City Research Online

City, University of London Institutional Repository

Citation: Wood, K. (2024). Can you hear us now? Adolescents share their experiences of mental health services using photo, sound and object elicitation.. (Unpublished Doctoral thesis, City, University of London)

This is the accepted version of the paper.

This version of the publication may differ from the final published version.

Permanent repository link: https://openaccess.city.ac.uk/id/eprint/34239/

Link to published version:

Copyright: City Research Online aims to make research outputs of City, University of London available to a wider audience. Copyright and Moral Rights remain with the author(s) and/or copyright holders. URLs from City Research Online may be freely distributed and linked to.

Reuse: Copies of full items can be used for personal research or study, educational, or not-for-profit purposes without prior permission or charge. Provided that the authors, title and full bibliographic details are credited, a hyperlink and/or URL is given for the original metadata page and the content is not changed in any way.

City Research Online: http://openaccess.city.ac.uk/ publications@city.ac.uk

Can you hear us now?
Adolescents share their experiences of mental health services using photo, sound and object elicitation.

A PORTFOLIO FOR THE
PROFESSIONAL DOCTORATE IN
COUNSELLING PSYCHOLOGY (DPSYCH)

Katie Wood

Department of Psychology

City, University of London

April 2024

Table of Contents

List of Tables, Figures, Photos & Images

Tables

Figures

Photos

Images

Acknowledgements

This project is dedicated to my dear father, David Wood and my darling friend Kat, who were there at the start of this journey, but sadly not for the end.

I am so grateful and feel so fortunate to have met the generous young people who were kind enough to take part in this research and brave enough to share their experiences. Thank you, you brilliant creatures. I am also very thankful to the wonderful parents and carers who supported their efforts, including the fantastic staff at the services who helped make this happen.

I owe a huge thank you to my supervisor, Dr. Tanya Lecchi, whose kind and gentle support kept me motivated, bolstered my self-belief when it flagged (oh so many times) and reminded me that my world outside was important, too. And to my two cohorts, my team players, who have reminded me that this was never just about the end goal, especially Faye and Alice, who worked alongside me and made those long nights seem not so long.

I am so grateful to my dear family and friends, too my many, many siblings and their gorgeous families, to my mum who showed such faith in me and spurred me on when she was the one needing support. To all my friends, thank you. We have some catching up to do, and I have a lot of making up to do.
And finally, to my partner James the Rock and my beautiful children Swan and Indigo, thank you for your patience, magic and sweet kindness. You are my safe haven.

Declaration

I, Katie Wood, hereby grant powers of discretion to the City, University of London Librarian to allow the thesis to be copied in whole or in part without further reference to me, Katie Wood (the author). This permission covers only single copies made for study purposes, subject to normal conditions of acknowledgement.

Preface

This portfolio for the Doctorate in Counselling Psychology consists of three parts: (A) a thesis detailing my original research, (B) a publishable article and (C) a combined process report and case study. As I approach the end of my training and reflect on the unique contributions of each component of my portfolio, I see two threads weaving through them: flexibility and young people, which I will discuss in each section.

The first section (Part A) of this portfolio encompasses my doctoral thesis, an original investigation aimed at exploring UK adolescents' experiences with mental health services ("MHS"), employing photo, sound, and object elicitation techniques. Reflecting on the genesis of this research as I approach the conclusion of my training, I recall how prior experiences underscored the crucial role of adapting both clinical interventions and service accessibility. Working in an adult learning disability service before my training, I was struck by the importance of these adaptations. The importance of flexibility as a clinician was first brought to my notice during my pre-training work as an Assistant Psychologist ("AP"). It was one of my critical learning skills in year two of training on a clinical health placement working with clients with COPD. That was also the year I committed to extending flexibility to the research arm of my work. This realisation deepened during my third year, while I was involved with a specialist eating disorder service for children and adolescents, where I learned about and was impressed by the significant efforts made to ease young people's engagement with MHS, despite the ongoing challenges in achieving consistent success. The stark contrast between potential interventions and their actual, consistent application left a lasting impression on me.

Given the acute need and the current crisis within young people's MHS, characterised by excessive waiting times and scarce resources, as highlighted by Brennan (2017), I felt compelled to delve deeper into this area. My research gradually took shape with the aim of uncovering recurring themes in the narratives of adolescent service users, finding both the effective and ineffective aspects of MHS for adolescents and pinpointing opportunities for enhancing service delivery to improve mental health outcomes. Additionally, this study aimed to determine the most appropriate types of MHS for adolescents and to consider how these services might be developed further.

A literature review revealed a notable gap: young people's perspectives on MHS were rarely sought, and even when they were, the necessary adaptations to traditional research methodologies to engage young people effectively, were seldom implemented. This gap highlighted the need for a more flexible and person-centred approach by researchers. This study looks to fill this gap in the literature by giving adolescents the platform to share their experiences of services in their own words. Within a critical-realist paradigm and guided by participatory epistemology, qualitative data was gathered through semi-structured interviews with adolescents aged 13-18 who had accessed publicly funded MHS within the three years prior to recruitment. I utilised a participatory elicitation technique to encourage the adolescents' active engagement with the research process, inviting them to bring photos, sounds, and objects to the interviews to aid in discussing their experiences with MHS. The data was then analysed using Braun & Clarke's expanded Reflexive Thematic Analysis ("RTA") (2012, 2013, 2014, 2020), resulting in the identification of six overarching themes: Feeling Invisible, The Fight, Open Wounds, Stuck in a Maze, Childhood and Help, with several sub-themes detected under each category.

"The Fight" theme highlights the adversarial experiences of adolescents as they strive to secure mental health support, underscoring the significant sacrifices made and the palpable sense of injustice they often feel. "Open Wounds" delves into the cyclical nature of vulnerability and distress, marking the profound, lasting effects of negative encounters within the mental health system on young people. "Feeling Invisible" reflects adolescents' feelings of being overlooked and misunderstood by MHS and, in turn, struggling to communicate effectively. The "Help" theme encompasses both "The Good Stuff' and "The Bad Stuff" to illustrate the range from supportive to problematic interactions. Adolescents' experiences with MHS are likened to navigating "Stuck in a Maze," characterised by daunting journeys, prolonged waits, and systemic shortcomings. Lastly, "Childhood" captures the interplay between vulnerability and emerging autonomy, shaping and being shaped by their mental health support experiences.

The second section (Part B) of my portfolio is a journal article intended for publication, which is an abridgement of my original research (Part A) exploring adolescents' help-seeking experiences with NHS-funded MHS. Through RTA, the study uncovered six themes highlighting the significant challenges young people face accessing services. These are examined in light of existing literature and research. The implications of these findings for healthcare professionals, particularly Counselling Psychologists, are explored, emphasising the potential for enhancing practice and policy.

This article is intended for submission to the Journal of Adolescence, chosen for its peer-reviewed, cross-disciplinary nature and international reach. This choice reflects my conviction that the insights gained from this research are universally applicable to all healthcare clinicians working with young people. The Journal of Adolescence is esteemed for its commitment to advancing research and promoting best practice, notably in its encouraging methodological innovations. This aligns with the distinctive participatory aspect of my study, where I adopted a novel approach and offered a variety of elicitation tools to express their experiences. Given its broad base and multidisciplinary approach, the journal is an ideal platform for disseminating these findings to a global audience. I am hopeful that insights gleaned from this study, such as the participatory research methodology, will resonate with researchers seeking to work with marginalised populations and young people and that the voices of the adolescents will resonate across disciplines and encourage services to confront and address poor practices.

The third and final part of this portfolio (Part C) consists of a clinical case study and process report conducted during my final year of training. It presents an in-depth and detailed analysis of a piece of therapeutic work with an 11-year-old girl, "Lizzy". This marked my first clinical intervention with a child and my first foray into working with CYP in a private clinical setting, diverging from my background in NHS-based services. Operating through a young person's perspective introduced challenges that demanded flexibility, both in my adapting the work for Lizzy's needs and ensuring her sense of agency. This aligned with the importance of tailoring cognitive-behavioural therapy (CBT) to the unique needs of each child (Ng & Weisz, 2016), which includes customising the intervention and the delicate negotiation of parental involvement in the therapeutic process.

Reflecting on my work with Lizzy offered valuable insights into my practice, particularly concerning how adaptations, including the therapeutic alliance, affect the therapeutic process. Balancing effective CBT session management with the need to tailor interventions to an individual's unique context was not always easy. For instance, focusing on session goals and maintaining energy levels sometimes reduced my ability to listen actively and remain fully present. I remain deeply grateful for the opportunity to have engaged in a year-long placement working with CYP and for Lizzy's and her mum's generosity in allowing me to analyse our work for my training. The case study enabled me to identify and assess the challenges systematically met while working with a young client and to contemplate how these challenges might vary with different age groups. An essential aspect of my approach was to appropriately pitch the therapeutic interventions for Lizzy, who was navigating the transition from childhood to adolescence—a distinction often emphasised in CBT literature.

By including Lizzy's case, I aim not only to share the specificities of our work together but also to illuminate the broader challenges and necessities of adaptability that come with engaging young clients at pivotal developmental milestones. Lizzy stood at the threshold of adolescence—a period marked by profound physical and psychological changes. This case exemplifies the nuanced approach needed to meet the complex needs of individuals navigating this critical juncture. It underscores the importance of flexibility and sensitivity in therapeutic practice, especially when supporting young people who are not just dealing with the typical issues of childhood but are also on the cusp of entering adolescence. The adaptability demonstrated in this work reflects a broader commitment to understanding and addressing the unique challenges faced by young individuals during these formative years, emphasising the developmental significance of this age and the critical role of tailored therapeutic interventions.

Although each piece of work stands independently, they are intricately linked by a common exploration of young individuals' mental health journeys through adolescence, their struggle to be heard and understood and the crucial role of flexibility in addressing their evolving needs. This not only mirrors the adolescents' pathways through their challenges but also parallels my own developmental journey towards becoming a Counselling Psychologist—a journey marked by adaptability, resilience, and a deep commitment to understanding and supporting the mental health of young people at a pivotal stage in their lives.

Together, these three pieces of work are the culmination of my abilities as a trainee psychologist, clinician, and researcher. I began my research in the first year, before taking two years out to have my son (including a difficult pregnancy). Not long after I resumed my training, the COVID-19 pandemic hit. This upended so-called life as we knew it, including my research and placements. Suddenly, what had seemed relatively straightforward had to be reconsidered, renegotiated and re-implemented, and every part of this portfolio was impacted. Thus, I had to approach every aspect of my work with a flexible stance.

As I stand on the threshold of transitioning from a trainee to a qualified Counselling Psychologist, I carry forward the invaluable lessons learned about the importance of flexibility into clinical practice and research. This journey has been defined by adaptability, emphasising the dynamic interplay between theory and practice, a principle I am deeply committed to as I move forward in my career. The case study, my research, and the journal article collectively weave a story of young people struggling to be heard and understood and for clinicians to respond appropriately. This journey also helps show my own professional evolution. They underscore my realisation that the heart of Counselling Psychology lies in the shared, mutually transformative process of help, where theory informs practice and, conversely, practice enriches theory. In turn, for me, this occurs on both a personal and professional level.

So far, my professional path has been deeply influenced by the importance of adaptability, especially in the context of young people's mental health. Moving forward, I am committed to weaving this flexibility into all facets of my work—by fostering meaningful therapeutic relationships and engaging in research that bridges gaps between theory and practice. As I embark on this next phase of my career, I am reminded of the profound privilege it is to share in the therapeutic journey with clients, to advocate for those whose voices are often unheard, and to contribute to the evolving landscape of MHS. It is with a sense of hope and determination that I look forward to the opportunity to apply the principles of flexibility, collaboration, and empowerment in my continued work, aiming always to foster positive change in the lives of individuals and the broader community.

References

Braun, V., & Clarke, V. (2012). Thematic analysis. In: Cooper, H., Camic, P.M., Long, D.L., Panter, A.T., Rindskopf, D., Sher, K.J. (eds.) *APA Handbook of Research Methods in Psychology, Research Designs* vol. 2 (pp. 57–71). American Psychological Association, Washington

Braun, V., & Clarke, V. (2013). *Successful Qualitative Research: A Practical Guide for Beginners*. Sage Publications, Thousand Oaks

Braun, V., & Clarke, V. (2014). What can "thematic analysis" offer health and wellbeing researchers? *International Journal of Qualitative Studies on Health and Well-being, 9*(1), 26152. https://doi.org/10.3402/qhw.v9.26152

Braun, V., & Clarke, V. (2020). One size fits all? What counts as quality practice in (reflexive) thematic analysis? *Qualitative Research in Psychology, 18*(3), 328–352. https://doi.org/10.1080/14780887.2020.1769238

Brennan, E. J. (2017). Towards resilience and wellbeing in nurses. *British Journal of Nursing, 26*(1), 43–47. https://doi.org/10.12968/bjon.2017.26.1.43

Ng, M.Y., & Weisz, J.R. (2016). Annual Research Review: Building a science of personalised intervention for youth mental health. *Journal of Child Psychology and Psychiatry, 57*, 216–236.

PART A: DOCTORAL RESEARCH STUDY

Can you hear us now?
Adolescents share their experiences of mental health services using photo, sound and object elicitation.

Research Supervisor: Dr Tanya Lecchi

Abstract

Amid growing concerns about adolescent mental health globally, the need to improve mental health services specifically tailored to the developmental stages and preferences of young people has become increasingly evident. Adolescents face unique psychological challenges that necessitate more inclusive and participatory research approaches to understand and address their specific needs more effectively. This qualitative exploratory study employed a participant-led, elicitation methodology to delve deeply into adolescents' experiences with mental health services in the UK, aiming to empower this vulnerable demographic to share their perspectives meaningfully and contribute to the broader literature on adolescent experiences. Nine adolescents (5 female, 4 male) from three geographic locations engaged in semi-structured elicitation interviews, where they shared personal photographs, objects and sounds to help them express what was important to them. Reflexive Thematic Analysis of the interviews yielded six main themes: Feeling Invisible, The Fight, Open Wounds, Stuck in a Maze, Childhood and Help, together with thirteen sub-themes. These themes illuminate the profound struggles young people have to go through in their quest for mental health support and highlight how frequently they feel overlooked and misunderstood by adults in caregiving roles across all services. The findings emphasise the need for mental health service providers to start actively encouraging and listening to the views of young service users. And to act on that information by designing services that are not only accessible but also responsive to the individual and developmental needs of adolescents. The practical implications for Counselling Psychologists and other healthcare professionals are discussed, and suggestions for future research are set out. This study advocates for research methodologies that integrate the voices of young people in ways that are meaningful to them.

Chapter 1

Literature Review

This chapter lays the groundwork for this research, offering a comprehensive exploration of the myriad facets that shape the landscape of adolescent mental health services (MHS) in the UK. It outlines the context and rationale for the research by examining key terms: adolescence, client experiences, elicitation methods, and MHS, supported by relevant literature. It delves into the intricate dynamics of adolescence as a developmental stage, characterised by profound physical, cognitive, and psychosocial changes. This exploration extends to dissecting the nuances of adolescents' perceptions and interactions with MHS, underpinned by a systematic literature review. This review not only highlights significant themes but also exposes gaps in how these services address the complex needs of adolescents. Through a critical analysis of the findings, the chapter underscores the scarcity of research dedicated to capturing the authentic voices of adolescents regarding their experiences with MHS. I argue that adopting a participatory paradigm will help strengthen our understanding of adolescents' genuine experiences and help shape support systems appropriate to their developmental and psychosocial contexts. The chapter concludes by outlining the research questions, aims and objectives and discusses the anticipated contributions to the field of Counselling Psychology, highlighting its potential to enrich professional practices and policy formation.

1.1 General Literature Review

1.1.1 Adolescence

Adolescence is a uniquely fascinating and complex stage of life, characterised by rapid developmental changes that are second only to those in infancy. This transitional period from childhood to adulthood is marked not only by physical and sexual maturation but also significant cognitive and psychosocial development essential for adult life. Adolescence begins with puberty, which makes pinpointing its onset difficult. Social science literature typically divides adolescence into early (10–13 years), middle (14–17 years), and late stages (18–21 years). However, recent research suggests that in Western societies, adolescence may extend further due to evolving social structures (Coleman, 2011). This research focuses on adolescents aged 13-18. Therefore, the terms "adolescent", "teenager" and "young person" will be used interchangeably throughout.

Significant biological changes occur during adolescence, including the brain's maturation, particularly the development of the pre-frontal cortex and synaptic pruning (Keating, 2004). As the brain develops and reorganises, becoming more attuned to its environment, adolescent cognition undergoes "explosive changes" (Giedd, 2004 p.83), while neuronal pathways that are not used, diminish according to the "use it or lose it" hypothesis (Giedd, 2004).

These neurological and cognitive changes occur in tandem with a psychosocial transition from childhood dependence to independent adult roles (Moses-Payne et al., 2021; Steinberg, 2019). This takes place as a young person moves away from the bosom of the family, gravitating towards peer groups which form around shared interests, values, language and rituals, influencing young people's beliefs about the world (Cicchetti & Schneider-Rosen, 1986; Emde et al., 1986; Nelson & Nelson, 2010). Nonetheless, parental and educational influences continue to play significant roles in shaping adolescents' worldviews, along with peer and media exposure (Ardèvol-Abreu, 2015; Valle et al., 2015). Adolescents begin to think in abstract terms about their social positioning and how relationships and environments affect them (Briggs, 2008; Steinberg, 2019).

1.1.2 Psychological Theories of Adolescence

The term "adolescence" (from the Latin "adolescere" meaning "to grow up") was first recognised as a distinct developmental stage by G. Stanley Hall when social transformations such as Child Labour Laws and universal education at the turn of the 20th Century, allowed young people more time to mature and delay the responsibilities of adulthood (Hall, 1904). Hall was critical of this new developmental period where mood disruptions, parental conflicts, and risky behaviours created a phase of "storm and stress" (Lerner & Israeloff, 2007, p.4) for teenagers and those close to them. However, more contemporary views dispute Hall's assertions, e.g. Bandura (1964) argued that adolescence does not inherently involve tumultuous conflict with parents; instead, societal views that stigmatise adolescents lead to a skewed perception of this developmental stage that can promote conflict (Vitelli, 2013).

Psychologically, adolescence involves the crucial task of identity formation. Erikson's theory of psychosocial development (1968) describes adolescence as the stage of identity versus role confusion.' As cognition matures, young people begin to establish their unique identity by experimenting with various roles and ideas, distinct from their family's values. Successfully navigating this stage results in fidelity, which is characterised by the ability to accept and relate to others and one's own identity development. Unfortunately, failure, can result in role confusion and difficulties in subsequent stages.

Developmental contextualism (Lerner & Kaufmann, 1985; Lerner, 1991) argues that development is relational, occurring through dynamic interactions between adolescents and their environments. This theory emphasises that young people are not passive recipients of environmental influences but actively shape their own development by influencing and being influenced by their surroundings. For instance, changes in adolescent behaviour might prompt adjustments in parental supervision, which in turn further influence the adolescent's development (Coleman, 2011).

Integral to this interactive process is the concept of 'goodness-of-fit', which describes the compatibility between a person's temperament and their environment (Thomas & Chess, 1997; Lerner & Lerner, 1994; Shiner et al., 2012). A good fit is crucial; if an adolescent's characteristics are compatible with their environment, healthy development is promoted. Whereas, a mismatch between the adolescent and their environment can lead to developmental challenges. As young people grow and encounter new environments, this fit may change, reflecting the evolving nature of their relationships with the world (Thomas & Chess, 1997). This dynamic process highlights the importance of fostering environments that align well with the evolving needs of young people to support healthy development.

Coleman's (1974) Focal Model of Adolescent Development offers an insightful perspective by suggesting that adolescence involves focusing on different developmental issues sequentially rather than simultaneously. These issues being predominantly centred around relationships. This model helps explain why some adolescents navigate this period with relative ease, while others encounter significant challenges, especially when confronted with multiple tasks at once. It corroborates findings that managing several tasks simultaneously can result in adverse effects such as diminished self-esteem and increased emotional distress (Goossens & Marcoen, 1999; Simmons et al., 1987; Lasgaard et al., 2016).

During this critical period of identity formation, it is argued that key events encountered at this time can impact a person's decisions in adulthood (Wray-Lake et al., 2010). Of course, people constantly revise their understanding of the world with new information and experiences (McLean, 2008), but our core values, attitudes, and behaviours can often be traced back to influences and events encountered during adolescence (Flanagan, 2004; White & Swartzwelder, 2009; Wray-Lake et al., 2010). With identity formation and abstract thinking development, comes advanced decision-making faculties, and so adolescents make more complex inferences about the world (Steinberg, 2019). Due to this confluence of factors and rapid change, adolescents are more vulnerable to first experiencing symptoms of mental distress (Kaasbøll et al., 2021; Okewole et al., 2016).

Understanding adolescence as a critical developmental stage is essential for interpreting how young people interact with MHS. Developmental theories, such as Erikson's theory of psychosocial development and the concept of 'goodness-of-fit' from Developmental Contextualism, provide a framework for analysing the data. These theories emphasise the importance of identity formation and the influence of environmental factors on development, which are crucial aspects when considering mental health interventions for young people. By integrating these theories, the research methodology was designed to focus not only on the adolescents' experiences of services but also on how these experiences align with their developmental needs and environmental context. This theoretical framework supports the use of elicitation methods that draw out rich, subjective insights into adolescents' perceptions, which might otherwise be overlooked in more traditional research approaches.

1.1.3 Adolescent Statistics

Given this backdrop, the rise in mental health problems among adolescents is both concerning and predictable. As of 2020, 16% of 5–16-year-olds in England were reported to be struggling with their mental health, a significant increase from 10.8% in 2017 (NHS England Digital, 2022). Despite this, there is evidence of a service gap, i.e. a disparity between the prevalence of these disorders and the proportion of young people accessing treatment, with as much as 70% of young people who experience mental health issues not receiving appropriate interventions at a sufficiently early stage (Royal College of Psychiatrists, 2010). These figures reflect an urgent need for effective adolescent MHS. Early intervention is crucial, as mental health challenges during this pivotal developmental phase can endure into adulthood (Caspi et al., 2020).

Given unique biological, cultural, and social experiences of adolescents, their interactions with MHS may differ significantly from adults. It is essential to incorporate adolescents' feedback into the design and adaptation of MHS to ensure they meet the specific needs of this dynamic developmental stage.

1.1.4 Client/Patient Experience

Patient experience is globally recognised as a critical dimension for determining the quality of healthcare (Doyle et al., 2013; Manary et al., 2013). Collecting what patients have to say about healthcare services seems, at face value, a straightforward exercise, yet while healthcare providers and users all agree on its importance, there is no clear definition of what constitutes a "patient's experience". As Robinson (2010) pointed out, "if you can't define what it is, you can't provide it—and you certainly can't measure it", so, "it's no wonder that hospitals are struggling with the best way to provide it." (Robinson, 2010, p.1). The Beryl Institute (2020) defines patient experience as the cumulative nature of interactions and perceptions shaped by an organisation's culture across the care continuum. This study adopts this broad perspective, seeking to understand adolescents' experiences in their full complexity.

In UK health policy, services are mandated to be 'patient-centred', where patients' and their carers' voices are heard and employed as agents of change (Department of Health, 2000). While adult patients' experiences are well-documented (Simpson & House, 2002), research into CYP experiences of MHS is notably sparse, reflecting a global trend of insufficient studies examining mental health issues among young people (Dunne et al., 2000; Funk et al., 2013; World Health Organization, 2017).

1.1.5 Adolescents in Research

The conventional narrative has often positioned young people as passive in research, relegating them to the background in discussions about their own health by using objective measures or seeking the views of proxies, usually parents or carers. This approach has sometimes been justified by the perceived developmental incapacity of young people to express informed opinions (Balen et al., 2006). Whilst such methods might be appropriate for very young children or CYP in significant distress, they ignore the competence of older children and reflect poorly on the ability of adults – clinicians, healthcare providers and researchers - to hear CYP and support their inclusion. More recent perspectives challenge this view by recognising that young people, from as early as age 4, are capable of engaging meaningfully in decisions about their health care (Persson et al., 2017; Sorsa et al., 2006; Morrow & Richards, 1996). These perspectives are supported by a shift towards recognising adolescence as a distinct phase of life, where young people are seen not just as recipients of adult protection but as active participants in shaping their interactions and relationships (Archard, 2004; James & Prout, 2015).

This evolving understanding underscores the importance of participatory research methodologies that prioritise the voices and perspectives of adolescents, thus challenging the traditional 'adultist' bias (Luttrell, 2010). These methodologies highlight the need for dynamic, action-oriented approaches that resonate with adolescents' unique needs and facilitate their direct involvement in the research process. By adopting such approaches, this study aims to encourage and promote the voices of young people, providing insights that can inform clinical and systemic improvements.

The importance of seeking the views of adolescents is not only necessary for their effective engagement in processes that affect their lives and health but is embedded in law (The Children's Act, 1989; United Nations Convention on the Rights of the Child, 1989). Realising this, the National Institute for Health and Care Excellence ("NICE") (NICE, 2013) has identified the lack of adolescent participation in decision-making as a significant safeguarding concern. Whilst the UK Government demanded that children and families be put at the heart of decision-making to improve every aspect of health services (Department of Health, 2013), there has been a failure to do so. In fact, most young people and their caregivers are unaware of the obligation of healthcare providers to hear CYP's views (Cleland & Sutherland, 2001).

Research suggests that adolescent participation not only benefits their psychosocial development but also enhances the effectiveness of interventions aimed at this demographic by fostering their confidence, assertiveness, and positive self-image (Eide & Winger, 2005; NICE, 2013; Triseliotis et al., 1995). Furthermore, studies promoting active involvement through participatory methods help adolescents develop a sense of control, responsibility, and self-expression and bolster their sense of self-efficacy and participatory and interpersonal skills (Morsillo & Prilleltensky, 2007; Sabo, 2001). Yet participatory practice must be carefully operationalised to avoid becoming tokenistic or adult-driven (Cavet & Sloper, 2004; Hill et al., 2004).

1.1.6 Elicitation Methods

Elicitation methods in qualitative research have evolved as powerful tools to provoke thoughtful engagement and gather deep insights from participants. Rooted in the anthropological work of pioneers such as Margaret Mead and Malinowski, these techniques aim to balance power dynamics in researcher-participant interactions, positioning participants as experts of their own experiences (Mead, 1930; Malinowski, 1922).

They generally refer to research tasks that employ visual, verbal, or written stimuli to prompt individuals to share their thoughts and ideas (e.g. Johnson & Weller, 2002). After all, direct questioning on sensitive subjects can often be challenging, as many people struggle to discuss such topics openly, particularly with an unfamiliar researcher. Elicitation techniques offer a valuable approach. Shifting the focus in a research interview to external stimuli, can help redress the power imbalance between the researcher and the participant, thus facilitating a more equitable and engaging dialogue (Barton, 2015). Therefore, these methods encourage young people to express complex feelings, thoughts and memories, making them particularly useful in the context of mental health research.

In formal interviews, questions that might be too abstract, broad or similar to test questions are often problematic. Interviews are usually anxiety-provoking, especially if participants are not sure what they are “really” being asked or what the researcher is expecting (Whyte, 1984). Participants’ responses can be influenced by feelings of self-worth, their memory, the personal relevance of the questions and a need to conform (Johnson & Weller, 2002). So, while participants often possess extensive knowledge and insights on a topic, it can be challenging to express themselves as much as they would like in a research setting. Elicitation techniques help individuals articulate these ideas in more depth and detail, making the research process more transparent and comfortable (Walker & Widel, 1985). This is achieved through the elicitation materials acting as a third party, building an atmosphere of collaboration as the researcher and participant work together to explore and understand their content. As Collier and Collier (1986) note, “verbal questioning can create a distance between interviewer and informants, whereas use of photographs can pull people together” (p. 131).

Research relationships are often characterised by power imbalances. However, when participants contribute to the meaning-making process, they transition from "subjects" of research to playing a more active, assertive role (Harper, 1988). In elicitation-based interviews, an individual takes on the role of an expert as they guide the researcher through the material (Collier & Collier, 1986), as opposed to mere holders of information that has to be extracted and analysed by the researcher (Banks, 2001). This gives participants greater control and more opportunity to steer the information exchange and introduce relevant and significant ideas. This helps shift the power imbalance between the researcher and participant towards a more equal footing and helps a more nuanced understanding of the data develop.

Photo elicitation involves participants capturing or selecting images that represent their experiences, thereby fostering their deeper engagement and discussion during interviews. This method has been notably effective in discussing topics such as health awareness, sexuality, self-understanding, and resilience among adolescents. Harper (2002) suggests that images can trigger deeper emotional responses than words alone, which is particularly advantageous in mental health research. An illustrative example is Matzka and Nagl-Cupal's (2020) study, where young carers used photo novellas to depict their daily challenges and resources, enriching the dialogue about their coping mechanisms and resilience.

Sound elicitation utilises music or ambient sounds to evoke emotional and sensory responses from participants. Allett (2010) highlighted the power of music elicitation to access deeply embedded personal and emotional experiences, which are potentially invaluable in mental health contexts. This method allows researchers to tap into adolescents' emotional landscapes that might have been difficult to articulate in conventional interviews.

Although less common, object elicitation involves participants choosing objects that hold significant personal meaning, potentially enriching the data with multi-sensory details and emotional depth. Willig (2017) successfully used this method with individuals living with terminal illnesses, demonstrating its potential to capture the nuanced aspects of lived experiences. Though studies specifically targeting adolescents using this method are limited, its success in other contexts suggests substantial potential for future research.

Thus photo, sound, and object elicitation in this study should allow for a deeper understanding of adolescents' perspectives by providing them with different ways to express their thoughts and feelings in a non-verbal manner, which can be more reflective of their developmental stage. Elicitation methods align with the Developmental Contextualism theory, wherein adolescents actively shape their development through interactions with their environment. By using these elicitation techniques, the study engages young participants in a form of interaction that respects and makes the most of their developmental capabilities.

However, while elicitation methods offer significant advantages in qualitative research, they also present several challenges that require careful consideration and navigation. The interpretation of elicited materials can be highly subjective and prone to misinterpretation, potentially complicating the research outcomes (Croghan et al., 2008). In addition, these methods raise ethical concerns, particularly regarding privacy, consent, and the management of emotionally charged material (Matthews, 2016). These challenges are especially pertinent when working with adolescents, who may be more vulnerable to emotional distress and might struggle with emotional regulation and coping. Consequently, I committed to handling these issues with heightened sensitivity and rigour to ensure the ethical integrity and accuracy of the findings. In order to address these ethical considerations, I anonymised all the data, including the visual data and conducted comprehensive discussions about the use of content with the teenage participants (Wiles et al., 2007). I also undertook a pilot study, an invaluable tool for refining methodological approaches (Kim, 2011).

1.1.7 Adolescent Mental Health Services

Within the UK, Children and Young People's Mental Health Services ("CYPMHS") encompass a broad spectrum of services designed to support the mental and emotional well-being of individuals from birth to age 25. These services are delivered through various entities, including local authorities, NHS mental health and community trusts, the private sector, and voluntary organisations. Child and Adolescent Mental Health Services ("CAMHS") are integral to these services and are designed to address the unique challenges faced by young people.

The National Health Service (NHS) acts as the primary provider of public health services in the UK, offering extensive healthcare services, including mental health support through CAMHS. These services cater to children and adolescents experiencing emotional and behavioural difficulties, their availability varying by region based on demographic needs and assessment of local resources.

Access to CYPMHS typically begins with a referral from a General Practitioner (GP), who evaluates the young person's condition and can direct them to the appropriate MHS. These services might be located within a GP's practice, a community health centre, a specialised mental health clinic, or a hospital. Notably, certain services, such as those for substance misuse and some talking therapies, allow self-referral, enabling access without a GP's referral. Educational settings such as schools and colleges also play a significant role in facilitating referrals to MHS and some provide mental health support on site.

Funding and oversight of these services are managed by Integrated Care Boards (ICBs), with some specialised services, including inpatient care for children, being commissioned directly by NHS England through provider collaboratives. Importantly, the funding for CYPMHS is typically discretionary at the local level, entrusted to the judgment of ICBs without specific earmarking by the government or NHS England.

A significant enhancement in the approach to delivering MHS for children and adolescents in the UK is embodied by the implementation of the THRIVE framework. This model restructures the traditional tiered system to categorise needs into five groups — Getting Advice and Signposting, Getting Help, Getting More Help, Getting Risk Support, and Thriving. THRIVE focuses on integrating health, education, and social care services to effectively promote mental health and wellbeing. By disseminating the idea that mental health is "everyone's business," THRIVE encourages support from a diverse range of professionals, not just those in medicalised roles. This inclusive, needs-based approach is designed to provide clear, differentiated pathways for care that are more closely aligned with the individual needs of young people, thereby improving the accessibility and effectiveness of MHS. This comprehensive framework emphasises the need for services that are not only accessible and widespread but also finely tuned to meet the complex and diverse needs of young individuals across the UK.

As CYPMHS is an umbrella term for services for young people up to the age of 25, I will refer to mental health services for adolescents in this paper as "MHS".

1.2 Systematic Literature Review

1.2.1 The Literature Search

This review is based on searches of several databases: PubMed Central, MEDLINE, and APA PsycINFO, together with Google Scholar and the City University Library database. When searching for articles about adolescents' experiences of MHS, literature relating to support systems outside the UK was excluded. This was because the focus of this study was on publicly funded mental health support offered to teenagers in the UK, and different countries have unique support systems relating to their economy, system of government, and social values. When searching for literature pertaining to elicitation methods with adolescents, due to its paucity, studies conducted abroad but written in English were accepted.

1.2.2 Inclusion and Exclusion Criteria

For the search focusing on adolescents' views of UK MHS:

<u>Inclusion criteria</u>:

- adolescents aged 13-18 (as puberty usually begins between 8-13 years old (John Hopkins Medicine, 2020) and in the UK young people transition to adult services at age 18);
- all publicly funded (i.e. NHS and/or third sector) UK MHS, including in-patient and out-patient settings;
- all mental health diagnoses, including co-morbidities;
- qualitative, quantitative, mixed and multi-method designs;
- studies published in English post-1999.

Exclusion criteria:

- literature concerning others' views of adolescents' experiences of CYPMHS (e.g. healthcare professionals', parents'/carers');
- where participants comprised mixed ages, 13 > mean age >18, or more than 50% of participants fell outside the 13-18 age range.

Key search terms included: *teenagers, adolescents, young people, young adults, children, mental health services, mental health sector, CAMHS, help-seeking, experiences, perceptions, attitudes, views, mental health service(s) utilisation, elicitation, elicitation techniques, photo elicitation, sound elicitation, object elicitation.*

Initially, 821 relevant papers were identified, and 232 duplicates were removed. 589 titles and abstracts were scrutinised by hand, and 537 that failed the inclusion criteria or fell within the exclusion criteria were rejected. 52 full texts were then reviewed against the inclusion and exclusion criteria, and their reference lists were searched, revealing 4 more papers. Further refinement of exclusion and inclusion criteria yielded 16 key papers. For thoroughness, published and unpublished papers were searched, but all key papers in this review were peer-reviewed.

1.2.3 Quality Appraisal

The final selection of 16 studies comprised 15 qualitative and 1 mixed methods (see table of studies below). Quality was assessed using the Critical Appraisal Skills Programme (CASP, 2018) checklist (See Appendix 1), recommended by the Cochrane Qualitative Research Methods Group (Hannes, 2011). Articles were assigned 'yes', 'no', or 'partially fulfilled" rather than 'can't tell' to recognise partial fulfilment of criteria. The results are presented in table format (see Appendix 2), using traffic light colours to show results at a glance. Quality appraisal was not a determinant of eligibility following Cochrane's advice that studies of "lower quality" due to methodological flaws or lack of reporting may generate new insights grounded in the data. In contrast, methodologically sound studies may suffer from poor interpretation of data, leading to insufficient insight into the phenomenon under study (Dixon-Woods, 2007). Please see Appendix 3 for a list of key studies, including details of their settings and methodological approaches.

1.2.4 Summary of Main Findings

An inductive thematic analysis of key studies identified four main themes central to understanding adolescent experiences in MHS. These themes are briefly outlined and then described more fully below. **Therapeutic Relationship** - This theme captures the quality of the relationship between healthcare providers and adolescent clients, highlighting the importance of mutual respect, empathy, and active collaboration. **The Engagement Process -** Engagement in treatment is seen as a dynamic process in this theme, and is significantly influenced by the therapeutic relationship, treatment setting, and individual motivations. Adolescents value having an active role in their treatment decisions and strategies tailored to their readiness and developmental stage. **Experiences of Treatment and Treatment Outcomes** - This theme examines both the adolescents' experiences during treatment and perceived outcomes following treatment, reflecting on the effectiveness of the therapeutic relationship and treatment approaches. **Experiences of Environment and Organisation of Services** - This theme examines how the accessibility and organisation of services, such as outpatient and inpatient settings, played crucial roles in shaping adolescents' experiences. Cultural and developmental sensitivities were critical factors that influenced all the above themes. Additionally, the review considers the impact of employing a qualitative approach to study these experiences in depth.

1.2.4.1 Theme 1: Therapeutic Relationship

The most dominant theme across all the studies was that a strong therapeutic relationship, characterised by mutual respect, empathetic understanding, and active collaboration, is pivotal for shaping adolescents' experiences and outcomes in MHS. (Therapeutic relationship was broadly conceptualised as the professional and interpersonal connection between healthcare clinician and adolescent client.)

Trust and safety underpinned effective therapeutic relationships, impacting adolescents' willingness to engage in treatment and were key in promoting or inhibiting progress in therapy (Donnellan et al. (2013). Trustworthiness and feeling safe are crucial in helping adolescents feel sufficiently comfortable sharing personal experiences and working collaboratively with healthcare professionals. Facilitating trust and safety was achieved through healthcare professionals showing genuine care, maintaining confidentiality and demonstrating cultural sensitivity.

Adolescents found it hard to trust therapists if they had previously encountered inconsistent or disrupted therapeutic relationships (Harper et al., 2014). The desire for continuity was especially pronounced among Black and minority ethnic young people, reflecting the broader significance of stable therapeutic relationships and the importance of fostering trust for marginalised young people. Refugees and ethnic minorities may face unique challenges establishing trust and safety within the therapeutic relationship due to cultural differences, language barriers, and previous negative interactions with healthcare systems.

Examining the obstacles faced by young refugees, Majumder et al., (2015) found that mistrust and feeling 'not safe' were significant obstacles to therapeutic engagement. This mistrust often stemmed from traumatic events and exploitation, highlighting the need for MHS to be perceived as trustworthy by young people. This was echoed in Fazel et al. (2016) whose study involving refugee and unaccompanied adolescents, highlighted how important establishing trust and understanding was for them to engage with MHS. Fazel et al. (2016) also found cultural sensitivity and empathy were crucial to a strong therapeutic alliance. Gurpinar-Morgan et al. (2014) found similar results, exploring the experiences of BME young people, emphasising the importance of the therapist's ethnic awareness and sensitivity, especially their ability to acknowledge and integrate cultural nuances to strengthen the therapeutic relationship. The study demonstrated that generic recommendations for addressing ethnicity may lead to negative perceptions of the therapist and adversely affect the therapeutic alliance. Similarly, Buston (2002) highlighted adolescents' appreciation for professionals who show genuine concern and effort to understand their unique circumstances.

The review highlighted how significant it was for young people to be treated as equal partners in the therapeutic process. In Harper et al. (2014), adolescents reported that collaborative decision-making in their mental health care, where they felt their autonomy was respected, enhanced their engagement in therapy. Colton and Pistrang (2004) and Harper (2014) underscored the high value adolescents placed on being seen and treated as individuals rather than diagnoses.

Less formal interactions, characterised by a more relaxed and personable communication style, helped adolescents foster stronger connections with clinicians. It also gave adolescents the space to “be themselves” and discuss problems more casually and with humour (Buston, 2002; Haynes et al., 2011), which, especially for inpatients, brought a sense of normality (Haynes et al., 2011). Friendly staff gave adolescents a sense of being listened to, understood and cared for, qualities that were key for an overall positive experience of MHS (Boyden et al., 2013; Buston, 2002; Colton & Pistrang, 2004; Davison et al., 2017; Donnellan et al., 2013; Gill et al., 2016; Harper et al., 2014;). On the other hand, overly formal relationships hindered rapport as adolescents perceived them as less genuine and supportive (Smart et al., 2023) and impacted their willingness to engage in therapy (Fazel et al., 2016). Within formal relationships, adolescents preferred “youth-friendly clinicians” who talked to them as individuals rather than focusing solely on their problems (Boyden et al., 2013; Colton & Pistrang, 2004; Harper et al., 2014). Confidentiality and feeling accepted were underscored in Davison et al. (2017) and Hassett & Isbister (2017), where young people expressed the need for a secure space to share personal experiences without judgment.

The perception of the therapeutic relationship can vary by age. Hassett and Isbister (2017) noted that older adolescents sought more collaborative and autonomous relationships, while younger adolescents prioritised feeling cared for and guided. The therapeutic relationship also varied among different healthcare professionals. For example, adolescents perceived GPs to be less accessible for emotional and psychological concerns compared to psychologists or counsellors (Majumder et al., 2015). Negative experiences, such as feeling misunderstood or judged, can hinder the therapeutic relationship. Gill et al. (2016) reported adolescents' frustrations with healthcare professionals who failed to engage them meaningfully in their care process. Whereas a supportive therapeutic relationship can lead to improved mental health outcomes and contribute to adolescents' overall satisfaction with MHS (Jones et al., 2017).

1.2.4.2 Theme 2: The Engagement Process

The engagement process refers to how adolescents become actively involved and committed to their treatment. This process is influenced by the therapeutic relationship, treatment setting and individual motivations. A shared finding across the studies was the need for adaptable, individualised treatment approaches that respect adolescents' perspectives and stages of readiness. Engagement was seen as a dynamic process requiring ongoing effort from both therapists and adolescents.

Several studies noted the importance of adolescents feeling that they have an active role in their treatment decisions, suggesting that engagement is enhanced when adolescents perceive their input as valued and influential (Colton & Pistrang, 2004; Gill et al., 2016; Harper, 2014). The emphasis on specific engagement strategies varied across the data. Some studies (e.g., Fazel et al. (2016), Majumder et al. (2015)) focused on overcoming barriers such as mistrust and cultural differences, while others (e.g., Colton & Pistrang, 2004; Harper, 2014) highlighted the importance of personal agency and the therapeutic relationship more broadly.

Donnellan et al. (2013) and Colton & Pistrang, (2004) discussed engagement in relation to adolescents' readiness for change, suggesting that engagement strategies must be tailored to the individual's stage of change. For example, in the theme "Mechanisms of Engagement" in Hassett and Isbister (2017) young men appreciated clinicians who offered a developmentally sensitive approach, helping them feel respected. This aligned with the findings from Naylor et al. (2008), which called for making therapy personally relevant and flexible to the needs of young people at risk of offending (Naylor et al., 2008).

Adolescents' perceptions of their parents', carers' and family involvement in their mental health journey varied significantly. While some adolescents appreciated family support in navigating MHS, others, especially older adolescents in specialised 16-18 services, sought autonomy and preferred minimal parental intervention (Harper et al., 2014). The importance of adult support in the initial stages of help-seeking was reported in several studies, including Jones et al. (2017) where older teenagers talked about the interplay between their reliance on adults recognising their distress and then helping them access professional help, and their own readiness and motivation to seek help. This variation underscores the need for developmentally attuned services, respecting adolescents' growing independence and evolving needs.

Continuity of care emerged as a critical factor in the engagement process. Disruptions in therapeutic relationships, often due to transitions between services, evoked feelings of loss and abandonment in some young people and potentially triggered past traumas (Harper et al., 2014). Therefore, ensuring continuity and stability in care, through stronger links within and between services, is essential for fostering sustained engagement (Harper et al., 2014). This was clearly highlighted by Hassett and Isbister (2017), who reinforced the significance of these elements, particularly for adolescents feeling stigmatised by their mental health issues. The stigma associated with mental health problems and negative perceptions of MHS can deter adolescents from seeking help. Fears of being labelled negatively impacted adolescents' willingness to engage with services, pointing to the need for improving mental health education and promoting mental health care (Majumder et al., 2015).

Cultural understanding and sensitivity were highlighted across studies, with Majumder et al. (2015) explicitly noting disparities in how mental health and illness are perceived and described by unaccompanied refugee adolescents. These differences can lead to miscommunication and thwart engagement, emphasising the importance of culturally competent care that acknowledges and respects the diverse backgrounds of young service users. Unaccompanied refugee adolescents admitted entering services with a baseline mistrust towards professionals that complicated their engagement process (Majumder et al., 2015). Their lack of trust was attributed to past experiences in their home countries and a fear of being misunderstood or misdiagnosed due to cultural differences. These findings underscore the need for mental health professionals to be pro-active in building trusting relationships and providing safe environments for vulnerable youths as a first step in the engagement process.

