THE TRANSITION FROM STATUTORY CHILD AND ADOLESCENT MENTAL HEALTH SERVICES INTO THIRD SECTOR VOLUNTARY AND CHARITABLE SERVICES: AN INTERPRETATIVE PHENOMENOLOGICAL ANALYSIS OF YOUNG PEOPLES' EXPERIENCES

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ABSTRACT

This research thesis qualitatively explores young peoples' lived experiences of transitioning from Child and Adolescent Mental Health Services (CAMHS) provided by the National Health Service (NHS) into voluntary and charitable sector services. Within the current NHS system as is stands today, services for young people in the UK are split between CAMHS and Adult Mental Health Services (AMHS). Despite the national policy, guidance and legislation in place to support the transitional process, many young people fall between the gaps in services. At a time that already poses many challenging and enduring life transitions for young people, they find themselves needing to transition to third sector organisations outside the statutory NHS system.

Semi-structured interviews were conducted with six young people aged 16-25 years who had transitioned from CAMHS into third sector charitable organisations in the counties of Bristol and Gloucestershire. Interpretative Phenomenological Analysis was utilised to analyse the data. Three superordinate themes emerged, of Power (the balance of power between young people and health professionals/charity staff, the experiences of autonomy), Rejection (the shock, loss, and emotional pain of the experience of abandonment) and Identity (the challenges of fitting into the adult world and making sense of their mental health), and an overarching theme voicing the need for quality mental health care for young people.

The research highlights the importance of acknowledging power imbalances, engaging in shared decision making, and empowering young people to develop independence and to identify and obtain their wellbeing needs. The importance of relationships for young people was also a significant finding, as was the role of attachment in the loss of relationships and stability from services. The research further emphasises the complexities and challenges for young people in understanding the self and their identity as they enter the 'adult' world.

The research stresses how young people have clear ideas as to how services should be run and in improving the quality of care they receive, especially in relation to their transition experiences. The research therefore has important implications not only for practitioner, but for commissioners and policy makers of mental health service provision pathways for young people.

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INTRODUCTION

This research qualitatively explores young peoples' lived experiences of transitioning from Child and Adolescent Mental Health Services (CAMHS) provided by the National Health Service (NHS) into voluntary and charitable sector services in the South West regions of Bristol and Gloucestershire. Young peoples' experiences of transitions from CAMHS is a much neglected and under-researched area in the field of psychology and mental health care provision and is considered an area of much needed attention. Within the current NHS system as is stands today, services for young people in the UK are split between CAMHS and Adult Mental Health Services (AMHS). Although there is national policy, guidance and legislation in place to support the transitional process, many young people fall between the gaps in services. It is understood that many young people do not fit referral criteria for AMHS or are not referred to AMHS when reaching the transition boundary, despite having ongoing mental health needs. Young people are therefore left with little choice but to transition to third sector organisations outside the statutory NHS system, at a time that already poses many life transitions that can be both challenging and enduring experiences.

The research aims to give voice to young peoples' experiences of these transitions. Herewith also lies the hope of increasing understanding for healthcare professionals, with the potential to adapt policies and procedures where needed and possible.

The research thesis will commence with a review of the existing literature in this area, detailing the prevalence and perspectives of mental health and the impact on young people, as well as literature on NHS mental health service provision, the prevalence of transitional issues and future directions. It will then move on to a detailed engagement with methodology and method, including an account of researcher reflexivity. The research utilises Interpretative Phenomenological Analysis (IPA) as a method of analysis which is committed to both phenomenology and interpretation. The practical details of how the research was conducted are also clarified in the method section.

The results section then follows with an extensive account of how young people have experienced their transition out of CAMHS when AMHS may not have been immediately available to them. It provides a clear exposition of the journey from participant statements to themes, and then to discussions and conclusions. The results section is centred on three emerging superordinate themes and their subordinate themes, and an overarching theme.

The discussion chapter will attempt to look at the results in relation to the literature review and provides additional literature deemed suitable to report in light of the results. The discussion section then closes with the concluding comments from the research.

LITERATURE REVIEW

In investigating the area of young peoples’ experiences of service transitions in the field of mental health, the researcher was first taken to acknowledging the age group itself and the corresponding developmental and social occurrences and challenges. An age group defined as ‘emerging adulthood’ is discussed in relation to being an important critical developmental period. It is this critical developmental period which coincides with the transition in mental health care provision and the high prevalence of mental health conditions, and thus exploring the developmental literature on this age group offers a valuable understanding of the wider context in which young peoples’ transitions are experienced.

The literature review then focuses on mental health in young people, the prevalence of such mental health difficulties and the psychiatric diagnostic labels this can attract. Mental health and diagnostic labels are inevitably intertwined, and it is difficult to discuss mental health without touching on diagnostic labels. Psychiatrists hold an important role and structure in CAMHS services in the UK, diagnostic labels are therefore common practice and often hold certain social meanings and narratives for individuals. It is for this reason that young people who have attended CAMHS services may be working with, have experience of, or indeed opinions around, diagnostic labels in relation to their mental health and their transitional experiences.

NHS CAMHS services are then discussed, allowing for an understanding of the range of mental health problems that CAMHS services typically treat, and the referral demand on such services. This is followed by a brief exploration as to what psychotherapeutic beginnings, and more importantly, endings can be like for those in therapy and services such as CAMHS, providing a background context to what young people may be experiencing during their transition.

The literature review then moves into looking at the definition and experience of transitional healthcare, the prevalence of transitional care and the issues this raises. Finishing with a look into the future directions of NHS mental health service provision for young people.

Transitions and Emerging Adulthood

Change, and periods of transition, are an inevitable part of life. Some life transitions may run smoothly, however, people can often struggle to adjust to change and may find these periods of life highly stressful and distressing. Although change is the one constant in life, people can often be taken by surprise when change occurs. People's coping styles vary depending on a variety of factors from biology to their family of origin (Schneiderman, 2012). Educational systems and social systems can often set progressive levels of security, reinforcing beliefs that skill mastery produces the predictable comforts of a settled life (Schneiderman, 2012).

Bridges (2004) highlighted some of the challenges in the nature of transitional periods of life. Bridges argued that transitions begin with an ending and end with a beginning, and in between each ending and beginning is a challenging neutral zone, where uncertainty, unpredictability and instability can be experienced. This neutral zone is thought to be discomforting, and something people would rather avoid, but is considered essential for personal growth. Bridges argues that the fundamental challenge with transitions is that they change our circumstances of what is expected, familiar and routine, into something unfamiliar and expected and people can often feel insufficiently equipped to manage.

Transitions can be complex, and can require huge cognitive and behavioural adjustments to be able to manage them effectively (Bridges, 2004). Bridges asserts that there are five main tasks that an individual must master if they are to manage a transition effectively. They are disengagement (separation from the familiar), dismantling (letting of what is no longer needed), disenchantment (discovering that certain things no longer make sense), disidentification (re-evaluating one's identity) and disorientation (a vague sense of losing touch with one's reality).

The transition from adolescence into early adulthood is a critical developmental period comprising major simultaneous changes in all areas of development, including psychological, social, and neurobiological domains (Baggio, Studer, Iglesias, Daeppen, & Gmel, 2017; Schulenberg, Sameroff, & Cicchetti, 2004). This is also the period in which NHS mental health provision is disrupted and transition out of CAMHS and into other mental health services is required. Transitioning into different services whilst in a stage of transitioning to adulthood has already been found to be a difficult experience for young people and they can find themselves being forced to 're-tell' their traumatic stories to new therapists (Harper, Dickson, & Bramwell, 2014). It is therefore important to consider the wider developmental context in relation to what young people are experiencing at the time of their transition from CAMHS. The literature on young people's development is vast and there is not scope within this research thesis to cover the broad range of theoretical understandings. A focus and brief introduction will therefore be given to some of the theories on psychosocial development in relation to identity as young people move into adulthood, and of the development of the ego, as well as neurocognitive developments and the structures of the brain with regards to self-regulation during the period of which young people are required to transition from CAMHS.

The concept of identity is considered to be one of the main psychosocial issues that young people experience as they move through adolescence into adulthood. Erik Erikson's (1950) influential model of psychosocial development provided a valuable framework for understanding psychosocial growth from infancy through to late adulthood. In particular, Erikson was the first to develop the idea of identity, proposing that it is mainly an issue in adolescence from ages 12-19. More recent theory considers identity explorations to take place in a slightly later phase of development in early adulthood from approximately ages 18-25 (Cote, 2006). Markers of psychosocial maturity, such as identity, intimacy and attributional complexity, in early adulthood are thought to predict wisdom and satisfaction in midlife (Sneed, Whitbourne, Schwartz, & Huang, 2012; Webster, 2013). It may therefore be important to consider that as young people are leaving services within CAMHS and entering new adult services, they are already grappling with a developmental process of self-discovery and identity, and learning how to interact with the world around them.

