contacted by the researcher for a 20-minute telephone appointment to go through the information sheet and they will be able to answer any questions you might have. If you decide you would like to participate, informed consent will be sought at this appointment. The consent form will be sent to you electronically via email and if you would like to take part you will be required to provide written consent. The consent form can be returned to the researcher electronically via email or can be collected from your base. Once informed consent is obtained, the researcher will book a date and time for an interview to take place. The interview will take a maximum of 60-minutes (including a 15-minute debrief) and will take place online via Microsoft Teams or face-to-face, if appropriate to do so. The interviews can take place at a time suitable for you and the researcher. The interviews will be audio-recorded and will be transcribed either by the researcher or the University of Nottingham Transcription Service.

At the start of the interview, the researcher will ask you for some demographic information. Then, ask some questions in order to understand what the experience of mental health crisis is for young people, from your experience of working with young people in crisis. You can take breaks at any point during the interview, if required. There will also be a short space at the end of the interview to de-brief.

Do I have to take part?

No. It is up to you to decide whether or not to take part. If you do not decide to take part you will have no further contact with the study.

Expenses and payments

Participants will not be paid to participate in this study. However, if interviews take place face-to-face, travel expenses will be offered for any visits incurred as a result of participation.

What are the possible disadvantages and risks of taking part?

It is expected that the potential disadvantages of taking part in this study would be minimal. Although, the main disadvantage may be the time you may take out of your schedule to take part in the interview. The interviews will take place at a time which is convenient for both of us. Some of the information discussed might be sensitive and/or distressing regarding your experiences of working with young people in crisis. there will be space at the end of the interview to de-brief.

What are the possible benefits of taking part?

There may not be any direct benefits for you, although some people find it is helpful talking about their experiences. It is hoped that the results from the research will contribute to gaining a more thorough understanding of the experience of a mental health crisis for children and young people from multiple perspectives. Consequently, this study hopes to provide a contribution to developing knowledge in this area and developments in crisis service provision for young people.

What happens when the research study stops?

The interview is a one-off interview therefore you will not be contacted after the interview. However, you will have the option to leave your email address to be directly informed about the results from the study.

Will my taking part in the study be kept confidential?

We will follow ethical and legal practice and all information about you will be handled in confidence.

If you join the study, we will use information collected from you during the course of the research. This information will be kept **strictly confidential**, stored in a secure and locked office, and on a password protected database at the University of Nottingham. Under UK Data Protection laws the University is the Data Controller (legally responsible for the data security) and the Chief Investigator of this study, named above, is the Data Custodian (manages access to the data). This means we are responsible for looking after your information and using it properly. Your rights to access, change or move your information are limited as we need to manage your information in specific ways to comply with certain laws and for the research to be reliable and accurate. To safeguard your rights, we will use the minimum personally – identifiable information possible. You can find out more about how we use your information and to read our privacy notice at: https://www.nottingham.ac.uk/utilities/privacy.aspx.

The data collected for the study will be looked at and stored by authorised persons from the University of Nottingham who are organising the research. They may also be looked at by authorised people from regulatory organisations to check that the study is being carried out correctly. All will have a duty of confidentiality to you as a research participant and we will do our best to meet this duty. In addition, a transcription service may be used to write up the interviews. The researcher may also write up some interviews. In this instance, the transcription service will be required to sign a confidentiality agreement prior to having any access to the interview in order to ensure confidentiality is maintained. All data will be kept securely for 7 years. After this time your data will be disposed of securely. During this time all precautions will be taken by all those involved to maintain your confidentiality, only members of the research team given permission by the data custodian will have access to your personal data.

In accordance with the University of Nottingham's, the Government's and our funders' policies we may share our research data with researchers in other Universities and organisations, including those in other countries, for research in health and social care. Sharing research data is important to allow peer scrutiny, re-use (and therefore avoiding duplication of research) and to understand the bigger picture in particular areas of research. Data sharing in this way is usually anonymised (so that you could not be identified) but if we need to share identifiable information we will seek your consent for this and ensure it is secure. You will be made aware then if the data is to be shared with countries whose data protection laws differ to those of the UK and how we will protect your confidentiality.

Although what you say to us is confidential, should you disclose anything to us which we feel puts you or anyone else at any risk, we may feel it is necessary to report this to the appropriate persons, following local policies.

What will happen if I don't want to carry on with the study?

Your participation is voluntary. You are able to withdraw consent at any time without giving any reason, and without your legal rights being affected. If you withdraw up to one week after the interview, your data can be withdrawn from the study and will not be used in the analysis. However, should you choose to withdraw after this time period then the information collected so far cannot be erased and that this information may still be used in the project analysis. The reason for this is because after one week the interviews will have been sent for transcription (typed up word for word). If you withdraw after this time period, we will no longer collect any information about you or from you but we will keep the information about you that we have already obtained as we are not allowed to tamper with study records and this information may have already been used in some analyses and may still be used in the final study analyses. To safeguard your rights, we will use the minimum personally-identifiable information possible. You do not need to give a reason to withdraw from the study and your legal rights will not be affected.

What will happen to the results of the research study?

The transcripts from your interview will be anonymised, collated with other participants' responses, and analysed to produce a set of findings. These anonymised transcripts may also be looked at by other researchers in the University of Nottingham. The findings will be summarised and reported in Danielle Hills's Doctorate in Clinical Psychology thesis. A copy of this thesis will be available at the University of Nottingham library. Findings may also be submitted for publication in an academic or professional journal and/or may be presented at any relevant conferences or events. Direct quotations from your interview may be used in any reports or publications; however, these will be anonymised so that you cannot be identified.

Who is organising and funding the research?

This research is forming part of a Doctorate in Clinical Psychology qualification at The University of Nottingham and is sponsored by The University of Nottingham.

Who has reviewed the study?

All research in healthcare is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed by the Health Research Authority West of Scotland Research Ethics Committee.

What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions. The researchers' contact details are given at the end of this information sheet. If you remain unhappy and wish to complain formally, you can do this by contacting;

[REMOVED]

In the event that something does go wrong and you are harmed during the research and this is due to someone's negligence then you may have grounds for a legal action for compensation against the University of Nottingham but you may have to pay your legal costs. The normal National Health Service complaints mechanisms will still be available to you.

Further information and contact details

If you require any further information about this study, please do not hesitate to contact us on the details below:

Danielle Hills
Researcher/Trainee Clinical Psychologist
E-mail: [REMOVED]

Dr Mark Hudson
Chief Investigator and Research Supervisor/ Clinical Psychologist
E-mail: [REMOVED]
/

Appendix B

Consent form for Parents/Carers and Professionals

Study Identification:

/

PARENTS/CARERS AND PROFESSIONALS CONSENT FORM
(Final Version 1.1: 28/01/2022, IRAS ID: 307581)

Title of Study: A Mental Health Crisis: Experiences of Young People (YP), Parents and Carers and Professionals.

Name of Researcher: Danielle Hills

Name of Participant:

Please initial box

1. I confirm that I have read and understand the information sheet version number 1.1 dated 28.01.22 for the above study and have had the opportunity to ask questions. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, and without my legal rights being affected. I understand that if I withdraw up to one week after the interview, my data can be withdrawn from the study and will not be used in the analysis. However, I understand that should I choose to withdraw after this time period then the information collected so far cannot be erased and that this information may still be used in the project analysis. ☐
3. I understand that the data collected in the study may be looked at by authorised individuals from the University of Nottingham, the research group and regulatory authorities where it is relevant to my taking part in this study. I give permission for these individuals to collect, store, analyse and publish information obtained from my participation in this study. I understand that my personal details will be kept confidential. ☐
4. I understand that the interview will be audio-recorded and transcribed by the University of Nottingham Transcription service or the researcher. Also, anonymous direct quotes from the interview may be used in the study reports. ☐
5. I understand that my interview with the researcher will be kept confidential unless the researcher is concerned about my safety or the safety of someone else or they are discussing the research with the other researchers involved in this project. If the researcher is concerned, they will tell the appropriate people. ☐
6. I agree to take part in the above study. ☐
7. I would like my contact details to be kept on file so I can be emailed a copy of the research findings. ☐

Name of Participant	Date	Signature
Name of Person taking consent	Date	Signature

Appendix C

16+ Participant Information Sheet

Young Person Aged 16-17 Participant Information Sheet
(Final Version 1.2: 29/04/2022, IRAS ID: 307581)
Name of Researcher: Danielle Hills
Chief Investigator: Dr Mark Hudson

Study Title
A Mental Health Crisis: Experiences of Young People (YP), Parents and Carer, and Professionals.

Introduction
I am a Trainee Clinical Psychologist based at the University of Nottingham completing a Doctorate in Clinical Psychology. I would like to invite you to take part in my research study. Before you decide, I would like you to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully. Please feel free to talk to others about the study if you wish. If anything is not clear, please ask me.

What is the study about?
Mental health crisis care for children and young people is a current focus within the NHS and is currently developing. The purpose of this study is to understand the experience of being in a mental health crisis for young people from the perspectives of young people, professionals and parents/carers. Through exploring multiple perspectives, we would like to gain an understanding of how mental health crises are conceptualised and the experience of being in a mental health crisis for young people. This study is being undertaken as a thesis for part of a Doctorate in Clinical Psychology.