In essence, a nuanced approach is essential when engaging adolescents in (MHS), particularly those experiencing significant life changes or from diverse cultural backgrounds. After all, many young individuals do not proactively seek out services. Therefore, we must recognise that their willingness to seek assistance and remain engaged might be limited. Throughout the data, a person-centred, collaborative approach by healthcare professionals emerged as crucial in facilitating young people's engagement. This includes clear, respectful communication, coupled with a strong therapeutic alliance.

1.2.4.3 Theme 3: Experiences of Treatment and Treatment Outcomes

Disappointingly, young people reported not being sufficiently involved in their own treatment decisions, as communication and information about the treatment process were poor. For example, adolescents were not informed of the outcome of assessments (Reavey et al., 2017) and medication was administered to them without explanation (Buston, 2002; Reavey et al., 2017) or accompanying information leaflets explaining possible side effects (Buston, 2002). This reinforced beliefs that staff were more interested in “keeping the peace”, i.e. quashing problematic behaviours rather than trying to understand them as coping strategies and treating the underlying distress (Colton & Pistrang, 2004; Reavey et al., 2017). Such beliefs were especially prominent in eating-disordered clients where symptoms manifest physically, and good outcomes were measured by staff in terms of weight gain (Colton & Pistrang, 2004).

The manner and structure of therapeutic delivery were pivotal factors for teenagers in many studies. Adolescents appreciated when therapy was delivered in a way that was engaging, understandable, and adapted to their pace. Therefore, practical, tangible techniques that allowed young people to participate actively in their recovery were particularly valued. Preferences for the type of therapeutic delivery varied, with some adolescents favouring more structured approaches like CBT (e.g. Donellan et al., 2013), while others preferred less structured, more relational types of therapy (Colton & Pistrang, 2004). The effectiveness of the delivery method often depended on the match between the therapeutic approach and the adolescent's needs and learning style.

Age was a factor in how adolescents experienced interventions. Older participants complained that their treatment was not sufficiently developmentally appropriate (Harper et al., 2014; Hassett & Isbister, 2017). They also believed that it would be beneficial to their experience of healthcare support if they were offered a choice concerning which healthcare person, such as a therapist, they worked with (Buston, 2002). They also emphasised that consistency regarding caregivers was very important (Buston, 2002; Davison et al., 2017).

Positive treatment outcomes were conceptualised differently by adolescents. Some young people viewed their improved mental health as the benefit of treatment (Reavey et al., 2017). However, for many, the benefits were construed through their positive personal development (Fazel et al., 2016; Gill et al., 2016; Harper et al., 2014) and improved family relations (Donnellan et al., 2013). For example, in Donnellan et al. (2013), girls reported their cognitive behavioural therapy (CBT) enabled them to resume normal everyday activities. It also led to them experiencing a more profound sense of self and character development.

1.2.4.4 Theme 4: Experiences of Environment and Organisation of Services

Outpatient services typically focus on ongoing therapy and support while allowing adolescents to remain in their community. Outpatient care emphasises continuity, flexibility and the importance of integrating therapeutic interventions into daily life. However, the inaccessibility of outpatient services was a recurring theme for adolescents (Buston, 2002; Davison et al., 2017; Fazel et al., 2016; Naylor et al., 2008). Refugees from twenty different countries espoused the benefits of more accessible MHS (Fazel et al., 2016). This hard-to-reach population preferred informal and convenient school-based services because they could promptly find help when things became overwhelming with minimal disruption to their school day. School-based services provided a "sanctuary" from chaos when other MHSs seemed inaccessible. For young offenders and those at risk of offending, flexibility of appointments and outreach services resulted in much higher attendance (Naylor et al., 2008).

Inpatient services, as discussed in studies like Colton and Pistrang (2004), often provide intensive care, focusing on acute stabilisation, especially for conditions requiring close medical supervision, such as eating disorders. Studies such as Colton and Pistrang (2004) and Reavey et al. (2017) brought attention to the physical and emotional environment of inpatient units. Whilst young people saw inpatient services as a refuge, they simultaneously found them confining and restrictive (Colton & Pistrang, 2004; Haynes et al., 2011). They felt deprived of privacy (Buston, 2002) and day-to-day activities (Haynes et al., 2011). Teenagers in these settings used metaphors such as "fake world", "alternate reality" and "zoo" to describe and make sense of their unusual environment (Haynes et al., 2011; Gill et al., 2016; Reavey et al., 2017). Unfortunately, young people's experiences of in-patient MHS left them feeling bored, isolated and disconnected from reality (Haynes et al., 2011; Reavey et al., 2017), potentially impacting mental health outcomes. In-patient settings offer a structured environment, which can be both supportive and restrictive, affecting adolescents' sense of autonomy and personal growth.

Adolescents value settings that are attuned to their developmental stage, offering a blend of support that recognises their growing independence while still providing necessary guidance. School-based services are valued and can be a critical portal to other services. Adolescents' experiences are shaped by the structure, restrictions, and milieu of the treatment setting, which can either foster a sense of safety and support or contribute to feelings of confinement and depersonalisation.

1.2.4.5 Qualitative vs. quantitative measurements

Adolescents' experiences of MHS have been traditionally assessed through quantitative satisfaction measures (Biering, 2010). Whilst relatively straightforward to administer, quantitative methods are subject to methodological problems, such as social desirability bias and the assumption they capture a particular experience, such as 'satisfaction', whilst revealing little of participants' lived experiences. Only one study reported quantitative findings in this review. Davison et al. (2017) employed a multi-methods design using semi-structured interviews and the Commission for Health Improvement Experience of Service Questionnaire (CHI-ESQ) to explore service users' satisfaction levels in CAMHS (Attride-Stirling, 2002), a valid subjective measure of services and linked to clinical effectiveness (Brown et al., 2014) which was developed in conjunction with young people with a 15-item self-report measure using Likert scales. Davison et al.'s (2017) study stands out in the review for its rigorous multi-methods approach, incorporating multiple data sources. They acknowledge the CHI ESQ's low uptake in CAMHS at less than 5% (Hall et al., 2013, 2014) but omit to report the uptake ratio in the study itself.

Recent shifts toward qualitative research highlight adolescents' perspectives, exploring their lived experiences, views, and perceptions more deeply. Qualitative research offers a richer understanding of adolescents' individual experiences with MHS, employing diverse methodologies. Despite their strengths in revealing nuanced insights, these approaches suffer inevitable tension between the validity of in-depth inquiry in naturalistic settings and sample size and selection (e.g. Boyden et al., 2013), making it harder to generalise findings. However, validity was enhanced through participant involvement such as teenagers helping to develop the interview schedule (Donnellan, 2013) and pilot testing (Boyden et al., 2013). Some studies used saturation of themes to determine sample size (Haynes et al., 2011), whereby data collection and analysis continued until new interviews no longer added any significant conceptual detail to young people's experiences.

Importantly, qualitative studies enabled adolescents to express more nuanced experiences. For example, many young people found that building relationships with peers, to be a supportive, shared experience (e.g. Hassett & Isbister, 2017; Haynes et al., 2011). Other teenage in-patients helped normalise experiences and were often a source of advice (Reavey et al., 2017). However, qualitative studies of inpatient units also revealed the darker side of peer relationships. Seeing peers in distress was upsetting and often frightening (Colton & Pistrang, 2004; Haynes et al., 2011), leaving young people feeling helpless (Haynes et al., 2011). And for teenagers with eating disorders, peers were simultaneously viewed as supporters and competitors for who could be thinnest (Colton & Pistrang, 2004).

Whilst an array of qualitative approaches enriched our understanding of adolescent MHS experience, interview-based qualitative studies, are not immune to bias. For example, in a study of young offenders, interviews took place in the same building as the Youth Offending Team, which is strongly affiliated with the Criminal Justice System, potentially increasing social desirability bias (Naylor et al., 2008). Efforts to mitigate these included validating interpretations with participants (e.g. Harper et al., 2014) and involving multiple researchers in data analysis (e.g. Donnellan et al., 2013).

Nonetheless, in several studies, participants were selected by their own clinicians, who, in some cases, interviewed them. It is hard to ignore the potential for experimenter and social desirability bias in such instances, but it was rarely acknowledged in the studies. It might have been that the participants put forward were the only available or appropriate given risk considerations, which could be addressed with more robust reporting.

Reavey et al.'s (2017) 'multi-modal' approach showcases innovative methods aimed at capturing intricate, embodied experiences that traditional verbal interviews might overlook. Their study incorporated photo-elicitation to assist young participants to express aspects of their experience that could be challenging to verbalise, drawing on research exploring embodied experiences, particularly those involving heightened emotions and distress (e.g., Barker et al., 2008; Reavey, 2011; Cromby, 2012; Reavey & Johnson, 2017). Two sets of photographs were used during the interviews: pre-existing photos of the SLaM in-patient wards that the young people had stayed in, and photos that the participants had taken prior to their contact with CAMHS. There is little discussion on the benefits or disadvantages of the photo elicitation technique. This might have been because, whilst wanting to elicit the young people's views of the ward spaces, there was a strong focus on the discharge process as the research was part of a wider study examining the effectiveness of a Supported Discharge Service (SDS). Nonetheless, the findings deeply explored the metaphor of wards being containment spaces. This went beyond the physical containment element to touch on the spaces representing an absence of one's humanity and being points of observation for others, both fascinating and threatening (Kearns and Barnett, 1999; Kövecses, 2003). In addition, Reavey et al. (2017) found that the wards were viewed as pressurised containers with pressure release valves that controlled the teenage in-patients distress, and that such release is not safe in all locations and conditions especially group therapy, in particular art therapy. Because expressing yourself in group situations can be triggering for other patients, one-to-one therapy was considered a safer environment for self-expression. Still, most participants reported a lack of opportunity for one-to-one therapy. For that reason, supportive relationships with peers were considered the safest and most reliable outlet.

1.2.5 Summary

Firstly, this review highlights that research exploring the views of young people regarding MHS is limited; and adolescents have not been actively engaged in or involved with, service development. Despite its limitations, the research demonstrates that young people want more accessible services with caregivers that they can trust and who demonstrate the ability to listen. Adolescents welcome a more collaborative approach to their treatment, wanting to be involved in the decisions made about them. Caregivers should be aware that adolescents might have treatment goals beyond a reduction of symptoms approach. And services need to adjust to make young people feel less isolated, confined and disconnected through more activities, greater access to outdoor space, education and safe privacy.

1.3 Conclusion

This literature review aimed to explore adolescents' experiences of MHS. The qualitative research helped build a comprehensive picture of young people's views across services and clinical presentations over the last 22 years. This review underscores the complex interplay between adolescents and the structural, relational, and procedural facets of MHS. There is a clear need for services to be more accessible, culturally sensitive, and responsive to the developmental stages of adolescents. Engaging young people in a collaborative manner and respecting their input into treatment decisions are paramount for improving mental health outcomes and service satisfaction. This approach not only aligns with contemporary healthcare paradigms but also ensures that services are genuinely attuned to the needs of young individuals navigating mental health challenges.

This review highlighted the lack of viable quantitative methods that successfully operationalise particular constructs to describe adolescents' experiences of MHS, such as 'satisfaction' and 'helpfulness'. Therefore, building on existing knowledge to develop an effective measure to capture adolescent experiences is a priority in this area. Qualitative methods were particularly well suited to exploring adolescents' experiences of services, drawing out themes across the literature whilst empowering participants by hearing their stories in their own words.

This literature review has explored the complex interplay between adolescents and the structural, relational, and procedural facets of MHS. It highlights the growing global concern regarding adolescent mental health, one of the leading causes of illness and disability among young people, with suicide being among the leading causes of death for those aged 15–19 years (WHO, 2024). Despite the growing prevalence of mental health issues among UK adolescents, existing services frequently fall short of consistently addressing their needs in ways that align with their developmental stages. This service gap underscores the urgent need for services to become more accessible, culturally sensitive, and attuned to the unique developmental requirements of adolescents.

The review also points to a significant gap in traditional research methods that often overlook adolescents' nuanced perspectives, emphasising the need for participatory approaches that allow young people to express their views and experiences directly. Such methodologies not only provide richer, more nuanced data but also empower adolescents by valuing their perspectives in research that affects them. This study advocates for a paradigm shift towards more inclusive participatory research with adolescents, using innovative methods like object, sound, and photo elicitation to offer deeper, more authentic insights into their perceptions and interactions with MHS.

By highlighting the lack of viable quantitative methods that successfully operationalize particular constructs to describe adolescents' experiences of MHS, such as 'satisfaction' and 'helpfulness', this review reinforces the need to develop more effective measures to capture these experiences. The qualitative research conducted over the last 22 years has helped build a comprehensive picture of young people's views across different services and clinical presentations, drawing out themes while empowering participants by hearing their stories in their own words.

Ultimately, engaging young people in a collaborative manner and respecting their input into treatment decisions are paramount for improving mental health outcomes and service satisfaction. This approach not only aligns with contemporary healthcare paradigms but ensures that services are truly attuned to the needs of young individuals navigating mental health challenges. This research seeks to bridge existing gaps, providing a platform where adolescents can voice their experiences and contribute to a more nuanced understanding of mental health care efficacy from their perspective. By doing so, the research can more effectively contribute to the development of services and policies that truly meet the needs of this vulnerable demographic, ensuring that their rights and voices are not only recognised but actively respected and integrated into healthcare practices.

1.4 Rationale and Aims of the Study

The pervasive challenges in adolescent mental health highlight a crucial need for innovative and effective research methodologies. As the global burden of mental health issues among adolescents escalates, traditional approaches often fall short of capturing the complex interplay of physiological, psychological, and social factors that characterise this vulnerable period. Moreover, existing services are not consistently meeting the developmental needs of young people, leading to significant gaps in care. This study advocates for a shift towards more inclusive and participatory research methodologies that authentically engage adolescents in the research process, ensuring their perspectives and voices are not only heard but also integrated into the development of MHS and policies.

The primary aim of my research was to explore adolescents' experiences of MHS in the UK through photo, sound, and object elicitation techniques. The intention of employing elicitation techniques was to put young people front and centre by providing a platform whereby teenagers have more control over the research process. By helping them feel more empowered and comfortable sharing their complex emotions, thoughts, and experiences, the hope was to elicit a richer, more authentic understanding of their interactions with MHS.

The second aim was to identify recurring themes within the narratives of adolescent service users. The third aim was to discern the effective and ineffective aspects of MHS for adolescents, highlighting areas where service delivery could be modified to enhance their mental health outcomes. The fourth and final aim was to explore what types of MHS are best suited to adolescents and how these services might be further developed. By focusing on publicly funded MHS in the UK, regardless of whether these services were provided within NHS facilities, schools, third sector or private settings may contribute to the development of policy and practice recommendations to enhance the design, delivery, and effectiveness of adolescent MHS. Also, by employing innovative elicitation methods, this research seeks to bridge existing gaps in our understanding of how adolescents perceive and interact with MHS, thus contributing to the enhancement of service delivery and policy formulation.

1.5 The Relevance to Counselling Psychology

Counselling Psychology, firmly rooted in humanistic principles, is deeply committed to prioritising individual subjective and intersubjective experiences and recognising the uniqueness of each person (Orlans & Van Scoyoc, 2008). These foundational values underscore the critical role Counselling Psychologists can play in both research and practical applications related to adolescent MHS.

Our profession is dedicated to understanding how individuals interpret and manage their experiences across various environments and how these experiences subsequently shape our therapeutic relationships with clients. This understanding extends beyond direct therapeutic interventions; many clients who seek our services may have previously navigated different services. By gaining insights into these past interactions, we can more effectively support our clients and advocate for improvements in care provision.

Moreover, Counselling Psychologists are committed to elevating the voices of those often marginalised, particularly through qualitative research that brings to light diverse personal experiences (Ponterotto, 2005). Combined with a strong emphasis on social justice (Winter & Hanley, 2015), our profession is well-equipped to tackle broader systemic issues impacting children and young people such as the effects of policy decisions and addressing discriminatory practices (Hanley et al., 2019; Tribe & Bell, 2018).

Corrie and Callanan (2000) argue that the 'scientist-practitioner' model is integral to our professional identity promoting the vital interaction between research and practice. This dual focus ensures that our work is both empirically grounded and practically applicable, enhancing our ability to deliver and facilitate the delivery of informed, effective MHS and conduct effective research. Through this integration, we strive to provide the highest standard of care to adolescents effectively addressing their unique developmental needs.

Reflexivity Box - Hope

I realise as I write this chapter that it comes with a lot of "hope". I hope this study will uncover insights that not only add depth to the current research but also inspire others to engage with this research with CYP, especially their experiences of mental health experiences and help-seeking journey. I would very much like the findings to be useful to Counselling Psychologists, along with other professionals and policymakers dedicated to improving adolescent mental health. I hope I am able to convey how fulfilling working with young people is and possibly inspire others.

I hope that this literature review conveys my passion and deep commitment to empowering marginalised communities, especially CYP. Giving them a platform that they (again hopefully) find interesting, creative and innovative on which to share their views, is exciting and something I deeply value. This work holds great personal significance for me, not only as a Counselling Psychology Trainee but also as an adult and a mother. I urge healthcare professionals, educators, policymakers and researchers to join me in moving forward with purpose, to truly listen and respond to the voices of young people.

Chapter 2

Methodology

The preceding chapter established the groundwork for this study by providing a critical overview of existing literature in this field, highlighting the pressing need for further research in this area, and elucidating the rationale behind this study. In this chapter, I will build on this foundation by describing the design of this study in detail, i.e. the path I took to probe the research question and fulfil the aims and objectives outlined in the previous chapter. It begins with the rationale for the research and its philosophical underpinnings. It proceeds with an exposition of the methodological procedures undertaken, including recruitment, participants, sampling, procedures, data collection and the use of reflexive thematic analysis explained. The closing section of this chapter will set out ethical considerations pertinent to the study and evaluation of methodological issues that potentially challenge the rigour of this research, concluding with reflections.

2.1 The Rationale

This study focused on adolescents aged 13-18 who had accessed publicly-funded UK-based MHS within the past three years, whether through the NHS, schools, the third sector or private settings. The overarching aim was: (i) to explore adolescents' experiences of MHS using photo, sound and object elicitation, with three further goals: (ii) to identify any recurring themes in adolescent service users' narratives; (iii) to discern effective and ineffective aspects of MHS, pinpointing areas where service delivery could be modified to enhance mental health outcomes; and (iv) to explore how MHS are best suited to adolescents and how these services might be further developed.

In order to explore the open-ended questions of the research, a qualitative approach was chosen (Cleland, 2017) so that individuals' narratives could be gathered together to illuminate current service provision. Counselling Psychology puts an emphasis on qualitative research and methods that facilitate in-depth exploration and yield rich, meaningful data (Henton, 2012). In addition, a qualitative paradigm aligns well with my Counselling Psychology training as it leverages my interpersonal and clinical skills, enabling close professional relationships to develop within a research context (McLeod, 2003).

Including the perspectives of young people in public policy development is recognised globally as a crucial element for enhancing health practices and research directives (Patton et al., 2016). This strategy is essential for mitigating ongoing inequalities as well as addressing emerging concerns that affect the present generation of young people (Alves et al., 2017; Ybarra et al., 2016). While it is important to regard adolescents as capable narrators of their own experiences, we must recognise the intrinsic power imbalance present in the adult-child dynamic within research settings. Acknowledging this imbalance is a crucial step towards effectively addressing it (Morrow & Richards, 1996). The transition from conducting 'research on' to 'research with' (and by) young people highlights the adoption of participatory research approaches, where young people play a central role in shaping the studies. Such a collaborative research approach acknowledges and leverages the agency that young people possess and empowers them to make choices like withdrawing or opting not to answer specific questions. To further redress the power imbalance, McLeod (2007) suggests using creative and visual methodologies are effective tools that help shift the power imbalance and gain insight into what is most important to young people. Therefore, a creative method comprising photo, sound and object elicitation was employed.

In order to find commonalities in young people's experiences of MHS, a reflexive approach to thematic analysis (Braun et al., 2019) was chosen. Thematic analysis enables patterns or themes to be identified and analysed in a data set (Braun & Clarke, 2012). Adopting a reflexive approach meant that my active role as the researcher would be fully acknowledged, along with its implications for knowledge production (Braun & Clarke, 2019).

2.2 Philosophical Bedrock

Researchers' perceptions of reality significantly influence knowledge production, which in turn shapes methodological exploration (Guba & Lincoln, 1994). In recognising this, I set out the philosophical foundations of this research, emphasising that meaningful inquiry necessitates thoughtful consideration of ontology, epistemology, and methodology (Cuthbertson et al., 2020). Ontology delves into the essence of reality, what truly exists, while epistemology examines our approach to acquiring knowledge about this reality and how we validate its authenticity (Crotty, 1998; Maxwell & Mittapalli, 2010; Slevitch, 2011). This integrated approach ensures a coherent and robust research framework, aligning with this study's aims.

This research is grounded in a critical realist ontology, which acknowledges the complexity of reality beyond direct human perception. However, unlike naïve realism, which posits that reality is as we perceive it, critical realism, developed by Roy Bhaskar, provides a more nuanced understanding whereby an objective reality exists, shaped by and independent of our subjective experiences (Bhaskar, 1975). This stance is essential for exploring the multifaceted experiences of adolescents within the UK's MHS. Bhaskar's evolution from transcendental realism to critical naturalism emphasises that the principles of realism can and should be applied to both natural and human sciences. However, given their inherent differences, the methods and strategies for research must adapt accordingly (Bhaskar, 1998b). In a critical realist approach, research data does not simply reflect reality; rather, it necessitates interpretation to uncover the underlying structures that produce the phenomena we aim to understand (Willig, 2013). My ontological stance maintains that an objective reality exists independently of my or my participants' knowledge (Willig, 2013), thus accommodating both ontological realism and epistemological relativism.

Critical theorists caution that focusing solely on individuals' interpretation of phenomena risks overlooking potentially real systemic structures (Houston, 2001). This reality is thought to impact behaviour and psychological processes. In addition, just as external, environmental factors affect individuals, people are also capable of changing their environments (Bhaskar, 2014), such as, by campaigning for better mental health care support. Therefore, data collected in this study should not be seen as a perfect or accurate reflection of objective reality (Willig, 2012), but as representing young people's perceptions of a 'real' system. Critical theory views the relationship between participants and researchers as dialectical and emphasises that research interactions should seek to empower and foster democratic change (Tolman & Brydon-Miller, 1997). This underscores the crucial role of research in addressing oppression and privilege within marginalised groups, a central aspect of the emancipatory branch of action research (Wallerstein & Duran, 2006). The significance of the researcher-participant relationship becomes part of the meaning-making process, making it essential to recognise that action research can stimulate systemic change only if participants' experiences are genuinely heard and not overshadowed by broader motivations (Levin & Greenwood, 2011).

The overarching theoretical paradigm of this research is participatory epistemology, a relatively modern development in the history of philosophy, influenced by various philosophical, sociological, psychological and cultural movements. Its origins lie in the "action research" of Kurt Lewin (1946) and the "participatory action research" of Fals Borda (1979a). Lewin posited that social experiments could be designed in natural settings to achieve real-life objectives (Greenwood & Levin, 1998). Fals Borda (1988) promoted a collaborative approach by conducting research alongside peasants in Nicaragua, Mexico, and Colombia to develop strategies to counter oppression.

Participatory epistemology emphasises the collaborative and social aspects of knowledge construction, asserting that knowledge is co-created by individuals interacting with their social, cultural, and historical contexts. In other words, people are elevated from mere passive recipients of knowledge to active participants in knowledge formation. Yet, by placing a strong emphasis on the contextual aspects of knowledge creation, participatory epistemology recognises that knowledge is invariably influenced by power dynamics and, therefore, seeks to understand how such factors affect knowledge production. Thus, inclusivity issues, such as who can participate in knowledge creation, validation, and dissemination, how diverse perspectives are included, and the role of power dynamics, are central to this approach.

In this research paradigm, it is inappropriate to theorise about individuals as mere subjects; to create reliable knowledge about a group and their experiences, these individuals must participate actively in generating this knowledge. Research participants are stakeholders in creating reliable knowledge.

This paradigm assumes that individuals in specific social positions have unique insights into how policies and governmental and social institutions impact them and how these might be improved. Participatory action research (PAR) was initially considered due to its effectiveness in engaging stakeholders to understand community issues (Jagosh et al., 2015). PAR promotes key values of community psychology (Suarez-Balcazar & Harper, 2003), such as social justice,, empowerment, and health promotion with the overarching goal of social change (Macaulay et al., 2011; Oden et al., 2010). It promotes inclusivity and collaboration, empowering participants to act as co-researchers, experts of their own lived experience and advocates for transformative change (Cargo & Mercer, 2008; Macaulay et al., 2011; Oden et al., 2010). However, due to the inability to engage a third party, e.g. secondary school or CAMHS, to carry out the original Photovoice design of this study, adjustments were made to involve adolescents directly. Whilst this change was made out of necessity, it does not diminish my commitment to the core principles of PAR.

2.3 Research Design

Qualitative research possesses a unique power in that it allows us to hear people's voices and immerse ourselves in their experiences helping us to see the world through their eyes. This approach integrates well within a participatory epistemology framework, which emphasises the co-creation of knowledge through active engagement and collaboration. By utilising a variety of non-numerical data forms, such as audio, text and video, qualitative methods yield rich, well-grounded descriptions and explanations that reveal the depth of individuals' lived experiences (Miles & Huberman, 2009), often beyond the reach of quantitative methods that lack the "voice of the participant" (Austin & Sutton, 2014, p. 436).

Incorporating a participatory research paradigm, this study engaged adolescents as active contributors rather than mere subjects of research. This is crucial for ensuring that research outcomes, particularly dissemination and impact, are compelling and relatable to a wide range of stakeholders, including other young service users, researchers, policymakers, and practitioners. By embedding the research within the lived realities of adolescents engaging with MHS, this approach provides deep insights and ensures these narratives resonate with a broader audience, fostering a shared understanding. Thus, a qualitative research design, underpinned by participatory epistemology, not only values the narratives of those it studies but also empowers them, highlighting their significance in shaping research, policy, and practice. This method facilitates persuasive storytelling that enhances the potential for impactful change, making it an ideal choice for this study's focus on practical outcomes and the experiences of young MHS users.

2.4 Thematic Analysis

I selected Reflexive Thematic Analysis (RTA) for its interpretive approach to qualitative data analysis, which allows patterns or themes within the data set to be identified and examined (Braun & Clarke, 2012). Unlike Content Analysis, which requires quantifiable measures for theme selection (Wilkinson, 2000), RTA provides flexibility in theme identification; it can be either inductive (‘bottom up’) or deductive (‘top down’), as long as the method chosen is consistent (Braun & Clark, 2006). This flexibility was crucial for exploring themes inductively, thus ensuring they emerged directly from the data, thereby reducing theoretical or analytic biases (Patton, 1990).

RTA acknowledges the researcher's active role in knowledge production, where coding and theme development are seen as interpretive acts, and reflexivity, subjectivity and creativity are seen as assets in knowledge production (Braun & Clarke, 2019). Therefore, this methodology required me to step out of my comfort zone - moving away from seeking 'accurate' or 'reliable' codes and themes, a remnant of my quantitative research background, and instead engage thoughtfully and reflectively with the data (Braun & Clarke, 2019). RTA's flexibility is ideal for exploring a wide range of ontological and epistemological positions (although it has increasingly been defined as a qualitative-only approach (Braun & Clarke, 2019, 2020)), making it an ideal choice for this study’s focus on practical outcomes and the experiences of young MHS users.

Reflexivity Box – Trusting the (RTA) Process

Knowing what other researchers have found is reassuring, particularly for someone like me who has not undertaken such a large research study. However, I’m keen to take a risk and take an inductive approach. This means I can’t pretend there are existing codes, the codes are MY interpretations of patterns of meaning - so another researcher probably won’t be able to reproduce my findings. And so, it’s me, myself and I – plus thoughtfulness and reflexivity.

Narrative Analysis (NA), another considered method, intensely focuses on the micro-analysis of language, specifically the structure, performance, and dialogue of storytelling, the "how" a narrative is conveyed. Unlike NA, Thematic Analysis (TA) seeks to identify patterns or themes across the data. Therefore, given the practical objectives of this research, NA was deemed less suitable, as it needs to align better with the need to produce actionable points. In contrast, RTA offers considerable advantages by facilitating the conceptualisation and dissemination of themes. This approach simplifies the process for service providers and policymakers to grasp and address particular issues effectively.

Grounded Theory (GT) was also considered but ultimately not chosen due to its theoretical orientation, which contrasts with the practical focus of this study. Although the method's respect for participant data is compelling, its outcomes typically aim to develop theory rather than direct practical applications. Despite its potential to establish a theoretical framework that could guide practical interventions, it felt too removed from the direct, practical implications of adolescents' experiences with MHS that this project aimed to address.

Interpretative Phenomenological Analysis ("IPA") (Smith et al., 2009), with its focus on capturing detailed personal experiences, would be a fitting methodological choice. However, IPA typically requires a highly defined, homogenous sample to explore experiences within a specific community (Smith & Osborn, 2003). This could limit the breadth of perspectives, especially as my goal was to include a broad spectrum of adolescents who had accessed services at various points along the mental health pathway, such as schools, CAMHS, and in-patient facilities. My recruitment strategy sought to encompass a diverse group of male and female teenagers aged 13-18, aligning with the inclusivity principle of participatory epistemology. Using a homogenous sample would potentially diminish the impact of the findings on community decision-making and contradict the inclusivity principle (Nykiforuk et al., 2011).

2.5 Research Procedures

2.5.1 Sampling and Recruitment

Participants were recruited from 3 separate geographic locations in the UK all of which had publicly funded mental health services for adolescents. The focus was on recruiting adolescents aged 13-18 who had accessed these services within the past 3 years. The sampling method used was maximum variation purposive sampling because it typically yields rich, diverse data (Patton, 2001), thus deepening our understanding of the field in question and enhancing the research's generalisability.

Research posters/flyers and brochures were created (see Appendix 4 and 5) and distributed to promote participation. Potential candidates were invited to contact the researcher directly via email to express their interest..

Initially, I contacted approximately fifty secondary schools, several CAMHS services, three general hospitals, and several third-sector mental health organisations by email, telephone and in-person.. Of the schools, only one expressed any interest but said they needed more resources to help. Therefore, I extended my recruitment strategy and advertised in GP surgeries, bus shelters, shops, cafes and restaurants, anywhere I thought young people might visit. I also placed adverts on social media (e.g. Reddit boards pertaining to mental health). I advertised through word of mouth, resulting in my research being posted on a social media board for carers of looked-after children. I also attended two third-sector adolescent MHS. One of these was a musical youth group that I attended one evening a week for several weeks to get to know everyone, outline my research, co-facilitate discussions with youth workers about mental health and general well-being and collaborate on a podcast about mental health. As a result of my extensive recruitment drive, I recruited participants from urban, suburban and rural settings.

2.5.2 Inclusion and Exclusion Criteria

Participants recruited for this project were adolescents aged 13-18 years old. The second inclusion criterion was that participants had accessed publicly funded UK-based MHS in the 36 months prior to recruitment. The sole exclusion criterion was if any candidates presented with any serious risk concerns, they would be sign-posted to appropriate support, including local mental health support services.

2.5.3 Screening and Consent

After initial contact, 54 candidates underwent a screening process to ensure they met the inclusion criteria. I emailed each person an email inviting them to attend a brief introductory online meeting and as a first step in the assessment process, asked a couple of short questions about their age and location. I attached a copy of the research brochure outlining the study. For candidates under the age of 16, initial contact was made with their parents or carers.

When candidates responded, I arranged a suitable time for the introductory meeting online (Zoom or Teams). For ineligible candidates (n=7 at this stage), I sent a polite email thanking them for their interest. Once a convenient date and time were agreed upon with eligible candidates, I confirmed the meeting via email.

The second screening phase involved a brief 15-minute online meeting (except for Billy's foster carer who requested a telephone call instead). This phase helped familiarise candidates with the research process and encouraged an open discussion about the study. It also allowed me to assess candidates based on the inclusion/exclusion criteria, collect basic demographic information, and gather key details such as their MHS usage (summarised in *Table 1* below). Additionally, I conducted a risk assessment, which included the Top Problems Assessment (TPA) (Weisz et al., 2011) (see Appendix 6).

During the call, I provided a concise overview of the study and explained what participation would involve, including timelines and ethical considerations. I described the elicitation method, reassuring candidates that it was not a test and that they could bring anything they felt was meaningful. To guide them, I provided some examples.

Although all the participants wished to take part in the study, 9 eligible candidates remained after this screening phase, only. (Reasons for ineligibility were primarily due to people being too old or not having accessed MHS in the UK.) Suitable candidates were immediately invited to begin preparing for the interview and encouraged to contact me with any follow-up questions or concerns. A 1-2-week period was suggested for creating/collecting photos, objects or sounds that represented their experiences with MHS, although flexibility was offered to accommodate participants' needs and preferences. I asked participants to email me copies of their photos, sounds and objects prior to the interview and were reminded of this requirement in the emailed interview invitation. Consent forms (see Appendix 7) were then emailed to candidates aged 16 and above. Parents and carers of participants under 16 received parent/guardian consent forms (seeAppendix 8) together with assent forms (Appendix 7) to be signed by their children. Consent to be photographed forms (see Appendix 17) were also emailed to participants who had been told that if they featured people in photographs beyond what could be photographed in the public domain then consent forms must be completed by those individuals. This thorough process ensured that all participants and their guardians were fully informed and provided consent for participation, emphasising the study's commitment to ethical standards and participants' comfort.

2.5.4 Participants

A total of 9 participants consented to participate in this study and completed individual interviews. Details of individual participants are shown in Table 1 below.

Participants' Demographic Information, Mental Health Service Use and Diagnoses	
Sex	Female (n=5) Male (n=4)
Age	13-18 years, mean age = 16.4 years
Ethnicity	White/British (n=3) British/Indian (n=1) Undisclosed (n=5)
Geographical Location	East Midlands (n=5) East Anglia (n=2) Southeast England (n=2)
Community	Large city - urban (n=2) Small town - urban/suburban (n=4) Rural (n=3)
MHS accessed	GP (n=6) CAMHS (n= 5) CMHT (n=1) CRISIS (n=1) IAPT (n=1) NHS Eating Disorder Service (n=1) NHS Family Therapy Service (n=1) School counsellor (n=1) Mind (n=4) Other third sector talking therapy services (n=5) Private therapy (n=1)
Diagnosis	Anxiety (n=5) Social anxiety (n=1) Depression (n=2) Attention Deficit Hyperactivity Disorder (n=1) Anorexia Nervosa (n=1) Functional Neurological Disorder (n=1) Awaiting autism assessment (n=2)

Table 1 - Participants' Demographic Information

2.5.5 Data Collection

2.5.5.1 Pilot Interview

I conducted a pilot interview to gain experience with the interview process, build confidence as a researcher, and obtain feedback on the elicitation method, SHOWeD interview schedule, and my interviewing style. The pilot encompassed all research phases, including screening, obtaining consent, and debriefing. I also transcribed and analysed the data using (RTA) to fully understand the analytic process and research.

I recruited "Freddie," who met the study's inclusion criteria. Freddie actively engaged with the elicitation task and responded well to the adapted SHOWeD interview schedule. As the interview was conducted during lockdown, it was held online via Microsoft Teams, offering valuable insights into managing virtual interviews. Freddie participated in a debrief session and received information about additional support services.

The pilot interview proved crucial in enhancing my confidence and familiarity with the interview process. Freddie's feedback on the interview style was positive, and our joint evaluation of the interview schedule's effectiveness was highly beneficial. Interestingly, Freddie brought three images rather than photos for discussion, which alerted me to being open to young people's interpretations of the elicitation technique. Encouraged by the pilot's success and after discussion in supervision, I proceeded with the recruitment phase for the main study.

2.5.5.2 Elicitation Methods

In this study, participant-generated materials (photos, objects and sounds) were employed to actively engage adolescents, enabling them to express complex emotions and experiences that might be difficult to express verbally, particularly given the sensitive nature of their lived experiences with MHS. Elicitation tools can originate from the researcher, the participant, or be chosen collaboratively (Lapenta, 2011). Here, participants were encouraged to take ownership of the process by creating or selecting items that they felt best represented their personal experiences.

This approach helped reduce the power imbalance between researcher and participant. By giving the young people control over the materials used to guide the interview, they became active contributors to the research rather than passive subjects. This participatory approach ensured that the adolescents' voices were central, aligning with the epistemological framework of this study.

Offering a choice of photos, objects or sounds allowed participants to select the medium that felt most meaningful or comfortable, fostering a more personalised research process. For instance, some participants brought videos with sound, others selected images from the internet, and one participant opted to participate without any materials. This flexibility encouraged greater engagement and accommodated diverse preferences, as summarised in *Table 2* below.

The selected tools functioned as structured prompts for discussion, helping participants to explain and interpret experiences through concrete, tangible representations (Lapenta, 2011). This method also allowed participants to lead the conversation, thus reducing researcher bias and facilitating the exploration of emotional and sensory aspects that might have remained unexpressed through standard interviews. Focusing on participant-selected materials enabled a more authentic engagement, capturing the richness and depth of their lived experiences.

Participant	**Photo**	**Object**	**Sound**	**Video**	**Image**	**None**
Mao	0	2	0	0	0	
Ryan	0	0	0	0	4 *(sourced from internet)*	
Dylan	2	0	0	0	0	
Billy						✓
Lara	3	0	0	0	0	
Grace	2	0	0	2 *(1 created by Grace with sound, 1 sourced from TikTok*	0	
Kali	6	0	0	1 *(created by Kali, with sound)*	0	
Rae	2 *(accompanied by Rae's written description)*	0	0	0	0	
Parker	19 edited down to 14 *(after discussion due to time constraints)*	0	0	0	0	
Total	**29**	**2**	**0**	**3**	**4**	**1**
Average number of elicitation tools per participant = 4.8						

Table 2 - A Summary of Elicitation Tools Brought by Each Participant

Reflexivity Box – From Chaos Comes Beauty

I had envisioned that the interviews would be predictable; the teenagers would bring photos, objects, or sounds as elicitation tools as per my instructions. But what emerged was something far more beautiful and spontaneous. Some participants brought videos that pulsed with life. Kali's single blurred shot of her trainers accompanied by Radiohead's mournful "No Surprises", captured a sense of weariness. Grace's nighttime video of a park, punctured briefly by the lights and siren of a Police car in the distance, before the darkness and quietness envelops her again, was an unsettling metaphor for being invisible to help. Grace also shared someone's TikTok video about CAMHS being useless, and as she scrolled to find it, she showed me the many other videos by teenagers voicing the same message – a stark wake up call for me and anyone involved in CAMHS, if they choose to look. Ryan, instead of taking photos, found pictures online that spoke to him more deeply than anything he could capture. And then there was Billy, who brought nothing at all - a quiet yet powerful statement, heart-breakingly poignant given that this boy's family had just fallen apart.

Rather than being a hindrance, this divergence from my outlined instructions was eye-opening and joyful. It became clear to me that, at the heart of this study, the most important thing was not strict adherence to method but the freedom for these young people to express their experiences their way. Some of the materials they brought were, in their own right, works of art - pieces of their lives, shared freely, not confined to a rigid structure. I told them I could imagine their work in an art gallery, each one revealing their creativity, their spirit, and their truth. It was an honour to witness their willingness to share, and a reminder that human expression often surpasses the limits of what we anticipate as researchers.

Cont'd overleaf

(Reflexivity Box - From Chaos Comes Beauty, cont'd)

Of course, there were challenges. Billy, who had just been placed in foster care, did not bring anything. I remember in that moment feeling a mix of anxiety and uncertainty, aware that I had to think on my feet, to pivot the conversation without making him feel uncomfortable, as if he had done something wrong. But what became more important in that moment was not what Billy *didn't* bring but what he *did* bring - his presence, his willingness to participate. His courage to sit with me and talk, despite his recent upheaval, became more significant than any adherence to a research protocol. It made me deeply aware of his generosity, and I felt honoured that he had chosen to share his experiences at such a difficult time in his life.

This moment made me reflect on the broader flexibility of the research process. Throughout this entire project, I have felt confused and worried about incorporating multiple types of elicitation tools. There was no precedent in the literature - everyone seemed to stick with one type of tool, and I kept wondering, "Why, what am I missing? Am I stepping into unchartered territory?". I felt conflicted, worrying I was doing something wrong, whilst feeling strong in my conviction that participants should be offered choices where possible in research. Thankfully, my supervisor reassured me that this openness was precisely what made the study more alive, more responsive to the individuality of my participants.

Cont'd overleaf

(Reflexivity Box - From Chaos Comes Beauty, cont'd)

This creative turn in methodology has led me to reflect on the importance of choice, of giving participants the space to make their own decisions about how to share their stories. In order to embrace their individuality, I realised that my research needed to be as flexible as their experiences were varied. Rather than trying to control the medium, I let the medium speak for them. And in doing so, I found that the outcomes, those deeply personal narratives of mental health service use, far outweighed any strict adherence to a preconceived method. These young people taught me something invaluable - my worry that I had to stick rigidly to research protocols was constricting, limiting the very soul of the work. Had I followed the method to the letter, I could have lost sight of the real heart of the study. It was a journey, and the unpredictability, the creativity, and the messiness were part of the magic.

2.5.5.3 Semi-Structured Interviews

Semi-structured interviews facilitated a non-directive exploration of topics related to the research question (Willig, 2008). Unlike structured interviews, which tether participants to pre-defined questions, semi-structured interviews allow space for new ideas and concepts to emerge naturally during the conversation. The interview framework drew on Bearman's (2019) approach to semi-structured interviewing and was adapted from the SHOWeD five-step questioning technique (Shaffer, 1983) (see Appendix). The interview schedule included prompts designed to be meaningful and easy to understand, creating an environment conducive to free expression, an essential consideration when engaging with adolescents who may find the research process daunting. Such open-ended questions were essential for eliciting "thick description" (a term Geertz (1973) p.1) borrowed from Gilbert Ryle (1971)), enabling a deep, nuanced understanding of participants' experiences. This approach has been shown to yield more genuine and accurate data from children and adolescents than other question types (Berg, 2019).

Interviews were conducted either online (n=5), via Teams or Zoom, or in-person (n=4), depending on participants' preferences. Among the in-person interviews, two took place in quiet, private rooms within third-sector MHS facilities, and two were held in participants' homes. Interviews ranged from 40-100 minutes. Special considerations were given for participants under the age of consent: in one case, a participant's mother was present during the introduction and conclusion, while another interview occurred in the living room of the participant's foster parents' home, with foster parents nearby in an adjacent room. Interviews were recorded using an encrypted digital voice recorder and Teams or Zoom.

Each interview began with an informal 10-minute period to address any IT issues, establish a relaxed atmosphere and build rapport. During this initial phase, I reviewed the purpose of the interview, covering key points from the participant information brochure, such as confidentiality and participants' rights to pause, skip questions or stop the interview at any time if they felt uncomfortable. Throughout the process, I remained attentive to signs of distress. Once participants confirmed they were comfortable and had signed their consent forms, I introduced the revised SHOWeD interview schedule, reassuring them of its simplicity and explaining that I would ask the same questions for each elicitation tool they chose. I then reviewed the study's aims, clarifying that the elicitation tools were simply a way to help participants discuss their experiences. For those who had sent their materials in advance (n=4), we reviewed them together on my computer screen. For those who brought materials on the day (n=4), we looked through them together, and they sent me electronic copies.

Billy did not bring any elicitation tools to the interview, which may have been due to his recent placement in foster care and his foster mother arranging the interview on his behalf. I had suggested Billy attend a screening interview to help familiarise him with the study and to ensure he understood the process, but his foster mother explained that he had declined, relaying that he was keen to participate, and she answered the screening questions for him. When Billy said he had not brought any elicitation tools, he seemed concerned, so I reassured him that it was fine, that we could continue as long as he was comfortable talking about his experiences with MHS. He assured me that he was, so I asked him where he would like to begin. As we proceeded, I incorporated the final three questions from the interview schedule, “How does this relate to your life?”, “Why does this concern, situation or strength exist?” and “What can we do about it?”, to structure our conversation.

