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An exploration of lasting responses to inpatient child and adolescent mental health care

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by

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Overview

This thesis portfolio comprises three parts:

Part One: Systematic Literature Review

Part one contains a systematic literature review which explores the experiences of caregivers who have a child they are directly caring for admitted to an inpatient child and adolescent mental health unit. A systematic search of six data bases retrieved ten suitable papers, the findings of which are presented using thematic synthesis. Themes of the roles for parents, interacting with the support network and managing a child growing up were generated. Conclusions and clinical implications for service development are discussed.

Part Two: Empirical Paper

Part two is an investigation into lasting responses of those who have previously experienced adolescent inpatient mental healthcare, considering the impact upon identity development. Five participant's interviews were analysed with narrative analysis, exploring powerlessness, being separated from the outside world, labelling, and difficult relationships. Story types following a Quest Narrative are discussed, along with stories of coping, resilience, and personal development. Clinical implications and conclusions are discussed.

Part Three: Appendices

Part three consists of appendices to support the previous parts. A reflective and epistemological statement is also included.

Total word count: 33032

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Part One – The experiences of caregivers for young people receiving care from inpatient mental health units: A systematic literature review.

This paper is written in the format ready for submission to the Journal of Family Studies.

Please see Appendix C for the Guideline for Authors.

Word Count: 10338 (excluding references)

Abstract

Internationally it is recognised that parents should be involved with the care of relatives. In the context of child mental health care, parents play a significant role in managing difficulties, and arguably should be significant in the planning of care for a child when healthcare services are involved. The benefits of parental engagement are widely documented across other clinical settings to impact both the parent and service user yet, this has not been considered for adolescents admitted to Child and Adolescent Inpatient Mental Health Units (CIMHU). Adolescents are often admitted during acute and chronic mental health difficulties. The admission is therefore likely to have an impact on the adolescent, parent, and family, as they seek to support their child within the community and whilst admitted. As parents play a primary role in the care of a child, understanding the extent that they feel involved in their care and the experience they have of the CIMHU, is vital for understanding and supporting the parent's likely distress of an admission, as well as the return of the child back to community care. Prior to this review, studies sought to explore experiences of parents from individual CIMHUs which has limited the generalisability of the experience due to the differing nature of each provision. This systematic literature review synthesises such studies to strengthen the understanding of common parental experiences when their child is admitted to a CIMHU. Ten studies were included for this review, which produced three super-ordinate themes: managing the role of a parent; the support network; and managing a child growing up. The review demonstrates the importance for parents to feel acknowledged and validated for their role within the child's care, acknowledging the difficulty of the parents' own experience, and discusses the influence of culture on the expectations for being involved in child mental health care.

Through this study, "parents" is used to describe those with parental responsibility for a child.

Introduction

The World Health Organization advocates that mental healthcare should not be limited to psychiatry but should include equal partners such as professionals from various training backgrounds, ‘informal’ mental healthcare leaders such as religious leaders and charities, families, and service users. All parties should be involved in patient care at all levels, from treatment planning through to service delivery (World Health Organization, 2013). In particular, the value of parent involvement, or those with parental responsibility, is heavily acknowledged within global healthcare policies and guidelines, yet the implementation is inconsistent and barriers are well documented (Macfarlane, 2013; Mairs & Bradshaw, 2005). Equally, the historical context of the family’s role within mental health has changed over time, with families previously experiencing blame for the mental health problems of family members, but also being expected to provide the required support (Dirik et al., 2017). Therefore, the effectiveness of family involvement is often dependent on the health systems and service’s existing values supporting the involvement of the family (Greenhalgh et al., 2004).

From a parent’s perspective, being involved in their child’s care leads to them feeling less stressed by the child’s difficulties, more equipped to manage the difficulties and assurance that they have accessed the right services (Kerbs, 2007). For this to be effective, parents need to experience high levels of engagement in the care process(Baker-Ericzén et al., 2013). Current research indicates that parent satisfaction is high when they feel that there is a strong therapeutic alliance between staff and the mental health providers, affirming the parent’s role and impact upon the child (Brinkmeyer et al., 2004; Gerson et al., 2009; Jakobsen & Severinsson, 2006; Scharer, 2002).

Most of the research for parental involvement in care is from either the professionals' or parental perspective. Within adult services, service users positively report that involving parents within their care is important, recognising that parents need to have sufficient information about the care and difficulties to be able to support (Giacco et al., 2017). However, this is more nuanced within child populations, as whilst parents are often sought for their involvement by children (Gondek et al., 2016), parents can also be described as overly intrusive, leading to children refraining from sharing information in front of them (Harper et al., 2014). These unique dynamics require close attention by staff to ensure that there is the right level of involvement from all parties within the care triad of professionals, parents, and the child. Although parental involvement has potential challenges, when parents are empowered appropriately, their involvement is widely documented to lead to better outcomes for service users (Storm & Edwards, 2013), reducing mental health symptoms (Amass et al., 2020; Sandler et al., 2011) and relapses in mental health (Falloon et al., 1999; Pilling et al., 2002), fewer hospital admissions (Falloon et al., 1999; Pharoah et al., 2010), and greater service involvement (Neely-Barnes et al., 2008). This "dance" (Hartley et al., 2022, p. 15) has yet to be considered across different CIMHUs, with studies often including only one CIMHU, (e.g., Brown, 2018; Geraghty et al., 2011; Hartley et al., 2022) limiting the understanding of how this relationship is navigated to primarily how well it is supported within that one CIMHU.

Children are often admitted to child inpatient mental health units (CIMHUs) as adolescents (Hayes et al., 2020a), to support risk and crisis (Delaney, 2017a). Whilst the child receives care for their mental health, parents are also likely to experience grief and loss about the mental health diagnosis of their child, as well as exhaustion from supporting their child (Delaney & Engels-Scianna, 1996; Gopalan et al., 2010). Ensuring that a parent's concerns are addressed, is likely to affect the child's outcomes (Salamone-Violi et al., 2017). This is important as the admission also comes at a stage of transition within the family when the adolescent child gains increasing freedom and may become materially less reliant upon parents (Carter & McGoldrick, 1989). Parents must learn how to navigate this transition; disruptions such as mental health crises are likely to impact the individual and familial developmental processes which occur during adolescence (Patterson & Garwick, 1994). Although each family will be influenced by their cultural understanding of development and definition of 'family' (McGoldrick, 1992), parents are likely to consider how they balance their role in supporting the transition to increased independence whilst also providing enough care for the child to cope with their mental health difficulties. This can have lasting effects for the relationship with their child as they move into adulthood (McGoldrick et al., 2015), suggesting that parental involvement not only can be beneficial for the CIMHU experience, but also for the longer-term outcomes of the child and stability of the family.

For this reason, family therapy has often been included within CIMHU design, recognising the significance that parents and families play in supporting and understanding the child's emotional difficulties (Palmer, 2022). Acknowledging the potential that an admission may have been due to relational difficulties or trauma within the family requires active engagement of parents to rectify the difficulties before the child can return home (Brown, 2018). The experience of those admitted to CIMHU suggests that relationships are a substantial contributory factor to the recovery and outcomes achieved, particularly when those involve collaboration (Bjønness et al., 2022; Lynch et al., 2021; Shin & Ahn, 2022). However, maintaining parent involvement can be particularly challenging for contexts which focus on risk reduction and crisis management, primarily the role of CIMHUs (Fadden, 2009). Understanding therefore how the CIMHU is experienced by parents to address the difficulties within the family is yet to be developed outside of the evaluation of single models of care.

The significance of the success of the parent, child and professionals' relationship is therefore inherently important for care beyond the CIMHU. Parents play an important role throughout the CIMHU journey, from obtaining the admission, during admission, and upon returning to community-based care (Regan et al., 2006). They are often the first to recognise relapse in the child and to ensure that clinicians respond appropriately (Herz et al., 2000). Children are also dependent on their parents to arrange and access help (Haine-Schlagel & Walsh, 2015; Rickwood et al., 2005) yet within the community, parents report how difficult it can be to be heard or to access the appropriate support, often describing feelings of isolation in looking after their child, while holding a significant amount of the responsibility for protecting and caring for the child's mental health (Dikeç et al., 2019; Hayes et al., 2020b). This has an impact when parents are significant in providing stability and wellbeing to children (Albanese et al., 2019; Kagan, 1999). They are more likely to seek support when the problem impacts on their own sense of competency (Farmer et al., 1997), or when feeling burdened by the needs of the child (Alegría et al., 2004), suggesting that when a child is admitted to a CIMHU, the parent may also be in their own crisis. To support this, parents desire treatment which educates, empowers, and equips them to manage their child's difficulties (Hoagwood, 2005), but we are yet to understand from a parent's perspective if the CIMHU can sufficiently provide this.

Although there is international recognition of the importance of parental involvement in a child's care (World Health Organization, 2013), research investigating the parental experience of the CIMHU is limited, coming from a broad range of different models of care and cultural understandings of mental health with varying systems and policies. This means that the modality of engagement and expectations from parents is likely to differ across each of these studies, currently making it difficult to draw inferences about the likely similarity in parental experience in other CIMHUs. Therefore, the aim of this study was to understand if there are commonalities across these different CIMHUs for parents with a child receiving their care with the hope of providing clinicians insight into potential improvements, whilst acknowledging the different health systems and policies in existence globally. To the best of the author's knowledge, a qualitative synthesis of the research surrounding parental experience of CIMHUs has not been undertaken and therefore, this review sets out to answer the question of: *What are the experiences of parents, or those with parental responsibility, with a young person admitted to an CIMHU?*

Method

The review adhered to the guidance described in the Preferred Reporting Items for Systematic Reviews and Meta Analyses (PRISMA) statement (Moher et al., 2009).

Search Strategy

A systematic strategy of keywords of published studies was employed across five databases: Academic Search Premier, CINAHL Complete, MEDLINE, APA PsychArticles and APA PsychInfo. The search was completed in January 2023. References of papers included within the search were also searched to locate any papers which may not have been captured by the initial search. Three additional papers were located.

Search terms

Search terms were selected through the use of the SPIDER tool (Cooke et al., 2012) and then developed through a process of evaluating the results of the search to ensure the relevant studies were retrieved. The search terms specifying mental health and adolescents were limited to title only due to too many irrelevant papers being initially returned. Limiters were also applied to retrieve full articles and those written in English to ensure that the studies could be read by the researcher. The search terms used were as follows:

TI(Child* OR Adolesce* OR “Young person” OR “young people” OR Teen* OR Youth* OR Juvenile*)

AND TI(mental* or psychiat*)

AND experience* or perception* or attitude* or view* or feeling* or qualitative or perspective* or opinion) N3 (parent* OR care* OR famil*

AND (unit* or inpatient* or Secure or Forensic* or Ward* OR Hospital* OR Acute OR crisis OR service*) or CAMHS

Study inclusion and exclusion criteria

Duplicate papers were identified and removed during screening. The remaining papers were then screened by title and abstract using the inclusion and exclusion criteria. To meet the inclusion criteria, the studies needed to incorporate a qualitative design and include: a) Participants who are a parent or have a parental role, of a young person receiving care within an inpatient mental health facility providing care for those under 18, b) reference to the experience of inpatient care from the perspective of a parent, and c) published after 2010 to include the most recent CIMHU models of care. Only primary research studies were included as this review sought to review original studies.

It was noted that many studies which referenced inpatient care also included the experience of parenting within the community prior to an inpatient admission. These were included due to this information being provided in the context of an admission. Some papers also included multiple perspectives from individuals within the CIMHU milieu. Papers where an explicit reference to the individual with parental responsibility could not be differentiated from those of either the service user, other relative or professional were excluded. These criteria were developed through discussion with the research supervisors. Full papers were then retrieved to assess eligibility and relevance to the research question. Figure 1 demonstrates the process of paper selection.

Data Extraction and Quality Assessment

A data extraction framework was developed to summarise the information about the studies and the key themes highlighted by each paper (See Appendix D). Information was collected on the CIMHU setting, demographics of the parent and adolescent, geographical origin, procedure, results and analysis. The quality of each paper was also assessed against the National Institute for Health and Care Excellence (NICE) quality appraisal for checklist for qualitative studies (NICE, 2012; Appendix E) due to the detailed guidance of application, to allow thorough consideration of each area evaluated. Quality is assessed across 14 areas of qualitative research using a 3-point rating system for each area, culminating in an overall evaluation of how sufficiently the checklist criteria have been met.

Data Synthesis

Thematic synthesis (Thomas & Harden, 2008) was used to analyse all the data within the studies, labelled as “findings”. The papers were read multiple times and line by line coding was undertaken of the raw data to identify emerging themes and concepts. As the papers were read, new themes and concepts were generated as appropriate. Once all papers were coded, descriptive themes were produced by looking for similarities and differences between the codes. To answer the research question, the researcher inferred what the experience was like for the parents and the resources they required to manage the situation they faced. Through an iterative process of reviewing the descriptive themes, analytical themes were inferred. The process of generating these themes was repeated until they adequately described the initial themes and concepts whilst also providing new insight into the experience for parents. Undoubtedly, the research will have been shaped by the researcher's own position and their lens upon the CIMHU (Berger, 2015). The researcher was aware that he did not have his own children or have a family member who had been admitted to a CIMHU, positioning them as an 'outsider' to the parental experience (Chavez, 2008). Their 'insider' experience of CIMHUs was based upon clinical experience of working within a UK CIMHU where there was little interaction with the parents within their role and my knowledge of family involvement was based upon the child's positioning, not the parent's position in the relationship with parent, child and CIMHU. The reflexive process involved the themes being discussed with supervisors and peer trainee psychologists then recorded within their reflexive diary to raise awareness of the primary researcher's biases and help minimise the influence of the researcher's position upon the interpretation of the included studies (Kacen & Chaitin, 2006).

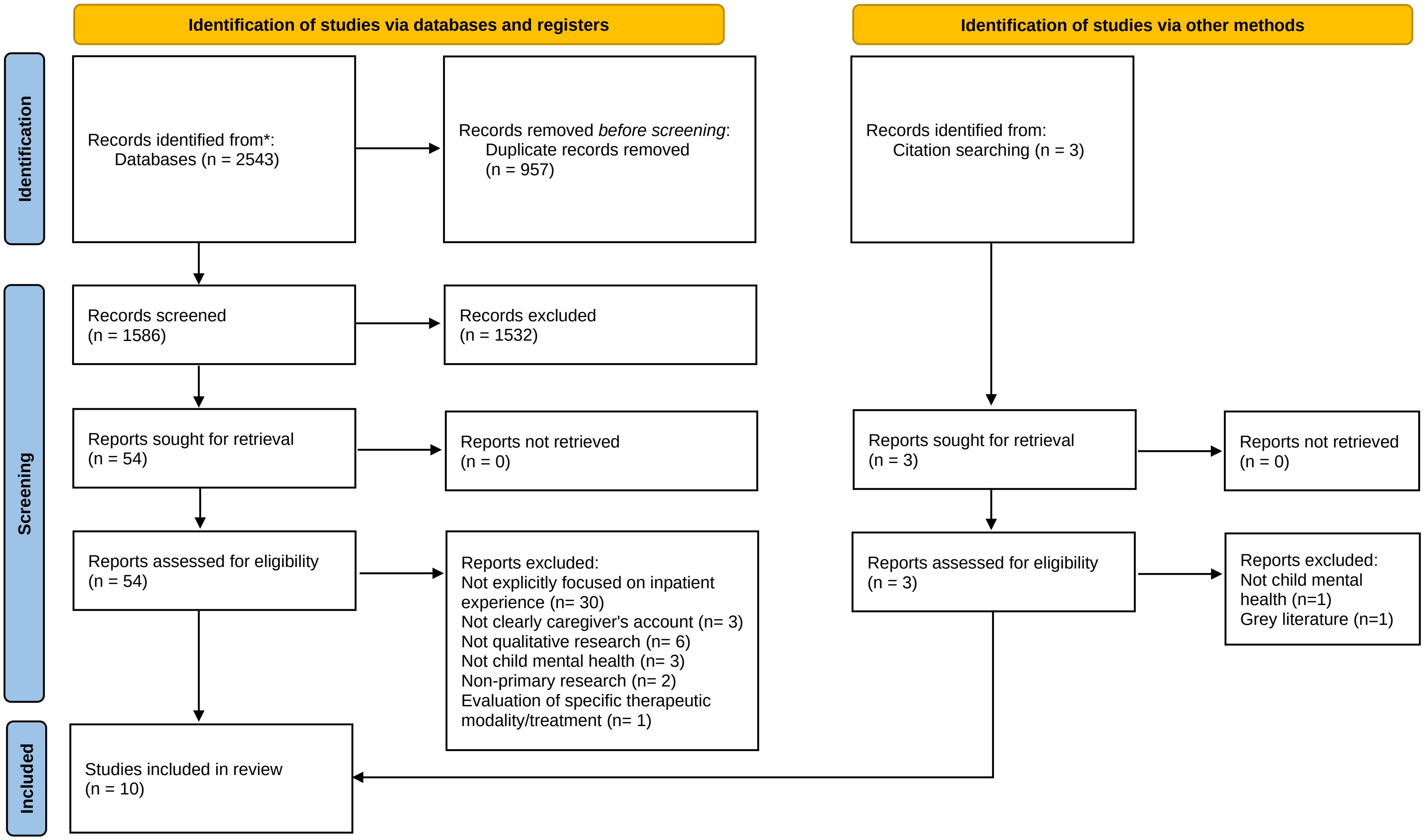

Figure 1 - PRISMA flowchart (Moher et al., 2009) used for paper selection

Results

Study characteristics

Of the initial 57 retrieved papers, 10 studies met the eligibility criteria to be included. Characteristics of each study are included in Appendix D. All papers used qualitative methodologies. Papers were from a primarily Western culture, representing Australia (N=4), Spain (N=2) UK (N=1), Norway (N=1), however papers from Turkey (N=1) and China (N=1) were also included. The combined total of participants across the study was 173 parents, with sample sizes ranging from 8 to 56 per study. Not all studies reported the number of adolescents that the parents represented. Papers primarily focused on the experiences of parents alone, however two papers also included the experiences of adolescents (Hayes et al., 2020b) and professionals (Hartley et al., 2022). These papers made explicit reference to the parent's contribution and only these elements were included for analysis within this review. All studies except Geraghty et al. (2011) involved interviews, with the aforementioned study involving content analysis of written records.

Quality assessment

The quality assessment process rated all studies as '++' except Dikeç et al. (2019) which was rated '+'. This was due to the lack of richness of data provided to illustrate the themes highlighted. Appendix F shows the outcome of the quality assessment for each study against the checklist's specific item ratings. Most papers were clear in providing detail on how they conducted the study, referencing the methodology they had followed to generate the themes from their data collection. A common strength was the attention to the researcher's reflexive position, implementing the mitigations to reduce researcher bias in the analysis such as analysis teams and participants reviewing themes. Whilst there were mixed levels of ethical reporting with some studies not clearly stating the ethical considerations which had been made as part of the study, they were included within the review due to the clear outline of the methodology followed by each study, allowing the researcher to evaluate that the findings were unlikely to be affected by the lack of ethical reporting.

Findings

The process of thematic synthesis (Thomas & Harden, 2008) produced three super-ordinate themes and five sub-ordinate themes (see Figure 2). Themes of parent experiences exist across a continuum and have been considered at three primary time points: (1) in crisis at home (prior to admission), (2) the turning point (at admission and during admission) and (3) preparing for discharge and being discharged. The themes are arranged interlinkedwith the parents having to manage the differing roles within parenting. This was prominent when the parent was both interacting with support networks around the child, whilst also supporting the admitted child. Parents also adopted a role of protecting the child from cultural and social discourse surrounding an admission, whilst also managing the discourses of how they should parent a child.

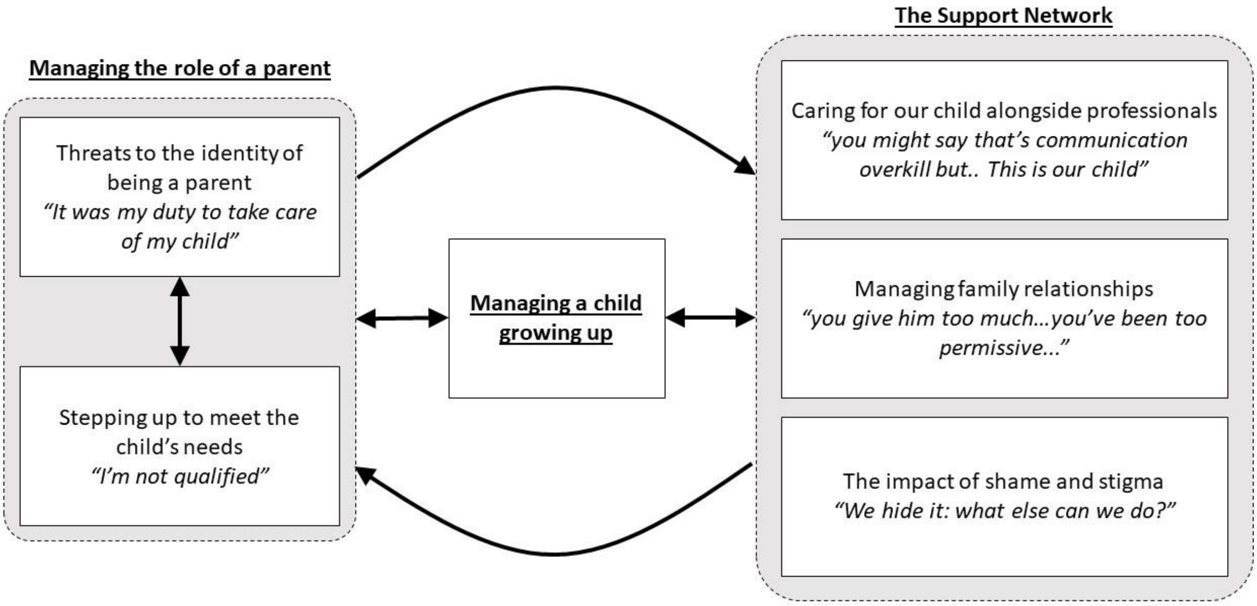

Figure 2 – Themes generated from thematic synthesis using Thomas and Harden (2008)

Managing the role of a parent

This theme explores the emotional experiences and need to manage the conflicting experiences of being a parent with a child in a CIMHU. The sub-themes explored the parent experiencing a threat to being able to maintain their identity as a parent, involving the innate sense to care for their child, as well as the parent's experience of feeling unqualified to meet the additional needs faced. These two parental experiences co-existed alongside one another and were often experienced by parents in unison without clear distinction, as the process of a CIMHU admission created confusion in the role of the parent in supporting their child. This encompasses the ever-changing emotional experience surrounding a CIMHU admission. Feelings ranged from isolation due to a lack of support from others (triggering blame within relationships and a sense of being overwhelmed), through to hope and agency as they regained some control within the situation.

Threats to the identity of being a parent - "It was my duty to take care of my child"

At home, parents had an instinctive, innate sense to protect and look after their child (Dikeç et al., 2019; Hayes et al., 2020b). Parents were willing to sacrifice much of their own sense of identity to fulfil the obligation of a parent to care for their child, particularly in a time of need, leading to feelings of isolation (Sheng et al., 2021). This was reinforced further by cultural narratives of needing to be able to manage independently as a parent. As the needs of the child increased, the parents' need to provide increasing levels of care meant that the relationship shifted as the focus became about keeping their child safe, rather than creating a supporting and nurturing development.

> *"[we] had to put a safe in the kitchen for the knives….those little things…they're not hard to manage…[but] it's symbolic of what the circumstances are…" (Hayes et al., 2020b, p. 13)*

Before parents had the realisation of how they would be providing care for their child beyond what is normally expected of as a parent, they would feel desperate, reaching a point when they acknowledged that their ability to care for the child was not sufficient to meet the child's needs. Parents would desperately seek professional help, resulting in limited support, which led to them developing a clinician-like role and feeling isolated in needing to contain the child until help arrived.

> *"we saw that there was something very rare... very rare that we didn't know what it was that was escaping us but needed attention now..." (Merayo-Sereno et al., 2021, p. 3)*

At the point of admission, parents went through a process of reflective sense making, due to the lack of structure experienced whilst managing in the community. Parents expressed tension between relief, hope and guilt. Relief and hope related to their child receiving the care parents perceived to be needed, whilst simultaneously feeling guilty that they had been unable to cope as a parent. This also became an indicator they were reliant on someone else to meet their child's needs (Geraghty et al., 2011; Hayes et al., 2020b; Merayo-Sereno et al., 2021). For some, this manifested into blame towards themselves or their partner as they attempted to source the loci of responsibility for the difficulties the family had experienced. These feelings arose because the need for support from the CIMHU reinforced their perception that they had 'failed' their child's needs due to their ability as a parent.(Sarrió-Colas et al., 2022).

> *"Am I doing the right thing? Am I a complete failure as a parent?" (Hayes et al., 2020b, p. 13)*
>
> *"To come here just took such a weight off our shoulders." (Brown, 2018, p. 650)*

Upon admission they grieved the loss of their child, who was being cared for by someone else, however, feelings of hope developed as parents noticed a change in the outlook for their child (Brown, 2018; Hayes et al., 2020b; Salamone-Violi et al., 2017; Sarrió-Colas et al., 2022). Parents expressed how admission was a time for their child to be able to consider their difficulties and gave the childa break from their previous circumstances at home, which may have exacerbated the difficulties (Hayes et al., 2020b; Salamone-Violi et al., 2017). In turn, it also allowed parents the opportunity to stop undertaking the additional caring responsibilities and understand as parents what was happening for their child.

> *"I think we have a better understanding of what's been happening for (son). It has gotten us more help, more regular help. 'I'm glad he's here because I can see he can do it..." (Salamone-Violi et al., 2017, p. 64)*

However, parents found the transition difficult from being the only carers for their child to being a part of a team, partially because of how they had been alone for most of the time in the community when the child was reliant on their protection. In returning to being a parent-figure, parents found themselves being pushed away from involvement with the child, which by the nature of the provision within CIMHU was often to stabilise the child's risk, which the parents had been attempting to manage in the community. The separation of child from parent created distance within the relationship and parents wanted to be acknowledged for their importance in their child's recovery.

> *"I felt very angry and hurt until we saw (therapist) and she said, no you can come in on the meetings" (Salamone-Violi et al., 2017, p. 63)*

> *"Parents are a resource in a slightly different way. Our resource is to be able to cheer them on, so to speak." (Bjønness et al., 2022, p. 999)*

At discharge, uncertainty about the future was prevalent across all themes. Within the parent role varying levels of optimism were held for how their child would manage within the community (Bjønness et al., 2022; Brown, 2018; Hayes et al., 2020b; Merayo-Sereno et al., 2021; Sheng et al., 2021) as parents re-adopted a more active caring role. Parents had the realisation as the admission progressed that their child was not likely to be fully recovered when discharged and may not be able to achieve everything they desired for them (Sarrió-Colas et al., 2022; Sheng et al., 2021). Parents were however apprehensive about whether they would be able to uphold the newfound parental qualities which had begun to be re-established during admission and able to engage in activities important for their own sense of identity, or if they would have to return to the previously needed role of extensive care for their child.

> *"we don't know whether we are going back to the same level of monitoring her safety constantly or not" (Hayes et al., 2020, p. 17)*

Despite a feeling of apprehension and ambivalence over discharge, one study by Brown (2018) explicitly sought to understand parental hope for their child. Hope was conceptualised to be dependent upon levels of engagement by parents and existed along a continuum. Findings suggested that hope was contingent on the level of involvement pre-discharge and parents benefit from increased involvement to develop increased insight into their child. In contrast, those who were less engaged, often found the discharge process more difficult as they focused on the child's diagnosis.

Stepping up to meet the child's needs - "I'm not qualified"

Parents were often left with no alternative but to step up and fulfil the role expected of clinicians to protect their child. Parents spoke of being under-equipped or feeling overwhelmed by the process of having to care for their child independently (Geraghty et al., 2011; Hayes et al., 2020b; Merayo-Sereno et al., 2021). Parents described difficulty in accessing professional support, particularly from community services which were also perceived as mixed quality or invalidating (Salamone-Violi et al., 2017; Sarrió-Colas et al., 2022). Parents often had feelings of desperation looking for any help available, and the lack of availability often meant that the care provided by parents led to uncertainty about what would ensue in the crisis they were experiencing.

> *"Every hour that passed my son got worse..." (Merayo-Sereno et al., 2021, p. 3)*
>
> *"You know it was hard before she came to hospital because no-one could work it out." (Salamone-Violi et al., 2017, p. 6)*

For parents, there was often a turning point where their ability to manage at home was depleted. Admission was often welcomed as an acknowledgement of how difficult the issues had been.