Another area of psychosocial development in the critical years between adolescence and young adulthood is the development of the 'ego'. Ego development describes an individuals' frame of reference by organising life experiences towards coherence and integration (Hy & Loevinger, 1996). Ego development also refers to a master trait signifying an individual's level of personality maturation, however, is not itself an indicator of social adjustment, mental health, or wellbeing (Hy & Loevinger, 1996). Westenberg and Gjerde (1999) argue that self-awareness (the awareness of personal thoughts and feelings in both self and others) represents a developmental 'hurdle' during the transition from adolescence to young adulthood. As ego development matures, it is thought that the individual becomes increasingly more cognitively complex: the self becomes more differentiated, impulses are under greater control, and the individual is more self-aware (Hy & Loevinger, 1996). Individuals experience psychopathology at all levels of ego development, although psychological disorder and dysfunction manifests in different ways depending on developmental history (Ausubel, 1996). These critical developments are happening just as young people are expected to navigate a transition from CAMHS to other services, such as AMHS or third sector mental health services.

In general, from adolescence through early adulthood, negative affect decreases (such as anger and depressive symptoms) while, at the same time, positive affect (such as self-esteem) increases. A number of factors contribute to individual differences in the level of self-esteem that adolescents and young adults experience. Having a partner, the transition to marriage, perceptions of social support, and personality traits (such as higher agreeableness, lower neuroticism) are associated with increases in self-esteem (Wagner, Ludtke, Jonkmann, & Trauwein, 2013).

Adolescence is a time during which brain systems that respond to the prospect of rewards are especially sensitive, but systems that regulate response inhibition, planned problem solving, flexible rule use, impulse control, and future orientation are still developing (Luna, Padmanabhan, & O'Hearn, 2010; Steinberg, 2008).

Research on adolescent brain development suggests that adolescence is emerging as a period of brain growth that is far more sensitive to experience than previously imagined (Steinberg, 2008; Steinberg, 2014). The brain is thought to be substantially more 'plastic' during adolescence than in the years immediately preceding and following adolescence. Adolescence is therefore considered to be the brain's last period of especially heightened malleability (Steinberg, 2014). The brain's malleability does not only permit change for the better, it also allows for change for the worst, and if problems are not treated in adolescence, problems can become entrenched with age (Steinberg, 2014).

Steinberg (2014) argues that developments in the science of the adolescent brain explains not only why adolescence is a valuable period, but why it has become a period in which young people are more susceptible to risky behaviour, mental health problems, and difficulties in making a successful transition to adulthood. Changes in the brain that take place when adolescence begins make adolescents more easily excited, emotionally aroused, and prone to getting angry or upset. However, these brain changes are thought to take place considerably earlier in adolescence than equally critical brain changes that strengthen the abilities to control thoughts, emotions, and behaviours (known as 'self-regulation').

The inability to control emotions and desires, which override logical thought processes, is considered to be caused by the conflict between the prefrontal cortex, the area of the brain that controls self-regulation, and the limbic system, the area that generates emotion (Steinberg, 2014). Given the complexity and depth of on-going brain development during the age at which young people are required to transition out of CAMHS, gives rise to the question as to the suitability of the timing of transfer out of CAMHS services.

The life stage between adolescence and early adulthood, lasting roughly from ages 18 to 25, can be considered the most volitional years of life and Arnett (2000) has termed this life stage as 'emerging adulthood'. Compared with other developmental stages, emerging adulthood is a period in which the greatest possibilities for change typically present themselves (Arnett, 2004b), and may therefore be a time when young people feel a little lost between adolescence and adulthood and experience a desire for self-exploration and experimentation; a time that is relatively independent from traditional social roles and normative expectations, rather than a time characterised as settling into traditional adult roles (Arnett, 2000; Baggio et al., 2017; Nelson & Barry, 2005). Emerging adulthood is a period in which young people experience different lifestyle and world views as well as different psychological states (Baggio et al., 2017).

Arnett (2004a, 2004b) proposed five dimensions related to psychological states in emerging adulthood, distinct from other life stages: that of 'identity exploration', 'experimentation', 'feeling in-between' adolescence and adulthood, 'negativity', and 'self-focus'. Identity exploration is a dimension in which individuals explore different ways of living as they grapple to decide how to define themselves. Experimentation corresponds to an optimistic period of life in which the individual engages in exploring opportunities, whereas negativity refers to the instability associated with emerging adulthood, such as feeling overwhelmed and unsettled. The dimension labelled feeling in-between translates to the uncertainty of individuals as they gradually become adults, that is, no longer identifying as an adolescent but not yet feeling fully adult. The last dimension of self-focus refers to the way in which individuals experience a greater sense of autonomy and personal freedom. Emerging adulthood is believed to be found mainly in industrialised countries and is thought to last the longest in UK, Europe, and Asian countries where the self-focused freedom of emerging adulthood is balanced by obligations to parents and by conservative views of sexuality Arnett (2004a).

Over the past two decades, emerging adulthood has gained considerable attention in public health research and the association between emerging adulthood and psychological correlates have become a major health concern (Baggio et al., 2017). Indeed, transitional life stages can imply significant changes in social roles and contexts, and such changes can contribute to alterations in mental health and psychopathology (Schulenberg, Sameroff, & Cicchetti, 2004).

More recent studies have investigated different patterns of social role configurations in early adulthood (Schulenberg & Schoon, 2012), such as individuals who have completed education with unemployment or who are in employment and living with parents. These studies have shown that individuals with incomplete transitions or who are still negotiating transitions had lower levels of psychosocial wellbeing (Conley, Kirsch, Dickson, & Bryant, 2014; Salmela-Aro, Taanila, Ek, & Chen, 2012).

Transitions to adulthood are no longer thought to be linear sequences. Indeed, young peoples' transitions to adult social roles are characterised by discontinuities and reversals (Seiffge-Krenke, 2013). Emerging adults remain relatively independent from social roles and normative expectations (Arnett, 2000; Nelson & Barry, 2005). As a result, classic adulthood markers may not capture the ambivalence inherent to emerging adulthood (Nelson & Barry, 2005), and because such transition patterns are multiple, using social roles to assess emerging adulthood may present a challenge (Baggio et al., 2017).

Tanner (2015) argues that as our understanding evolves with regards to emerging adulthood as a distinct stage of the life course, there is much to be gained from using the developmental lens to conceptualise a model of mental health in emerging adulthood. The emphasis on emerging adulthood as a critical stage of human development highlights the specific demands placed on young people during the late teenage years and through the 20s. Reconstructing the transition to adulthood from a developmental systems perspective highlights the central importance of the individual making gains in taking responsibility for oneself, meeting one's own needs, and nurturing and scaffolding one's own development and adjustment. Moving away from a social address model of the transition to adulthood (i.e., focusing on role markers such as graduation, employment, marriage, and parenthood) directs focus and attention away from equating educational attainment and occupational prestige with success, therefore neglecting the role of mental health. Tanner further argues that a developmental lens encourages an understanding of mental health for emerging adults as a multidimensional construct that evolves from optimising the person-environment fit towards the realisation of developmental potential.

Tanner considers a developmentally informed model of mental health in emerging adulthood as essential for reducing the unmet needs of this age group within mental health services. Emerging adults are at a critical juncture in the life span, and Tanner proposes that getting mental health needs met in emerging adulthood is of significant importance. Tanner therefore urges for the age-specific and stage-specific barriers to be addressed between emerging adults and the mental health services they need. This speaks directly to the challenges young people face in the need to change between CAMHS and AMHS in the current NHS system. It is a time of significant change in all areas of development as well as a developmentally influential time in terms of mental health, all coming together simultaneously with significant disruption in service provision for young peoples' mental health.

Mental Health in Young People

Half of all mental health disorders over the lifespan are said to occur in the first instance between the age of 7 and 24 years (Jones, 2013). One in ten young people in the United Kingdom have a diagnosed mental health disorder, of whom 75% do not get access to the support they need (Green, McGinnity, Meltzer, Ford, & Goodman, 2005). Literature from the USA reveals that more than 40% of 18 to 29-year-olds meet criteria for at least one psychiatric disorder within a period of 12 months (Kessler, Chiu, Demler, & Walters, 2005).