I initiated each interview by asking participants which elicitation tool they wanted to start with, and moved through the questions for each tool brought, using the interview schedule as a flexible guide. Insights from the pilot study underscored the dynamic nature of semi-structured interviews, highlighting the importance of adapting and improvising based on the natural flow of conversation. Therefore, I incorporated additional prompts as needed, that were clear and meaningful to participants, tailoring questions to the participants’ narratives. This flexibility was crucial in allowing participants to guide the discussion while ensuring that I pursued relevant narratives and experiences.

In line with Bearman’s (2019) recommendations, I stayed attentive to the improvisational nature of semi-structured interviews, remaining alert to significant points and exploring emerging narratives as appropriate. I returned to the interview schedule as needed to ensure all areas were covered. This approach helped balance structure with the participant-led nature of the interviews, ensuring that participants’ perspectives and experiences remained central throughout. At the end of each elicitation tool discussion, I checked if the teenagers wanted to add anything further before asking which tool they would like to explore next, creating a natural, cyclical flow to the interviews.

2.6 Data Analysis

2.6.1 Analytic Strategy

The six-phase analytical process adopted for this research is based on Braun and Clarke's expanded work on Reflexive Thematic Analysis ("RTA") (2012, 2013, 2014, 2021). The new terminology, "Reflexive thematic analysis", was introduced to clarify the method and address misconceptions (Braun & Clarke, 2019). The new branding emphasises the importance of adhering to the updated methodological guidance that incorporates an inductive approach to identifying themes and emphasises the researcher's engagement in a reflective and iterative process. The RTA focus on the reflexivity of the analyst distinguishes it from other TA approaches that focus on coding reliability or a strict codebook approach (Braun & Clarke, 2019; Terry et al., 2017).

While the phases are presented sequentially, they should not be perceived as rigid steps to be followed in order. Instead, RTA is inherently recursive and iterative, requiring the researcher to move back and forth across the phases, adapting as insights evolve and the data demands (Braun & Clarke, 2021). Therefore, the phases should be viewed as flexible guidelines that adapt to the nuances of the data and the research questions (Braun & Clarke, 2013, 2021). This flexibility is vital because TA is a nuanced, time-intensive process that often yields new interpretations, prompting further examination and adjustment of previously analysed data. Here follows a detailed outline of each phase.

2.6.2 The Six Steps of RTA

2.6.2.1 Step 1 - Data Familiarisation

I listened to each audio-recorded interview in full before using transcribing software to provide a draft transcript of each interview. I then read each draft transcript whilst simultaneously listening to the recording, making necessary amendments. Significant pauses, non-verbal behaviour e.g. laughter, pauses, or speech disfluencies were included to keep the data as rich as possible. Identifying or contextual information about individuals or organisations was anonymised. Each interview was then read through several times, and I documented initial thoughts and reflections.

Reflexivity Box - The Orchestra

It's all here, all their words, their "not" words – their pauses, their yawns, their sighs, their laughter, even their tears. that make up their thoughts, emotions, bodily sensations, their voices and I can hear them in my mind, see them in my mind's eye, it's all there. And somehow, I have to make sense of it all. It's like an orchestra before me, each instrument playing its own part. What I hear now is a cacophony, yet somehow, I have to draw these musicians together and find a way to bring some harmony. Thank goodness I love a puzzle.

2.6.2.2 Step 2 - Generating Initial Codes

For each interview, I coded the data line-by-line, using descriptive words and phrases to capture patterns of meaning across the dataset (Clarke & Braun, 2018). To begin with, I looked at each transcript separately when generating initial codes and when I had completed each one, I wrote all the codes for each transcript on a piece of paper to give me an overview of what I had found and also so that I could start making links within each transcript and across the transcripts (please see Appendix for examples).

When all the transcripts had been coded manually, I realised there were so many codes that I was struggling, so I uploaded all the transcripts to ATLAS.ti and recoded electronically. (Please see Appendix for examples of manual and electronic coding.) This allowed me to refine the codes and examine the data more easily. When all the transcripts had been coded manually and electronically using ATLAS.ti, I began manually cutting out the paper quotations for each code and reading them to make sure, in isolation, each quotation related to the code(s) identified.

Reflexivity Box - To Use Software or Not To Use Software, That Is the Question

As I stare at my screen weighing up the pros and cons of using software, I feel like I'm standing at the edge of a lake. I've had a perfectly nice time on the shore, coding manually, but I'm curious how the water feels. Software has not been particularly emphasised at University, but in the face of so much data – 9 long interviews – I feel a need to somehow store and systemise things. Yet I cannot ignore my lack of confidence in this analytic process and wonder how much this is driving me. I'm second guessing myself, worrying that I've missed something. My comfortable place is numbers, words are a bit of an unknown quantity. And of course there are the tools, the analytic tools, the pretty graphics – which makes it so much more appealing. So here I go…

2.6.2.3 Step 3 - Identifying Themes

I began laying out the paper quotations to see how they related to each other and to look for themes. This was very labour-intensive and due to the huge amount of data, I started to do this electronically and started to identify themes (please see Appendix). I had to consider whether themes should be identified at the semantic (descriptive) level or the latent (interpretive) level of data. TA typically focuses on one level or the other (Braun & Clarke, 2006) so I was heartened that my examining both levels was recommended (Campbell et al., 2021). I did not want to restrict the analysis to just surface-level meaning i.e. what was explicitly said, but to be open to exploring underlying ideas and conceptualisations within the data which would also reflect my own theoretical frameworks (Terry et al., 2017).

2.6.2.4 Step 4 - Reviewing Themes

Themes were reviewed and revised multiple times (please see Appendix 13 for an example of an early iteration of themes). This stage sometimes led to the refinement or discarding of themes based on their links with the data. I oscillated between the two stages of identifying and reviewing themes multiple times and revisited the transcripts so often during the process of coding and constructing themes, checking that the themes were meaningful and strongly linked to the data. For example, initially I thought the theme of "Journey" was apparent which would encapsulate hope and loss amongst other things and that there was a theme relating to Service Accessibility which incorporated waiting. However, after much to-ing and fro-ing between the dataset, the codes, and the initial themes, I started to see a pattern of a "Maze", that encapsulated a lot about the journey and accessibility of services. I was also initially convinced that "Loss" was a key theme (please see Appendix) yet going back through all the codes and transcripts and coding summaries, I realised that "Child", and a part of "Invisible" needed to be tied with "Childhood", which had fallen under "Loss". By returning to the transcripts again and again I was able to see more clearly how the young people positioned themselves, which was very much separate to adults, hence the theme "Childhood". (Please see Appendix on recognising the importance of Childhood and Being a Child.)

Reflexivity Box - Patterns of positivity

I notice I've been holding a lot of anger and frustration on behalf of the participants today, and perhaps the last couple of days. Whilst sometimes these emotions are helpful motivators, I don't want them to cloud my judgement and my ability to analyse the data as well as I can do – to try to identify those patterns of positivity and hope! So, at times like these, stepping back from the cliff face is so helpful. Grabbing a coffee, creating pretty (and really helpful) diagrams in ATLAS.ti, examining code reoccurrences reorganising my literature… creating my own pattern of positivity.

2.6.2.5 Step 5 - Defining and Naming Themes

I refined the names of each theme so that they were clear, descriptive and accurately represented the underlying data.

Reflexivity Box - Resonance

The penultimate stage has been hard because when I compared my themes to those in the systematic literature review, I realised mine were quite different. For most of mine I was not "pulling any punches" the sentiment behind The Fight, Stuck in a Maze, Feeling Invisible, Open Wounds is clear. I went back to the literature to remind myself what was expected or "allowed". Finlay's (2021) paper was a breath of fresh air, helpful and emboldening. She cites the four key criteria to evaluate TR, rigour, resonance, reflexivity and relevance. To determine resonance, we should ask "Is the thematic analysis poignant, powerful, evocative, touching, graceful, and/or vivid?" Therefore, "we might judge that theme titles such as "perception" and "body" are somewhat bland, uninteresting, and uninformative", where themes "lost in a fog" or "stuck in a hamster wheel…work better because they draw on evocative imagery." (Finlay, 2021, p.112). Encouraged, I raised the issue in supervision and my supervisor encouraged me further, so "The Maze" became "Stuck in the Maze" "Invisible" became "Feeling Invisible".

2.6.2.6 Step 6 - Report Production

The final phase was the write-up. Yet this belies its complexity as it involved not just writing the results chapter, which was extremely labour-intensive, it also included describing the analytic process herein, going through the photos and diary entries that show and describe the process.

Throughout this process, it was important to remember that thematic analysis is not strictly linear but recursive. I frequently revisited earlier phases to refine codes and themes, ensuring that the analysis accurately reflected the data's depth and complexity. The iterative nature of this method meant that understanding deepened over time, necessitating adjustments to initial codes and themes. This analytical journey was guided by the principles of reflexivity, ensuring that my interpretations remained grounded in the data while being conscious of my influence as a researcher. Each phase was approached with an open mind and a critical eye, aiming to produce a rich, nuanced understanding of the data that speaks authentically to the experiences of the research participants.

Reflexivity Box - My Own

As I look at my final themes, I notice I feel a degree of “affection”, perhaps attachment to them. They have come about through a lot of effort, from much coding, re-coding, new cycles of coding, manually and then through ATLAS.ti. I enjoy seeing my hand-drawn pictures in pretty colours, it feels creative and refreshing to step away from academic writing. I have enjoyed this process, but it has also been anxiety provoking and involved a lot of second-guessing. I was often struck by the sense that managing all this data (such a small word for such a lot of information!) has felt like I was wrestling a giant beast to the ground.

2.7 Ethical Considerations

As this research was conducted with adolescents aged 13-18, ethical compliance had to be rigorous and robust. The research followed the BPS Code of Human Research Ethics (BPS, 2021) and Ethics Guidelines for Internet-mediated Research (BPS, 2021), and complied with the Data Protection Act (2018) and City, University of London's data protection policies. The study was approved by City, University of London’s Ethics Committee (ETH2223-0834, 2254, 2468)

The main ethical issues that arose in this research was the protection of participant health and wellbeing, informed consent, confidentiality and data protection.

2.7.1 Consent

Research indicates young people generally favour a shared decision-making approach to consent/assent, being actively involved and supported by, for instance, parents and researchers (Swartling et al., 2014; Unguru et al., 2010). Nonetheless, studies involving homeless adolescents suggest some youth believe their consent, independent of parental approval, should suffice (Ensign, 2006). In response, a balance was struck between parental involvement and the adolescents' need for privacy and autonomy (Cohn et al., 2005; Fisher, 2003). Adolescents aged 16 and over were encouraged to discuss their participation with parents or friends, at their discretion. For those under 16, parental consent was obtained, and these adolescents were urged to review all informational materials, pose questions, and sign an assent form—a practice recommended by the World Medical Association (2013). In addition, I spoke to each adolescent directly about research participation, separately to their parents, and provided written materials that were appealing and understandable (Brawner et al., 2013; Burke et al., 2005; Swartling et al., 2011; Swartling et al., 2014; Unguru et al., 2010). I also took care to consult with adolescents and youth workers at a youth group about the consent/assent processes, aiming to preserve parent-child relationships (Fisher, 2003).

To ensure participants could fully provide their assent/consent, they were afforded ample opportunity to grasp the nature, purpose, and potential outcomes of their involvement in the research. Before the research interviews, participants received a comprehensive briefing on the study's nature, its objectives, and the expectations placed upon them. This information was conveyed both verbally and in written form through flyers, brochures, assent, and consent documents. The research's aims and requirements were further elucidated verbally during the initial meeting, where candidates were invited to pose questions. In the assent and consent forms, the introductory meeting, and the interview, participants were informed about the voluntary nature of their participation, guaranteed confidentiality and anonymity, and reminded of their right to withdraw at any time. Participants, and where applicable, parents and guardians, were advised of their freedom to exit the study during the interview phase and the option to retract their data until publication. Consent was secured for the research to be compiled into a thesis for a Doctorate in Counselling Psychology, with an advisory note on the potential for further publication. Informed consent and assent, including permission to record interviews, were obtained verbally and by signing the respective forms. The language used in the forms and verbal explanations were intentionally made easy to comprehend, ensuring the information was age-appropriate and accessible to adolescents. Following each interview, I encouraged participants to contact me if any concerns arose regarding the process.

2.7.2 Privacy & Consent of Photographed Subjects

Photographing individuals in public presents a range of ethical considerations. It is crucial to uphold people’s privacy although there is a lack of specific legal regulations in this regard in the UK. In cases where photographs are taken in public spaces, individuals have the legal right to photograph others without requiring prior permission, with exceptions for minors. The acceptability of photographing children depends on the potential harm inflicted or the intended use of the images. In the majority of cases, therefore, individuals photographed in public have limited legal right to control their image. However, adhering to these legal standards does not necessarily align with ethical best practice.

To address such ethical dilemmas, participants received guidance to avoid capturing photographs that could jeopardise their safety or the safety of others. Participants were instructed to refrain from taking pictures that infringe upon an individual's privacy. In instances where photographic subjects are easily identifiable, participants were required to obtain written consent (please see Appendix 17:). Participants were asked to send copies of elicitation photos, sounds and photos of objects to me 1-2 days, prior to the interview, for review. No materials posed any ethical concerns and therefore none were excluded.

2.7.3 Confidentiality & Data Protection

Confidentiality (and its limitations due to safety concerns) was discussed with each participant during the introductory meeting and interview. Participants were advised that all personal details and identifying information in the data comprising interview transcripts, images, sounds and objects would be anonymised. Each participant was assigned a random number and name (electronically generated) their data associated with their code and pseudonym (participants were told their pseudonyms and given the opportunity to change them, which one person did). Participants were advised that all data excerpts, including elicitation tools, would be anonymised and that no identifiable personal data such as names, faces were included in the write-up, future publications or given to any other party.

All interview data was stored on an encrypted audio recorder (or computer) and immediately transferred to a laptop, so that data could not be transferred beyond these devices. All electronic (including elicitation data) and written data was digitally stored in a password-encrypted folder on a password-protected computer and in a locked filing cabinet. All personal information was stored separately from the research data, including consent forms, in a password-protected work account on Dropbox. Names and coded information were kept in separate password-encrypted folder to ensure confidentiality and anonymity. All transcripts and data were anonymised and saved as a password-protected document. All participants were initially randomly allocated a number code during transcription and analysis, and then randomly allocated a pseudonym for the purpose of reporting. Data storage and destruction management follows City, University of London's data protection policies, and complies with UK GDPR legislation and the Data Protection Act (UK Government, 2018).

At the beginning and end of the interview, participants were reminded that if they felt uncomfortable about anything they had shared, to contact the researcher to discuss removing that part of the data. A follow-up email was sent at the end of analysis, to share the study themes, their pseudonym, a Top Problem Risk assessment form (see Error! Reference source not found.), an elicitation tool release form and a copy of the debrief information form (see Appendix). Any concerns, questions, suggested changes were welcomed, and a follow-up telephone/online discussion offered. All data will be destroyed within 10 years.

2.7.4 Assessment & Management of Risk / Emotional Harm

Given the sensitive nature of the research topic, it was important to anticipate that participants might experience some level of emotional distress during the research process. To address this concern, several protective measures were implemented. Potential candidates underwent a screening procedure that recorded mental health diagnoses to give me a general sense of their particular struggles, and to highlight any psychotic symptom risk, plus a risk assessment and briefed on the nature of the study and interview process. If they agreed to proceed, they were sent a copy of the consent/assent form and encouraged to read it carefully and ask questions. I used the Top Problems Assessment (TPA) - a brief, idiographic assessment that allows researchers to identify adolescents' problems that are especially important from the perspective of the adolescent (see Error! Reference source not found.). Conducted at assessment, interview and in the email with feedback of results, meant I could look out for problems and changes in problems across time. No participants presented any serious risk concerns, so none were excluded from the study. During pre-interview housekeeping, participants were asked how they were, reminded their participation was voluntary, that they did not have to talk about anything or answer questions that made them feel uncomfortable and could stop the interview at any point. A debrief at the end of the interview allowed participants an opportunity to discuss their experience and ask any questions. The researcher checked to see how the participants were and reminded them that should they experience any adverse effects, to contact her, their parents or carers, their GP, or local NHS services.

A key consideration for the researcher was that whilst adolescents may understand their research rights, they might not be or feel capable of using the knowledge and exerting them (Bruzzese & Fisher, 2003; Unguru et al., 2010). Therefore, the right to stop or pause the participation process, to decline to answer a question or discuss a particular topic and the right to withdraw part or all of their data up to the point of publication was reiterated at both the introductory meeting and beginning and end of the interview. The researcher was also vigilant during the interview to check participants' reactions and would check if they seemed upset and remind them it was okay and important to pause sometimes and that the interview could terminate with no redress. Managing participants' expectations around the impact of the research on service change and policy change was important, I did not want to set them up with false hope.

2.8 Evaluation of Quality of Research

In qualitative research, rigour involves researchers demonstrating the quality of their research and its adherence to established guidelines which serve as a measure of quality assurance (Meyrick, 2006). I chose the four "trustworthiness" criteria set out by Lincoln and Guba (1985): credibility, transferability, dependability and confirmability.

Credibility in qualitative research assesses the alignment between participants' views and the researcher's depiction of those views (Tobin & Begley, 2004). To address credibility, I adopted several techniques recommended by Lincoln and Guba (1985). I dedicated considerable time conducting and analysing the data, which included transcribing the interviews using basic software as a preliminary base, repeatedly reading the transcripts, and manually coding before moving to electronic coding through multiple iterations. Additionally, I spent several weeks identifying and reviewing themes. It could be argued that data collection triangulation was partially achieved through the elicitation technique, however, focus group discussions could have strengthened credibility. The use of both manual and electronic coding and theme generation might be considered a form of researcher triangulation. Peer debriefing was conducted through research supervision, providing an external check that increased the credibility of the research process. Moreover, conducting a pilot study and its subsequent write-up allowed me to check preliminary findings and interpretations in the context of the literature and assess the elicitation method. I sent the final themes to all participants as part of a member-checking process (Lincoln & Guba, 1985). However, the credibility of the findings could have been further strengthened had there been more extensive feedback on the themes, as suggested by Guba and Lincoln (1989).

Transferability is synonymous with generalisability in quantitative research and my role was to provide "thick description" of both the participants and the research process so that a reader can assess if the findings are transferable to their own setting. I hope this has been achieved with sufficient detail and clarity in this chapter.

.

The dependability of this study depends on my ensuring the process is logical, traceable, and clearly documented (Tobin & Begley, 2004) so that readers can judge. I believe I have outlined a clear rationale for the study based on the literature review. My research design fits my philosophical framework, and the research aims set out. I hope I have been transparent and clear in the steps taken to conduct this study but acknowledge that whilst in my mind it makes sense, to an outside perspective, my assumptions have not been sufficiently detailed. It is my hope that I have been able to strengthen the dependability of this study by keeping records of and referencing the interview recordings, transcripts, field notes, and reflexive diary, creating a clear audit trail (Halpren, 1983).

Finally, confirmability seeks to establish whether the findings and their interpretations were derived from the data. This step is established when credibility, transferability, and dependability are achieved (Guba & Lincoln, 1989). I hope this step is demonstrated robustly in the following chapter and the interaction of all four criteria for "trustworthiness" summarised in the discussion.

2.9 Summary

This research aimed to produce a study worthy to join the literature base on young people and their MHS use. Underpinned by critical realism and participatory epistemology, a qualitative approach was taken. Semi-structured interviews using elicitation methods were conducted with adolescents. The interviews were transcribed and analysed using RTA in order to explore adolescents' experiences of MHS. Ethical guidelines, a quality framework and supervision were used throughout the research process. The next chapter describes the findings of the analysis.

2.10 Reflexivity

Reflexivity is a dynamic process that extends beyond simply recognising one's personal biases (Flanagan, 2012) it entails expanding our understanding through both our own reactions and those of our participants during the research journey. This evolving awareness is then applied systematically to enhance the integrity and rigour of the research process. To support this continuous reflective practice, I maintained a reflexive journal throughout the project, often making real-time reflective notes during the different research phases. As reflections were captured both in a traditional paper notebook and in electronic format, they were sometimes disorganised. The journal served as a repository for my thoughts, opinions, musings, discussions, and reflections on the research process and its participants. I also used supervision to discuss progress or concerns. This was particularly important when I shifted from the Photovoice methodology to elicitation-led interviews, necessitated by both the COVID-19 pandemic and a lack of engagement from participating schools.

This layered approach to reflexivity ensured that I remained flexible and responsive throughout the study, which I believe was instrumental in producing authentic, rich, and nuanced findings.

Greater self-awareness was invaluable in helping to prepare for the interviews, helping me to remain open to new insights about young people's experiences of therapy, beyond my initial assumptions shaped by personal and professional experiences.

My interest in exploring adolescents' perspectives on MHS is deeply personal. Reflecting on my teenage years, I recognise I had limited understanding of the distinction between typical teenage difficulties and mental health issues, as well as the range of available mental health support. This lack of awareness led me to believe that mental health management was solely a personal responsibility, which in turn, made me feel ashamed during times of struggle. And I struggled because while my GP had recognised early on that I was hyperactive, it was not until much later, that I was diagnosed with ADHD. These personal insights were crucial in guiding how I approached and interpreted the themes that emerged from participants' narratives, particularly concerning awareness, autonomy and feeling invisible.

During my Counselling Psychology training, reflecting on my personal experiences in therapy proved invaluable, both personally and in preparation for conducting interviews. Additionally, my professional identity as a trainee counselling psychologist inevitably influenced my research. I frequently felt the instinctual pull to don my therapist "hat," especially when young participants expressed feelings of invisibility and abandonment. This emotional pull was particularly resonant due to my identity as a mother to a young daughter approaching adolescence, marked by a strong urge to comfort, guide, and offer solutions. Consequently, documenting my thoughts, feelings, and reflections after each interview became essential. This oscillation between my identities underscores that my role as a researcher was not always distinctly separate. The continuous reflexivity I exercised throughout this process, highlights of which are presented in distinct boxes within the thesis, has enabled me to maintain an actively engaged and curious stance towards the research. I hope this transparency underscores the subjectivity inherent in qualitative research while upholding the study's validity and quality.

Chapter 3

Results

This chapter presents an in-depth analysis of the experiences of nine adolescents interacting with MHS, utilising photo, sound, and object elicitation to capture their narratives. The aim is to authentically convey their help-seeking and therapeutic journeys, exploring these through RTA.

In line with the study's primary objective and prioritise adolescents' perspectives, the analysis was inductive to avoid shoehorning the data into a pre-existing coding frame and (as much as possible) the influence of my own analytic preconceptions. To achieve this, I had to assume a conscious awareness or "phenomenological psychological attitude" (Finlay, 2008) to balance my pre-analytic understandings and reflexive thinking and stay as close to the participants' perspectives as possible (Larkin et al., 2006). Therefore, the data-driven analysis produced themes that are strongly linked to the data (Patton, 1990). The narrative is enriched with the authentic voices of the young participants, using verbatim transcripts and interwoven with demographic and descriptive details, giving life to each person's narrative and situating their experiences within their personal and broader social realms (Larkin et al., 2006).

3.1 The Findings

Six master themes (Childhood, Help, Feeling Invisible, The Fight, Stuck in a Maze and Open Wounds) and 13 subthemes were identified in analysis (see *Figure 1*below). These themes, structured to reflect the adolescents' mental health help-seeking journey offer a detailed insight into their lived experiences; highlighting the obstacles and setbacks young people encountered and illuminating moments of empathy and assistance that have significantly impacted their therapeutic journeys.

Figure 1 - Thematic Map of Themes and Sub-themes After Reflexive Thematic Analysis

3.2 Theme 1: Feeling Invisible

The thematic analysis of adolescents' experiences in MHS revealed “Feeling Invisible” as a prominent theme. It encapsulates young people’s sense of disconnection from others, and their feelings of not being properly seen or understood. This was especially true in their interactions with the professionals tasked with their care. It features two sub-themes: “Struggling to communicate” and “Unseen/unheard/misunderstood”, the latter’s prevalence depicted graphically in a word cloud of all sub-themes below (see *Figure 2* below).

Figure 2 - Word Cloud Showing Most Frequently Occurring Sub-Themes Across the Data

3.2.1 Sub-theme 1: Unseen/unheard/misunderstood

“Unseen/unheard/misunderstood" captures the profound feelings of neglect that adolescents’ experience at various points along mental health pathways, reflecting system-wide shortcomings in recognising and responding to their unique needs effectively.

Adolescents consistently reported feeling invalidated. Grace encapsulated this sentiment saying, **“I feel like the most common thing…is even though like these places are here to listen to you...that feeling of not being heard”**. She captured her sense of isolation in a video of a dark, quiet street. In the video, a police car passes in the distance, its faint siren briefly breaking the silence before fading away, leaving her once again engulfed in darkness and quiet. The scene symbolises help as distant and out of reach - MHS are “there” but are ultimately unattainable, mirroring Grace's feelings of vulnerability and amplifying her sense of feeling disregarded. This sentiment was echoed in numerous accounts of unmet needs and dismissed distress. For example, Harper expressed a lack of support despite severe losses, **"I was supposed to be given bereavement counselling...Never happened. When I'd total lost three people in the space of six months"**. She also highlighted the lack of support during crises, sharing, **"running away from home, having suicidal attempts…moving out of my mum's house. I've had no support".** Lara expressed her frustration, highlighting the critical gaps in service responsiveness, **"But it was the fact that the CRISIS team didn't even speak to me,"** indicative of a failure to prioritise adolescent mental health.

Instances of being unseen often manifested in the misinterpretation or outright dismissal of symptoms and needs. **Harper's self-portraits, showing herself shrouded in a hoodie and partially hidden behind a teddy bear, capture a powerful sense of hiding and withdrawal. This imagery underscores her sense of being overlooked, even when in visible distress and highlights the disconnect between her visible struggles and the invisibility she felt during interactions with services. She** described an acute episode being ignored, **"I've just had a seizure and they go, what? They weren't looking. They were sat there looking on bloody computer screens"**. This imagery and her words reflect the suffering adolescents experience in plain sight yet unseen by adults: **"They don't recognise when people are struggling. Or they don't try look for what's behind everything. They just see what's right in front of them and then brush it off."**

Indeed, Lara testified to the lack of recognition of her distress describing how her struggles were misunderstood and minimised:

> **"it was just the way he said it… as if I wasn't doing anything between sessions when in reality I was really struggling…I'm just trying to get by and like, even if**

> **that's the bare minimum, …because, you know, at that capacity, I'm not able to do more because, you know, getting by is such an extreme task.** (Lara)

This sense of invalidation was so significant to her that she captured a photo of a letter from her clinician, in which they criticised her for not completing tasks outside of sessions. The image serves as a stark reminder of the division between her internal struggles and the clinician's perception, highlighting the profound frustration she felt at being judged rather than supported. Unsurprisingly, the lack of recognition of adolescent distress from adults charged with their care was for some like Grace, **"Weird, I guess...like people not understanding fully. What's wrong. Or them not wanting to put such a big label on things".** Harper articulated the distress, saying, **"horrible because I know there's something wrong and they won't do anything to fix it. Because apparently it's all in my head".** The disturbing trend of invalidating adolescents' suffering potentially signifies a gap in age-appropriate care.

This was evident in Dylan and Ryan's experiences of therapy where insufficient effort was made to ensure young people's understanding, which is fundamental to effective care. Dylan reported, "**they saw that I was actually confused, they would try to reword it. And then sometimes they wouldn't bother trying to ask or anything"**. Ryan admitted, **"struggling with what he was talking about"** and when asked if the therapist checked for understanding, he replied emphatically, **"No, definitely not. No"**.

Female adolescents frequently felt ignored by services, highlighting a critical area of concern. Their experiences often underscored systemic failures to recognise and appropriately respond to sex or gender-specific needs. For instance, Rae and Lara's experiences exemplify the disregard for female preferences in therapeutic settings. Despite their explicit requests for female clinicians due to past traumas associated with men, they were often compelled to either see male clinician or face prolonged wait times. Rae stated, **"most of the time, I have to have females...Cos the reason that I can't trust is because of men"**, yet she was told that **"no one else was**

available". This highlights a service-level disregard for female comfort and trauma-informed care, potentially re-traumatising vulnerable girls.

The misinterpretation of female adolescents' issues, permeated down to an individual level, further compounding their feelings of not been heard and understood and to the misdirection of care. For example, Lara's distress at seeing a male psychologist, prompted the therapist to initiate an inappropriate autism assessment. In another instance indicative of a lack of understanding of the female experience, she shared:

> **"the psychologist…when I went to CAMHS, he was like, like, do you not like having periods. And I was like…I don't like them they're not very nice. And he was like, would you stop eating to stop having periods? And I was like, that's not really what it is.**" (Lara)

This not only demonstrates a lack of understanding but trivialises the complex reasons behind disordered eating.

Different points of entry into the mental health system also failed young female individuals. GPs showed a poor understanding of female-based problems. For example, Kali's trauma-based distress was misattributed many times by her GP, **"I have really bad period pains and they know about that…they then started trying to blame how upset I was on the fact of PMS"** and **"I had a rash…I'm on meds for it…And he told me that he thinks it's a form of self-harm…no, I just have a rash."**

School-based support also often failed to recognise female pupils who were struggling. Kali was reliant on school-based support, but her significant distress was consistently deprioritised, overshadowed by more aggressive pupil problems. She explained:

> **"it was always, I'll speak to you in a minute…I've got bigger things to deal with cos someone had had a fight and someone had been arguing…So then it just got to a point where I was like, well, why am I even bothering?"** (Kali)

Even Grace's graphic distress through self-harm was dismissed at school. She recalled:

> **"I thought it would be obvious…I was covered in blood because I remember cutting my nose as well, just blood pouring down my face…And ummm I don't think anything happened. They just took me up to like the little safe space they had. And I don't think they said anything to me, they just kind of left me there. Called my parents…Parents weren't very helpful… my dad being more annoyed about the fact that he had to come pick me up."** (Grace)

This neglect at a critical point of support diminishes young people's struggles and sends a clear message that their mental health is not a priority.

Moreover, stereotypes and biases heavily influenced the treatment of young females. Lara noted, **"I just think you're working with children and children aren't always able to like express things…articulate things or communicate or even understand what they're feeling. So, it's just the approach that they have to fit in this narrow box."** This sentiment of being boxed in by adults' expectations was a recurring theme. Grace expressed, **"I think it's like that genuine feeling, like you have to look a certain way to be counted or something".** Lara's appearance led to assumptions that precluded her from receiving appropriate care for an eating disorder. She explained, **"I'm seen as someone who wouldn't have an eating disorder**", because **"of the way I umm appeared outwardly…I had really short hair…girls that are very feminine, are the kind of people that get eating disorders. So whenever it was mentioned, they brushed over it"**. This stark example of bias shows how stereotypes can cloud clinical judgment and lead to inadequate treatment.

"Unseen/Unheard/Misunderstood" reveals critical gaps in how clinicians and services interact with adolescents, particularly females. As Lara articulated:

> **"psychologists, or psychiatrists, like it's not just about having that qualification. It's about understanding people and like being connected and understanding what children's needs are and how children act…I feel like that is probably what helped me the most, people just trying to understand and see your perspective. And I think that should be more central to the way people are given care, because you know, that's what is important."**
> (Lara)

Lara's insight makes it clear that the efficacy of mental health care hinges not only on clinicians' professional credentials but also their empathy and engagement with adolescents' lived experiences. This gap in empathetic understanding often translates into a lack of effective communication and care, particularly for female adolescents who may feel their specific needs and perspectives are overlooked or inadequately addressed in the current frameworks of care.

The pervasive experience of feeling unseen and unheard deeply impacted the adolescents' willingness and ability to express themselves. For many, the repeated dismissal of their concerns led to a painful self-censorship, where silence felt safer than speaking out. This adopted invisibility contributed to significant challenges in communication, as young people navigated a mental health system that often seemed indifferent to their voices. In this way, "Unseen/Unheard/Misunderstood" seamlessly intertwines with the struggles adolescents face in "Struggling to Communicate."

3.2.2 Sub-theme 2: Struggling to Communicate

"Struggling to communicate" delves into the challenges young people face in articulating their mental health struggles, serving as a natural progression from the previously discussed "Unseen/Unheard/Misunderstood." This sub-theme underscores how the pervasive feelings of being overlooked by MHS can significantly deter adolescents from speaking out, as Lara described: **"when you haven't been listened to a lot of the time, it's very hard to put yourself out there and open up again"**.

Therefore, not being seen or understood by services, understandably contributes to a debilitating cycle of silence and means young people are more reluctant to engage with services, perpetuating and exacerbating their struggles. This reluctance often stems from fear as Lara summarised, **"you're scared that people aren't going to hear you".** Harper's experience reflects this sentiment, **"I've wanted to not be open and I've wanted to just shut myself off from everyone. Because before, I've never had any support even when I was open".** This resignation is echoed by Grace, who notes, **"Cos you reach a point where it feels like no one listens to you (laughs) or helps properly, so you just kind of go with it"**, her laughter perhaps indicative of how she copes in the face of despair.

The fear of being dismissed was often deeply rooted as Rae shared, **"I've always struggled like talking about things, because when I've tried in the past it just gets shut down (pause) and it feels like no one's listening"**. This sentiment echoes Ryan's past experiences of bullying, **"I told I told too many people I was adopted. And I got made fun of for it,"** instilling a deep-seated fear of sharing, **"people that will keep stuff away cos they're scared to tell"** yet later Ryan's reflection, **"But you shouldn't feel scared to talk to people about stuff"**, revealed the internal conflict between the desire to open up and fear of potential repercussions.

Thus, by the time they reach help, adolescents have often learnt to mask their distress, as Lara explained:

> "**by the time I first saw a person at CAMHS, I like I never felt that bad…I wasn't feeling things properly, like, I felt pretty okay, because it was like, everything was so bad, like my brain was kind of just, you know, it wasn't**

> **feeling things as much anymore…they didn't really recognise that even because they're like, Oh, well, you're not really talking about any problems.**" (Lara)

Concealing their mental states serves as a protective mechanism for teenagers. It not only protects them but also shields their loved ones from the weight of their struggles. Ryan highlighted the paradox of this protection: **"He kept a brave face on to keep his family happy"** and described the extreme lengths the lack of a safe communication space can drive young people: **"get hit by a car or jump off a bridge or like stuff like that and that that's sometimes due to the fact that they don't feel comfortable...safe enough to talk to people about what they feel."**

Harper's reflection on the futility of openness, **"There's been plenty of times where I've wanted to not be open and I've wanted to just shut myself off from everyone. Because before, I've never had any support even when I was so open"** underscores the profound sense of isolation adolescents feel, caught in the cycle of silence. This loneliness is illustrated by Kali's account of sitting on NHS waiting lists for two years, only to feel abandoned by her friends:

> **"every time I try talking to them, I just, I can always feel them just being like, 'oh God she's on about it again'. But then they don't seem to understand that me talking about it a couple of times is nothing compared to what I have to go through… it's the only thing that's ever on my mind."** (Kali)

In summary, the thematic exploration of "Feeling Invisible" unearthed an acute disconnection between young people and the professionals tasked with their care. The sub-theme "Unseen/Unheard/Misunderstood" highlights the chronic neglect and invalidation that adolescents face in services. Critical service gaps, such as overlooked crises and dismissed symptoms, show a system ill-equipped to recognise and respond to the unique needs of young individuals. This sub-theme captures how marginalised young people, especially females feel, whose experiences are frequently trivialised or misunderstood due to prevailing gender biases and stereotypes. Complementing this, the sub-theme "Struggling to Communicate" demonstrates how damaging, dismissing young people is – metaphorically muzzling them. This analysis has shown that the pervasive feeling of being overlooked contributes significantly to adolescents' reluctance to speak out, thus perpetuating a debilitating cycle of silence and exacerbating young people's distress.

Despite overwhelming communication challenges, there were glimmers of hope in the narratives. Instances of recognition and understanding, though rare, demonstrated the profound impact genuine, empathetic care can have on adolescents. For example, Lara's interaction with a dietician who provided understanding and safety illustrates the positive outcomes when young people feel genuinely seen and heard, **"She wasn't even like a psychologist, but she genuinely understood me back then and that like CAMHS, I just didn't get any of that recognition from anyone else"**. Lara's appreciation for being able to freely express her experiences in this research underscores the critical need for MHS to foster environments where adolescents can openly share without fear of dismissal: **"I really appreciate having the opportunity to talk about it…a small person how can I express this experience…It's nice…being able to speak about it."** Nonetheless, moments of empathy and understanding, were starkly overshadowed by feelings of invisibility. The data analysis confirmed that feeling invisible remains a pervasive issue, significantly impacting how young people interact with MHS. This conclusion calls for a systemic overhaul to ensure that MHS not only recognise but actively respond to the needs of adolescents. By fostering environments of genuine empathy and understanding, and addressing the specific challenges faced by female adolescents, these services can begin to break the cycle of invisibility and improve the overall efficacy of mental health care for all young individuals.

Reflexivity Box - The One that Got Away

Originally, I had planned a Photovoice study and there is a sadness in me for the one that got away. I think this is also tinged with frustration and tiredness – at all the work that was wasted and the pressure I felt starting the process all over again…having to do a new literature review, coming up with a new method and writing a new methodology. I remember my motivation ebbing in the face of many phone calls, emails and knocking on doors to schools, and not ONE responded. One school administrator expressed an interest after I chased, he had previously been a pupil at the school and saw the merit in the research, but it came to nothing. The explanations from teacher friends were that schools simply didn't have the resources and also educators and administrators probably felt they needed to "protect" their young charges from the perils of research. It made me recognise how powerless we are as students or "trainees" and I need to hold on to that, remember those feelings of frustration, tiredness and sadness, because that is what I am hearing in my interviews.

Reflexivity box – Peace of Mind

After seeing how invisible young people felt, I wanted to check whether my bias was affecting the analysis. Therefore, I recoded the data to check for patterns of visibility. The bar chart below illustrates how feeling invisible prevails in young people's experiences of mental health services.

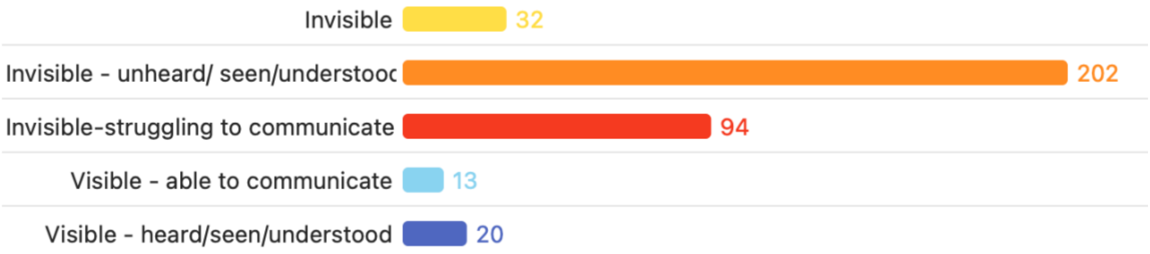


Figure 3 - Bar chart comparing invisible sub-themes against visible sub-themes. Numbers indicate number of instances recorded/quotations.

Reflexivity Box – The Impact of Me

I first noticed the teenagers describing a metaphorical struggle during the interview process which became more evident whilst listening back to the audio recordings and during transcription. I wondered whether this was driven by my emotional reaction to the teenagers' experiences (I often sensed my anger and frustration), rather than the data itself, so I made a concerted effort to set aside my own personal beliefs or judgements on the data and be as open to the data as possible, whilst analysing manually.

3.3 Theme 2: The Fight

The theme "The Fight" captures the arduous struggles that young people endured in their quest for support through MHS. It describes a linear journey marked by teenagers' relentless effort to engage services, the heavy sense of responsibility they shoulder and significant sacrifices they make, their palpable sense of injustice and regrettably the moments they succumb to defeat and disengage from seeking further help. This theme is enriched by one sub-theme, "The Losses".

Young people expended considerable effort and psychological labour in seeking help, as Harper poignantly articulated, **"I've asked for it and asked for it and asked for it and it's not happened"** the repetition underscoring the persistent neglect, especially of females, in their battle for recognition and support. The struggle to access help was vividly conveyed through the adolescents' language, as Lara described, **"who I am today is because I fought so hard. And even fought in this mental health service,"** and

> **"even accessing mental health services under the NHS, it is a fight. And it's like, I've literally fought to be here and you're saying it's the bare minimum and especially in regards to that statement, it was, ummm when I, they were making me see a male psychologist, even though I specifically said like, I've been umm**

> **sexually assaulted multiple times by men and I don't feel comfortable talking about that with a man." (Lara)**

For many, like Harper, their battle to access help began at a very young age:

> **"I've got used to it. I've truly gotten used to it. Because even from the first on with CAMHS where they'd shut me off, kept cancelling and cancelling the appointments, saying the doctor was ill and then closing the case. From there I was like, this ain't gonna go good. I was 10 when then happened. And then ever since then it's just been, well I might as well just suck it up and deal with it. I'm ex-army cadet for a reason." (Harper)**

"The Fight" also captures adolescents' internal battles and self-reflection as they tried to make sense of their experiences. Ryan's introspective, **"but there were, there were points when that happened and I thought, thought...(pause) why, why, why, there's obviously a reason of why you were brought into this world"**, reveals a search for meaning and purpose amidst the fight. These accounts are a reminder that teenagers are still developing psychologically and physically. So trying to grapple with their mental health struggles in the face of unhelpful help systems, is extremely confusing and distressing.

Unsurprisingly, a strong sense of injustice prevailed. Rae believed, **"it's cos I went there to try and explain how I feel about things, try and get some help, maybe feel better about things…And it just weren't happening"**, highlighting the sense of disillusionment felt by young people following poor care in MHS. Lara's insight that CAMHS, **"is a service for vulnerable people, people that are hurting and it shouldn't be right that people who are accessing it, are like, have to fight so hard, because not everyone can"** underscores the injustice of systemic failings and need for reform.

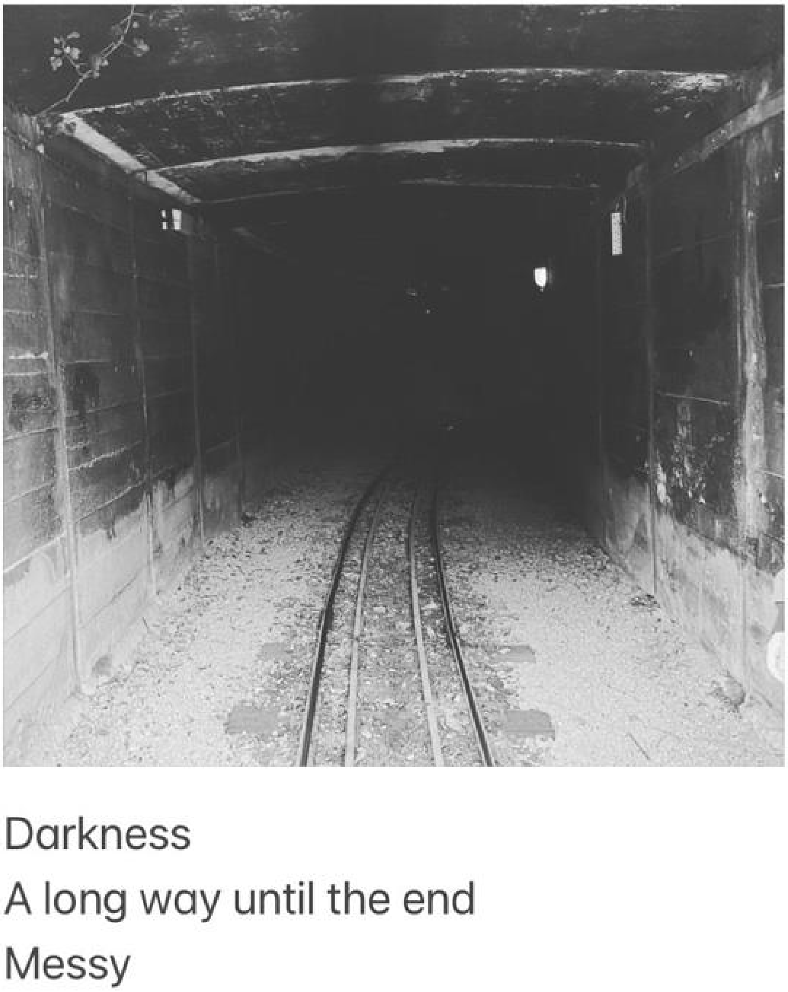
3.3.1 Sub-theme 1: The Losses

Fights typically result in both victories and losses, and unfortunately, strong patterns of loss were clear in the data. "The Losses" reflects the defeats and deep-seated resignation expressed by young people after relentless struggles. The most common loss identified was hope followed by enjoyment of life and childhood itself. Eventually many young people gave up the will to fight for better mental health support.