Why have I been invited?
I would like to interview young people who have experienced a mental health crisis. You must be aged 13-17 to take part and have accessed the Child and Adolescent Mental Health Service (CAMHS) Crisis Team. You must have been discharged from the CAMHS crisis team in the last 12 months. We are inviting 4 to 5 other participants like you to take part.

What will happen to me if I take part?
If you decide after reading this information sheet that you are interested in taking part in this research your CAMHS clinician will ask for your permission for them to pass on your details to the researcher so the researcher can get into contact with you by telephone. If you do give permission, you will be asked to fill in a form to record your contact details. Then, the following steps will be taken:

1. The CAMHS clinician will pass your contact details onto the researcher. The researcher will contact you within 7 working days by telephone to book in a 20-minute telephone call to go through this information sheet and answer any questions.
2. During the 20-minute telephone call, if you decide you would like to take part, then you will be asked to give your informed consent by filling in a consent form. The consent form can be returned to the researcher electronically via email or can be returned at your next routine CAMHS appointment. If you provide consent, an interview appointment will be booked in. You will be asked if you would like your interview to be online, via a programme called Microsoft Teams, or face-to-face.

3. Two days prior to your interview appointment you will be contacted by the researcher to remind you of your appointment.
4. The appointment will last approximately 60-minutes. There will be a 45-mintue interview which involve the researcher asking some general questions about you (such as your age etc.) and questions about your experience of being in a mental health crisis. The interviews will be audio-recorded. The interviews will be audio-recorded and will be transcribed either by the researcher or the University of Nottingham Transcription Service.
5. Immediately after the interview, you will be offered a 15-minute space to de-brief to discuss the interview and if anything has come up for you.
6. Your CAMHS clinician will also be told that you have taken part but will not be told the content of the discussion, unless any concerns are raised. This is so that if you need any additional support, this can be provided.

Do I have to take part?

No. It is up to you to decide whether or not to take part. If you do not decide to take part you will have no further contact with the study.

Expenses

Participants will not be paid to participate in this study. However, if interviews take place face-to-face, any reasonable travel expenses will be offered for any visits incurred as a result of participation.

What are the possible disadvantages and risks of taking part?

It is expected that the potential disadvantages of taking part in this study would be minimal. Some of the information discussed might be sensitive and/or distressing as we will be talking about your experiences of supporting a young person in crisis. There will be a space at the end of the interview to de-brief.

What are the possible benefits of taking part?

There may not be any direct benefits for you, although some people find it is helpful talking about their experiences. It is hoped that the results from the research will contribute to gaining a more thorough understanding of the experience of a mental health crisis for children and young people from multiple perspectives. This study hopes to provide a contribution to developing knowledge in this area and developments in crisis service provision for young people.

What happens when the research study stops?

The interview is a one-off interview therefore you will not be contacted after the interview. However, you will have the option to leave your email address to be directly informed about the results from the study.

Will my taking part in the study be kept confidential?

We will follow ethical and legal practice and all information about you will be handled in confidence.

If you join the study, we will use information collected from you during the course of the research. This information will be kept **strictly confidential**, stored in a secure and locked office, and on a password protected database at the University of Nottingham. Under UK Data Protection laws the University is the Data Controller (legally responsible for the data security) and the Chief Investigator, named above, is the Data Custodian (manages access to the data). This means we are responsible for looking after your information and using it properly. Your rights to access, change or move your information are limited as we need to manage your information in specific ways to comply with certain laws and for the research to

be reliable and accurate. To safeguard your rights, we will use the minimum personally – identifiable information possible. You can find out more about how we use your information and to read our privacy notice at: https://www.nottingham.ac.uk/utilities/privacy.aspx.

The data collected for the study will be looked at and stored by authorised persons from the University of Nottingham who are organising the research. They may also be looked at by authorised people from regulatory organisations to check that the study is being carried out correctly. All will have a duty of confidentiality to you as a research participant and we will do our best to meet this duty.
As the interviews are audio-recorded, they will be typed up word for word (transcripts) and the transcripts will not contain any identifiable information (such as staff or family members names). A transcription service will be used to write up the interviews. The researcher may also write up some interviews. In this instance, the transcription service will be required to sign a confidentiality agreement prior to having any access to the interview in order to ensure confidentiality is maintained. All data will be kept securely for 7 years. After this time your data will be disposed of securely. During this time all precautions will be taken by all those involved to maintain your confidentiality, only members of the research team given permission by the data custodian will have access to your personal data. Direct quotes may be used in the write up of this study, however, they will be anonymised and you will not be able to be identified.

In accordance with the University of Nottingham's, the Government's and our funders' policies we may share our research data with researchers in other Universities and organisations, including those in other countries, for research in health and social care. Sharing research data is important to allow peer scrutiny, re-use (and therefore avoiding duplication of research) and to understand the bigger picture in particular areas of research. Data sharing in this way is usually anonymised (so that you could not be identified) but if we need to share identifiable information we will seek your consent for this and ensure it is secure. You will be made aware then if the data is to be shared with countries whose data protection laws differ to those of the UK and how we will protect your confidentiality.

Although what you say to us is confidential, should you disclose anything to us which we feel puts you or anyone else at any risk, we may feel it necessary to report this to the appropriate persons following local policies.

What will happen if I don't want to carry on with the study?

Your participation is voluntary. You are free to withdraw any time, without giving any reason, and without their care or legal rights being affected. If you withdraw up to one week after the interview, your data can be withdrawn from the study and will not be used in the analysis. Should you withdraw after this time period then the information collected so far cannot be erased and that this information may still be used in the project analysis. The reason for this is because after one week the interviews will have been sent for transcription (will be typed up word for word). If you withdraw after this time period, we will no longer collect any information about you or from you but we will keep the information about you that we have already obtained as we are not allowed to tamper with study records and this information may have already been used in some analyses and may still be used in the final study analyses. To safeguard your rights, we will use the minimum personally-identifiable information possible. You do not need to give a reason to withdraw from the study and your legal rights will not be affected.

What will happen to the results of the research study?

The transcripts from your interview will be anonymised, collated with other participants' responses, and analysed to produce a set of findings. These anonymised transcripts may also be looked at by other researchers in the University of Nottingham. The findings will be summarised and reported in Danielle

Hills's Doctorate in Clinical Psychology thesis. A copy of this thesis will be available at the University of Nottingham library. Findings may also be submitted for publication in an academic or professional journal and/or may be presented at any relevant conferences or events. Direct quotations from your interview may be used in any reports or publications; however, these will be anonymised so that you cannot be identified.

Who is organising and funding the research?

This research is forming part of a Doctorate in Clinical Psychology qualification at The University of Nottingham and is sponsored by The University of Nottingham.

Who has reviewed the study?

All research in healthcare is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed by the Health Research Authority West of Scotland Research Ethics Committee.

What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions. The researchers' contact details are given at the end of this information sheet. If you remain unhappy and wish to complain formally, you can do this by contacting;

[REMOVED]

In the event that something does go wrong and you are harmed during the research and this is due to someone's negligence then you may have grounds for a legal action for compensation against the University of Nottingham but you may have to pay your legal costs. The normal National Health Service complaints mechanisms will still be available to you.

Further information and contact details

If you require any further information about this study, please do not hesitate to contact us on the details below:

Danielle Hills
Researcher/Trainee Clinical Psychologist
E-mail[REMOVED]

Dr Mark Hudson
Chief Investigator and Research Supervisor/ Clinical Psychologist
E-mail: [REMOVED]

Appendix D

Under 16s Participant Information Sheet

Young Person (Aged 13-15) Information Sheet
A Mental Health Crisis: Experiences of Young People (YP), Parents and Carers, and Professionals.
(Final Version 1.2: 29/04/2022, IRAS ID: 307581)
Name of Researcher: Danielle Hills Chief Investigator: Dr Mark Hudson

Hello, my name is Danielle Hills. As part of my training to be a Clinical Psychologist, I am doing some research about the experiences of being in a mental health crisis for young people.

I would like to invite you to take part in this research. However, before you decide it is important that you understand what is involved. Please read this information carefully. It may be helpful to talk to your parents/carers about it too.



Why are you asking me?
I would like to talk to young people, aged 13-17, who have experienced a mental health crisis and had contact with the Child and Adolescent Mental Health Service (CAMHS) Crisis Team. You must have been discharged from the CAMHS crisis team in the past 12 months.

Do I have to take part?
No. It is completely up to you whether you take part. Your decision will not affect your care from CAMHS services.

Do I need permission from my parent/carer?
If you are under the age of 16, you will need permission from your parent/legal guardian to take part.

Will my travel be paid?
If you have to travel to see the researcher, you will be paid reasonable travel expenses.

What will I be asked to do?
Your CAMHS clinician will pass your details or your caregivers details on to me. I will then contact your care-giver within 7 working days to book in a 20-minute conversation. We will then have a 20-minute conversation to answer any questions you might have. We will also discuss informed consent with your caregiver for you to take part in the research and you/your caregiver will be asked to fill in a form either online or the paper copy can be handed in at your next CAMHS appointment.

If you are interested in taking part, we will then book in a 60-minute appointment where you will have a 45-minute conversation, either face to face or online via Microsoft Teams, about your experiences of being in a mental health crisis. You can have your parent/caregiver in the appointment with you but they will not be able to answer questions for you. Parents/caregivers should be there at the start of the interview, but if you do not want them to be present for the whole time, they can then leave the meeting. The interviews will be audio-recorded and will be written up either by the researcher or the University of Nottingham Transcription Service. After this conversation, you will be offered a 15-minute space to talk about how you are feeling after the conversation.