Although little is known about mental health in emerging adulthood, there is a significant need to attend to the mental health needs of young people in their late teenage years and into their 20s. Life events during emerging adulthood shape personal identity and have a lasting impact throughout adulthood (Demiray, Gulgoz, & Bluck, 2009; Elnick, Matgrett, Fitzgerald, & Labouve-Vief, 1999). These years are also renowned for neuroplasticity (Anderson, 2003) and the potential for both continuity and discontinuity in mental health pathways (Schulenberg, Sameroff, & Cicchetti, 2004).

The literature around attachment and mental health in young people suggests some interesting correlations. Insecure attachments, as originally defined by Ainsworth, Blehar, Waters, and Wall (1978), are associated with increased likelihood of meeting diagnostic criteria for a psychiatric disorder (Mikulincer & Shaver, 2013). Research identifies neurobiological pathways that extend from insecure attachments in infancy that persist as neurobiological vulnerabilities into early adulthood (Moutsiana et al., 2014).

Despite the high prevalence of mental health difficulties, in emerging adulthood compared to later stages of adulthood, service use during these years can be significantly lower than in adulthood (Kessler et al., 2007; Wang, et al., 2007). Young people are often reluctant to access mental health services (Kranke et al., 2010), with male adolescents being significantly less likely to seek professional help compared to females (Chandra & Minkovitz, 2006). The main barriers for young people seeking help have been found to be: fear of peer exclusion, fear of stigmatisation, embarrassment, the belief that seeking help is a weakness, denial of the problem, and not knowing where to find help (Burnham-Riosa, Preyde, & Porto, 2015; Chandra & Minkovitz, 2006; Kranke et al., 2010; Moskos, Olson, Halbern, & Gray, 2007). Although mental health in emerging adulthood historically has not attracted significant attention, recognising these years as a period of the lifespan during which there is an intersection of risk for experiencing psychopathology and unmet need for mental health services points to the need for a developmentally informed conceptual model of mental health in emerging adulthood (Tanner, 2015).

With regards to psychological wellbeing and mental health, emerging adults are deemed to be especially at risk for psychiatric disorders (Kessler, Berglund, Demler, Jin, Merikangas, & Walters, 2005), such as mood and personality disorders (Baldwin et al., 2005; Blanco et al., 2008; Kessler et al., 2005). Among the many mental health problems that can present for young people, depression has been said to remain the most concerning due to its link to suicidal ideation, attempts, and completion (Burns & Rapee, 2006), and the increased risk of further mental health problems in later life (Kessler et al., 2010).

The most common mental health difficulties in emerging adulthood are anxiety disorders, followed by substance and mood disorders (Kessler, et al., 2005). Approximately 22% of emerging adults meet criteria for an anxiety disorder, and 22% meet criteria for a substance use disorder. Among the anxiety disorders, specific and social phobia are most common (10.3% and 9.1%, respectively). Mood and impulse control disorders are less common, but each respectively affects more than 10% of the emerging adult population (i.e., 12.9%, mood disorders; 11.9%, impulse control disorders; Kessler et al., 2005). During the late teens and 20s (those aged 18–29), major depressive disorders are the most common mood disorders (8.3%), followed by bipolar disorders (I and II; 4.7%) and dysthymia (1.1%). Less common yet severe and debilitating disorders are also likely to appear in or around emerging adulthood: schizophrenia, bipolar disorder, and eating disorders (American Psychiatric Association, 2013).

Psychiatric Diagnostic Labels

Psychiatric diagnostic labels often form a significant part of the statutory mental health pathways for young people. Psychiatrists hold an important role and structure in CAMHS services, diagnostic labels are therefore common practice and often hold certain social meanings and narratives for individuals. Diagnostic labels can form a significant journey into and through CAMHS services for young people, and potentially beyond CAMHS and through their transition into further mental health services. Young people who have attended CAMHS services may therefore be working with or have experience of diagnostic labels in relation to their mental health and their transitional experiences between services. The use and value of diagnostic labels is highly debated, and it's position in young people's mental health holds both limitations and benefits.

The NHS system relies upon publications from the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Statistical Classification of Diseases and Related Health Problems (ICD) to provide psychiatric mental health diagnoses and treatment pathways for the population (NHS, 2013). The DSM provides standardised classifications of mental disorders for assisting the process of making a mental health diagnosis. The fifth edition of DSM (DSM-5; American Psychiatric Association, 2013) conceptualises each mental disorder as: "[A] syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning" (p. 20).

The ICD, a medical classification list by the World Health Organization (WHO), is a global health information standard for mortality and morbidity statistics and is increasingly used in clinical care and research to define diseases and study disease patterns, as well as manage health care, monitor outcomes and allocate resources. The eleventh edition of ICD (ICD-11; World Health Organization, 2018) encompasses a mental, behavioural, and neurodevelopmental disorders category, defined as: "syndromes characterized by clinically significant disturbance in an individual's cognition, emotional regulation, or behaviour that reflects a dysfunction in the psychological, biological, or developmental processes that underlie mental and behavioural functioning. These disturbances are usually associated with distress or impairment in personal, family, social, educational, occupational, or other important areas of functioning" (section 6).

The DSM and ICD diagnostic manuals, dubbed 'the psychiatrist's bible', is a tool that many NHS health professionals report to be invaluable in having a diagnostic guide for doctors and psychiatrists to refer to and would proudly defend given the uncertain knowledge of mental health (NHS, 2013). The concept and practice of diagnosis in psychiatry has, however, always been controversial (Kiderman, Allsopp, & Cooke, 2017). Psychiatric diagnostic criteria are revised regularly and it is often assumed that updates of diagnostic manuals reflect scientific advances (Kendler, 2014), however, these changes are thought to be better indications of the socio-political needs and values of the time (Bowker & Star, 1999; Fulford, Thornton, & Graham, 2006; Scott, 1990). The British Psychological Society (BPS, 2011) argues that the putative diagnoses presented in DSM-V are based largely on social norms, with symptoms that rely on subjective judgements, and with little confirmatory physical signs or evidence of biological causation. The criteria are not considered value-free, but rather reflect current normative social expectations.

There is a significant body of literature that argues that experiences of distress can be seen as a natural part of everyday life, and do not form a separate, singular category of symptoms that can be understood in isolation from everything else (Cromby, Harper, & Reavey, 2013). Like all other experiences, experiences associated with distress are bound up with social, cultural and material conditions, and with personal biographies, relationships, and life events (Bentall, 2003; Cromby et al., 2013). Newness, Holmes, and Dunn (1999) argue that a diagnosis is a way of thinking about people's behaviour and their distress, not a way of describing it: a diagnosis involves many assumptions about behaviour and experience that have not been proven to be valid.

The BPS (2011) considers individuals and the general public to be negatively affected by the continued and continuous medicalisation of natural and normal responses to life experiences; responses which undoubtedly have distressing consequences which demand helping responses, but which do not reflect illnesses so much as normal individual variation. Diagnostic systems are also based on identifying problems as located within the individual, bypassing the relational context of problems and the undeniable social causation of many such problems (BPS, 2011). The BPS (2011) also state their concern at the increasing use of diagnostic criteria and of the increasing use of medication for children and young people.

Moncrieff (2013) argues that diagnostic labels do not predict an individual's response to medication or other interventions and are less useful than a description of a person's problems, specific formulations, or symptom clusters for predicting treatment response. Diagnostic systems therefore fall short of the criteria for legitimate medical diagnoses, and alternatives should be preferred, and should be developed (BPS, 2011). The BPS recommends a revision of the way mental distress is thought about, starting with recognition of the overwhelming evidence that it is on a spectrum with 'normal' experience, and that psychosocial factors such as poverty, unemployment and trauma are the most strongly-evidenced causal factors.

Jahoda (1958) once declared that the absence of mental illness is not an indicator of mental health. This was a challenge to the established mental health system, which focused and continues to focus on reducing symptoms of mental illness while ignoring mental health promotion. A comprehensive revision of the way in which we think about and understand psychological distress is considered necessary and important (Cromby et al., 2013; Kinderman, 2014; Kiderman, Allsopp & Cooke, 2017). Proposals for radical change to mental health care come from both the field of psychology (e.g., Kinderman, 2014) as well as the field of psychiatry (e.g., Bracken et al., 2012). It is important to acknowledge that distress is a normal, rather than abnormal, part of human existence and that human beings will naturally respond to difficult circumstances by becoming distressed (Kiderman, Allsopp & Cooke, 2017). Such an approach recognises that there is no straightforward cut-off between 'normal' experience and a 'disorder' (BPS, 2011), and that psycho-social factors such as poverty, unemployment, and trauma are the most strongly evidenced causal factors for psychological distress (Read & Bentall, 2012). Kiderman, Allsopp & Cooke, (2017) argue that while some people find a diagnostic label helpful, this is only because of the implication that their problems are recognised, validated, and understood, and that help is available. Within the current system and frames of reference, a psychiatric diagnosis is often the only way that an individual in distress can have important needs met (Kiderman, Allsopp & Cooke, 2017): validation - acknowledgement that they have a significant and understandable problem for which they are not to blame; income - access to sickness pay and/or disability benefits; and support - emotional and practical support from professionals and those around them.