> *"The situation had to be stopped because it was getting out of hand and was being detrimental to her" (Merayo-Sereno et al., 2021, p. 4)*
>
> *"To come here just took such a weight off our shoulders." (Brown, 2018, p. 650)*

However, admission often occurred after a risk event (Dikeç et al., 2019) or took a long period of time to arrange (Hayes et al., 2020b; Sarrió-Colas et al., 2022). This further exacerbated feelings of being out of control due to parents' perceptions of being "under-qualified' to manage the difficult presentation of the child, intensifying the feeling of desperation for external help. Despite the relief of care for the child upon admission to the CIMHU, parents commented on the need for information as a way of managing their own levels of anxiety. It was important for them to know how their child was managing; however information could only be gained when staff were available to communicate with them, leaving parents feeling no longer a part of their child's care (Hartley et al., 2022; Merayo-Sereno et al., 2021; Sheng et al., 2021).

Whilst the admission brought reassurance for the parent that their child was safe, there was also a significant change in role. Parents experienced a shift from being actively involved in direct care for the child, to allowing others to adopt the role of everyday care for the child which they had fulfilled. Despite feelings of being out of control and under-qualified to provide the relevant care to their child, the process of handing over care to others was difficult for parents to manage, signifying a loss of both their temporary role in providing extensive care for their child and some of their identity as a parent.

> *"But those 24 hours are ... we were crying for hours in bed without moving, thinking about what is happening to him, what problems he has, what they are doing to him..." (Merayo-Sereno et al., 2021, p. 5)*

Parents seemed to have mixed feelings about the effectiveness of the intervention offered by professionals, resulting in varying levels of optimism about coping within the community. Most parents however, acknowledged the admission would not be a solitary event of recovery but would be part of a much broader journey (Hayes et al., 2020; Merayo-Sereno et al., 2021; Sarrió-Colas et al., 2022). For some parents, there were feelings of frustration that after their struggle to obtain inpatient care, their child was not fully 'treated' or recovered and they would be required to continue managing the child's difficulties (Salamone-Violi et al., 2017).

> *"This was the second time for the child to be hospitalized. When will my son become healthy? How long would this life last?" (Sheng et al., 2021, p. 33)*

Parents who had reportedly had higher confidence in their own ability as parents and developed skills from the CIMHU to support their child, were more likely to feel positive about discharge, and they were less dependent on needing complete recovery within the CIMHU (Brown, 2018). The CIMHU was perceived to be helpful to stabilise medication and then equipping the parents to be able to manage the environmental factors present in the community such as relational factors.

> *"What has been most helpful? I mean I don't think any of this works unless the medication's right but having said that the family doesn't operate if there's no one really leading the family." (Brown, 2018, p. 653)*

For those less confident in their own ability, there were worries about how they would be responsible for weathering the change in intensity of support from CIMHU to community care (Bjønness et al., 2022; Hayes et al., 2020b; Salamone-Violi et al., 2017), and self-doubt if they had the skills and techniques to translate CIMHU care into the home environment (Merayo-Sereno et al., 2021; Salamone-Violi et al., 2017), fearing the risk that they might fail again to support their child at home. Some parents explicitly suggested that it would be better if the CIMHU staff were able to provide care for their child in the community (Salamone-Violi et al., 2017).

> *“we don't know whether we are going back to the same level of monitoring her safety constantly or not” (Hayes et al., 2020b, p. 17)*
>
> *“Now when we go home, what do we do?” (Merayo-Sereno et al., 2021, p. 5)*

The Support Network

This theme explores the experience parents have of interacting with those around them and the influence they have on their experience of the CIMHU. It considers the effects of stigmatisation, finding support from others and managing relationships with others.

Caring for our child alongside professionals: “you might say that’s communication overkill but…this is our child”

Parents believed that they were vital for the success of any intervention offered within the CIMHU. Parent’s felt they had a role to advocate for and desired involvement with the care of their child. This was felt strongly after struggling to receive the help they needed prior to admission, and when forced to adopt the additional caring responsibilities for their child (Brown, 2018; Hayes et al., 2020; Sarrió-Colas et al., 2022), meaning they wanted to be acknowledged for their significance in the upbringing of the child.

> *"I brought him up when he was a baby and I am the one who knows him best…. Indeed, every time he became emotionally unstable, I found out first." (Sheng et al., 2021, p. 31)*

The struggle to achieve community support was often linked to being unable to access the right professionals, as they were perceived to be either dismissive of concerns raised by parents or lacked the understanding to be able to manage their child's difficulties, leaving parents feeling invalidated (Dikeç et al., 2019; Merayo-Sereno et al., 2021). The relationship that parents had with professionals was often limited and parents were left feeling uncontained, alone or stigmatised (Dikeç et al., 2019; Salamone-Violi et al., 2017).

> *"They've explained everything to us, but no offense, we have heard it all before, we understand why she might be doing what she is doing but none of that takes the feelings away, none of that makes us feel safe." (Salamone-Violi et al., 2017, p. 8)*

The frequent reporting by parents of less communication than they hoped for with the CIMHU (e.g., Geraghty et al., 2011) was often qualified by parents noting that a lack of staffing or staff availability contributed significantly to the level of information and involvement they were offered (Hartley et al., 2022; Merayo-Sereno et al., 2021; Sheng et al., 2021). When staff were honest with parents about the constraints they faced, parents were more accepting of the reduced communication between themselves and the CIMHU.

> *"People saying if I've got time I'll speak, we'll talk later, so that's good because it's being honest about how busy everything is, but maybe if it then doesn't happen a few times I suppose the young person could get quite disappointed." (Hartley et al., 2022, p. 7)*

Parents also believed that communication between themselves and the CIMHU was vital because they were part of the treatment provision within the CIMHU. However, for some parents who believed that the CIMHU would 'fix' the problems, this was difficult to accept due to feeling it was the role of professionals (Merayo-Sereno et al., 2021), or because they felt their role involved being hands-off coordinators for the care whilst the child was admitted (Geraghty et al., 2011).

Whilst acknowledging the difficulties of the CIMHU, parents drew comparisons with their care in the community, describing how the admission had been a positive change compared to that within the community as they had the difficulties leading up to admission validated by the CIMHU staff (Brown, 2018; Hartley et al., 2022; Hayes et al., 2020b; Merayo-Sereno et al., 2021).

Hartley et al. (2022) specifically explored the impact of therapeutic relationships within CIMHU, where parents highlighted the importance of developing a working alliance between the staff, parent, and the child. It was acknowledged that this comes with difficulties from the environmental pressure of an acute environment, the limited duration of the relationship, and the impact of these difficulties on the capacity and resilience of staff working within CIMHU. Emphasis was placed upon the ability of the CIMHU to adapt to the individual needs of the child and parents which also required the parent adjusting to a new way of supporting their child. Whilst Hartley et al. (2022) noted that relationships are the responsibility of all within the triad relationship, parents often experienced finding themselves being required to actively promote their significance to be involved within the child's care. Some parents experienced disproportionate emphasis on the child and/or professionals to make decisions in regards to the care (Bjønness et al., 2022), leaving them to feel that they had either too much or too little emphasis over care planning and outcomes. This resulted in them having to balance driving care forwards, advocating for the child, whilst equally ensuring that their maturing adolescent child was offered a voice alongside the professionals.

Managing family relationships: "you give him too much…you've been too permissive…"

Whilst the primary focus for many parents within the included studies was understandably the child who was involved with the CIMHU, some parents also referenced the wider familial impact on their child's experience (Dikeç et al., 2019; Geraghty et al., 2011; Merayo-Sereno et al., 2021; Sheng et al., 2021). In particular, the emphasis was greater in studies conducted within Turkey and China where collectivist values are more dominant (Minkov & Kaasa, 2022), where an emphasis on community cohesiveness is valued over individual preference and independence. Parents perceived that others were questioning what impact the parent's parenting approach had on the child's mental health (Merayo-Sereno et al., 2021; Sheng et al., 2021). Relatives could be dismissive of the severity of the difficulties being faced by the child and questioned why parents had not managed to resolve the problems independently. Parents were left feeling guilty and ashamed as they attempted to support their child and arranging the specialist care of a CIMHU (Geraghty et al., 2011). Parents described the difficulty for their family to accept that a child within their family may be 'ill', which threatened the familial scripts of the child's future expectations. Mental health difficulties in these studies (Dikeç et al., 2019; Sheng et al., 2021) were perceived to be a limitation for the child's future outcomes which induced feelings of being judged for the parents who felt that they were assigned responsibility for the difficulties the child was experiencing. Some parents did receive support from within the family (Sheng et al., 2021) however, for parents whose families were less involved in the care of the child, there was a lack of understanding of the extent of the difficulties faced.

> *"After my husband left me because of my daughter's illness, I moved to my mother's place. However, my uncles and their wives were rude to my daughter. My daughter hurts herself due to her disease, and this was disturbing to my relatives. They said to me that my daughter was a bad example to their children and asked me not to come back to their apartment." (Dikeç et al., 2019, p. 339)*

> *"….relatives and friends just say: 'It's simple; just make her eat!'" (Geraghty et al., 2011, p. 257)*

Some parents discussed the material impact of an CIMHU admission upon them and their family. Inpatient admission affected their ability to work, required parents to find accommodation closer to the CIMHU, and potentially finance any care needed (Bjønness et al., 2022; Geraghty et al., 2011). This required parents to give additional time and focus on the admitted child at the expense of their other children's needs, acknowledging that the difficulties of one child often cascaded to affect the others. Parents had to try to provide stability to a fragile and de-stabilised family unit.

> *"…They have three other children. The younger girls had been in trouble at school with acting-out behaviours. The children had been arguing more, and both parents were feeling very stretched." (Geraghty et al., 2011, p. 258)*

The impact of shame and stigma: "We hide it: what else can we do?"

Stigmatisation from those outside of the family unit came from the parents, child's friends, school and other professionals outside of mental health (Dikeç et al., 2019; Geraghty et al., 2011; Merayo-Sereno et al., 2021; Sarrió-Colas et al., 2022; Sheng et al., 2021). School was a key milieu for families, turning to them when professional mental health services were not available, attempt to work with school to mediate any educational disruption caused by the mental health difficulties, and have hope that the child could re-integrate once they returned from the CIMHU. Parents found that schools would struggle to adapt to their child's needs or would insinuate blame on the parent for the difficulties the child faced, contributing to the child being isolated. Parents also noted the impact of peers within school on the child and the stigmatisation that the child experienced. This was corroborated through the parallel process parents were exposed to through parents who reduced the level of social contact with the family and passed judgement on the child's difficulties. (Dikeç et al., 2019; Sarrió-Colas et al., 2022). Equally, parents also intentionally reduced the level of social interaction they participated in as a way of minimising the level of stigmatisation they and their child were subjected to.

> *"Her school friends were calling her mad, crazy, and insane due to her illness. My daughter's condition worsened because she could not express herself. We cannot do anything at all."(Dikeç et al., 2019, p. 4)*

At admission however, parents found that they were in a shared experience with other parents who had previously felt isolated (Geraghty et al., 2011; Hartley et al., 2022; Sheng et al., 2021). Geraghty et al., (2011) reported a peer-support system which was established within the CIMHU and run by parents to support others with children within the CIMHU. Participants explicitly referenced their appreciation for such peer-support, referencing the benefit of a shared experience with another adult who can empathise with the difficulties they experienced as parents and not pass judgement. It allowed them to discuss their experiences of care and the emotional toll of having a child admitted to an CIMHU. Other parents without such established frameworks developed organic relationships with other parents, with similar benefits of a shared experience being observed.

> *"I met one of the other patient's mums . . . and I've since developed this friendship with her and that's been really helpful because you have somebody to talk to about the same experiences and how you've felt" (Hartley et al., 2022, p. 19)*

Managing a child growing up

This theme explores the parent navigating the changing relationship with the child as they move from adolescence into adulthood. It explores the influence of the CIMHU on this process from a parent's perspective and interfaces with the super-ordinate theme of "managing the role of a parent".

Prior to admission, parents found themselves in the position of supporting a child who has put much of their life on hold by the ongoing crisis to manage their mental health, noticing how their child was *"coping externally, yet in the background...really struggling"* (Hayes et al., 2020b, p. 12). As a parent there is the realisation that the child's outcome is likely to change and much of the work to support their independence is put on hold. Taking on additional caring responsibilities was needed to manage the situation, at times arranging care without involving the child (Bjønness et al., 2022; Hayes et al., 2020b; Sheng et al., 2021). Parents appeared to feel driven to take control of the situation after witnessing their child retreat from much of their usual activity and become isolated (Bjønness et al., 2022; Dikeç et al., 2019), contributing to them feeling guilty about having to undertake such a decision without the child's involvement.

When the child was admitted, parents noticed a shift in the power the child received within the CIMHU to be involved in decision making. The CIMHU allowed enough safety and containment for the child and parents, to allow the child to be involved with decision making, which parents acknowledged was beneficial (Bjønness et al., 2022; Hartley et al., 2022). Parents wanted guidance and recognition for the role they played in being actively involved in care as they knew their child the best, but also in order to support a young adult become increasingly independent. They found the process of accepting that their child has increasing power in their care to be difficult and sought CIMHU staff support to navigate the transition of handing responsibility over to the child for their mental health and cultivating this new chapter in the child-parent relationship.

> *"The most challenging thing during admission was to let him participate in the treatment without influencing him about what is best. We must leave the choices to him. It's his role, not mine, although I fear and dread of where it might lead him. It's terribly difficult not to be part of decisions, even though you know you must leave it to him." (Bjønness et al., 2022, pp. 998–999)*

However, those parents who were focused on an 'illness' within the child, often emphasised biological factors at the expense of work to strengthen the child-parent relationship (Brown, 2018). These parents also perceived that increasing the responsibility for the child led to them being more passive in their care, contributing to a feeling of confusion. These feelings were particularly exacerbated at discharge where uncertainty was present in most parents about how their future relationship would manifest (Brown, 2018; Hayes et al., 2020b; Sarrió-Colas et al., 2022; Sheng et al., 2021). Parents who had the opportunity to strengthen their relationship with the child within CIMHU reported greater confidence in knowing how to adopt a helpful parenting approach with their child and optimism that they had a future beyond CIMHUs and to engage in ‘normal life’.

> *“I’ve always just met all her needs. So I guess for me, learning to say no and take a stand now, although it hurts, I know it’s improving her future.” (Brown, 2018, p. 652)*

Discussion

This review aimed to explore the experience of parents whose child is admitted to a CIMHU. To the author’s knowledge, this is the first review synthesising studies from multiple CIMHUs which explore the parent’s experience. Three superordinate themes were derived: managing the role of a parent, the support network and managing a child growing up. The review demonstrates that for parents, there is the continual experience of contrasting emotions as their child transitions through the CIMHU, of uncertainty, anticipation, and hope of what is to come. The 173 parent’s voices represented in the review highlight the nuances of different care providers who place a varying degree of emphasis on their involvement within the care of their child. Whilst the review included papers back to 2010, most were published within the last five years, suggesting increasingly it is being understood that parent’s perspective of care and involvement is important for effective care.

Parents throughout the CIMHU process often found themselves being the linchpin of protecting the child and containing them from the pressures of stigma, lack of professional support and isolation, placed upon the child by the systems associated with the CIMHU. This is equally at a time when parents are attempting to support their child to become more independent in the community (McGoldrick et al., 2015), allowing them to make more independent decisions about their care and future. This increased protection understandably was driven by the parent’s innate desire and identity that they were responsible for caring, protecting and supporting their child. The inclusion of international studies emphasises that the expectations and manifestation of parents being the linchpin are varied and motivated by the cultural expectations of family responsibility. Within China, where family responsibility is high within cultural discourse (Yin et al., 2018), parents were more explicit about the child's dependence upon them and how they continued to see themselves as being directly responsible to physically care for the child whilst admitted, regardless of the severity of mental health difficulties (Sheng et al., 2021). Equally, the one-child policy increases the expectations upon each child to succeed (Wei et al., 2016), meaning that parents were more determined and saw it their responsibility that their child overcame their illness. This differed from the experience for those in Norway, where individualism is valued over conformity (Stevens, 1989), leading to parents often seeing themselves to advocate that the child's treatment was individualised and tailored to their needs rather than limited to a diagnosis (Bjønness et al., 2022). The popularised models to understand variation in culture such as Hofstede's six dimensions (1984), Schwartz's et al. seven value orientations (2004), and project GLOBE (House et al., 2004), suggest that the values which are prevalent within cultures are often complex and likely to affect in nuanced ways a parent's engagement with healthcare and their expectations of involvement. The international nature of this study highlights the importance in understanding these nuances in expectations from parents, and the professionals' role within the CIMHU building therapeutic relationships with parents by understanding such motivations for involvement.

Whilst the variations in culture shaped the motivation of parents, the underlying role of a parent to care for and protect their child was universal and they had to adapt to providing the additional support required by their child. However, this came at the expense of being the parent they had hoped to be by focusing more on keeping their child safe during an ongoing mental health crisis. CIMHUs were called upon by parents often as a last resort once other treatment options had been exhausted, resulting in parents developing feelings that they had failed in their duty to the child as they only stabilised once the child was admitted. The CIMHU provided relief to the family, potentially due to the CIMHU milieu offering a structure which had been difficult for parents to achieve prior to admission (Delaney, 2017a). The feelings of failure appeared to be reinforced by the external stigma parents experienced of judgements on their parenting style, child's behaviour, or potential of having a child with a mental health condition. This study supports the previous research that parents seek help when their own competency is threatened and when feeling burdened (Alegría et al., 2004; Farmer et al., 1997). Clinically, it requires professionals to be aware of the crises which the family is experiencing and acknowledgement of the parent's sense of competency being challenged. The parents within the study who described feeling heard, listened to, and valued by staff, often had more positive experiences and more hope for their child (Brown, 2018; Hartley et al., 2022), but were also empowered to move beyond the CIMHU effectively as observed within other inpatient clinical populations (Storm & Edwards, 2013). Factors which appeared to contribute to the parent's feelings of failure were often systemic, with ideas and beliefs existing within the exosystem (e.g., school, other parents, other professionals) and macrosystem (e.g., parental expectations, cultural assumptions of mental health) influencing the burden felt by parents. Although the amount of influence each source had upon parents varied, both within each study and across the studies, it was apparent that where the CIMHU was responsive and understanding of such stigma, parents felt better supported and understood. These parents were often engaged in CIMHUs where a particular emphasis was placed on family-based interventions compared to traditional psychiatric approaches to stabilisation, supporting the evidence that the effectiveness of family involvement is often based upon the service values to implement and intentionally seek out the experience of parents (Greenhalgh et al., 2004). It appeared that understanding parental experience was not purely based upon the quantity of time spent with staff, as parents often acknowledged that there was limited staff availability due to care pressures and limited staffing. Rather, the emphasis was upon the ability and skill of the staff to listen and learn about what parents had experienced and being responsive to include them as they desired. For those studies from countries where there was a stronger cultural narrative of mental health being an illness (Dikeç et al., 2019), parents appeared to not value family intervention as an effective way to support their child's needs (Brown, 2018), potentially based on the cultural idea that the loci of difficulties are within the individual and not in relationships around the person. Staff knowledge and skill are needed to ensure that the benefits of family intervention are effectively communicated in settings where these dominant illness narratives exist, and interventions need to be implemented in a way which does not insinuate blame, further triggering the feelings of failure. Whilst standards such as the Royal College of Psychiatrist's within the UK outline that parents should be offered individual time with staff within 48 hours of admission (Quality network for inpatient CAMHS, 2021), this review emphasises that parents also need to meet with staff who are adequately trained and skilled in developing an understanding of their experience, with flexibility to involve them as desired.

Whilst parents were initially expecting the staff to be the people attached to the CIMHU milieu who would support them and understand them, surprisingly, parents also found new community and support in the form of those who shared the identity of their child "living in an alternative reality" (Haynes et al., 2011, p.152). The ability for parents to be able to find others who could understand and appreciate the difficulties they faced, often changed the experience of the CIMHU to be more hopeful. This supports previous research that parents benefit from peer support due to an increase in social support (January et al., 2016) and accessing information which is not provided by professionals (Leggatt, 2007). Whilst one study within the review particularly looked at a formalised provision for such support (Geraghty et al., 2011), parents in settings where such provision did not exist would attempt to make relationships with others. With staffing for inpatient facilities a known challenge (Marklund et al., 2020; Wood & Alsawy, 2016), there is potential that formalised peer-support provisions could improve the ability for parents to feel understood, recognising the burdens placed upon the family and the difficulties associated with promoting the development of adolescent independence when they require the additional support around their mental health difficulties.

Limitations

PRSIMA guidelines (Moher et al., 2009) were followed to maintain methodological rigour of the review. The quality assessment demonstrated that all studies were of satisfactory quality to be included. All studies considered the position of the researchers within their research and the relationship they had with the parents or children admitted to the CIMHU. An equal split of the studies in the review included researchers who were associated or had a clinical connection to the CIMHU where research was conducted (Brown, 2018; Geraghty et al., 2011; Hartley et al., 2022; Hayes et al., 2020b; Salamone-Violi et al., 2017) compared to those studies not having a clinical connection (Bjønness et al., 2022; Dikeç et al., 2019; Merayo-Sereno et al., 2021; Sarrió-Colas et al., 2022; Sheng et al., 2021). Three studies (Geraghty et al., 2011; Hartley et al., 2022; Hayes et al., 2020b) acknowledged that the researchers had a closer clinical connection with the participants, either being staff on the CIMHU where children of participants were cared for (Hayes et al., 2020b) or being parents who were involved within the peer support service which was analysed (Geraghty et al., 2011). Hartley et al. (2022) had a clinical relationship with some of the participants but it was unclear if this was with the staff, parents, or children within the CIMHUs. All three studies acknowledged the potential limitations of the connection between researcher and participant and outlined processes to mitigate the bias. Hartley et al. (2022) reflected on how prior relationships seemed to ease the openness of participants with the researchers, concurring with observations from Geraghty et al. (2011) and Sheng et al. (2021) whereby parents found it beneficial to be able to share their experiences with someone who has understanding and insight into the difficulties they face. Within this review, it was not possible to determine if a researcher connection had an impact on the participants involved in the studies, or information shared by the researchers in their studies.

The limited research within the area meant the included studies included variations in therapeutic priorities and mental health presentations. As the studies were from varying cultures too, the different systems, customs and policies for providing healthcare are also likely to differ and inherently, this limits the generalisability of the study. Importantly, when making the comparison of provision across CIMHUs, understanding the variation was important for assessing the similarity of experience. Each study included provided some description of the context of the CIMHU, and all sought to provide treatment to those with severe or acute mental health difficulties. However, the extent to which this was described varied considerably, with some higher quality studies giving detailed accounts of the child's presentation, admission length, treatment provision and philosophy (Bjønness et al., 2022; Brown, 2018; Salamone-Violi et al., 2017), whilst others provided more simplistic descriptions such as “adolescent inpatient mental health wards” (Hartley et al., 2022, p. 3) or “child and adolescent inpatient service of a regional hospital” (Dikeç et al., 2019, p. 337). Some of the studies showed a broad range of presentations amongst the children admitted to a single CIMHU, potentially suggesting that the treatment provision was primarily based on crisis management and containment rather than therapeutic treatment, in turn leading to the uncertainty felt by parents of how they would manage supporting the child after discharge. Only Salamone-Violi et al. (2017) reported the legal status of the children admitted, which is likely to change the relationship between the parent and the professional or child. Equally, whilst parental experience of struggling to access services appeared to be homogenous, it was not clear what the different paths were to admission, or what the treatment provision specifically involved. This is important as parent experience and perception of the CIMHU is understandably less positive if their child is admitted to a CIMHU which does not provide specific treatment to their child’s needs. This lack of clear reporting on CIHMU demographics has been highlighted previously, leading to the development of a checklist for reporting the descriptions of CIMHU to include significantly more information (Hayes et al., 2023). Future research in the field would benefit from providing more thorough contextual information around the CIMHU.

The lack of clear reporting about the length of admission for each child from all but Geraghty et al. (2011) and Hayes et al. (2020b) also meant that it was unclear to fully understand the influence of admission length on parental experience. Parents with a child in a longer admission, may experience different relationship effects between the child and parent, as the relationship has time to stabilise and allow the parents to be involved with treatment provision, such as family therapy. As policy encourages children to be cared for in the community (Delaney, 2017b), two of the studies described how the CIMHU operated a ‘day-hospital’ provision (Brown, 2018; Sarrió-Colas et al., 2022) whereby children could potentially engage in some community activities such as education whilst experiencing the intensive support found in CIMHUs. However, there was no distinction in parental experience between traditional and day hospital provisions.

Equally, parents' experience of community-based provisions for those in crisis is similar to that observed in this review, where parents experience poor communication with professionals, a lack of validation of their experience, and having to "battle" to get the care they felt their child needed (Vusio et al., 2020, p.1627). To be able to evaluate the effectiveness of these alternative models compared to the CIMHUs discussed in this review, research should be conducted to understand the parental experience of a child receiving care within these newer provisions.

Future Directions

The review highlighted the change in dynamics as the child was given increasing decision-making power, meaning that parents at times felt excluded from the care process and needing to advocate for themselves, rather than having a professional do so. As the child is admitted, parents' perspective of staff is that *"you're guarding them…but it's not a triangle."* (Hartley et al., 2022, p. 16) and feeling unheard. Parents expect CIMHU staff to identify their role and purpose swiftly, incorporating the parents support within the child's care. However, from the staff and child's perspective, some of the difficulties the child faces may be perpetuated by the relationship they have with their parents, and the CIMHU provides respite from the difficulties they had at home. The prevalence of feeling uninvolved may also have arisen within the data due to the selection bias of the parents willing to share their perspectives of CIMHUs, also being the ones who more strongly believe in their inclusion in care. The desire of parents to know as much information and be as actively involved as possible with their child poses a dilemma for care professionals who have to manage the confidentiality and wishes of the child. Although not included within this review, Hartley's et al. (2022) involvement of staff views within their study, highlighted that current systems act as barriers to the relationships being facilitated safely. The World Health

Organization Mental Health Action Plan (2013) states that mental health work should include the involvement of families and emphasis on nurturing the parent-child relationship. The Triangle of Care model (Murray et al., 2020), places emphasis on the value of the working relationship between clinicians, parents, and the child, but requires the clinicians to establish the framework for this to exist within. CIMHUs therefore need systemic structures in place to value the triadic relationship and to ensure that staff are given the appropriate training and support to be able to establish relationships so that all feel contained and safe enough to explore the difficulties present in the family.

Conclusion

The quote *"*if there is a parent sat there, who is bringing her daughter or son to appointments week after week, year after year, they're invested and they care, but they're suffering as well, I don't think it's rocket science to realise that, to acknowledge it." (Hartley et al., 2022, p. 12) encapsulates the parental experience of difficulty experienced both during and in the lead up to an admission to a CIMHU. Parents want to be involved both because of their innate need to care for their child, but also to experience recognition for the experience they have had. The mixed experience of parental involvement in care was indicative that further work needs to be done to support parents and ensure that services are attentive to their needs. Although this review included various CIMHU models of care, offering differing experiences for parents, it was apparent that there was a universal desire to have the range of intertwined emotions associated with admission acknowledged by professionals. The study's findings were supportive of the wider body of literature of parental involvement, suggesting that the experiences captured within this review are likely to be generalisable across other CIMHU contexts, providing insight into how services can ensure that their care model values and appreciates the involvement of parents in the care of adolescents admitted to CIMHUs.

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Part Two – Behind closed doors: A narrative analysis of the lasting responses to inpatient child mental healthcare

This paper is written in the format ready for submission to Children and Youth Services Review.

Please see Appendix G for the Guideline for Authors.

Word Count: 10368 (excluding references, figures and tables)

Abstract

Child inpatient mental healthcare often involves significant disruption to an adolescent's life, affecting education, relationships, and social development. Admission to inpatient mental units is likely to be disruptive to the usual developmental processes which occur as the adolescent integrates their childhood experiences into their adulthood identity. Currently, the lasting impact of inpatient care for children is yet to be fully explored. This study used a narrative analysis approach to understand the experiences of those who have received care from a child inpatient unit, and how the stories of their care are used for identity formation. The results suggested that the experience was often traumatic, with feelings of powerlessness, stigmatisation, and exclusion experienced. These feelings were communicated through stories of needing to survive and cope, alongside the development of resilience and increased independence. The results suggested that interventions to improve the child's voice in their care should be adopted, along with increased public understanding on inpatient care. The short-term and long-term implications of admission are also considered.