There are no right or wrong answers and we can take as many breaks as you like. The researcher will call you two days before your appointment to remind you.

What is the point in doing this research?
Some people find it is helpful talking about their experiences. It is hoped that the results from the research will help to understand the experience of a mental health crisis for young people which we hope will help in improve crisis services for young people and families.

Will the conversation be private?
Yes. Everything we talk about in our conversation will be kept private between you and the research team, but there are sometimes where we may have to break this. For example, if you tell me anything that makes me worried about your safety or the safety of others then I will have to talk to appropriate people in order to keep you safe. Where possible, I will tell you if I have to do this.

Your CAMHS clinician will also be notified that you have taken part in the research but, unless there are any concerns, they will not be told about what you have said. This is just so that if you need support, they can offer this.

When writing up the study, I might use some quotes from what you have said. However, people reading this will not know it is you. as I would use a different name for you and remove anything that could identify you.

What will happen to the results?
When your meeting has finished, the conversation we have audio-recorded will be typed up word for word. I will write up a report which will be submitted as part of my university assignment and the findings might also be shared with local services.

The findings may also be sent to a journal, which is looked at by experts in the area and if they decide that this piece of research can feature in the journal. It can then be read by people online or be presented at a conference. I will change your name and any other details so no one can tell it is you.

Are there any disadvantages with taking part?
The disadvantages are expected to be minimal. Although we will be talking about your experiences of a mental health crisis, we can take breaks when you need to and will make sure there is a space at the end to discuss how you are feeling after the session and any more support you might need.

Can I change my mind about taking part?
Yes. You can change your mind at any time. You do not have to give a reason for doing so. If you change your mind about taking part up to one week after the interview, your data will not be used in the study. However, if you change your mind after this time, the data will not be able to be removed but you will no longer be contacted by the research team.

Where will all the information be kept and for how long?
I will keep the information I collect in a locked cupboard or on a secure server. After the research is finished, the files will be stored for 7 years and then safely deleted after this.

Is anyone checking this project?
This study has been reviewed by the Health Research Authority West of Scotland Research Ethics Committee.

What if there is a problem?
If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions. If you remain unhappy and wish to complain formally, you can do this by contacting;
[REMOVED]

Contact details and further information:
If you require any further information about this study, please do not hesitate to contact us on the details below:
Danielle Hills
Researcher /Trainee Clinical Psychologist
E-mail: [REMOVED]
Dr Mark Hudson
Chief Investigator and Research Supervisor/ Clinical Psychologist
E-mail: [REMOVED]
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Appendix E

Parent/Carer of under 16- Participant Information Sheet

Parents and Carers of Young People (Under 16s) Participant Information Sheet
(Final Version 1.2: 29/04/2022, IRAS ID: 307581)
Name of Researcher: Danielle Hills
Chief Investigator: Dr Mark Hudson

Study Title

A Mental Health Crisis: Experiences of Young People (YP), Parents and Carers, and Professionals.

Introduction

I am a Trainee Clinical Psychologist based at the University of Nottingham completing a Professional Doctorate in Clinical Psychology. I would like to invite your child to take part in my research study. Before you decide if you would like your child to take part, I would like you to understand why the research is being done and what it would involve for the young person who would like to take part. Please take time to read the following information carefully. Please feel free to talk to others about the study if you wish. If anything is not clear, please ask me.

What is the study about?

Mental health crisis care for children and young people is a current focus within the NHS and is currently developing. The purpose of this study is to understand the experience of being in a mental health crisis for young people from the perspectives of young people, professionals and parents/carers. Through exploring multiple perspectives, we would like to gain an understanding of how mental health crises are conceptualised and the experience of being in a mental health crisis for young people. This study is being undertaken as a thesis for part of a Doctorate in Clinical Psychology.

Why have I been invited?

I would like to interview young people who have experienced a mental health crisis. The young person must be aged 13-17 and have accessed the Child and Adolescent Mental Health Service (CAMHS) Crisis Team. The young person must have been discharged from the CAMHS crisis team in the past 12 months. You must be the primary care giver for the young person in order to provide consent. We are inviting 4 to 5 other participants like you to take part.

What will happen to the young person if they take part?

If you decide after reading this information sheet that you are happy for your child to take part in this research, their CAMHS clinician will ask for your permission for them to pass on your details to the researcher so the researcher can get into contact with you by telephone. If you do give permission, you will be asked to fill in a form to record your contact details. Then, the following steps will be taken:

1. The CAMHS clinician will pass your contact onto the researcher. The researcher will contact you within 7 working days by telephone to book in a 20-minute telephone call which we ask for the young person who is interested in taking part and yourself to be present for.
2. During the 20-minute telephone call, you and the young person who would like to take part will have the opportunity to go through the information sheet again and ask any questions you might have. If you decide that you are happy for your child to take part, then you will be asked to give

your informed consent by filling in a consent form. The consent form can be returned to the researcher electronically via email or can be returned at your next routine CAMHS appointment. The young person will be asked to provide assent, which is an agreement to take part in the research. However, if the young person does not want to fill this in, but provides verbal agreement, this is also accepted and will be recorded on your form that this is the case. After parental consent has been obtained, an interview appointment will be booked in.

3. Two days prior to the interview appointment you will be contacted by the researcher to remind you of your child's appointment. You will be asked if you would like your interview to be online, via a programme called Microsoft Teams, or face-to-face.
4. The 60-minute interview appointment will consist of a 45-mintue interview and a 15-minute de-brief after the interview. The 45-minute interview will involve the researcher asking some demographic questions and open-questions about your child's experience of a mental health crisis. The interviews will be audio-recorded and will be transcribed either by the researcher or the University of Nottingham Transcription Service.
5. Immediately after the interview, your child will be offered a 15-minute space to de-brief to discuss the interview and if anything has come up for your child.
6. Your child's CAMHS clinician will also be notified that they have taken part but will not be told the content of the discussion, unless any concerns are raised. This is so that if additional support is required, this can be provided.

Does my child have to take part?

No. It is up to you to decide whether or not they take part. If you do not give your permission for your child to take part you will have no further contact with the study.

Expenses

Participants will not be paid to participate in this study. However, if interviews take place face-to-face, any reasonable travel expenses will be offered for any visits incurred as a result of participation.

What are the possible disadvantages and risks of taking part for my child?

It is expected that the potential disadvantages of taking part in this study would be minimal. Some of the information discussed might be sensitive and/or distressing as we will be talking about your child's experiences of a mental health crisis. There will be a space at the end of the interview to de-brief.

What are the possible benefits of taking part?

There may not be any direct benefits for your child, although some people find it is helpful talking about their experiences. It is hoped that the results from the research will contribute to gaining a more thorough understanding of the experience of a mental health crisis for young people from multiple perspectives. Consequently, this study hopes to provide a contribution to developing knowledge in this area and developments in crisis service provision for young people.

What happens when the research study stops?

The interview is a one-off interview therefore you and your child will not be contacted after the interview. However, you will have the option to leave your email address to be directly informed about the results from the study.

Will my child's taking part in the study be kept confidential?

We will follow ethical and legal practice and all information about you will be handled in confidence.

If your child joins the study, we will use information collected from your child during the course of the research. This information will be kept **strictly confidential**, stored in a secure and locked office, and on a password protected database at the University of Nottingham. Under UK Data Protection laws the University is the Data Controller (legally responsible for the data security) and the Chief Investigator, named above is the Data Custodian (manages access to the data). This means we are responsible for looking after your child's information and using it properly. Yours and your child's rights to access, change or move your information are limited as we need to manage your information in specific ways to comply with certain laws and for the research to be reliable and accurate. To safeguard yours and your child's rights, we will use the minimum personally – identifiable information possible. You can find out more about how we use your information and to read our privacy notice at: https://www.nottingham.ac.uk/utilities/privacy.aspx.

The data collected for the study will be looked at and stored by authorised persons from the University of Nottingham who are organising the research. They may also be looked at by authorised people from regulatory organisations to check that the study is being carried out correctly. All will have a duty of confidentiality to you as a research participant and we will do our best to meet this duty.

As the interviews are recorded, they will be typed up word for word (transcripts) and the transcripts will not contain any identifiable information (such as staff or family members names). A transcription service may be used to write up the interviews. The researcher may also write up some interviews. In this instance, the transcription service will be required to sign a confidentiality agreement prior to having any access to the interview in order to ensure confidentiality is maintained. All data will be kept securely for 7 years. After this time your data will be disposed of securely. During this time all precautions will be taken by all those involved to maintain your child's confidentiality, only members of the research team given permission by the data custodian will have access to your personal data. Direct quotes may be used in the write up of this study, however, they will be anonymised and your child will not be able to be identified.

In accordance with the University of Nottingham's, the Government's and our funders' policies we may share our research data with researchers in other Universities and organisations, including those in other countries, for research in health and social care. Sharing research data is important to allow peer scrutiny, re-use (and therefore avoiding duplication of research) and to understand the bigger picture in particular areas of research. Data sharing in this way is usually anonymised (so that you could not be identified) but if we need to share identifiable information we will seek your consent for this and ensure it is secure. You will be made aware then if the data is to be shared with countries whose data protection laws differ to those of the UK and how we will protect your confidentiality.