Despite the debate and controversy around psychiatric diagnostic labels, support remains in many areas for traditional psychiatric diagnosis. Much of this support is pragmatic and reasonable - many practitioners point out that, until there are workable alternatives, diagnosis serves some useful purposes (Kiderman, Allsopp & Cooke, 2017). While diagnostic labels are subject to biases, lack empirical evidence, and are plagued by problems of reliability, validity, prognostic value, and co-morbidity (BPS, 2011), it is considered to be better than anything else currently available (NHS, 2013). Care must be taken to ensure that formulations are genuinely collaborative and co-produced with the individual, rather than becoming another example of something 'done to' service users by professionals.

All views and approaches around psychiatric diagnostic labels are acknowledged by the researcher. Whilst at times diagnostic labels provide a value for individuals within current society, the researcher argues for mental health reform and a social, cultural, and political change to how human distress is understood and treated.

Child and Adolescent Mental Health Services

CAMHS consists of targeted, specialist services for the welfare of children and adolescents. The Social Care Institute for Excellence (SCIE; 2011) stresses the variation of psychological, emotional, and behavioural problems that young people present with when accessing CAMHS, and the rate of co-morbidities is high. These problems can include clinical depression, eating disorders, Autistic Spectrum Disorder, Attention Deficit Hyperactivity Disorder, emerging personality disorders, early psychosis, self-harm, and drug and alcohol misuse.

Between 2013 and 2015, referrals to CAMHS increased by 64% (NHS Benchmarking Network, 2015). A consequence of increased demand in some areas has been increased referral thresholds, meaning services are now accepting fewer referrals, prioritising those with the highest levels of need (Frith, 2016). CAMHS are having to turn away 23% of referrals, and those who are successfully accepted have an average maximum waiting time of 6 months for an initial appointment and almost 10 months until the start of treatment (Frith, 2016).

Psychotherapeutic Beginnings and Endings

Individuals arriving at therapy may have varying emotions at the prospect of embarking on psychological work. They may feel fearful, anxious, ashamed, embarrassed, or antagonistic (Cogan & Porcerelli, 2005; Culley & Bond, 2009), and often judge themselves harshly and anticipate criticism from others (Culley et al., 2009). Individuals may initially mistrust life, other people, and ultimately themselves (Jacobs, 1998), and thus the initial stages of working together will be to develop a secure foundation in the therapeutic relationship from which to work (Culley et al., 2009).

The ending, or 'termination', of psychotherapeutic therapy is widely viewed in the literature as a complex stage, and the manner in which termination occurs can determine whether the gains of therapy are consolidated or damaged (Quintana & Holahan, 1992). Termination is recognised as an emotionally difficult experience for both client and therapist. When questioned about their responses to ending therapy, adult clients most commonly identify a variety of feelings, including: accomplishment, ambivalence, autonomy, independence, sadness, and rejection (Baum, 2005; Bury, Raval, & Lyon, 2007; Fortune, 1987; Fortune, Pearlingi, & Rochelle, 1992; Marx & Gelso, 1987; Roe, Dekel, Harel, Fennig, & Fennig, 2006). Such emotional reactions following termination have been identified as stemming from the degree to which the client and therapist have: reached the goals of therapy, engaged in a gradual process of termination, had the opportunity to explore feelings surrounding termination, and engaged in future orientated discussions (Baum, 2007; Knox et al., 2011; Marx & Gelso, 1987; Roe, Dekel, Harel, & Fennig, 2006). Indeed, Roe, Dekel, Harel, Fennig, and Fennig (2006) found that clients experienced termination as a process in establishing independence, as well as a reflection of the positive aspects of the therapeutic relationship; clients who reported negative feelings about termination voiced feeling that their therapy was not complete and had not had enough opportunity to process their reactions to the termination. It was therefore argued to be understandable that clients in long-term treatment had more satisfaction with the process and more positive feelings towards termination.

Mirabito (2006) explored therapeutic endings for adolescents in a mental health service offering open-ended therapy. Termination from treatment was often unplanned, unannounced, and unilaterally initiated by the clients. Clinicians identified the developmental tasks of adolescence as factors that clearly influenced the ways that they engaged in, and terminated, treatment. Developmental challenges, such as separation, individuation, and autonomy, made forming and ending therapeutic relationships emotionally demanding. A key difference was discovered in the treatment goals of the clients and the therapist which contributed to unplanned terminations: the adolescents generally preferred problem-focused crisis-orientated treatment, whilst therapists preferred insight-orientated long-term treatment. Mirabito therefore argues that consistency in treatment goals can be achieved by developing specific, collaborative, and culturally relevant goals that enable therapists to provide client-centred mental health services.

Transitional Healthcare

NHS services for young people in the UK are split between CAMHS and AMHS. The time point when a young person transfers to AMHS differs according to local service design (such as locality and diagnosis-specific services), and can occur between the ages of 16 and 18 years, although typically before their 18th birthday (Singh, Paul, Ford, Kramer, & Weaver, 2008). Transitional care refers to the co-ordination and continuity of healthcare between different sub-locations or levels of care within the same general location, and describes a process that begins with preparing a service user to leave one setting and is complete when the service user is accepted into the next setting (Coleman & Berenson, 2004).

It is believed that half of all adult mental health disorders begin in adolescence (Jones, 2013), affecting young people just when they require transition into adult services (Paul, Street, Wheeler, & Singh, 2015). Although many health professionals view transitions within the healthcare system as both a necessary and inevitable component of a patients' pathway (Carroll, 2013), it has been argued that mental health services underestimate the anxiety that young people experience when transitioning between services (Dunn, 2017). Young people and their families can feel ambivalent towards their unknown future, as well as unsettled, anxious, stressed, abandoned, and confused about the transition process, and often express a lack of regard for their preferences regarding the planning of their healthcare (Burnham-Riosa et al., 2015; Carroll, 2013).

Reports from over two decades ago showed that only 23% of mental health services in the UK had specific arrangements for transition from CAMHS to AMHS (Audit Commission, 1999) and a widespread view was that the process of transition was unsatisfactory for users, carers and professionals. In the current day, although a few pioneering regions of the UK have transformed young peoples' mental health services to offer provision up to the age of 25, most still require young people attending CAMHS to transition to an adult service for ongoing mental health or psychosocial problems, or to be discharged at age 17/18 (Department of Health, 2004; Dunn, 2017). From the mental illness and social adjustment perspectives, this age cut off is considered an artificial boundary, creating a system which is "weakest where it needs to be strongest" with risks to ongoing treatment and care (McGorry, Bate, & Birchwood, 2013, p30), and still often leads to a "cliff-edge of lost support as young people with mental health needs reach the age of 18" (Department of Health, 2014, p26). Transition occurs during a period of increased risk for onset of mental health difficulties and young people are negotiating complex physical and psychosocial changes and demands, and the current system offers little flexibility to account for individual differences in maturity, readiness, functioning, wellbeing, or life context (Dunn, 2017). Reports have even shown that young people have been known to commit suicide during their transition (Healthcare Safety Investigation Branch, 2018).

Consensus is growing, however, that this age-based cut-off, albeit convenient for service providers, is not in the best interests of young people (McGorry, Bate, & Birchwood, 2013). Inefficiencies and weaknesses in the current system have been highlighted and have triggered renewed focus in exploring services for the 14–25 year age group, which includes looking at cross-service approaches to better manage this period of incident risk for mental illness and personal adjustment into more independent adult living (Department of Health, 2014).

It is estimated that more than 25,000 young people transition from CAMHS to AMHS each year (Healthcare Safety Investigation Branch, 2018), and although there is national policy, guidance and legislation in place to support the process, the TRACK study reported that only 4% of young people received an 'ideal' transfer (Singh, Paul, Ford, Kramer, & Weaver, 2008). The TRACK study was a study of the transitions of care from CAMHS to AMHS, conducted to identify transition protocols, population served and referral rates to AMHS. It was found that three quarters of the transition protocols had no provision for ensuring continuity of care for cases not accepted by AMHS. The discrepancy in numbers thought suitable for transition and the numbers that actually make the transition, raises questions about the outcomes of those who 'graduate' from CAMHS but are not accepted by AMHS. Since only a small proportion of these cases continue to receive care from CAMHS beyond the transition boundaries, it was argued that the outcome for the rest, who slip through the care net, must become an area of urgent priority.