Keywords: Inpatient, adolescent, identity, hospitalisation, mental health

Introduction

Recent estimates suggest that 4% of all children accessed mental health services within 2019/20 in the UK (Children's Commissioner, 2021) with approximately 3500 children admitted to a Child Inpatient Mental Health Unit (CIMHU; Children's Commissioner, 2020). CIMHUs are an integral care model to support children and young people, providing intensive support within either a secure or non-secure environment (Delaney, 2017b). Whilst current directives continue to emphasise the importance of community care for people with mental health difficulties (Centre for Mental Health, 2020), inpatient stays are still used to manage acute crises. By nature of the care model, CIMHUs result in disruption to daily life such as education and relationships as children are taken out of their usual environments. For the system it is also the most resource intense child care model (Children's Commissioner, 2017; McDougall et al., 2008). Therefore, evaluating the longer-term impacts on child wellbeing should be an important component of their continued usage.

However, developing a complete understanding of the impact of CIMHUs on mental health treatment is currently not achievable as data collection and availability has been limited: data are incoherent or insufficiently complete to offer the full understanding of those who need and access services, and the long-term effectiveness of the provision (Children's Commissioner, 2023). Inpatient care has been described as "behind locked doors" (Children's Commissioner, 2020) both for the children admitted and those seeking to evaluate the care model. Few studies have explored the experience of CIMHUs from the child's perspective (Shin & Ahn, 2022), limited to only include their views whilst admitted, making it difficult to understand the longer term implications a of an CIMHU admission.

Capturing the narratives of those who have experienced CIMHU admissions is essential to understand the personal implications that care has on one's life and longer-term outcomes. Shifting emphasis from 'patient experience' (a story) to 'patient journey' (a narrative) allows for the broader stories of care to be captured as young people move beyond a CIMHU admission (Braithwaite et al., 2016). Narratives are important for individuals as they hold the meaning and purpose behind the events which are significant to people (Frank 2010). Frank suggests that narratives differ from stories, which are localised and specific to events, with narratives being templates from which individuals can tell stories and assign meaning, serving individuals a purpose in the future. What is currently known about the CIMHU experience is limited to the 'stories' told. This means that the current variation in accounts, meaning, and appraisal of the CIMHU experience make it difficult to understand what significance an admission has on a young person's recovery. For example, the stories used to portray the boundaries within CIMHUs range from it being "prison-like", communicating experiences of punishment (Reavey et al., 2017) through to "tough love", suggesting care and affection (Biering & Jensen, 2017). This variation in the meaning ascribed to the environment is mirrored across the relationships, value of therapy, and staff interaction (Shin & Ahn, 2022). Undoubtedly, the use of such varied language by young people to describe their experience is likely to be shaped by their previous care experiences, and the narratives which hold power around them. However, it is unclear how the stories of CIMHUs are told beyond the admission, as their outlook on the events potentially changes and as their narrative develops.

From a narrative therapy perspective, understanding the world and self is based upon the relationships and shared experiences with others, shaped by one's responses and expectations to such events (Combs & Freedman, 2016). Stories are inherently 'polyphonic'; always resonant with other’s stories and cultural narratives (Bakhtin, 1984). Individuals draw upon memories of prior experiences to consider how others respond and learn what is expected of them (Combs & Freedman, 2016). Within these relationships, the expectations of a young person are derived from the social and cultural narratives which are present and embodied by others. Inherently the narratives which have the most power and dominance within a young person’s life, are the ones which have a greater influence over what is expected of them in future situations. Young people within CIMHUs are more likely to have experienced complex developmental trauma, instability and attachment difficulties (Nadkarni et al., 2012). They are also more likely to have experienced prior involvement of multiple services such as social care or community mental health services which likely hold significant influence over the care decisions and outcomes for the young person. An admission will therefore be appraised differently based on the narratives held by the family, friends, and organisations involved with the individual. For some, an admission is “traumatic, frightening and confusing” (Wessley et al., 2018, p. 4), whilst others feel it is a safe and stable environment; an experience which may have been missing for the young people prior to admission (Delaney, 2017a). The current accounts of the CIMHU experience may also be influenced by the dominant narratives and discourses existing within the CIMHU milieu. Conversely, the accounts may lack the contextual implications of the prior experiences a child underwent before a CIMHU admission. Understanding the inpatient story from an alternative, more time distant perspective, should allow for a different account of the experience, and in turn, allow for a different understanding of the impact of the experience in the individuals’ broader sense of self and wellbeing.

The timing of an inpatient admission further contributes to the impact it could have on long-term wellbeing for young people. In the UK, 72% of children admitted to CIMHUs are aged between 15-17 (Clarke & Nelson, 2020), which is one of the most significant developmental stages (Williams et al., 2002). Within a psychosocial development model (Erikson, 1959), the process of adolescence involves the development of an individual adult identity, later operationalised by Marcia (1966) into the process of moving from crisis, a period of exploration and consideration of life's direction and purpose, to commitment, resolving the crisis and developing a sense of self. In contrast, identity diffusion, the "loss of capacity for self-definition and commitment to values, goals or relationships" (Goth et al., 2012, p. 3) is associated with poorer psychological functioning (Berman et al., 2009). Understandably, the primary role of the CIMHU is based upon risk and mental health management (Delaney, 2017b), however, the admission also comes in a period of normal adolescent 'crisis' whereby adolescents encompass various personal, cultural, and social values and roles (Christie & Viner, 2005; Marcia, 1966) and therefore indirectly contributes to the development of a young person's identity. This is pertinent when also considering identity from a relational perspective, understanding that identity is constructed between people (Combs & Freedman, 2016), suggesting that the dominant narratives that exist within relationships in the CIMHU of being an adolescent, mental health, or inpatient care may differ from relationships within the community. Admissions are described as "living in an alternative reality" (Painter, 2008, p. 100), suggesting admission during adolescence is likely to be influential on the development of adulthood identity as young people experience a new environment with potentially different social and cultural values.

Within the narrative identity model, identity crises are resolved through stories, selectively reconstructing, and integrating past experiences to give a subjective explanation of who the person is based on such cultural, social and political narratives (McAdams, 2018). Adolescents who require CIMHU care are at risk of developing an "overly narrow and negative identification"

(Haynes et al., 2011, p. 154) of their self-identity due to being increasingly influenced by the narratives that are valued and accepted within the CIMHU milieu (Stuenkel & Wong, 2010). The sudden change of cultural and social context which occurs at admission to a CIMHU, requires the individual to reconcile the previously held discourses alongside those held within the CIMHU. Equally, when the cultural narratives about CIMHU admission are likely to be stigmatising, it puts the individuals self, group and social identity at risk (Byrne & Swords, 2015). Those who can reconcile their identity as an 'inpatient', and within their narrative, display higher wellbeing (Adler et al., 2016), suggesting that developing a coherent and healthy identity is an important part of making sense of the inpatient environment which ensures that the experience can be beneficial. This developmental view of self, and integration of the inpatient experiences cannot be captured by recording the stories of those currently experiencing CIMHU care.

The critical nature and timing of a CIMHU admission is understood by those being admitted (Livermore, 2023). Young people consider the long-term implications of their admission (Gill et al., 2016; Moses, 2010; Stanton et al., 2020) but report concern about the transition back into the community, being discharged prematurely and fear going *"back to square one"* (Gill et al., 2016, p. 60). Investigating the stories of those who experienced CIMHUs and who are currently living within the community is important to understand if, and how, individuals can integrate their stories of admission into their narrative identity, finding purpose and meaning of their CIMHU admission, and understanding if the experience is thought to be helpful to future wellbeing. It is hoped the research will benefit service provision planning and support clinical decision making when admissions are considered. The study sought to investigate:

1. *What are the stories that people tell of their inpatient CAMHs experience once discharged?*

2. *How do the stories of inpatient CAMHs impact and shape people, and their identity, from a post-discharge perspective?*

Method

Design

The exploration of the phenomenology (i.e., meaning and experience) of the response to the CIMHU and experiential nature of the research aims dictated a qualitative methodology. The research used semi-structured interviews, analysed through a dialogical narrative analysis (DNA) approach to generate results (Frank, 2012).

DNA considers narratives as not only an interpretation of lived experiences and the representations they generate (e.g., Emerson & Frosh, 2004; Hiles & Cermák, 2007), but also considers stories to be enablers of actions, animating life (Frank, 2010). Therefore, the position required within the research is to consider that the stories shared shape the future experience of the individuals' life and are also a snapshot of the individual at one time point: the principle of unfinalisability (Bakhtin, 1984). This aligns with the research questions, as participants' mental health journey was not likely to be 'finished' and the positioning of CIMHUs within their mental health journey could change.

The heuristic nature of exploring narratives within DNA results in a non-prescriptive methodology (Frank, 2010) and should be used as a "recipe" which is suggestive of application (Caddick, 2016). The research design was based upon the framework outlined by Caddick (2016) and Smith (2016) .

Participants and Recruitment

DNA or narrative analysis do not dictate number of participants but emphasise richness of narrative. Patton's (2002) principles were followed throughout the study. They suggest that when using purposeful sampling, recruitment should cease once data saturation is met. Data saturation was understood to have occurred when the addition of new participant information did not add alternative information to the study, met within this study by evaluating if the last participant's data generated any new material or information.

Participants were concurrently recruited via social media and through purposeful sampling in a specialist NHS service, supporting adults experiencing emotional dysregulation with or without a personality disorder diagnosis. Social media recruitment involved the use of groups where members expressed a shared interest in CAMHS. Recruitment through both sources occurred concurrently, with one participant recruited from the NHS service. The participant inclusion and exclusion criteria are in

Table 1.

Table 1 – Inclusion and Exclusion Criteria

Inclusion Criteria	Rationale	Exclusion Criteria	Rationale
Received care from CIMHUs within the UK either informally or when under the Mental Health Act.	The scope of the study is of UK care provision	Lack of fluent English	Ensuring the researcher can fully understand the participants
Spent at least four weeks within a CIMHU	A shorter inpatient stay is likely to not have as significant an impact on identity development. The median length of stay in the UK is 60 days (Clarke & Nelson, 2020)	Unable to give informed consent	Participants needed awareness of rationale to participate.
Be at least six months post-discharge from CIMHUs.	Required to reveal the reflections of participants post - discharge.		
Aged 18-35 years old	Those over 35 are likely to have too distant retrospective accounts of the experience and experienced an inpatient CAMHs unit which differs significantly from the current provision.		

Procedure

Recruitment of participants followed the process as seen in Appendix H. Participants were provided with an opportunity to ask questions about the study with the researcher via telephone after reading through the information sheet (Appendix I). Participants were also asked to self-report if they met the inclusion criteria and were asked to give informed consent (Appendix J). The interviews commenced with a preamble before the participant was asked to share their narrative. Questions followed to clarify and develop the researcher's understanding of their experience (Appendix K). Participants were not rewarded financially for their participation and were given information to access support if required after the study (Appendix L).

Interviews took place both online and in person based on participant preference between January 2023 and June 2023. Participants were from across the UK. Interview duration ranged from 50-88 minutes (*M*=72). Interviews were transcribed verbatim, with identifiable information removed to protect participants' anonymity. Participant pseudonyms and demographic information can be found in **Table 2**.

Table 2 – Participant Demographics

Pseudonym	Age	Gender	Ethnic Background	Number of CAMHS inpatient admissions	Type of CAMHS inpatient facility	Age at longest admission	Longest admission length
Tiffany	25	Female	White British	3	ED	17	8 months
Lucy	19	Female	White British	2	GAU	17	2 months
Belle	19	Female	White British	5	GAU & PICU	17	8 months
Ellie	19	Female	White British	1	GAU	14	3 months
Adele	21	Female	White British	1	GAU	17	12 months

General Admission Unit (GAU), Eating Disorder Service (ED), Psychiatric Intensive Care Unit (PICU)

Ethical Approval & Researcher Speaking Position

Ethical approval was obtained from the University of Hull Faculty of Health Sciences Research Ethics Committee (Appendix M) and NHS REC (Appendix N).

As outlined by Caddick (2016) and Smith (2016), the process of DNA requires situating the researcher within the narratives shared. This is significant in narrative research, acknowledging that the researcher has a role in the stories which are told by participants and how they are portrayed, potentially being more attentive to certain stories (Silver, 2013). The primary researcher is a male Trainee Clinical Psychologist who has not received care from a CIMHU but has previously worked within a secure UK CIMHU within the chaplaincy department. The positioning of the chaplaincy role in being an insider/outsider to the clinical care meant the researcher would often have conversations with young people around identity, belonging and purpose, noting at times the struggle to hold onto these personal characteristics whilst admitted. The researcher was aware that they were only privy to witnessing a small section of a service users' mental health journey during their admission, and therefore was aware that their insight into the treatment experience was void of the service users' prior experiences. Equally whilst the researcher was working within the CIMHU and then conducting the research, they noted the negative discourses within the UK media which were not representative of the experience they had witnessed. The experience prompted a strong personal interest into understanding what happened for individuals after discharge and how they made sense of CIMHUs as part of growing up. The study was conducted by the researcher as part of their doctoral training, which allowed them to draw on their experiences of being an insider to the CIMHU milieu but also an outsider by being not directly involved with participants' care (Chavez, 2008). The researcher equally acknowledged that as a male, there may have been barriers to the all-female participant group sharing their stories, further being an outsider to their perspective of their experiences. The researcher was conscious that some women shared experiences of vulnerability and abuse from men as part of their narratives and considered the significance of the interview process for participants to share their stories with him when attempting to communicate their experiences within this research, which potentially shaped what was shared by them (Lazard & McAvoy, 2020).

Given the researcher's prior experience of a CIMHU and personal interest in drawing attention to aspects of the CIMHU environment which are neglected in the UK media narrative, they took part in research reflexivity groups, engaged in a reflexive interview during research supervision and kept a reflective diary. This was to increase awareness of how their speaking position affected the narrative interpretation, ensuring to not prioritise those stories which differed from the public discourse. Current service users of a CIMHU were involved in supporting the researcher, pointing out important aspects of the CIMHU experience, ensuring that greater privilege was not given to the researcher's own experiences shaping the interview prompts. These processes are in line with qualitative research guidance which emphasises the requirement for such measures due to the ideographic nature of the research (Malterud, 2001). During analysis, transcripts were shared with research supervisors and themes were discussed, again as a reflexive exercise to ensure the data were adequately captured (Mays & Pope, 2000) in acknowledgement that the analysis was not nomothetic (Frank, 2010).

Data Analysis

Data analysis followed the framework outlined by Caddick (2016) and Smith (2016). This included the following steps:

Indwelling: The raw transcripts were read whilst recruitment was ongoing, to help inform new questions to be asked in future interviews and open understanding in unanticipated directions. During the process of indwelling in the transcripts, the broad questions from the research were held in mind and initial thoughts about the narratives were noted. The researcher held the position during this phase that the participant was not an information source, but a storyteller sharing a story with the researcher. A summary of each participant's narrative was also produced (Appendix O).

Identifying stories: Stories were then identified by drawing together the information within the raw data where participants talked about the same situation. It was noted during the indwelling of the first transcripts, that participants would often revisit parts of their story to add information and provide them in a non-chronological order. These were coded separately within the data (Appendix P).

Identifying narrative themes and thematic relationships: Attention was then turned to identifying narrative themes and thematic relationships between the content of the stories, identifying patterns and structural elements to compare across the participants. Key theme material was highlighted, and summaries were placed in the margin to highlight the apparent and underlying meanings of the data.

Opening up analytical dialogue further: Using the original dialogical questions posited by Frank (2012), the data were re-read to open up new understanding of each narrative. These dialogical questions were based on the concepts of resources (who needs what), circulation (who affects who), affiliation (who will associate with who), identity (how people are taught by their story) and what is at stake (how the storyteller holds their own in their narrative).

A table was produced (Appendix Q) where thoughts were recorded surrounding the important questions relating to each participant.

Results

The results are presented following the over-arching focus of DNA: focussing on the "mirroring between what is ***told*** in the story – the story's content – and what happens as a result of ***telling*** that story – its effects." (Frank, 2010, pp. 71–72). The Told highlights themes of powerlessness, separation, labelling, and relationships. The Telling discusses Quest Narratives and stories of coping, resilience, and personal development.

1. The Told

Key aspects of the CIMHU experience are discussed, with the theme of powerlessness intertwined throughout the themes of separation, labelling, and difficult relationships within the CIMHU, portraying the CIMHU to be a traumatic experience.

1.1. Powerlessness

The theme of powerlessness underpinned the experience highlighted through the other themes, often leading to participants perceiving the CIMHU experience as traumatic. Participants shared how when they were admitted, they lost control over how they were perceived by others, what their daily routine consisted of, and how the restrictions on their lives prevented them being themselves. Admission was often the culmination of unaddressed need and distress within the community, but the challenges of feeling misunderstood for the difficulties experienced continued from community care into admission. At the point of admission, lack of power in the situation became apparent, as participants enacted threat-responses to cope with the difficulty of the environment and to respond to the oppression of the CIMHU. The feelings of powerlessness often started at the point of admission, where most participants experienced being sectioned under the Mental Health Act.

> *"I just remember having a mental health act assessment and 'right, you're on a section 2, you're going tomorrow morning.' and it was terrifying no one told me what it was like nothing. So I ended up being transported by a secure ambulance three hours away from home and umm I was carried into my room and that was that." (Belle, 79-82)*

Admission meant that participants felt they were being restricted on expressing their self-identity. They acknowledged that this was understandable to provide safety, however, the rationale for rules was unclear, or they were too restrictive, preventing them from holding onto their identity they held within the community. This was difficult for participants to navigate because at the same time, they felt an expectation from staff to continue to be themselves. The participants often turned to staff for direction in this, but staff were either unavailable or did not fully understand who they were as a person. Participants described feeling that they had no control over how the staff saw and understood them, even though the intense support and observation from staff meant that participants expected staff would get to know them for who they wanted to be. Participants often felt like they were seen by the staff as a ‘problem’ that needed fixing or containing.

> *“When the staff found out about everything going on at home is when I think I lost myself a little because…to the staff…it became ‘Adele who’s not very well and has problems at home’…I was kinda just this diagnosis and this back story…and it very much dictated how I was treated” (Adele, 63-66)*

Participants were also often critical of the care received within the CIMHU. They shared stories of care being inappropriate or unhelpful. At the time, they seemed aware of these issues but were unable to instigate change and had to manage what was happening to them. The inability to change the experience left participants feeling powerless over their care contributing to some having flashbacks or triggers whilst in the community post-discharge.

> *“Everybody had to witness somebody being restrained and literally just dragged along the floor...you never felt like you could just talk to somebody, you just felt like you’re walking on eggshells all the time...” (Ellie, 100-111)*

> *“Luckily I don’t suffer from any PTSD and stuff that I know my friends do who I made whilst I was there. But you’re obviously left with I guess you could say scars in a sense” (Tiffany, 96-98)*

Participants initially felt it was unclear what the benefit was from an admission, with some saying that it made them worse, such as learning new self-harm behaviours or being discharged without community care. Ellie felt that *“to actually get out of there, I pretended that I was OK when I wasn’t.” (94-95).* Belle and Adele discussed how the CIMHU created a dependency within them to need the CIMHU; they felt the CIMHU was not conducive to recovery but was the only place they felt contained or safe. They appeared to lose their sense of agency in managing distress, and therefore they adopted the narrative of the professionals around them that CIMHU was their only option.

> *“I wanna go back inpatient because I feel tired fighting myself. It’s not like I wanna be there. But this kind of longing for safety for a bit because...you get used to people being there to save you” (Belle, 483-485)*

There was a shift in perspective for four participants, as they were able to work with the CIMHU staff to take some control over their own care, seeing the CIMHU as a resource which required them to actively participate in receiving care, rather than being done to.

> *"I didn't gain a single thing from it because I wasn't in the right frame of mind…But if you were to have, say, put me back in there the third time around, I feel like I would have used it a lot more differently." ... Each time I had been admitted I had learned something new about myself" (Tiffany, 132-134)*

1.2. Separation from the outside world: "it sucks the life out of you" (Ellie)

Participants spoke about being admitted to a CIMHU resulted in them being disconnected from the outside world, losing the features of their lives which acted as reminders for having a familiar routine and sense of who they were as individuals. The separation they felt from their normal community was noticeable, both physically and relationally. In participants' stories there was a turning point of becoming an inpatient which marked a distinct change in their care. Participants' language around an admission often focused on the "going to" inpatient, describing the process as "locked away", "chucked in here", "sent to", "taken away", "put in there". All participants spoke about how the decision for the initial admission was not made by them, but often involved the judgement of parents and professionals, leaving the participants feeling they had been "done to".

Participants shared how the experience of rules and procedures in CIMHU further exacerbated the separation from their life and the coping strategies they used before admission, for example friends, family, school, and hobbies or regular activities. Four participants reported that at the time of their admission they were not allowed mobile phones on the ward, which limited their ability to maintain regular routes of communication with friends. Equally, participants appeared to notice the disconnect from the outside world when they were unable to experience significant events or rites of passage such as funerals or birthdays.

> *"Family and friends are a very, very big part of my life…we weren't allowed mobile phones…we were only allowed limited access as to when we could have them…so contact was very sparse which again do think at the time kind of formed little separations and distance between some of the relationships [I had] with friends in particular." (Tiffany, 384-395)*

For some this loss was observed by noticing how they were unable to engage in activities perceived to be important steps towards adulthood, such as increased independence or drinking alcohol. The lack of these experiences meant that participants felt their social development was delayed and that they were left behind, or that their friends had changed post-discharge. Combined with the feeling that the discharge process lacked support in the transition back into the community, participants felt the CIMHU focused on managing people within the unit, rather than being integrated into a broader care system spanning into community life.

> *"…my friends all made new friendships groups and moved on.. because at 15/16 you are going to house parties…going shopping…'oh I thought we'd sit at home and watch TV... or go to each other's house for meals'…it felt like I was paused at the age I went in because they'd all moved up and I was like I don't know how to do that…" (Belle, 126-132)*

> *"I ended up discharged from there and then again it only lasted two days because there was no support in place after the discharge, it was 'that's it, you're gone now'" (Belle, 36-37).*

Some participants shared how they were admitted many miles from their home which put pressure on families to maintain regular visits and involvement in their care. Feelings of guilt arose for the emotional and physical burden placed upon families, empathising that their parents would have similarly felt burdened within the community. Tiffany drew connections between the similarity of her experience and her parents' experiences, by noticing how they too were unable to engage with the activities which usually come with parenthood, and the emotional toll of having the familial routine and structure disrupted.

> *"I did feel like I was almost stopping them from getting on with their lives and even in a sense of like the travel, like the physical sense, but also like mentally for them, and it must have been really difficult to see like other parents and like my friends coming out of school with their mums and dads yet, their daughter was 200 miles away." (Tiffany, 612-615)*

Whilst most participants spoke negatively of this separation and loss of community connection, for Lucy the admission came in the context of ongoing familial difficulties and the welcome ability to have significant disconnection from that context. This brought stability and containment; safety from traumatic experiences at home and allowing her to focus on herself.

> *"it wasn't a positive experience but getting out of that home environment where I lived was probably one of the best things that happened for me…" (Lucy, 208-209)*

1.3. The label of being an inpatient: "People were walking on eggshells around me" (Adele)

Prior to admission, participants were able to manage their mental health independently or within the confines of trusted close relationships such as family or friends. The language used at this point by participants described struggling with difficult emotions, confiding about the difficulties within trusted relationships. However, once they were admitted and then discharged, the narrative others used to describe their difficulties changed; from a personal struggle in an understandable situation, to a narrative of the person being abnormal.

> *"…A lot of my friends that I had in school, they'd never known anyone that had ended up in hospital for mental health. It's always been like a bit of anxiety or depression, it's never been like anything crazy….*
>
> *….I think it freaked them out a little bit… 'Who is this crazy person? What is going on?'" (Adele, 232-234 and 242-243)*

> *"I thought I stood out like a sore thumb because I was in foster care and I felt exactly the same with inpatient…but it took over the foster care, no one care about that, it was more of a 'she's crazy now'" (Belle, 332-334)*

People noticed their friends becoming cautious around them, reducing the contact. Upon discharge, this meant that re-integration was difficult. This shift in perception by others changed the way that participants viewed their own difficulties, reinforcing that they had something ‘wrong’ with them. They now felt that they needed treatment even though the difficulties had not changed at the point of admission, they had just been noticed more. At admission, the language started to become more medicalised and appeared to reflect the language which might have been used by the CIMHU staff such as “incident”, “more behaviour”, “going in for treatment”. They began adopting their diagnosis as the primary identifier that people saw in them, with some participants also feeling that it meant they were a failure for not being able to manage their mental health within the community.

> *“…so in my CAMHs admission, I believed my disorder was my identity, like that was my identity.” (Tiffany, 231-232)*

> *“Q: When you got the label of being an inpatient, did that change the way you viewed yourself?*
> *Belle: Yeah, I viewed myself as a failure…saying well you’ve shot yourself in the foot.” (Belle, 237-240)*

This change in perception by the individual and those around them, led to all participants feeling ostracised within friendship groups, in school, or at home. The participants experienced people becoming more cautious around them as they implemented stricter boundaries, to keep them safe and to prevent triggering another admission. However, the participants were left feeling confused at how the external world perceived their risk compared to internally how they felt, whilst also making them feel increasingly different. Adele shared how she also feels different within the mental health community, with the inpatient label bringing another layer to being what she describes as “a CAMHS kid”. Belle and Lucy also alluded to a similar experience whereby friends with mental health difficulties started to look at them differently after they had received inpatient care.

> *"…… a lot of people struggle with their mental health but the mental illness aspect, it suddenly changes [how] people treat you as the ill person… (Lucy 162-163)"*

The explanation for the newfound judgement after receiving inpatient care may come from the narrative resources which participants drew upon to describe what they expected from the CIMHU prior to admission. They often had limited expectations of what the CIMHU milieu would be like, and where they did, it was limited to small amounts of information or cultural narratives around mental health hospitals. It may be that the participants were drawing on the same shared understandings of CIMHUs that those around them used to make the judgements about the inpatient label.

> *"I thought I was gonna get some intense therapy sessions or something to help [slight laugh]. But obviously I didn't." (Lucy, 88-89)*

> *"I don't know what I expected, but I didn't expect that...There was already 12/13 kids in there that shocked me because…I didn't realise there was even more people who ended up in this situation." (Adele, 305-309)*

The participants also believed that others expected them upon discharge to be 'well', struggling to understand the role of the CIMHU in a recovery pathway. This meant that participants felt they had to appear as if they were coping in the community, whilst not receiving the support that they still required. This led to relapse for four participants, perpetuating the feelings of failure for needing the CIMHU.

> *"there's this big misconception someone goes into an inpatient unit and they're suddenly fixed when in reality, you don't start the therapy and actual recovery process until you're out and people don't really realise they think you go into hospital and you get fixed" (Lucy, 150-153)*

Most participants also talked about how the inpatient label continued to affect their future, with either the care decisions made about the best interventions, or with future vocations where it inhibited them accessing certain career paths.

> *“So then the solution for the next well..has been for the last kind of three years has always been admissions. Which is really not helpful, but because they've seen it's kept you safe in the past instead of finding work on keeping you safe in the community, it's like ‘shove her in hospital for a bit.’” (Adele, 143-146)*

> *“I’m trying to apply for the army and the inpatient setting this is the bit which has shot me in the foot.” (Belle, 297-298)*

1.4. The hyper-vigilance within peer relationships

This subtheme describes the significance of the relationships made in CIMHU with peers. Participants often described the relationships with peers in the unit being the closest they had whilst admitted to the CIMHU, helping them to feel that they were surviving the admission. The stories about the relationships within the CIMHU however portrayed that participants were often hyper-vigilant to one another, driven by the need to keep themselves safe as they watched others around them go through distressing situations or serious harm.

With the separation from the outside world, peers in the CIMHU became the primary place for finding support and understanding, being the few people who could understand what the CIMHU milieu is like. Participants described a mutual understanding with others in the ward about their experiences, often for the first time. The shared understanding meant that participants felt they did not need to explain themselves to one another to be understood.

> *“...you develop friendships in the hospital because you can just say something and they get it straight away. You don’t have to go into loads of detail and cause you see them everyday, they can tell if you’re having a bad day.” (Adele, 267-270)*

However, these relationships were complicated, further intensified by living with others who were also struggling with ongoing emotional difficulties and risk behaviour. Participants’ accounts of the experience portrayed an environment of hyper-vigilance to who is the most in need, due to the perceived lack of staff availability. Staff? support was only received when participants displayed behaviours which required immediate attention (i.e., self-harm). As a result, some participants describe being drawn into participating in increasingly riskier behaviour to gain the attention of the staff.