Reflexivity Box – A Picture Tells a Thousand Words

It was hard hearing young people talk about the difficulties of mental health ill health and even harder hearing how much they fought to find help. As I gather their stories, I feel sad and incensed at the damage wrought and reflect that if it is uncomfortable for me to hear, then living them, remembering and talking about them must be so hard for such young individuals. Kali said, **"words are difficult...you know it's going to get better and you know it should get better"** and I realise how their photos, sounds and objects have helped deepen my understanding of their losses.

Loss of hope was keenly felt (n=47) and often depicted visually. Rae talked about her struggle to stay optimistic using a black and white photo (see *Photo 1* below) to symbolise her current state, saying, **"I like to imagine things in my head and it's like with everything that's going on now in I'm not like...truly like fully happy, it's just black and white…And then I feel like once...the this group well, I've got the help I need, then it's colour."**.



Darkness
A long way until the end
Messy

Photo 1 - Rae's photo of a railway tunnel (and her accompanying words): "I'm not like…truly like fully happy, it's just black and white" – symbolising her current state of emotional despair.

The starkness of Rae's image conveys how joy and hope feel distant and diminished in her life, as though the colour and warmth she once knew have faded leaving only a muted existence.

Grace illustrated her dwindling hope after MHS failed her, with a photo of an old lamp (see **Error! Reference source not found.** below) saying, **"I think that's when you first go, like your first time in it and stuff. It's kind of like you have like this hope, but it kind of gets extinguished every time."**.

Photo 2 - Grace's photo of a lantern: "you have like this hope, but it kind of gets extinguished every time."

Young people talked about missing out on typical childhood experiences due to mental health problems. It was vividly described by Grace as something being slowly engulfed in negativity:

> **"it was kind of like mental health is like in a way. It's like negative atmosphere in a way and you've got like your inner childhood in a way, but like it like closes in on that and it gets rid of it in a way"** (Grace)

Adolescents also spoke about their loss of enjoyment in life. Kali articulated a monotonous existence, lamenting the impact of her mental health struggles:

> **"Every day is kind of the same. Nothing ever feels different. It's just everything is just wake up, go to school, and then kind of go back to bed. And it's kind of just**

> **nothing really excites me in the same way it used to before. It's very repetitive and dull, I guess.”** (Kali)

The deep impact of unhelpful services on childhood was vividly depicted in Lara’s photo of a Christmas fair (see **Error! Reference source not found.** below). She described how this typically joyful scene, “supposed to be a happy time of year,” felt tainted with fear and sadness:

> “**it's just like, so many times I've not been able to experience that. It's just kind of filled with fear because it makes me think back to when I first got referred to mental health services umm in 2018.”**

Lara’s winter fairground photo captures the loss of joy and childhood she associated with her mental health struggles, mirroring the ongoing loss of innocence and normalcy many adolescents experience in their mental health journeys.

Photo 3 - Lara's photo of a winter fairground: “supposed to be a happy time of year…It’s just kind of filled with fear”

The sacrifices adolescents made were often steep, affecting critical areas of their lives such as education. Ryan lamented the extensive time lost to therapy:

> **"Nearly 100 hours. That's a lot, isn't it? Of missing out on education…I said to my mum, I thought, I can't be doing it…I said I don't think I can carry on, one he's not helping and two, I'm missing so many hours of education."** (Ryan)

Harper reflected on the loss of typical childhood experiences due to her prolonged battles with mental health systems:

> **"I never got to experience much when I was younger...That would have been something that should have happened when you were six or seven, yeah. But then I had to wait until I'm almost 19 to be able to do that"**

The culmination of these losses often led to a palpable sense of exhaustion and defeat, often a result of systemic failures:

> **"…because it's like you get to a point of where you just…hit a like stopping point. You don't know what to do and you're just so tired. You can't be bothered finding another way of dealing with it."** (Grace)

This sentiment was echoed by Kali who felt neglected and unsupported: **"…I gave up with school entirely cos I was like, well, if you're not going to try with me, why should I actually try with you?".**

The narratives collectively portrayed a disillusionment and withdrawal after repeated failures in support. This insight is crucial for understanding the depths of despair that can lead to severe mental health crises and highlights the critical need for reform in how MHS engage and support young people.

"The Fight" theme captures not only the external and internal battles that adolescents endure but their resilience, determination and the resultant sacrifices, losses and sense of injustice they encountered on their journey through MHS. Through these narratives, the adolescents articulated a compelling call for a mental health care system that is more accessible, understanding, and supportive of their needs.

3.3.2 Sex Differences

Whilst not the most frequently occurring theme (n=173), "The Fight" was widespread across participants as shown graphically below (see *Figure 4* below).

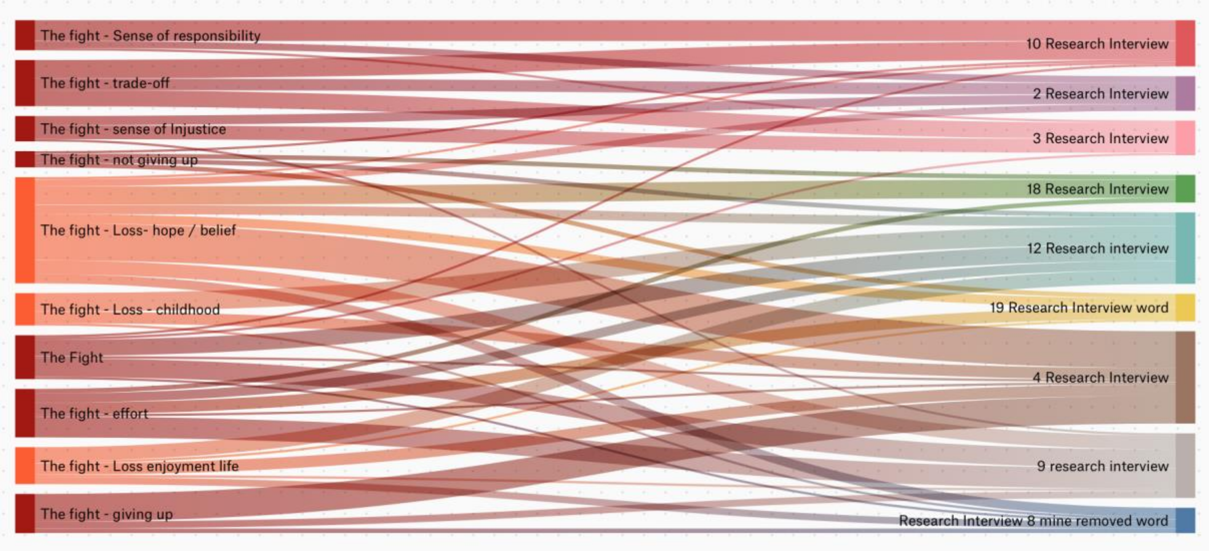


Figure 4 - Sankey diagram of The Fight across all participants

However, there were differences with regards to loss between the sexes (pictorially represented with by side-by-side Sankey diagrams for ease of comparison in *Figure 5* below). Losses were keenly felt by all the girls, especially loss of hope or belief, whereas the boys mainly experienced a sense of loss of hope or belief. On the other hand, unlike the girls, the boys were keenly aware of the sacrifices they had to make with in order to receive help for their mental health.

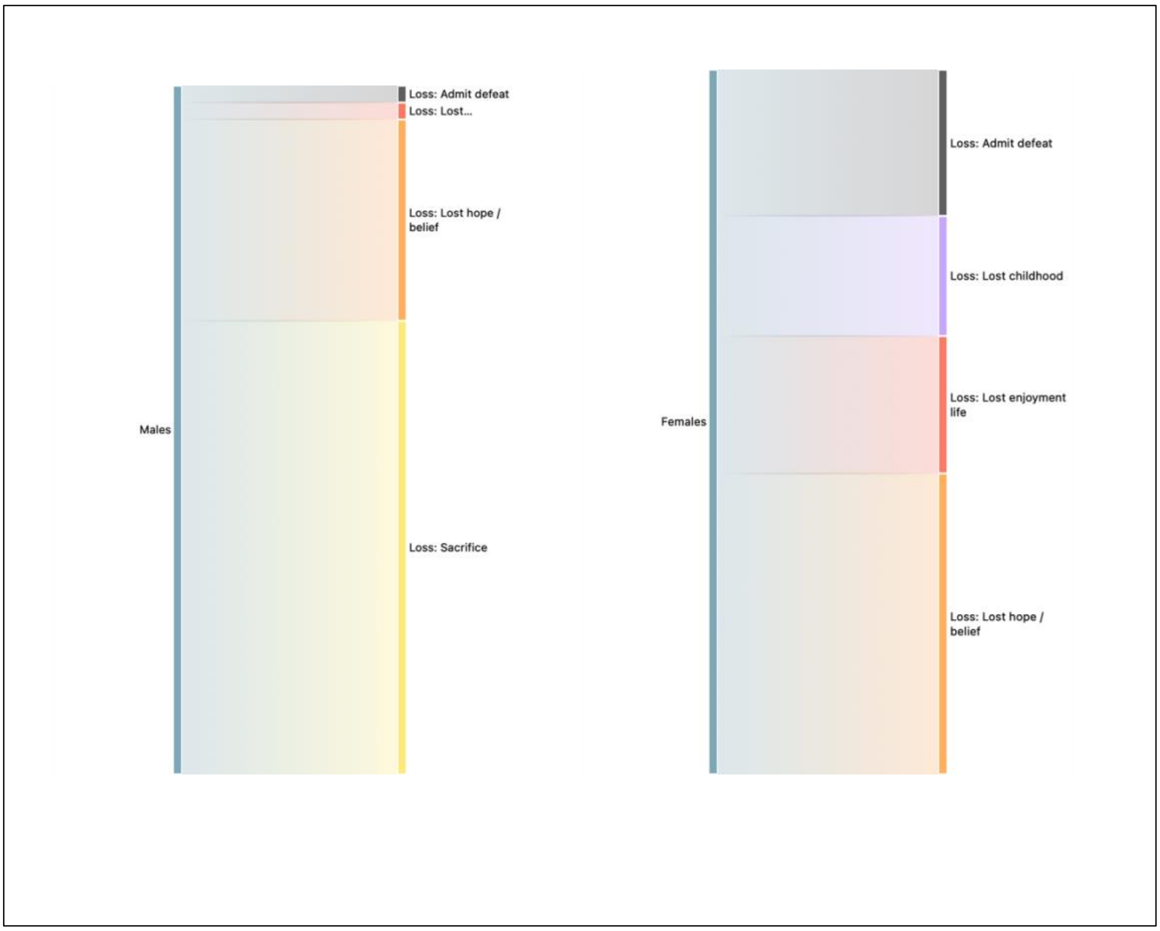


Figure 5 - Sankey diagrams showing boys' losses (left) compared to girls' losses (right)

3.4 Theme 3: Open Wounds

The theme "Open Wounds" was borne from the intricate interplay between two powerful themes, "Vulnerability" and "Distress", that arose in the data. These themes are inherently interconnected, with vulnerability often serving as both precursor to and a result of distress. By synthesising insights from "vulnerability" and "distress" while examining their dynamic interplay, the integrity of the individual themes was maintained, whilst exploring how they exacerbate each other, leading to the metaphorical "open wounds" that represent the profound and damaging impact these experiences having on adolescents' in MHS.

3.4.1 Sub-theme 1: Vulnerability

Adolescents frequently conveyed their sense of being exposed to potential harm or attack within MHS. Given the latent vulnerability of children "Vulnerability" aligns with "Childhood" theme, but its prominence in the data justified distinct positioning. Three sub-sub-themes capture different facets of vulnerability, revealing their fear of mental health deterioration, the sense of being trapped by circumstances or the system itself and the daunting task of navigating mental health issues without adequate assistance. The interviews and narratives revealed a deep sense of isolation and struggle for help within a system that often felt rigid and unresponsive to their individual needs.

3.4.1.1 Sub-sub-theme 1: Caught in a Trap

Everyone, except Mao, described a pervasive sense of entrapment in an unresponsive and adversarial system where options felt limited or non-existent, leaving them feeling marginalised and judged.

Dylan's experience highlights the vulnerability specific to adolescents in the system. An administrative oversight meant he was expected to confide in an unknown therapist without notice.

> **"Well at the time they didn't actually tell me that the person I'd normally have is on holiday…but I'm just supposed to like talk to someone different now who I've never actually spoke to before. It was a bit of like, do I really want to do it or not?"**.

His reliance on adults for transportation to the service in another town, underscored his lack of autonomy, trapping him in a situation where he felt he had no choice: **"So like if I was there and left there, I wouldn't exactly know where to go. So I had to just go to the counselling."**

The girls' narratives all conveyed a pattern of invalidation and blame by healthcare professionals. For example, the dissonance between Lara's strenuous efforts to manage her mental health and the perceptions of clinicians, framing her struggles as a matter of insufficient effort rather than complex challenges requiring compassionate care:

> **"it was like, Oh, you're not trying hard enough. Like, ummm, a lot of things I had from different mental health professionals in CAMHS, like, it was, you know, you're not doing enough. And it seemed, it was just obscene because, like, I'd been, well, I've been coping for my whole life with mental health issues"**. (Lara)

This reflects a broader issue of adolescents' efforts being minimised or dismissed completely, exacerbating their distress, and reinforcing their sense that they are trapped in an unsupportive system.

The interplay between vulnerability and distress was evident, for instance, Lara, who had suffered with anorexia nervosa throughout her teen years, recounted a distressing interaction with her psychologist:

> **"I wasn't eating properly at the time and…like my parents knew about it and she was like, Oh, it's good you communicate with them and I said, I didn't really communicate with them, I would just wasn't eating, so they could tell. And she's like, well, that's good that you were expressing that to them and I'm like, No, it's not, it's not good I'm not eating. And then when I said I was uncomfortable with her as a psychologist because she doesn't understand eating disorders…ummm they just said, well, you know, you'll just be put at the end of a waiting list. So… you're giving me treatment that is inadequate, and it becomes my problem. Like, either way, I can't do anything about it."**

The help she receives due to her vulnerability being very ill and very young leaves her feeling upset, then asking for help she is punished, feels trapped and more upset.

The relationship between vulnerability and distress was exemplified by Harper's physical and psychological distress, dismissed as figments of imagination, left her ensnared in an unending cycle of pain and despair and exacerbating her sense of entrapment within her own body:

> **"It's horrible. I'm constantly in pain, constantly having in-and-out migraines, dizziness, seizures, going in and out of hospital, and they just turn a blind eye. I've lost 60% of my vision, had ophthalmology appointments, and they won't do anything because of my FND diagnosis saying FND can make you go blind. We can't do anything to treat that. It's all in your head."** (Harper)

Invalidation, blame and inappropriate support were experienced by teenagers like Kali, whose school's inadequate response to her trauma, left her grappling to cope in isolation:

> **"I knew they were going to contact them, but they told me that they would speak to them erm and tell them. But because they couldn't get in contact with my parents, they just left a voicemail…when I then got home from school, they were just like, what the hell happened?"**

illustrating the gap in appropriate care that exists at the first signs of distress in young people.

At the heart of this theme lies the poignant contradiction between young people's search for autonomy and the systemic forces that constrain it. Lara's and Billy's experiences illustrated the disconnect between treatment options and their actual needs. Lara's account: **"CAMHS kind of don't really give me any proper support and then I was kind of forced onto medication"** was echoed by Billy who expressed a desire for more meaningful therapeutic help, rather than medication that made him feel worse not better: "**Yeah cos like it's all well and dandy being good on the tablets but I don't want to take tablets that make me feel like shit and like I**

can't sleep for the rest of my life." The enforced path emphasises their vulnerability, leaving young people feeling powerless and exposed in their quest for help.

There were glimmers of hope. Grace's reflections on help she finally received from third-sector organisations, highlighted the positive impact when she could choose what to discuss in therapy sessions: **"I think that's why it helped so much cos instead of focusing on one thing, you could choose what to talk about in a way and like they could help you with that"**, suggesting that when adolescents are given more control over their treatment process, it can significantly enhance the therapeutic experience, making it more relevant and effective.

Nonetheless, Grace described the harsh reality of being let down by services time and time again, **"It's like the same thing over and over. It feels like you're trapped in the cycle as well."**, which ultimately cannot end well: **"they just feel like they can't be helped so that's how they feel like everything will kind of end"**.

"Caught in a Trap" is not just a reflection on the challenges within adolescent mental health care; it is a clarion call for transformation. It invites us to envision a responsive care system that not only acknowledges the unique needs of young people, but also actively protects and empowers them, allowing their metaphorical wounds to heal.

3.4.1.2 Sub-sub-theme 2: Abandoned and on the brink

This sub-theme delves into the intense sense of vulnerability teenagers experience when they find themselves teetering on the edge of crisis. Despite their acute need for support, they often feel isolated and abandoned by the very systems designed to protect them. These narratives not only highlight the severity of their anguish but also underscore the gaps in MHS that exacerbate their sense of vulnerability.

Lara’s shed light on the abandonment she felt in the absence of adequate support: **"I don't have a psychiatrist anymore. So, I go to the GP and then the GP often don't really know what they're saying, they're not really understanding so it feels kind of like I'm on my own."** Similarly, Harper's confronted systemic indifference despite a litany of diagnoses: **"While I've got social workers saying you've got way more than autism, ADHD, and anxiety - social identity disorder, bipolar, PTSD, psychosis, schizophrenia...Yet, mental health services won't do it. They won't help."**

Harper goes on to describe her worsening mental health spreading like a physical disease, “**It doesn't just affect your brain, it then affects your body, and then the doctors won't do anything to help.**” Her struggle is a testament to the chasm between recognising mental health issues and providing actionable, compassionate care before the damage is too severe: “**It's horrible. I'm constantly in pain, constantly having in-and-out migraines, dizziness, seizures, going in and out of hospital, and they just turn a blind eye. I've lost 60% of my vision, had ophthalmology appointments, and they won't do anything because of my FND diagnosis saying FND can make you go blind. We can't do anything to treat that. It's all in your head.**”

The dismissal of Kali’s sexual abuse trauma by the safeguarding team at school epitomises the systemic oversight that leaves young people, often victims, feeling abandoned, "**all safeguarding did the first time was give me numbers for...Kooth and things, and they were like, deal with it on your own.**" Such responses, lacking compassion or practical assistance, dehumanise young people in crisis. Similarly, Grace’s experience of self-harming at school, revealed her acute vulnerability being met with indifference:

> “**They just took me up to like the little safe space they had. And I don't think they said anything to me, they just kind of left me there. Called my**

> **parents…And my dad being more annoyed about the fact that he had to come pick me up for work**." (Grace)

Adolescents described their unresolved mental health struggles reaching a critical juncture where the neglect, lack of adequate support and sense of abandonment escalate their suffering:

> **"You have like your emotions building up in a way...Like the worsening symptoms until it finally hits like a boiling point. And it just gets too hard to deal with...And you just hit a point when you lose that flame.**" (Grace)

The boiling point metaphor points to the dire consequences when support and intervention are absent. Kali used a similar metaphor to describe her breakdown:

> **"I tend to bottle up my feelings a lot. And so then when it just kind of tends to all explode in panic attacks and… it just kind of explodes all at once… I only had seven sessions of counselling. Ummm so when it was over, it was very much like, what do I do with myself now? I don't have anyone to talk to. I don't know what to do with myself…spiralling out of control because I'm not good with change**" (Kali)

Experiences converged to a point of desperation and desolation, where the absence of support magnified their plight. Lara' significant weight loss and the lack of intervention, is a harrowing example of reaching a breaking point: **"I lost about five kilos and I was already underweight...surely someone had the position to think, you know, maybe I could have been offered some support in that period of time, but I just didn't get it."** Ryan's reflection on the lethal consequences of untreated mental health issues underscores the ultimate cost of systemic abandonment:

> **"Being down and depressed, there are people that obviously like you know, end their lives or whatever because they're so upset or they just think oh I'm so upset with my life I'm going to hurt myself"** (Ryan)

"Abandoned on the Brink" is a powerful indictment of the failings of children and adolescents' MHS in the UK. It is a call to action—for a system that not only but actively seeks to understand and intervene before the distress of young people descends into tragedy.

3.4.1.3 Sub-sub-theme 3: Walking the Tightrope

Under the theme of "Vulnerability", this sub-sub-theme delves into the teenagers' mental health journeys and the perils they sense on the way. Therefore, it unveils a balancing act between seeking solace while confronting dangers, illustrating their ongoing struggle for stability and support in an unpredictable environment.

Central to many adolescents' stories is the pivotal role of safety in fostering their willingness to divulge their inner turmoil. Ryan reflected on a therapeutic environment that engendered trust and openness: "**her voice like made you feel safe and the way she spoke to me made me feel safe…didn't make me feel like I had to be scared…she actually made me feel was the word yeah safe…to explain and stuff.**" Highlighting the indispensable need for creating safe spaces in services.

Grace testified to the nurturing ambience of third sector services compared to NHS mental health provision:

> **"as a kid…you're used to busy school settings…and like hanging out with groups of people…and for things to be kind of quite alive to be quite busy. I think the thing nice with it…is the fact of that even when you are like alone and you're like talking like confidentially in like a room, you can still hear like the noise of everyone. And it still feels comfortable cos you don't feel like alone…Or like just empty in a way….Cos with CAMHS or the doctor's office, you don't hear anyone else really. Everyone's silent, there's like no**

> **talking…I think that's why I like MIND so much because…you get used to the workers and they're like really friendly…and it feels safer to talk about things**." (Lara)

Harper whose mental health had declined due to a combination of complex childhood trauma and minimal mental health support admitted: "**If I didn't find music, if I didn't find the gaming, if I didn't find my comfort animals, and my comfort items, I would have been dead**," illustrating the importance of finding personal sanctuaries and the need for alternative safe environments when institutional support falls short.

Some of the teenagers explored the negative side of medication as a sole form of intervention. Lara's concerns about medication, compounded by her negative experiences with services meant she was too scared to act:

> "**I've been on sertraline for over four years now…I don't really know how much help it's given me. But…I've just been on it so long. And you know, whenever I wanted to come off it…It's like, when is a good time? Or when I tried to talk to my psychiatrist …she was like, Oh, do you want to go on a higher dose? And then it kind of made me fearful to say no, I want to like come off it…Especially when you don't get given much support when you're in crisis.**" (Lara)

The teenagers' sensitivity to the power dynamics at play was poignantly expressed through Mao's perspective on his therapeutic relationship: "**you already have a lot of power and a lot of strength and control over the youth's mind is an incredibly important thing…with great power comes great responsibility you need to use that power wisely and help children onto the path of correctness**." The Spider-Man reference underscores a young teen's viewpoint (aged 13) that morality is binary, where they trust caregivers and professionals to "do the right thing". Therefore, mental health practitioners play a critical role in safely guiding adolescents, whilst recognising that influence.

"Walking the Tightrope" poignantly captures the adolescents' ongoing battle to find stability and safety in a world fraught with challenges and danger. Through their voices, the theme illustrates a critical need for empathetic, responsive, and supportive systems that understand and address the complexities of adolescent mental health, ensuring that no young person feels abandoned.

3.4.2 Sub-theme 2: Distress

"Distress" emerged as a prominent theme in all the adolescents' narratives, shedding light on their psychological turmoil. This exploration is crucial for understanding how young people navigate their pain, pinpointing its origins, and examining the precipitating factors that lead to a breaking point in their mental health including the part that MHS play.

Adolescents used different approaches to describe their distress. Ryan's use of sparse language and minimal detail reflected the approach adopted by all the boys when trying to articulate complex emotional experiences; he glossed over being fostered later adopted: **"so like after all of the trauma that happened like with my past and stuff"** and **"It was more things that were going on at school and yeah, sometimes the past and everything."** This could be simply a lack of language to accurately describe his feelings, or a discomfort with vulnerability or difficulty understanding or processing his emotions. He admitted compartmentalising his distress:

> **"because stuff at school should stay at school, it should never come home…but I always let it come home and …it'd get into arguments and be like, no, that's not right, …this, this, this and it just escalated further and further to the point where I'd go out the door, slam the door behind and just go up to my room and slam that door behind and start getting angry."** (Ryan)

The eventual failure of his strategy to maintain control over his emotions and the impact on his home life, underscores the overwhelming nature of his distress; his emotional burden is too heavy to be neatly segmented in different contexts of his life.

It was noteworthy that the boys shared little detail of their distress. Mao couched his pain in terms of his father's alcohol-related actions and impact on others:

> **"they're really amplified when he is drinking like he's quite xenophobic, he is quite conservative, even though he claims not to be. And I feel that some of the things he says can be quite hurtful to a lot of people. And…he seems to have a lack of empathy and that's some of what we talked about during our therapy sessions."** (Mao)

Billy's psychological pain was significant by its absence in the interview, minimising his family struggles: **"just I know that they were originally sent in because me and my mum had a bad relationship and it was to help us, like get better"**, despite his recent move to foster care. The lack of detail potentially serves as a protective mechanism allowing the boys to recount experiences without reliving the associated emotions. This potentially facilitates communication of painful topics, but leaves significant gaps in understanding the full scope of his distress for listeners or support providers.

Conversely, the girls used much fuller descriptions to describe their emotional turmoil, encompassing feelings of sadness, anxiety, hopelessness, and profound isolation. Grace vividly conveyed the horror of a self-harming incident at school: **"it was in the toilets, I was covered in blood because I remember cutting my nose as well, just blood pouring down my face. And I remember being found by umm the people there."** Harper's graphic account of her trauma was unrelenting:

> **"I was sexually assaulted by my own stepdad while I was unconscious. The police got told but they wouldn't do anything…They said they would report me for slander if I kept trying to. Because I was unconscious at the time, but**

> **then my family were denying the fact I was pregnant…my water breaks and I end up giving birth to him. And I had to sit there and watch for 15 minutes while they were trying to resuscitate this tiny 28-week baby**. (Harper)

The teenagers' photos, objects and sounds helped bring their distress to life. Grace's photo of a swing set in the rain symbolised her lost childhood and innocence in an atmosphere of sadness and hardship. Her video of a Police car passing in the distance conveyed her belief that help is unreachable. Ryan's represented his emotions pictorially. For example he conveyed his anger as a result of being bullied at school with a simple emoji image (see *Image 1* below).

Image 1 - Ryan's Angry Emoji, illustrating his anger as a result of bullying at school

Rae, who struggled with speaking, brought photos with text to portray feeling trapped by her mental health problems. Kali described the inner turmoil resulting from hiding distress using a beautiful photo:

> **"…on one side, it was cloudy, it was muggy, it was horrible. And on the other side, it was sunny and it was bright and it was happy…it was a good way of like explaining how like when you don't want people to worry about you, the difference…you kind of struggle with how you're actually feeling and you just end up being numb"**

These narratives provide insight into the complex interplay between personal experiences and environmental factors, underscoring the need for a holistic approach to mental health care that addresses both individual symptoms and underlying causes of distress.

3.4.2.1 Sub-sub-theme 1: Intersectionality of Vulnerability and Distress

This sub-theme illuminates the intricate dance between vulnerability and distress among teenagers, revealing a relentless cycle where vulnerability begets distress, which in turn, exacerbates vulnerability. This cycle challenges young people's resilience as they are trapped in a self-sustaining loop of suffering.

Pre-existing vulnerabilities are a fertile ground for distress. Ryan's concern for his friends' depressive states, given his own history of suicidal ideation, **"I've had a couple of mates that have been depressed...I don't know what you're going to be like and I'll be a bit worried"**, highlights how vulnerabilities predispose individuals to distress. Ryan's harrowing reflections, **"Being down and depressed, there are people that obviously like, end their lives...because they're so upset"**, starkly encapsulate how distress can amplify existing vulnerabilities.

> **"you're, you're a child, you're a child in a system…if people are really well off, then they can go privately and they don't have experience with it. So you have often like, people that don't really have any other means, or any other options, and then they're mistreated so badly, but they can't do anything about it" (**Lara)

Lara's struggle with the seasonality of her mental health, **"winter is something I kind of struggle with a lot"** and the exacerbation of her distress due to inadequate support, showcases how vulnerabilities can be both intrinsic and situational, leaving fertile ground for distress.

Lara's experience further illustrates this amplification, where systemic neglect in mental health care during her most vulnerable moments led her to question the worth of her existence, **"I was like, I just can't see myself living through this"**. This statement does not merely speak to her distress but also to a profound vulnerability rooted in a lack of support and understanding from the very systems meant to offer relief.

This intersectionality is perhaps most poignantly reflected in the narratives that highlight the cyclical nature of vulnerability and distress. Ryan's insight into the silent battles his peers face, **"You never have to feel like you have to keep...keep in your pain"**, alongside Lara's frustration with the system, **"I genuinely came to you like in crisis and you didn't contact me"**, exemplify how distress can both emerge from and contribute to a state of vulnerability.

> **"it's kind of like probably what most people feel like. You have like your emotions building up in a way…Like like all like the negative feelings, everything you were trying to get help with, during the thing just not being helped with so it starts building up. Like the worsening symptoms until it finally hits like a boiling point…And it just gets too hard to deal with…And you just hit a point when you lose that flame."** (Grace)

This section delved into the ways vulnerability and distress interact. With a deeper understanding of the intricate ways in which these phenomena are intertwined, insight into potential pathways to care that acknowledge the multifaceted nature of young peoples struggles become clearer.

3.5 Theme 4: Stuck in a Maze

The metaphor of a maze vividly captures the complex and disorientating experiences adolescents faced when trying to access mental health support in the UK. The pathways they described were convoluted, fraught with obstacles, systemic shortcomings and dead ends, leaving them feeling lost, confused and disheartened. This pervasive sense of being "stuck" or "trapped" took a toll on their mental health, reinforcing feelings of hopelessness and helplessness in the face of a system that seemed to thwart rather than facilitate their recovery.

The theme of "Stuck in a Maze" comprises four inter- related sub-themes: "Journey", "Waiting", "Dead End" and "System Failure". Together, these sub-themes paint a bleak picture of the challenges young people face in their quest for mental health support, highlighting the urgent need for a more accessible, responsive and youth-centric mental health care system. This maze-like system often amplified their distress rather than alleviating it, underscoring the pressing need for reform.

3.5.1 Sub-theme 1: Journey

All the adolescents conveyed their experiences with MHS as a long and convoluted journey, even Mao, aged 13: **"I'm in year nine now so it's been a while…I feel like I've gone through a journey through therapy". The journey is often** fraught with uncertainty as Rae conveyed: **"You don't know you don't know when you're going to get to the end. Ummm...pause...messy". This sense of confusion and frustration was visualised in Rae's photo of a dark railway tunnel with tracks leading into an indefinite distance (see Photo 1 above), symbolising her seemingly endless path through MHS with no clear destination in sight. For many,** repeated attempts to seek help, indicated journeys filled with stops and starts but little resolution, as Billy described, **"I've seen her about four times and I'm going to be going again in about a week. So I should hopefully be hearing whether or not they finally got this counselling sorted out."**

Young people's disappointment and sense of futility from having to repeat the same processes were obvious. Rae, who had been in and out of talking therapies pointed out: "**I feel like I shouldn't have to. Like it should have helped at least the first couple of times."** The repercussions of this arduous journey extended beyond frustration, impacting the mental and physical health of teenagers. Harper, whose experiences with MHS were punctuated by frequent hospital visits, revealed, **"Since the beginning of 2023, I have been hospital in A&E, 11 times"**, her complex health issues accompanied by a profound sense of despair: **"It's horrible, it's horrible because nobody gave me support at the beginning, which is why it's so complex."**

For Lara, the journey in the maze reduced her sense of agency:

> **“you've been under service for so long and then you leave and it's like, you can't do anything because you know, you have mental health issues but you need like, it's just the way it works. Like you need a doctor to basically recognise that you've got this condition so you can seek help from other things. Because otherwise, you become kind of powerless again, because they won’t.” (Lara)**

Lara’s account highlights the paradox many young people face: a quest for meaningful support that instead of empowering them, often leaves them feeling disenfranchised. Teenagers seeking help from MHS face a challenging and often disheartening journey, characterised by repeated efforts and uncertainty; reflecting the urgent need for a responsive, accessible and supportive system for young people’s mental health needs.

3.5.2 Sub-theme 2: Waiting

Teenagers described protracted periods spent awaiting help, that intensified their feelings of helplessness, abandonment and being caught in a perpetual state of limbo. The narratives highlighted systemic shortcomings, including inflexible protocols and unresponsive services.

Poor communication compounded the feelings of despair and isolation felt by the adolescents. For instance, Harper described her difficulties contacting her GP, **"It'll be, your queue number 48. And then by the time I get through to them, there's no appointments left"**. Such experiences underscore a systemic incapacity to deliver timely assistance. Delays were felt all along the pathways to care, for example Billy's four-month wait for therapy, a period marked by repeated inquiries and unmet promises: **"every time I go to the doctor I ask her have you sorted out the counselling yet and she's like no I'm still waiting on it"**.

When services did eventually open up, adolescents reported that they were not appropriate to meet their specific needs. Therefore, many teenagers faced the dilemma of whether to accept inadequate care or face longer wait times, as Lara illustrated, **"if you have a problem with like, the care you're receiving, they just say, well, you'll be put at the end of the waiting list if you do"**. The system's failure to prioritise patient well-being over procedure adherence was clear. For instance, Kali was offered further sessions by CAMHS, but the offer was conditional, confusing and made her worry whether to talk about the sex abuse she had suffered:

> **"we can offer you 12 more, but it'll be another wait. And depending on risk assessment and like what you would talk about in it and what you spoke about in this, whether it would be on something different or the same thing, depends on where you'd get put on the list."**

The consequences of long delays in accessing care were vividly illustrated through the adolescents' experiences of deteriorating mental and physical health. Harper had, **"been now off of my pain meds for two months...because I can't get a hold of them"** and Kali's increased vulnerability to abuse while awaiting therapeutic services, underscore the heart-breaking suffering that results from waiting.

> **"I was on the wait list for the thing that happened when I was a kid. And it was like two weeks before I got the message saying that I, I finally in for counselling, he did the same thing to me that happened when I was a child, that he was very mad that had happened to me."** (Kali)

Billy, coping with severe depression and anxiety following his entry into care, said, **"the main issue I feel is that it's just taken so long and is currently taking so long to get me any help"**, highlighting the urgent need for timely interventions.

Visual metaphors were brought to life through photo elicitation, such as Kali's photo of a candle, serving as a symbol of hope amidst the despair (please see *Photo 4* below). Describing the photo, Kali reflected:

> **"it was very much like in a place of darkness. Just like the very little glimpse of light, whilst sort of like, whilst waiting almost. It was like very hard, but at the same time…well there'll be benefits at the end, you know? And there's that sort of light that I am getting help, I just have to wait…"** (Kali)

Photo 4 – Kali's Photo of a Candle

Kali's photo symbolises the fragility of hope. Its faint glow offers a fleeting promise of support, yet the encircling darkness highlights the distance and isolation adolescents feel as they await help. The dimness of the light underscores how tenuous their connection to support feels, leaving them clinging to fragile hope in a seemingly endless waiting period. Despite feeling abandoned by MHS, this small light of hope reflects the resilience of these adolescents as they continue to hold on amidst the uncertainty and systemic failings.

"Waiting" paints a distressing picture of a mental health care landscape marred by inconsistency and a profound disconnect from the needs of the individuals it is supposed to serve. The experiences of the teenagers call for a re-evaluation of the system, to one that is responsive, compassionate and person-centred.

3.5.3 Sub-theme 3: Dead Ends

The adolescents often described insurmountable barriers along pathways to care, impeding their progress and amplifying feelings of helplessness and frustration. Ryan's image of a maze around a young person's head (please see *Image 2* below) helped him richly describe the rupture with his therapist. because of the "dead end" Ryan experienced. He described reaching a point where he, "**couldn't go past that dead end, I had to go back"**, and he was forced to "take another path" without support, "for about…half a year, I didn't have anyone." This decision to "step back" and "start a new path" illustrates the emotional toll of navigating unhelpful therapeutic relationships that ultimately lead to disappointment and disengagement. reflecting the often indirect and disorienting path many adolescents encounter.

Image 2 – Ryan's Image of a Maze, symbolises the "dead ends" he encountered in his relationship with his therapist, Luke.

Kali's encounter with help in a school setting, exemplifies obstacles to mental health support early in the pathway to care,

> **"And then when I got home from school after I'd been, like I'd been called out of English and they were just basically like, we can't do anything for you because you would have left by the time that we can do anything. My mum was raging, she was like, you're gonna to be there for another two years, you're going to sixth form. And I was like, yeah, I know. I was still going to be at the school for like four more years. And…we can't do anything for you." (Kali)**

The system's distressing inadequacy in handling complex cases was highlighted by Harper. Early life trauma, including neglect, abuse, and eviction from the family home, resulted in Harper's complex psychological problems, and compounded her need for consistent support. Yet her case fell through the cracks of an ill-equipped system:

> **"It's like IAPT wouldn't take me on because it's specified for anxiety and depression. But because everything is labelled into one…They won't take me on because it's too much of a complex case. It's like even the social worker**

> **that I've currently got, she's a student...She was warned that I was a complex case before she even started."** (Harper)

Dylan's account showed that even accessing information was a barrier, **"I think I was going to give them a go, but then I kind of lost the leaflet and then couldn't find out anything about it."** Such narratives underscore the urgent need for pathways that lead to meaningful support rather than "Dead Ends". However, these dead ends are symptomatic of wider failings across the maze, exacerbating the challenges faced by young people seeking mental health support.

3.5.4 Sub-theme 4: System Failure

The sub-theme "System Failure" reveals the multi-faceted and deeply frustrating experiences teenagers have with MHS. But rather than isolated, one-off problems, this sub-theme reveals systemic breakdowns, including bureaucratic obstacles, inconsistent and impersonal care, causing young people to feel as though they are in a continuous state of falling without support.

This sense of instability is vividly captured in Rae's photo of a "Big drop" (please see *Photo 5* below). The image shows a steep descent, symbolising how seeking help can feel like a journey with treacherous falls and no easy way to climb back up. Rae described it as, **"It's as if it starts helping at the beginning, then it doesn't, and it's a struggle to get back up."** Both Rae's words and image illustrate the disheartening pattern where initial glimpses of support fade, leaving young people feeling unsupported, lost, and without a way to regain stability.

Big drop
It's as if it starts helping at the beginning then it doesn't, it's a struggle to get back up

Photo 5 – Rae's Photo of "Big drop"

Rae's experience, echoed by other participants, underscores how inconsistent care and interruptions in care can foster profound insecurity. Much like navigating a steep drop, adolescents described how navigating MHS can feel treacherous, with setbacks that felt insurmountable without reliable support systems.

Harper's experience exemplifies these issues:

> **"When I was in year six, I had a CAMHS worker, they gave me one session, then kept saying they were unwell for six months straight and then closed the case, saying that I was suitable to be discharged when I'd only ever had one session. YouthWorks, I had three sets of it, one-to-one, and one lot of group counselling. The group counselling, they put my little sister in it as well, in which I then couldn't open up."** (Harper)

Lara's experience further illustrates these issues. She included an image of her Sertraline prescription, representing both the support and the limits of pharmacological intervention in her care (please see *Photo 6* below).

Photo 6 - Lara's Photo of Prescribed Medication

For Lara, medication symbolised the impersonal and inadequate care she received, a treatment option that ultimately failed to meet her broader needs and left her feeling unsupported and disempowered. Her reliance on Sertraline highlighted a lack of holistic support, as services seemed to prioritise quick pharmacological fixes over comprehensive care.

Teenagers often described MHS as difficult to access due to bureaucratic hurdles. For example, service protocols often prevented young people enjoying stable, continuous care. Harper's experience underscores this, revealing a system that is both inappropriate and heartless: **"And then the third time, it was working really well and I was managing fine. Then my dad passed away and they only gave me two extra sessions. And then they shut the case"**.

Harper's use of impersonal language, such as "they only gave me two extra sessions" and "they shut the case," emphasises the cold and unfeeling nature of the response. The impact of such unreliable care was deeply felt. As Rae reported, **"And then the counselling would stop and then my mental health went downhill again, so I'd go back and it was someone different for the next couple of weeks"**, highlighting a system that, for many young people, exacerbates their struggles rather than alleviating them.

The MHS system often failed to provide person-centred care for young people. This was most evident when two girls, Rae and Lara, both requested female clinicians due to sexual trauma by males, but were both assigned male therapists, despite their distress. This illustrates a complete insensitivity to the needs of vulnerable young females. The consequences were predictably catastrophic. For Rae, unable to articulate her distress effectively, her **"anxiety basically went to the roof**", resulting in her complete disengagement with services: **"I got messages from them…errrm asking why I missed the appointment. And because I didn't really know how to say why I felt uncomfortable, I just sort of said, oh, sorry, I was busy."**
This typifies the communication struggles regarding their mental health that young people described in the theme "Feeling Invisible" (see 3.2 above). Importantly, it also highlights a lack of robust follow-up and feedback gathering from services. Inevitably, when such difficulties on both sides collide, a complete breakdown in service engagement ensues. Dylan's experience epitomises this, **"I think I was going to give them a go, but then I kind of lost the leaflet and then couldn't find out anything about it."** These examples show the knock-on effects that problems within the system generate, creating layers of issues. Unfortunately, young people pay the price for the "system failure". Kali reported, **"when we got nothing back from them, my mum then called back again in August, when they referred me to [third sector service]. And then I didn't really hear anything else for another year"**. Like so many of the teenagers, Kali's distress subsequently escalated whilst her trust in MHS eroded.

The culmination of these experiences, the "System Failure" is vividly captured in Dylan's words and imagery. Like Rae who described her interactions with services as "messy" (see 3.4.1 "Journey" above), Dylan summed his experiences as, "Just a lot of mess and I dunno really. Mess." emphasising his point with *Photo 7* below:

Photo 7 - Dylan's Photo: "messy" visually represents the disarray he encountered in MHS

The catalogue of problems Dylan faced in services, from disorganisation to lack of person-centred care, ultimately led to his involuntarily disengagement and belief that, "Nothing's always as clean and easy as it looks." His narrative along with those of others, underscore how "System

Failure" exacerbates the challenges faced by vulnerable adolescents, by treating them as mere numbers, rather than vulnerable individuals in need of compassionate care.

"The Maze" presents a broader view of adolescents' arduous journey through UK MHS, characterised by bureaucratic obstacles, prolonged waits, and a marked lack of person-centred care, contributing to young people feeling lost in an overwhelming system. It is a call for a comprehensive overhaul of the current mental health care provision for young people to a well-defined, supportive pathway that prioritises early intervention, continuity of care, and a holistic approach to adolescent psychological well-being.

3.6 Theme 5: Childhood

The theme of "Childhood" resonated deeply throughout the adolescents' interviews, painting a vivid picture of vulnerability interwoven with burgeoning autonomy experienced by adolescents against the backdrop of their interactions with MHS. This theme captures the complex journey young people with mental health struggles navigate as they move towards adulthood. It highlights their remarkable resilience and inspiring optimism amidst systemic shortcomings, alongside the innocence and vulnerability inherent to this life stage. However, it also reveals a discernible erosion of optimism, underscoring the nuanced challenges these young individuals face.

3.6.1 Sub-theme 1: Being a Child

"Being a Child" surfaced as a poignant reflection on the innocence and vulnerability characteristic of childhood, alongside adolescents' expectations for empathy, understanding and support. It is crucial for adults to recall the terror that young people feel when confronting mental health issues for the first time, as Lara points out, **"it's very scary to think about your mental health for the first time"**. This underscores the essential role that adults caring for adolescents, play. For instance, despite her efforts, Lara was criticised by her CAMHS therapist for doing **“the bare minimum”**. She stressed the fundamental misunderstanding of her situation, saying: **"Yeah, it’s like a child you're talking about...It’s like you don't get it"** and insists, **"your job is to help children, surely you recognise the importance of that"**. This plea for understanding is echoed by Billy who argues, **"I just feel like that it should be easier for people under 16 to access like help for mental health"**. Yet it is evident that children's voices are often marginalised and their capacity for self-advocacy, underestimated, as Grace observed, **"they don't think it's as serious or they think like the kids are too...even now kids don't know better".**

Harper’s experiences were particularly affecting:

> **"When I was in year six, I had a CAMHS worker, they gave me one session, then kept saying they were unwell for six months straight, and then closed the case, saying that I was suitable to be discharged when I'd only ever had one session"** (Harper)

Yet, most adolescents remained optimistic, a testament to their resilience. Ryan's reflections, **"Yeah, there's always going to be ends in your life where you always need to overcome"** and Mao's commitment to a better future, **"I plan to do everything and anything for a better future".** Lara's positive experiences with a solitary, empathetic dietician in a raft of mental health professionals, highlight the transformative power of compassionate care, **"she showed me that like, you can get care, like people can take the time to like support you"**. This forward-looking view, grounded in their experiences, underscores the importance of fostering hope and positive engagement in MHS to empower adolescents.