Indeed, Memarzia, St Clair, Owens, Goodyer, and Dunn (2015) went on to follow two vulnerable groups of young people, each facing transition from a child and adolescent centred service by age 18, one such group was young people from CAMHS facing discharge, transferral to GP care, AMHS or other services. These young people showed extensive and persistent psychosocial difficulties and psychiatric disorder after leaving CAMHS. The prevalence of psychiatric disorder was more than four times higher than observed in the local community, and non-suicidal self-injury and psychotic-like symptoms were three to five times higher. In effect, more than 80% of participants showed persisting mental health, social or employment problems that were largely unchanged over the 12-month follow-up period.

Furthermore, Islam et al (2016) conducted a secondary analysis of the TRACK study data to investigate healthcare provision for young people with ongoing mental health needs, who were not transferred to AMHS. Over four-fifths of the TRACK cohort cases were considered suitable for transfer to AMHS (85.1%), but over a third of these (40.0%) were not referred when reaching the transition boundary, despite having ongoing mental health needs. These cases typically had neurodevelopmental or emotional disorders, highlighting that young people with these disorders are those most likely to fail to access secondary healthcare. Although a small proportion of cases were referred to other third sector services, these were not always focused on the mental health needs of the young person. Islam et al. also report that the most common reasons for CAMHS not making a referral to AMHS was rejection of the referral by the young person and/or their carer, the resolution of clinical need, and failing to refer to AMHS/identify need.

The literature on transitions between CAMHS and AMHS highlights that young people who have received a service from CAMHS may continue to experience a high degree of impairment in the context of mental health problems that do not clearly fulfil diagnostic criteria, but are nevertheless not referred or accepted into AMHS (Islam et al., 2016; Lamb, Hall, Kelvin, & van Beinum, 2008; Lamb & Murphy, 2013; Memarzia et al., 2015; Singh et al., 2010). The ageist structure of mental health and social care services results in vulnerable young people losing access to stable youth supports and entering an unfamiliar and highly variable system of care and service provision (Memarzia et al., 2015).

The planning and management of transitions is said to be a key element in the organisation and delivery of healthcare (National Mental Health Development Unit, 2011; Reiss & Gibson, 2002). Significant discontinuity exists between CAMHS and AMHS services, primarily due to poor planning and lack of co-ordination (Paul et al., 2015; Singh, 2009). Successful transition is believed to require high mental health self-efficacy and self-confidence (Burnham-Riosa et al., 2015). An individual's readiness for transition is also said to be a key factor for the success of the transition and should take priority over age (Dimitropoulous, Tran, Agarwal, Sheffield, & Woodside, 2012; Delman & Jones, 2002). Indeed, Colver et al. (2013) urge that approaches to improving transition between services must be set in a developmental context.

Burnham-Riosa et al. (2015) captured the underpinnings of the transition process that is of importance to young people for its success: a gradual transition process; to receive detailed information regarding the transition process and the subsequent service; to continue in an engaging, open and client-centred relationship with health professionals; and to have open communication between child and adult health professionals through the transitioning period. Young people often have clear ideas about the preparation they require to leave CAMHS with the confidence to take responsibility for their own healthcare; they want to be included and play an active role in the transition process, and to feel empowered as agents of their own mental health journey (Dunn, 2017; Burnham-Riosa et al., 2015). However, these needs are said to be met with considerable difficulties due to lack of funding and rigid NHS policies and procedures that create barriers to the implementation of young peoples' ideas and wishes (Dunn, 2017).

Mental health disorders in children and young people continue to rise in the UK, with one in eight (12.8%) 5 to 19 year olds having at least one mental disorder according to latest figures from NHS Digital (2018), and many young people are slipping through the gap between mental health service provision. The true current extent and prevalence of this issue, however, is largely unknown.

The Future for Mental Health Services for Young People

In recent years, the importance of providing more efficient and effective services for child and adolescent mental health has risen up the political agenda (Frith, 2016). The NHS England (2015) taskforce report, 'Future in Mind', provides a vision for a comprehensive approach to promoting, supporting, and treating children and young people's mental health. This taskforce report argues that making mental health support more visible and accessible should be a priority. It is recognised that the voluntary and charitable sector can be especially effective in reaching out to children and young people to provide help and support in non-stigmatised, accessible, and welcoming environments, thus NHS services should form stronger partnership working with the voluntary and charitable sector and local communities.

The Department of Health and Department for Education (2017) Green Paper reports that financial incentives have been introduced by NHS England to improve the experiences of young people leaving mental health services on the basis of age. This sets out a framework for joint-agency transition planning with young people, parents, and carers involved in all key decisions.

In January 2019, NHS England published the 'NHS Long Term Plan' setting out key ambitions for NHS services over the next 10 years. The plan reaffirms that mental health funding, provided through a ring-fenced investment fund, will outstrip total NHS spending growth in each year between 2019/20 and 2023/24 so that by the end of the period, mental health investment will be at least £2.3 billion higher in real terms. There are two significant commitments to developing new models of care. The first is to create a comprehensive offer for children and young people, from birth to age 25, with a view to tackling problems with transitions of care. The second is to redesign core community mental health services by 2023/24, reinforcing components such as psychological therapies, and introducing personalised care within NHS mental health services. These commitments will be backed up by new waiting time standards covering emergency mental health services and children and young people's mental health services.

In July 2019, NHS England and NHS Improvement published the NHS Mental Health Implementation Plan 2019/20-2023/24 (NHS England & NHS Improvement, 2019) to provide guidance for local areas on how to deliver the mental health ambitions within the Long Term Plan through the development and delivery of their local plans for the next 5 years. The guidance is primarily aimed at the leaders of local Sustainability and Transformation Partnerships (STPs) and Integrated Care Systems (ICSs) and sets out information on funding, transformation activities and indicative workforce numbers to support the development of local plans. By 2023/24, 345,000 additional children and young people aged 0-25 years will have access to support via NHS-funded mental health services and school or college-based Mental Health Support Teams. There is stated to be a comprehensive offer for 0-25 year olds that reaches across mental health services for children and young people, and there is stated to be 100% coverage of 24/7 mental health crisis care provision for children and young people which combines crisis assessment, brief response and intensive home treatment functions.

These NHS plans are much welcomed and, although yet to be seen in practice, it is hoped that these plans help to provide a transparent, workable and valued transitional pathway for young people with mental health difficulties in the UK.

RESEARCH RATIONALE, AIMS AND OBJECTIVES

Research Rationale

Young people face many transitions that can be both challenging and enduring experiences. Mental health problems amongst young people are extremely prevalent, and the vast majority of young people are not able to receive the support they need. NHS England therefore stress the importance of developing more consistent and cohesive partnerships between CAMHS and voluntary/charitable organisations, recognising the value these organisations hold in reaching out to young people in non-stigmatised and client-centred environments, in order to better promote, support, and treat mental health problems.

Within the current NHS system as is stands today, transitions to organisations outside the statutory NHS system is both inevitable and important, thus it is of value for healthcare professionals to understand how these transitions can be experienced. To the investigator's knowledge, young people's experiences of transition from CAMHS into the voluntary and charitable sector has not yet been explored, and therefore an understanding of these experiences can further develop supportive, efficient, and effective transitional healthcare.

Research Aims and Objectives

The research aims to explore how young people, aged 16-25 years, experience the transition from CAMHS into the voluntary/charitable sector in Bristol and Gloucestershire. Attention will be given to young people's experiences, understandings, and views about their healthcare transition. The research will generate knowledge that helps to assist health professionals and therapists to enter into the service user's lived experiences, and in doing so, will be able to offer a relational experience and empower young people to be involved in the decision-making processes regarding their healthcare. Extending knowledge in this area may also further inform NHS policy and the voluntary/charitable sectors in helping to establish greater partnership working.

METHODOLOGY AND METHOD

Methodology

In Counselling Psychology, the scientist-practitioner model is well understood and respected (e.g. Douglas, Woolfe, Strawbridge, Kasket, & Galbraith, 2016). However, Counselling Psychologists have contributed to extending the notion of what is scientific beyond positivist perspectives to include qualitative, intersubjective accounts which are perhaps more relevant to its practice than the production of nomothetic data (Douglas et al., 2016).