> *"if there's an incident it creates a domino effect and one person will do something and then suddenly loads of people are doing something and there's loads of incidents it all becomes chaotic quite quickly" (Lucy, 115-117)*

Many acknowledged this was unhelpful, but at the time, it felt like the only way to get help or be seen. This hypervigilance to one another for care was complicated further by participants who had peers in CIMHUs who committed suicide. Participants' accounts of this experience seemed to be used to illustrate the difficulty of surviving in a complex environment and to demonstrate that they had managed to make it through the difficult situation by both having close relationships with others, but also remaining focused on their own recovery journey to mitigate any risk to themselves.

> *"And she actually ended her life in one of the units…If was her parent your child goes there to be safe to try and to be kept safe like…They shouldn't have let that happen…" (Ellie, 121-123)*

The careful navigation of relationships was also required post-discharge. The relationships formed were strong enough that they often continued beyond the CIMHU, with participants maintaining contact with one another, and forming online groups for those who were admitted at a similar time. However, they also served as a reminder of the CIMHU label and traumatic experiences they had witnessed or been involved in.

2. The Telling

This section reviews the way that participants held the stories of their CIMHU experience within the broader context of mental health recovery and development as a young adult. It considers the narrative structure (The Quest Narrative), followed by two themes which arose from the way that participants told their stories.

2.1. The Quest Narrative (Frank, 1995)

Participants' reflection of their CIMHU experience often followed the story structure outlined by Frank (1995) of being a quest, suggesting that people "meet suffering head on; they accept illness and seek to *use* it." (p. 115). Participants were able to step back and consider the CIMHU experience as part of a broader recovery journey, and the impact on their identity.

Quest narratives can follow a journey, whereby individuals move through different phases of how they relate to their difficulty. The structure presented by Frank (1995) suggests that illness stories may follow a phase of departure (noticing something is difficult but refusing to attend to it); initiation (after a significant event which cannot be unnoticed and the period of time associated with the struggles which come as a result of the difficulty); and return (the story teller is no longer 'ill' but can also relate to the experience had across the illness journey). Participants are placed across this journey in Figure 3.

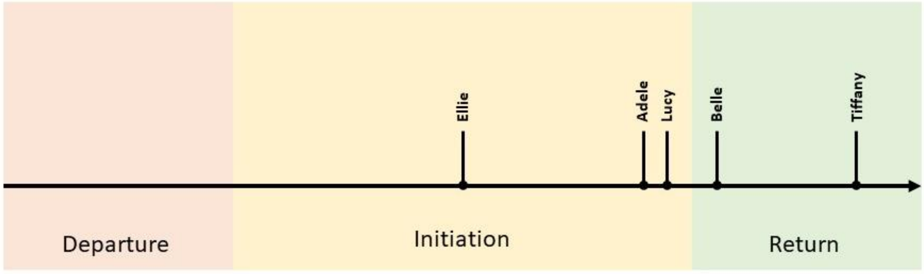

Figure 3 - The Quest Narrative (Frank, 1995) illness journey position for each participant

Belle and Tiffany were deemed to be in the 'return' phase due to all sharing stories of how they perceived their life had moved on from needing CIMHU support, but could acknowledge why they had struggled with the experience and how they continued to make use of the experience. Tiffany wanted to use her voice to help others who might experience CIMHUs, through her vocation, and through sharing positives about the experience when much of the press coverage about the CIMHU she was admitted to was negative.

> *"Because I feel like my experience, it really helped me. So, I feel like it should be praised from my point of view…all you ever see in the press is negative things about mental health hospitals…I don't think I've ever really seen a positive article about it. I feel like that's what hurts because if it wasn't for the staff there, I wouldn't be at the place that I am today." (Tiffany, 794-798)*

Belle however, felt that whilst the CIMHU helped develop personal resilience overall, it hampered her efforts in recovery due to stigma of being admitted.

> *"I've not had any issues with my mental for nearly two years now...which I 100% take full credit for but still to this day the inpatient label it stabs me...I'm going to start a life where no one knows who I am and that's not because I'm running away from the label…I wanna form an identity for myself that doesn't involve my mental health but involves who I am." (Belle, 265-272)*

Adele, Ellie and Lucy were deemed to still be in the 'initiation' phase, due to still receiving ongoing inpatient care as an adult; they were still on the recovery journey from the difficulties they had experienced. Lucy and Adele's narratives suggested that they had begun to use their CIMHU experiences to understand their identity formation, noticing characteristics which were being shaped by their admission.

However, Ellie seemed to struggle with integrating the story of her CIMHU experience, with her narrative being less clear about how the experience fitted into a mental health journey or adolescent development. The stories told focused heavily on the traumatic events which happened within the CIMHU. Compared to others, Ellie’s narrative seemed to place her more closely to experiencing the trauma of the CIMHU, whilst others appeared more distant, and reflective of the experience. This has led to Ellie choosing to keep her experience private, including from family and friends, with fear of upsetting others who care about her.

> *“…if it's hard for me it's gonna be hard for them because they love me so I don't want to let them know what I went through… I don't want them to be upset.” (Ellie, 324-326)*

2.2. Stories of coping and surviving: “it’s like surviving and then you come out” (Belle)

Stories of the CIMHU experience were told, portraying the CIMHU experience as traumatic, which required participants to enter survival-like states to be able to cope with and manage the adversity presented to them in the CIMHU. At the time, participants would initially enter the ward with a fight response, attempting to protect themselves:

> *“I was kind to people, I was nice, I was a good friend, I’d always be there for people but then….in the inpatient it’s sort of like every man for himself.” (Ellie, 466-468)*

> *“I acted like I didn’t care, like rebellious against it…and then when I was there I was actually quite scared.” (Lucy, 443-444)*

which would lead to a ‘fawn’ response (Walker, 2013), after the acceptance that a ‘fight’ response could not protect them.

> *“Inpatient units come with their own trauma and quite a lot of people end up in those units for childhood trauma anyway. It creates this sense of ‘that’s what I’m used to, I deserve more trauma, I deserve more hurt.’” (Lucy, 122-125)*

For Adele and Ellie, there was a realisation as part of the story-telling process that the experiences were traumatic:

> *“It’s weird because I’ve never spoken about how much it’s messed me up I guess.” (Adele, 153)*

As participants felt their identity was imposed upon them by the CIMHU, it meant that some participants felt there was incongruency with how others saw them and how they felt about themselves (as described in *the label of being an inpatient*). The experience of increased rules meant participants felt more child-like. However, at the same time, participants also described being expected to be increasingly mature in managing their emotions. This meant that participants struggled to understand what was expected of them and they seemed to be in a position of trying to adapt to the conflicting expectations of the CIMHU, which was a condition of discharge.

Participants at times struggled to provide detailed accounts of what the experience was like, instead often sharing a generalised feeling about the CIMHU experience. Some explained how difficult it was to portray what the experience is like to an outsider. Belle and Lucy used COVID-19 as a common story which could be shared by the researcher and the participant, and they used the experience of lockdowns to explain how the restrictions felt to them. The use of this comparison seemed to demonstrate how difficult it is for others to understand what the experience of admision is like, drawing on the unfamiliarity society faced during the outbreak of COVID-19. It seemed to also be used as a comparison to demonstrate how difficult the restrictions placed upon them were and how it required them to adapt to cope with a new way of life.

> *"but it kind of softened the transition because I couldn't go out when I wanted to I couldn't do what I wanted. So, it was similar to hospital, but I was gagging for normality." (Belle, 177-179)*

Lucy was admitted and discharged in the context of COVID-19 highlighting how cut-off she felt from home life and the new societal rules like face mask wearing. It served as a reminder to her how she had become detached from her normal way of life.

> *"I kind of forgot that COVID existed and then…I came out and face masks were still a thing and I was like 'this is really weird'…because I forgot what all these issues on the outside" (Lucy, 543-547).*

2.3. Being resilient and becoming independent: "no you don't reside to that label, you don't want to be like that!" (Belle)

Most participants talked about the realisation after discharge that the CIMHU label and associated stigma is almost impossible to shift, thus requiring integration into their self-identity to regain some control over the label. The power that this stigma and social discourse held was apparent within all stories and overcoming this meant dictating their own self-identity as the major step after discharge. Participants had to be resilient to the possibility that stigma might be impactful for the foreseeable future, affecting work and friendships. The missed opportunities to engage in social activities associated with growing up meant that participants had to set their own developmental path to achieve their goals.

> *"I missed out on my 18th birthday... it pains me to know that all my friends got to experience these things like growing up underage drinking…if you go into a bar at 18 and with your mates and they're like 'oh my god what do you drink?' and you're like 'I don't know I've never tried alcohol before' it's……you're just so behind constantly trying to catchup…*
>
> *…I'm trying to understand what is socially normal."*
> *(Belle, 306-314 & 322)*

This different social path meant that participants often became more independent and determined in their values. This led to participants either hiding the CIMHU experience from others or only sharing in situations where it helped them to meet their life goals. Overall, participants often only told their CIMHU story to a small number of people who could help.

> *"it helped me with which friendships are good for me cause you feel that you need to hold onto friends even if they're not good for you." (Lucy, 263-264)*

All participants portrayed that being independent and resilient were positive qualities and were used synonymously to describe the process whereby they adopted a newly established focus on life goals. Some participants reflected that although their current life goals are different to those pre-admission, the CIMHU left them feeling alone in coping whilst admitted, meaning that they had to independently reconsider what they would be striving for in the future.

> *"I suddenly had to do things for myself…I went to start a new course completely which actually helped me reach my future goals….it made me really have to re-evaluate my life and re-evaluate my goals" (Lucy, 200-203)*

Tiffany, Lucy and Adele positively associated the CIMHU with developing this self-reliance, acknowledging that although it was difficult to be detached from relationships and miss out on rites of passage, in the long term, the admission gave them the skills to manage transitions they see peers struggle with.

> *"being so far from home really caused a lot anxiety and panic initially, but in the long run, I actually think it has helped me because I felt like I was quite prepared when I had to go to university." (Tiffany, 54-56)*

> *"I think it makes you a more independent and resilient person when you come out because even though the support is around you…you have to get on with yourself and realise things that help yourself cause you can't rely on other people all the time when there's everyone else who is unwell." (Lucy, 221-224).*

Whilst Belle & Ellie's stories blamed the CIMHU for the unhelpfulness of the system and exposure to traumatic incidents, Ellie's stories and post-traumatic symptoms reflected the development of resilience to cope with such symptoms, being left alone to work out how to move beyond them. Belle felt that the discharge was achieved because she developed independence and resilience as a coping strategy to leave the CIMHU.

> *"it was kind of like the wake up call like 'no you don't reside to that label [inpatient care], you don't want to be like that!'…and that's been my motto since day 1. And so that shake up that you are starting to do something else." (Belle, 356-360)*

Discussion

This study sought to understand the experiences of those who have previously been admitted to a CIMHU and the way that the stories of such experiences are impactful on identity formation beyond discharge. It became apparent through the stories that the CIMHU is generally portrayed to be a traumatic experience which affects the individual both at the time of admission, but also once discharged into the community. The experience required not only management of the emotional difficulties which resulted in admission, but also learning how to adapt to a new environment, sharing stories of needing to "survive" the experience to protect their sense of self.

The stories of the CIMHU being traumatic encompassed not only specific events witnessed within the CIMHU, but trauma was implied through the culmination of a separation from relationships, routine and structure to daily life, and activities. This contributed to a sense of losing the self, as the CIMHU became the discourse which shaped identities due to the CIMHU being in control of many of the elements which participants sought to hold onto to be themselves. This resonates with previous literature which has suggested that CIMHUs are impactful on relationships (Biering & Jensen, 2017; Haynes et al., 2011), routine and structure (Gill et al., 2016; Haynes et al., 2011). Although not all participants began their narratives discussing their difficulties prior to admission, it was clear that the CIMHU admissions came at a point in the participants' lives when they were experiencing many threats to their sense of self, after experiencing difficult family relations, schooling, or lack of support from care systems. This meant that participants entered the CIMHU after already experiencing some powerlessness. However, the stories were indicative that feelings of powerlessness increased at admission and went beyond what was expected from the CIMHU, with a much greater level of separation and detachment from their milieu within the community than they felt was needed. This resulted in the CIMHU admission appearing to exacerbate the difficulties experienced by participants in understanding who they were.

The Power Threat Meaning Framework (PTMF; Johnstone & Boyle, 2018) suggests that the changes in power experienced by the participants upon admission contributed to them feeling that the experience was traumatic. The participants within this study all described how prior to admission they experienced some autonomy and competency in their routine, feeling connected in their local community (i.e., school, family and friends), and able to maintain hobbies. This lack of autonomy upon admission removed the power of the individuals to be in control of much of their lives, leading to them feeling that their sense of self was threatened. Participants developed 'fight and fawn' threat responses (Walker, 2013) in an attempt to manage their situation or regain some power. For some, these threat responses remained after the admission and were triggered by reminders of the CIMHU. Whilst some could directly describe the CIMHU as being traumatic, for others, this was implied through their narrative, needing to adapt and cope with a challenging environment. The changes in power were not limited to the physical separation and boundaries, but also the ideological power (the ability to feel in control of their own mental health narrative and identity), legal power (the restrictions associated with sectioning), interpersonal power (through the ability for staff to care or not care for participants), and social capital (the ability to have social status amongst peers) REF PTMF here. The results suggested that the power held within these different domains was experienced by participants through the dominant narratives present within the CIMHU milieu (White & Epston, 1990) – the social and cultural accounts which are enforced upon a person and result in the individual creating a problem saturated narrative about themselves.

For the participants who were able to reflect upon regaining more control in their care, an important step was forming trusting relationships with staff to feel safe and understood, by creating a shared meaning of the participant's experience with staff, contributing to feeling some competency in their own care. The participants within this study who described more positive relationships with staff, perceived their outcomes within the CIMHU to have a positive impact upon their sense of self. This is unsurprising when considering the perspective that identity is relational and created in the narratives constructed between people (Combs & Freedman, 2016), but it emphasises the important role that CIMHU staff have beyond crisis and risk management in contributing to their service user's identity.

A noticeable impact of the stories of CIMHU care upon participants' identity was the shift from feeling powerlessness in their sense of self during the early stages of admission, to becoming increasingly independent and resilient as their time within the CIMHU progressed. This did not occur after a single event or significant turning point, but was the gradual development and impact of needing to "survive" the CIMHU, which in turn required them to develop the skills needed to become resilient. The shift for each participant occurred at different points and with different levels of awareness at the time. Whilst some noted their increasing independence whilst admitted, for others this was only noticeable once discharged. It appeared that the participants ability to recognise their increase in independence and resilience was dependent on where they were within *The Quest Narrative*, with those able to move from the 'initiation phase' (the narrative section dominated by the identity of being 'an inpatient') unable to see the development of the independence and resilience, whilst those within the 'return phase' (the narrative section of finding meaning and purpose of the 'inpatient' identity) were able to discuss their increased resilience and independence as a result of the CIMHU.

For those within the ‘return phase’, this resilience and independence was portrayed by the participants as becoming heroes in their own story, often seeing themselves to be responsible for the positive changes which had occurred in their lives, such as new vocations and ‘surviving’ the difficulties they had experienced whilst in the CIMHU. This resonates with Neimeyer's (2004) idea that once an individual can externalise the dominant narrative, separating the problem saturated narratives from the self, it can lead to post-traumatic growth; the development of new meaning and schemas after experiencing traumatic events (Tedeschi & Calhoun, 2004). The participants who positioned themselves as the hero, appeared to use their stories of the CIMHU to continue to drive and motivate them moving forwards in their goals, making them determined to achieve them. For those who could not see themselves as a hero in their own narrative, rescuing themselves from the traumatic experiences of the CIMHU, the story-telling process highlighted how they had been protecting themselves from the experience, minimising their exposure to the story and reminders of the impact it had on their lives. For two participants, this research was the first time they had spoken at length or in detail about their CIMHU experiences. It appeared that the story-telling process was to some extent therapeutic, helping participants to process how they had reached the stage in their life they were, and using the space within the interview to process some of the dominant narratives of the CIMHU. This aligns with previous research suggesting that the re-telling of trauma stories helps to create a linguistic representation of trauma and identify the purpose and value of the adversity (Kaminer, 2006) and highlights that clinicians should support individuals who have experienced CIMHUs, whilst admitted but also once discharged, to construct narratives about their CIMHU care and the impact it has had on shaping them into the person they are now.

Limitations

The participants involved within the study were all female, White British and most had been admitted longer than the UK median length of stay of 60 days (Children's Commissioner, 2020). The small sample size means that this is not proportionately representative of the CIMHU population demographics, however, does include participants from the largest population group within CIMHUs. Equally, the majority of CIMHUs within the UK are general adolescent or eating disorder wards (Clarke & Nelson, 2020) which this sample represented. The study is missing voices from racialised minority communities within the UK, who are more likely to be held in secure units than their White peers who are more often cared for in general wards (Clarke & Nelson, 2020). The nature of self-selection for the study also means that it is likely that only those who came forward to speak were those either interested in sharing their story about CIMHUs, which may come with the agenda of wanting the care provision to change, or to change the public discourse surrounding CIMHUs. Qualitative research does not seek to generalise findings and so the experiences captured may not reflect the mixed experiences of most people discharged from CIMHUs in terms of effectiveness and/or quality of experience (Livermore, 2023). For example, those who still experience threat responses because of admission may feel unable to discuss their experiences due to them being too traumatic or triggering. Equally, others who are discharged may feel that the experience was insignificant in their mental health care and therefore it would not be a priority to take part in this study.

The research design also had an inherent focus on the individual. It is known that the impact of CIMHU extends much more broadly beyond the adolescent admitted, as it also affects close relations such as parents and close family (White, 2023). Under the Five Year Forward View for Mental Health (NHS England, 2016) children should not be placed out-of-area by 2020/21, yet it still occurs (Livermore, 2023). With adolescents reporting increased independence and having little reference to family within the stories shared as part of this research, understanding from a family's perspective what the lasting impact is of having a child admitted to a CIMHU is important for considering the wider disruption caused by CIMHUs.

Clinical Implications

It must be considered that the aim of the research was not generalisability, indeed, the unfinalisability of the narratives shared means the analysis could only be made in the context of what the participants had experienced and shared (Frank, 2010). Therefore, as time progresses for them, so too may their narratives and the roles the stories serve.

Firstly, all the participants within this study talked of witnessing traumatic incidents of self-harm or clinical practice which did not meet expectations. It is beyond the scope of this qualitative research to comment on effectiveness of CIMHUs, however, the participants' experiences d question whether they contribute to recovery and if within the short-term, an admission is beneficial. As the participants often felt powerless during admission, frameworks need to be established to ensure that young people can contribute and question the care they receive. None of the participants talked about provisions such as advocacy which could help to provide a voice over their care. Under the Mental Health Act (2007), advocacy is offered upon request. Clinicians should ensure that local policy ensures that all new admissions are offered an advocate and establish regular times to meet with one at regular points throughout their care, rather than waiting for the service user to request one from a professional who is perceived to hold the power over their care.

The research suggested that an important part of feeling that you are succeeding within the CIMHU is the ability to have some power over oneself whilst admitted. Nearly half of young people report not being involved in care planning (Livermore, 2023). Primarily, the findings of the study suggest that young people when admitted want to be meaningfully included within the treatment plan, from admission through to discharge. The participants who discussed gaining control over their care and their identity within the CIMHU began to speak positively about the experience in the long-term, also sharing how it had contributed to their sense of vocation and desire to work in mental health. This corroborates previous findings suggesting that decision making power can contribute to increased self-confidence beyond treatment (Jager et al., 2017). Further, the recommendations of Bjønness et al. (2020) and Livermore (2023) are also supported, emphasising developing meaningful therapeutic relationships between nursing staff and service users, where staff are able to fully understand the adolescent from their perspective. Using tools such as the PTMF (Johnstone & Boyle, 2018) may assist clinicians in developing an understanding of the difficulties faced by the adolescent prior to and during admission.

The impact that social discourse had upon the participants' ability to feel part of the community meant that they had to become increasingly independent and resilient. Increasing the publicly available material to assist those being admitted to CIMHUs would help in the understanding and expectations of managing the sudden transition. Co-producing this material with previous service users, would increase the richness of the information produced by including the most relevant information.

Conclusion

This study aimed to shed light on the impact of being admitted to a CIMHU. As demonstrated through the participant's stories, the impactful and memorable elements of their care often go beyond the primary treatment focus of the CIMHU. *"Till the day I die I will take these experiences I've had through it" (Tiffany, 735)* resonated through all the participants' stories. Being aware of these lasting factors is important to ensure that any decision to make an admission is in the context of knowing that the short-term treatment impacts the long-term recovery.

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Part Three: Appendices

Appendix A - Reflective statement

Systematic Literature Review

Initially, I set out for my literature review, uncertain about what area I wanted to focus on as I had always been clear that I wanted to complete the empirical research in the field of child inpatient care. I spent time thinking about ideas within the child mental health field, however, I realised that my research interest lay with the specific milieu of inpatient care for children, so set about to investigate what literature was available. After my own experiences of working within a child inpatient facility, I had my own thoughts on the experience and was curious to investigate how children who are currently admitted made sense of the experience. To my initial surprise, the literature was quite limited, considering that within the news there had been many accounts about inpatient care for children, but also adults, and the difficult experience which is faced by them. As I initially started out on this synthesis of understanding the experience, I was sadly 'pipped to the post' by another researcher who reviewed the literature on the inpatient experience. As I went back to the drawing board, I started to think about the experience again from those around the child within the inpatient facility. I knew that I had some insight into what the professionals might experience but realised that the only perspective of the experience I had was limited to when the child was admitted. Now being outside of the inpatient milieu, I realised that I had no real understanding of what it was like for the parents whose children were many miles from home when admitted. I remembered a couple of families I briefly encountered with whilst working in the CIMHU and they shared details about the arduous journeys they were making to see their child, only to find out that there had been a crisis on the ward or the child did not want to see them. I then started to investigate the research from a parents' perspective. As I was reading the literature, it became apparent that often the parent's experience was intertwined with the professional’s experience or was unclear about specifically who was speaking about the inpatient experience and if it related to a child’s mental health experience. I spent time refining my inclusion criteria and, in the end, included studies where I could feel confident to assign specific research findings to the parent’s (and other family members who were fulfilling the parental role), limiting the analysis to only those parts of the study.

I enjoyed the quite methodical process of thematic analysis. Being someone who enjoys nicely organised information, meant that using Nvivo to support my analysis was a natural step. As I learnt about the coding process, I had underestimated how much time and energy this would take to complete however, when it came to the synthesising themes, I began to thank myself for spending the time upfront coding all the data.

My desire for neatness and organised data also arose in my initial themes and I am thankful for the support of supervision which helped me realise that this came at the expense of neglecting the messiness and difficulty which underpinned a lot of the parental experience. Although initially difficult, moving towards more emotionally driven themes, is something I am proud of for hopefully communicating the experience the parents felt within the review. Overall, I feel that the review helped me to think systemically about what might be happening around those who are admitted to inpatient care. This was beneficial when it came to writing up my empirical results and thinking about my themes as the data were often very individualistic, focusing on the service user’s experience when the admission has a much broader and wider reaching impact on those around the child.

Empirical Research

Setting out – defining the research area

As with my systematic literature review, my interest has always lay in the desire to investigate inpatient mental healthcare. One specific person I worked with during my chaplaincy role allowed me to see as the transition into the community as they were discharged into the local area of the hospital. He was left moving from a ward milieu with supportive adults around him, a group of friends he had made on the ward, and the safety of having everything organised by those around him. On discharge, he was left to move into a flat in an unfamiliar area and with no friends. Many miles away from his home, it made me realise how little input the hospital and unit had once the individual had been discharged. This experience particularly resonated with my interest about the inpatient environment and specifically what happens post-discharge.

Designing the study and ethical approval

Through supervision and increasing exploration of the research area, I realised that I needed to develop my research question around my interest to fit within the body of psychological literature. Identity was a topic which I would spend a large proportion of time exploring with service users when working within the inpatient unit, and I started to explore the identity development literature, exploring how identity development occurs during adolescent and the impact of disruptive life events. I also wanted to hold onto the idea of narratives, and the piecing together of information to make up one's identity which also helped me to decide upon narrative analysis.

Throughout the planning, I always knew that participants were going to be difficult to find – I had preliminary conversations with another researcher within the field and she explained that she had struggled to maintain contact after following people out of the inpatient environment after just six months. I started to think about other places that people would be, rather than just trying to connect with them via the child mental health sphere, leading me to adult mental health services. This meant applying for NHS ethics which I knew, and had been warned, would be a mammoth task. A running theme developed through the ethical approval (which extended into the data collection) of beginning to feel out of control of the research process, as it took many months to get through all the hurdles, often waiting for different people or bodies to reply to the research. On the day in November 2022 when the email came through to say I had ethical approval it felt as if I'd achieved the first major milestone in completing the thesis as it had required such a large piece of work to get to it.

Data collection

As data collection started, I became increasingly excited to have some control over my research again, as the first few participants signed up to participate. The interviews were extremely insightful, honest, and showed vulnerability from the participants which I'm truly grateful for as otherwise the results would not have been as rich as they were. I began working with the local NHS team and it felt promising knowing that I would have several participants who were likely to be able to participate. Although this did not materialise in the same way as I had expected, it was a useful learning experience about the importance of being able to recruit participants myself from people who I can access rather than requiring others to be the gateway to them. Through all the difficulties however of the last few months of recruitment, every interview continued to motivate me to keep going as I heard another story reminding me to keep going. Equally, several articles appeared in the news at the time of those who had also experienced inpatient units previously sharing about their experiences and this too reminded me of the importance of these narratives being documented in the research arena.

Analysis and writeup

Starting out on narrative analysis went against my usual preference for projects of meticulous planning of how every step will be and having a clear roadmap to follow through it. As I set out, it seemed like a foreign methodology of ambiguity and creativity. I read different books, examples, and guides of ‘how to do narrative analysis’ trying to learn how it worked and looked, trying to create the research path that would bring me security in knowing what I had to do in the project. But as I read, I became increasingly aware that part of the narrative process is the uncertainty and the gradual development of the research process. The idea of a “recipe” helped me to think about how I needed to use the previously tested approaches but adapt them to my research question to get the best outcome and best presentation of the ingredients (interviews) I had. The writing process was iterative in nature, as I thought about the way to present the findings, balancing the mix of what was being told directly and how participants were telling their stories. I found that the writing came quite readily due to the amount of time I’d spent indwelling in the data which meant that writing it up was an enjoyable process of communicating something I was passionate to share with others.

Looking back at myself at every hurdle I faced through the research, I feel proud of what this thesis represents, from all the preparation work at ethics, to the interviews and listening to extraordinary stories as I transcribed, to the writing and presenting of all the information. As I sit here writing this reflective statement at the end of this thesis journey, I look back fondly over what it represents and how it encompasses three years of interest in this research field.

Appendix B - Epistemological statement

The epistemological position and stance of the researcher underpins the approach taken throughout the research, shaping decisions and interpretations. This statement summarises the researcher's lens which was held through the stages of the research.

The researcher takes a critical realist position to the research: accepting a realist ontology with a relativist epistemology. This position recognises that cannot access a definitive truth of reality, only through 'windows' into it shaped by individual meaning, context, and social factors (Coyle, 2021). This lies between the continuum of realism and constructionism whereby reality is existent without perception, through to reality being existent only through the perspective we create. This position was upheld as it allowed the researcher to be able to maintain the research aims of understanding individuals' experiences, and to gain an insight into the "reality" that is experienced for those surrounding the inpatient milieu.

By taking a critical realist perspective the researcher acknowledges the subjective role of individual interpretation to defining reality as knowledge that can be uncovered and interpreted in different ways (Edwards et al., 2014; Popper, 2014). Therefore, a narrative methodology is beneficial as it assumes that "stories work with people, for people, and always stories work *on* people, affecting what people are able to see as real" (Frank, 2010, p. 3). The researcher did not want to assume the negative social narrative which is present within the media that mental health inpatient facilities, but rather, perceive the reality of them through the eyes of those who have direct experience, whilst also assuming that these social narratives contribute to the contextual development of their lens in which they perceive their own lives.