“Being a Child” captures the essence of childhood, marked by physical and emotional immaturity, and a dependency on adults that is often met with varying degrees of understanding within MHS and is a stark reminder of the consequences of neglect and the urgent need for a compassionate, responsive mental health system attuned to the unique needs of children and adolescents.

3.6.2 Sub-theme 2: Autonomy vs. Support

Adolescents navigating mental health challenges often grappled with the delicate balance between self-reliance and the need for external support. This dynamic interplay underscores their quest for independence against a backdrop of necessary reliance on various support systems, including family, educational professionals, and peers. A notable disparity emerges between these support mechanisms and the adolescents' frequent need to fend for themselves, often a direct result of systemic inadequacies.

Family was a foundational support system for some adolescents, providing a sanctuary and strong advocacy. For example, Ryan described his parents' pivotal role in his care management: **"I was safe at home and everything was safe because actually mum and dad were brilliant. They were really brilliant."** Dylan also noted the pro-active role of his parents in initiating and perpetuating help-seeking: **"I think my parents asked if I would like to go and if it would benefit and I said, yeah, I'd like to go and talk to someone."** Schools and mental health professionals also played a crucial role. Ryan credited his school **"team"**, including his SENCO and mentor, for his progress saying: **"Mum dad, me, Miss B, …and Miss X, …I think without them I wouldn't have got where I was today. Definitely not. 100% not."** Yet, the support provided by adults often fell short. Grace notes, **"But that's kind of how it feels in a way like adults will notice things, they just don't try to help"** because **"they don't think it's as serious"**. Harper's experience was particularly telling; following her step-father's sexual abuse, she faced denial from family, threats from police, and neglect from health systems. The pervasive overestimation of adolescents' capacity to manage their situations often places undue burdens on them, a gap in adult responsibility vividly described by Grace in her interactions with healthcare: **"most people don't know what to do when it comes to**

doctors… Cos sometimes like you've never gone type of thing…you're lost, you know and just don't know what you're supposed to be doing."

Peer support emerged as a critical yet sometimes unreliable source of empathy and understanding. Grace, for instance noted, **"Yeah, cos it's like everyone upstairs, like they have their little close-knit friends and they feel like if anything happens, they can always count on them being there for them."** Kali expresses frustration when a friend prioritised a boyfriend over her during a crisis: **"I was like…you ditched me for Pete. And she was like, yeah, he needed me. And I just kind of lost it. And I was like, well, I needed you Carol and you have plans with me. And she was like, I'm sorry, but Pete needed me." (Kali)**

Instances of support were eclipsed by numerous accounts of self-reliance, wherein adolescents were compelled to navigate their mental health challenges solo. Instead of a naturally developing autonomy aligned with their age-related drive toward independence, a forced self-reliance emerged as a survival mechanism, poignantly articulated by Grace, "And it's just no one's helped you now, so you've just learned to try and help yourself." Similarly, Billy's responsibility for **"taking care of me and my sister"** in the absence of parental support starkly illustrates the burdens prematurely placed on young individuals. This enforced independence often arose from systemic failures, including unresponsive or unsupportive MHS. For instance, Harper's struggle to access necessary medication and consistent care led to her words of resignation, "I've got used to it. I've truly gotten used to it," and "If I didn't find music...I would have been dead," underscores how personal passions can become critical coping mechanisms. Lara expressed discomfort with the burden of advocacy and its consequences: **"I think it's just when I've seen the GP on various issues, it's very much, I've had to explain to them, like in depth, like issues and things. And then it's just like, I don't really want to be explaining medication to a GP. That's then going to like change my dose because then it's like, you know, it feels very much like I'm going to be on my own about it."** These narratives collectively highlight a distressing pattern where self-reliance is not a choice but a necessity driven by the failings of the systems meant to support them. Ryan's sombre reflection highlights the extreme consequences of inadequate support: **"Being down and depressed, there are people that...end their lives...and that's sometimes due to the fact that they don't feel comfortable...safe enough to talk to people about what they feel."**

Digital platforms emerged as important adjuncts to traditional support mechanisms, offering adolescents new ways to seek connection, express themselves, and validate their experiences. Grace used social media to share her frustrations with CAMHS, **"the first pictures showed the word 'useless' "**. And because, **'They do have like 100,000 likes as well, so a lot of people agree"**, Grace felt her frustrations were validated. Similarly, Kali's experience highlighted how digital narratives can catalyse awareness and support:

> **"…and someone was talking about a similar situation to what I'd been through. And I just remember feeling so awful for them and that it was just such a horrible thing to do, for someone to have gone through and then I just remember sitting there and I was like, well I've been through that. And before I noticed, I was already having my first panic attack."** (Kali)

Mao, the youngest teenager admitted, **"I've gone through a journey through therapy...but also through social media"**, demonstrating that social media can sit side by side with formal interventions.

In conclusion, while traditional support systems frequently fall short, digital platforms suggest a potential pathway, offering real-time empathy and support that can complement formal mental health care. This evolving landscape underscores the need for a more integrated approach that embraces the complexities of adolescent mental health needs. These narratives emphasise the importance of recognising adolescents' vulnerabilities (see Theme "Open Wounds") and the urgent need for adults and systems to provide collaborative supportive, empathetic, and effective care. Addressing these gaps is essential for fostering an environment where adolescents feel supported, understood, and equipped to navigate their mental health challenges.

3.7 Theme 6: Help!

"Help" was quantitively the strongest theme, spanning adolescents' experiences of MHS at all points along relevant pathways of care. It shows a diverse range of experiences, encompassing supportive and problematic interactions that are encapsulated in two sub-themes "Good Help" and "Bad Help", to support clear dissemination to services and action for change.

3.7.1 Sub-theme 1: The Good Stuff

Sadly, the number of positive experiences with MHS was half that of negative interactions. Critical elements of effective support included beneficial therapeutic relationships: supportive environments and most importantly, person-centred, empathetic care.

The therapeutic relationship emerged as a beacon of hope and healing in the narratives. Ryan described his therapist's reassuring demeanour, **"her voice...made me feel safe...she made me feel...safe to explain and stuff,"** illustrating that feeling safe is foundational, enabling adolescents to open up without fear of judgment. This sense of safety was symbolised by an image of a safe Ryan brought (please see *Image 3* below), representing the secure, trustworthy environment his therapist created with him – a place where he felt protected and able to express his vulnerabilities.

Image 3 – Ryan's Safe

Ryan reflected on the importance of his therapist's approach which integrated personal interests into their sessions, **"You want to talk about what you're going to do this week… And that's what my therapist does now. We talk about the football matches I'm going to go to". This illustrates** the importance of acknowledging the individual's life context, making therapy, in Ryan's words, **"worthwhile….It's worthwhile…due to the fact that she's actually worth the time for being there". For Ryan, this person-centred approach has led to meaningful change, as he noted, "It's made me such a calmer person...I haven't had an argument with my parents in at least four five months"** highlighting the broader impact of empathetic, individualised care.

A person-centred approach was cited as a cornerstone of meaningful mental health support in other points of the mental health pathway. For example, Ryan, who had been adopted, relied on his "team" at school, including **"Miss X was my mentor, but she was more like a friend…like my school grandma in a way."** Recognition and empathy were recurring themes in adolescents' positive experiences. Lara shared a poignant moment with a dietician who **"genuinely understood me,"** a testament to the deep impact of authentic understanding and recognition on an individual's healing journey.

The physical accessibility of services was crucial for adolescent engagement. Grace's account of walk-in sessions at a third-sector service, and their proximity to essential amenities like schools and public transport underscores the importance of making mental health support readily available for young people, **"It's close to the buses...so you can just stop in town and go there"**.

In addition to these positive experiences, the teenagers in this study offered several insightful suggestions for improving MHS. Ryan suggested that mental health check-ups should be regularly conducted for everyone. He also proposed the creation of dedicated spaces, like specialised wards, where individuals can discuss their mental health comfortably: **"like rooms that you can sit in and talk to them about your mental health."** He emphasised that services should not be limited to doctors' surgeries but should be available anywhere, including home visits, **"They could come to your house"**. Ryan also highlighted the importance of advertising MHS, **"they could put posters on the wall or on billboards...like, if you've got a bad knee, go to the doctors, but if you've got mental health issues, go to the doctors."**

Billy highlighted the need for easier access to MHS for younger adolescents: **"I just feel like it should be easier for people under 16 to access help for mental health. They need to fix the cause of the issue instead of just treating the symptoms with tablets."** He also called for a more urgent and holistic approach to mental health care: **"I think it should just be a lot more urgent. My GP has had to push for this to happen for four months now, and it still hasn't. It should just be knocked up the ladder and seen as more important."**

Many of the teenagers emphasised the need for mental health professionals to better understand children's needs and behaviours. Harper emphasised the need for greater recognition and understanding of those struggling with mental health issues: **"They don't recognise when people are struggling or try to look for what's behind everything. They just see what's**

right in front of them and then brush it off." This reinforces the importance of vigilance among mental health professionals as young people often hide their distress. Rae's words, **"I'd quite like them to act like they actually care"** indicate a pervasive need for genuine empathy in children's services. This is particularly important in moments of crisis. Grace suggested improvements in safeguarding and support during such times: **"I would have expected them to check if I was okay and not just call my parents straight away. It's safeguarding, like having people there to talk to me or making sure I was safe, not leaving me alone."** Billy highlighted the need for easier access to MHS for younger adolescents: **"I just feel like it should be easier for people under 16 to access help for mental health. They need to fix the cause of the issue instead of just treating the symptoms with tablets."** He also called for a more urgent and holistic approach to mental health care: **"I think it should just be a lot more urgent. My GP has had to push for this to happen for four months now, and it still hasn't. It should just be knocked up the ladder and seen as more important."**

Several suggestions were made that therapy be more engaging, especially given excrutiating experiences such as Lara's:

> **"When I first went to CAMHS, I was seeing this man, and we basically just used to sit in silence for an hour. Thinking back, something that I would find helpful is if I could draw or do something on paper. It was just talking, even though it didn't work for me. They should be more proactive and try different things."** (Lara)

Dylan also provided practical suggestions for making therapy sessions more effective and engaging: **"Probably not try cramming so much into one session, just take it a bit slower. At the end of each session, make sure the person is fully satisfied with what happened and willing to come back again."**

Lara also emphasised the need for more rigorous feedback procedures, recognising that it must be accompanied by pro-active listening, **"They need to be a lot more responsive and**

definitely seek more feedback from people and actually listen. Parents, children, people with past experiences should be central to them." This would help ensure greater accountability in services which Lara was keen to emphasise:

> **"I feel like one thing would be that CAMHS has a better system of accountability like, you know, you actually have a way for some of these complaints to go. I think, like, people definitely shouldn't be punished for raising concerns or being given inadequate care."**

These suggestions, combined with the positive experiences shared, underscore the need for MHS that are not only accessible and comprehensive but also genuinely compassionate and attuned to the unique experiences of young people. "The Good Stuff" sub-theme highlights the importance of therapeutic relationships, personalised and holistic care, safe and inclusive environments, recognition and validation, and accessibility and flexibility in creating positive experiences for adolescents in MHS. These elements are crucial in designing and implementing mental health support systems that effectively meet the needs of young people.

3.7.2 Sub-theme 2: The Bad Stuff

"The Bad Stuff" delves deeply into the troubling aspects of MHS according to young people; focusing on the failure to provide adequate, timely and empathetic support, often exacerbating young people's sense of isolation and distress. Adolescents shared poignant stories of feeling misunderstood or trivialised by professionals, but these are captured in the theme "Feeling Invisible".

Adolescents often highlighted the daunting challenge of managing educational commitments alongside navigating mental health care, revealing a system that struggles to accommodate the complexities of their lives. Harper's experience illustrates this tension vividly. She faced significant bureaucratic hurdles that almost cost her necessary exam accommodations due to a delayed autism diagnosis, stating, **"they almost didn't give me my exam arrangements for having ADHD because they hadn't diagnosed me with autism,"** and further complicating her situation, **"I had the diagnosis done...it was just before I did my exams the whole day before."** This lack of timely support and rigid procedural adherence left her feeling neglected and invalidated at a critical juncture in her educational journey.

Echoing this sentiment, Ryan pointed out the logistical difficulties of balancing intense academic schedules with necessary therapy sessions, especially during crucial periods like the GCSE exams, noting, **"it was also more of the fact of GCSEs were coming up. [...] That's eight hours a month. Times that by 12 is like…a massive amount of hours."** Ryan's account underscores the substantial time commitment required by therapy, which often conflicts with the demanding schedules of school, highlighting a systemic inflexibility that fails to consider the dual pressures faced by adolescents juggling both school and mental health challenges.

Several core issues emerged from young people's experiences with therapists and counsellors, including lack of understanding, empathy and person-centred help. Billy's reflection on his school counsellor, **"She's just really weird...she said that she didn't really like talking about stuff as much…cos…If it doesn't help then why talk about it cos it just makes you feel worse. I don't know if she was onto something with that but…I don't really feel like it helped me at all."** and Rae's frustration being told to, **"Try and talk to them about it and it's like, that doesn't work. But with all of the counsellors that I've seen, it's all basically, oh, try and talk to them. Try and talk to your family. I've tried talking to them. They don't listen."**

Dylan found the pace of his sessions overwhelming, **"cramming so much into one session…it was a lot to process"**, making it seem like a tick-box exercise, **"they started basically just like I said, trying to cram everything in and just just try to get over and done with it as quick**

as they could." These instances indicate a more generalised rather than a patient-centred approach. The lack of child-focused intervention for Lara makes uncomfortable reading and illustrates a rigidity of approach rather than considering young individuals who might benefit from more varied and interactive methods.

> **"when I first went to CAMHS, I was seeing this man, and we basically just used to sit in silence for an hour …and I think it's making sure people feel comfortable to like draw…if it's like this dynamic of two people just sitting here, it feels weird … they should be more pro-active and try different things".** (Lara)

Boredom ensued for some, e.g. Ryan, **"you're sitting there just going I'm tired now I just want to go to sleep…It was just boring, confusing." e**xemplified by his yawning during recollection, Ryan: **"(Yawns) No, definitely not."** Several ruptures occurred for others, like Rae who pretended to forget her appointment.

Lara's frustration with being mislabelled reflected a common sentiment among adolescents who felt pigeonholed by professionals: **"it's just like of all the things they could have brought up, they just say something completely ridiculous...it just didn't make sense"**. This type of interaction can drive adolescents like Lara away from seeking help, as she notes, **"it kind of put me off reaching out to any NHS service for support"**.

Interactions with GPs were frequently perceived as problematic by young people. This might be in some part due to a confusion about their role in mental health as Grace pointed out, **"Lots of kids don't know...I only found out about my doctor this year…Cos sometimes like you've never gone…(laughs)"**, her laughter a defense mechanism against the discomfort of venturing into the unknown. Having a named GP however, was no guarantee of help as teenagers including Harper testified: **"I tried getting in contact with my GP and I can't get an**

answer…It'll be your queue number 48. And then by the time I get through to them, there's no appointments left.”

Teenagers described shortcomings in GP responses and failure act upon adolescents’ disclosures. Kali’s experience, **"He was a nice enough man, he just, he would say things and then just kind of not do anything about it,"** Lara elucidated, **"I went to the GP a couple of months ago and they, like, they told me to do a self-referral to something. And I got back and they were like …you've got such varied mental health problems and you've like seen so many different things that we can't give you any support."** Lara’s mistrust in GPs handling of mental health medication, **“I find it strange that GPs can like prescribe antidepressants and things...a GP isn't specialised in mental health issues,"** was compounded by systemic problems, **"I don't really want to be explaining medication to a GP…it feels very much like I'm going to be on my own about it"** calls for a more integrated and specialised approach to mental health care.

Diagnosis elicited mixed feelings among teenagers. For Harper, who had been imprisoned in her room for hours each day, diagnosis represented validation and a means to communicate her struggles:

> **“All I want is for somebody to agree with me… so I can actually finally sit at peace knowing I've got that thing…then I can say to my friends, I've got this, there is these things you can do to help without having to explain every single thing that's got wrong with me.”** (Harper)

However, Lara’s experience of being misdiagnosed with autism, **“purely because of like, my discomfort with men – being sexually assaulted”** highlights the reductive nature of assessments and potential pitfalls of diagnosis.

Unhelpful interactions fostered a mistrust of healthcare professionals, disillusionment with services and exacerbated mental health struggles. Harper: **"I've got used to it. I've truly gotten used to it. Because even from the first one with CAMHS where they'd shut me off, kept cancelling and cancelling the appointments, saying the doctor was ill, and then closing the case"**. Her resignation reflecting the deep-seated impact of repeated negative experiences with MHS, contributing to a cycle of disengagement and worsening mental health. For Rae, such experiences led to feelings of hopelessness, **"because some of the stuff that was said in the sessions, it just makes me feel like I'm not going to get better. I'm always going to feel this way"** such disillusionment potentially deterring young people from seeking further help.

"The Bad Stuff" illustrates the numerous challenges faced by adolescents navigating UK MHS. From systemic barriers to a lack of empathy and person-centred care, it is clear that urgent reform is imperative. Addressing these issues requires a concerted effort to understand and meet the unique needs of young people, ensuring that mental health support acts as a bridge to recovery rather than a barrier.

Reflexivity Box – Telling the Story

This chapter was one of the hardest to write. I wanted to include far more quotations than my word count would allow; the reason being I wanted to convey as fully as possible these vulnerable young people's experiences in order that services can see just how awful things are. I'd originally chosen thematic analysis because I wanted to be able to present the findings clearly, for dissemination to services, and for ease of translation into action for change. Therefore, I noticed I felt simultaneously saddened that young people face such poor performance of services, whilst simultaneously frustrated with the constraints of the thesis.

Chapter 4

Discussion

This chapter delves into the analysis and interpretation of the study's findings, situating them within the broader context of existing literature to evaluate their significance. This qualitative study sought to explore adolescents' experiences of MHS in the UK through RTA. It identified six themes: Feeling Invisible, The Fight, Open Wounds, Stuck in a Maze, Childhood, and Help, that illuminate the complexities adolescents face as they navigate their mental health during "one of the most fascinating and complex transitions in the lifespan" (Kipke, 1999, p.1). The subsequent sections will discuss these themes in light of empirical evidence and literature on adolescence. The chapter also presents an evaluation of the study's strengths and limitations, followed by a discussion on the implications for practice. This achieves a primary goal of the research: to translate the findings into actionable recommendations for a more empathetic, responsive, and youth-centred MHS. Additionally, the implications for the field of Counselling Psychology are explored, highlighting its critical role in advancing adolescent mental health care.

4.1 Interpretation of Findings

4.1.1 Stuck in a Maze

Adolescents portrayed their encounters with MHS as if navigating a maze, characterised by an onerous journey, fraught with long waiting periods, dead ends and systemic failings. These hurdles often left them feeling bewildered, forsaken and alienated by a system that seemed out of touch with their individual needs, as illustrated by the sub-themes: "Journey," "Waiting," "Dead Ends," and "System Failure". This sense of being trapped in a maze echoes the principle finding

“Living in an alternative reality” from Haynes et al.’s, (2011, p.152) grounded theory study, which explored adolescents’ experiences with psychiatric inpatient care.

Although none of the adolescents in this study had direct experience of inpatient facilities (although two had been recommended to voluntarily admit themselves), their sense of being ensnared in a maze symbolises the accumulation of challenges that have significantly hindered access to support. This metaphor reflects broader systemic issues as evidenced by external data. A 2022 survey by stem4 revealed that 95% of GPs observed a decline in CAMHS for over 6 years, describing them as “critically failing” (stem4, 2022). Furthermore, by the end of December 2023, CAMHS referrals reached an unprecedented peak (507,738) (NHS England, 2023), coinciding with a notable deterioration in young people’s mental health exacerbated by the COVID-19 pandemic. This period saw an increase in social, emotional and behavioural problems, alongside a rise in depression rates among young people (Montero-Marin et al., 2023). These external pressures compound the individual struggles described by the adolescents, highlighting a system overwhelmed and under-resourced. The feeling of living in an "alternative reality" underscores the critical need for mental health care systems to become more responsive and attuned to the lived experiences of young individuals, ensuring they receive timely and appropriate support.

The notion of adolescents’ experiences comprising a cumulative journey, rather than isolated attempts at seeking help, was a recurring theme. Even Mao, the youngest participant at 13, reflected on his therapy as a significant journey, “it's been a while…I feel like I've gone through a journey through therapy”, indicating a tendency among adolescents to evaluate their overall experiences rather than focusing on specific encounters. Despite individual instances of effective support, like Harper's beneficial counselling at age 10, the overarching perception of MHS remained negative due to cumulative service failures. This was echoed in findings by Harper et al. (2014), which pointed to a disruption in the continuity of therapeutic relationships in CAMHS, emphasising a journey peppered with frequent interruptions.

The metaphor of a journey with "stops and starts" used by Rae who imagined herself as a train, traversing the mental health system track, brings to light the sense of having no option but to follow the one-track system. Her "messy" journey showed the impact of the journey. The teenagers confidently described the emotional and physical toll of an often inaccessible and unresponsive system. Experiences such as Harper's deteriorating physical and mental health and numerous hospital visits and Lara's fluctuating mental health and diminished sense of agency, reveal a system that not only fails to support young people adequately but even exacerbates their mental (and sometimes physical) health.

Therefore, adolescents' conceptualisation of their "Journey" comprised not just their interactions with mental health clinicians but reflected their evolving selves amidst these experiences. This is supported by Harper et al.'s (2014) theme "Continuity and Loss of Relationships" which captured the anxiety felt by the young people, as a result of their disrupted care in CAMHS. This aligns with Erikson's theory of psychosocial development, which asserts that identity formation is a critical task of adolescence (Erikson, 1968), although later research asserts that identity formation generally continues into young adulthood for most people (Côté, 2006). (Although more recent theories of identity development have been proposed (e.g., McAdams' (2011) narrative identity), Erikson's remains the dominant theoretical framework (Schwartz et al., 2013). Forming a stable identity relies on committing to important choices in various areas of life. For teenagers who have struggled with their mental health since the onset of puberty, their identity formation has been impacted by their mental health struggles and inadequate support from services. While strong commitments can provide a sense of continuity, meaning and direction are linked with well-being, (Meeus, 2011), poor identity formation is linked to poor psychosocial functioning and different psychiatric disorders. These narratives paint a vivid picture of a journey marked by frustration, despair, and a profound need for a more accessible and responsive mental health care system.

The teenagers described “Waiting” for long periods for help, which exacerbated their feelings of abandonment and limbo. Harper and Billy shared their frustrations with systemic delays and the inappropriateness of the services eventually offered, spotlighting the need for timely, relevant support. Similarly, in Davison et al.’s (2017) theme “Access and Continuity”, nearly half the young people described long wait times for CAMHS appointments and a desire for earlier interventions due to their failing mental health. Lara's dilemma, choosing between unsatisfactory care or facing even longer wait times, illustrates a common predicament for many adolescents, who are often forced to choose between inadequate help or prolonged suffering. Kali's narrative revealed how CAMHS’s practice of making further sessions contingent on risk assessment and topics of discussion, underscored a systemic failure to prioritise patient well-being, leading to both mental and physical health deterioration while waiting for help. The prolonged wait times for assistance are particularly concerning in the context of adolescents’ mental health. Young people often delay seeking help, usually relying on significant adults to recognise their needs and support them. This delay is compounded by the time it takes for adolescents to form an internal realisation that they need help (Hassett & Isbister 2017; Jones et al., 2017).

The adolescents faced formidable obstacles (“Dead Ends”) in their quest for help. These barriers often stemmed from systemic issues such as young people being turned away from overstretched services, the discontinuation of support due to policy changes, or problems with clinicians. Harper's experiences highlighted the distressing reality of young people slipping through the gaps of a system ill-prepared to handle complex cases. While Ryan's metaphorical dead end with his therapist reflected the experiences of older teens in CAMHS, as reported by Harper et al. (2014). These adolescents encountered a series of broken attachments encapsulated in the theme

“Continuity and Loss”, which made them feel as though they had returned to “square one” illustrating the convoluted and often bewildering paths that many young people face in MHS.

The sub-theme “System Failure” captured a catalogue of severe deficiencies, including bureaucratic hurdles, impersonal care, and a pervasive sense of neglect that adolescents experienced in MHS. Harper's long history of neglect and abuse followed by her experiences of being passed from one inadequate service to another without receiving the necessary support, which severely impacted her mental and physical health, is a stark example of this systemic failure. Rae and Lara being assigned male therapists despite their male-based trauma and request for female clinicians, is a clarion call for urgent reform to create a more accessible, responsive, and tailored mental health care system for young people, especially females.

Such comprehensive problems with services were described by unaccompanied refugee adolescents in Majumder et al. (2015). These challenges were partly due to cultural disparities that affected the service providers’ understanding of the teenagers, compounded by, but also exacerbating, the young people’s distrust of health services. Such mistrust is theorised to be a protective mechanism in the wake of trauma and exploitation by others. MHS perceive themselves to be trustworthy, but trust was not cultivated in these young people who described having to recount and relive their trauma experiences repeatedly only to then find interventions ineffective. Services are inaccessible for many young people and the lack of stable, continuous care significantly affected them. Whilst this theme illustrates the obstacles young people face encountered in MHS, it simultaneously underscores their resilience and determination.

Significant sex differences arose in "The Maze." Females, like Lara and Harper, often voiced their battles with systemic invalidation and bias, highlighting a healthcare system that habitually overlooks the complexities of female mental health needs. Conversely, males, like Ryan and Mao, faced similar systemic challenges, but their difficulties came in the form of accessing suitable support and the impact of the system's rigidity on their lives. No such sex differences were identified in the literature, putting the spotlight on an important area for further research. Despite these differences between the sexes, the shared experiences among adolescents reveal a universal challenge, navigating a fragmented unresponsive, and often inaccessible mental health care system.

Across the board, adolescents face lengthy waits, bureaucratic obstacles, and a lack of personalised care, highlighting the widespread nature of these systemic issues. It underscores the need for a systemic overhaul to eliminate bureaucratic obstacles, ensure timely and relevant support, and prioritize a holistic, youth-centric approach to mental health care. By integrating the vivid narratives of adolescents, this analysis highlights the critical need for a mental health care system that is not only accessible and responsive but also attuned to the unique and diverse needs of young people navigating their mental health journey.

4.1.2 The Fight

Adolescents struggled to secure mental health support and expended great effort in doing so. They reported making significant sacrifices to get help and were left feeling a palpable sense of injustice. The toll that young people endured as a result of their experiences battling for mental health help was captured in the sub-theme, "The Losses". These struggles resonate with findings from Harper et al. (2014), in particular the theme “Power Differentials”, who described an 'us-and-them' dynamic in CAMHS, highlighting a power differential where young people felt disempowered, unheard, and blamed by healthcare professionals.

Adolescents conveyed a palpable sense of injustice as they navigated MHS, similar to that felt by the service users in Harper et al. (2014). Lara's exhaustive battle just to be heard within CAMHS showcases the disparity between the needs of vulnerable young people and the actual care received. This sense of fighting a battle is mirrored by Rae's poignant lament, "I've asked for it and asked for it and it's not happened," emphasising repetitive neglect and the mental exhaustion it breeds.

The psychological toll is further illustrated through their losses which were vividly portrayed using elicitation methods. For instance, Rae reflected on her diminishing hope using a black and white photograph to symbolise her deep unhappiness, while Grace likened her dwindling hope to a lamp, an emblem of hope gradually being snuffed out by persistent neglect. Such visual depictions underscore the deep-seated emotional and psychological impacts of these struggles. Adolescents felt a loss of their childhood, a loss of enjoyment of life and the biggest loss, hope or belief. Losses were noticeable for their frequency and their repercussions. For example, Harper's loss of childhood experiences due to parental abuse and neglect, crucial for development, left her with physical and psychological losses, that left untreated proliferated into further losses. Sadly, the losses for some of the teenagers became overwhelming resulting in them giving up altogether.

Young people often faced difficult choices and trade-offs in pursuit of mental health support. One of the most significant "opportunity costs" is education. Ryan's experience of missing substantial school hours for therapy, highlights the harsh reality of having to prioritise health over education, a choice that is detrimental as both are crucial for healthy development. Another common dilemma faced by young people was whether to compromise certain aspects of their lives when medication is presented as the sole solution by MHS, mirroring findings from Buston, (2002). For instance, alongside adjusting to a new foster care environment, Billy struggled with sleep loss due to medication, the only help available for his mental health struggles. Lara too faced difficulties in having her medication reviewed, worried about its long-term impact and potential dependency, yet found little support when considering reducing her dosage. According to Buston's (2002) study, medication was seen as beneficial by adolescent in-patients because it "blunted" or "removed" emotions, a coping mechanism encouraged by staff. Another significant "opportunity cost" for adolescents with eating disorders in this study was the environment of living with other patients who understood and supported them. However, this came at a cost as it included comparisons and competition with fellow inpatients on thinness and adopting "bad habits" and self-harming techniques.

There were differences in how females and males conceptualised and endured their struggle. Girls frequently reported feeling let down by a system that fails to provide gender-sensitive care. For example, Lara's distress at being assigned a male psychologist despite her history of sexual assault and stated preferences, starkly illustrates the significant sacrifices in personal well-being that females often endure in seeking help. This neglect starkly contrasted with the expedited help some males received, potentially reflecting a systemic bias that favours certain demographics over others. The males focused on the opportunity cost of help. For example, Ryan underscored the sacrifice of his education and personal development, reflecting a broader societal expectation for males to prioritise academic and career success, even at the expense of their mental health. Notably, sex differences might be masking expedited help which three of the four males received (Ryan and Billy's a function of their respective adopted and "looked after" status and Mao's mum facilitating private mental health care). Nonetheless, we cannot ignore the evidence that teenage girls feel they must fight for mental health help. This may be down to the fact that services have been designed around the needs of men (Aitken & Noble, 2001) and are therefore potentially discriminatory towards women (Department of Health & Social Care, 2019).

4.1.3 Feeling Invisible

Young people felt a profound sense of being overlooked and misunderstood within MHS. This encompassed feelings of being ignored, dismissed and misunderstood as well as a struggle to communicate effectively. As a result, adolescents often felt that their true mental states were concealed. This cycle of invisibility perpetuated the distress and isolation felt by these young people, emphasising the systemic shortcomings in recognising and addressing the unique needs of young people. This theme splits into two significant sub-themes: "Struggling to Communicate" and "Unseen/Unheard/Misunderstood." Interestingly, findings from Gill et al.'s (2016) in-patient study both align and diverge from this theme. They identified that adolescent in-patients often felt "understood by others" within the inpatient unit, which provided a contrast to their broader sense of invisibility in community settings. Inpatient care facilitated a shared experience and mutual understanding among peers and staff that was less prevalent in outpatient contexts. This difference underscores the varied nature of adolescents' experiences, highlighting the importance of supportive environments where young people feel genuinely understood and validated. The divergence also indicates that while inpatient settings may mitigate feelings of invisibility through close-knit supportive relationships, these feelings persist in more fragmented and less intensive community care settings.

"Struggling to Communicate" explores the barriers adolescents face in articulating their mental health struggles. This sub-theme reveals a cycle of silence fuelled by fear and past rejections, leading teenagers to face what seems a daunting challenge in expressing their needs. In Harper et al. (2014), participants felt they could express themselves in older (16-18) CAMHS, whereas previously they had been treated like children which left them feeling disempowered and unable to challenge professionals, reflecting the Unseen/unheard/misunderstood sub-theme. Also, the young people expressed a preference for the developmentally attuned approach in older children's services where less parental involvement allowed teenagers more freedom to express themselves. Unfortunately, their fears were often exacerbated by previous negative encounters in healthcare systems. For instance, Harper's reluctance to open-up, driven by a history of unmet need, alongside Grace's resignation at being unheard, underscore the despair and isolation adolescents, in particular females, feel in the face of an unresponsive care framework.

"Unseen/Unheard/Misunderstood" delves into the systemic failure to acknowledge and appropriately respond to young people's unique needs. This sub-theme brings to light stories of adolescents like Harper who, despite significant losses and crises, found herself without the necessary bereavement counselling or support. Lara's account of being ignored by the CRISIS Team despite her vulnerability, illustrates that neglect and oversight is pervasive across all services, even those designed to respond to emergency scenarios. The sense that adolescents were not truly recognised by others mirrors findings in the literature. In Buston's (2002) study, the theme "The doctor-patient relationship" examined young people's perceptions of mental health care professionals using various criteria of whether they talk to them, listen to them, understand their illness, believe them, and whether the young person felt able to talk to them. Most interactions were viewed negatively. In Davison et al. (2017), a key theme was "Listening" as all twelve participants emphasised the need to be heard when using MHS, underscoring that their views should be valued and respected in a non-judgemental and empathetic atmosphere.

Refugee adolescents' concerns about the negative impact of the asylum application process on social functioning and ability to focus at school echo the feelings of being "unseen/unheard/misunderstood". The asylum process exacerbates feelings of insecurity and distracts from educational and social integration, further marginalising refugee adolescents. Interestingly, Naylor et al. (2008) found that despite initial resistance, for many young people at risk of offending, the specialist MHS they attended helped them, indicating a shift from feeling invisible to being recognised and supported. This was achieved effected by practitioners demonstrating respect, operating flexibly, and making therapy sessions personally relevant, resonating with both the "struggling to communicate" and "unseen/unheard/misunderstood" sub-themes in this study. This sub-theme is a testament to the adolescents' struggles with being misinterpreted, dismissed, or entirely overlooked by those tasked with their care, emphasising the systemic shortcomings in recognising and addressing the nuanced needs of young individuals.

Experiences of invisibility differed significantly between female and male adolescents when navigating MHS. These sex differences illuminated the varying degrees of feeling unseen, unheard, and misunderstood, further compounding the complexity of addressing adolescents' needs within the mental health framework. Female adolescents frequently recounted feeling misunderstood and not taken seriously, exacerbating their sense of invisibility. Harper and Lara's accounts, which described the neglect and stereotyping they faced, exemplify the systemic shortcomings in recognising the complexity of their mental health needs and providing appropriate care. The narratives highlighted a pattern of females being disproportionately affected by the failure of MHS to see beyond surface-level interpretations or biases. For male adolescents, the feeling of being unseen and unheard was often described in the context of a failure to acknowledge their struggles without explicit communication. The males' experiences suggest a societal expectation for them to articulate their needs overtly, failing which, their struggles remain invisible to the professionals tasked with their care. This reflects a broader cultural norm that may discourage males from expressing vulnerability, further complicating their interactions with MHS and contributing to a different dimension of invisibility where their needs are overlooked due to a lack of outward expression.

Among female adolescents, their struggle to communicate was often exacerbated by feelings of not being taken seriously or being dismissed by healthcare professionals. This revealed a pronounced tendency for females to feel their emotional distress was frequently minimised or misattributed to stereotypes or misdiagnoses. For example, Lara's experiences of not being heard by the CRISIS team and her frustration with the lack of response reveal a systemic failure to appreciate and validate the voices of female adolescents. Instances where females felt their distress was overlooked or misinterpreted were numerous. Instances such as Harper's ignored need for bereavement counselling and Lara's overlooked eating disorder due to stereotypical biases highlight a disturbing trend of invalidation that particularly affects females, emphasising the need for a more nuanced understanding and response to their expressed needs.

Conversely, while male adolescents also experienced difficulties in being heard, their narratives often emphasised a different aspect of invisibility. Males reported a sense of being overlooked in terms of their internal struggles, with a focus on the lack of proactive engagement from mental health professionals to explore deeper underlying issues. This suggests that while females struggle against a backdrop of misinterpretation and dismissal, males face challenges in initiating and deepening discussions about their mental health, pointing to a gendered discrepancy in how invisibility manifests within therapeutic contexts.

4.1.4 Open Wounds

In their experiences with MHS, adolescents described a cycle whereby vulnerability breeds distress, which in turn exacerbates vulnerability, evidence of the deep, lasting impact of negative experiences within the mental health system on young people. The "Vulnerability" sub-theme exposes the fear, isolation, and sense of entrapment young people feel, while "Distress" uncovers the psychological turmoil and breaking points they encounter. the critical need for MHS to address not just the symptoms but the root causes of young people's suffering, fostering an environment of support, empathy, and healing.

Vulnerability is portrayed through adolescents' narratives as a state of being exposed to potential harm within the mental health system. Their vulnerability is multifaceted, including a fear of mental health deterioration, feeling trapped by circumstances, and the overwhelming nature of facing mental health challenges, without adequate support.

Adolescents describe feeling “Caught in a Trap” within an unresponsive and sometimes adversarial system, leaving them feeling dismissed and attacked. For instance, Dylan's narrative highlights the vulnerability specific to adolescents in the system, where he was expected to confide in an unknown therapist due to an administrative oversight. This sense of entrapment is strengthened by systemic shortcomings that fail to provide adequate care or understanding, illustrated by Lara's and Harper's experiences of being minimised or dismissed by healthcare professionals.

Distress sheds light on the psychological turmoil adolescents experience, emphasising the varied ways they articulate their pain and the factors leading to their breaking point. Adolescents articulate a profound sense of abandonment by the mental health system at critical moments, feeling isolated despite their acute need for support “Abandoned and on the Brink”. Lara's and Harper's stories vividly depict this sense of isolation, where the lack of adequate support and systemic indifference to their conditions amplify their distress, leaving them feeling on the brink of crisis.

All the studies reviewed in the systematic literature review shared themes of vulnerability and distress, aligning closely with core aspects of “Open Wounds”. Several studies underscored the feelings of vulnerability that adolescents reported in seeking mental health care e.g. Naylor et al 2008 where initially wary young people were resistant to engaging with MHS. Worries about being labelled and didn’t fully understand the role of the service, increasing their sense of vulnerability. Several studies mirrored the interplay of vulnerability and distress felt by young people in MHS. Boyden et al. (2013) captured the interplay of vulnerability and distress felt by adolescents accessing a learning disability CAMHS service. Already vulnerable, the teenaged participants recollected their distress at their initial meeting with a service professional. Reavey et al.’s (2017) study mirrored the ongoing interplay between vulnerability and distress in their study of in-patient services. In their theme “Behavioural Surveillance as Care Surrogate” young people described the service as a holding place to contain behaviour, rather than a setting for treatment using metaphors such as “a prison”, “zoo” and “Place of horror”, where their underlying distress was not recognised by staff. The absence of information and explanation of their difficulties left the participants feeling frightened not just of the ward, but also for their future and how their in-patient treatment would affect their relationships with family and friends.

The young people reported a culture on the ward of hiding their distress, i.e. feeling they had to suppress "difficult" or "triggering" emotions due to the fear of emotional contagion on the ward. This discouraged them from joining activities and adopting an openness in therapy. Ultimately, the teenagers reported that by finding ways of hiding their distress and using medication to dampen their problems so as 'not to feel anything', their docility was the only means by which to evade re-admission.

There were indications of sex differences in how adolescents experience and express vulnerability and distress, with females more likely to report feeling misunderstood or trivialised and males potentially facing challenges in articulating their mental health struggles. For example, Lara and Harper provided detailed accounts of their struggles, emphasising the lack of understanding and support they encountered. In contrast, the other teenagers, particularly the males, did not articulate their distress explicitly. During the interviews, the females frequently laughed and cried, whereas the males all laughed but did not cry. Ryan brought a picture of an angry emoticon to convey his anger. Sex difference in expressing and processing emotional pain aligns with research showing men tend to inhibit expressing certain emotions and are less likely to self-disclose intimate feelings ("restrictive emotionality") (Jansz, 2000), whereas women express their feelings more often (Kring & Gordon, 1998). Such differences start as early as 4 years old, with girls expressing more sadness and anxiety and displaying emotions more overtly, e.g. smiling, nodding and using hand gestures, the one exception being anger, which men express more (Brody & Hall, 2008). This suggests a need for gender-sensitive approaches within MHS that recognise and address the unique ways in which males and females experience and navigate their mental health.

These insights call for a mental health care system that is not only more responsive and empathetic but also attuned to the individual and collective needs of adolescents, recognising the nuances in their experiences of vulnerability and distress.

4.1.5 Help

Adolescents navigating the UK's MHS landscape revealed a complex interplay between experiences of "Good Help" and "Bad Help." The teenagers' experiences with MHS encapsulated a broad spectrum of interactions, ranging from profoundly supportive to distinctly problematic, articulated through two sub-themes: "Good Help" and "Bad Help". Help was the most dominant theme in the data, but overall, examples of lousy help overwhelmed instances of good.

According to adolescents, positive experiences within MHS are characterised by a constellation of factors, including empathy, understanding, and accessible support that respects young people's unique needs and circumstances. The therapeutic relationship often served as a cornerstone for healing and hope. For example, Ryan emphasised the significant impact of his therapist's comforting presence, which made him feel safe and fostered openness. Despite interactions with multiple clinicians, Lara distinctly remembered only one positive relationship with an empathetic dietician. This underscores the importance of creating supportive environments that acknowledge and validate adolescents' experiences, thereby promoting openness and vulnerability.

Personalised care emerged as another cornerstone of effective mental health support, with Ryan's therapy sessions integrating personal interests, such as football, which enhanced the therapeutic value and made the sessions feel "worthwhile." This approach not only acknowledges the individual's whole life context but also strengthens the therapeutic relationship. This aligns with Hassett & Isbister's (2017) findings, emphasising the importance of engaging vulnerable adolescents in a manner that respects their individual journeys and struggles. This collective insight underscores a fundamental principle: "Good Help" is not merely about the availability of services but about delivering care that is responsive, respectful, and tailored to the unique needs of each adolescent.

Supportive relationships within schools play a vital role, as evidenced by Ryan's reliance on his "school grandma" and “school team” for emotional support. Recognition and validation are recurrent themes in the adolescents' positive experiences, underscoring the transformative power of empathy in the healing process. Fazel et al. (2016) highlighted the value adolescents place on school-based services that reduce stigma and provide a familiar environment for receiving support. The physical accessibility of services was essential to teenagers who often rely on others for lifts to and from services. Grace's account of local walk-in sessions near essential amenities highlights the importance of removing barriers to care and encouraging young people to seek help.

This resonates with findings from Harper et al. (2014) and Fazel et al. (2016), where the importance of accessibility, empathy, and the therapeutic relationship were underscored. Like Ryan's appreciation for a therapist who integrated personal interests into sessions, "Bad Help," on the other hand, delves into the negative aspects of MHS, revealing systemic shortcomings that often exacerbate adolescents' sense of isolation and distress. Adolescents shared stories of feeling misunderstood, trivialised, and invalidated by professionals, pointing to bureaucratic hurdles and a lack of urgent, caring, and even a human response. This echoes findings from Davison et al. (2017) and Boyden et al. (2013), where young people reported feeling overlooked and inadequately supported by MHS. The widespread reporting of negative experiences, such as Harper's frustration with bureaucratic hurdles and a lack of urgent response, overlaps with the "System Failure" sub-theme (under the Maze theme).

The struggle to access services due to systemic barriers was a recurring theme, with adolescents facing challenges such as balancing educational commitments and therapy sessions. This reflects a rigid system that disregards the complexities of young people's lives. Core issues with therapists and counsellors included a lack of understanding, empathy, and personalised help. For instance, Billy's and Rae's frustrations with their counsellors highlight a generalised rather than patient-centred approach, suggesting a need for more child-focused interventions. Moreover, the studies by Naylor et al. (2008) and Majumder et al. (2015) contribute to this discourse by highlighting the systemic barriers and stigmatisation that alienate adolescents seeking help. The collective narratives from these studies, alongside the experiences shared by participants in this research, underscore a critical gap in MHS: the failure to provide a supportive, understanding, and seamless pathway to care for adolescents in distress.

Adolescents interacted with MHS in a diverse range of ways. The narratives reveal a pressing need for MHS that are not only accessible and responsive but also tailored to meet the unique needs of young people. Creating positive experiences in MHS necessitates a holistic approach that incorporates therapeutic relationships, personalised care, supportive environments, recognition, validation, and physical accessibility.

4.1.6 Childhood

By drawing out teenagers' perceptions of their interactions with MHS, a clear interplay arose between their vulnerability and burgeoning autonomy, which influenced their perceptions of support. Their stories highlighted a sense of separateness between the worlds of children and adults (Archard, 2004). The sub-themes: "Being a Child" and "Autonomy vs. Support" reflect the delicate balance between seeking independence and the critical need for understanding and support from MHS. Analysing these narratives revealed the nuanced challenges young people face in navigating their mental health journey, emphasising the importance of a robust care system that recognises and nurtures their emerging autonomy while providing the empathetic support they require.