Although what your child says to us is confidential, should your child disclose anything to us which we feel puts your child or anyone else at any risk, we may feel it necessary to report this to the appropriate persons.

What will happen if my child doesn't want to carry on with the study?

Your child's participation is voluntary. You are free to withdraw any time, without giving any reason, and without their care or legal rights being affected. If you withdraw up to one week after the interview, your child's data can be withdrawn from the study and will not be used in the analysis. Should you withdraw after this time period then the information collected so far cannot be erased and that this information may still be used in the project analysis.The reason for this is because after one week the interviews will have been sent for transcription. If you withdraw after this time period, we will no longer collect any information about your child or from you but we will keep the information about your child that we have already obtained

as we are not allowed to tamper with study records and this information may have already been used in some analyses and may still be used in the final study analyses. To safeguard yours and your child's rights, we will use the minimum personally-identifiable information possible. You or your child does not need to give a reason to withdraw from the study and your legal rights will not be affected.

What will happen to the results of the research study?

The transcripts from your child's interview will be anonymised, collated with other participants' responses, and analysed to produce a set of findings. These anonymised transcripts may also be looked at by other researchers in the University of Nottingham. The findings will be summarised and reported in Danielle Hills's Doctorate in Clinical Psychology thesis. A copy of this thesis will be available at the University of Nottingham library. Findings may also be submitted for publication in an academic or professional journal and/or may be presented at any relevant conferences or events. Direct quotations from your interview may be used in any reports or publications; however, these will be anonymised so that your child cannot be identified.

Who is organising and funding the research?

This research is forming part of a Doctorate in Clinical Psychology qualification at The University of Nottingham and is sponsored by The University of Nottingham.

Who has reviewed the study?

All research in healthcare is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed by the Health Research Authority West of Scotland Research Ethics Committee.

What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions. The researchers' contact details are given at the end of this information sheet. If you remain unhappy and wish to complain formally, you can do this by contacting;

[REMOVED]

In the event that something does go wrong and your child is harmed during the research and this is due to someone's negligence then you may have grounds for a legal action for compensation against the University of Nottingham but you may have to pay your legal costs. The normal National Health Service complaints mechanisms will still be available to you.

Further information and contact details

If you require any further information about this study, please do not hesitate to contact us on the details below:

Danielle Hills
Principal Investigator/Trainee Clinical Psychologist
E-mail: [REMOVED]
Dr Mark Hudson
Chief Investigator and Research Supervisor/ Clinical Psychologist
E-mail: [REMOVED]

Appendix F

Contact Details Form

Contact Details Form
(Final Version 1.0: 13/12/2021, IRAS ID: 307581)

Title of Study: A Mental Health Crisis: Experiences of Young People (YP), Parents and Carers, and Professionals.

Name of Researcher: Danielle Hills
Thank you for taking the time to read the information and expressing interest in taking part in the study. The purpose of this form is so that the CAMHS clinician can pass your details onto the researcher. The researcher will then use these contact details to make initial contact with you within 7 working days. By filling in this form you give permission for the CAMHS clinician to send this form to the researcher and for the researcher to make initial contact with you. If you are under the age of 16, please get your parent/carer to write their contact details on this form.

I am a young person (under 16 years)/ young person (16+ years)/ parent and/or carer wanting to take part in the study. *(Delete as appropriate)*

Name of Participant:

Date of Birth of Participant:

Name of Parent/Carer (if young person is under 16 years old as we need a parent/carer present at the telephone call):

Phone number:

Can a voice mail be left, if no answer *(Delete as appropriate)*: Yes/No

E-mail address:

The best time to contact me is: Morning (8am-12) / Afternoon (12-5pm). The best days to contact me on are: Mon/Tues/Wed/Thurs/Fri

Please give this form back to the CAMHS Clinician.

For the CAMHS Clinician to fill in:

Name of Community CAMHS Professional:

Your email address:

Contact Number for Community CAMHS Service:

This form will now be sent to the researcher. The participant will be contacted within 7 working days.

Appendix G

Parent/Carer Consent form for under 16s

Study Identification:

CONSENT FORM FOR PARENTS OF YOUNG PEOPLE UNDER 16
(Final Version 1.1: 28/01/2022, IRAS ID: 307581)

Title of Study: A Mental Health Crisis: Experiences of Young People (YP), Parents and Carers, and Professionals.

Name of Researcher: Danielle Hills

Name of Parent/Carer with Parental Responsibility who is consenting:

Name of Participant (Child):

Please initial box

1. I confirm that I have read and understand the information sheet version number 1.1 dated 28.01.22 for the above study and have had the opportunity to ask questions. ☐
2. I understand that my child's participation is voluntary and that they/we are free to withdraw any time, without giving any reason, and without their care or legal rights being affected. I understand that if they/we withdraw up to one week after the interview, my child's data can be withdrawn from the study and will not be used in the analysis. I understand that should they/we withdraw after this time period then the information collected so far cannot be erased and that this information may still be used in the project analysis. ☐
3. I understand that the data collected in the study may be looked at by authorised individuals from the University of Nottingham, the research team and regulatory authorities where it is relevant to my taking part in this study. I give permission for these individuals to collect, store, analyse and publish information obtained from my participation in this study. I understand that my child's personal details will be kept confidential. ☐
4. I understand that the interview will be audio-recorded and transcribed by the University of Nottingham Transcription service or the researcher. Also, anonymous direct quotes from the interview may be used in the study reports. ☐
5. I understand that my child's conversation with the researcher will be kept private unless the researcher is worried about their safety or the safety of someone else or they are discussing the research with the other researchers involved in this project. If the researcher is worried, they will tell the appropriate people and will try to inform my child about this, where possible. ☐
6. I understand that my child's named CAMHS clinician will be informed that they have taken part in this research, but will not be informed about what they discussed, unless the researcher is worried. This is so they can offer my child support if needed. ☐
7. I agree for my child (named above) to take part in the above study. ☐
8. I would like my contact details to be kept on file so I can be emailed a copy of the research findings. ☐

Name of Parent	Date	Signature
Name of Person taking consent	Date	Signature

Appendix H

Assent Form

Study Identification:

YOUNG PERSON ASSENT FORM
(Final Version 1.1: 28/01/2022, IRAS ID: 307581)

Title of Study: A Mental Health Crisis: Experiences of Young People (YP), Parents and Carers and Professionals.

Name of Researcher: Danielle Hills

Name of Participant (your name):

Please put your initials in the box

1. I have read the information sheet version 1.1, date: 28.01.22 and I understand what taking part involves. I have been able to ask questions about the study and have them answered. ☐
2. I understand that it is my decision if I take part or not and that my decision will not affect my care. ☐
3. I understand that my parent/carer or I can change our minds about taking part at any time and we don't have to give a reason. If I change my mind about taking part up to one week after the interview, my data will not be used in the study. However, if I change your mind after this time, the data will not be able to be removed but I will no longer be contacted by the research team. ☐
4. I understand that the data collected in the study may be looked at by people from the University of Nottingham, the research team and professionals involved in making sure research is done correctly. I understand that my personal details will be kept private. ☐
4. I understand that my conversation with the researcher will record only our voices (the video will not be recorded) and that the researcher might use some of my words in the report to explain the findings but my name and any other information which could identify me will be changed so it stays anonymous. The interview will be written up by either the University of Nottingham Transcription service or the researcher. ☐
5. I know that my parent/carer has had to give their permission for me to take part in this study. ☐
6. I understand that my conversation with the researcher will be kept private unless the researcher is worried about my safety or the safety of someone else or they are discussing the research with the other researchers involved in this project. If the researcher is worried, they will tell the appropriate people and will try to inform me about this, where possible. ☐
7. I understand that my CAMHS clinician will be informed that I have taken part in this research, but will not be told about what I discussed, unless the researcher is worried. This is so they can offer me support if needed. ☐
8. I am happy to take part in the study. ☐

Name of Participant _____ Date _____ Signature _____

Appendix I

Parent/Carer Participant Information Sheet

Parent and Carer Participant Information Sheet
(Final Version 1.2: 29/04/2022, IRAS ID: 307581)
Name of Researcher: Danielle Hills
Chief Investigator: Dr Mark Hudson

Study Title
A Mental Health Crisis: Experiences of Young People (YP), Parents and Carer, and Professionals.

Introduction
I am a Trainee Clinical Psychologist based at the University of Nottingham completing a Doctorate in Clinical Psychology. I would like to invite you to take part in my research study. Before you decide, I would like you to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully. Please feel free to talk to others about the study if you wish. If anything is not clear, please ask me.

What is the study about?
Mental health crisis care for children and young people is a current focus within the NHS and is currently developing. The purpose of this study is to understand the experience of being in a mental health crisis for young people from the perspectives of young people, professionals and parents/carers. Through exploring multiple perspectives, we would like to gain an understanding of how mental health crises are conceptualised and the experience of being in a mental health crisis for young people. This study is being undertaken as a thesis for part of a Doctorate in Clinical Psychology.

Why have I been invited?
I would like to interview parents or carers who care for a young person that has experienced a mental health crisis. The young person must be aged 13-17 and have accessed the Child and Adolescent Mental Health Service (CAMHS) Crisis Team. The young person must have been discharged from the CAMHS crisis team in the last 12 months. You must be the primary caregiver for the young person. We are inviting 4 to 5 other participants like you to take part.