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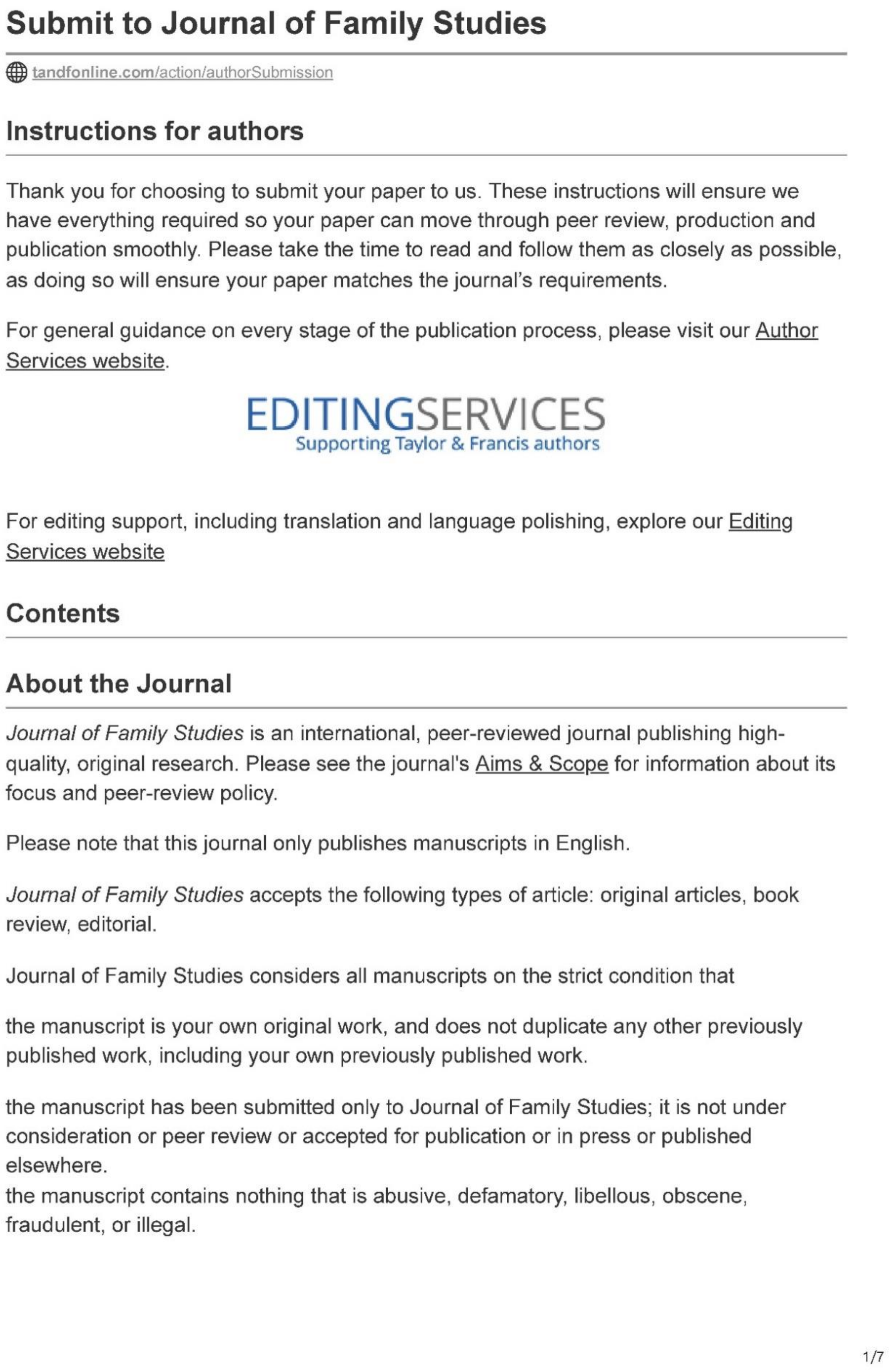
Appendix C – Notes or Guideline for authors for the systematic literature review



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Appendix D – Data extraction form and key characteristics of the papers reviewed

Author (year)	Aims/Research Questions	Location	Methodology	Participants (size, age, gender, relationship to inpatient, length of admission, ethnicity, diagnosis)	Key Findings	Conclusions	Quality Rating
Bjønness, Grønnestad and Johannessen (2021)	Explore parent's role in shared decision making in inpatient CAMHS.	Norway 2 acute inpatient units (ages 13-18) and 2 treatment clinics with inpatient and outpatient treatment for young adults aged 16-24.	Semi-structured interviews via purposeful sampling. Adolescent service users involved in interview protocol development. Thematic analysis (Braun & Clarke, 2019)	**Parents (10 families)** • Male/Father: 3, Female/Mother: 9 **Adolescents (n=10)** • Female: 7 Male: 3 • Age Range: 15-22 • Average Age: 17.5 • Those over 18 had experiences of inpatient CAMHS. <u>Adolescents contributed to questionnaire development (unclear if related to parents). Parents only interviewed for research question.</u>	<u>**Four major themes collected from the study:**</u> • **Self-determined treatment, within limits** ○ Self-determined treatment reflects the idea of adolescents being in control of their own care and engaging themselves in it – driving it with a steering wheel. ○ Portrayed as the right thing for adolescents. ○ The parental dilemma was the extent to which they should strengthen their adolescents' autonomy by allowing them to make decisions. ○ Parents felt compelled to use coercion and organise treatment for specific conditions. ○ Acknowledged that treatment does not work unless adolescent is engaged. • **The essential role of parents** ○ Parents' role before the decisions and in supporting the adolescents through treatment and recovery. ○ Parents had to juggle multiple roles aside from just parent – experienced holding an important role in making decisions for the adolescent. ○ Felt compelled to carry the voice of the adolescent and on request of the adolescent. ○ Provided encouragement to continue treatment. • **The need for information and support** ○ Mixed reports on trust levels of professionals. ○ adolescents pushed out some parents from receiving information. ○ Being the parents of a severely mentally ill adolescent was described as a crisis for the whole family. Difficult transition back to community. • **The fight for individualised treatment and service coordination** ○ Fight to get individualised treatment for adolescents and for professionals to listen to them. ○ parents had to coordinate multi-agency services. ○ Diagnosis not relevant to parents.	• Parents play a key role in the information exchange that underpins shared decision-making. • Findings suggest that if parents support user participation and shared decision-making, their adolescents are more likely to stick to the interventions. • Parents had mixed feelings about capacity of mentally ill adolescents to make decisions about their care. • Role of parents more nuanced than being just involved – their role in the development of mental illness may influence the role they can play in treatment. • Parental involvement is on a spectrum of involvement.	++

Author (year)	Aims/Research Questions	Location	Methodology	Participants (size, age, gender, relationship to inpatient, length of admission, ethnicity, diagnosis)	Key Findings	Conclusions	Quality Rating
Brown (2018)	How does parents' involvement in the child/adolescent's treatment influence their perception of how they can be helpful in their child's recovery?	Australia Adolescents aged 12–18 into either a day program or inpatient program each Monday to Friday for one school term.	Semi-structured interviews with a purposive sample of parents. Data collection points were at admission, at discharge, and at 6-month follow-up. Grounded Theory	**Parents (n=14 sets)** • 11 Female, 6 Male • 6 biological parents; 3 biological mothers & stepfathers; 4 single mothers • 1 foster/adoptive parent pair. • 2 parents culturally and linguistically diverse parents (English second language); 2 families from other English-speaking countries; 1 indigenous mother. • 4 households middle class; 8 lower middle class/working class; 2 solely receiving welfare benefits. **Adolescents (n=16)** • 12-18 • 9 Female, 5 Male • mixed diagnoses, including various anxiety disorders, depression, oppositional defiance, psychosis, and school refusal. • Length of admission unknown. <u>Parents only interviewed. Adolescents are related to the parents interviewed.</u>	<u>**Overall theme of parent helplessness and hope invested in external treatment.**</u> Model generated whereby parental level of engagement changes treatment focus and outcomes: **Strong engagement – parent involved** • On parent insight • Step back > promote independence • Step up leads to firmer limits and calmer connection • Improved parent partnership • **Hope after 6 months:** sustained hope **Ambiguous engagement – parent involved** • On directing parents to step back so promote child's independence • Calmer connection • Improved parent partnership • **Hope after 6 months:** sustained hope – tentative hope ***or*** • On understanding child's condition • On parents stepping back to promote child's independence • **Hope after 6 months:** tentative hope – low hope/helplessness **Poor engagement - parent sidelined** • On child on child's condition • **Hope after 6 months:** low hope/helplessness	• Some symptom improvement and/or an alliance with program workers appear to be necessary conditions for development of parent hope, but they are not sufficient in accounting for the variations in parents' hope. • quality of the parent–child relationship is an important contributor to children's and adolescent's mental health symptoms • When parents shifted from being invested in external "expert" treatment to having a sense of their own capacities to make a difference for their child, they finished the program with increased hope. • The degree to which parents discover things within their own capabilities to affect their child's environment for the better seems to be central to building sustained hope.	++
Dikeç, Uzunoğlu and Gums (2019)	The stigmatization experiences of parents with a child who received inpatient treatment	Turkey Inpatient service of a regional mental and neurological disease hospital	Semi-structured interviews using purposive sampling with parents. Content analysis used to determine data saturation. Thematic analysis	**Parents (n=15)** • Female/mother: 8 • Male/father: 7 • 7 single, 8 married • 1 good economic status; 9 moderate; 5 poor. **Children** • Mean age: 15.33 (13-17) • Mean number of admissions: 1.73 (1-3) • Diagnosis: 3 bipolar; 5 conduct disorder; 4 substance abuse and conduct disorder; 3 mental	**Themes of stigmatisation were examined under the 6 themes of:** 1. <u>Exclusion</u> a. Exclusion within school and group of friends b. Exclusion within the family c. Exclusion within a residential area d. Exclusion by health workers outside the mental health field 2. <u>Labelled</u> a. Labelled within the school environment b. Labelled by others 3. <u>Hiding the child's disorder</u> a. Hiding the child's disorders from everyone b. Hiding the child's disorders only to newly met acquaintances	• Both participant parents and their children with mental disorders were excluded by schoolmates, group of friends, their family members, neighbours, landlords, and healthcare workers outside the mental health field. • Parents reported their child with a mental disorder was ridiculed, labelled, and given a nickname by schoolmates and other individuals. All identity features that patients with mental disorders had before being diagnosed with their mental disorders were removed by the stigmatization of	+

Author (year)	Aims/Research Questions	Location	Methodology	Participants (size, age, gender, relationship to inpatient, length of admission, ethnicity, diagnosis)	Key Findings	Conclusions	Quality Rating
				retardation and conduct disorder Parents only interviewed and related to the children	4. Positive discrimination 5. Coping strategies 6. Despair	society and the society labelled them with just one word, “mad,” referring to a “stained identity.” • Parents sometimes desperate to adopt new situations whilst others accepted that mental disorders are more prevalent and believed it was important to re-educate those around them, changing expressions of stigmatisation and discrimination.	
Geraghty et al., (2011)	How parents have utilized a consumer consultant support service provided in the inpatient unit of a Queensland child and youth mental health service	Australia Specialist mental health unit. Short-term treatment for children and young people experiencing acute mental health problems.	Content analysis (Consensual qualitative research; Hill at al., 1997) of records from consultancies collected over two year period (2006-2008). Consumer consultancy = peer support between parents who have children admitted to the inpatient service.	**Parents (n=50 families)** • 41 parents (either both or just mothers, unspecified breakdown) • 7 grandparents • 5 fathers only • 3 siblings. **No information on associated adolescents to the families**	**Four broad domains identified:** **Experience of services directly or indirectly associated with the admission** • Negative responses about mental health care more prevalent than positive. Positive experiences related to experience of staff members. • Beneficial peer support between parents. Value of talking to non-clinical people. • Criticism of treatment in hospital but overall positive satisfaction positive. • Relief of child being admitted. **Emotional response to the child’s admission** • Most common feelings were guilt and blame, worry and anxiety. • Feeling that they failed the child or contributed to illness. • Blame associated with others around the parents holding them responsible for the child’s difficulties. • Anxiety around the safety of the ward or loss of childhood experiences. **Coping with challenges associated with the admission** • Very disruptive event for family. • Impact on other children in the family, experience of child without any wider family support, difficulties managing a normal parental role when child needs special consideration/attention. • Dealing with practical issues which arose from the illness: economic costs, difficulties finding somewhere to stay during admission, work commitments. **Need for information** • Only present in 36% of records. Most comments were around the need for more information, not	• Difficult emotions experienced when child admitted to inpatient unit. • Mix of relief, stress, confusion and anxiety considering the effect on the family. • Parents are in a heightened state of arousal/trauma response. Contributes to the way that parents interact with staff/the hospital. • Stigma and shame for family associated with child admission. • The empathy received from being with others who’ve experienced something similar positive. Different role to that of nursing staff/expectation of the other person to provide support. • Some dissatisfaction with care model due to stigma and not receiving enough information. • ¼ talked about the problems/frustrations associated with accessing other services (not just hospital) • Loss/grief not prominent – felt not to be documented and communicated through other emotions. • Parents need: compassion and empathy to difficulties; information about child’s problems; practical support/information. • Consumer consultants are able to share their wisdom with staff/other parents to help them understand the vulnerabilities experienced, helping to	

Author (year)	**Aims/Research Questions**	**Location**	**Methodology**	**Participants (size, age, gender, relationship to inpatient, length of admission, ethnicity, diagnosis)**	**Key Findings**	**Conclusions**	**Quality Rating**
					accepting/understanding information to better understand the child.	empower families and staff to work more collaboratively and sensitively.	
Hartley, Redmond and Berry (2022)	Lived experiences of services users, family members/carers and nursing staff	UK 4 sites used. Unspecified the type of inpatient provision recruited from.	Semi-structured interviews exploring experience of the ward; experience of relationships between young people, family members and nursing staff on the ward; barriers and facilitators of positive therapeutic relationships; impact of therapeutic relationships. Thematic analysis	**Adolescents (n=8)** • 5 Female, 3 Male • Mean age: 15.6 (13-17) • 7 White British; 1 British Pakistani • 2 MHA; 6 Informal **Caregivers (n=8)** • 6 Female/Mother, 2 Male/Stepfather • 7 White British; 1 British Pakistani **Nursing Staff (n=8)** • 6 Female, 2 Male • 6 White British; 1 Black African; 1 Mixed Race • 3 Nurse, 5 Nursing Assistant No details on if parties are related/not related. All parties interviewed.	**Six major themes were developed:** 1. Therapeutic relationships are the treatment a. The definitions and importance of therapeutic relationships b. What helps build therapeutic relationships c. Barriers to therapeutic relationships d. Impact and outcomes of therapeutic relationships 2. Cultivating connection a. Quality of connections b. Mutual ingredients of connections c. How staff cultivate relationships 3. Knowledge is power a. Developing knowledge both professionally and personally b. Sharing knowledge 4. Being human a. Family members as human b. Young people as human c. The staff member-human spectrum 5. The dance a. Positions and power b. Roles c. Movement and flexibility over space and time 6. It's tough for all of us in here. a. What makes inpatients units difficult b. Shared and unshared challenges c. Mitigating the impact of the system	• Therapeutic relationships within inpatient CAMHS are essential, complicated and unique in their contents, process and impact – they are the treatment. • The environment has a negative impact on the relationships, therefore mitigation has to be put in place to manage the experience. There are systemic barriers which act as barriers rather than facilitators of the relationship, harming individuals and groups. • There was a spread of converging and diverging themes within the results which suggests the triumvirate nature of the experience. • For therapeutic relationships to be maintained and developed, time is needed to spend cultivating relationships across all parties.	++
Hayes et al., (2020)	Understand how adolescents and caregivers experience an inpatient model of care and perceive the helpfulness of this over time.	Australia Private 10-12 bed adolescent inpatient unit providing voluntary inpatient treatment for adolescents between the ages of 12	Semi-structured individual interviews with adolescents and caregivers separately at baseline or admission to the inpatient unit (T1), discharge from the inpatient unit (T2) and six months post discharge (T3).	**Adolescents (n=16)** • 14 female, 2 male • M Length of stay: 35.3 days • 15 Caucasian • 7 = mood disorders, 6 anxiety disorders, 2 psychotic disorders **Caregivers (n=12)** • 11 Mother • 1 Father Caregivers and adolescents interviewed and related to one another.	Overarching trajectory theme of "winding road to recovery" splitting into 3 main themes at the different time points, and 10 subthemes: **T1 – Waiting for Help** • Getting through the day • Tried everything • Holding on • Key expectations **T2 – Help Arrived** • Safe environment • Relationships • Skill development • Returning to the real world	**Waiting for Help** • Much distress in the family environment prior to admission • Tension waiting for admission to the unit/bed being available • Inpatient viewed as "last resort" – may relate to stigma of inpatient admission leading to barrier of care. **Help arrived** • Therapeutic input was turning point, providing safe/secure environment. Some relief/resentment from caregivers.	++

Author (year)	Aims/Research Questions	Location	Methodology	Participants (size, age, gender, relationship to inpatient, length of admission, ethnicity, diagnosis)	Key Findings	Conclusions	Quality Rating
		and 22 years old	Thematic analysis followed by trajectory analysis		**T3 – Returned to regular life** • The winding road of recovery	• Relationships with peers helpful for young people however, unhelpful ones need monitoring (adolescents feeling responsible for one another) • Value of group therapy/skills developed in therapeutic intervention. • Expression of fear/uncertainty of discharge home. **Returned to regular life** • Number of admissions changes ability to manage. • Recognise that shared decision making important as part of admission but acknowledge the difficulty due to entering inpatient care in crisis. • More equipped to manage life's challenges.	
Merayo-Sereno et al., (2021)	Experience of parents of adolescents with mental health needs who were admitted to child & adolescent psychiatric inpatient unit to provide useful meaning to the subjective experience.	Spain Child and adolescent psychiatric inpatient unit	Grounded Theory – use of focus groups of parents through convenience sampling.	**Adolescents (n=16)** • First admission: 10 • Anorexia nervosa: 6; Severe stress/adjustment disorder: 3; Personality disorder: 3; Psychotic: 2, Bi-polar: 1, developmental disorder: 1 **Parents (n=22)** • Female: 12, Male: 10 • Mean age: 50.5, SD: 6.03 • Biological parents: 16; Adoptive parents: 2; Separated parents: 9 <u>Adolescents not involved in any part of study.</u>	**3 temporal themes with 3 further themes modulating across all 3 themes covering time:** <u>**Experience before admission**</u> • Contemplative state of illness • Previous difficulties prior to admission • Motivation to seek admission • Emotional suffering increases • Pre-admission expectations/balance of needing help and the suffering cause by being aware of own limitations. <u>**Experience during stay (primary category)**</u> • Day of admission – traumatic • Visits – important for maintaining relationships, role of parents as therapists, own feelings of needing children to remain admitted • Functions attributed to nursing staff – different functions/roles of staff expected by parents and their satisfaction. Positive for nursing, mixed for psychiatry. • Share information about admission – limited people told by parents of the admission. • Discharge – fear, uncertainty and unequipped. <u>**Experience after discharge**</u> • Results of hospitalisation – greater insight about illness, acceptance that hospital is part of process that continues afterwards.	• Explores data through the Prochaska and DiClemente (1983) model of change. • Parents find it difficult to accept inpatient admission and to engage when their children are initially admitted due to being in the precontemplative/contemplative stages. • Increase in insight into the treatment programme, child's difficulties, allows them to move into the preparation stage and think about how they can support the child whilst admitted. Able to think about what life might be without the health problem being present as part of entering the action/maintenance phases. • Parents need to be aware of the rationale for security/physical procedures and inpatient process to be able to engage and to make it less traumatic. Seen as beneficial care if explained calmly and rationally to parents. • Parents acknowledge the role eventually they play in supporting the child but feel unequipped to help.	++

Author (year)	Aims/Research Questions	Location	Methodology	Participants (size, age, gender, relationship to inpatient, length of admission, ethnicity, diagnosis)	Key Findings	Conclusions	Quality Rating
					• Repercussions on the family – high impact on family for both health and relationships, especially with disagreement. Siblings at risk of having less attention. • Repercussions at school – support highly valued. Children afraid of peer reactions. • Follow-up – more positive in hospital outpatient vs community teams. • Successive admissions – increased anxiety as problems evolve. Relationships with hospital already developed. **<u>Proposals for Improvement</u>** • Communication between community/hospital. • Uniformity in professional accounts • More detailed information provided. • Work with families centre of treatment **<u>Feeling of guilt</u>** • We did not notice • Will there be another option? • Guilty for the disease itself. • I felt helpless **<u>Stigma</u>** • Triggers of police/emergency units at home address. (structural stigma) • Family stigma – in the entire family • Self-stigma – comparisons to society. • Consequences of stigma – need to protect children.	• Shorter admissions lead to more anxiety around discharge vs longer admissions. • Professionals should tailor intervention with parents based on level of change they are in. • Maintenance phase would begin at end of hospitalisation period.	

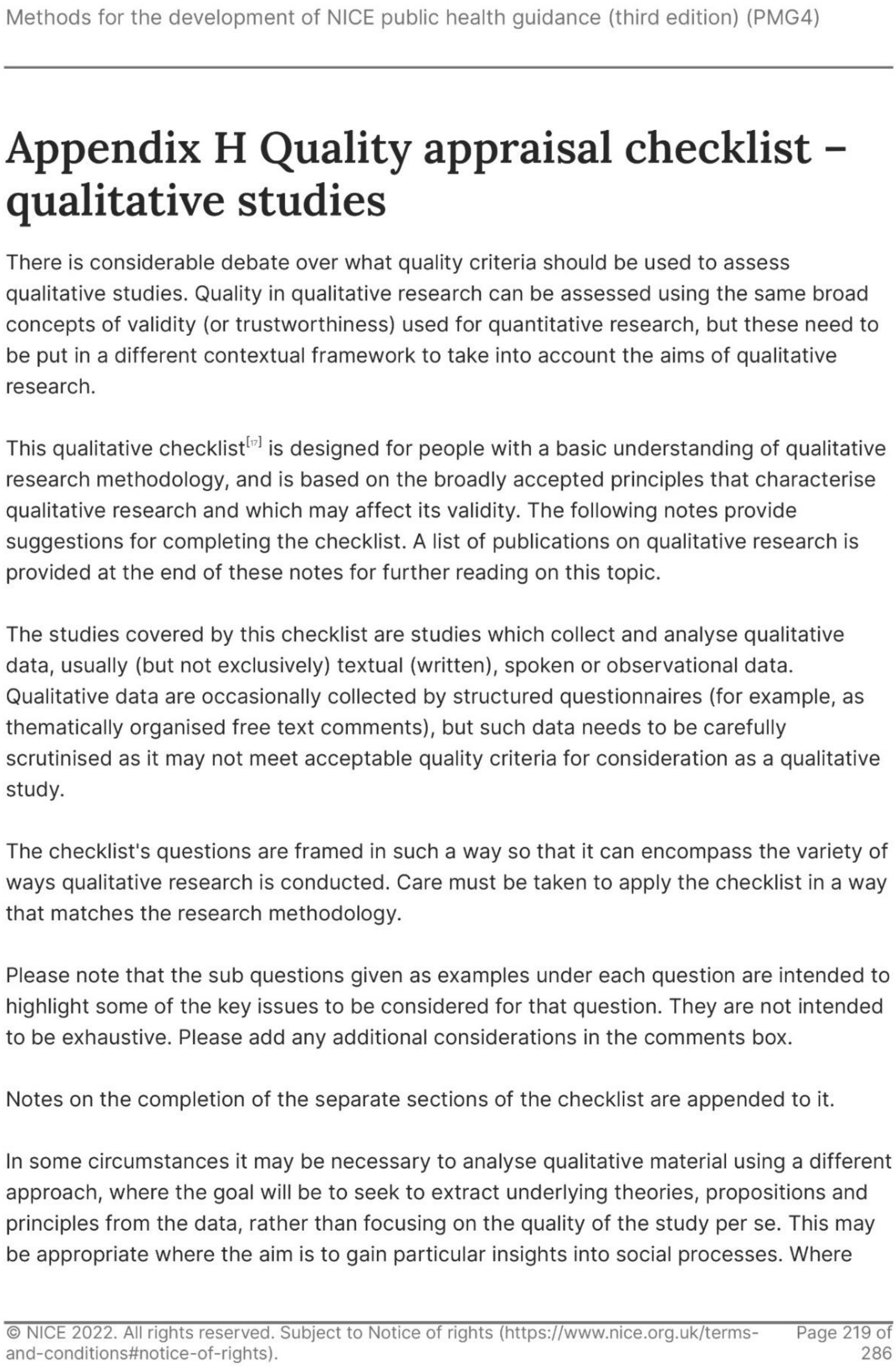
Salamone-Violi, Chur-Hansen and Winefield (2016)	Identify perceptions and experiences of children and young people accessing mental health services	Australia
		
		Inpatient provision for those with enduring mental health problems and those in crisis. Average length of stay is 5 days.
			Semi-structured interviews with carers who the research (unit clinical psychologist) had no working relationship with.
			
			Thematic Analysis (Braun & Clarke, 2003)
				Adolescents (not interviewed)
				• Diagnosis: adjustment disorder; suicidal ideation; depression; psychosis; mania; delusional disorder
				• Length of admission: 2-35 days
				• 2 children under Involuntary Treatment Order
				Carers (n=11)
				• 9 Female, 2 Male.
				• 10 Biological parents; 1 maternal grandmother (legal custodian)
				
				<u>Only carers interviewed – related to children</u>
					Three overarching themes developed:
					• Experiences prior to admission
					  ○ Accessibility –geographically far to community services
					  ○ Service quality – mixed experiences of frequency of appointments; insufficiency of treatment and exclusion from therapy sessions.
					  ○ Barriers to admission – when carer has a preference for hospitalisation, frustration that assessment did not lead to admission.
					• Expectations about admission
					  ○ Assessment – admission an opportunity to have in-depth assessment for both inpatient and community treatment.
					• Inpatient experience
						• Participants reported greater dissatisfaction with community-based settings rather than the inpatient unit.
						• Important to carers to have comprehensive assessment of their child, inclusion in decision-making about their child's care, positive interactions with staff, education about their child's illness and liaising with other services on behalf of the child and their carer.
						• Inpatient unit provides both physical containment of the individual and emotional containment for the carer who is often experiencing fear about maintaining their child's safety.
						• Important to include carers in the care programme even if young person
							++

Author (year)	Aims/Research Questions	Location	Methodology	Participants (size, age, gender, relationship to inpatient, length of admission, ethnicity, diagnosis)	Key Findings	Conclusions	Quality Rating
					○ Relationship with staff – able to communicate concerns/decision making readily viewed as positive ○ ongoing concerns - security of inpatient admission means that concerns often resurfaced at point of discharge. Themes of length of stay; relapse and safety arose for concerns people had for the discharge process. ○ Desired changes – changes which will be beneficial for their child and themselves. Included admission based on perceived degree of "wellness" and continuity of care into the community.	declines due to often the carer being significant in community care/support. Negotiation process of working out where staff/young person and carer are amicable. • Participants acknowledged greater understanding of their child's illness as a consequence of the admission process, that did not alleviate any of their concerns about responsibility for ensuring their child did not relapse once discharged.	
Sarrió-Colas et. al. (2022)	What is the caregiving experience of parents when their adolescent children require admission to a day treatment hospital?	Spain Any day hospital within Spain	Semi-structured interviews with custodial parents/carers of children who have entered a day hospital. Convenience sampling. Interpretative Phenomenological Analysis methodology with inductive thematic analysis (Ho, Chiang & Leung, 2017)	**Adolescent (n=11)** • Age: 12-17 • Diagnosis: 2 Psychosis; 2 Anxiety; 2 Autism; 2 Disturbance of emotions and behaviour; 1 ADHD; 1 OCD; 1 APD **Parents (n=18)** • 7 Female/Mothers; 11 Male/Fathers • 11 Families represented • 7 Married; 3 Divorced; 3 Widow • SES: 1 Upper-Middle; 7 Middle; 1 Lower-Middle; 2 Lower Interview with parent only and no child present.	Overall findings of problems acknowledging the mental illness; dealing with manifestations of illness; coping with adolescent refusal to attend school; lack of tangible help; internalised stigma of admission; and future planning/help for their children. **Themes identified were:** • Questioning an unseen disease • Abnormal behaviour • a long road • truancy and loss of parental authority • internalised stigma on admission • regaining the meaning of life	• The parents created a sense of "being there" based on "the things themselves", a perspective that was as close to the lived experience as possible. The journey made by the parents from the start of the search for help to the present was observed, and demonstrated the various emotional, psychological, interpersonal and physical barriers they experienced. • parents had difficulty in perceiving the manifestations of mental illness which only became visible with highly destructive behaviours, they had problems in finding tangible treatment, they were afraid of losing their parental authority, they experienced internalized stigma on admission, they needed to regain the meaning of life, and they faced an uncertain future. • Physical indicators such as self-harm and aggressiveness helped parents acquire a vision of mental illness and authorized them to seek help • Reluctancy to seek formal help due to fear of possible consequences of being recognised and stigma attached. • Refusal to go to school a decisive moment.	++

Author (year)	**Aims/Research Questions**	**Location**	**Methodology**	**Participants (size, age, gender, relationship to inpatient, length of admission, ethnicity, diagnosis)**	**Key Findings**	**Conclusions**	**Quality Rating**
						• Mothers experiences the admission as abrupt separation – fathers more positive attitude. • Admission perceived as end of the healthcare journey > sadness depending on level of child's non-conformity. • Hope for recovery afterwards and rebuilding of life.	
Sheng et al., (2021)	Describing parents' experiences of caring for their only child with mental illness from an inside perspective and sustain caregiving role.	China Psychiatric hospital. Length of stay mostly ranged from 3-5 weeks but could be as long as 3 months.	Semi-structured interviews via purposeful sampling. Language translated prior to analysis. Thematic Analysis (Braun & Clarke, 2006)	**Parents (n=14)** • 9 mothers, 5 fathers • Age: 33-49, M=40.5 • Married: 11, Single: 3 **Adolescent (n=14)** • Male: 6, Female: 8 • Age: 12-18, M=15.1 • Diagnosis: Bi-polar: 5; Depression: 6; Schizophrenia: 3	**<u>Five main themes:</u>** **Having Responsibility to care for Children** • Having to care day-day for their children. Unconditional aspect of having a hospitalised child. Child unable to look after themselves and adapt to the hospital routine. • Parents required to be active in treatment processes roles due to staffing demands. **Feeling guilt and self-blame** • Guilt and shame due to cultural assumption that children who have material needs met will not have emotional disturbance. • Only children protected from normal life and unable to cope with the turmoil of normal life. • Parents spent more time monitoring child's behaviour rather than with older family members. **Experiencing loneliness and helplessness** • Lack of support/understanding from friends/family/society • Lack of professional guidance/help to meet complex needs. Some reported otherwise and mentioned importance of peer support. • Internet information difficult to discern from. • Stigma of mental illness – fear of being judged. **Drained by caregiving** • Lack of adequate support led to parents feeling that they were burdened with challenges of caring for their child. • Lost freedom/ability to engage in their own activities/social life. Decrease in their wellbeing. **Worrying about the future** • Higher expectations of child's future – majority of children (60%) had multiple admissions. Concern about potential for recovery after multiple relapses/hospitalisations.	• Parents believed it was their responsibility to accompany and take care of them during hospitalization, especially in the context of staffing shortages and cultural expectations to care for family members. • An only child, viewed as the "only hope" of the family – the overprotected nature by parents/grandparents leads to them feeling guilt/blame when child develops mental illness. Guilt also for neglecting their own parents. • Responsibility of being a caregiver and lack of support resulted in the experiences of loneliness and being drained by caregiving. • Caregivers had considerable concerns in relation to their child's social relationships and the ability to work, study, and live life as an adult. • No mention about finance of care even for those on low income – could be due to cultural expectation not to discuss finance with non-family members.	