4.1.6.1 Autonomy vs. Support

This delicate balance between seeking independence and requiring support is a developmental hallmark of adolescence. There was considerable variability in access to supportive networks, and this affected young people's experiences of MHS.

Ryan and Billy's experiences as "looked after" children shed light on the significant impact of a nurturing support network on their mental health journeys. Adolescents like Ryan, benefited from a robust support network, including caring, adoptive parents and his "school team". This aligns with research showing how parents, friends and schoolteachers are key to helping young people acknowledge their need for help and initiating the help-seeking process (Hassett & Isbister, 2017; Jones et al., 2017). In contrast, Billy's recent transition into the care system, midway through secondary school, highlights the challenges of seeking mental health support without an established support network, emphasising his forced reliance on professionals due to his developmental stage and circumstances. Such contrasting experiences of adolescents underscore the importance of a tailored approach in MHS, taking into account each young person's unique social and familial contexts.

A common thread among the adolescents' stories was their reliance on others through community and peer support, and digital platforms in order to navigate their mental health challenges and validate their inadequate or distressing experiences in services. This underscores the value of shared experiences, empathy, and mutual support, suggesting potential avenues for incorporating these communal forums into formal mental health care provision to foster a more compassionate and effective support system. This does not necessarily extend to interventions, as Smart et al. (2023) demonstrated the limitations of digital interventions. However, the lack of a robust feedback system for services, reported by the teenagers, is a crucial area for development.

Adolescents expressed a desire for a supportive care system that acknowledges their growing independence while offering necessary support for their mental health, echoing research by Harper et al. (2014). However, a recurring pattern showed that the autonomy teenagers practised was often not by choice but forced upon them due to the lack of support from services such as teachers, GPs and clinicians. Grace's insight into the need for more guidance from adults in navigating health care and life skills points to a broader issue of missed opportunities for empowering adolescents through collaborative efforts between families and professionals.

In summary, within the context of adolescents' experiences with MHS exists a complex interplay between the need for independence and the indispensable role of supportive networks. Adolescents navigate this continuum, often resorting to self-reliance in the face of inadequate support. Thus, adolescents are both dependants with the "needs of children" who need adult "providers" to protect and support them (Woodhead, 2015) and who simultaneously have lives and relationships which they are active in constructing (Archard, 2004; James & Prout, 2015).

4.1.6.2 Being a Child

Interestingly, adolescents, even older adolescents such as Lara frequently self-identified as children. This often arose because of the lack of help they experienced in services, where their voices were marginalised as if they were children that lacked capacity and self-advocacy. The "them and us" dynamic is akin to that found in Harper et al. (2014) (mentioned above in "The Fight"), where teenagers reported being treated like children by healthcare professionals. Not being listened to and blamed for their mental health problems led to a sense of disempowerment.

Identifying as a child could indicate role confusion, a concept Erikson (1968) identified as normal during adolescence. However, teenagers experiencing mental health issues during puberty may face more significant challenges in forming a stable identity (Klimstra & Denissen, 2017). Setting aside the impact of traumatic childhood experiences, which often lead to developmental problems and maladaptive behaviour (Arvidson et al., 2011), teenagers who encounter unhelpful healthcare professionals may struggle even more to develop a stable personal identity, especially in the absence of positive relationships with friends and family (Walsh et al., 2010). This can result in a vicious cycle where the only stable identity they form is centred around their mental health difficulties. Erikson (1968) described identity as an intrapersonal process of self-definition and an interpersonal process between the individual and significant others. Recent research supports the idea that mental health issues intersect these processes, affecting how teenagers view their inner world and their relationships with others (Lukoševičiūtė-Barauskienė et al., 2023). These adolescents' struggles often involve internal factors like their goals and values, as well as external factors, such as behaving consistently across different contexts and sustaining friendships over time (Côté, 2014; Côté & Levine, 2014).

"Childhood" provides a rich backdrop for understanding the interplay between vulnerability, burgeoning autonomy, and the impact of MHS on adolescents' transition towards adulthood. These insights emphasise the importance of a personalised, empathetic approach in MHS that acknowledges the complex interplay of factors affecting adolescents' mental health and their journey towards adulthood.

4.2 Summary of Findings

Using a participant-led, elicitation methodology, this study explored adolescents' experiences with MHS in the UK. Through semi-structured interviews that utilised personal artefacts such as photographs, objects, and sounds, nine adolescents from diverse geographical locations provided rich, nuanced insights into their interactions with mental health systems. The analysis revealed six main themes, Feeling Invisible, The Fight, Open Wounds, Stuck in a Maze, Childhood, and Help, each with its own sub-themes, illustrating the complex emotional and psychological landscapes navigated by young people seeking mental health support.

Feeling Invisible and The Fight highlight how hard it is for adolescents to feel seen and heard within the healthcare system, echoing research that young people are marginalised in therapeutic settings (e.g., Gill et al., 2016). The theme of Open Wounds underscores the cumulative impact of mental health issues that are inadequately addressed by current service offerings. This supports literature underscoring the need for continuous and accessible care for young people (Green et al., 2012).

The theme Stuck in a Maze reflects the confusion and helplessness that many young people feel when navigating the complex pathways of MHS, resonant with critiques of the service accessibility and integration reported in the broader mental health literature (Banwell et al., 2023). Childhood and Help bring attention to the specific needs and experiences of adolescents, underlining the importance of developmentally appropriate interventions and the need for empowerment and agency within the treatment process—themes that are frequently absent in existing models but highlighted as crucial by frameworks such as THRIVE (Wolpert et al., 2019).

Integrating these findings with the current literature emphasises a clear gap in service provision, particularly in the acknowledgement and integration of adolescent perspectives in designing mental health interventions. This study's findings advocate for a paradigm shift towards more inclusive, participatory research methodologies and therapeutic practices that not only acknowledge but actively incorporate the voices of adolescents. This approach ensures that services are not only accessible but are also effectively tailored to meet the unique developmental needs of this demographic.

The findings of this study are set against a backdrop of consistently low use of mental health resources by adolescents despite the prevalence of mental health issues within this demographic (MacDonald et al., 2018). This is caused by multiple barriers, such as limited mental health literacy, challenges in disclosing mental health concerns, and the variable availability of services.

These barriers are not static but evolve with the developmental stages of adolescents, suggesting that the obstacles faced by younger adolescents may differ markedly from those encountered by older teens (Gulliver et al., 2010; Schnyder et al., 2020).

The significance of these barriers is underscored by this study's findings, which revealed similar challenges in MHS accessibility and effective engagement of young people. The themes identified in this research, such as "Feeling Invisible" and "Stuck in a Maze", echo the difficulties highlighted by previous studies, where adolescents feel overlooked by health systems not adequately equipped to address their specific needs. This study contributes to the existing literature by providing detailed, qualitative insights into how these barriers manifest in the everyday experiences of adolescents seeking mental health care.

By aligning these findings with broader research, it becomes evident that enhancing mental health literacy, improving communication channels for discussing mental health, and ensuring the availability of age-appropriate services are essential steps towards bridging the gap between the need for and utilisation of MHS. Addressing these barriers requires a concerted effort to tailor mental health interventions that are not only accessible but are also perceived as relevant and responsive by adolescents themselves.

By drawing upon a diverse array of elicitation methods, this study contributes to a more nuanced understanding of adolescent mental health challenges, offering actionable insights that can help reshape how services are structured and delivered. These insights can potentially improve the alignment of MHS with the actual needs of young people, fostering more positive long-term outcomes and greater patient satisfaction.

4.3 Strengths and Limitations

This study had 4 aims: (1) to explore adolescents' experiences of MHS in the UK; (2) to identify any themes from adolescent service user narratives; (3) to identify what works well and what does not in MHS for adolescents and highlight any areas of service provision that should be changed to improve to adolescents' mental health; (4) to explore what types of service are particularly suited to adolescents and why and how they might be developed. The following sections will discuss and evaluate to what extent the study met these aims.

4.3.1 Strengths

Taking a participant-led approach and being mindful of power differentials allowed me to intervene where imbalance was recognised. However, as some of these were unseen or not fully addressed, power differentials remained (Gallacher, 2008; Lukes, 2021). This research was conducted with teenagers themselves, rather than parents, carers, or healthcare professionals, so that their voices were clear and in line with the values of Counselling Psychology.

Consideration was given to the methodological process to allow participants increased choice and control. There was the opportunity to pick interviewing online (n=5) or in person (n=4), and interview location for in-person interviews (3rd sector organisations (n=2), home (n=2)). Two participants requested a friend be present to support them. In both instances, friends wore headphones and played games. Although having options is generally preferred, exercising choice can be stressful (Schwartz, 2005). To minimise choice-related stress, I facilitated discussions about options with the teenagers, allowed ample time for decision-making and assured them that we could make joint decisions if necessary.

A key element of participatory research is helping to redress power imbalances (Karnieli-Miller et al., 2009). Elicitation techniques give participants more control, thus reducing power differences in researcher/participant and adult/child interactions (McLeod, 2007; Packard, 2008). Choice for young people is essential, if it pertains to their values, interests, and goals (Assor et al., 2002). Therefore, participants were allowed to choose any selection of elicitation tools from objects, sounds or photos (I suggested choosing about 3). I have not found any research that has offered participants a choice, nor could I find any research or guidance suggesting its inadvisability.

Another benefit of elicitation methods is that they give the participant time to engage with the research and to explore their own experiences. When I read some interview questions posed to young people in the literature, I reflected that if I were faced with such questions, even as an adult, I would struggle to give an answer that truly reflected my lived experience. Whereas, having a week or two (another choice given to the adolescents) to think of things to bring to an interview, helped them engage more fully with their experiences. Based on the results of this research, elicitation may have allowed young people to moderate what and how much was shared with the researcher. Overall, the feedback was that the elicitation method helped young people describe their experiences because, for many, like Kali, "words are difficult”.

The participants had some control over the topics discussed in the interviews as photo-elicitation allowed them to choose what was introduced in the interview. Nonetheless, the researcher retained control over what was asked, although participants were shown the SHOWeD questions in the preamble to the interview to demonstrate the lack of interrogation, following pilot study feedback. The SHOWeD questions were repeated for each photo, image, video or object, leading to the interview having a cyclical nature, returning to the beginning of the interview guide for each elicitation tool, with some unstructured exploration based on what was said. I would begin by asking something along the lines of “What do you see/hear/feel here" (depending on the item brought)? This allowed interviewees to choose the direction of discourse. I would take their lead, asking occasional questions, while keeping to the conversation they had initiated. Comments afterwards suggested that interviews were experienced positively, that familiarity with the questions was less threatening, and several reported that it had been a good opportunity, that no one had been bothered to listen before.

To ensure participants feel heard, research outcomes must be communicated back to them (McLeod, 2007). I contacted all participants to share the resultant themes and solicited their feedback. While some participants responded, none expressed any comments or concerns about the results. Additionally, the teenagers were informed of their randomly allocated pseudonyms and given the opportunity to request changes, which one participant did. Overall, although the method was participatory in spirit, the lack of adolescent involvement in the analysis and write-up highlights a power imbalance (Karnieli-Miller et al., 2009).

Weighing the impact of providing feedback on research results to young people requires consideration of a protectionist approach, which limits the participation of young people to shield them from potential harm and burden (Pinkney, 2011). Although some participants became upset during the interviews and all discussed personal content that could potentially distress them, ongoing distress was not reported. Those few who were distressed during the interview were offered the option to take a break or stop entirely, with reassurances that their well-being was paramount and that it was important to prioritise their care. One participant chose to pause the interview but resumed after a short break. Notably, all distressed participants were females who tended to minimise their discomfort; therefore, I made a concerted effort to ensure their distress was recognised and understood, and emphasise that their well-being was more important than the research.

4.3.2 Limitations

The sample size, as is common in critiques of qualitative research, raises questions about the generalisability of the findings. However, as Margaret Myers (2000) notes, "while qualitative studies are not generalisable in the traditional sense of the word, nor do they claim to be, they possess other redeeming qualities that make them highly valuable." (p.3). I believe that while generalisation to other adolescents who access MHS in this country might be limited, the findings of this study are significant in their own right (Adelman et al., 1980).

Data saturation is often regarded as "the flagship of validity for qualitative research", fulfilling the ontological and epistemological criteria essential to this approach (Constantinou et al., 2017, p. 585). However, Braun and Clarke (2021) argue that the relevance and quality of a theme in relation to the research question are crucial, overshadowing the mere recurrence of themes. They emphasise the importance of asking: "Does it tell a compelling, coherent and useful story in relation to the research question? Does it offer useful insights that speak to the topic in relation to context and sample?" (Braun & Clarke, 2021, p. 207). In this study, I sensed data saturation, undoubtedly assisted by the elicitation techniques that allowed adolescents to share their experiences thoroughly. This ensured that the identified themes were robust and reflective of the participants' experiences, thus enhancing the study's validity. By reaching a point where little or no new information emerged, the study confirmed that the collected data comprehensively covered the phenomena under investigation, ensuring the themes were both relevant and insightful in addressing the research questions.

The sample included a good representation of sexes (5 females, 4 males), diagnoses, and spread of ages. Participants were recruited from three geographically distinct locations in the UK: East Midlands, East Anglia, and Southeast, as well as three different communities: large city-urban, small town-urban/suburban, and rural. However, the sample primarily consisting of White-British teenagers, lacked diversity (although some demographic data was unknown). It included one looked-after child and another who was previously looked-after and then adopted, which influenced their accessibility to services, as they are prioritised in services.

All participants were volunteers. To mitigate social desirability bias, I engaged with youth organisations, spoke to staff, and became familiar with and known by the young people, ensuring I was perceived as more than just a researcher.

Overall, the potential of participant-led research to empower is constrained by the limits of the researcher's conscious considerations. For research to fully empower, there must be ongoing supervision and reflection throughout the process, with each step and action deeply considered and informed by previous experiences with young people. I discuss how I addressed these concerns in the Methodology Chapter.

4.4 Future Research

The scarcity of research exploring young people's experiences of MHS, combined with the broad findings of this small-scale study, highlights a pressing need for further investigation in this area. Future research should involve more diverse samples and extend across different points of mental health care pathways for adolescents to influence social change and action on a larger scale. Although sex differences were apparent, a more rigorous exploration of these differences would be insightful. Integrating qualitative and quantitative data through triangulation could test the validity of these findings and deepen our understanding of adolescents' experiences within the healthcare system.

The CASP analysis of the systematic review literature revealed deficiencies in the rigour of recruitment strategies, often defended as purposive sampling aimed at achieving homogeneity, a pre-requisite for IPA studies. However, as Smith and Osborn (2008) caution, "The logic is like that employed by the social anthropologist conducting ethnographic research in one particular community. The anthropologist then reports in detail about that culture but does not claim to be able to say something about *all* cultures." (p.56).

This study highlights the benefits of community-based recruitment, offering a comprehensive view of young people's service provision across various regions. Clearly, consistent community mental health support post-discharge is critical, aligning with findings from Gill et al. (2016). This necessity is supported by Green et al. (2012), who linked follow-up services to positive long-term outcomes. Therefore, service-led research, serving as an essential feedback mechanism, should involve users who have transitioned to other local services post-discharge, helping to build a comprehensive picture of community resources.

Contrary to adult-centric beliefs that young people need to be protected from engaging in research, the teenagers in this study showed high levels of reflexivity, in line with Gill et al. (2016). Allowing young people to express their opinions gives them a meaningful and active role in shaping their treatment plans (e.g., Biering, 2010; Every Child Matters, DfES, 2004). This approach not only acknowledges their rights but also supports their developmental need for independence and autonomy. While this study only heard outpatient experiences, it would be advantageous for both inpatient units and outpatient services to promote young people's self-reflection and their perception of themselves as active participants in the therapeutic process (Hepper et al., 2005).

Elicitation techniques are underutilised yet potent tools in psychological research, particularly in studies involving children and adolescents. This study took a novel approach, by offering participants a choice in elicitation methods therefore gaining deeper insights into the diverse aspects of adolescents' lives, whilst respecting their right to choose. Extending these methods to other populations could help uncover perspectives and needs that are currently underrepresented.

Beyond elicitation, other significant ways exist to empower CYP within the research framework. Offering interviews alongside focus groups where group discussion and interpretive feedback could be sought would potentially allow young people greater control over the discourse. This approach not only aligns with their developmental need for autonomy but also enriches the research data, and fosters their sense of validation of their experiences.

Finally, by broadening the use of elicitation techniques and adopting more participant-driven research methods, we can transform how adolescent mental health research is conducted. Ensuring that research is guided by the participants themselves will undoubtedly yield more nuanced insights and more effective mental health interventions.

4.5 Implications for Practice and the Role of Counselling Psychology

This study revealed significant implications for clinical practice, highlighting the vital role Counselling Psychologists can play in advancing MHS for adolescents. These recommendations emphasise the need for systemic and practice-based changes, drawing on specific studies and suggestions from the adolescents for support.

4.5.1 Accessibility and MHS Settings

Challenges in accessing services are particularly notable for young people in rural and suburban areas who rely on limited public transportation, underlining the need for strategically placed MHS. Counselling Psychologists should advocate for and actively participate in service planning to ensure services are accessible to this demographic. Ryan suggested that services should be available in different locations, including home visits, and that by creating dedicated spaces, such as specialised wards, young people would be encouraged to open up.

Additionally, Ryan suggested implementing annual mental health check-ups for adolescents, similar to physical health check-ups. This proactive approach could help identify mental health issues early and provide timely interventions, ensuring that young people receive the support they need before their problems escalate. This recommendation highlights the importance of integrating mental health assessments into routine healthcare, making MHS more accessible and reducing the stigma associated with seeking help.

4.5.2 School-based Services

Aligning with the findings from Fazel et al. (2016), adolescents preferred school-based MHS due to their safety, familiarity, and convenience. Reflecting the THRIVE Framework's successful implementation of Mental Health Support Teams in schools across England since January 2020, this integration recognises schools not only as educational institutions but as vital community hubs for delivering mental health support. Given that school attendance is mandatory, and schools are present in rural and urban areas, making services accessible through schools not only democratises access but also aligns with THRIVE's emphasis on community-based support, enhancing the coordination and integration of care to address CYP's educational, emotional and behavioural needs (Fazel et al., 2014). Counselling Psychologists can play a pivotal role in supporting this integration by offering services directly, delivering psychoeducation, and implementing early intervention strategies to support young people's mental health effectively.

4.5.3 Digital Technology and Mental Health

Young people more frequently turn to online resources for mental health information and support (Lal et al., 2018). The COVID-19 pandemic further accentuated this trend by restricting access to in-person services, making online platforms, including social media, pivotal for mental health support. Social media not only offers a forum for sharing information but can also provide a level of anonymity that is appealing, particularly in reducing stigma around mental health issues (Valentine et al., 2019) and allowing for more open discussions. This digital shift suggests a need for Counselling Psychologists to engage with and leverage these platforms to enhance accessibility and connect with adolescents in their preferred spaces.

4.5.4 Service-Wide Understanding and Training

Echoing the findings of Harper et al. (2014), adolescents reported facing challenges with clinicians when dealing with issues such as eating disorders and self-harm. The perceived competency and training of these clinicians significantly influence therapeutic outcomes (Buston, 2002; Cooper et al., 2000; Thom & Campbell, 1997). Counselling Psychologists can play a crucial role in boosting service-wide understanding of clinicians' roles and specialties, facilitating team supervision as well as the triage process. Moreover, Counselling Psychologists can help clinicians develop a more holistic approach to working with young people. This is vital, as the findings from this research underscore the profound impact understanding the teenager's world has on the therapeutic process.

4.5.5 Therapeutic Relationship

The study findings emphasise the importance of the therapeutic relationship, for young people, with all clinicians. This aligns with previous research (Day et al., 2006, 2011) and its importance in the recovery process (e.g., Green, 2006; Harper, 2014). Underpinned by humanistic values, Counselling Psychology prioritises the therapeutic relationship (Strawbridge & Woolfe, 2010) and is thus well-positioned to promote it in team settings through supervision, dissemination, policy development, service structuring and leadership roles. Emphasising the link between the initial session with a client and engagement, Bor et al.'s (2016) Guide for Counselling & Psychotherapy Trainees sets out five stages for building a solid therapeutic alliance: (i) Preparation – including initial contact, consideration of practical factors, e.g., location and hypothesising about the client's issues; (ii) Meeting – including asking questions that facilitate dialogue and acceptance and validation to establish rapport and building the therapeutic relationship; (iii) Assessment – includes information sharing, defining and exploring the problem, and benefit of therapy; (iv) Session Ending – involves session planning, session reflections, formulation; (v) Post-Session – comprises reflective notes, hypothesis or formulation and preparation for the next session. This stage helps ensure continuity and effective planning for future sessions.

These stages provide a structured approach to an initial therapy session, ensuring that important aspects are addressed and that both therapist and client clearly understand the therapeutic process. However, this framework is adaptable for various healthcare professionals across different services to ensure comprehensive engagement with clients. An abridged version could be adopted for shorter appointments, maintaining core elements while fitting into limited time frames.

The teenagers made practical suggestions for sessions. They all talked about the importance of healthcare clinicians making an effort to speak to them as individuals, talking about their current life beyond their distress and their interests, rather than just focusing on their problems. This is endorsed by the THRIVE Framework's needs-led approach, which emphasises services be tailored to the specific needs of individuals rather than being driven by diagnosis or severity. Dylan suggested therapists and counsellors should be careful not to cram too much into one session and to check in at the end of each appointment to encourage honest feedback and assess their engagement level. Counselling Psychologists can also ensure smooth transitions for young people within and between services to reduce potential mistrust and improve therapeutic outcomes, particularly during therapeutic endings, which pose significant challenges for adolescents (Davison et al., 2017; Harper et al., 2014).

4.5.6 Person-Centred Care (PCC)

PCC must be at the core of any approach, supporting informed decisions and respecting people's preferences, abilities, lifestyles, and goals (Harding et al., 2015). The THRIVE model empowers children and families by actively involving them in managing their mental health, which Counselling Psychologists can facilitate. However, professionals often lack confidence in working collaboratively with service users (Abrines-Jaume et al., 2014; Bee et al., 2015). Counselling Psychologists are ideally positioned to facilitate training and opportunities for healthcare staff to enhance their skills within a PCC framework. Additionally, as CYPMHS often operate in silos, promoting shared PCC practices across services, as advocated by THRIVE, can help prevent communication breakdowns and disagreements regarding treatment provision (Bee et al., 2015).

4.5.7 Information Provision and Advocacy

Adolescents showed a lack of knowledge about MHS, including many not knowing the role of the clinicians they saw. Information should be jargon-free, developed jointly with service users to tackle power imbalances, and provided in a positive therapeutic relationship. Counselling Psychologists can play a vital role in facilitating the development and dissemination of tailored information, leveraging their expertise to ensure that service delivery adheres to a needs-led model that supports adolescents' empowerment and active participation.

4.5.8 Gender-Sensitive Practices

Implementing gender-sensitive practices to address the unique needs of male, female, and non-binary adolescents ensures inclusivity and equity in service delivery. Counselling Psychologists should understand and address the unique ways in which adolescents experience and express distress, enhancing the therapeutic relationship through selective self-disclosure (Chang & Berk, 2009) and discussions about the client's background.

4.5.9 Engagement and Social Justice

Engaging adolescents in MHS requires a nuanced, individualised approach that builds on a foundation of trust and respect. A strong TA, alongside culturally responsive and accessible services, can significantly improve engagement outcomes. Counselling Psychologists should also advocate for systemic changes that address barriers to care, emphasising policy reforms that prioritise MHS for adolescents and tackle systemic inequities. Counselling Psychologists are advocates for social justice (Fassinger & Morrow, 2013), yet are sometimes hesitant to promote social change and action (Ivey & Collins, 2003). My hope is that these young individuals' voices will ring clearly and that the findings will inspire readers, regardless of role, to advocate for the needs of young people.

In summary, Counselling Psychologists are positioned to significantly enhance MHS for adolescents by adopting a multifaceted approach that considers young people's diverse needs and experiences. Integrating findings from this research with those from other studies can drive forward a more empathetic, responsive, and youth-centred paradigm in mental health care.

4.6 Conclusion

The study presents an in-depth insight into how adolescents experience MHS in the UK. The findings from this project have added to the research base by advancing our understanding of how to tailor the research process to capture the voices of young people better, whilst also showing that we still have a long way to go to address power differentials. The findings have highlighted implications for practice, and I hope they will be of interest to anyone involved in supporting young people's mental health, particularly Counselling Psychologists. My overall aim was for adolescents' voices to be heard throughout this project and potentially inspire further research in this area.

References

Abrines-Jaume, N., Midgley, N., Hopkins, K., Hoffman, J., Martin, K., Law, D., & Wolpert, M. (2014). A qualitative analysis of implementing shared decision making in Child and Adolescent Mental Health Services in the United Kingdom: Stages and facilitators. *Clinical Child Psychology and Psychiatry*, *21*(1), 19–31. https://doi.org/10.1177/1359104514547596

Adelman, C., Jenkins, D., and Kemmis, S. (1980). Rethinking Case Study: Notes from the Second Cambridge Conference. In H. Simons (ed.) *Towards a Science of the Singular.* (pp. 45-61) Centre for Applied Research in Education, University of East Anglia.

Aitken, G. & Noble, K. (2001). Violence & violation: Women & secure environments. *Feminist Review, 68*, 68–88.

Allett, N. (2010). *Sounding Out: Using music elicitation in qualitative research* [Working Paper]. Realities / Morgan Centre. http://www.socialsciences.manchester.ac.uk/morgancentre/realities/wps/

Alves, P., Miranda, L., & Morais, C. (2017). The Influence of Virtual Learning Environments in Students' Performance. *Universal Journal of Educational Research*, *5*(3), 517–527. https://doi.org/10.13189/ujer.2017.050325

Archard, D. (2004). Children: Rights and Childhood. 2nd ed. London / New York, NY: Routledge

Ardèvol-Abreu, A. (2015). Framing theory in communication research. Origins, development and current situation in Spain. *Revista Latina de Comunicacion Social*, *70*, 423–450. https://doi.org/10.4185/RLCS-2015-1053

Arvidson, J., Kinniburgh, K., Howard, K., Spinazzola, J., Strothers, H., Evans, M., Andres, B., Cohen, C., & Blaustein, M. E. (2011). Treatment of Complex Trauma in Young Children: Developmental and Cultural Considerations in Application of the ARC

Intervention Model. *Journal of Child & Adolescent Trauma*, *4*(1), 34–51. https://doi.org/10.1080/19361521.2011.545046

Assor, A., Kaplan, H., & Roth, G. (2002). Choice Is Good, but Relevance Is Excellent Autonomy Enhancing and Suppressing Teaching Behaviors Predicting Students' Engagement in Schoolwork. *British Journal of Educational Psychology, 27*, 261-278. -

Attride-Stirling, J. (2002). Development of methods to capture users' views of Child & Adolescent Mental Health Services in clinical governance reviews. Commission for Health Improvement

Austin, Z., & Sutton, J. (2014). Qualitative Research: Getting Started. *The Canadian Journal of Hospital Pharmacy*, *67*(6), 436–440. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4275140/

Balen, R., Blyth, E., Calabretto, H., Fraser, C., Horrocks, C., & Manby, M. (2006). Involving Children in Health and Social Research: 'Human becomings' or 'active beings'? *Childhood*, *13*(1), 29–48. https://doi.org/10.1177/0907568206059962

Bandura, A. (1964). The stormy decade: Fact or fiction? *Psychology in the Schools, 1*(3), 224–231. https://doi.org/10.1002/1520-6807(196407)1:3<224::AID-PITS2310010303>3.0.CO;2-I

Banks, M. 2001. Visual Methods in Social Research. Thousand Oaks, CA: Sage.

Banwell, E., Humphrey, N., & Qualter, P. (2023). Reformed child and adolescent mental health services in a devolved healthcare system: A mixed-methods case study of an implementation site. *Frontiers in Health Services*, *3*. https://www.frontiersin.org/articles/10.3389/frhs.2023.1112544

Barker K. K. (2008). Electronic support groups, patient-consumers, and medicalization: The case of contested illness. *Journal of Health and Social Behavior*, 49, 20–36. doi: 10.1177/002214650804900103

Barton, K. C. (2015). Elicitation Techniques: Getting People to Talk About Ideas They Don't Usually Talk About. *Theory & Research in Social Education*, *43*(2), 179–205. https://doi.org/10.1080/00933104.2015.1034392

Bearman, M. (2019). Focus on Methodology: Eliciting rich data: A practical approach to writing semi-structured interview schedules. *Focus on Health Professional Education: A Multi-Professional Journal*, *20*(3), Article 3. https://doi.org/10.11157/fohpe.v20i3.387

Bee, P., Price, O., Baker, J., & Lovell, K. (2015). Systematic synthesis of barriers and facilitators to service user-led care planning. *The British journal of psychiatry : the journal of mental science*, *207*(2), 104–114. https://doi.org/10.1192/bjp.bp.114.152447

Berg, R., Munthe-Kaas, H., Baiju, N., Muller, A., & Brurberg, A. (2019). *The accuracy of using open-ended questions in structured conversations with children: A systematic review*. Norwegian Institute of Public Health. https://www.fhi.no/globalassets/dokumenterfiler/rapporter/2019/the-accuracy-of-using-open-ended-questions-in-structured-conversations-with-children-rapport-2019.pdf

Bhaskar, R. (1975). *A Realist Theory of Science*. Routledge.

Bhaskar, R. (1998b) 'Philosophy and scientific realism', in Archer, M.S. (ed.) *Critical Realism: Essential Readings*: Routledge, pp. 16-47.

Bhaskar, R. (2014). Foreword. In P. K. Edwards, J. O'Mahoney, & S. Vincent (Eds.), Studying organizations using critical realism: A practical guide (pp. v – xv) Oxford, UK: Oxford University Press.

Biering, P. (2010). Child and adolescent experience of and satisfaction with psychiatric care: a critical review of the research literature. *Journal Of Psychiatric And Mental Health Nursing*, *17*(1), 65-72. https://doi.org/10.1111/j.1365-2850.2009.01505.x

Bor, R., Chaudry, S. & Miller, R. (2017). The first session with a new client: five stages. In: Bor, R. & Watts, M. (Eds.), *The Trainee Handbook: A Guide for Counselling & Psychotherapy Trainees.* 269-294. Sage Publications Limited.

Boyden, P., Muniz, M., & Laxton-Kane, M. (2013). Listening to the views of children with learning disabilities: An evaluation of a learning disability CAMHS service. *Journal of Intellectual Disabilities*, *17*(1), 51–63. https://doi.org/10.1177/1744629512469923

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Braun, V., & Clarke, V. (2012). Thematic analysis. In H. Cooper, P. M. Camic, D. L. Long, A. T. Panter, D. Rindskopf, & K. J. Sher (Eds.), *APA handbook of research methods in psychology, Vol. 2. Research designs: Quantitative, qualitative, neuropsychological, and biological* (pp. 57–71). American Psychological Association. https://doi.org/10.1037/13620-004

Braun, V., & Clarke, V. (2013). *Successful Qualitative Research: A Practical Guide for Beginners.* India: SAGE Publications.

Braun, V., & Clarke, V. (2014). What Can "Thematic Analysis" Offer Health and Wellbeing Researchers? *International Journal of Qualitative Studies on Health and Well-Being, 9*, Article No. 26152. https://doi.org/10.3402/qhw.v9.26152

Braun, V., & Clarke, V. (2019) Reflecting on reflexive thematic analysis. *Qualitative Research in Sport, Exercise and Health, 11*:4, 589-597, DOI: 10.1080/2159676X.2019.1628806

Braun, V., Clarke, V., Hayfield, N., & Terry, G. (2019). Answers to frequently asked questions about thematic analysis (2019). Retrieved from https://cdn.auckland.ac.nz/assets/psych/about/our-research/documents/Answers%20to%20frequently%20asked%20questions%20about%20thematic%20analysis%20April%202019.pdf

Braun, V., & Clarke, V. (2021). One size fits all? What counts as quality practice in (reflexive) thematic analysis? *Qualitative Research in Psychology*, *18*(3), 328–352. https://doi.org/10.1080/14780887.2020.1769238

Brawner, B.M., Volpe, E. M., Stewart, J.M., & Gomes, M. M. (2013). Attitudes and beliefs toward biobehavioural research participation: Voices and concerns of urban adolescent females receiving outpatient mental health treatment. *Annals of Human Biology.* 2013;40(6):485–495. doi: 10.3109/03014460.2013.806590.

Briggs S. (2008). *Working with adolescents and young adults: A contemporary psychodynamic approach* (2nd ed.). Palgrave Macmillan.

Brody, L. R., & Hall, J. A. (2008). Gender and emotion in context. In M. Lewis, J. M. Haviland-Jones, & L. F. Barrett (Eds.), *Handbook of emotions., 3rd ed.* (2008-07784-024; pp. 395–408). The Guilford Press.

Brown, A., Ford, T., Deighton, J., & Wolpert, M. (2014). Satisfaction in Child and Adolescent Mental Health Services: Translating Users' Feedback into Measurement. *Administration And Policy In Mental Health And Mental Health Services Research*, *41*(4), 434-446. doi: 10.1007/s10488-012-0433-9

Bruzzese, J. M., & Fisher, C. B. (2003). Assessing and enhancing the research consent capacity of children and youth. *Applied Developmental Science*, *7*(1), 13-26

Burke, T. M., Abramovitch, R., & Zlotkin, S. (2005) Children's understanding of the risks and benefits associated with research. *J Med Ethics,* 31(12):715–720. doi: 10.1136/jme.2003.003228.

Buston, K. (2002). Adolescents with mental health problems: What do they say about health services? *Journal of Adolescence*, *25*(2), 231–242. https://doi.org/10.1006/jado.2002.0463

Campbell, K., Orr, E., Durepos, P., Nguyen, L., Li, L., Whitmore, C., Gehrke, P., Graham, L., & Jack, S. (2021). Reflexive Thematic Analysis for Applied Qualitative Health Research. *The Qualitative Report*. https://doi.org/10.46743/2160-3715/2021.5010

Cargo, M., & Mercer, S. L. (2008). The Value and Challenges of Participatory Research: Strengthening Its Practice. *Annual Review of Public Health*, *29*(1), 325–350. https://doi.org/10.1146/annurev.publhealth.29.091307.083824

Caspi, A., Houts, R. M., Ambler, A., Danese, A., Elliott, M. L., Hariri, A., Harrington, H., Hogan, S., Poulton, R., Ramrakha, S., Rasmussen, L. J. H., Reuben, A., Richmond-Rakerd, L., Sugden, K., Wertz, J., Williams, B. S., & Moffitt, T. E. (2020). Longitudinal Assessment of Mental Health Disorders and Comorbidities Across 4 Decades Among Participants in the Dunedin Birth Cohort Study. *JAMA Network Open*, *3*(4), e203221. https://doi.org/10.1001/jamanetworkopen.2020.3221

Cavet, J., & Sloper, P. (2004). The participation of children and young people in decisions about UK service development. *Child: Care, Health and Development*, *30*(6), 613–621. https://doi.org/10.1111/j.1365-2214.2004.00470.x

Chang, D. F., & Berk, A. (2009). Making cross-racial therapy work: A phenomenological study of clients' experiences of cross-racial therapy. *Journal of Counseling Psychology*, *56*(4), 521–536. https://doi.org/10.1037/a0016905

Cicchetti, D., & Schneider-Rosen, K. (1986). An organizational approach to childhood depression. In M. Rutter, C. Izard, & P. Read (Eds.), *Depression in young people, clinical and developmental perspectives* (pp. 71–134). Guilford.

Clarke, V., & Braun, V. (2018). Using thematic analysis in counselling and psychotherapy research: A critical reflection. *Counselling & Psychotherapy Research, 18*(2), 107–110. https://doi.org/10.1002/capr.12165

Cleland, J. A. (2017). The qualitative orientation in medical education research. *Korean Journal of Medical Education*, *29*(2), 61–71. https://doi.org/10.3946/kjme.2017.53

Cleland, A., & Sutherland, E. (Eds.). (2001). *Children's rights in Scotland* (2nd ed). W. Green/Sweet & Maxwell.

Cohn, J. M., Ginsburg, K. R., Kassam-Adams N., Fein, J. A. (2005). Adolescent decisional autonomy regarding participation in an emergency department youth violence interview. *American Journal of Bioethics.* 5(5):70–74. doi: 10.1080/15265160500246319.

Coleman, J. C. (1974). Relationships in adolescence. London: Routledge & Kegan Paul.

Coleman, J. C. (2011). *The nature of adolescence* (4th ed). Routledge.

Collier, J. & Collier, M. (1986) *Visual anthropology Photography as a research method. University of New Mexico Press, Albuquerque.*

Colton, A., & Pistrang, N. (2004). *Adolescents' experiences of inpatient treatment for anorexia nervosa*. European Eating Disorders Review. https://doi.org/10.1002/erv.587

Constantinou, C. S., Georgiou, M., & Perdikogianni, M. (2017). A comparative method for themes saturation (CoMeTS) in qualitative interviews. *Qualitative research*, *17*(5), 571-588.

Cooper, H., Lindsay, J. J., & Nye, B. (2000). Homework in the Home: How Student, Family, and Parenting-Style Differences Relate to the Homework Process. *Contemporary Educational Psychology*, *25*(4), 464–487. https://doi.org/10.1006/ceps.1999.1036

Corrie, S., & Callahan, M. M. (2000). A review of the scientist-practitioner model: Reflections on its potential contribution to counselling psychology within the context of current health care trends. *The British Journal of Medical Psychology*, *73 (Pt 3)*, 413–427. https://doi.org/10.1348/000711200160507

Côté, J. E. (2006). Emerging Adulthood as an Institutionalized Moratorium: Risks and Benefits to Identity Formation. In J. J. Arnett & J. L. Tanner (Eds.), *Emerging adults in America: Coming of age in the 21st century* (pp. 85–116). American Psychological Association. https://doi.org/10.1037/11381-004

Côté, J. E. (2014). The Dangerous Myth of Emerging Adulthood: An Evidence-Based Critique of a Flawed Developmental Theory. *Applied Developmental Science*, *18*(4), 177–188. https://doi.org/10.1080/10888691.2014.954451

Cote, J.E., & Levine, C.G. (2002). Identity, Formation, Agency, and Culture: A Social Psychological Synthesis (1st ed.). Psychology Press. https://doi.org/10.4324/9781410612199

Critical Appraisal Skills Programme. CASP qualitative checklist, https://casp-uk.net/wp-content/uploads/2018/01/CASP-Qualitative-Checklist-2018.pdf (accessed 14 February 2024)

Croghan, R., Griffin, C., Hunter, J., and Phoenix, A., (2008), 'Young people's constructions of self: notes on the use and analysis of the photo-elicitation methods', *International Journal of Social Research Methodology*, 11 (4): 345–356.

Cromby, J. (2012). Beyond belief. Journal of Health Psychology, 17(7), 943–957. https://doi.org/10.1177/1359105312448866

Crotty, M. (1998). *The Foundations of Social Research: Meaning and Perspective in the Research Process*. London: SAGE Publications Inc.

Cuthbertson, L. M., Robb, Y. A., & Blair, S. (2020). Theory and application of research principles and philosophical underpinning for a study utilising interpretative phenomenological analysis. *Radiography (London, England: 1995)*, *26*(2), e94–e102. https://doi.org/10.1016/j.radi.2019.11.092

Davison, J., Zamperoni, V., & Stain, H. J. (2017). Vulnerable young people's experiences of child and adolescent mental health services. *Mental Health Review Journal.* https://doi.org/10.1108/MHRJ-09-2016-0016

Day, C., Carey, M., & Surgenor, T. (2006). Children's Key Concerns: Piloting a Qualitative Approach to Understanding Their Experience of Mental Health Care. *Clinical Child Psychology and Psychiatry*, *11*(1), 139–155. https://doi.org/10.1177/1359104506056322

Day, C., Michelson, D., & Hassan, I. (2011). Child and adolescent service experience (ChASE): Measuring service quality and therapeutic process. *The British Journal of Clinical Psychology / the British Psychological Society*, *50*, 452–464. https://researchonline.lshtm.ac.uk/2697271/

De Choudhury, M., & De, S. (2014). Mental Health Discourse on reddit: Self-Disclosure, Social Support, and Anonymity. *Proceedings of the International AAAI Conference on Web and Social Media*, *8*(1), 71–80. https://doi.org/10.1609/icwsm.v8i1.14526

Department for Education and Skills. (2003) *Every Child Matters*. Green Paper, Cm. 5860. London: The Stationery Office (TSO) .

Department of Health (2013). *Improving Children and Young People's Health Outcomes: a system wide response*. London: Department of Health

Department of Health, (2000). *The NHS Plan: A Plan for Investment, a Plan for Reform*, London, UK: HMSO, 2000. [Google Scholar]

Department of Health & Social Care. (2019). *The Women's Mental Health Taskforce: Final Report.* GOV.UK. https://www.gov.uk/government/publications/the-womens-mental-health-taskforce-report

Dixon-Woods, M., Booth, A., & Sutton, A. J. (2007). Synthesizing qualitative research: a review of published reports. *Qualitative Research*, *7*(3), 375–422. https://doi.org/10.1177/1468794107078517

Donnellan, D., Murray, C., & Harrison, J. (2013). An investigation into adolescents' experience of cognitive behavioural therapy within a child and adolescent mental health service. *Clinical Child Psychology and Psychiatry*, *18*(2), 199–213. https://doi.org/10.1177/1359104512447032

Doyle, C., Lennox, L., & Bell, D. (2013). A systematic review of evidence on the links between patient experience and clinical safety and effectiveness. *BMJ Open*, *3*(1), e001570. https://doi.org/10.1136/bmjopen-2012-001570

Dunne, F. Nave, B., & Lewis, A. (2000). Critical friends groups: Teachers helping teachers to improve student learning. [electronic version]. Phi Delta Kappan, 28.

Eide, B. J., & Winger, N. (2005). From the children's point of view: methodological and ethical challenges. In A. Clark, A. T. Kjorholt, & P. Moss (Ed.). Beyond listening: Children's perspectives on early childhood services, Bristol, UK: Policy Press (pp. 71-90).

Emde, R., Harmon, R., & Good, W. (1986). Depressive feelings in children: A transactional model for research. In M. Rutter, C. Izard, & P. Read (Eds.), *Depression in young people; developmental and clinical perspectives* (pp. 135 - 162). New York: The Guildford Press.

Ensign, B. J. (2006). Perspectives and experiences of homeless young people. *Journal of Advanced Nursing*, *54*(6):647–652. doi: 10.1111/j.1365-2648.2006.03853.x

Erikson, E. H. (1968). Identity youth and crisis, New York (WW Norton).

Fals Borda, O. (1979a). *El problema de como investigar la realidad para transformarla: Por la praxis*. Bogotá, Colombia: Ediciones Tercer Mundo.

Fals Borda, O. (1988). *Knowledge and people's power: Lessons with peasants in Nicaragua, Mexico and Colombia*. New York, NY: New Horizons Press.

Fassinger, R., & Morrow, S. L. (2013). Toward Best Practices in Quantitative, Qualitative, and Mixed- Method Research: A Social Justice Perspective. *Journal for Social Action in Counseling & Psychology*, *5*(2), 69–83. https://doi.org/10.33043/JSACP.5.2.69-83

Fazel, M., Garcia, J., & Stein, A. (2016). The right location? Experiences of refugee adolescents seen by school-based mental health services. *Clinical Child Psychology and Psychiatry*, *21*(3), 368–380. https://doi.org/10.1177/1359104516631606

Fazel, M., Patel, V., Thomas, S., & Tol, W. (2014). Mental health interventions in schools in low-income and middle-income countries. *The Lancet Psychiatry*, *1*(5), 388–398. https://doi.org/10.1016/S2215-0366(14)70357-8

Finlay, L. (2008). A dance between the reduction and reflexivity: Explicating the" phenomenological psychological attitude". *Journal of phenomenological psychology*, *39*(1), 1-32.

Finlay, L. (2021). Thematic Analysis: : The 'Good', the 'Bad' and the 'Ugly'. *European Journal for Qualitative Research in Psychotherapy*, *11*, 103–116. Retrieved from https://ejqrp.org/index.php/ejqrp/article/view/136

Fisher, C. B. (2003). Adolescent and parent perspectives on ethical issues in youth drug use and suicide survey research. *Ethics Behav*. 2003;13(4):303–332. Retrieved from http://search.ebscohost.com/login.aspx?direct=true&db=rzh&AN=2004184880&site=ehost-live

Flanagan, C. A. (2004). Volunteerism, leadership, political socialization, and civic engagement. In R. M. Lerner & L. Steinberg (Eds.), *Handbook of adolescent psychology* (2nd ed.,). Hoboken, NJ: John Wiley & Sons.