What will happen to me if I take part?
If you decide after reading this information sheet that you are interested in taking part in this research your CAMHS clinician will ask for your permission for them to pass on your details to the researcher so the researcher can get into contact with you by telephone. If you do give permission, you will be asked to fill in a form to record your contact details. Then, the following steps will be taken:

1. The CAMHS clinician will pass your contact details onto the researcher. The researcher will contact you within 7 working days by telephone to book in a 20-minute telephone call to go through this information sheet and answer any questions.
2. During the 20-minute telephone call, if you decide you would like to take part, then you will be asked to give your informed consent by filling in a consent form. The consent form can be returned to the researcher electronically via email or can be returned at your child's next routine CAMHS appointment. If you provide consent, an interview appointment will be booked in. You will be asked

if you would like your interview to be online, via a programme called Microsoft Teams, or face-to-face.

3. Two days prior to your interview appointment you will be contacted by the researcher to remind you of your appointment.
4. The appointment will last approximately 60-minutes. There will be a 45-mintue interview which involve the researcher asking some demographic questions and questions about your experience of caring for a young person who has experienced a mental health crisis. The interviews will be audio-recorded. The interviews will be audio-recorded and will be transcribed either by the researcher or the University of Nottingham Transcription Service.
5. Immediately after the interview, you will be offered a 15-minute space to de-brief to discuss the interview and if anything has come up for you.

Do I have to take part?

No. It is up to you to decide whether or not to take part. If you do not decide to take part you will have no further contact with the study.

Expenses

Participants will not be paid to participate in this study. However, if interviews take place face-to-face, any reasonable travel expenses will be offered for any visits incurred as a result of participation.

What are the possible disadvantages and risks of taking part?

It is expected that the potential disadvantages of taking part in this study would be minimal. Some of the information discussed might be sensitive and/or distressing as we will be talking about your experiences of supporting a young person in crisis. There will be a space at the end of the interview to de-brief.

What are the possible benefits of taking part?

There may not be any direct benefits for you, although some people find it is helpful talking about their experiences. It is hoped that the results from the research will contribute to gaining a more thorough understanding of the experience of a mental health crisis for children and young people from multiple perspectives. Consequently, this study hopes to provide a contribution to developing knowledge in this area and developments in crisis service provision for young people.

What happens when the research study stops?

The interview is a one-off interview therefore you will not be contacted after the interview. However, you will have the option to leave your email address to be directly informed about the results from the study.

Will my taking part in the study be kept confidential?

We will follow ethical and legal practice and all information about you will be handled in confidence.

If you join the study, we will use information collected from you during the course of the research. This information will be kept **strictly confidential**, stored in a secure and locked office, and on a password protected database at the University of Nottingham. Under UK Data Protection laws the University is the Data Controller (legally responsible for the data security) and the Chief Investigator, named above, is the Data Custodian (manages access to the data). This means we are responsible for looking after your information and using it properly. Your rights to access, change or move your information are limited as we need to manage your information in specific ways to comply with certain laws and for the research to be reliable and accurate. To safeguard your rights, we will use the minimum personally – identifiable

information possible. You can find out more about how we use your information and to read our privacy notice at: https://www.nottingham.ac.uk/utilities/privacy.aspx.

The data collected for the study will be looked at and stored by authorised persons from the University of Nottingham who are organising the research. They may also be looked at by authorised people from regulatory organisations to check that the study is being carried out correctly. All will have a duty of confidentiality to you as a research participant and we will do our best to meet this duty.
As the interviews are audio-recorded, they will be typed up word for word (transcripts) and the transcripts will not contain any identifiable information (such as staff or family members names). A transcription service will be used to write up the interviews. The researcher may also write up some interviews. In this instance, the transcription service will be required to sign a confidentiality agreement prior to having any access to the interview in order to ensure confidentiality is maintained. All data will be kept securely for 7 years. After this time your data will be disposed of securely. During this time all precautions will be taken by all those involved to maintain your confidentiality, only members of the research team given permission by the data custodian will have access to your personal data. Direct quotes may be used in the write up of this study, however, they will be anonymised and you will not be able to be identified.

In accordance with the University of Nottingham's, the Government's and our funders' policies we may share our research data with researchers in other universities and organisations, including those in other countries, for research in health and social care. Sharing research data is important to allow peer scrutiny, re-use (and therefore avoiding duplication of research) and to understand the bigger picture in particular areas of research. Data sharing in this way is usually anonymised (so that you could not be identified) but if we need to share identifiable information we will seek your consent for this and ensure it is secure. You will be made aware then if the data is to be shared with countries whose data protection laws differ to those of the UK and how we will protect your confidentiality.

Although what you say to us is confidential, should you disclose anything to us which we feel puts you or anyone else at any risk, we may feel it necessary to report this to the appropriate persons following local policies.

What will happen if I don't want to carry on with the study?

Your participation is voluntary. You are free to withdraw any time, without giving any reason, and without their care or legal rights being affected. If you withdraw up to one week after the interview, your data can be withdrawn from the study and will not be used in the analysis. Should you withdraw after this time period then the information collected so far cannot be erased and that this information may still be used in the project analysis. The reason for this is because after one week the interviews will have been sent for transcription (will be typed up word for word). If you withdraw after this time period, we will no longer collect any information about you or from you but we will keep the information about you that we have already obtained as we are not allowed to tamper with study records and this information may have already been used in some analyses and may still be used in the final study analyses. To safeguard your rights, we will use the minimum personally-identifiable information possible. You do not need to give a reason to withdraw from the study and your legal rights will not be affected.

What will happen to the results of the research study?

The transcripts from your interview will be anonymised, collated with other participants' responses, and analysed to produce a set of findings. These anonymised transcripts may also be looked at by other researchers in the University of Nottingham. The findings will be summarised and reported in Danielle Hills's Doctorate in Clinical Psychology thesis. A copy of this thesis will be available at the University of

Nottingham library. Findings may also be submitted for publication in an academic or professional journal and/or may be presented at any relevant conferences or events. Direct quotations from your interview may be used in any reports or publications; however, these will be anonymised so that you cannot be identified.

Who is organising and funding the research?

This research is forming part of a Doctorate in Clinical Psychology qualification at The University of Nottingham and is sponsored by The University of Nottingham.

Who has reviewed the study?

All research in healthcare is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed by the Health Research Authority West of Scotland Research Ethics Committee.

What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions. The researchers' contact details are given at the end of this information sheet. If you remain unhappy and wish to complain formally, you can do this by contacting;

[REMOVED]

In the event that something does go wrong and you are harmed during the research and this is due to someone's negligence then you may have grounds for a legal action for compensation against the University of Nottingham but you may have to pay your legal costs. The normal National Health Service complaints mechanisms will still be available to you.

Further information and contact details

If you require any further information about this study, please do not hesitate to contact us on the details below:

Danielle Hills
Researcher/Trainee Clinical Psychologist
E-mail: [REMOVED]

Dr Mark Hudson
Chief Investigator and Research Supervisor/ Clinical Psychologist
E-mail: [REMOVED]

Appendix J

Debrief Sheets

Young People's Participant Debrief Sheet
(Final Version 1.0: 13/12/2021, IRAS ID: 307581)

Title of Study: A Mental Health Crisis: Experiences of Young People (YP), Parents and Carers and Professionals.

Name of Researcher: Danielle Hills

We'd like to thank you for taking part in our research study. This research will be really helpful information and will hopefully broaden our understanding of what it means to be in a mental health crisis for children and young people. Please discuss with the researcher any concerns that this interview has brought up for you. I am now going to write up what I found out in my study. As we discussed, I will not use your real name or any other personal information you gave me. If you would like a summary of the study and the findings, please let the researcher know and a copy can be emailed to you on the email address you provided at the start of the study.

Questions

If you have any further questions about the study, please feel free to ask the researcher before you finish or alternatively contact the researcher at any time via email [REMOVED] or the researcher's supervisor, Dr Mark Hudson [REMOVED]

Further help and support

If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions. The researchers' contact details are given at the end of this information sheet. If you remain unhappy and wish to complain formally, you can do this by contacting:

[REMOVED]

If you have been affected by any of the issues raised by taking part in this study the following organisations may be able to provide help and advice:

- Your GP
- Your CAMHS Clinician
- Samaritans: 116 123
- Mind: 0300 123 3393
- Young Minds Crisis Messenger: Text YM to 85258, text helpline.
- ChildLine, Tel: 0800 1111 (free), Website: www.childline.org.uk
- Kooth: Website: www.kooth.com, online counselling service.
- Emergency Services: 999
- Non-emergency number:111

CAMHS Crisis Professional Participant Debrief Sheet
(Final Version 1.0: 13/12/2021, IRAS ID: 307581)

Title of Study: A Mental Health Crisis: Experiences of Young People, Parents and Carers and Professionals.

Name of Researcher: Danielle Hills
We'd like to thank you for taking part in our research study. This research will provide **important** information and broaden our understanding of what it means to be in a mental health crisis for children and young people. Please discuss with the researcher any concerns that this interview has brought up for you. I am now going to write up what I found out in my study. As we discussed, I will not use your real name or any other personal information you gave me. If you would like a summary of the study and the findings, please let the researcher know and a copy can be emailed to you on the email address you provided at the start of the study.