The benefits of qualitative research include its flexibility, the opportunity to access meanings, perspectives and interpretations while remaining sensitive to all types of diversity (Willig, 2008). Qualitative methods explore and reveal the complex reality constructed by individuals in the context of their everyday worlds (Erlingsson & Brysiewiez, 2013). Qualitative methods can also give voice to those who may have difficulties being heard in everyday life, provide opportunities for service users to express their perspectives therefore informing service provision, and can challenge disempowerment and stereotypes by validating individuals' experiences (Nelson & Quintana, 2005; Peters, 2010; Willig, 2008).

Mental health research is complex and engagement with mental health research can also be challenging for all involved. Topics may be highly sensitive, individuals may have impaired capacity or be at high risk, and mental health problems are multifactorial in their aetiology and the consequences they have on the individual, families, and societies (Peters, 2010). Qualitative methods are particularly suited for explorations around mental health (Peters, 2010) and for use with children and young people (Nelson & Quintana, 2005). Qualitative methods are also suited to research by clinicians, who are skilled at listening and making sense of peoples' lived experience (Nelson & Quintana, 2005).

In light of this, and considering that the research was concerned with the exploration of lived experiences, the design of the research employed a qualitative methodology. A qualitative methodology allowed for exploration of young peoples' subjective experiences of transitioning from a statutory mental health service into a third sector mental health organisation and allows their voices to be heard (Braun & Clarke, 2013). In particular, Interpretative Phenomenological Analysis (IPA) was considered the most relevant methodology to use as it is concerned with the examination of how people make sense of their lived experiences (Smith, Flowers & Larkin, 2009), and the anticipated outcome was one of understanding rather than explanation (Smith & Osborn, 2003).

Epistemology of IPA.

What is IPA?

IPA is a qualitative research approach committed to the examination of how people make sense of their lived experiences (Reid, Flowers & Larkin, 2005) and has an emphasis on exploring experiences both flexibly and in detail (Smith & Osborn, 2003). Even though IPA aims to explore the research participants' experience from their perspective, it recognises that such an exploration must necessarily implicate the researchers' own view of the world as well as the nature of the interaction between researcher and participant. As a result, the analysis produced by the researcher is therefore an interpretative account of the participants' experience (Smith, Flowers & Larkin, 2009). IPA occupies a critical-realist ontological perspective, assuming the existence of an ultimate reality while acknowledging that our understanding of this reality is characterised by external factors such as culture, language, and political interests (Braun & Clarke, 2013). It is assumed that people hold insight into their own lived experiences, but that these insights may be sculpted by their own perspectives. The epistemology is broadly contextualist which assumes that meaning is related to the context in which it is produced (Braun & Clarke, 2013).

The foundation of IPA is set within some of the principles and methods associated with the branch of philosophical thought known as phenomenology (Smith, et al., 2009). Phenomenology is concerned with how people experience the world around them within a specific context and timeframe, as opposed to abstract statements about the nature of the world in general (Willig, 2008). Phenomenological perspectives view the self and the world as "inseparable components of meaning" (Moustakas, 1994, p28) in that meaning is not inserted into perception as a later reflection; instead, perception is intentional and therefore constitutive of experience itself (Smith et al., 2009). The founder of IPA, Jonathan Smith, describes IPA as an attempt to unravel the *meanings* contained within accounts through a process of interpretative engagement with the transcripts (Smith, 1997).

The second major theoretical underpinning of IPA therefore comes from hermeneutics which is concerned with the interpretation of meaning. IPA aims to gain an understanding of how participants' view and understand their world and researchers therefore engage with participants' accounts in such a way as to encourage an insider perspective (Willig, 2008). When participants are engaged with 'an experience' of something important in their lives, they begin to reflect on the significance of what is happening, and IPA research attempts to engage with these reflections (Smith et al, 2009).

Furthermore, it can be said that the researcher is engaged in a 'double hermeneutic' as the researcher is trying to make sense of the participant trying to make sense of their experiences (Smith et al, 2009). IPA therefore acknowledges that a researcher's understanding of the participants' experiences will be influenced by their own beliefs and assumptions. This captures the dual role of the researcher. The knowledge produced by IPA is therefore also reflexive as it recognises its dependence on the researcher's own standpoint (Willig, 2008).

The third major influence upon IPA is idiography. Idiography is concerned with the particular, locating participants in their particular contexts and exploring their personal perspectives. This is in contrast to most psychology, which is 'nomothetic' and concerned with making claims about groups or populations and therefore with establishing general laws of human behaviour (Smith et al, 2009). IPA's commitment to the particular operates at two distinct levels. There is firstly the commitment to the particular in level of detail and therefore depth of analysis, and to achieve this, the analyst must be thorough and systematic. Secondly, the commitment to understanding how particular phenomena have been understood from the perspectives of particular people within a particular context and time.

IPA therefore appears to be consistent with the philosophy and practice of the Counselling Psychology profession which is broadly concerned with the study of being (ontology), the nature of 'how we know what we know' (epistemology) and praxis (clinical application) (BPS, 2018). Counselling Psychology is also concerned with meanings, beliefs, context and processes that are constructed both within and between people and which affect an individual's psychological wellbeing (BPS, 2018). Furthermore, the explicit use of a phenomenological and hermeneutic inquiry enhances the inquisitive, reflexive, and critical attitudes of Counselling Psychologists (BPS, 2018).

Rationale for choosing IPA.

It was acknowledged that various methodologies could have been employed to conduct this research, and it is therefore of value to explain the decision-making process in relation to the choice of methodology. Indeed, it is considered that what is important is that the theoretical framework and methods match what the researcher wants to know, and that the researcher acknowledges the decisions made (Braun & Clarke, 2013; Marecek, 2003).

Two alternatives to IPA were considered by the researcher which were judged to be well established and documented methods. Thematic Analysis was considered. This is a widely used qualitative methodology and has been described as a method for identifying, organising, and describing patterns within data (Braun & Clarke, 2006). Thematic Analysis can be applied across a range of epistemological and theoretical approaches thus the method allows a flexible and creative way of working. However, it can be criticised for the absence of clear and concise guidelines on how to carry out such analysis, and therefore if not applied carefully can create little beyond mere description and has insufficient interpretative value (Braun & Clarke, 2006). A theoretical issue with Thematic Analysis has also been identified in that interpretation is in fact the interpretation of others' actions through the researchers' understanding (Javadi & Zarea, 2016), something that it of course shares with IPA, yet IPA is more robust in engaging proactively and openly with this situation.

Grounded Theory is another established and respected qualitative methodology and was also thought to be an option worthy of consideration. Grounded Theory involves the identification and integration of categories of meaning from data; it is both the process of categorisation (as method) and its product (as theory) (Willig, 2008). As method, it provides guidelines on identification of categories and establishing relationships between them. As theory, it generates the end product of this process – an explanatory framework from which to understand phenomena. However, Grounded Theory has a preoccupation with uncovering social processes which limits its applicability to more phenomenological research questions and is thus more suited to questions about influencing factors within a particular social setting (Braun & Clarke, 2013).

The researcher decided that for the purposes of this research, IPA was the more appropriate choice. IPA is specifically a psychological research method designed to primarily gain insight into peoples' lived experiences to facilitate understanding of the phenomenon under investigation (McLeod, 2011). In contrast, Grounded Theory has been traditionally used to address sociological research questions as it aims to identify and explain contextualised social processes which *account* for phenomena (Willig, 2008). By contrast, IPA is concerned with the *nature or essence* of phenomena (Willig, 2008) and precisely matches the research question of how young people experience mental health service transition.

On a more practical basis, IPA allows for a small, purposive sampling strategy that can overcome some of the inherent difficulties in recruiting participants in a relatively short time frame. It also overcomes some of practical and ethical problems in conducting large scale randomised control studies. In common with other qualitative methods, IPA uses semi-structured interviews which allow the researcher and participant to enter into a dialogue where questions can be modified in light of responses and particular areas of interest that may arise can be probed in more detail than more structured methods may allow (Smith, 1995). This flexibility allows detailed investigation, relevant for what is largely an under-explored area.

Method and Procedure

Ethical approval and risk management.

Ethical approval was gained through The University of the West of England (reference HAS.18.07.199; appendix 1) and their code of ethics and conduct were followed and respected. The British Psychological Society's (2009) Code of Ethics and Conduct - organised around four principles of respect, competence, responsibility, and integrity - were also followed to safeguard participant wellbeing. A risk assessment was completed prior to commencing the research which determined the research to be the lowest risk level of 'negligible' (appendix 2). DBS clearance was provided to the university, as well as completion of refresher training for Children's Safeguarding (appendix 16).

Public and participant involvement.