Flanagan, P. (2012). Ethical review and reflexivity in research of children's sexuality. *Sex Education*, *12*(5), 535–544. https://doi.org/10.1080/14681811.2011.627731

Funk, A., Van Borek, N., Taylor, D., Grewal, P., Tzemis, D., & Buxton, J. (2013). Climbing the "Ladder of Participation": Engaging Experiential Youth in a Participatory Research Project. *Canadian Journal of Public Health. Revue Canadienne de Santé Publique*, *103*, e288-92. https://doi.org/10.1007/BF03404237

Gallacher, L.-A., & Gallagher, M. (2008). Methodological Immaturity in Childhood Research?: Thinking through `participatory methods'. *Childhood*, *15*(4), 499–516. https://doi.org/10.1177/0907568208091672

Geertz, Clifford (1973). Thick Description: Towards an Interpretive Theory of Culture. In *The Interpretation of Cultures*. Basic Books.

Giedd, J. N. (2004). Structural magnetic resonance imaging of the adolescent brain. *Annals of the New York Academy of Sciences, 102*, 77-85.

Gill, F., Butler, S., & Pistrang, N. (2016). The experience of adolescent inpatient care and the anticipated transition to the community: Young people's perspectives. *Journal of Adolescence*, *46*, 57–65. https://doi.org/10.1016/j.adolescence.2015.10.025

Goossens, L., & Marcoen, A. (1999). Adolescent loneliness, self-reflection, and identity: From individual differences to developmental processes. In K. J. Rotenberg & S. Hymel (Eds.), *Loneliness in childhood and adolescence* (pp. 225–243). New York: Cambridge University Press.

Green, J. (2006). Annotation: The therapeutic alliance – a significant but neglected variable in child mental health treatment studies. *Journal of Child Psychology and Psychiatry*, *47*(5), 425–435. https://doi.org/10.1111/j.1469-7610.2005.01516.x

Green, C. A., Wisdom, J. P., Wolfe, L., & Firemark, A. (2012). Engaging Youths with Serious Mental Illnesses in Treatment: STARS Study Consumer Recommendations. *Psychiatric Rehabilitation Journal*, *35*(5), 360–368. https://doi.org/10.1037/h0094494

Greenwood, D. J., & Levin, M. (1998). Action research, science, and the co-optation of social research. *Studies in Cultures, Organizations and Societies*, *4*(2), 237–261. https://doi.org/10.1080/10245289808523514

Guba, E. G., & Lincoln, Y. S. (1989). *Fourth generation evaluation*. Sage.

Guba, E. G., & Lincoln, Y. S. (1994). Competing paradigms in qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 105–117). Sage Publications, Inc.

Gulliver, A., Griffiths, K. M., & Christensen, H. (2010). Perceived barriers and facilitators to mental health help-seeking in young people: A systematic review. *BMC Psychiatry*, *10*(1), 113. https://doi.org/10.1186/1471-244X-10-113

Gurpinar-Morgan, A., Murray, C., & Beck, A. (2014). Ethnicity and the therapeutic relationship: Views of young people accessing cognitive behavioural therapy. *Mental Health, Religion & Culture*, *17*(7), 714–725. https://doi.org/10.1080/13674676.2014.903388

Hall, G. (1904). *Adolescence: Its Psychology and its Relations to Physiology, Anthropology, Sociology, Sex, Crime, Religion, and Education* (New York: Appleton and Company), 2 vols.

Hall, C., Moldavsky, M., Baldwin, L., Marriott, M., Newell, K., & Taylor, J. et al. (2013). The use of routine outcome measures in two child and adolescent mental health services: a completed audit cycle. *BMC Psychiatry*, *13*(1). doi: 10.1186/1471-244x-13-270

Hall, C. L., Moldavsky, M., Taylor, J., Sayal, K., Marriott, M., Batty, M. J., Pass, S., & Hollis, C. (2014). Implementation of routine outcome measurement in child and adolescent mental health services in the United Kingdom: A critical perspective. *European Child & Adolescent Psychiatry*, *23*(4), 239–242. https://doi.org/10.1007/s00787-013-0454-2

Halpren, E. S. (1983). Auditing naturalistic inquiries: The develop- ment and application of a model (Unpublished doctoral dissertation). Indiana University, Bloomington.

Hanley, T., Winter, L. A., & Burrell, K. (2019). Supporting emotional well-being in schools in the context of austerity: An ecologically informed humanistic perspective. *British Journal of Educational Psychology*, *90*(1). https://doi.org/10.1111/bjep.12275

Hannes, K. (2011). Critical Appraisal of Qualitative Research. In *Supplementary Guidance for Inclusion of Qualitative Research in Cochrane Systematic Reviews of Interventions*. Cochrane Qualitative Research Methods Group; http://cqrmg.cochrane.org/supplemental-handbook-guidance. https://lirias.kuleuven.be/1794169

Harding, S., Read, U. M., Molaodi, O. R., Cassidy, A., Maynard, M. J., Lenguerrand, E., Astell-Burt, T., Teyhan, A., Whitrow, M., & Enayat, Z. E. (2015). The Determinants of young Adult Social well-being and Health (DASH) study: Diversity, psychosocial determinants and health. *Social Psychiatry and Psychiatric Epidemiology*, *50*(8), 1173–1188. https://doi.org/10.1007/s00127-015-1047-9

Harper, D. (1988). Visual sociology: Expanding sociological vision. The American Sociologist, 19, 54–70.

Harper, D. (2002). Talking about Pictures: A Case for Photo Elicitation. Visual Studies 17 (1):13–26.

Harper, B., Dickson, J. M., & Bramwell, R. (2014). Experiences of young people in a 16-18 Mental Health Service. *Child and Adolescent Mental Health*, *19*(2), 90–96. https://doi.org/10.1111/camh.12024

Hassett, A., & Isbister, C. (2017). Young Men's Experiences of Accessing and Receiving Help From Child and Adolescent Mental Health Services Following Self-Harm. *SAGE Open*, *7*(4), 2158244017745112. https://doi.org/10.1177/2158244017745112

Haynes, C., Eivors, A., & Crossley, J. (2011). 'Living in an alternative reality': Adolescents' experiences of psychiatric inpatient care: Adolescents' experiences of psychiatric inpatient care. *Child and Adolescent Mental Health*, *16*(3), 150–157. https://doi.org/10.1111/j.1475-3588.2011.00598.x

Haynes, S. N., O'Brien, W. H., & Kaholokula, J. K. (2011). *Behavioral assessment and case formulation*. Wiley.

Henton, I. (2012). Practice-based research and counselling psychology: A critical review and proposal. *Counselling Psychology Review, 27*(3), 11–28.

Hepper, F., Weaver, T., & Rose, G. (2005). Children's Understanding of a Psychiatric In-patient Admission. *Clinical Child Psychology and Psychiatry*, *10*(4), 557–573. https://doi.org/10.1177/1359104505056318

Hill, N. E., & Taylor, L. C. (2004). Parental School Involvement and Children's Academic Achievement. *Current Directions in Psychological Science*, *13*(4), 161–164. https://doi.org/10.1111/j.0963-7214.2004.00298.x

Houston, S. (2001). Beyond social constructionism: Critical realism and social work. *British Journal of Social Work, 31*(6), 845–861. https://doi.org/10.1093/bjsw/31.6.845

HMSO. (1989). The Children Act, London: HMSO.

Ivey, A. E., & Collins, N. M. (2003). Social justice: A long-term challenge for counseling psychology. *The counseling psychologist*, *31*(3), 290-298.

Jagosh, J., Bush, P. L., Salsberg, J., Macaulay, A. C., Greenhalgh, T., Wong, G., Cargo, M., Green, L. W., Herbert, C. P., & Pluye, P. (2015). A realist evaluation of community-based participatory research: Partnership synergy, trust building and related ripple effects. *BMC Public Health*, *15*(1), 725. https://doi.org/10.1186/s12889-015-1949-1

James, A., & Prout, A. (Eds.). (2015). *Constructing and Reconstructing Childhood: Contemporary issues in the sociological study of childhood* (3rd ed.). Routledge. https://doi.org/10.4324/9781315745008

Jansz, J. (2000). Masculine identity and restrictive emotionality. In A. H. Fischer (Ed.), *Gender and Emotion* (1st ed., pp. 166–186). Cambridge University Press. https://doi.org/10.1017/CBO9780511628191.009

John Hopkins Medicine (2024, March). *The Growing Child: Adolescent 13 to 18 Years*. John Hopkins Medicine.https://www.hopkinsmedicine.org/health/wellness-and-prevention/the-growing-child-adolescent-13-to-18-years

Johnson, J, & Weller, S. (2002). Elicitation Techniques for interviewing. Handbook of Interview Research.

Jones, S., Hassett, A., & Sclare, I. (2017). Experiences of Engaging With Mental Health Services in 16- to 18-Year-Olds: An Interpretative Phenomenological Analysis. *SAGE Open*, *7*(3), 2158244017719113. https://doi.org/10.1177/2158244017719113

Kaasbøll, J., Sigurdson, J. F., Skokauskas, N., & Sund, A. M. (2021). Cohort profile: The Youth and Mental Health Study (YAMHS) – a longitudinal study of the period from adolescence to adulthood. *PLOS ONE*, *16*(2), e0247036. https://doi.org/10.1371/journal.pone.0247036

Karnieli-Miller, O., Strier, R., & Pessach, L. (2009). Power Relations in Qualitative Research. *Qualitative Health Research*, *19*(2), 279–289. https://doi.org/10.1177/1049732308329306

Keating, D. P. (2004). Cognitive and brain development. In R. Lerner, & L. Steinberg (Eds.), *Handbook of Adolescent Psychology* (2nd ed., pp. 45-84). Hoboken, NJ: Wiley & Sons.

Kim Y. (2011). The pilot study in qualitative inquiry: Identifying issues and learning lessons for culturally competent research. *Qualitative Social Work*, 10(2), 190–206. https://doi.org/10.1177/1473325010362001

Klimstra, T. A., & Denissen, J. J. A. (2017). A theoretical framework for the associations between identity and psychopathology. *Developmental Psychology*, *53*(11), 2052–2065. https://doi.org/10.1037/dev0000356

Kring, A. M., & Gordon, A. H. (1998). Sex differences in emotion: Expression, experience, and physiology. *Journal of Personality and Social Psychology*, *74*(3), 686–703. https://doi.org/10.1037//0022-3514.74.3.686

Lal, S., Nguyen, V., & Theriault, J. (2018). Seeking mental health information and support online: Experiences and perspectives of young people receiving treatment for first-episode psychosis. *Early intervention in psychiatry*, *12*(3), 324-330.

Lapenta, F. (2011). Some Theoretical and Methodological Views on Photo-Elicitation. In L. Pauwels, & E. Margolis (Eds.), *The SAGE Handbook of Visual Research Methods* (pp. 201-213). SAGE Publications.

Larkin, M., Watts, S., & Clifton, E. (2006). Giving voice and making sense in interpretative phenomenological analysis. *Qualitative Research in Psychology*, *3*(2), 102–120. https://doi.org/10.1191/1478088706qp062oa

Lasgaard, M., Armour, C., Bramsen, R. H., & Goossens, L. (2016). Major life events as predictors of loneliness in adolescence. Journal of Child and Family Studies, 25, 631637.

Lerner, R. M. (Ed.). (1983). Developmental psychology: Historical and philosophical perspectives. Hillsdale: Erlbaum.

Lerner, R. M. (1991). Changing organism-context relations as the basic process of development: A developmental-contextual perspective. *Developmental Psychology, 27*, 27–32.

Lerner, R. M., & Israeloff, R. (2007). *The good teen: Rescuing adolescence from the myths of the storm and stress years*. New York, NY: Stonesong Press Book/Crown.

Lerner, R.M., & Kauffman, M.B. (1985). The concept of development in contextualism. *Developmental Review, 5*, 309-333.

Lerner, J. V., & Lerner, R. M. (1994). Explorations of the goodness-of-fit model in early adolescence. In *Prevention And Early Intervention*. Routledge.

Levin, M., & Greenwood, D. (2011). Revitalizing universities by reinventing the social sciences. *Handbook of qualitative inquiry*, 27-42.

Lewin, K. (1946). Action research and minority problems. *Journal of Social Issues, 2, 4,* 34–46. https://doi.org/10.1111/j.1540-4560.1946.tb02295.x

Lincoln, Y., & Guba, E. G. (1985). Naturalistic inquiry. Newbury Park, CA: Sage.

Lukes, S. (2021). *Power: A radical view* (Third edition). Red Globe press.

Lukoševičiūtė-Barauskienė, J., Žemaitaitytė, M., Šūmakarienė, V., & Šmigelskas, K. (2023). Adolescent Perception of Mental Health: It's Not Only about Oneself, It's about Others Too. *Children*, *10*(7), 1109. https://doi.org/10.3390/children10071109

Luttrell, W. (2010). 'A camera is a big responsibility': a lens for analysing children's visual voices. *Visual Studies, 25*, 224 - 237.

Macaulay, A. C., Jagosh, J., Seller, R., Henderson, J., Cargo, M., Greenhalgh, T., Wong, G., Salsberg, J., Green, L. W., Herbert, C. P., & Pluye, P. (2011). Assessing the benefits of participatory research: A rationale for a realist review. *Global Health Promotion*, *18*(2), 45–48. https://doi.org/10.1177/1757975910383936

MacDonald, K., Fainman-Adelman, N., Anderson, K. K., & Iyer, S. N. (2018). Pathways to mental health services for young people: A systematic review. *Social Psychiatry and Psychiatric Epidemiology*, *53*(10), 1005–1038. https://doi.org/10.1007/s00127-018-1578-y

Majumder, P., O'Reilly, M., Karim, K., & Vostanis, P. (2015). 'This doctor, I not trust him, I'm not safe': The perceptions of mental health and services by unaccompanied refugee adolescents. *International Journal of Social Psychiatry*, 8.

Malinowski, B. (1922). Argonauts of the Western Pacific. In *PhilArchive*. George Routledge & Sons. https://philarchive.org/rec/MALAOT-2

Manary, M. P., Boulding, W., Staelin, R., & Glickman, S. W. (2013). The Patient Experience and Health Outcomes. *New England Journal of Medicine*, *368*(3), 201–203. https://doi.org/10.1056/NEJMp1211775

Matthews, F. T. (2016). *What is important to looked-after young people during adolescence? A qualitatively driven photo-elicitation study.* [Dclinpsychol, University of Leeds]. https://etheses.whiterose.ac.uk/13752/

Matzka, M., & Nagl-Cupal, M. (2020). Psychosocial resources contributing to resilience in Austrian young carers - A study using photo novella. *Research in Nursing & Health*, *43*(6), 629–639. https://doi.org/10.1002/nur.22085

Maxwell, J. A., & Mittapalli, K. (2010). Realism as a stance for mixed methods research. *SAGE handbook of mixed methods in social & behavioral research*, *2*, 145-168.

McAdams, D. P. (2011). Narrative identity. In S. J. Schwartz, K. Luyckx, & V. L. Vignoles (Eds.), *Handbook of identity theory and research* (pp. 99–115). Springer Science + Business Media. https://doi.org/10.1007/978-1-4419-7988-9_5

McLean, K. C. (2008). The emergence of narrative identity. *Social and Personality Psychology Compass*, *2*(4), 1685-1702.

McLeod, J. (2003). *Doing counselling research* (2nd ed). Sage Publications.

McLeod, A. (2007). Whose agenda? Issues of power and relationship when listening to looked after young people. *Child and Family Social Work, 12,* pp. 278-286.

Mead, M. (1930). *Growing Up in New Guinea. A Comparative Study of Primitive Education.* New York William Morrow.

Meeus, W. (2011). The study of adolescent identity formation 2000–2010: A review of longitudinal research. *Journal of Research on Adolescence, 21*(1), 75–94. https://doi.org/10.1111/j.1532-7795.2010.00716.x

Meyrick J. (2006). What is good qualitative research? A first step towards a comprehensive approach to judging rigour/quality. *Journal of health psychology*, *11*(5), 799–808. https://doi.org/10.1177/1359105306066643

Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis: An expanded sourcebook* (2nd ed). Sage Publications.

Montero-Marin, J., Hinze, V., Mansfield, K., Slaghekke, Y., Blakemore, S.-J., Byford, S., Dalgleish, T., Greenberg, M. T., Viner, R. M., Ukoumunne, O. C., Ford, T., Kuyken, W., & MYRIAD Team. (2023). Young People's Mental Health Changes, Risk, and Resilience During the COVID-19 Pandemic. *JAMA Network Open*, *6*(9), e2335016. https://doi.org/10.1001/jamanetworkopen.2023.35016

Morrow, V., Richards, M. (1996). The Ethics of Social Research with Children: An Overview. *Children & Society*, 10(2), 90–105. 10.1111/j.1099-0860.1996.tb00461.x [Google Scholar]

Morsillo, J., & Prilleltensky, I. (2007). Social action with youth: Interventions, evaluation, and psychopolitical validity. *Journal of Community Psychology*, *35*(6), 725–740. https://doi.org/10.1002/jcop.20175

Moses-Payne, M. E., Habicht, J., Bowler, A., Steinbeis, N., & Hauser, T. U. (2021). I know better! Emerging metacognition allows adolescents to ignore false advice. *Developmental Science*, *24*(5), e13101. https://doi.org/10.1111/desc.13101

Myers, M (2000). Qualitative Research and the Generalizability Question: Standing Firm with Proteus. *The Qualitative Report, 4*(3) https://nsuworks.nova.edu/cgi/viewcontent.cgi?article=2925&context=tqr

National Institute of Clinical Excellence (2013). NICE Public Health Guidance 28: Looked after children and young people. Retrieved May 2014, from http://www.nice.org.uk/guidance/ph28/resources/guidance-lookedafter-children-andyoung-people-pdf

Naylor, C., Lincoln, J., & Goddard, N. (2008). Young People at Risk of Offending: Their Views on a Specialist Mental Health Service in South East London. *Clinical Child Psychology and Psychiatry*, *13*(2), 277–286. https://doi.org/10.1177/1359104507088347

Nelson, T. D., & Nelson, J. M. (2010). Evidence based practice and the culture of adolescence. *Professional Psychology: Research and Practice, 41*, 305-311.

NHS England Digital (2023). *Mental Health Services Monthly Statistics , Performance December 2023*. NHS England Digital. Retrieved 26 January 2024, from https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-services-monthly-statistics/performance-december-2023

NHS England Digital (2022). *Mental Health of Children and Young People in England 2022 — Wave 3 follow up to the 2017 survey*. NHS England Digital. Retrieved 26 January 2024, from https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2022-follow-up-to-the-2017-survey

Nykiforuk, C. I. J., Vallianatos, H., & Nieuwendyk, L. M. (2011). Photovoice as a Method for Revealing Community Perceptions of the Built and Social Environment. *International Journal of Qualitative Methods*, *10*(2), 103–124. https://doi.org/10.1177/160940691101000201

Oates, J., Carpenter, D., Fisher, M., Goodson, S., Hannah, B., Kwiatowski, R., Prutton, K., Reeves, D., & Wainwright, T. (2021). *BPS Code of Human Research Ethics*. British Psychological Society.

Oden, K., Hernandez, B., & Hidalgo, M. (2010). Payoffs of participatory action research: Racial and ethnic minorities with disabilities reflect on their research experiences. *Community Development*, *41*(1), 21–31. https://doi.org/10.1080/15575330903477275

Okewole, A. O., Ogunwale, A., Mosanya, T. J., & Ojo, B. M. (2016). A 12 year chart review of childhood and adolescent onset psychosis at a Nigerian tertiary mental health facility. *Journal of Child & Adolescent Mental Health*, *28*(3), 189–197. https://doi.org/10.2989/17280583.2016.1245194

Orlans, V., & Van Scoyoc, S. (2008). *A short introduction to counselling psychology*. SAGE.

Packard, J. (2008). 'I'm gonna show you what it's really like out here': the power and limitation of participatory visual methods. *Visual Studies*, *23*(1), 63–77. https://doi.org/10.1080/14725860801908544

Patton, M. Q. (1990). *Qualitative evaluation and research methods* (2nd ed.). Sage Publications, Inc.

Patton, M. Q. (2001). Qualitative research and evaluation and methods (3rd ed.). Beverly Hills, CA: Sage.

Patton, G. C., Sawyer, S. M., Santelli, J. S., Ross, D. A., Afifi, R., Allen, N. B., Arora, M., Azzopardi, P., Baldwin, W., Bonell, C., Kakuma, R., Kennedy, E., Mahon, J., McGovern, T., Mokdad, A. H., Patel, V., Petroni, S., Reavley, N., Taiwo, K., … Viner, R. M. (2016). Our future: A Lancet commission on adolescent health and wellbeing. *The Lancet*, *387*(10036), 2423–2478. https://doi.org/10.1016/S0140-6736(16)00579-1

Persson, S., Hagquist, C., & Michelson, D. (2017). Young voices in mental health care: Exploring children's and adolescents' service experiences and preferences. *Clinical Child Psychology and Psychiatry*, *22*(1), 140–151. https://doi.org/10.1177/1359104516656722

Pinkney, S. (2011). Participation and Emotions: Troubling Encounters Between Children and Social Welfare Professionals. *Children & Society*, *25*(1), 37–46. https://doi.org/10.1111/j.1099-0860.2009.00261.x

Ponterotto, J. G. (2005). Qualitative research in counseling psychology: A primer on research paradigms and philosophy of science. *Journal of counseling psychology*, *52*(2), 126.

Reavey, P., Poole, J., Corrigall, R., Zundel, T., Byford, S., Sarhane, M., Taylor, E., Ivens, J., & Ougrin, D. (2017). The ward as emotional ecology: Adolescent experiences of managing mental health and distress in psychiatric inpatient settings. *Health & Place*, *46*, 210–218. https://doi.org/10.1016/j.healthplace.2017.05.008

Robinson, J. (2010). What is the "patient experience"? https://news.gallup.com/businessjournal/143258/patient-experience.aspx (accessed February 25, 2024).

Royal College of Psychiatrists. (2010). No health without public mental health: the case for action. Position Statement PS4/2010. Available at: http://www.rcpsych.ac.uk/pdf/Position%20Statement%204%20website.pdf (accessed 6 December 2016).

Ryle, G. (1971). *Collected papers* (Vol. 1). London: Hutchinson.

Sabo, D., Kupers, T., & London, W. J. (2001). *Prison masculinities / edited by Don Sabo, Terry A. Kupers, and Willie London*. Semantic Scholar. https://www.semanticscholar.org/paper/Prison-masculinities-edited-by-Don-Sabo%2C-Terry-A.-Sabo-Kupers/0c493269400e229796eb9c33262e75c737f7bbec

Schnyder, N., Lawrence, D., Panczak, R., Sawyer, M. G., Whiteford, H. A., Burgess, P. M., & Harris, M. G. (2019). Perceived need and barriers to adolescent mental health care: Agreement between adolescents and their parents. *Epidemiology and Psychiatric Sciences*, *29*, e60. https://doi.org/10.1017/S2045796019000568

Schwartz, S. (2005). *Basic human values: Their content and structure across countries* (pp. 21–55).

Schwartz, H. A., Eichstaedt, J. C., Kern, M. L., Dziurzynski, L., Ramones, S. M., Agrawal, M., Shah, A., Kosinski, M., Stillwell, D., Seligman, M. E. P., & Ungar, L. H. (2013). Personality, Gender, and Age in the Language of Social Media: The Open-Vocabulary Approach. *PLoS ONE*, *8*(9), e73791. https://doi.org/10.1371/journal.pone.0073791

Shaffer, R. (1983). *Beyond the Dispensary*. African Medical and Research Foundation.

Shiner, R.L., Buss, K.A., McClowry, S.G., Putnam, S.P., Saudino, K.J., & Zentner, M. (2012). What Is Temperament Now? Assessing Progress in Temperament Research on the Twenty-Fifth Anniversary of Goldsmith et al. *Child Development Perspectives, 6*, 436-444.

Simmons, R. G., Burgeson, R., Carlton-Ford, S., & Blyth, D. A. (1987). The impact of cumulative change in early adolescence. Child Development, 58, 1220-1234.

Simpson, E., & House, A. (2002). Involving users in the delivery and evaluation of mental health services: Systematic Review. *BMJ (Clinical Research Ed.)*, *325*, 1265. https://doi.org/10.1136/bmj.325.7375.1265

Slevitch, L. (2011). Qualitative and Quantitative Methodologies Compared: Ontological and Epistemological Perspectives. *Journal of Quality Assurance in Hospitality & Tourism*, *12*(1), 73–81. https://doi.org/10.1080/1528008X.2011.541810

Smart, K., Smith, L., Harvey, K., & Waite, P. (2023). The acceptability of a therapist-assisted internet-delivered cognitive behaviour therapy program for the treatment of anxiety disorders in adolescents: A qualitative study. *European Child & Adolescent Psychiatry*, *32*(4), 661–673. https://doi.org/10.1007/s00787-021-01903-6

Smith , J.A. , Flowers , P. and Larkin , M. 2009 . *Interpretative phenomenological analysis: theory, method and research* , London : Sage .

Smith, P. K., Cowie, H., & Blades, M. (2003). Understanding Children's Development (4th ed.).Oxford, UK: Blackwell Publishing.

Smith, J. A., & Osborn, M. (2003). Interpretative Phenomenological Analysis. In *Qualitative Psychology: A Practical Guide to Research Methods.*

Osborn, M., & Smith, J. A. (2008). The fearfulness of chronic pain and the centrality of the therapeutic relationship in containing it: An interpretative phenomenological analysis. *Qualitative Research in Psychology*, *5*(4), 276-288.

Sorsa, M., Ranta, T., Hartikainen, A.-L., & Paavilainen, E. (2006). Children's Views on Their Own Hospitalization at a Child Psychiatric Ward. *Nordic Journal of Nursing Research*, *26*, 14–23. https://doi.org/10.1177/010740830602600304

Steinberg L. (2019). *Adolescence* (12th ed.). McGraw-Hill.

stem4. (2022, April 4). *"A service in crisis" survey reveals GPS concerns about ...* stem4: supporting teenage mental health. https://stem4.org.uk/wp-content/uploads/2022/04/A-service-in-crisis-Survey-reveals-GPs-concerns-about-mental-health-services-for-CYP-Apr-22.pdf

Strawbridge, S. & Woolfe, R. (2010). Counselling psychology: Origins, developments and challenges. In Woolfe, R., Strawbridge, W., Douglas, B., & Dryden, W. (Eds.) *The handbook of counselling psychology* (3rd ed.) (pp. 3–22). London: Sage.

Suarez-Balcazar, Y., & Harper, G. (2003). *Empowerment and participatory evaluation of community interventions: Multiple benefits.* Haworth Press.

Swartling, U., Hansson, M. G., Ludvigsson, J., & Nordgren, A. (2011). "My parents decide if I can. I decide if I want to." Children's Views on Participation in Medical Research. *Journal of Empirical Research on Human Research Ethics*, *6*(4), 68-75.

Swartling, U., Helgesson, G., Ludvigsson, J., Hansson, M. G., & Nordgren, A. (2014). Children's views on long-term screening for type 1 diabetes. *Journal of Empirical Research on Human Research Ethics,* 9(4):1–9. doi: 10.1177/1556264614544456.

Terry, G., Hayfield, N., Clarke, V., & Braun, V. (2017). Thematic analysis. In C. Willig, & W. Stainton Rogers (Eds.), The SAGE Handbook of Qualitative Research in Psychology (17-37). (2nd). London: SAGE Publications

The Beryl Institute. (2020). Defining patient experience. https://www.theberylinstitute.org/page/DefiningPX (accessed February 25, 2024).

The British Psychological Society. (2021). *Ethics guidelines for internet-mediated research.* The British Psychological Society.

Thom, D. H., & Campbell, B. (1997). Patient-physician trust: an exploratory study. *The Journal of family practice*, *44*(2), 169–176.

Thomas, A., & Chess, S. (1977). Temperament and development. New York: Brunner/Mazel.

Tobin, G. A., & Begley, C. M. (2004). Methodological rigour within a qualitative framework. *Journal of advanced nursing*, *48*(4), 388-396.

Tolman, D. L., & Brydon-Miller, M. (1997). Transforming psychology: Interpretive and participatory research methods. *Journal of Social Issues, 53*(4), 597–603. https://doi.org/10.1111/j.1540-4560.1997.tb02450.x

Tribe, R., & Bell, D. (2018). Social justice, diversity and leadership. *The European Journal of Counselling Psychology*, *6*(1), 111–125. https://doi.org/10.5964/ejcop.v6i1.145

Triseliotis, J., Borland, M., Hill, M. & Lambert, L. (1995). Teenagers and the social work services. HMSO: London.

Unguru Y, Sill AM, Kamani N. (2010). The experiences of children enrolled in pediatric oncology research: Implications for assent. *Pediatrics.*125(4):e876–e883. Retrieved from http://search.ebscohost.com/login.aspx?direct=true&db=aph&AN=49753789&site=ehost-live.

UNICEF. (1989). *UN Convention on the Rights of the Child (UNCRC). UNICEF https://www.unicef.org.uk/what-we-do/un-convention-child-rights/*

Valentine, L., McEnery, C., D'Alfonso, S., Phillips, J., Bailey, E., & Alvarez-Jimenez, M. (2019). Harnessing the potential of social media to develop the next generation of digital health treatments in youth mental health. *Current Treatment Options in Psychiatry*, *6*, 325-336.

Valle, A., Massaro, D., Castelli, I., & Marchetti, A. (2015). Theory of Mind Development in Adolescence and Early Adulthood: The Growing Complexity of Recursive Thinking Ability. *Europe's Journal of Psychology*, *11*(1), Article 1. https://doi.org/10.5964/ejop.v11i1.829

Vitelli, R. (2013). Suicide and the internet. Can online suicide sites increase suicide risk? *Retrieve from* https://www.psychologytoday.com/us/blog/media-spotlight/201310/suicide-and-the-internet

Walker, R., & Widel, J. (1985). Using photographs in a discipline of words. In R. G. Burgess (Ed.), Field methods in the study of education (pp. 191–216). Philadelphia, PA: Falmer.

Wallerstein, N., & Duran, B. (2010). Using community-based participatory research to address health disparities. *Health Promot Pract.* 2006;7(3):312–323

Weisz, J. R., Chorpita, B. F., Frye, A., Ng, M. Y., Lau, N., Bearman, S. K., Ugueto, A. M., Langer, D. A., Hoagwood, K. E., & Research Network on Youth Mental Health. (2011). Youth Top Problems: Using idiographic, consumer-guided assessment to identify treatment needs and to track change during psychotherapy. *Journal of Consulting and Clinical Psychology*, *79*(3), 369–380. https://doi.org/10.1037/a0023307

White, A.M., Swartzwelder, H.S. (2009) Inbound college students drink heavily during the summer before their freshman year: Implications for education and prevention efforts. *American Journal of Health Education. 40*:909–96.

Whyte, W. F. (1984). Learning from the field. Beverly Hills: Sage.

Wiles, R., Crow, G., Charles, V., & Heath, S. (2007). Informed Consent and the Research Process: Following Rules or Striking Balances? *Sociological Research Online*, *12*(2), 99–110. https://doi.org/10.5153/sro.1208

Willig, C. (2008). *Introducing qualitative research in psychology (2nd ed.). New York: Open University Press.*

Willig, C. (2012). Perspectives on the epistemological bases for qualitative research. In H. Cooper, P. M. Camic, D. L. Long, A. T. Panter, D. Rindskopf, & K. J. Sher (Eds.), *APA handbook of research methods in psychology, Vol 1: Foundations, planning, measures, and psychometrics.* (pp. 5–21). American Psychological Association. https://doi.org/10.1037/13619-002

Willig, C. (2013). *Introducing qualitative research in psychology* (3rd ed.). Open University Press.

Willig, C., & Rogers, W. S. (Eds.). (2017). *The SAGE handbook of qualitative research in psychology.* Sage.

Winter, L. A., & Hanley, T. (2015). "Unless everyone's covert guerrilla-like social justice practitioners...": A preliminary study exploring social justice in UK counselling psychology. *Counselling Psychology Review*, *30*(2), 32-46.

Wolpert, M., Harris, D. R., Hodges, D. S., Fuggle, D. P., James, D. R., McKenna, D. C., Jones, D. M., Fonagy, P., Fleming, D. I., Munk, D. S., Payne, C., & Perry, E. (2019). *THRIVE Framework for system change*. https://implementingthrive.org/wp-content/uploads/2019/03/THRIVE-Framework-for-system-change-2019.pdf

Woodhead, M. (2015). Psychology and the cultural construction of children's needs. *Constructing and Reconstructing Childhood: Contemporary Issues in the Sociological Study of Childhood: Classic Edition*, 54–73.

World Health Organization (2017). WHO recommendations on adolescent health: guidelines approved by the WHO guidelines review committee. Available at https://www.who.int/publications/i/item/WHO-MCA-17.09

World Health Organization (2024). *Adolescent and young adult health: Key facts.* WHO. https://www.who.int/news-room/fact-sheets/detail/adolescents-health-risks-and-solutions

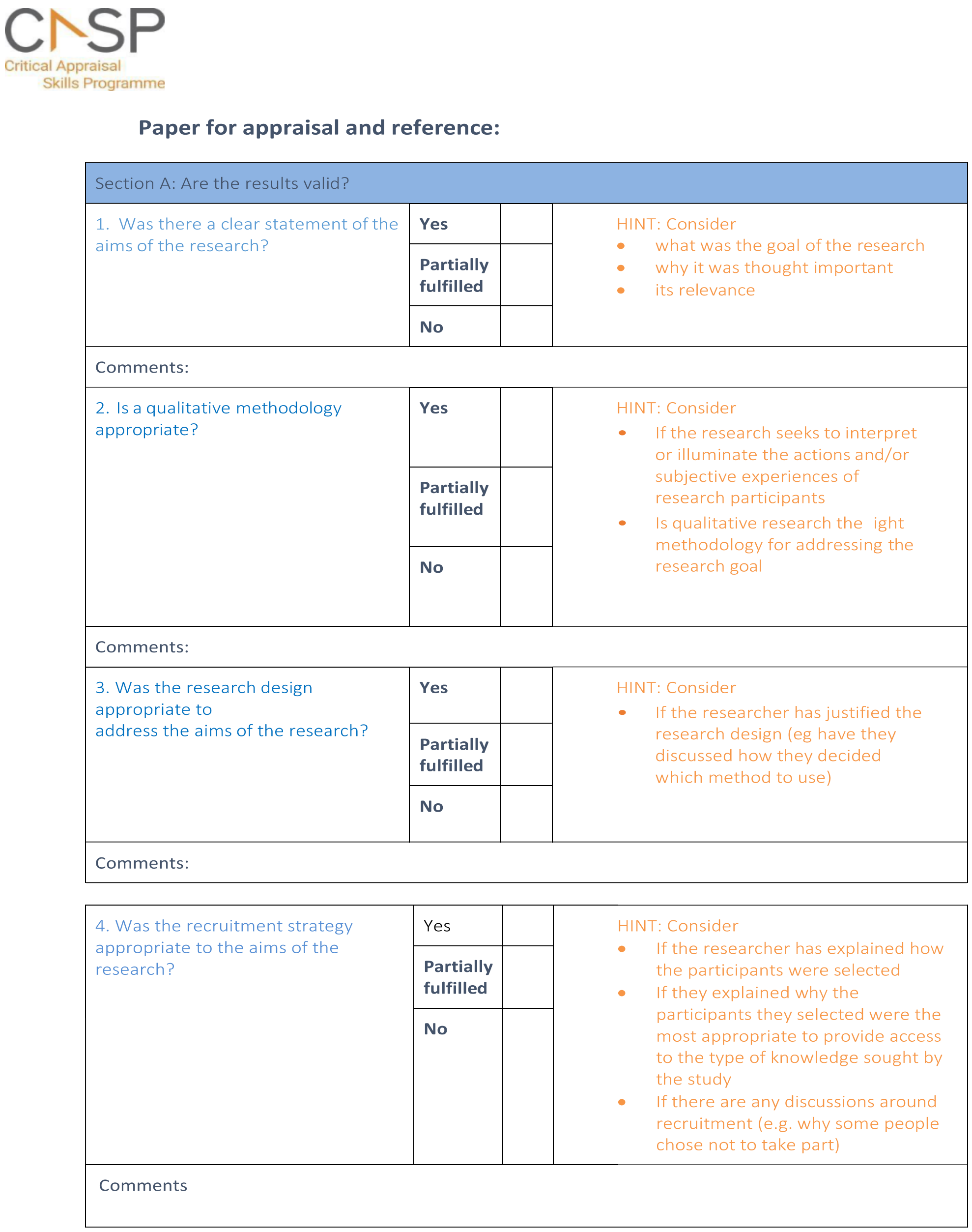
World Medical Association. (2013). Declaration of Helsinki: Ethical principles for medical research involving human subjects. *Journal of the American Medical Association*. 2013;310(20):2191–2194. doi: 10.1001/jama.2013.281053.

Wray-Lake, L., Crouter, A. C., & McHale, S. M. (2010). Developmental patterns in decision-making autonomy across middle childhood and adolescence: European American parents' perspectives. *Child development*, *81*(2), 636-651.

Ybarra, M. L., Espelage, D. L., Langhinrichsen-Rohling, J., Korchmaros, J. D., & Boyd, D. (2016). Lifetime Prevalence Rates and Overlap of Physical, Psychological, and Sexual Dating Abuse Perpetration and Victimization in a National Sample of Youth. *Archives of Sexual Behavior*, *45*(5), 1083–1099. https://doi.org/10.1007/s10508-016-0748-9

Appendices

Appendix 1: Critical Appraisal Skills Programme (Casp, 2018) Checklist



CASP
Critical Appraisal
Skills Programme

Paper for appraisal and reference:

Section A: Are the results valid?			
1. Was there a clear statement of the aims of the research?	**Yes**		HINT: Consider • what was the goal of the research • why it was thought important • its relevance
	Partially fulfilled		
	No		
Comments:			
2. Is a qualitative methodology appropriate?	**Yes**		HINT: Consider • If the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants • Is qualitative research the ight methodology for addressing the research goal
	Partially fulfilled		
	No		
Comments:			
3. Was the research design appropriate to address the aims of the research?	**Yes**		HINT: Consider • If the researcher has justified the research design (eg have they discussed how they decided which method to use)
	Partially fulfilled		
	No		
Comments:			

4. Was the recruitment strategy appropriate to the aims of the research?	Yes		HINT: Consider • If the researcher has explained how the participants were selected • If they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study • If there are any discussions around recruitment (e.g. why some people chose not to take part)
	Partially fulfilled		
	No		
Comments			

5. Was the data collected in a way that addressed the research issue?	**Yes**		HINT: Consider • If the setting for the data collection was justified • If it is clear how data were collected (e.g. focus group, semi-structured interview etc.) • If the researcher has justified the methods chosen • If the researcher has made the methods explicit (e.g. for interview method, is there an indication of how interviews are conducted, or did they use a topic guide) • If methods were modified during the study. If so, has the researcher explained how and why • If the form of data is clear (e.g. tape recordings, video material, notes etc.) • If the researcher has discussed saturation of data
	Partially fulfilled		
	No		
Comments			

6. Has the relationship between researcher and participants been adequately considered?	**Yes**		HINT: Consider • If the researcher critically examined their own role, potential bias and influence
	Partially fulfilled		
	No		
Comments			

Section B: What are the results?			
7. Have ethical issues been taken into consideration?	**Yes**		HINT: Consider • If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained • If the researcher has discussed issues raised by the study (e.g. issues around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study) • If approval has been sought from the ethics committee
	Partially fufilled		
	No		
Comments			

8. Was the data analysis sufficiently rigorous?	**Yes**		HINT: Consider • If there is an in-depth description of the analysis process • If thematic analysis is used. If so, is it clear how the categories/themes were derived from the data • Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process • If sufficient data are presented to support the findings • To what extent contradictory data are taken into account • Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation
	Partially fulfilled		
	No		
Comments			
9. Is there a clear statement of findings?	**Yes**		HINT: Consider • If the findings are explicit • If there is adequate discussion of the evidence both for and against the researcher's arguments • If the researcher has discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst) • If the findings are discussed in relation to the original research question
	Partially fulfilled		
	No		
Comments:			
Section C: Will the results help locally?			
10. How valuable is the research?	**Yes**		HINT: Consider • If the researcher discusses the contribution the study makes to existing knowledge or understanding (e.g. do they consider the findings in relation to current practice or policy, or relevant research-based literature • If they identify new areas where research is necessary • If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used
	Partially fulfilled		
	No		
Comments:			

Appendix 2: Summary Table of CASP Assessment of Literature

Results of the Critical Appraisal Skills Programme (CASP) quality assessment for the qualitative studies (n = 16)

	Clear statement of aims?	Qualitative method appropriate?	Design appropriate to address aims?	Recruitment strategy appropriate to aims?	Data collection addressed research?	Role of the researcher considered?	Ethical issues considered?	Data analysis rigorous?	Clear statement of findings?	Is the research valuable?
Boyden et al., (2013)	Y	Y	Y	P	P	N	Y	P	P	Y
Buston, (2002)	Y	Y	Y	Y	Y	p	Y	Y	Y	Y
Colton & Pistrang, (2004)	Y	Y	Y	Y	Y	Y	P	Y	Y	Y
Davison et al., (2017)	Y	Y	Y	p	Y	Y	P	Y	Y	Y
Donnellan et al., (2013)	Y	Y	Y	P	P	N	P	Y	Y	Y
Fazel et al., (2016)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Gill et al., (2016)	Y	Y	Y	N	Y	Y	P	Y	Y	Y
Gurpinar-Morgan et al., (2014)	Y	Y	Y	p	Y	N	P	Y	Y	Y
Harper et al., (2014)	Y	Y	Y	p	Y	Y	p	Y	Y	Y
Hassett & Isbister, (2017)	Y	Y	Y	N	Y	Y	N	Y	Y	Y
Haynes et al., (2011)	Y	Y	p	Y	p	N	p	Y	Y	Y
Jones et al., (2017)	Y	Y	Y	N	Y	p	Y	Y	Y	Y
Majumder et al., (2015)	Y	Y	Y	N	P	N	P	P	Y	Y
Naylor et al., (2008)	Y	Y	Y	Y	P	N	P	Y	Y	Y
Reavey et al., (2017)	Y	Y	Y	p	p	N	p	Y	Y	Y
Smart et al., (2023)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y

Appendix 3: Table of Key Studies

Table of Studies: Adolescents' Experiences of Mental Health Services

Setting	Service	Country	Study	Research Method		
				Quantitative	Qualitative	Mixed
Outpatient care	School	UK	Fazel et al 2016		✓ semi structured + framework analysis	
	CAMHS	UK	Boyden et al 2013		✓ semi structured interviews + thematic analysis	
		UK	Davison et al 2017	❏CHI ESQ	semi structured interviews + thematic analysis	✓
		UK	Donnellan et al 2013		✓ semi structured interviews + IPA	
		UK	Harper et al 2014		✓ semi structured interviews + IPA	
		UK	Hassett & Isbister 2017		✓ semi structured interviews + IPA	
		UK	Jones et al 2017		✓ semi structured interviews + IPA	
		UK	Majumder et al 2015		✓ semi structured interviews + thematic analysis	
		UK	Smart et al 2023		✓ semi structured interviews + reflexive thematic analysis	
	Specialist mental health service for young people at risk of offending	UK	Naylor et al 2008		✓ semi structured interviews + grounded theory	
Inpatient care	Psychiatric	UK	Colton & Pistrang 2004		✓ semi structured interview + IPA	
	psychiatric	UK	Gill et al 2016		✓ semi structured interview + thematic analysis	
	psychiatric	UK	Haynes et al 2011		✓ semi structured interview + grounded theory	
	Psychiatric	UK	Reavey et al 2017		✓ semi structured visual interview + thematic decomposition analysis	
Mixed - out and inpatient care	Participants in contact with psychiatrists in various localities	Scotland	Buston 2002	(Offer Self-Image Questionnaire – but only interview data reported here.)	✓ semi structured interview + grounded theory	
					✓	

Appendix 4: Research Poster/Flyer

Department of Psychology, City, University of London

CO-RESEARCHERS NEEDED

FOR RESEARCH INTO ADOLESCENTS' EXPERIENCES OF MENTAL HEALTH SERVICES

- We're looking for volunteers to take part in a study exploring what adolescents think about mental health services using photos, objects and sounds.
- As a co-researcher in this study you will be asked to take photos, collect objects and/or sounds (whatever you choose) and discuss them in a relaxed interview lasting 60-90 minutes either online or in-person.
- To thank you for your time you will receive a £20 voucher (Amazon/ ASOS/Next - your choice).