Questions
If you have any further questions about the study, please feel free to ask the researcher before you finish or alternatively contact the researcher at any time via email [removed] or the researcher's supervisor, Dr Mark Hudson [removed]

Further help and support
If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions. The researchers' contact details are given at the end of this information sheet. If you remain unhappy and wish to complain formally, you can do this by contacting:

[REMOVED]

If you have been affected by any of the issues raised by taking part in this study the following organisations may be able to provide help and advice:

- Your NHS Trust Employee Welfare Support System
- Your GP
- Samaritans: 116 123
- Mind: 0300 123 3393
- NHS: 111

Parent/Carer Participant Debrief Sheet
(Final Version 1.0: 13/12/2021, IRAS ID: 307581)

Title of Study: A Mental Health Crisis: Experiences of Young People (YP), Parents and Carers, and Professionals.

Name of Researcher: Danielle Hills

We'd like to thank you for taking part in our research study. This research will provide crucial information and broaden our understanding of what it means to be in a mental health crisis for children and young people. Please discuss with the researcher any concerns that this interview has brought up for you. I am now going to write up what I found out in my study. As we discussed, I will not use your real name or any other personal information you gave me. If you would like a summary of the study and the findings, please let the researcher know and a copy can be emailed to you on the email address you provided at the start of the study.

Questions

If you have any further questions about the study, please feel free to ask the researcher before you finish or alternatively contact the researcher at any time via email [removed]or the researcher's supervisor, Dr Mark Hudson [Removed]

Further help and support

If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions. The researchers' contact details are given at the end of this information sheet. If you remain unhappy and wish to complain formally, you can do this by contacting:

[removed]

If you have been affected by any of the issues raised by taking part in this study the following organisations may be able to provide help and advice:

- Your GP
- Samaritans: 116 123
- Mind: 0300 123 3393
- Young Minds Parent Helpline: 0808 802 554

Appendix K

Interview Schedules

Interview Schedule for Young People (IRAS ID: 307581)

Introduction

- Complete introductions for those present in interview.
- Explain confidentiality and limitations.
- Inform participant that the interview can be stopped at any point for a break. There will be a 15-minute space to de-brief at the end of the interview.
- Explain the structure of the 45- minute interview.
- Opportunity to ask any questions.

Background Information

- Age:
- Gender:
- Ethnicity:
- How many months/years have you been in contact with mental health services for?

Questions and possible follow-up questions

- Tell me about the experience that led you to becoming involved with the CAMHS Crisis Team?
  - How did you make sense of what was happening?
- What do you think a mental health crisis is?
  - How would you describe a mental health crisis to a young person who has not experienced one before?
  - What do you think contributes to a mental health crisis?
- What was it like to be in a mental health crisis?
  - How did you make of what was happening?
  - If you did notice, how did you know you were in crisis?
  - If you received support, how did you find the timing of the support you got?
  - What do you think are/were the signs of recovery from a mental health crisis? If you feel you are in recovery, how did you recover and what helped you move towards recovery?
- Tell me about how you think others around you, such as professionals or parents/carers, made sense of the mental health crisis.
  - How did those around you make sense of what was happening?
  - If you felt you were offered support, how did others support you through a mental health crisis?
  - If anything, what would you consider as being helpful whilst you were experiencing a mental health crisis?
  - If anything, what would you consider as being unhelpful whilst you were experiencing a mental health crisis?
- What do you feel it is important for others to understand about mental health crisis for young people?
- Is there anything else you would like to say about your experiences?

Prompts:

- For chronology- okay, and then what happened next?

- For detail- can you give me an example of that.
- For clarification- I want to make sure I am understanding you correctly, can you explain that some more for me.
- For explanation – how come…? why is that so?

Interview Schedule for CAMHS Crisis Professional (IRAS ID: 307581)

Introduction

- Complete introductions for those present in interview.
- Explain confidentiality and limitations.
- Discuss nature of distressing information and inform participant that the interview can be stopped at any point for a break. There will be a 15-minute space to de-brief at the end of the interview.
- Explain the structure of the 45- minute interview.
- Opportunity to ask any questions.

Background Information

- Age:
- Gender:
- Ethnicity:
- How many years have you worked with young people in crisis for?
- What is your professional role?

Possible Questions and follow-up questions

- Based on your experiences of working with young people, what is a mental health crisis?
  - Describe the key features of a mental health crisis.
  - From your experiences of working with young people in crisis, what do you think contributes to a mental health crisis?
  - From your experience of working with young people in crisis, what would you consider as the commonalities in the mental health crisis experiences of young people you have worked with?
- From your experience of working with young people in crisis, what are the signs that a young person is starting to experience a mental health crisis?
  - What do you think this feels like for young people?
  - How would you differentiate between a young person who is experiencing a mental health crisis and a young person who is not experiencing a mental health crisis?
  - What do you think are the signs of recovery from a mental health crisis?
- Tell me about what you feel your role is when working with young people experiencing a mental health crisis.
  - If any, what are the challenges to carrying out this role?
  - Based on your experiences, how do you support a young person through a mental health crisis?
  - What do you feel the role of the family/caregivers are in a mental health crisis?
- What do you feel it is important for others to understand about mental health crisis for young people?
- Is there anything else you would like to say about your experiences?

Prompts:

- For chronology- okay, and then what happened next?
- For detail- can you give me an example of that?
- For clarification- I want to make sure I am understanding you correctly, can you explain that some more for me.
- For explanation – how come…? why is that so?

Interview Schedule for Parents/Carers (IRAS ID: 307581)

Introduction

- Complete introductions for those present in interview.
- Explain confidentiality and limitations.
- Inform participant that the interview can be stopped at any point for a break. There will be a 15-minute space to de-brief at the end of the interview.
- Explain the structure of the 45- minute interview.
- Opportunity to ask any questions.

Background Information

- Age:
- Gender:
- Ethnicity:
- What is your relationship to the young person who has experienced a mental health crisis?
- How many months/years has the young person been in mental health services?

Questions and possible follow-up questions

- Tell me about the experience that led you to becoming involved with the CAMHS Crisis Team?
  - What sense did you make of what was happening?
- What do you think a mental health crisis is?
  - How would you describe a mental health crisis for a young person to a parent/carer who has not cared for a young person experiencing one before?
  - What do you think contributes to a mental health crisis for young people?
- How did you know that the young person you were caring for was in crisis?
  - What signs did you notice?
  - What do you think are/were the signs of recovery from a mental health crisis for the young person you were caring for? What helps young people move towards recovery from a crisis?
- Tell me about your experience of caring for a young person in a mental health crisis.
  - How do you support a young person through a mental health crisis?
  - If anything, what would you consider as being helpful whilst you were caring for a young person experiencing a mental health crisis?
  - If anything, what would you consider as being unhelpful whilst you were caring for a young person experiencing a mental health crisis?
- What do you feel it is important for others to understand about mental health crisis for young people?
- Is there anything else you would like to say about your experiences?

Prompts:

- For chronology- okay, and then what happened next?
- For detail- can you give me an example of that?
- For clarification- I want to make sure I am understanding you correctly, can you explain that some more for me.
- For explanation – how come…? why is that so?

Appendix L

Example of Inductive Coding

Kathryn: They don't know how to communicate their feelings or how to tolerate those intense feelings of grief or sadness. So they have this thought that I'd be better off dead and they act on it. And I think that's possibly something to do with, sort of.I don't know if maturity is the right word, but sort of. I think, I think it is, you know, as an adult you'd be able to sort of reflect a little bit more and think and understand grief and sadness a bit more, whereas I think it's such a young children they don't, they don't have that insight into that. This will pass. And then I think if you add a few other difficult things in their life, then that's what makes them so impulsive. And I think because they've seen a lot on social media and are aware that people do this and like, you know, when I was at secondary school and in year nine. So what like 12-13 years old I had no idea about taking an overdose or self harming um where is the kids these days they do. They all look like majority of them have had friends that have done it and I think once you plant that seed in someone's head as well, it's even harder to resist it.	Lacking skills to express emotion Unable to tolerate feelings perceived as negative Suicidal ideation as a way to escape feeling Adolescence means they cannot reflect like adults Lack of insight that emotions come and go Struggle to understand emotion Stressors contribute to overwhelm and impulsive decisions Learn ways to harm self on social media Social media is an opportunities for YP to learn how to hurt themselves Social media increases peer influence

Appendix M

Example of Deductive Coding

M: not speaking about something, keeping it all to yourself. I: Yeah, and why might that be? M: Because it seems to build up and then you don't really know how to get out of it after it's a bit too much. I: Mmm OK. So kind of that building up and then kind of feeling stuck and my understanding that yeah, that, right and and then what happens next? M: I Think you try and get out of it in an unhealthy way which then leads to the crisis. I: OK. So that's the kind of build up to to the crisis?Kind of why do you think that's so? M: You don't really know what else to do, really. Seems like the only thing reasonable.It's quite a lot at the time, but when you reflect on it, it gets easier. But at the time it just seems like there's so much going off and you just Feel like you are stuck? I: Yeah, yeah. And what goes kind of how Were you, how were you kind of aware of what was happening and that kind of that feeling stuck? M: Um.I think it's because I was more all on my own and I just felt.I didn't know who to talk to or what to do, so I was just.	Lack of opportunity for attunement due to withdrawal Moving to a state of disequilibrium, feelings of stuckness Point of disequilibrium is started, risk behaviour as communication Old coping mechanisms not working Loss of communication – system instability