Patients' experiences of health services are widely recognised as being a valuable resource for informing commissioning, planning and service improvement work (Department of Health, 2009). The purpose is to enhance depth, credibility and applicability of findings, improve clarity of research reports and recommendations and ensure immediate links between practice-based evidence and evidence-based methodology (Boote, Baird & Sutton, 2011; Braye & Preston-Shoot, 2005; Smith et al., 2009). Public and participant involvement is therefore a vital part of research, and such engagement can significantly enhance the quality of the research (Morrow, Ross, Grocott, & Bennett, 2010). Service user and service staff involvement were a key element in the development of the design and focus of the current research to enable the research to be more relevant and engaging to potential participants and thus generating more meaningful outcomes. The researcher's steps in participant and public involvement and engagement will now be outlined.

The researcher met with the Lead Social Worker at one of the charitable organisations, a young peoples' mental health charitable organisation located in Bristol which offers a range of projects and services to young people aged 11-25. Discussions were held around the transition pathway from CAMHS into the charity and the triage system in place, which provided useful information to the researcher in understanding current transition processes. Discussions also centred on the direction and focus of the research, as well as recruitment strategies for engaging young people. Possible research directions discussed were as follows: 1) practitioner experiences and/or service user experiences; 2) service user experiences transitioning into CAMHS after charity and/or transitioning into charity after CAMHS; and 3) experiences of transitions between types of therapy (one-to-one, groups) within an organisation or between different organisations.

These discussions led the researcher to attend a service user group at Off the Record (OTR), a young peoples' mental health organisation, to discuss further the direction and design of the research that would be most meaningful to young people. The 'Mentality' group is a proactive youth campaigning group for young peoples' mental health. A summary of possible research directions and methods was put together in a document which was taken to the group for discussion (see appendix 7). The group of nine service users unanimously voted for the research to focus on the transition experiences from CAMHS and into the charitable sector with the use of one-to-one interviews for confidentiality and ease of speaking openly. Discussions were also held around recruitment and locations for advertising research participation, both within OTR and other mental health services for young people.

The researcher also met with the manager of Barnardo's 'HYPE' service which stands for Helping Young People (children and families) to Engage. HYPE work with the Community Children's Health Partnership (CCHP) in Bristol, North Somerset and South Gloucestershire; supporting children and families to have a voice, recognising them as experts in their own lives so that they can influence how their health services are delivered. This discussion centred around the practicalities of engaging young people in research. Topics discussed included: usefulness of offering incentives; building rapport and offering a caring and 'human' approach; creating eye-catching recruitment posters and flyers with age-suitable language; and engagement of young people in the design of the research.

Further participant involvement was included in the evaluation of the research interview schedule. The first participant to take part in the research was asked to provide feedback on the interview schedule which provided valuable insight into how the questions were received and led to a change in the interview schedule. This is further explained in the 'Data Collection' sub-section.

Sample considerations.

The age limit of the majority of CAMHS services is 18 years, however many young people leave services before this at the age of 16 or 17. Young people entering voluntary mental health services may leave CAMHS some time prior to their 18th birthday. It was therefore important to include the ages of 16 and 17 years in this research to capture these individuals in the research which solely looks to understand the experiences of those leaving CAMHS services and entering voluntary services. Those aged below age 16 were excluded from the study. The reasons for this lower age limit are firstly, this is the cut off for which parental consent is required and secondly, age 16 is the lower age limit of many young peoples' charitable organisations and therefore a likely age of transition from CAMHS. Participants are likely to have mental health difficulties at the time of the interview and this is important for the research, however, the focus of the research is on the transition experience which in itself will detail many specifics on how this transition was experienced within an overall umbrella of mental health difficulties.

Participants were young people who had previously accessed services within CAMHS and were now accessing mental health support from third sector voluntary and charitable organisations within the Bristol and Gloucestershire areas of the South West of England.

Recruitment.

The researcher contacted 24 young people's mental health charitable organisations. Four mental health organisations supporting young people in Bristol and Gloucestershire agreed to be collaborators for the research. The collaborating organisations agreed for participants to be recruited from their services whereby posters with tear-off slips with researcher contact information (see appendix 8) and flyers (see appendix 9) were displayed in waiting areas and communal areas advertising participation in the research. Where possible, the participant information sheet was also available for potential participants to take away. Staff within the organisations helped to identify potential participants who fulfilled the inclusion criteria by directly providing the participant information sheet or directing them to the posters and flyers for information. The researcher also created short recruitment videos for potential participants that a couple of the organisations were able to upload onto their websites/internal systems, videos were also made for staff which were shared internally. These videos were created for staff and participants to see the person behind the research and allow a human touch which hoped to encourage young people to take interest in the research.

Potential participants who were interested in taking part contacted the researcher directly via email and had opportunity to ask questions about the research. Participants were emailed a participant information sheet (see appendix 10) outlining the intentions of the study, support resources and further details about accessing therapy. This included information regarding their right to withdraw from the study up until the point of data analysis. Sent along with the participant information sheet was the consent form (see appendix 11) for participants to read through and consider the information and discuss with family should they wish to. A mutually convenient time to conduct the interview was then arranged via email.

Interviews took place in a quiet and confidential room within the premises of the consenting organisation from which the participant was recruited so that the participants were familiar and comfortable with their surroundings, and any potential power imbalance with the researcher would also have been reduced. Immediately before the interview was due to take place, a paper copy of the participant information sheet, consent form and demographics form (see appendix 12 for demographics form) were provided. Participants were encouraged to ask any further questions regarding the research, to complete the demographics form, and finally to sign two copies of the consent form – one copy for the researcher and one copy for the participant. Once the recording had started, it was stated by the researcher the aims of the research and what participation involved, and that the participant had given written consent. The interviews followed a pre-determined interview scheduled (see appendix 13). An interview checklist was also used to help the researcher make sure all aspects of the young persons' transition was captured (see appendix 14).

The participants' right to withdraw was stated on the participant information sheet and the consent form. The participant was asked to contact the researcher via email within two weeks of participation should they wish to withdraw from the research. No reason for withdrawal was required and withdrawal of data would not be judged. Should a participant have withdrawn from the research, their data would have been immediately destroyed. Participants were also reassured that their participation was voluntary and that their data was anonymised where possible.

All participants were given pseudonyms, and all other personal and identifying information was anonymised by being removed or replaced. The audio-recording of the interview was uploaded to the researcher's UWE OneDrive account (which is username and password protected) via a laptop immediately after the interview had finished. The audio-recording on the encrypted dictaphone was then immediately deleted. Recordings will be deleted once the research has been published. All participant data complied with General Data Protection Regulation (GDPR) 2018 regulations.

The consent forms were scanned as a PDF file and uploaded onto OneDrive and the original consent forms were confidentially disposed of. The translation document of the pseudonyms to participants' real names was also stored on OneDrive. The transcription data was electronically stored within a password protected and encrypted file on a username and password protected PC held within a secure locked room. Only the researcher had access to this room and PC.

The researcher followed the standard research safety buddy protocol and informed a trusted person before and after each interview. This person knew the researcher's location and how long they expected to be there. Should the researcher not phone following the interview at the agreed time to inform of their safety, the buddy would have followed agreed escalation procedures.

Following the interview, participants were emailed a £10 Amazon voucher as a thank you for their participation. The voucher was not advertised on the posters, flyers, or recruitment videos. Participants were informed of the voucher by the member of staff who put the participant in contact with the researcher, or by the researcher herself.

Data collection.

Data was collected through semi-structured audio-recorded interviews, which is the recommended data collection method for IPA (Smith et al., 2009). Interviews are well suited to experience-based research questions and is a method that invites participants to offer rich, detailed, first-person accounts of their experiences and perspectives; the semi-structured format gives flexibility to exploring perspectives and can potentially generate unanticipated insights (Braun & Clarke, 2013; Smith et al., 2009). As interviews were held in private and on a one-to-one basis, they provided scope to develop a trusting relationship so that participants are comfortable disclosing personal experiences and even socially undesirable views (Peters, 2010). It was possible that some participants would express difficult emotions with their experiences of transition. It was therefore important to build trust and rapport with participants, and to respect participants' preferred level of anonymity to feel comfortable divulging personal information (Braun & Clarke, 2013). Interviews were conducted face-to-face as this is considered to be a suitable method of data collection for exploring potentially sensitive topics (Elmir, Schmied, Jackson, & Wilkes, 2011), especially as it involves close human interaction (Creswell, 2007). Data remained confidential and stored securely.