Author (year)	Aims/Research Questions	Location	Methodology	Participants (size, age, gender, relationship to inpatient, length of admission, ethnicity, diagnosis)	Key Findings	Conclusions	Quality Rating
					- Mixed hope about future of the child.		

Appendix E – NICE Quality Appraisal Checklist for qualitative studies



Appendix H Quality appraisal checklist – qualitative studies

There is considerable debate over what quality criteria should be used to assess qualitative studies. Quality in qualitative research can be assessed using the same broad concepts of validity (or trustworthiness) used for quantitative research, but these need to be put in a different contextual framework to take into account the aims of qualitative research.

This qualitative checklist[17] is designed for people with a basic understanding of qualitative research methodology, and is based on the broadly accepted principles that characterise qualitative research and which may affect its validity. The following notes provide suggestions for completing the checklist. A list of publications on qualitative research is provided at the end of these notes for further reading on this topic.

The studies covered by this checklist are studies which collect and analyse qualitative data, usually (but not exclusively) textual (written), spoken or observational data. Qualitative data are occasionally collected by structured questionnaires (for example, as thematically organised free text comments), but such data needs to be carefully scrutinised as it may not meet acceptable quality criteria for consideration as a qualitative study.

The checklist's questions are framed in such a way so that it can encompass the variety of ways qualitative research is conducted. Care must be taken to apply the checklist in a way that matches the research methodology.

Please note that the sub questions given as examples under each question are intended to highlight some of the key issues to be considered for that question. They are not intended to be exhaustive. Please add any additional considerations in the comments box.

Notes on the completion of the separate sections of the checklist are appended to it.

In some circumstances it may be necessary to analyse qualitative material using a different approach, where the goal will be to seek to extract underlying theories, propositions and principles from the data, rather than focusing on the quality of the study per se. This may be appropriate where the aim is to gain particular insights into social processes. Where developments of the processes of appraisal are required these will be discussed with the CPHE team.

Checklist

Study identification: Include author, title, reference, year of publication		
Guidance topic:	**Key research question/aim:**	
Checklist completed by:		
Theoretical approach		
1. Is a qualitative approach appropriate? For example: • Does the research question seek to understand processes or structures, or illuminate subjective experiences or meanings? • Could a quantitative approach better have addressed the research question?	Appropriate Inappropriate Not sure	Comments:
2. Is the study clear in what it seeks to do? For example: • Is the purpose of the study discussed – aims/objectives/research question/s? • Is there adequate/appropriate reference to the literature? • Are underpinning values/assumptions/theory discussed?	Clear Unclear Mixed	Comments:
Study design		

3. How defensible/rigorous is the research design/ methodology? For example: • Is the design appropriate to the research question? • Is a rationale given for using a qualitative approach? • Are there clear accounts of the rationale/justification for the sampling, data collection and data analysis techniques used? • Is the selection of cases/sampling strategy theoretically justified?	Defensible Indefensible Not sure	Comments:
Data collection		
4. How well was the data collection carried out? For example: • Are the data collection methods clearly described? • Were the appropriate data collected to address the research question? • Was the data collection and record keeping systematic?	Appropriately Inappropriately Not sure/ inadequately reported	Comments:
Trustworthiness		
5. Is the role of the researcher clearly described? For example: • Has the relationship between the researcher and the participants been adequately considered? • Does the paper describe how the research was explained and presented to the participants?	Clearly described Unclear Not described	Comments:

6. Is the context clearly described? For example: • Are the characteristics of the participants and settings clearly defined? • Were observations made in a sufficient variety of circumstances • Was context bias considered	Clear Unclear Not sure	Comments:
7. Were the methods reliable? For example: • Was data collected by more than 1 method? • Is there justification for triangulation, or for not triangulating? • Do the methods investigate what they claim to?	Reliable Unreliable Not sure	Comments:
Analysis		
8. Is the data analysis sufficiently rigorous? For example: • Is the procedure explicit – i.e. is it clear how the data was analysed to arrive at the results? • How systematic is the analysis, is the procedure reliable/dependable? • Is it clear how the themes and concepts were derived from the data?	Rigorous Not rigorous Not sure/not reported	Comments:

9. Is the data 'rich'? For example: • How well are the contexts of the data described? • Has the diversity of perspective and content been explored? • How well has the detail and depth been demonstrated? • Are responses compared and contrasted across groups/sites?	Rich Poor Not sure/not reported	Comments:
10. Is the analysis reliable? For example: • Did more than 1 researcher theme and code transcripts/data? • If so, how were differences resolved? • Did participants feed back on the transcripts/data if possible and relevant? • Were negative/discrepant results addressed or ignored?	Reliable Unreliable Not sure/not reported	Comments:
11. Are the findings convincing? For example: • Are the findings clearly presented? • Are the findings internally coherent? • Are extracts from the original data included? • Are the data appropriately referenced? • Is the reporting clear and coherent?	Convincing Not convincing Not sure	Comments:

12. Are the findings relevant to the aims of the study?	Relevant Irrelevant Partially relevant	Comments:
13. Conclusions For example: • How clear are the links between data, interpretation and conclusions? • Are the conclusions plausible and coherent? • Have alternative explanations been explored and discounted? • Does this enhance understanding of the research topic? • Are the implications of the research clearly defined? **Is there adequate discussion of any limitations encountered?**	Adequate Inadequate Not sure	Comments:
Ethics		
14. How clear and coherent is the reporting of ethics? For example: • Have ethical issues been taken into consideration? • Are they adequately discussed e.g. do they address consent and anonymity? • Have the consequences of the research been considered i.e. raising expectations, changing behaviour? • Was the study approved by an ethics committee?	Appropriate Inappropriate Not sure/not reported	Comments:
Overall assessment		

As far as can be ascertained from the paper, how well was the study conducted? (see guidance notes)	++ + −	Comments:

Notes on the use of the qualitative studies checklist

Section 1: theoretical approach

This section deals with the underlying theory and principles applied to the research.

1. Is a qualitative approach appropriate?

A qualitative approach can be judged to be appropriate when the research sets out to investigate phenomena which are not easy to accurately quantify or measure, or where such measurement would be arbitrary and inexact. If clear numerical measures could reasonably have been put in place then consider whether a quantitative approach may have been more appropriate. This is because most qualitative research seeks to explain the meanings which social actors use in their everyday lives rather than the meanings which the researchers bring to the situation.

Qualitative research in public health commonly measures:

- personal/lives experiences (for example, of a condition, treatment, situation)
- processes (for example, action research, practitioner/patient views on the acceptability of using new technology)
- personal meanings (for example, about death, birth, disability)
- interactions/relationships (for example, the quality of the GP/patient relationship, the openness of a psychotherapeutic relationship)
- service evaluations (for example, what was good/bad about patients experiences of a smoking cessation group).

2. Is the study clear in what it seeks to do?

Qualitative research designs tend to be theory generative rather than theory testing;

therefore it is unlikely that a research question will be found in the form of a hypothesis or null hypothesis in the way that you would expect in conventional quantitative research. This does not mean however that the paper should not set out early and clearly what it is that the study is investigating and what the parameters are for that. The research question should be set in context by the provision of an adequate summary of the background literature and of the study's underpinning values and assumptions.

Section 2: study design

Considers the robustness of the design of the research project.

3. How defensible is the research design?

There are a large number of qualitative methodologies, and a tendency in health to 'mix' aspects of different methodologies or to use a generic qualitative method. From a qualitative perspective, none of this compromises the quality of a study as long as:

- The research design captures appropriate data and has an appropriate plan of analysis for the subject under investigation. There should be a clear and reasonable justification for the methods chosen.
- The choice of sample and sampling method should be clearly set out, (ideally including any shortcomings of the sample) and should be reasonable. It is important to remember that sampling in qualitative research can be purposive and should not be random. Qualitative research is not experimental, does not purport to be generalisable, and therefore does not require a large or random sample. People are usually 'chosen' for qualitative research based on being key informers.

Section 3: data collection

4. How well was the data collection carried out?

Were the method of data collection the most appropriate given the aims of the research? Was the data collection robust, are there details of:

- how the data were collected?
- how the data were recorded and transcribed (if verbal data)?

- how the data were stored?
- what records were kept of the data collection?

Section 4: trustworthiness

Assessing the validity of qualitative research is very different from quantitative research. Qualitative research is much more focused on demonstrating the causes of bias rather than eliminating them, as a result it is good practice to include sections in the report about the reflexive position of the researcher (what was their 'part' in the research?), about the context in which the research was conducted, and about the reliability of the data themselves.

5. Is the role of the researcher clearly described?

The researcher should have considered their role in the research either as reader, interviewer, or observer for example. This is often referred to as 'reflexivity'. It is important that we can determine: a clear audit trail from respondent all the way through to reporting, why the author reported what they did report, and that we can follow the reasoning from the data to the final analysis or theory.

The 'status' of the researcher can profoundly affect the data, for example, a middle aged woman and a young adult male are likely to get different responses to questions about sexual activity if they interview a group of teenage boys. It is important to consider age, gender, ethnicity, 'insider' status (where the interviewer/researcher is part of the group being researched or has the same condition/illness, for example). The researcher can also profoundly influence the data by use of questions, opinions and judgments, so it is important to know what the researchers' position is in that regard and how the researcher introduced and talked about the research with the participants.

6. Is the context clearly described?

It is important when gauging the validity of qualitative data to engage with the data in a meaningful way, and to consider whether the data are plausible/realistic. To make an accurate assessment of this it is important to have information about the context of the research, not only in terms of the physical context – for example, youth club, GP surgery, gang headquarters, who else was there (discussion with parents present or discussion with peers present are likely to cause the participant to position himself very differently and thus to respond very differently) – but also in terms of feeling that the participants are described in enough detail that the reader can have some sort of insight into their life/situation. Any potential context bias should be considered.

7. Were the methods reliable?

It is important that the method used to collect the data is appropriate for the research question, and that the data generated map well onto the aims of the study. Ideally, more than 1 method should have been used to collect data, or there should be some other kind of system of comparison which allows the data to be compared. This is referred to as triangulation.

Section 5: analysis

Qualitative data analysis is very different from quantitative analysis. This does not mean that it should not be systematic and rigorous but systematicity and rigour require different methods of assessment.

8. Is the data analysis sufficiently rigorous?

The main way to assess this is by how clearly the analysis is reported and whether the analysis is approached systematically. There should be a clear and consistent method for coding and analysing data, and it should be clear how the coding and analytic strategies were derived. Above all, these must be reasonable in light of the evidence and the aims of the study. Transparency is the key to addressing the rigour of the analysis.

9. Are the data rich?

Qualitative researchers use the adjective 'rich' to describe data which is in-depth, convincing, compelling and detailed enough that the reader feels that they have achieved some level of insight into the research participants experience. It's also important to know the 'context' of the data, that is, where it came from, what prompted it and what it pertains to.

10. Is the analysis reliable?

The analysis of data can be made more reliable by setting checks in place. It is good practice to have sections of data coded by another researcher, or at least have a second researcher check the coding for consistency. Participants may also be allowed to verify the transcripts of their interview (or other data collection, if appropriate). Negative/discrepant results should always be highlighted and discussed.

11. Are the findings convincing?

In qualitative research, the reader should find the results of the research convincing, or credible. This means that the findings should be clearly presented and logically organised, that they should not contradict themselves without explanation or consideration and that they should be clear and coherent.

Extracts from original data should be included where possible to give a fuller sense of the findings, and these data should be appropriately referenced – although you would expect data to be anonymised, it still needs to be referenced in relevant ways, for example if gender differences were important then you would expect extracts to be marked male/female.

12–13. Relevance of findings and conclusions

These sections are self-explanatory.

Section 6: ethics

14. How clear and coherent is the reporting of ethics?

All qualitative research has ethical considerations and these should be considered within any research report. Ideally there should be a full discussion of ethics, although this is rare because of space limitations in peer-reviewed journals. If there are particularly fraught ethical issues raised by a particularly sensitive piece of research, then these should be discussed in enough detail that the reader is convinced that every care was taken to protect research participants.

Any research with human participants should be approved by a research ethics committee and this should be reported.

Section 7: overall assessment

15. Is the study relevant?

Does the study cast light on the review being undertaken?

16. How well was the study conducted?

Grade the study according to the list below:

++ All or most of the checklist criteria have been fulfilled, where they have not been fulfilled the conclusions are very unlikely to alter.

+ Some of the checklist criteria have been fulfilled, where they have not been fulfilled, or not adequately described, the conclusions are unlikely to alter.

– Few or no checklist criteria have been fulfilled and the conclusions are likely or very likely to alter.

---

[17] This checklist is based on checklists in:

Spencer L. Ritchie J, Lewis J et al. (2003) Quality in qualitative evaluation: a framework for assessing research evidence. London: Government Chief Social Researcher's Office

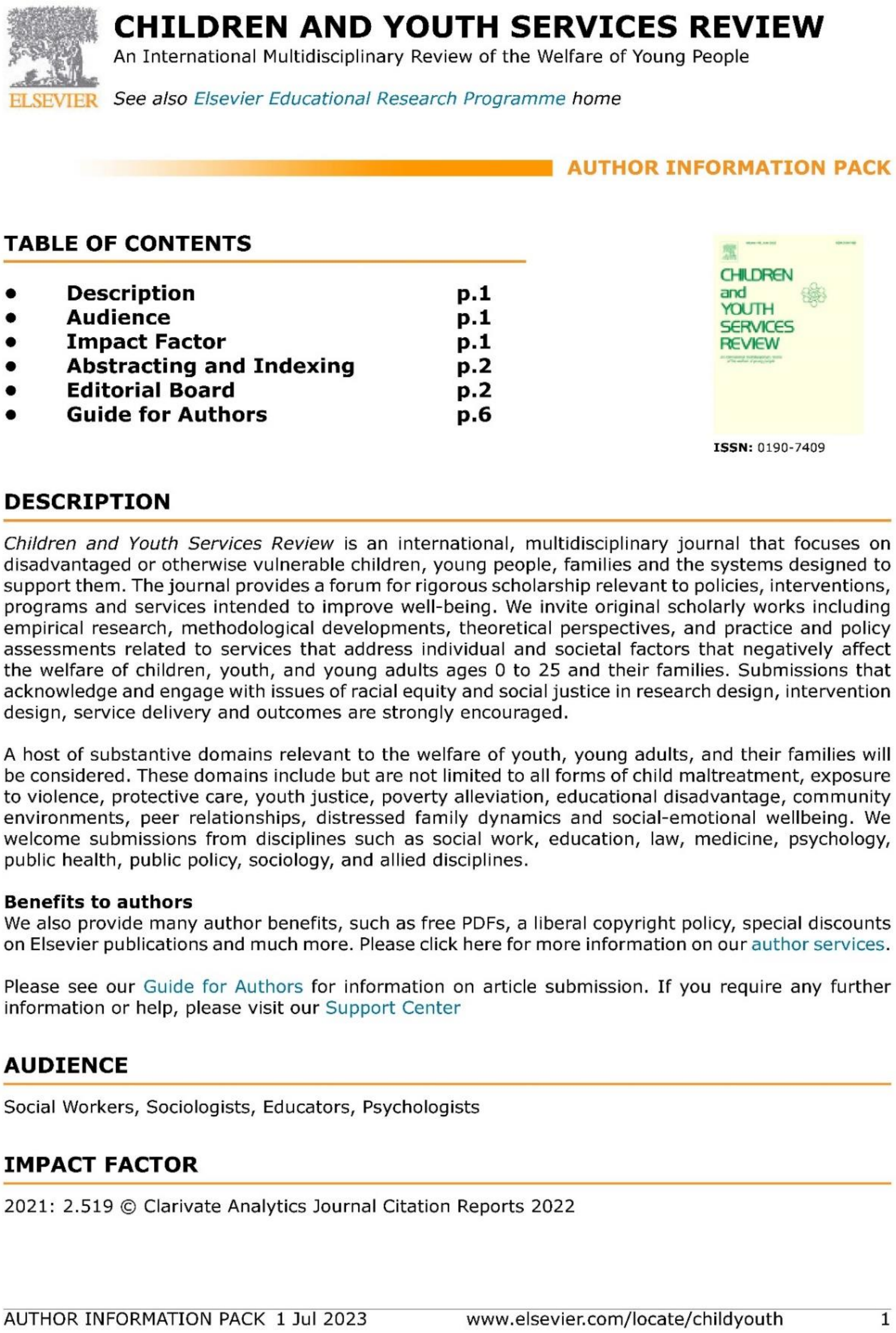
Public Health Resource Unit (2006) 10 questions to help you make sense of qualitative research [accessed 7 July 2008]

North Thames Research Appraisal Group (NTRAG): 1998 Critical review form for reading a paper describing qualitative research British Sociological Association (BSA)

Appendix F – Summary of quality assessment checklist ratings

Study Author	Checklist Item														
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	Grade
Brown (2018)	Appropriate	Clear	Defensible	Appropriately	Clearly Described	Clear	Unreliable	Rigorous	Rich	Unreliable	Convincing	Relevant	Adequate	Not sure/not reported	++
Dikeç, Uzunoğlu and Gümüş (2019)	Appropriate	Mixed	Defensible	Appropriately	Clearly Described	Clear	Reliable	Rigorous	Poor	Reliable	Convincing	Relevant	Adequate	Not sure/not reported	+
Hartley, Redmond and Berry (2022)	Appropriate	Clear	Defensible	Appropriately	Clearly Described	Clear	Reliable	Rigorous	Rich	Reliable	Convincing	Relevant	Adequate	Appropriate	++
Hayes et al., (2020)	Appropriate	Clear	Defensible	Appropriately	Clearly Described	clear	Reliable	Rigorous	Rich	Reliable	Convincing	Relevant	Adequate	Not sure/not reported	++
Salamone-Violi, Chur-Hansen and Winefield (2016)	Appropriate	Clear	Defensible	Appropriately	Clearly Described	Clear	Reliable	Rigorous	Rich	Reliable	Convincing	Partially Relevant	Adequate	Not sure/not reported	++
Sarrió-Colas et. al. (2022)	Appropriate	Clear	Defensible	Appropriately	Clearly Described	Clear	Reliable	Rigorous	Rich	Reliable	Convincing	Relevant	Adequate	Appropriate	++
Merayo-Sereno et al., (2021)	Appropriate	Clear	Defensible	Appropriately	Clearly Described	clear	Reliable	Rigorous	Rich	Reliable	Convincing	Relevant	Adequate	Appropriate	++
Bjonness et al (2021)	Appropriate	Clear	Defensible	Appropriately	Clearly Described	Clear	Reliable	Rigorous	Rich	Reliable	Convincing	Relevant	Adequate	Appropriate	++
Geraghty et al., (2011)	Appropriate	Clear	Defensible	Appropriately	Unclearly Described	Unclear	Reliable	Rigorous	Rich	Reliable	Convincing	Relevant	Adequate	Appropriate	++
Sheng et al., (2021)	Appropriate	Clear	Defensible	Appropriately	Clearly Described	Clear	Reliable	Rigorous	Rich	Reliable	Convincing	Relevant	Adequate	Appropriate	++

Appendix G - Notes or Guideline for authors for the empirical paper



CHILDREN AND YOUTH SERVICES REVIEW

An International Multidisciplinary Review of the Welfare of Young People

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AUTHOR INFORMATION PACK

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A host of substantive domains relevant to the welfare of youth, young adults, and their families will be considered. These domains include but are not limited to all forms of child maltreatment, exposure to violence, protective care, youth justice, poverty alleviation, educational disadvantage, community environments, peer relationships, distressed family dynamics and social-emotional wellbeing. We welcome submissions from disciplines such as social work, education, law, medicine, psychology, public health, public policy, sociology, and allied disciplines.

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Comparative child protection systems, Child sexual abuse prevention, Mixed mehods
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Foster care, out-of-home placement, Child protection, Child maltreatment
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Child and family welfare, child protection, poverty, race, refugees, children in foster care, Adoption
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Child Protection, Social Protection, Care Leavers, Family
Wendy Haight, University of Minnesota Twin Cities, Minneapolis, Minnesota, United States of America
Qualitative (ethnography, life story, narrative), and mixed methods, Experiences of BIPOC families and children in the child welfare system
Hongwei Hu, Renmin University of China, Beijing, China
Health Development of Children and youth, Children welfare policy, Social Survey Methodology, Social Experiment, Econometric Analysis
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Poverty and child welfare, Survey and quantitive research
Sigrid James, University of Kassel, Kassel, Germany

youth residential care, foster care, child welfare, adolescent mental health, careleaver, education/labor market integration of adolescent and young adult refugees, evidence-based practice, international social work
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Emily Keddell, University of Otago, Dunedin, New Zealand
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Child welfare, Child poverty, Child indicators, Early intervention, Children's subjective well-being, Public policy evaluation research
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substance use and mental health services, intervention research, implementation science
Colette McAuley, University of Bradford, Bradford, United Kingdom
Child Well-Being, especially Children's Subjective Well-Being, Child Welfare Outcomes, especially outcomes for children in out-of-home care and the voices of children in out-of-home care, Poverty and Child Well-Being, especially the lived experiences of adults and children living in poverty, Research with and by children, including creative approaches to engaging children in research, Qualitative research
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juvenile offenders, juvenile delinquency, African American boys, children and adolescents, mental health
Patricia McNamara, The University of Melbourne, Melbourne, Australia
Philip Mendes, Monash University, Clayton, Victoria, Australia
Young people transitioning from out-of-home care; Jewish community responses to institutional child sexual abuse; Welfare conditionality; Supervised injecting facilities.
Linda Mills, New York University, New York, New York, United States of America
Faye Mishna, University of Toronto Factor-Inwentash, Faculty of Social Work, Toronto, Ontario, Canada
Bullying/cyberbullying among youth, including college/university students, Sexting among youth (consensual) and non-consensual sharing of sexts, and unsolicited sexts, The use of information and communication technology (ICT) in therapy (not formal e-therapy but used in conjunction with therapy), Clinical practice, with contemporary psychodynamic approach
Asha Mukundan, Tata Institute of Social Sciences, Mumbai, India
Child Rights, Juvenile Justice, Rehabilitation, victimology, Aftercare.
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Child protection policy analysis, Comparative studies, Child and family social work
Leila Patel, University of Johannesburg Centre for Social Development in Africa (CSDA), Johannesburg, South Africa

Child and family welfare policy and practice in development contexts, social protection, youth development and youth transitions, youth employment, gender and development, and cross country comparative research, qualitative and quantitative methods, and intervention research

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Child welfare administration, Policy and practice, Mixed methods evaluation, CPS, Foster care, Home-based services

Cheryl Regehr, University of Toronto, Toronto, Ontario, Canada

Stress and trauma exposure amongst child welfare workers, High-risk decision-making in child welfare, Models for improving decision-making, Methods, experimental design, survey, qualitative

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Quantitative methods, Research and evaluation design, Causal inference, foster placement, behavioral health, academic outcomes

GINA SAMUELS, The University of Chicago, Chicago, Illinois, United States of America

Youth Aging Out of Foster Care, transracial adoption, multiraciality, critical qualitative methods

Josefina Sala-Roca, Autonomous University of Barcelona, Barcelona, Spain

Residential Foster care, Care leavers, Program assessment, Quantitative methods and Systematic reviews

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Trina R. Shanks, University of Michigan School of Social Work, Ann Arbor, Michigan, United States of America

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Adolescence, Positive youth development, Families, well-being, Mental health, Addiction, Spirituality, Social indicators, Evaluation, Social science research methods, Leadership, Service learning, Psychology

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Childhood trauma, child maltreatment, substance misuse, mental health, child development, problem behaviors

Amanda Telias, University of Chile, Santiago, Chile

implications of poverty and disadvantage in childhood, child poverty measures, child development, child welfare, policies for low-income families and children, social protection policies, social justice, inequality measures

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Child welfare policy and programs, Epidemiology of child maltreatment

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Poverty and social policy , Child welfare, Comparative analysis , The impact of public policy on child wellbeing, Work and family policies

Abigail Williams-Butler, Rutgers University School of Social Work, New Brunswick, New Jersey, United States of America

Child welfare, Juvenile Justice, Adolescence, African American youth, Intersectionality, Trauma-informed interventions

Fred Wulczyn, The University of Chicago, Chicago, Illinois, United States of America

Child and youth services broadly defined but with an emphasis on maltreatment, , prevention, and foster care. Methods expertise, quantitative research broadly defined.

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INTRODUCTION

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- Make sure you use uniform lettering and sizing of your original artwork.
- Preferred fonts: Arial (or Helvetica), Times New Roman (or Times), Symbol, Courier.
- Number the illustrations according to their sequence in the text.
- Use a logical naming convention for your artwork files.
- Indicate per figure if it is a single, 1.5 or 2-column fitting image.
- For Word submissions only, you may still provide figures and their captions, and tables within a single file at the revision stage.
- Please note that individual figure files larger than 10 MB must be provided in separate source files.

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You are urged to visit this site; some excerpts from the detailed information are given here.
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Please ensure that every reference cited in the text is also present in the reference list (and vice versa). Any references cited in the abstract must be given in full. Unpublished results and personal communications are not recommended in the reference list, but may be mentioned in the text. If these references are included in the reference list they should follow the standard reference style of the journal and should include a substitution of the publication date with either 'Unpublished results' or 'Personal communication'. Citation of a reference as 'in press' implies that the item has been accepted for publication.