Appendix N

Example Coding/Themes Spreadsheet to demonstrate process

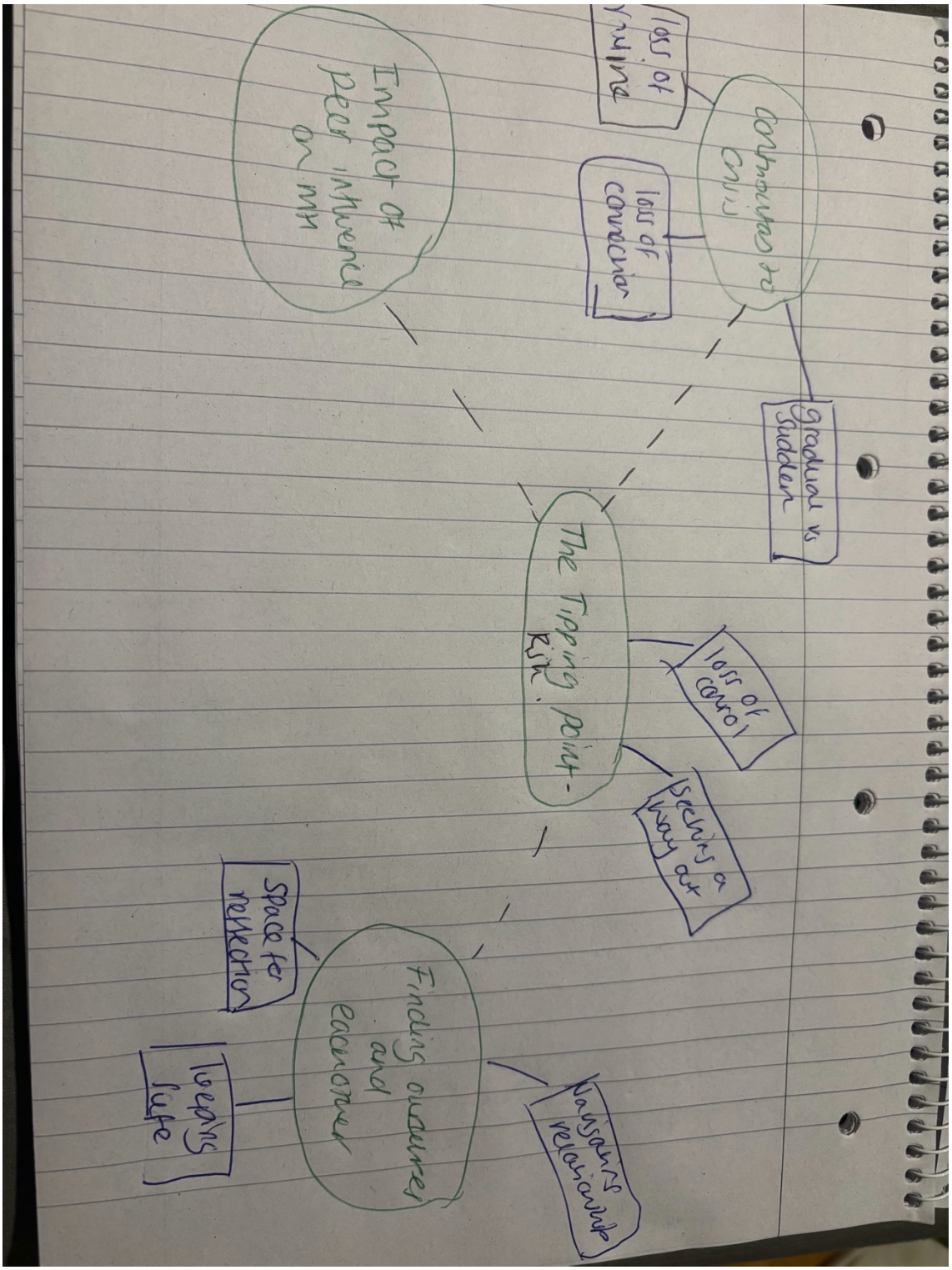
100	Laura	214	Crisis management is risk focused	risk focused
101	Laura	226	Risk assessment are conducted subjectively	determining risk is subjective
102	Laura	238	Recovery is seeing young people become more connected and confident	recovery is about building connection
103	Laura	252	Recovery is about changing relationship with stressors	recovery is about navigating relationships
104	Laura	271	Recovery is demonstrating more rational thinking	recovery is rational thinking
105	Laura	276	Recovery is reflecting on how one would have responded to things and not doing that	space for reflection
106	Laura	302	Supporting young people to problem solve	building confidence in problem solving
107	Laura	340	Compassion, listening and empathy are key	empathy and compassion
108	Laura	346	Importance of offering space to children in crisis	space for reflection
109	Laura	350	Therapeutic alliance supports recovery	therapeutic alliance supports recovery
110	Laura	362	Emotional burden of caring for someone in a crisis	emotional burden as a carer role
111	Laura	392	Offering a supportive space to young people is important	reflective space
112	Laura	401	The crisis team supports parents to support their children	building parent-child relationships
113	Laura	411	Parents role is to maintain safety	parents job to maintain safety
114	Laura	415	Parents need to implement boundaries	boundaries to contain crisis

All Codes | Kathryn | Aniya | Hazel | Charlotte | Laura | Trisha | Carmel | Tilly | Samantha | Maisie

Noticing/Not Noticing onset of crisis	Kathryn	263	Crisis is gradual	crisis is gradual
	Kathryn	273	The start of a crisis often goes unnotic	crisis is un noticed
	Kathryn	278	A crisis is when it is too late and everything has f	crisis is unnoticed
	Kathryn	298	Escalation to a crisis point happens quickly in chil	crisis is sudden
	Laura	177	Crisis is a gradual emotional experienc	crisis is noticing gradual emotional chang
	Trisha	57	Build up to suicide attempt	crisis is gradual
	Trisha	138	Crisis was gradual and risk was gradual	crisis is gradual
	Trisha	160	Crisis is secretive	crisis is hidden
	Trisha	316	Crisis is gradual	crisis is gradual
	Trisha	337	Didn't recognise the crisis until after it	not noticing crisis
	Tilly	154	Struggle to notice signs of crisis	crisis unnoticed
	Samantha	262	Crisis was gradual but not noticed at ti	crisis unnoticed
	Samantha	268	Crisis is gradual	crisis is gradual
	Maisie	95	Crisis is gradual	crisis is gradual
	Maisie	251	Crisis is gradual	crisis is gradual
	Carmel	176	No signs to MH crisis	unnoticed crisis
	Kathryn	271	Warning signs to a crisis can be low lev	subtle signs of crisis
	Trisha	200	Gradual signs of being in a crisis	gradual crisis

Appendix O

Initial Thematic Map



Appendix P

First Author CASP

Section A Are the results valid?	
1. Was there a clear statement of the aims of the research?	☒ Yes ☐ No ☐ Can't Tell The aim is stated clearly at the end of the introduction and rationale is given.
CONSIDER: • *what was the goal of the research?* • *why was it thought important?* • *its relevance*	
2. Is a qualitative methodology appropriate?	☒ Yes ☐ No ☐ Can't Tell Exploration of subjective experiences hence qualitative methodology was appropriate
CONSIDER: • *If the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants* • *Is qualitative research the right methodology for addressing the research goal?*	
3. Was the research design appropriate to address the aims of the research?	☒ Yes ☐ No ☐ Can't Tell Research used 3 groups of participants to capture holistic understanding of the research question.
CONSIDER: • *if the researcher has justified the research design (e.g., have they discussed how they decided which method to use)*	
4. Was the recruitment strategy appropriate to the aims of the research?	☒ Yes ☐ No ☐ Can't Tell Recruitment strategy is clearly stated. Discussion around why recruitment target was not met.
CONSIDER: • *If the researcher has explained how the participants were selected*	

• *If they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study* • *If there are any discussions around recruitment (e.g. why some people chose not to take part)*	
5. Was the data collected in a way that addressed the research issue?	☒ Yes ☐ No ☐ Can't Tell
CONSIDER: • *If the setting for the data collection was justified* • *If it is clear how data were collected (e.g. focus group, semi-structured interview etc.)* • *If the researcher has justified the methods chosen* • *If the researcher has made the methods explicit (e.g. for interview method, is there an indication of how interviews are conducted, or did they use a topic guide)* • *If methods were modified during the study. If so, has the researcher explained how and why* • *If the form of data is clear (e.g. tape recordings, video material, notes etc.)* • *If the researcher has discussed saturation of data*	
6. Has the relationship between researcher and participants been adequately considered?	☒ Yes ☐ No ☐ Can't Tell Positionality was explored and quality checks were implemented.
CONSIDER: • *If the researcher critically examined their own role, potential bias and influence during (a) formulation of the research questions (b) data collection, including sample recruitment and choice of location* • *How the researcher responded to events during the study and whether they considered the implications of any changes in the research design*	
Section B: What are the results?	
7. Have ethical issues been taken into consideration?	☒ Yes ☐ No ☐ Can't Tell Ethical consideration was provided. Ethical issues associated working with CYP has been explored.
CONSIDER:	