- Are you aged 13-18?
- Have you talked to your GP about mental health or used mental health services in the past 3 years?
- Do you like taking pictures (you don't need your own camera!), or creating or collecting sounds or objects?
- Do you want to share your point of view and help make a difference?

THEN PLEASE COME JOIN OUR STUDY!

For more information or to volunteer for this study, please contact Katie Wood, Trainee Counselling Psychologist (supervised by Dr Tanya Lecchi) at Department of Psychology by email: katie.wood@city.ac.uk. We look forward to hearing from you!

CITY
UNIVERSITY OF LONDON
EST 1894

This study has been reviewed and received ethics clearance by the Psychology Committee, City, University of London (ETH2223-2468).

If you would like to complain about any aspect of the study, please phone 020 7040 3040 to speak to Annah Whyton, Secretary to Senate Research Ethics Committee.

City, University of London is the data controller for the personal data collected for this research project. If you have any data protection concerns about this research project, please contact City's Information Governance Team at dataprotection@city.ac.uk

Appendix 5: Research Brochure

What is Research?

A research study is a way to find out new information about something. It is voluntary, you don't have to take part if you don't want to.

Why me?

We're trying to learn more about teenagers and how they've found mental health services. You are invited to be in the study because you're a teenager and have used mental health services in the last 3 years.

How will this affect me?

Being part of a research team sharing your experiences and having your voice heard by mental health providers, will be en empowering experience. Your participation will directly benefit other young people who use mental health services that improve as a result of your work. There is a risk you might get upset sharing your experiences but can discuss this one-to-one or find someone you find comfortable with.

What will I have to do?

You will have a brief introductory meeting with Katie Wood (Principal Researcher and Trainee Counselling Psychologist) to talk about the study (about 10mins). Then you can take photos and/or create/collect sounds or objects (you can do just one or a combination, it's your choice) that you think help show your experiences of mental health services. You then bring these photos, sounds or objects to an informal discussion with Katie Wood. This will last about 60-90 minutes and can be online or in an appropriate public place where you feel comfortable.

Do my parents know?

You can talk this over with them before you decide. If you want to be in the study and are under 16 years old, your parents will need to sign a form too. If you are 16 or over, you can choose whether to share this with them or not.

Will I get anything?

Yes! In appreciation for your time you will receive a £20 Amazon, ASOS or Next voucher (you choose).

Do I have to be in this study?

No! You don't have to be in the study. No one will be upset if you don't want to do it or want to leave during it. If you don't want to be involved, you just have to tell us. It's up to you.

Privacy

We take your privacy very seriously, so the information collected about you during the study will be anonymised, kept confidential and safely locked up. Only the researchers will know. If we ask you about something you don't want to talk about, you can just tell us and we can talk about something else.

What is Research?

A research study is a way to find out new information about something. It is voluntary, you don't have to take part if you don't want to.

Why me?

We're trying to learn more about teenagers and how they've found mental health services. You are invited to be in the study because you're a teenager and have used mental health services in the last 3 years.

How will this affect me?

Being part of a research team sharing your experiences and having your voice heard by mental health providers, will be en empowering experience. Your participation will directly benefit other young people who use mental health services that improve as a result of your work. There is a risk you might get upset sharing your experiences but can discuss this one-to-one or find someone you find comfortable with.

What will I have to do?

You will have a brief introductory meeting with Katie Wood (Principal Researcher and Trainee Counselling Psychologist) to talk about the study (about 10mins). Then you can take photos and/or create/collect sounds or objects (you can do just one or a combination, it's your choice) that you think help show your experiences of mental health services. You then bring these photos, sounds or objects to an informal discussion with Katie Wood. This will last about 60-90 minutes and can be online or in an appropriate public place where you feel comfortable.

Do my parents know?

You can talk this over with them before you decide. If you want to be in the study and are under 16 years old, your parents will need to sign a form too. If you are 16 or over, you can choose whether to share this with them or not.

Will I get anything?

Yes! In appreciation for your time you will receive a £20 Amazon, ASOS or Next voucher (you choose).

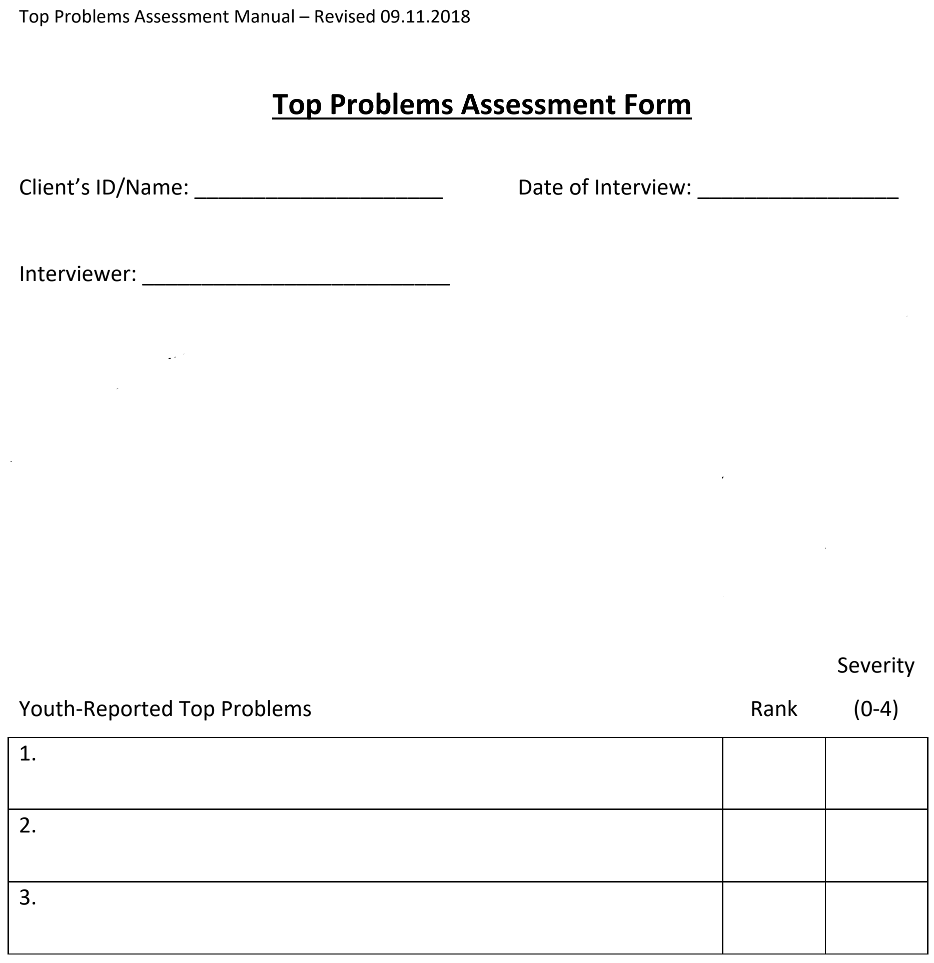
Do I have to be in this study?

No! You don't have to be in the study. No one will be upset if you don't want to do it or want to leave during it. If you don't want to be involved, you just have to tell us. It's up to you.

Privacy

We take your privacy very seriously, so the information collected about you during the study will be anonymised, kept confidential and safely locked up. Only the researchers will know. If we ask you about something you don't want to talk about, you can just tell us and we can talk about something else.

Appendix 6: Top Problems Risk Assessment Form (TPA)



Top Problems Assessment Manual – Revised 09.11.2018

Top Problems Assessment Form

Client's ID/Name: ______________________ Date of Interview: __________________

Interviewer: ___________________________

Youth-Reported Top Problems	Rank	Severity (0-4)
1.		
2.		
3.		

Appendix 7: Consent Form

INFORMATION GUIDANCE AND ASSENT/CONSENT FOR MINOR TO PARTICIPATE IN RESEARCH

'Can you hear us now? Adolescents share their experiences of mental health services using photo, sound and object elicitation'

Principal Researcher:	Katie Wood, Trainee Counselling Psychologist
Supervised by:	Dr Tanya Lecchi, Lecturer, Professional Doctorate in Counselling Psychology
REC Ref No:	ETH2223-2468

We'd like to invite you to take part in a research study. Before you decide if you'd like to take part, it is important that you understand why the research is being done and what it will involve for you. Please take time to read the following information carefully and discuss it with others if you wish. Please ask us if there is anything that isn't clear or if you'd like more information. You'll be given a copy of this information sheet to keep.

What is the purpose of this study?

As part of the Counselling Psychology Doctorate programme we are interested in adolescents' experiences of NHS mental health services. Young people are not often asked what their views of health services are, so these services are not always helpful for this age group. The purpose of this study is to empower 8-10 adolescents to find their "voice" and tell mental health service providers what works well and what doesn't. We want to explore what types of service work well for adolescents and why and how those might be developed. We also want to identify any themes that come up repeatedly in adolescents' experiences of mental health services.

What will it involve?

You're invited because you're aged between 13-18 and have used NHS mental health services in the last 3 years. Participation will involve meeting Katie Wood (Researcher and Trainee Counselling Psychologist), for a quick introductory chat (about 10 mins) about the project and discuss you taking photos, creating or collecting sounds and objects (you choose) that help show your experiences of mental health services. You'll then meet Katie again about a week later, for an informal interview, lasting 60-90 minutes. You will bring your photos, sounds and/or objects to help you talk about your experiences of mental health services. Both meetings will take place online or in an appropriate public place e.g. school, university, library, where you feel comfortable. Katie will audio record the interview and take copies of your photos, sounds and objects.

What are the possible disadvantages and risks of taking part?

Being part of a research team, sharing your experiences and having your voice heard can be an empowering experience. Your participation could help other children who use mental health services that value young people's perspectives. You will receive a £20 Amazon, ASOS or Next voucher (you choose) for your time at the end of the interview. There is a risk you might become distressed sharing your experiences of mental health services. In which case, you can decide whether to discuss this with Katie or to your school counsellor (if available). Should we think you need further support we will advise you talk to a close family member or friend, your GP or local NHS mental health service or charity.

Confidentiality and Anonymity

Your responses will be anonymous. To do this, we will not use your name, we will assign you a code and all the digital copies of your photos, sounds and objects will be stored under this code. So no one can identify you from your information. However, there are some instances when we would have to share your information with other people: if you say at any point that you are at risk of harm from yourself or others. In such a case, we may deem it necessary to contact services for your safety and the safety of others.

Do I have to take part?

No, being part of this study is voluntary and you can choose not to participate in part or all of the project. You can withdraw at any stage of the project without any penalty or being disadvantaged in any way. If you are asked a question at any time during this research that you don't want to answer, you are completely within your rights to decline, and this won't affect your part in the research.

It is up to you to decide whether you want to take part. If you decide to take part, you will be asked to sign the form below. But even if you sign this form, you can still withdraw at any time and without giving a reason. Once the information we collect has been anonymised and published, you will no longer be able to withdraw it.

If you want to stop participating in the study, we will ask you if we can continue to use the information we already have. If you don't want us to, we will destroy the information. If you decide that we can keep the data, we may use this in our analyses to better understand how teenagers experience mental health services. All information will be stored securely and confidentially, digitally on a password encrypted computer.

What happens when the study stops?

Once all the information has been collected from all the teenagers taking part, Katie will write about it as part of her final doctoral thesis (which she aims to finish within 6 months from now). Katie might present it at professional presentations and publish it in professional journal publications. Your anonymity will be maintained, and no personally identifiable information will be used. If further research in this area is conducted, researchers might compare their study findings with the information from this study. Your data will only be reused in studies that have been ethically approved. In this case, we will contact you to see if you consent to your information being used again. Your information will be kept for a maximum of 10 years, after which it will be deleted.

Who approved this research?

This study has been approved by City, University of London, Psychology Research Ethics Committee.

What do I do next?

If you have any questions, please don't hesitate to contact us. If you'd like to participate, please fill out the form below and email or post it to Katie Wood.

Katie Wood, Principal Researcher and Trainee Counselling Psychologist
Department of Psychology
City, University of London
Northampton Square
London EC1V 0HB
Tel: 020 7040 0249

[redacted]

		Please tick or initial box
1	I confirm that I have read and understood this information guidance. I have had the opportunity to think about the information and ask questions which have been answered satisfactorily.	
2.	I understand that my participation is voluntary and that I am free to withdraw our consent without giving a reason without being penalised or disadvantaged.	
3.	I understand that I will be able to withdraw my data up to the time of publication.	
4.	I agree to the interview being audio recorded.	
5.	I agree to the researcher taking copies of my photos, making digital copies of my sounds and photographing my objects.	
6.	I agree to maintain the confidentiality of the interview.	
7.	I agree to the researcher using direct quotes from me (but which are anonymous).	
8.	I agree to City recording and processing this information about me. I understand that this information will be used only for the purpose(s) explained in the participant information and my consent is conditional on City complying with its duties and obligations under the General Data Protection Regulation (GDPR).	
9.	I would like to be informed of the results of this study once it has been completed and understand that my contact details will be retained for this purpose.	
10.	I agree to taking part in the above study.	

____________________ ____________________ ____________________

Name of Participant Signature Date

____________________ ____________________ ____________________

Name of Researcher Signature Date

(When completed, 1 copy for participant, 1 copy for researcher file.)

Data Protection Privacy Notice

What are my rights under the data protection legislation?
City, University of London is the data controller for the personal data collected for this research project. Your personal data will be processed for the purposes outlined in this notice. The legal basis for processing your personal data will be that this research is a task in the public interest, that is City, University of London considers the lawful basis for processing personal data to fall under Article 6(1)(e) of GDPR (public task) as the processing of research participant data is necessary for learning and teaching purposes and all research with human participants by staff and students has to be scrutinised and approved by one of City's Research Ethics Committees.

The rights you have under the data protection legislation are listed below, but not all of the rights will be applied to the personal data collected in each research project.

- right to be informed
- right of access
- right to rectification
- right to erasure
- right to restrict processing
- right to object to data processing
- right to data portability
- right to object
- rights in relation to automated decision making and profiling

For more information, please visit www.city.ac.uk/about/city-information/legal

What if I have concerns about how my personal data will be used after I have participated in the research?
You should raise any concerns with the research team first, but if you are not happy with their response, please contact the Information Governance Team (see below), who will liaise with City's Data Protection Officer Dr Emma White to answer your query.

Information Governance Team
Email: dataprotection@city.ac.uk
Tel: 020 7040 4000

If you are dissatisfied with City's response you may also complain to the Information Commissioner's Office (see below):

Information Commissioner's Office
Website: www.ico.org.uk

What if there is a problem?
If you have any problems, concerns or questions about this study, you should ask to speak to a member of the research team. If you remain unhappy and want to complain formally, you can do so through City's complaints procedure. To complain about the study, you need to phone 020 7040 3040. You can then ask to speak to the Secretary to Senate Research Ethics Committee and tell them that the name of the project is 'Can you hear us now? Adolescents share their experiences of mental health services using photo, sound and object elicitation'. You can also write to the Secretary at:

[redacted]

City holds insurance policies, which apply to this study. If you feel you have been harmed or injured taking part in this study, you may be eligible to claim compensation. This does not affect your legal rights to seek compensation. If you are harmed due to someone's negligence, then you may have grounds for legal action.

Thank you for taking the time to read this information sheet!

Appendix 8: Parent/Carer Consent Form

PARENTS'/CARERS' INFORMATION GUIDANCE AND CONSENT FOR MINOR TO PARTICIPATE IN RESEARCH

'Can you hear us now? Adolescents share their experiences of mental health services using photo, sound and object elicitation'

Principal Researcher:	Katie Wood, Trainee Counselling Psychologist
Supervised by:	Dr Tanya Lecchi, Lecturer, Professional Doctorate in Counselling Psychology
REC Ref No:	ETH2223-2468

What is the purpose of this study?

As part of the Counselling Psychology Doctorate programme we are interested in adolescents' experiences of mental health services. Young people are not often asked what their views of services are, so services are not always helpful for this age group. The purpose of this study is to empower 8-10 adolescents to find their "voice" and tell mental health service providers what works well and what doesn't. We want to identify any themes that come up repeatedly in adolescents' experiences of mental health services. We want to discover what types of service work well for adolescents and why and also how these might be developed. To allow your child to express themselves most fully we will use photo, sound and object elicitation whereby your child can bring photos, sounds and objects to help them express issues that are important to them.

What will it involve?

Your child has been invited because they are aged between 13-18 and have used mental health services in the last 3 years. Participation will include: taking photos, creating/collecting sounds and objects to show their experiences of mental health services. They will then discuss their photos, sounds and objects in an informal interview with Katie Wood (Researcher and Trainee Counselling Psychologist) lasting 60-90 minutes either online or in an appropriate public place e.g. school, university, library, where your child feels comfortable. Katie will audio record the interview and take copies of the photos, sounds and objects.

What are the benefits and risks?

Being part of a research team, sharing their experiences and having their voice heard can be an empowering experience for your child. Their participation could help other children who use mental health services that value young people's perspectives. Your child will receive a £20 Amazon/ASOS or Next voucher (depending on their preference) for their time at the end of the interview. There is a risk that your child might become distressed sharing their experiences of mental health services. In this case, they will be asked if they want to discuss this with Katie, or be guided to a school counsellor (if available). Should we think your child needs further support we will advise they talk to yourself/another close family member or friend, their GP or local NHS mental health service or charity.

Confidentiality and Anonymity

Your child's responses will be anonymous. In order to do this, we will not use your child's name, instead we assign them a code and all the digital copies of their photos, sounds and objects and information will be stored under this code. However, there are some instances when we would have to share yours or your child's information with other people. If your child says at any point that they are at risk of harm from themselves or to others or from others. In such a case, we may deem it necessary to contact services without discussing this with your child or yourself first, for their safety and the safety of others.

Voluntary Participation?

This study is voluntary which means that you don't have to let your child participate. You also have the option to allow them to start and then stop at any point should you or they wish. There will be no penalty or repercussion for you or your child if your child decides to stop participating. If your child is asked a question at any time during the course of this research that they do not want to answer, they are completely within their rights to decline. This will not affect their part in the research.

If you wish your child to withdraw from the study, I will ask you if we can continue to use the information we already have. If you don't want me to, I will destroy that information. If you decide that I can keep the data, I may use this in my analyses to better understand how adolescents experience mental health services. All information will be stored securely and confidentially, digitally on a password encrypted computer.

It is up to you to decide whether or not you want your child to take part. If you decide they can, please sign the consent form below on your child's behalf. Even if you sign the consent form, you or your child may still withdraw at any time and without giving a reason. Once information we collect has been anonymised and published, you will no longer be able to withdraw it.

What happens when the study stops?

Once all the information has been collected, Katie will write about it as part of her final doctoral thesis (which she aims to finish within 6 months from now). Katie might present it at professional presentations and publish it in professional journal publications. Anonymity will be maintained and no personally identifiable information will be used. If further research in this area is conducted, researchers might compare their study findings with the information from this study. Your child's data will only be reused in studies that have been ethically approved. In this case, we will contact you to ask if you consent to the information being used again. The information will be kept for a maximum of 10 years, after which it will be deleted.

Who approved this research?

This study has been approved by City, University of London, Psychology Research Ethics Committee.

What do I do next?

If you would like your child to participate, please fill in the form below and email or post it to Katie (details below). If you have any questions please do not hesitate to contact Katie.

Katie Wood, Principal Researcher and Trainee Counselling Psychologist
Department of Psychology
City, University of London
Northampton Square
London EC1V 0HB
Tel: 020 7040 0249
[redacted]

		Please tick or initial box
1	I confirm that I have read and understood this information guidance. I have had the opportunity to consider the information and ask questions which have been answered satisfactorily.	
2.	I understand that my child’s participation is voluntary and that my child and/or I am free to withdraw our consent without giving a reason without being penalised or disadvantaged.	
3.	I understand that I will be able to withdraw my child’s data up to the time of publication.	
4.	I agree to the interview being audio recorded.	
5.	I agree to the researcher taking copies of my child’s photos, making digital copies of their sounds and photographing their objects.	
6.	I agree to maintain the confidentiality of the interview.	
7.	I agree to the researcher using direct quotes from my child (but which are anonymous).	
8.	I agree to City University recording and processing this information about my child. I understand that this information will be used only for the purpose(s) explained herein and my consent is conditional on City University complying with its duties and obligations under the General Data Protection Regulation (GDPR).	
9.	I would like my child to be informed of the results of this study once it has been completed and understand that my contact details will be retained for this purpose.	
10.	I agree to my child taking part in the above study.	

____________________ ____________________________ _____________
Name of Participant (Child) Signature Date

____________________ ____________________________ _____________
Name of Parent/Carer Signature Date

____________________ ____________________________ _____________
Name of Researcher Signature Date

(When completed, 1 copy for participant, 1 copy for researcher file.)

Appendix 9: Adapted SHOWeD Guide

SHOWeD Guide (Shaffer, 1983): Questions to elicit group discussion of photographs

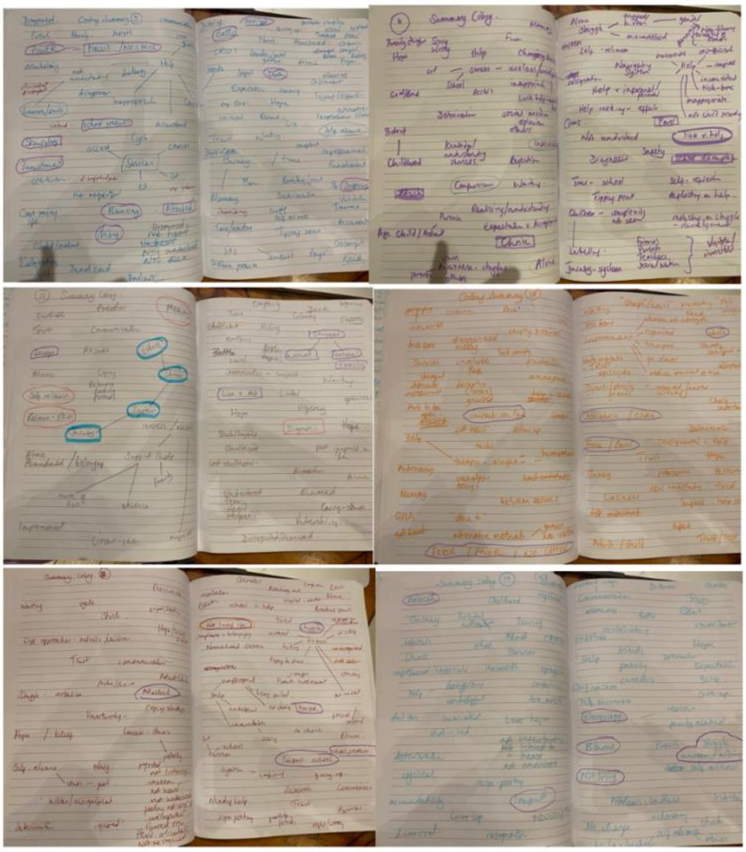
Research	S - What do you **S**ee here?	New Knowledge
	H - What is really **H**appening here?	
	O - How does this relate to **O**ur lives?	
	W - **W**hy does this concern, situation, or strength exist?	
Disseminate	E - How can we become **E**mpowered through our new understanding?	Change
	D - What can we **D**o?	

Adapted to:

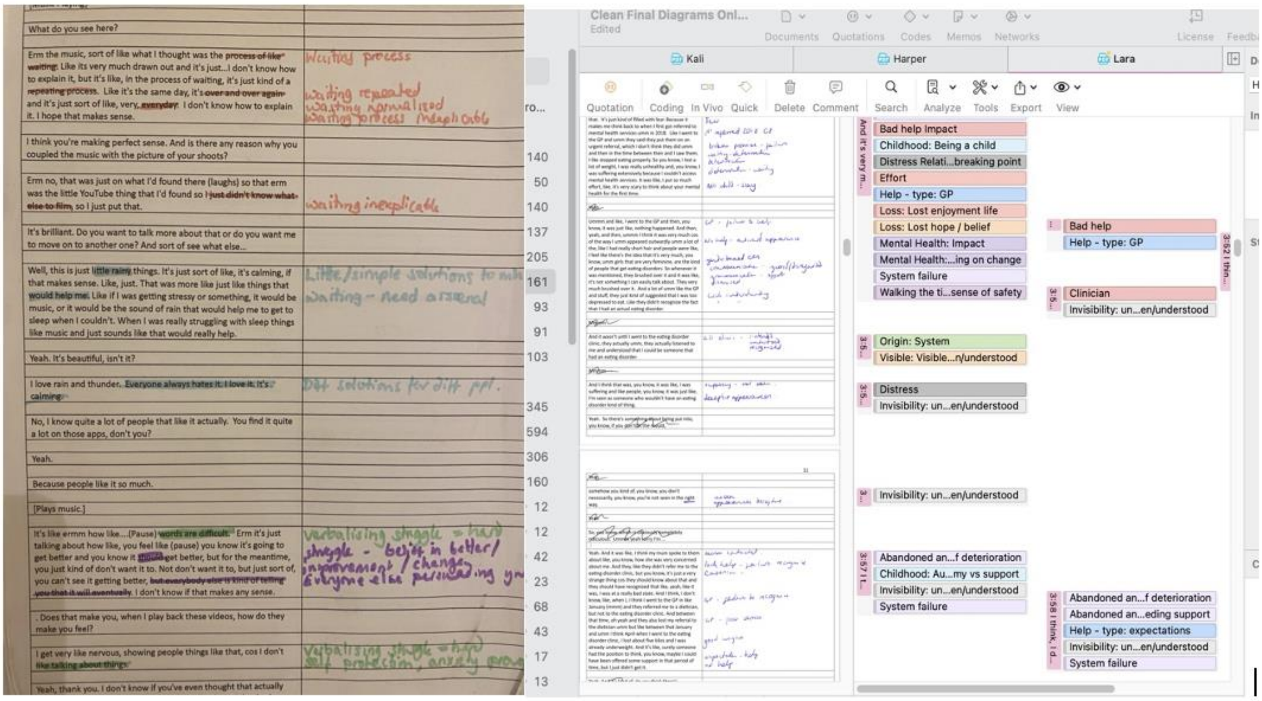
Questions to prompt discussion of images, sounds and objects in semi-structured interview

Research	What do you **S**ee/hear/feel here?	New Knowledge
	What is really **H**appening here? Why did you take this photo/choose or create this sound/choose this object?	
	How does this relate to your life?	
	Why does this concern, situation, or strength exist?	
Disseminate	What can we do about it?	Change

Appendix 10: The Analytic Process – Generating Initial Codes

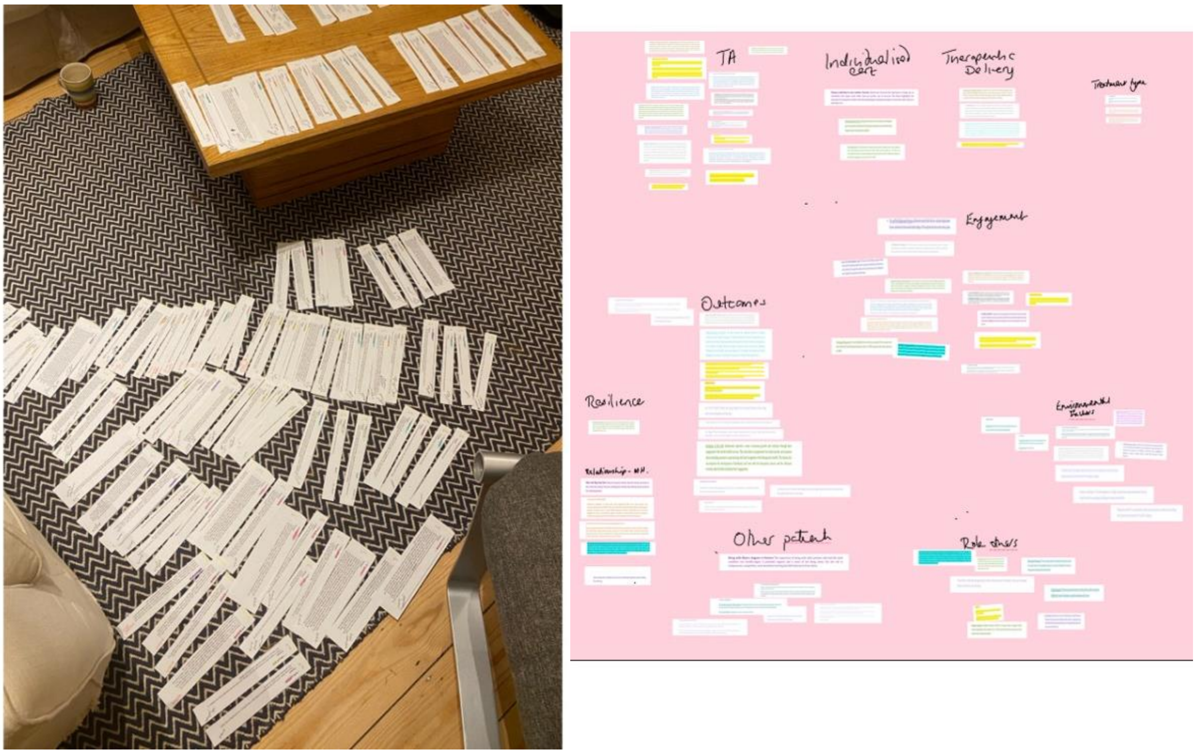


Initial coding summaries for individual transcripts – trying to see the patterns



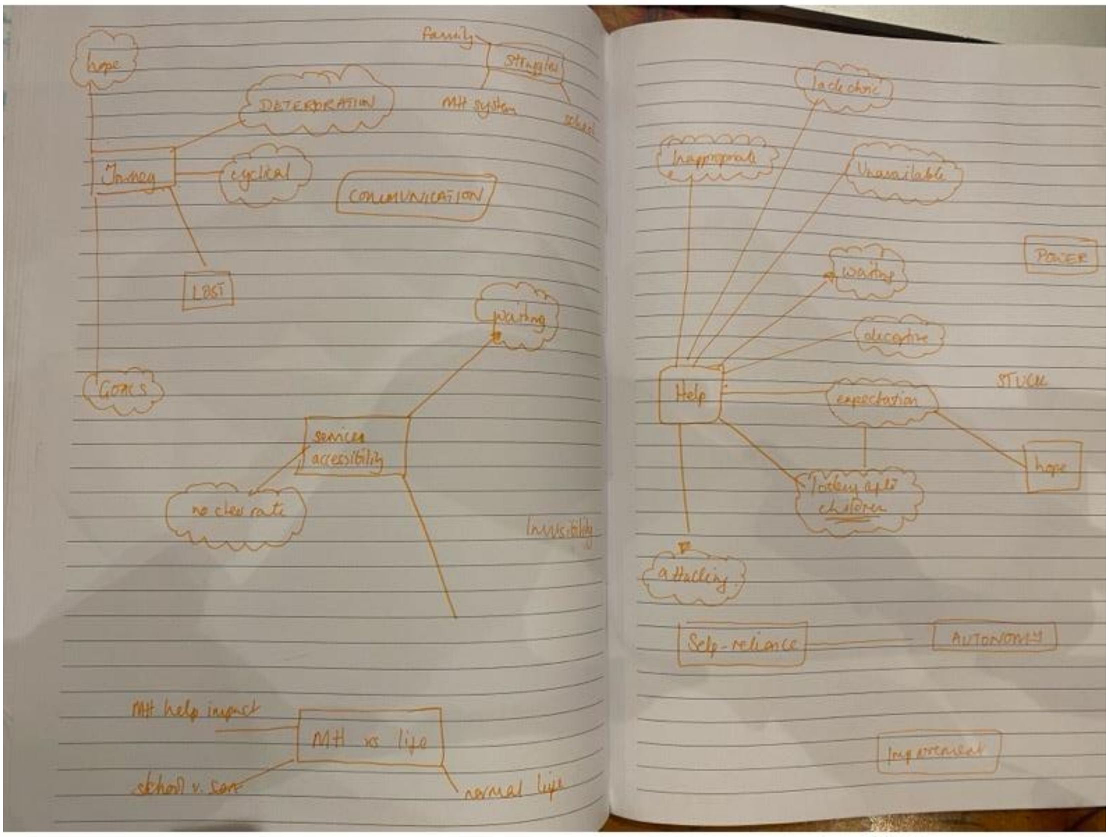
What do you see here?	
Erm the music, sort of like what I thought was the process of like waiting. Like its very much drawn out and it's just...I don't know how to explain it, but it's like, in the process of waiting, it's just kind of a repeating process. Like it's the same day, it's over and over again and it's just sort of like, very, everyday. I don't know how to explain it. I hope that makes sense.	Waiting process waiting repeated waiting normalized waiting process inexplicable
I think you're making perfect sense. And is there any reason why you coupled the music with the picture of your shoots?	
Erm no, that was just on what I'd found there (laughs) so that erm was the little YouTube thing that I'd found so I just didn't know what else to film, so I just put that.	waiting inexplicable
It's brilliant. Do you want to talk more about that or do you want me to move on to another one? And sort of see what else...	
Well, this is just little rainy things. It's just sort of like, it's calming, if that makes sense. Like, just. That was more like just like things that would help me. Like if I was getting stressy or something, it would be music, or it would be the sound of rain that would help me to get to sleep when I couldn't. When I was really struggling with sleep things like music and just sounds like that would really help.	Little/simple solutions to waiting - need arsenal
Yeah. It's beautiful, isn't it?	
I love rain and thunder. Everyone always hates it. I love it. It's calming.	Diff solutions for diff ppl.
No, I know quite a lot of people that like it actually. You find it quite a lot on those apps, don't you?	
Yeah.	
Because people like it so much.	
[Plays music.]	
It's like ermm how like....(Pause) words are difficult. Erm it's just talking about how like, you feel like (pause) you know it's going to get better and you know it should get better, but for the meantime, you just kind of don't want it to. Not don't want it to, but just sort of, you can't see it getting better, but everybody else is kind of telling you that it will eventually. I don't know if that makes any sense.	verbalising struggle = hard struggle - belief in better/ improvement / change Everyone else persuading
. Does that make you, when I play back these videos, how do they make you feel?	
I get very like nervous, showing people things like that, cos I don't like talking about things.	Verbalising struggle = hard self protection, anxiety
Yeah, thank you. I don't know if you've even thought that actually	

Examples of manual coding (left) and electronic coding using ATLAS.ti (right)



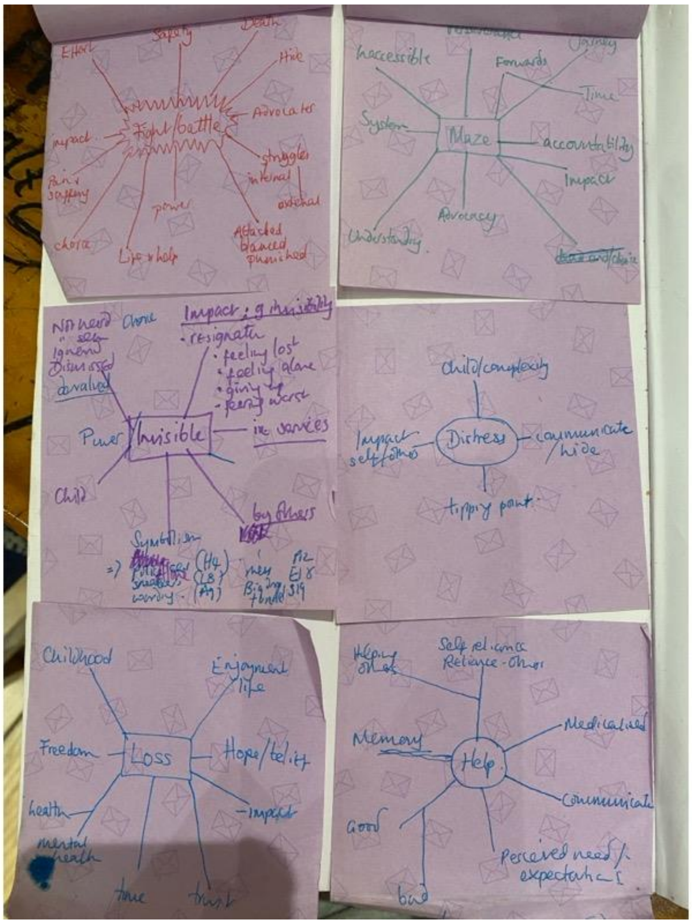
Identifying themes – manually (left) and electronically (right)

Appendix 13: The Analytic Process - Identifying and Reviewing Themes



An early iteration of themes

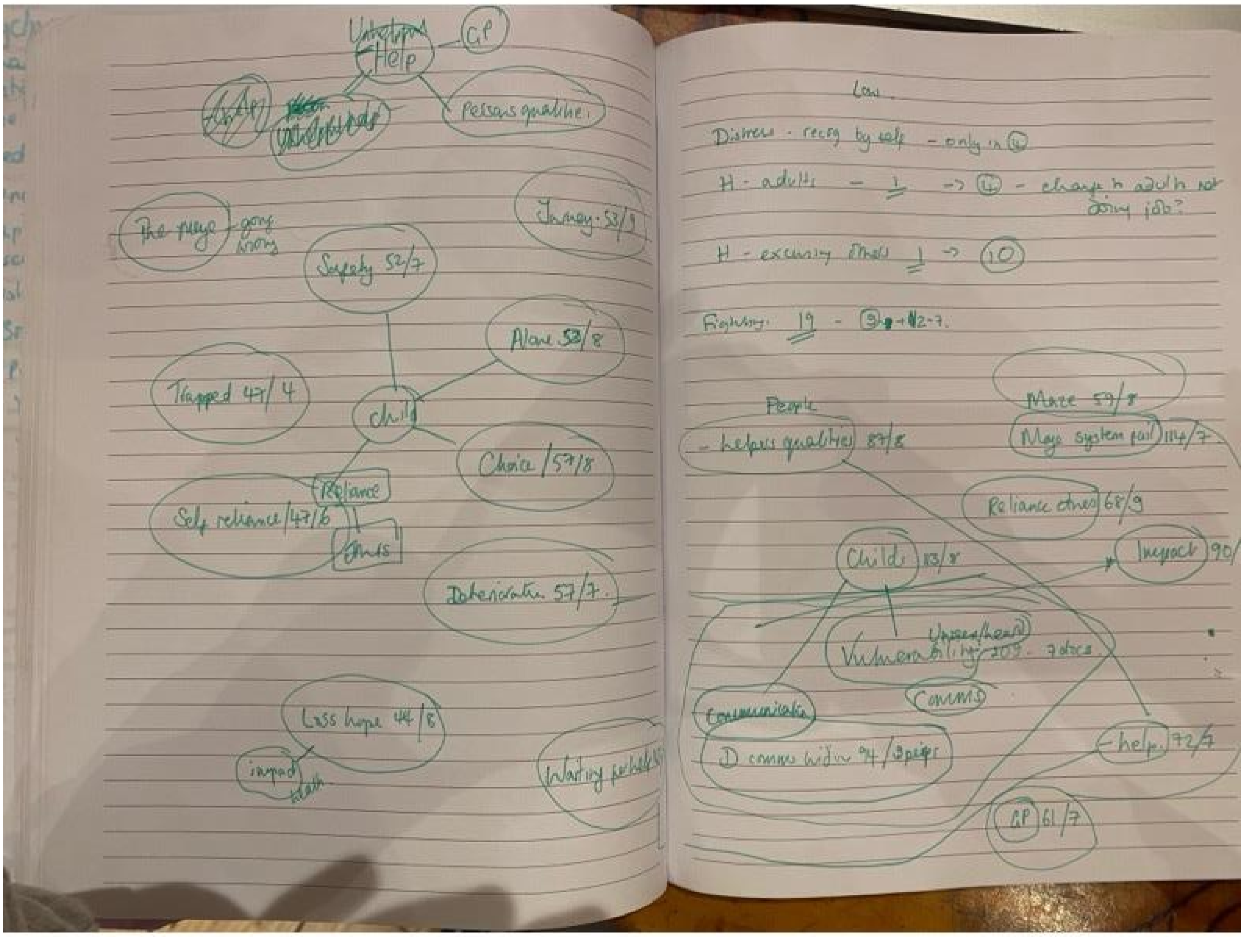
Appendix 14: The Analytic Process - Identifying and Reviewing Themes – Recognising the Importance of Childhood/Child



Starting to make sense of the data, but it did not fit properly, so back to the drawing board.

Appendix 15: The Analytic Process - Identifying and Reviewing Themes – Recognising the Importance of Childhood and Being a Child

---



Recognising the significance of Childhood and Being a Child

Can You Hear Us Now? Adolescents share their experiences of mental health services using photo, sound and object elicitation

DEBRIEF INFORMATION

Thank you for your hard work in this study and for being such a great co-researcher! Now that it's finished, we'd like to tell you a bit more about it.

What did we do? Our research wanted to find out what adolescents' experiences of mental health services are. More specifically, we wanted to:

- ☐ identify any recurring themes and sub-themes from adolescent service users' narratives, images, sounds and objects, and explore how these aspects can be communicated to and inform mental health service development;
- ☐ discover what works well and what doesn't in MHS for adolescents;
- ☐ highlight any areas of services that could be changed to improve adolescents' mental health and communicate these to relevant stakeholders;
- ☐ explore what types of service are particularly suited to adolescents and why and how these might be developed and convey this to service providers.

How did we do it? To achieve these goals, we asked you to take photos or create/collect sounds and/or objects that show your experiences of mental health services. We then discussed these photos, sounds and objects and talked about your experiences.

Further support… Going through your experiences, showing them through photos, sounds and objects and discussing them might have been hard or upsetting for you sometimes. So, we'd like to recommend you contact any of the following places if you need any help:

School or college -	If your school or college has a school nurse, pupil support or counselling service, these can be really helpful if you want to discuss any issues. If you're not sure, you can ask a teacher or a member of staff you trust.
Your local doctor (GP)	Doctors can answer any questions you have about your health and give you a safe space to talk. They can also ☐ give you information ☐ offer you support and treatments (such as counselling and medication) ☐ refer you to a specialist mental health service such as Child and Adolescent Mental Health Services (CAMHS). If you're not sure who your GP is, please ask your parents or caregiver. If you're aged 16 or over, not registered with one, or want to change your GP, find your nearest GP surgery, call them and ask to sign up. https://www.nhs.uk/nhs-services/gps/how-to-register-with-a-gp-surgery/
Child and Adolescent Mental Health Services (CAMHS) **and** **Children and Young People's Mental Health Services (CYPMHS)**	CAMHS is the name for NHS services that assess and treat young people with emotional, behavioural or mental health difficulties. You might also see CYPMHS, which is a new term that includes ALL services that might be available to help you, as well as CAMHS. Local areas have different support services available. ☐ National Website: https://www.nhs.uk/mental-health/children-and-young-adults/mental-health-support/ You can be referred to CAMHS or CYPMHS by your parents, teacher, social worker or GP. But if you're old enough (over the age of 16), you can refer yourself. You can look up your local area CAMHS here: https://www.nhs.uk/service-search/other-health-services/child-and-adolescent-mental-health-services-camhs For **urgent** help please go to: https://www.nhs.uk/nhs-services/mental-health-services/get-urgent-help-for-mental-health/
Mind -	Mind provides advice and support to empower anyone experiencing a mental health problem. They offer: ☐ A great website packed with lots of award-winning publications about mental health https://www.mind.org.uk/for-young-people/

Would you have your photo taken?

Please take a minute or two to review the
information about our project.

Who are we? Myself and several other adolescents are participating in a research project conducted by Katie Wood, a Counselling Psychology Trainee at City University of London.

What are we doing? We are taking photos of things in daily life that show our experiences of mental health services.

What am I asking you to do? I want to take a picture of you because you are meaningful to my experiences of mental health services.

How will we use the photos?
I will discuss the photos with Katie. Your name will not be shared and your face and other identifiable information will be blurred to protect your identity.

What rights do you have? You have ***full right*** to decide whether or not to be photographed, without having any consequences. Please feel free to contact:

Katie Wood
Trainee Counselling Psychologist
Department of Psychology
City, University of London
Katie.wood@city.ac.uk
Work tel: 020 7040 0249

Supervised by: Dr Tanya Lecchi
Lecturer, Professional Doctorate in Counselling Psychology
Tanya.lecchi@city.ac.uk

Thank you for your participation and for supporting our project!

-------------------------- Return slip for photographer -----------------------------

Name………………………………………………….   Signed: …………………………………………….

Date……………………………

1