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As a minimum, the full URL should be given and the date when the reference was last accessed. Any further information, if known (DOI, author names, dates, reference to a source publication, etc.), should also be given. Web references can be listed separately (e.g., after the reference list) under a different heading if desired, or can be included in the reference list.

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List: references should be arranged first alphabetically and then further sorted chronologically if necessary. More than one reference from the same author(s) in the same year must be identified by the letters 'a', 'b', 'c', etc., placed after the year of publication.

Examples:

Reference to a journal publication:

Van der Geer, J., Hanraads, J. A. J., & Lupton, R. A. (2010). The art of writing a scientific article. *Journal of Scientific Communications, 163*, 51–59. https://doi.org/10.1016/j.sc.2010.00372.

Reference to a journal publication with an article number:

Van der Geer, J., Hanraads, J. A. J., & Lupton, R. A. (2018). The art of writing a scientific article. *Heliyon*, *19*, Article e00205. https://doi.org/10.1016/j.heliyon.2018.e00205.

Reference to a book:

Strunk, W., Jr., & White, E. B. (2000). *The elements of style* (4th ed.). Longman (Chapter 4).

Reference to a chapter in an edited book:

Mettam, G. R., & Adams, L. B. (2009). How to prepare an electronic version of your article. In B. S. Jones, & R. Z. Smith (Eds.), *Introduction to the electronic age* (pp. 281–304). E-Publishing Inc.

Reference to a website:

Powertech Systems. (2015). *Lithium-ion vs lead-acid cost analysis*. Retrieved from http://www.powertechsystems.eu/home/tech-corner/lithium-ion-vs-lead-acid-cost-analysis/. Accessed January 6, 2016

Reference to a dataset:

[dataset] Oguro, M., Imahiro, S., Saito, S., & Nakashizuka, T. (2015). *Mortality data for Japanese oak wilt disease and surrounding forest compositions*. Mendeley Data, v1. https://doi.org/10.17632/xwj98nb39r.1.

Reference to a conference paper or poster presentation:

Engle, E.K., Cash, T.F., & Jarry, J.L. (2009, November). *The Body Image Behaviours Inventory-3: Development and validation of the Body Image Compulsive Actions and Body Image Avoidance Scales*. Poster session presentation at the meeting of the Association for Behavioural and Cognitive Therapies, New York, NY.

Reference to software:

Coon, E., Berndt, M., Jan, A., Svyatsky, D., Atchley, A., Kikinzon, E., Harp, D., Manzini, G., Shelef, E., Lipnikov, K., Garimella, R., Xu, C., Moulton, D., Karra, S., Painter, S., Jafarov, E., & Molins, S. (2020, March 25). *Advanced Terrestrial Simulator (ATS) v0.88 (Version 0.88)*. Zenodo. https://doi.org/10.5281/zenodo.3727209.

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To foster transparency, we require you to state the availability of your data in your submission if your data is unavailable to access or unsuitable to post. This may also be a requirement of your funding body or institution. You will have the opportunity to provide a data statement during the submission process. The statement will appear with your published article on ScienceDirect. For more information, visit the Data Statement page..

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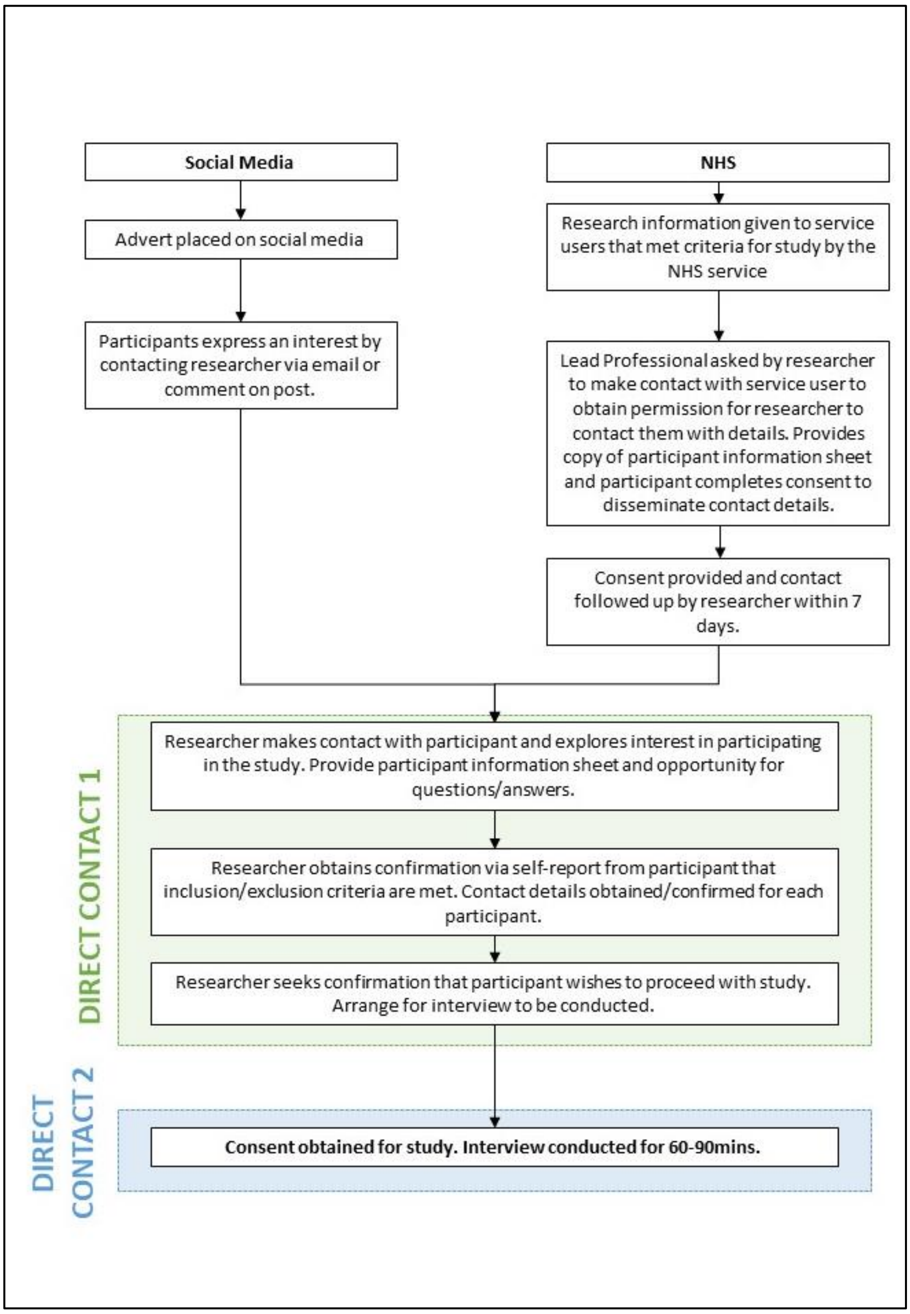
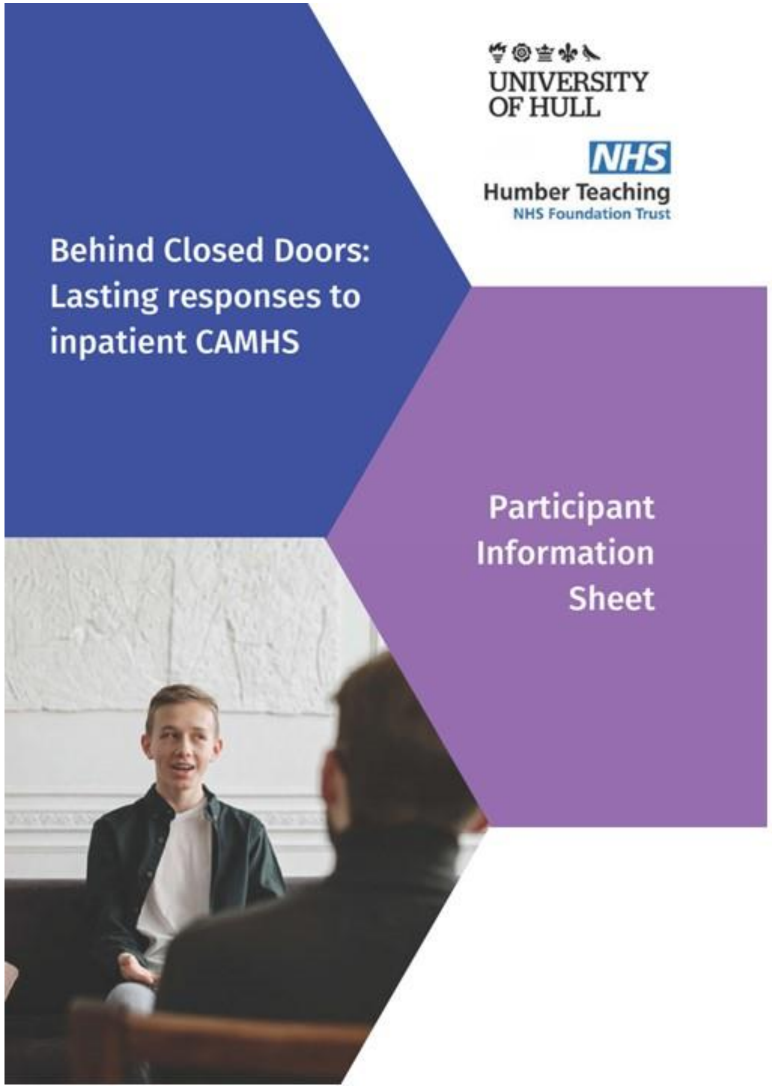
Visit the Elsevier Support Center to find the answers you need. Here you will find everything from Frequently Asked Questions to ways to get in touch.

You can also check the status of your submitted article or find out when your accepted article will be published.

Appendix H – Recruitment of participants procedure



Appendix I – Participant Information Booklet



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Behind Closed Doors: Lasting responses to inpatient CAMHS

Participant Information Sheet

Hello, I'm Tom White a Trainee Clinical Psychologist at the University of Hull. I'm looking into how people who have used inpatient Children and Adolescent Mental Health Services (CAMHs) reflect on their experiences and see them to be important as part of their recovery. Having worked within inpatient CAMHs, I am interested to see how people find the experience after they have left. This research is part of my Doctorate in Clinical Psychology. The sponsor of this research is the University of Hull.

Before you decide if you want to take part, it is important for you to understand why the research is being done and what is involved. Please take time to read the following information carefully and discuss it with others if you wish.

Ask me if there is anything that is not clear or if you would like more information with the details on the back page.

What is an inpatient?
Inpatient describes someone who has had to stay away from home to have care. You might have called it a hospital, ward or unit.

WHY IS THE STUDY NEEDED?

The purpose of this research is to learn about the experiences of those who have had care from inpatient CAMHs. It also will look at if the experience has had an impact on your identity.

Currently, there is a limited body of research looking at the effects of inpatient CAMHs once people have left. This will be important to learn about if there are lasting benefits of being cared for within inpatient CAMHs.

WHY HAVE I BEEN INVITED TO TAKE PART?

You are being invited to take part in this study because you have been identified by your care-coordinator that you have had care from inpatient CAMHs. This information sheet is being shared with people who may meet the criteria to take part in the study as they may be interested in taking part in the research. To be able to take part you need to be:

To be able to participate you need to be:

- Aged 18-35 years old
- Received care within a inpatient CAMHs unit in the UK for at least four weeks.
- Been discharged from inpatient CAMHs at least 6 months ago.
- Speak English as a first language.

DO I HAVE TO TAKE PART?

Taking part is completely voluntary. You should only take part if you want to and choosing not to take part will not disadvantage you in any way. Once you have read the information sheet, please contact me if you have any questions that will help you make a decision about taking part.

WHAT WOULD TAKING PART INVOLVE?

Taking part in the study would involve you:

- Completing a form with your care-coordinator to share your contact details with me. I will then contact you so that I can any answer any further questions you may have about the research.
- Checking that you meet the requirements for the study and completing a consent form which you will be given a copy of.
- An interview that is likely to be 60 minutes which will be audio-recorded. We will arrange this at a time and place that is convenient for you and can be via video call if you would prefer.
- During the interview, I will invite you to talk about your mental health care (including inpatient CAMHs) and identity.

During the interview you will be invited to talk about your identity which might involve some of these areas. However, you are free to talk about whatever has been important to you.

WHAT ARE THE POSSIBLE BENEFITS OF TAKING PART?

There are no direct benefits guaranteed for participating. It is hoped that you would like to take part in this research to contribute to the understanding of inpatient CAMHs. There are no other benefits or payment for participation in the research.

WHAT ARE THE POSSIBLE DISADVANTAGES AND RISKS OF TAKING PART?

Some people may become emotionally distressed when they talk about their experiences within their journey of mental health care. You are free to share as much or as little information about what you have experienced. If this happens for you, the researcher will offer support and give you advice on who to contact for further help if needed. They can also inform your care-coordinator if you would like them to do so.

There is also a risk that you may disclose malpractice or abuse which has occurred within your care. If this occurs, you will be supported to share this information with the appropriate organisations. Sometimes, the researcher may have to do this without your consent, but they will explain this to you at the time. You can also ask me more questions before taking part in the research.

Disclosure of Malpractice or Past Abuse

Some people who have had care from inpatient CAMHs may have experienced abuse or malpractice (where people caring for others have not done so to the expected standard).

The research team is bound by professional rules to share concerns of malpractice and abuse with others. We will help you to disclose information, but sometimes may have to share information when you do not want us to. We will explain why information has been shared and who it has been shared with police, local authorities, care providers and professional bodies. I will tell you who has been given any information.

WHAT IF I CHANGE MY MIND ABOUT PARTICIPATING?

You are free to withdraw your data from the study up until audio recordings have been written up. After which removal of your data will no longer be possible due to data beyond this point being anonymised and the researcher not being able to identify individual participant information. If you choose to withdraw prior to this from the study we will not retain the information you have provided.

Withdrawing from the study will not affect you in any way or any care you receive.

HOW WILL WE USE INFORMATION ABOUT YOU?

We will need to use information from you for this research project. This information will include your:

- Name
- Contact Details

People will use this information to do the research or to check your records to make sure that the research is being done properly. People who do not need to know who you are will not be able to see your name or contact details. Your data will have a code number instead. We will keep all information about you safe and secure.

Once we have finished the study, we will keep some of the data so we can check the results. We will write our reports in a way that no-one can work out that you took part in the study.

Your data will be processed in accordance with the General Data Protection Regulation 2016 (GDPR). Interview recordings will remain identifiable by your consent form up to the point of when your audio recording will be anonymously written out, and names replaced with pseudonyms (another name which is not yours).

Your name and contact details will be kept for the duration of the study. Your anonymised data will be kept for 10 years by the University of Hull.

What are your choices about how your information is used?

You can stop being part of the study at any time, without giving a reason, but we will keep information about you that we already have as outlined above.

We need to manage your records in specific ways for the research to be reliable. This means that we won't be able to let you see or change the data we hold about you.

What are your choices about how your information is used?

You can find out more about how we use your information:

- at www.hra.nhs.uk/information-about-patients
- our leaflet available from www.hra.nhs.uk/patientdataandresearch
- by asking one of the research team
- by sending an email to dataprotection@hull.ac.uk, or by ringing us on 01482 466594.
- by reviewing the University of Hull Research Participant privacy notice: https://www.hull.ac.uk/choose-hull/university-and-region/key-documents/docs/quality/research-participant-privacy-notice.pdf

Who has reviewed this study?

Research studies are reviewed by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and been given a favourable opinion by Faculty of Health Sciences Ethics Committee at the University of Hull, the Health Research Authority and East Midlands (Leicester South) Research Ethics Committee.

Who is organising and funding the study?

The study has been set up by the University of Hull and is running in collaboration with Humber NHS Foundation Trust and Rotherham, Doncaster and South Humber NHS Foundation Trust.

The study has received no funding.

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WHAT WILL HAPPEN TO THE RESULTS OF THE STUDY?

The results of the study will be summarised in a written thesis as part of a Doctorate in Clinical Psychology. The thesis will be available on the University of Hull's on-line repository https://hydra.hull.ac.uk. The research may also be published in academic journals or presented at conferences. You can also choose to receive a written summary of the results once the research has been completed.

WHO SHOULD I CONTACT FOR MORE INFORMATION

If you have any questions or require more information about this study, please contact me using the following contact details:

Tom White
Clinical Psychology
Aire Building
The University of Hull
Cottingham Road
Hull
HU6 7RX

Email: t.h.white-2017@hull.ac.uk
Phone: 07976072624

WHAT IF I HAVE FURTHER QUESTIONS OR SOMETHING GOES WRONG?

If you have any questions or require more information about this study, please contact me using the following contact details:

Dr Anjula Gupta
Clinical Psychology
Aire Building
The University of Hull
Cottingham Road
Hull
HU6 7RX
Email: A.Gupta@hull.ac.uk

Complaints can also be made to university-secretary@hull.ac.uk.

IRAS ID: 312519 | V1.31 | 04/10/2022
Version A

Appendix J – Consent Form

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Behind Closed Doors: Lasting responses to inpatient CAMHs

CONSENT FORM

Name of Researcher: Thomas White

Please initial box

1. I confirm that I have read the information sheet dated 04/10/2022 (version 1.31) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected. I understand that once interviews have been transcribed and anonymised, I will no longer be able to withdraw. ☐

3. I understand that the research interview will be audio recorded and that my anonymised verbatim quotes may be used in research reports and conference presentations. ☐

4. I agree for my personal information to be used to contact me throughout the study duration. ☐

5. I would like the researcher to contact me with the results once the study has been completed. ☐

6. NHS PARTICIPANTS: I agree that if the researcher has concerns about my wellbeing after the study they may contact my clinical care team to inform them. ☐

7. I agree to take part in the above study. ☐

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

05/10/2022 | V1.1 | IRAS ID: 312519

Appendix K – Interview Schedule

- *Semi-Structured Interview*: The interviews will not have a pre-defined length – participants will be encouraged to speak about their experiences for as long as they wish too. However, an estimation of between 60-90 minutes will be given to participants, to ensure that stories are told with the level of detail required for the study.
- Each participant may be introduced to the interview using the following:

"As you are aware, I have an interest in understanding the experience of being an inpatient and how you have made sense of that experience now you have been discharged. I am interested to know how you have made sense of your identity through growing up to be where you are now and if inpatient CAMHs had any impact.

Some people might think of identity to include:
-Goals
-How other people see you
-How you relate to others
-Your beliefs
-Your sexuality, race or gender
-Your mental health

However, you are free to talk about whatever you feel is relevant and important and it may have changed over time.

What I would like you to do is to tell me about your journey to being an inpatient all the way through to where we meet today. You can decide where you begin your story, and what you choose to include. I can help you if you feel unsure what to talk about."

- The interview will be led by the participant's story telling, although the following questions may be useful to elicit more detail about features of their story. These questions are shaped by the concepts of resources highlighted within the DNA process (see above for more details)

<u>Identity</u>

- *What do you think of yourself?*
- *What do you value?*
- *Does anything influence your identity?*
- *How do you think you came to develop that aspect of your identity?*
- *Is your identity similar to anyone around you?*

- *Do you feel proud of your identity?*
- *Are you clear in how you view yourself?*
- *Do you have aspects of yourself that contradict each other?*
- *Do you question the person you are?*
- *Where do you belong?*
- *What gives you meaning and/or purpose?*
- *What aspects of your identity are important to you? (E.g. family, religion, history, education, culture, interests, language, friends...)*
- *How important are other people in how you see yourself?*
- *Do you ever have difficulty fitting into the wider society because of your background?*

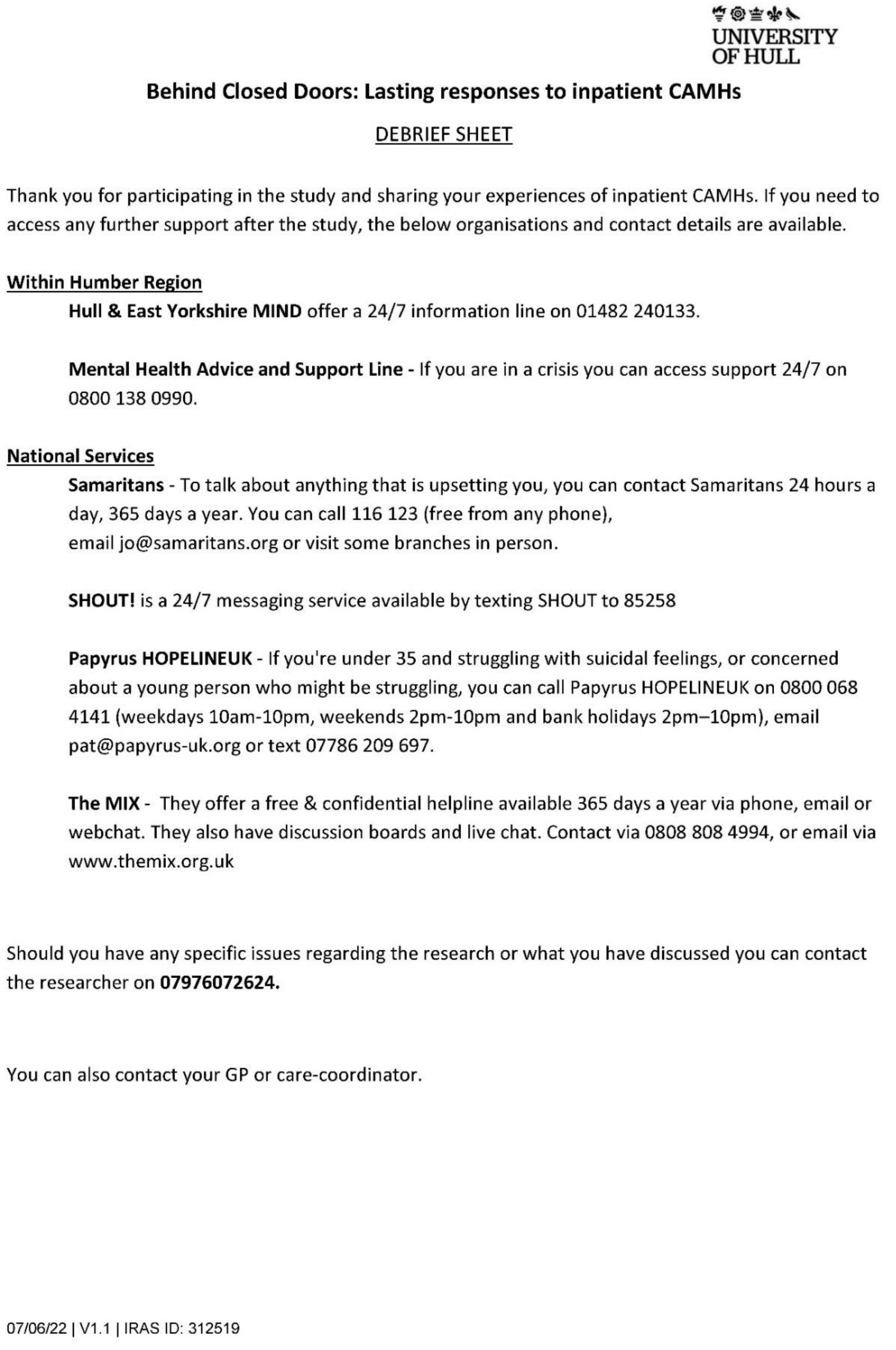
Inpatient Experience

- *How did you feel about becoming an inpatient?*
- *What did you expect being an inpatient to be like? Was it the same as you expected?*
- *What changed in your life whilst there?*
- *How did you keep hold of your identity whilst there?*
- *How has it impacted your life now to have been an inpatient?*
- *What does it mean to have inpatient care as part of your recovery journey?*
- *Who was affected by you going into inpatient care?*
- *What has inpatient care taught you?*

Mental Health Identity

- *How does your mental health fit into your life?*
- *How do you identify your mental health difficulty?*
- *How do you relate to your mental health difficulty?*
- *Has the way you see your mental health difficulty changed?*
- *Who or what has been important for you to see your mental health difficulty the way you do?*
- *How do others around you make sense of your difficulties?*
- *Does it change the way you feel about yourself?*
- *Has it ever stopped or allowed you to do something unexpected?*
- *What has your mental health journey taught you?*
- *Where do you see your mental health journey going forwards?*

Appendix L – Participant Debrief Information



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Behind Closed Doors: Lasting responses to inpatient CAMHs

DEBRIEF SHEET

Thank you for participating in the study and sharing your experiences of inpatient CAMHs. If you need to access any further support after the study, the below organisations and contact details are available.

Within Humber Region

Hull & East Yorkshire MIND offer a 24/7 information line on 01482 240133.

Mental Health Advice and Support Line - If you are in a crisis you can access support 24/7 on 0800 138 0990.

National Services

Samaritans - To talk about anything that is upsetting you, you can contact Samaritans 24 hours a day, 365 days a year. You can call 116 123 (free from any phone),
email jo@samaritans.org or visit some branches in person.

SHOUT! is a 24/7 messaging service available by texting SHOUT to 85258

Papyrus HOPELINEUK - If you're under 35 and struggling with suicidal feelings, or concerned about a young person who might be struggling, you can call Papyrus HOPELINEUK on 0800 068 4141 (weekdays 10am-10pm, weekends 2pm-10pm and bank holidays 2pm–10pm), email pat@papyrus-uk.org or text 07786 209 697.

The MIX - They offer a free & confidential helpline available 365 days a year via phone, email or webchat. They also have discussion boards and live chat. Contact via 0808 808 4994, or email via www.themix.org.uk

Should you have any specific issues regarding the research or what you have discussed you can contact the researcher on **07976072624.**

You can also contact your GP or care-coordinator.

07/06/22 | V1.1 | IRAS ID: 312519

Appendix M – University of Hull Ethical Approval & Sponsorship Letter

UNIVERSITY
OF HULL

University of Hull
Hull, HU6 7RX
United Kingdom
T: +44 (0)1482 463336 | **E:** e.walker@hull.ac.uk
w: www.hull.ac.uk

PRIVATE AND CONFIDENTIAL
Thomas White
Faculty of Health Sciences
University of Hull
Via email

13th June 2022

Dear Thomas

REF FHS439 - Behind closed doors: A phenomenological exploration into the lasting responses of experiencing inpatient CAMHs and implications for identity development

Thank you for your responses to the points raised by the Faculty of Health Sciences Research Ethics Committee.

Given the information you have provided I confirm approval by Chair's action.

Please refer to the Research Ethics Committee web page for reporting requirements in the event of any amendments to your study.

Should an Adverse Event need to be reported, please complete the Adverse Event Form and send it to the Research Ethics Committee FHS-ethicssubmissions@hull.ac.uk within 15 days of the Chief Investigator becoming aware of the event.

I wish you every success with your study.