• *If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained* • *If the researcher has discussed issues raised by the study (e.g. issues around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study)* • *If approval has been sought from the ethics committee*	
8. Was the data analysis sufficiently rigorous?	☒ Yes ☐ No ☐ Can't Tell The analysis process was described thoroughly and examples of coding were provided. All findings were supported by quotes. Contradictory data was captured in themes.
CONSIDER: • *If there is an in-depth description of the analysis process* • *If thematic analysis is used. If so, is it clear how the categories/themes were derived from the data* • *Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process* • *If sufficient data are presented to support the findings* • *To what extent contradictory data are taken into account* • *Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation*	
9. Is there a clear statement of findings?	☒ Yes ☐ No ☐ Can't Tell Clearly stated in discussion
CONSIDER: • *If the findings are explicit* • *If there is adequate discussion of the evidence both for and against the researcher's arguments* • *If the researcher has discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst)* • *If the findings are discussed in relation to the original research question*	
Section C: Will the results help locally?	
10. How valuable is the research?	☒ Yes ☐ No ☐ Can't Tell Novel study and findings have strong clinical applicability. New research areas are identified and findings are considered in relation to current policy.
CONSIDER: • *If the researcher discusses the contribution the study makes to existing knowledge or understanding (e.g., do they consider the findings in relation to current practice or policy, or relevant research-based literature* • *If they identify new areas where research is necessary*	

- *If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used*

Appendix Q
Independent Researcher CASP

Section A Are the results valid?	
11. Was there a clear statement of the aims of the research?	☒ Yes ☐ No ☐ Can't Tell The aim is stated clearly and a clear rationale is provided. The introduction lends clear thought to why this is the aim of the research and provides helpful context.
CONSIDER: • *what was the goal of the research?* • *why was it thought important?* • *its relevance*	
12. Is a qualitative methodology appropriate?	☒ Yes ☐ No ☐ Can't Tell The use of qualitative methodology is appropriate and is justified on multiple levels. Such as exploration of direct experiences, subjective experiences and wanting to explore conceptualisation. This methodology is appropriate to address the aim of the research.
CONSIDER: • *If the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants* • *Is qualitative research the right methodology for addressing the research goal?*	
13. Was the research design appropriate to address the aims of the research?	☒ Yes ☐ No ☐ Can't Tell The research design was appropriate to address the aim. The use of a qualitative approach, including semi-structured interviews with specific consideration given for CYP was noted. The use of TA and a hybrid inductive-deductive approach was appropriate at addressing the aim.
CONSIDER: • *if the researcher has justified the research design (e.g., have they discussed how they decided which method to use)*	
14. Was the recruitment strategy appropriate to the aims of the research?	☒ Yes ☐ No ☐ Can't Tell Whilst there were difficulties in recruitment, the approach was appropriate given the population. The limitations to the recruitment strategy were reflected upon and consideration is given as to why the recruitment target was not met.
CONSIDER: • *If the researcher has explained how the participants were selected*	

• *If they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study* • *If there are any discussions around recruitment (e.g. why some people chose not to take part)*	
15. Was the data collected in a way that addressed the research issue?	☒ Yes ☐ No ☐ Can't Tell Extensive and thorough detail provided on data collection and examples of resources used.
CONSIDER: • *If the setting for the data collection was justified* • *If it is clear how data were collected (e.g. focus group, semi-structured interview etc.)* • *If the researcher has justified the methods chosen* • *If the researcher has made the methods explicit (e.g. for interview method, is there an indication of how interviews are conducted, or did they use a topic guide)* • *If methods were modified during the study. If so, has the researcher explained how and why* • *If the form of data is clear (e.g. tape recordings, video material, notes etc.)* • *If the researcher has discussed saturation of data*	
16. Has the relationship between researcher and participants been adequately considered?	☒ Yes ☐ No ☐ Can't Tell Extended reflection was provided on the research process.
CONSIDER: • *If the researcher critically examined their own role, potential bias and influence during (a) formulation of the research questions (b) data collection, including sample recruitment and choice of location* • *How the researcher responded to events during the study and whether they considered the implications of any changes in the research design*	
Section B: What are the results?	
17. Have ethical issues been taken into consideration?	☒ Yes ☐ No ☐ Can't Tell Ethical consideration was provided and approval was noted.
CONSIDER:	

• *If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained* • *If the researcher has discussed issues raised by the study (e.g. issues around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study)* • *If approval has been sought from the ethics committee*	
18. Was the data analysis sufficiently rigorous?	☒ Yes ☐ No ☐ Can't Tell Examples of analysis were provided, multiple quotes were provided to support claims with a wide range of viewpoints considered.
CONSIDER: • *If there is an in-depth description of the analysis process* • *If thematic analysis is used. If so, is it clear how the categories/themes were derived from the data* • *Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process* • *If sufficient data are presented to support the findings* • *To what extent contradictory data are taken into account* • *Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation*	
19. Is there a clear statement of findings?	☒ Yes ☐ No ☐ Can't Tell A clear summary to answer the research aim was provided at the start of the discussion.
CONSIDER: • *If the findings are explicit* • *If there is adequate discussion of the evidence both for and against the researcher's arguments* • *If the researcher has discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst)* • *If the findings are discussed in relation to the original research question*	
Section C: Will the results help locally?	
20. How valuable is the research?	☒ Yes ☐ No ☐ Can't Tell Clear recommendations which impact clinical practice and ones which are discussed in relation to current policy is made. The findings are discussed in relation to current research. There is clear recommendations for future research.
CONSIDER: • *If the researcher discusses the contribution the study makes to existing knowledge or understanding (e.g., do they consider the findings in relation to current practice or policy, or relevant research-based literature* • *If they identify new areas where research is necessary*	

- *If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used*

Appendix R
Ethical Approval Documents

WoSRES
West of Scotland Research Ethics Service

NHS
Greater Glasgow and Clyde

West of Scotland REC 5

Dr Mark Hudson

[redacted]

[redacted]

Please note: This is the favourable opinion of the REC only and does not allow you to start your study at NHS sites in England until you receive HRA Approval

Dear Dr Hudson

Study title:	**A MENTAL HEALTH CRISIS: EXPERIENCES OF YOUNG PEOPLE,PARENTS AND CARERS,AND PROFESSIONALS**
REC reference:	**22/WS/0008**
Protocol number:	**21081**
IRAS project ID:	**307581**

Thank you for your letter received in full on 1 February 2022, responding to the Research Ethics Committee's (REC) request for further information on the above research and submitting revised documentation.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

NHS
Health Research Authority

Dr Mark Hudson
[redacted]

Email: approvals@hra.nhs.uk

02 February 2022

Dear Dr Hudson

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**A MENTAL HEALTH CRISIS: EXPERIENCES OF YOUNG PEOPLE,PARENTS AND CARERS,AND PROFESSIONALS**
IRAS project ID:	**307581**
Protocol number:	**21081**
REC reference:	**22/WS/0008**
Sponsor	**University of Nottingham**

I am pleased to confirm that **HRA Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

A Mental Health Crisis: Experiences of Young People (YP), Parents and Carers, and Professionals

Danielle Hills, Dr Mark Hudson, Dr Anna Tickle, Dr Sarah Wilde, Barbara McGrath
Trent Doctorate in Clinical Psychology

University of Nottingham UK | CHINA | MALAYSIA

University of Lincoln

Academic Poster

Background

The number of YP presenting in a mental health crisis is increasing[1]. There is often a discrepancy between what YP define as a mental health crisis and services perceptions[2]. Crisis care is an international policy priority[3]. Hence, experiential research is required to understand the conceptualisation and experience of mental health crisis for YP to contribute to re-configurations of service provision and accessibility to services[4].

Aim: to explore the conceptualisation and experience of a mental health crisis for YP from the perspectives of YP, parents/carers and professionals.

Methodology

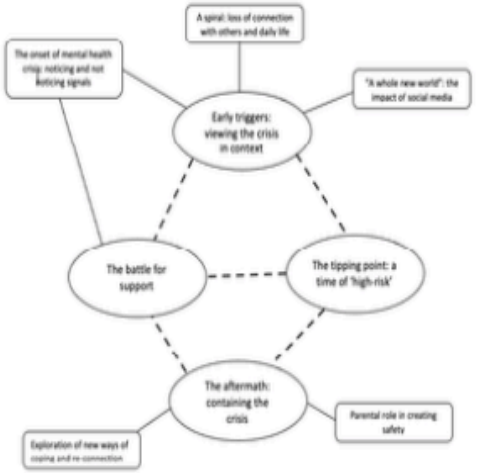
Participants: 10 participants were recruited. There were 5 CAMHS Crisis Professionals, 4 parents/carers, and 1 young person.

Procedure: All participants were recruited via NHS CAMHS Teams in two regions and individual interviews with participants were conducted.

Analysis: The audio-recorded interviews were transcribed and analysed using mixed inductive-deductive reflexive thematic analysis[5].

Findings

Four themes, alongside sub-themes were developed. Themes demonstrated mental health crisis for YP was conceptualised in a a temporal manner. Themes illustrated key indicators of direct crisis experience for YP. Professionals and parents/YP had differences in conceptualisations of crisis due to parents/YP viewing the crisis in context of their lives with early warning signs whereas professionals viewed crisis in a risk-focused discourse. All participants recognised the lack of responsive support. After the 'tipping point' attempts were made to contain the Crisis.



Conclusions

To the best of our knowledge, this is the first study to explore multiple perspectives and direct experiences of mental health crisis for YP. Findings demonstrate YP and parents/caregivers conceptualise crisis differently to professionals, which often impacts accessibility to services.

The relational themes of connection, communication, responsiveness, and availability were present throughout the crisis experience for YP. These findings should be considered by clinicians and service managers in the development of crisis prevention initiatives and considering designs of crisis services to support YP and families.

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