Yours sincerely

Professor Liz Walker
Chair, FHS Research Ethics Committee

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9th August 2022

Tom White
University of Hull

Dear Tom

Project Title : Behind closed doors: A phenomenological exploration into the lasting responses of experiencing inpatient CAMHs and implications for identity development
RS179

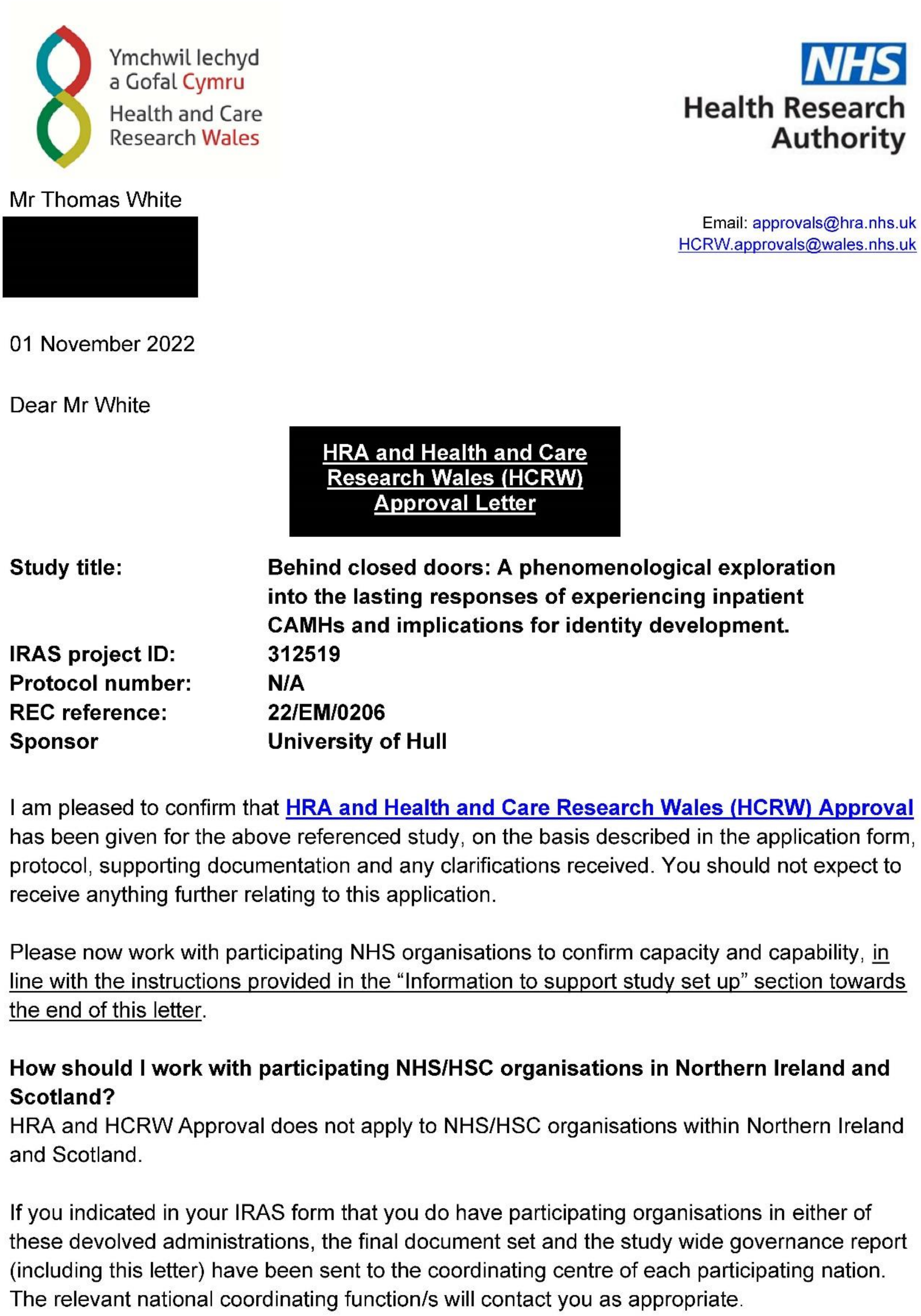
I am writing to confirm that the University of Hull has agreed to act as sponsor, subject to approval being granted in accordance with the Department of Health Research Governance Framework for the project: Behind closed doors: A phenomenological exploration into the lasting responses of experiencing inpatient CAMHs and implications for identity development.

Yours sincerely,

Dr David Richards, FEI
Pro-Vice-Chancellor (Research & Enterprise)
(Chair of University Research Committee)

cc Dean
Research Governance

Appendix N – NHS REC Ethical Approval



Ymchwil Iechyd
a Gofal Cymru
Health and Care
Research Wales

NHS
Health Research
Authority

Mr Thomas White
[redacted]

Email: approvals@hra.nhs.uk
HCRW.approvals@wales.nhs.uk

01 November 2022

Dear Mr White

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

Study title:	**Behind closed doors: A phenomenological exploration into the lasting responses of experiencing inpatient CAMHs and implications for identity development.**
IRAS project ID:	**312519**
Protocol number:	**N/A**
REC reference:	**22/EM/0206**
Sponsor	**University of Hull**

I am pleased to confirm that **HRA and Health and Care Research Wales (HCRW) 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.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?

HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?
HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?

The standard conditions document "*After Ethical Review – guidance for sponsors and investigators*", issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

Who should I contact for further information?
Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **312519**. Please quote this on all correspondence.

Yours sincerely,
Chris Kitchen

Email: approvals@hra.nhs.uk

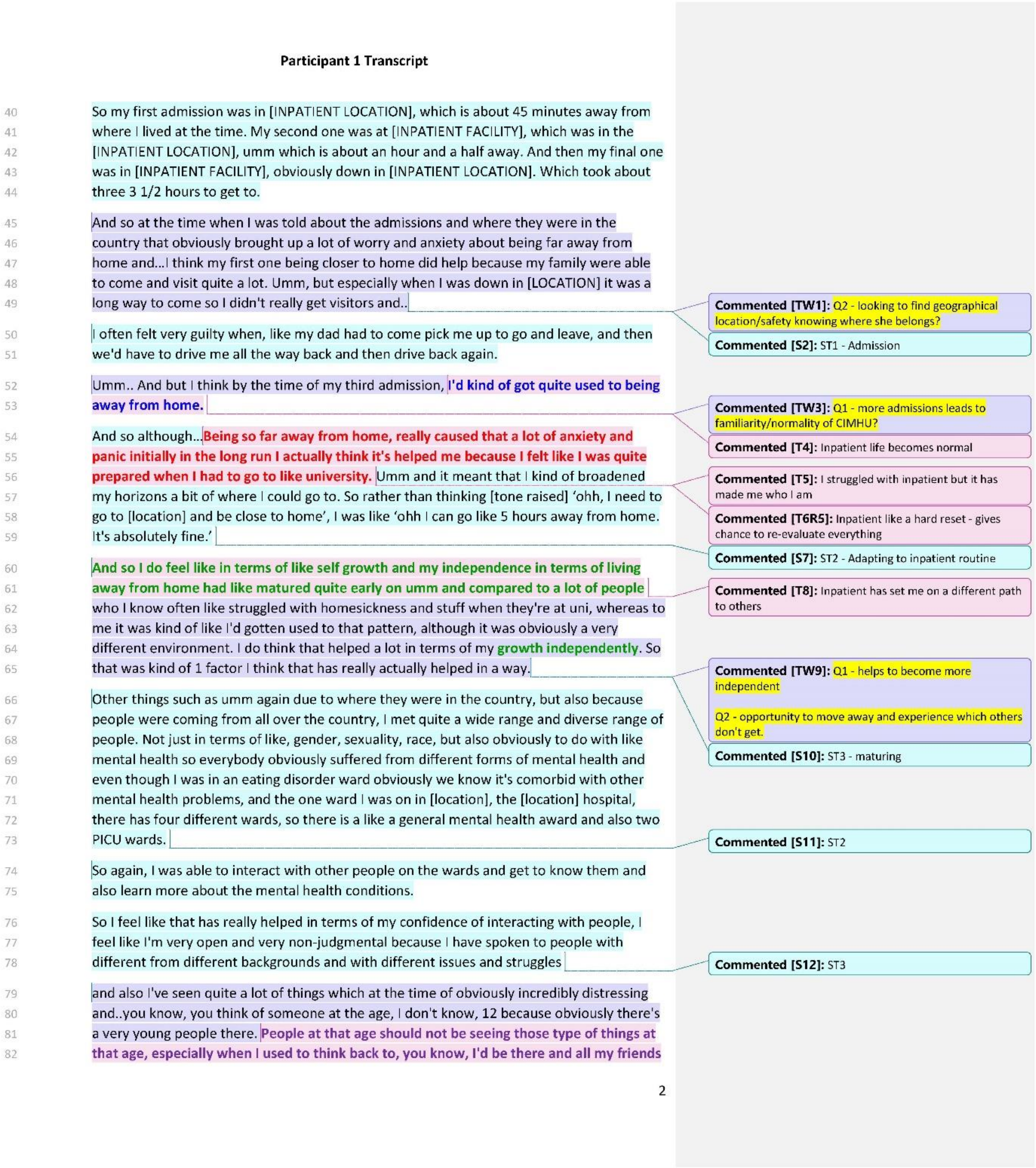
Copy to: *Katie Skilton*

Appendix O – Participant Narrative Summary

Participant	Narrative Summary
Tiffany	Started off with the eating disorder becoming her identity to which inpatient offered a confused outlook on the experience, both helping to challenge the ongoing problem but also reinforcing how the situation required intense support. Inpatient has helped her to turn around the way she relates to inpatient care and shaped her future direction, motivating her to become a clinical psychologist, making up for the past. Feeling perhaps inpatient was needed to help get to the outlook on life she has now, even though it wasn't nice. Passionate to share her experience and feels indebted to make a difference to inpatient care as her experience as she perceives her narrative differs from others who have experienced it. Stories shared were often neither positive/negative of the experience, attempting to focus on what meaning and value could be extracted from them to best serve her now. The experience has shaped participants desire to work in the field.
Lucy	She was admitted in the context of ongoing family difficulties and the admission provided space for her to stop, take check of what was going on and make sense of her difficulties. Inpatient changed a lot around her, from how people would treat her and react, and this meant that although the feelings remained the same, she found the people and rules around her changed. Equally, when discharged or on leave, she found that it was like being in a parallel world and things changed she didn't expect. As she experienced more inpatient admissions, it seems that she attempted to take things as they came more, and this has carried forward into her outlook on life where she tries to be more accepting. Her story is one of inpatient being a time to stop and pause, and then redefining who she wants to be and coming to understand what she needs to do to overcome the difficulties she has experienced. She is still on this journey of working through these difficulties but has placed emphasis on safeguarding her independence and sense of self.
Belle	This participant's experience is anchored in having previously experienced the care system which did not do enough to care for her, moving between several placements. Inpatient came after many did not know how to look after her and the lack of support/treatment received by inpatient means she further felt failed by the system which she believed was supposed to care for her. She appears resentful for being admitted and now having to live with the stigma associated with inpatient care which has impacted her life now, especially when she feels it did not contribute to any mental health changes. She is frustrated that the experience did not help her when it seems that the system around her relied upon it to make a

	difference and she is frustrated that she had to take ownership of what was happening (when it should have been the job of the system) and she feels that she has been the one to turn her life around. She shares a story of how she has been able to reclaim some of the "straight a student" she used to be when at school because of the motivation she has had to make a change and to set her own direction.
Ellie	Ellie initially recalls her experiences of being treated badly, recalling times when she seems to be mistreated but does not want to label it as that. She appears to have trauma responses still to the experiences she had and tries to avoid talking about her experiences with others at fear of it distressing them too much or making them feel guilty for not helping her. She went into inpatient and although struggled to have a sense of self, she lost the key markers she had in her life and felt like she had to try survive on her own, doing what she needed to do to get through it. She also seems to have felt like she was not human during her time in inpatient and the experience did not live up to her limited prior expectation of it being caring. Her inpatient care left her with no clearer sense of herself and she has been unable to rekindle with some of the key identity factors which she previously had.
Adele	Adele shares her experiences of having some difficulties at home prior to admission and experiencing some anxiety and depression which she attempts to manage herself, but her friends are also supportive and understanding of what this might mean. However, as she is admitted, her friends perceive her to be crazy dangerous and start to withdraw from her, leaving her on her own in inpatient. During this admission, she tries to hold onto herself however, finds that the staff begin to see her as a diagnosis and treat her as a medical problem rather than as the Adele who has interests. She also describes the unhealthy competition that there is between others who are in a similar difficulty to her and they are competing for attention from the staff through escalating behaviour. She describes how she lost sense of herself and became aggressive/violent towards others which she does not associate with. She started to take ownership of her difficulties when given a second chance and when she started to be able to see how she had changed compared to how she was previously. She struggles to integrate with her old friends and has turned to the mental health community online who offer are able to support her/integrate with her however, she struggles with them and how they idolise inpatient and make judgements based on the level of risk people present with without fully understanding what is going on for her. She now still is in a pattern of inpatient/community but has insight into where she wants to be in the future and the markers she uses to measure how well she is doing.

Appendix P – Analysed transcript exert



Participant 1 Transcript

So my first admission was in [INPATIENT LOCATION], which is about 45 minutes away from where I lived at the time. My second one was at [INPATIENT FACILITY], which was in the [INPATIENT LOCATION], umm which is about an hour and a half away. And then my final one was in [INPATIENT FACILITY], obviously down in [INPATIENT LOCATION]. Which took about three 3 1/2 hours to get to.

And so at the time when I was told about the admissions and where they were in the country that obviously brought up a lot of worry and anxiety about being far away from home and…I think my first one being closer to home did help because my family were able to come and visit quite a lot. Umm, but especially when I was down in [LOCATION] it was a long way to come so I didn't really get visitors and..

I often felt very guilty when, like my dad had to come pick me up to go and leave, and then we'd have to drive me all the way back and then drive back again.

Umm.. And but I think by the time of my third admission, **I'd kind of got quite used to being away from home.**

And so although…**Being so far away from home, really caused that a lot of anxiety and panic initially in the long run I actually think it's helped me because I felt like I was quite prepared when I had to go to like university.** Umm and it meant that I kind of broadened my horizons a bit of where I could go to. So rather than thinking [tone raised] 'ohh, I need to go to [location] and be close to home', I was like 'ohh I can go like 5 hours away from home. It's absolutely fine.'

And so I do feel like in terms of like self growth and my independence in terms of living away from home had like matured quite early on umm and compared to a lot of people who I know often like struggled with homesickness and stuff when they're at uni, whereas to me it was kind of like I'd gotten used to that pattern, although it was obviously a very different environment. I do think that helped a lot in terms of my **growth independently**. So that was kind of 1 factor I think that has really actually helped in a way.

Other things such as umm again due to where they were in the country, but also because people were coming from all over the country, I met quite a wide range and diverse range of people. Not just in terms of like, gender, sexuality, race, but also obviously to do with like mental health so everybody obviously suffered from different forms of mental health and even though I was in an eating disorder ward obviously we know it's comorbid with other mental health problems, and the one ward I was on in [location], the [location] hospital, there has four different wards, so there is a like a general mental health award and also two PICU wards.

So again, I was able to interact with other people on the wards and get to know them and also learn more about the mental health conditions.

So I feel like that has really helped in terms of my confidence of interacting with people, I feel like I'm very open and very non-judgmental because I have spoken to people with different from different backgrounds and with different issues and struggles

and also I've seen quite a lot of things which at the time of obviously incredibly distressing and..you know, you think of someone at the age, I don't know, 12 because obviously there's a very young people there. **People at that age should not be seeing those type of things at that age, especially when I used to think back to, you know, I'd be there and all my friends**

2

Commented [TW1]: Q2 - looking to find geographical location/safety knowing where she belongs?

Commented [S2]: ST1 - Admission

Commented [TW3]: Q1 - more admissions leads to familiarity/normality of CIMHU?

Commented [T4]: Inpatient life becomes normal

Commented [T5]: I struggled with inpatient but it has made me who I am

Commented [T6R5]: Inpatient like a hard reset - gives chance to re-evaluate everything

Commented [S7]: ST2 - Adapting to inpatient routine

Commented [T8]: Inpatient has set me on a different path to others

Commented [TW9]: Q1 - helps to become more independent

Q2 - opportunity to move away and experience which others don't get.

Commented [S10]: ST3 - maturing

Commented [S11]: ST2

Commented [S12]: ST3

would be at school and I'd be like they would not ever, like, imagine witnessing things like this.

So I do think although at the time it is.. **incredibly difficult and it has shaped me into the person I am,** and I feel that I'm now very....Calm in my approach to things like that, so I have used my experiences to work as like a support worker and things at inpatient wards. And I feel like because I've kind of seen for like seeing things first hand previously and also being on the other side of the fence, I'm able to kind of, UM, empathize and relate a lot to what the patients are going through at that time and how I respond to situations might be very different to somebody who has never actually witnessed that before. So I do think that's really helped..

Umm. My confidence in interacting with people and deepening my understanding of mental health issues, which obviously really does help when we go into the training that we're doing...

As I did say like it does bring around a lot of like trauma, and **luckily I don't suffer from any like PTSD and stuff that I know some of my friends do who I made whilst I was there.** But you obviously are left with I guess you could say scars in a sense, UM, and these mental images that do come to light and I think the longer I've been out of the inpatient, the less they've got.

And I know that like when I first got discharged from every admission I've had, I used to find it incredibly difficult because you're so.... Isolated and kind of kept away from the reality of the world. And even though I was having leave and time out and time at home and integrating back into school and the things I used to do.. It's still not real life because, you know, at the end of the day you're going back to this place, which.. Although yes, you do need to be there in it. I do believe it can serve a purpose, but only if you allow it to. It's still not normality.

You know, there's so many rules and there's, like, a routine you have to follow and it's so strict and rigid and you've got that support around you 24/7, which is what you need but it's so artificial so whenever I was discharged, **I would find it really difficult to kind of go from that isolated strict routine of 24/7 care to then straight into kind of what life actually is like but when you've been kept away from that for you know several months, it's really, really difficult to kind of adjust that to that**

so I do feel that in terms of inpatient care, there needs to be more of, like, a gradual approach to discharge, because I do think that the first kind of few weeks and few months out of the inpatient are very like imperative to keeping you on the right track and not having that gradual kind of approach to discharge..kind of stumped you a little bit and I do feel that because I didn't really have that much support in terms of my discharge it did throw me off and I think that's why I ended up relapsing time and time again. And obviously if that could have been prevented the first time I was in hospital, I might have not had all the admissions that I did have.

But again each admission I've had has been very different and in terms of the hospitals themselves, they are of all very different. Their approaches are very different. Their meal plans and things. They're obviously a few things that are the same throughout. Umm, but some are obviously more strict, some are more lenient. And I do think it's good that you've kind of got...

Commented [TW13]: Q1 - Able to see that it was not normal - traumatic.

Commented [T14]: I'm on my own surviving this

Commented [TW15]: Q2 - resilient to distress, ability to sympathise leads to being drawn to career.

Commented [T16]: We're in this trying to survive together

Commented [TW17]: Q1 - different to others experience,

Started off positive impacts. "obviously" - normal to have 'scars' from CIMHU? Where is this narrative from?

Commented [S18]: ST4- coping with the trauma of inpatient

Commented [TW19]: Q1 - within the world but not really within due to overhanging thoughts of going back. Difficult to accept the reality of this

Commented [TW20]: Q1 - need for individual to be the one to take from the inpatient unit rather than wait for them to bring?

Commented [TW21]: Q1 - relationships important but the protection is limited/she knows there is a reason they do it. Different to parents?

Commented [T22]: Inpatient - community left me uncontained

Commented [TW23]: Q1&2 - resentment/blame towards unit for not doing job properly?

Commented [TW24]: Q1 - ability to contrast/compare helps to evaluate effectiveness?

Both sides that I feel like you have to be in the right place for which one you're at, because my second admission the place I went to was quite an open ward and it was very lenient compared to the first one I'd been to. And at that time, I was not in the right mind frame for that so my eating disorder took advantage completely of it. And although I was there for a think, it was about 5-6 months I didn't gain a single thing from it because I wasn't in the right mind frame and I then got discharged and then was back in hospital within a month. But then, if you were to have, say, put me back in there the third time around, I feel like I would have used it a lot more differently.

Commented [TW25]: Q1 - unit for right time/right place. Appreciation of how each unit has their own dynamic and offers unique approach.

Commented [T26]: Inpatient needs me to use it

And perhaps that's because.....Each time I had been admitted I had learned something new about myself. UM, although it did make me feel like a failure and....**You know, very kind of embarrassed that I was having to be readmitted time and time again I do feel that I had a greater understanding of myself, but also also of my condition.**

Commented [TW27]: Q2 - two steps forward, one step back?

Commented [S28]: ST2

When I first went into inpatient, obviously it was a completely.. Well, different environment that you know you don't ever expect to be in and I wasn't as kind of clued up about my eating disorder, I was obviously with camhs as an outpatient before but had never really had a very good camhs outpatients experience with my camhs worker who I was allocated and I never really did any kind of psychoeducation around my eating disorder so a lot of the stuff that I knew was from my own kind of research and like social media, which obviously isn't always a very good source to go by.

Commented [TW29]: Q1 - no clarity on what the ED's identity was prior to being admitted?

So when I went into inpatient, I did learn a lot about my eating disorder, through like psychoeducation and different types of groups and each time I was going into hospital, I was learning a little bit more and understanding it more. Umm. So I do think that inpatient did help... in terms of my self-awareness around my eating disorder umm and that in turn I think helped me to get to the point where I am at today.Umm. And like being recovered from it and..

Commented [S30]: ST1

Commented [T31]: Community support was not helpful prior to admission

Alongside, obviously the kind of self-awareness around your eating disorder and you know, like over exercising and dietary requirements we did do a lot of work on like self esteem and self worth which I do think has actually really helped me in the long run because... **I think I've always lacked quite a lot of self belief and self worth and so kind of doing that in a safe environment and potentially if I'd never got my eating disorder, I wouldn't have had the chance to do that..so I don't think I would...**

Commented [TW32]: Q2 - inpatient helps to find clarity on self identity.

You know, obviously I still suffer with self esteem problems and self worth problems, but I feel like I can kind of...Bring in the techniques and things that I've used and learned before, and I've still got all like my paperwork and things from things I did when I was there.

Commented [TW33]: Q2 - increased reflectiveness after inpatient on self?

So it's very nice to kind of look back and be able to reflect and see how....Me going into hospital for the first time the day after my 16th birthday to now be in 25. How I've kind of...Not changed, but **grown** through that process and I think every admission I've had, I've **grown** that little bit more and I do think it's really helped kind of like I said about the independence thing, but like with my maturity. **And I do feel like I've matured quite quickly because of what I've been through.**

Commented [TW34]: Q1 - grown up quickly due to required level of independence? Survival of CIMHU/missed process steps? Becoming an adult before peers a benefit.

So those things looking back I can see what they like, how much they've helped, whereas at the time I do think because you're in that so much of a bubble and so if you see and consumed by your eating disorder, ever think that inpatient's gonna help you in the slightest.

Commented [TW35]: Q2 - consumed by struggles prior to admission.

But I definitely do think in terms of my self growth especially and kind of my.. **widening of my lens** that it has really helped in terms of like perspective UM and things like that. So yeah, they're kind of the positive type things I think.

Commented [TW36]: Q2 - clarity after inpatient

Commented [S37]: ST3

Have I.. is that right?..... Am I going completely off topic like I don't know.

INT No, not at all. I think it's all really really interesting and really helpful and and I'm really yeah, it's a really interesting story you've got... It's just I can really see how you're trying, like how you pieced it together and kind of how there's been. It feels like there's been a journey for you through the different inpatients and every time it feels like you've built upon a different experience and that you taken away something from each inpatient admission now and when looking back on it and it, it feels like perhaps each of those things are almost like another piece of a jigsaw.

Yeah...

INT ....Tell me if that's right or wrong..

TIFFANY Yeah, 100%. **Like I I definitely think that and I often.. Kind of sometimes stop and think back and think... If I had never developed an eating disorder and if I'd never been into inpatient, would I still be in the same place that I am now in terms of my self development and in terms of like my career choice?** And I don't know it's it's a difficult one to know because you know never, ever gonna know the answer to it umm, but I do very much think that it has shaped my future UM in a very strange way,

Commented [TW38]: Q1 - appreciative of experience?

Q2 - Significant in shaping who they are becoming.

Commented [T39]: Wondering through this - hesitant to commit to it being helpful?

but I do think your mindset and mentality over your experiences very much shapes your experience because.. I like to think I'm quite positive person and I do always believe that even though you might not realize it at the time, everything you go through in life has a purpose. So obviously when I was going through at the time, **I hated every second of it. I hated the staff, I hated the place. I hated everybody for making me do things I didn't want to do, but.....**

Commented [T40]: Clear memory of what the experience felt like at the time. This has shifted now though?

Now looking back, I think, OK, maybe there was a reason that I went through that and perhaps that I had to go through that and get that experience so that I can now use that in later life to help other people because I do believe that you can never truly understand. something like that unless you've been through it, you can do to a degree, but not fully. Umm so I do think that I now you use it as a positive experience and like to think that I might be able to help someone like myself in the future and and you know,

Commented [TW41]: Q1 - where does this belief come from?

Commented [TW42]: Q2 - what is feeding this? Repaying for care received/making bad experience better?

I have had people message me before being like, oh, **I'm going to inpatient treatment for the first time. Like, what do I take? What do I expect? And because of what I've been through, I'm able to kind of help them maybe a little bit about what they might experience or expect.**

Commented [T43]: Inpatient label becomes identifiable support - other person asking "you got through it, how can I?"

Umm, so yeah, it's....In hindsight, perhaps it did serve a purpose. [small laugh] And I think without it, obviously in terms of my mental health, I wouldn't have got to the place that I am because I think I'd still be very much in denial and it like it did help me come to terms with the fact that it did have an illness and and

Commented [TW44]: Q2 - surprise that it could have served a purpose? This realisation only available in retrospect?

learning all the different techniques and things... because I do still use some of them daily, you know, like, even like mindfulness exercises and things like that and CBT approaches and all of that kind of things

Commented [T45]: Inpatient if used carried on into the community

Appendix Q – Dialogical Questions Table Example

Participant 2 – Lucy

	Example	Summary
Resource Questions	What resources shape how the story is being told? What resources shape how listeners comprehend the story? How are narrative resources distributed between different groups? Who has access to which resources? Who is under what form of constraint in the resources they utilize?	• Draws on stories about expectations for what a teenager should be focusing on to do when becoming an adult (university/job prospects) and also that becoming 18 should be marked in a particular way and come with particular freedoms/responsibilities. These are coming from broader society. • The narrative of what an inpatient unit is drawn upon "loony bin" – feels like a punishment when admitted and leads to feeling defective that she has to be admitted to manage with what's going on. • Lack of accurate material to make sense/understand how to describe what the environment is like to those who have not been admitted. Makes it difficult to describe in detail what it is like to be admitted – equally feels like there is the assumption that researcher will know as privy to the experience – makes it easier/more tolerable to talk about? • Language around trauma – perceives potentially poor care to be trauma (feels as if she cannot do anything about what happened to her).
Circulation questions	Who tells which stories to whom? Who would immediately understand that story and who wouldn't? Are there some people whom you wouldn't tell that story to, and why not?	• It seems that she has quite a guarded story which isn't shared with many people. It seems that the story is kept from people due to the fear that people may judge based off the stigma of an inpatient unit. Mum appears to be the closest relation who would have some awareness of what has happened however, the running theme of the environment changing around her is one which is kept to herself. • It appears that there are few people consistent through her story – maybe due to the impact that holding onto the old sense of self has when coming into inpatient but also the desire of her to recreate her own destiny and future.
Affiliation questions	Who will be affiliated into a group of those who share a common understanding of a particular story? Whom does the story render external or other to that group? Who is excluded from the "we" who share the story?	• Her story is initially accessible to some friends who she has shared with about her mental health however, inpatient label changes this and makes people disappear from helping her. • Her story is focused on her journey to recovery and much of the focus is on how she has changed herself (with little reference to if people have contributed to the progress made). Her stories seems to make her want to take ownership of her own path and future rather than being dictated by the inpatient label and what other prescribe to being possible by it. • People around her throughout her time back in the community seem to never fully understand how to support her – they are unable to see beyond the inpatient label, yet it seems that they do not share the same perception of what the function of inpatient care offers.

Participant 2 – Lucy

Identity question	How is the story teller's identity being shaped by the story they are telling? How are people holding onto aspects by acting out certain things in their lives? how do people tell stories to explore whom they might become? How do others influence this process/interact with it?	• Initially starts out being caught up in the difficulties experienced at home – somewhat appears to be confusing/chaotic. The more she experiences inpatient, the more stability there is, and she is provided space to reflect on her experiences and who she wants to be. • Initially it is difficult to see who she is as a person prior to admission – perhaps this is lost in the crisis which builds up? She starts to explore some of what might become her when in inpatient, going into town etc., which she used to hold onto but finds this to be difficult as it feels different to how she has previously experienced these settings. Staff attempt to hold onto these elements for her, but they feel different/artificial to her. • She shares how inpatient has given an opportunity to think about who she wants to become, space to question/stop/pause and think. These are stories often of being able to step out of the crisis and have space to think. • She struggles to hold onto herself when she is in the community and under 18 as others put in place restrictions which do not match to her own sense of identity. However, when 18, seems to be left more (allowed to become the independent adult she'd felt prior to turning 18). • She describes how the inpatient label means that she seeks to turn to others with that label too for support as they understand her experience. However, she also acknowledges that this comes with the risk of people not being helpful for recovery as it becomes quite insular.
What is at stake?	How is the storyteller holding his or her own in the act of telling that particular story, in that way? How do the stories that some people have available convince them of what they have to do and to be in order to hold their own?	• She seems to struggle to have control over what is expected of her/how to manage when everyone around her cannot contain her so she implements her own structure by putting in place routines/plans which she can take ownership of herself and manage. At admission, there seems to be to some extent some helplessness that she cannot change the direction/predicament that she is going to hospital so she is going to have to accept it and put up with it. • In this process, she begins to come to realise that she can start to determine her own future and can make plans based on her own interests. • Her stories of nobody understanding and being on her own means that she comes to learn that she is going to have to manage and cope on her own – she develops a priority to look after herself.