Guidance in the literature on conducting research interviews with young people (e.g., Eder & Fingerson, 2002; Shaw, Brady, & Davey, 2011) informed the creation of the interview protocols and the conduct of the interviews. For example, interviews utilised sensitive, short, and open-ended questions, and prompts helped participants if they were struggling with the question. Preliminary interview protocols were piloted with one participant who met the inclusion criteria, and then modified based on their feedback. This participant felt the interview went too deep too quickly and that a more gentle introductory question would be helpful. This was valuable feedback that led to the researcher's decision to insert an additional question as the first question asked, which read as: "What interested you to want to participate in this research?". Interview questions focused on the circumstances surrounding their transition, their emotional experiences of the transition, and the wider social context and implications. The interview started with introductory questions that were less probing, sensitive, and direct than questions that were asked later on in the schedule, ending the interview with a closing question that allowed participants to raise anything that had not already been covered. This took the shape of a funnel design moving from general to specific questions (Braun & Clarke, 2013).

Further ethical considerations.

A presumption of mental capacity was taken for all participants engaging in the research, as per principle 1 of the Mental Capacity Act 2005. It was possible that for some participants, engagement in the research would raise uncomfortable or difficult emotions with their expression of their experiences of transition. It was therefore important to build trust and rapport with participants through all interactions to allow participants to feel as comfortable as possible in divulging their personal stories. Participants were reminded that they did not have to answer any questions that they did not wish to or which they felt uncomfortable to do so at the beginning of the interview and at any point in the interview if deemed necessary. The researcher's therapeutic skills enabled attunement into the participant's language, tone of voice, and body language to pick up on any signs of distress. Should such distress be observed, the participant would have been offered a break or to stop the interview. The participant information sheet offers sources of support which the researcher reminded the participant of, if necessary, at any point in the interview process. The researcher also stated these sources of support at the end of the interview as part of a debrief and closing should the participant later feel any distress following the interview. The opportunity, however, for these participants to voice their experiences and to be heard was also believed to have benefited participants. Indeed, the Department of Health (2005) provide a compelling ethical argument that service users and the public have a right to have a say about services that are provided for them. The participant information sheet draws attention to both possibilities.

Participant information.

A purposive homogenous sample of six participants, which is considered suitable for doctoral level research (Smith et al., 2009), were recruited. Participants were to be aged 16-25 years, however if sufficient participants came forward, selection would focus on ages 18-22 years for enhanced homogeneity.

Participants were aged 18-23 years and of White British ethnicity. With regards to gender identification, three participants identified as female, one participant identified as male, and two participants identified as 'other'. With regards to sexuality, three participants identified as hetero-sexual, one identified as queer, one identified as gay, and one identified as bisexual. Three participants described themselves as middle-class, whilst two participants described themselves as working-class. Two participants regarded themselves to have a disability. With regards to employment and student status, three participants were unemployed, one participant was employed full-time, one participant was self-employed, and one participant was a full-time student. The shortest interview lasted 38 minutes and 15 seconds, the longest interview lasted 1 hour and 55 minutes. The average interview time was 57 minutes.

Data analysis.

Interviews were audio-recorded and transcribed orthographically. The investigator kept a reflective diary whilst undertaking the interviews and analysis. Interviews were anonymised and pseudonyms were given. To allow for the vigorous exploration of idiographic subjective experiences, and the exploration of how people ascribe meaning to these experiences in their interactions with their environment (Smith et al., 2009), IPA was used to analyse the data.

Analysis was conducted from a critical-realist ontological perspective, assuming the existence of an ultimate reality while acknowledging that our understanding of this reality is characterised by external factors such as culture, language, and political interests (Braun & Clarke, 2013). It was assumed that participants had insight into their own lived experiences, but that these insights may be sculpted by their own perspectives. The epistemology was broadly contextualist which assumes that meaning is related to the context in which it is produced (Braun & Clarke, 2013). These ontological and epistemological perspectives are congruous with the philosophical framework of IPA.

The production of key themes which best illustrate the data, as well as in-depth examination of the data, supported the interpretation of processes as experienced and understood by participants. As defined by Smith et al. (2009), IPA involves six distinct steps which were adhered to as follows: -

1) *Reading and re-reading*: The first stage is conducted to ensure the participant becomes the focus of the analysis. Immersion in the data is vital in order to enter the participants' world, and a repeated reading allows a model of the overall interview structure to develop and allows for an understanding of how narratives can bind sections of the interview together. This reading also facilitates an appreciation of how rapport and trust may build across an interview and thus identify areas of richer and more detailed sections, or indeed contradictions.
2) *Initial noting*: This step examines semantic content and language use on a very exploratory level. The analyst maintains an open mind and notes anything of interest within the transcript. This aims to provide a detailed set of notes illustrating descriptive comments (descriptions of the content), linguistic comments (explorations of the specific use of language), and conceptual comments (interrogative and conceptual level comments).
3) *Developing emergent themes*: Using the initial notes, the analyst identifies emergent themes at the local level on discrete chunks of the transcript. The task of managing the data is a considerable one, for the analyst simultaneously attempts to reduce the volume of detail (the transcript and initial notes) whilst maintaining complexity in mapping the interrelationships, connections, and patterns between exploratory notes. The themes reflect not only the participant's original words but the analyst's interpretation.
4) *Searching for connections across emergent themes*: This stage involves the development of a mapping of how the themes are considered to fit together and identifying like-for-like in the creation of sub-ordinate themes.

5) *Moving to the next case*: The process is repeated for the next participant's transcript. Although it is inevitable that the previous case may influence the interpretation of the next, each case is to be treated individually. This means, as far as possible, bracketing the ideas emerging from the analysis of the first case whilst working on the second. This then continues for each subsequent case.
6) *Looking for patterns across cases*: The final step involves looking for patterns across all cases. This will sometimes lead to reconfiguring and relabelling the themes. The final result of this can be presented in a number of ways (e.g. in the form of a table or a graph) showing how themes are nested within superordinate themes.

Considerations of Quality in Qualitative Research

Due to the diversity of perspectives in qualitative research, the concepts of validity and quality have been widely questioned which has prompted the development of a number of guidelines for enhancing and evaluating the validity of qualitative methodology (Smith et al., 2009; Yardley, 2000).

Smith, Flowers and Larkin (2009) highlight the relevance of four broad principles proposed by Yardley (2000) to the evaluation of research using IPA methodology. Such criteria were embraced and incorporated throughout this research study to ensure quality in the research. Each principle will be discussed here in turn and related to the current research project.

1) *Sensitivity to Context:* Sensitivity to context can be demonstrated throughout all stages of the research process. Sensitivity can be especially present in the researcher's consideration of the interactional nature of data collection and within the interview situation. The researcher has spent many years working in a number of services providing psychological therapy and therapeutic support to young people, adults and their families, who experience mental health difficulties. The researcher has therefore developed valuable awareness of the challenges and stereotypes surrounding mental health and the approaches that need to be taken to ensure that participants were able to express and communicate their experiences with relative

ease. Considerable time and care were taken in the analysis process to ensure that interpretations were grounded in the narratives of participants and verbatim extracts were used to highlight salient points. An in-depth literature review was also conducted by the researcher to orient the research and position it within a context.

2) *Commitment and Rigour:* Commitment can be demonstrated in a number of ways, and in IPA research there is an expectation that commitment will be shown in the degree of attentiveness to the participant during data collection and the care with which the analysis of each case is carried out. The consideration of each participant in making them comfortable in engaging in the interview process, in-depth interviews, and the attention to detail at every stage of the research process all demonstrate the researcher's personal commitment and investment in the study. Rigour relates to the thoroughness of the study. The researcher took great time, consideration and value in the involvement of young people and services in the development of the research, and the researcher's counselling and therapeutic skills meant that the researcher was able to balance closeness and separateness, picking up on important cues and knowing when to probe and be more curious. Furthermore, the researcher's previous experience of undertaking qualitative research ensured appropriate skills in eliciting and analysing data beyond a purely descriptive sense of experience to offer interpretations.
3) *Transparency and Coherence:* Transparency refers to how clearly the stages of the research process are described in the write-up of the study. The researcher attempted to enhance transparency by describing in detail how participants were selected, how the interview schedule was constructed, how the interview was conducted, and what steps were undertaken in the analysis. Transparency is also demonstrated through sections of reflexivity. Coherence can be thought of as the fit and flow between all aspects of the research write-up. The researcher presents a coherent argument and story development through the research, and links are highlighted between themes in a logical manner. There is also coherence between the nature of the research carried out, the principles of IPA and the personal values of the researcher.

4) *Impact and Importance:* Yardley argues that a test of true validity in qualitative research lies in whether it tells the audience something interesting, important, or useful. Undeniably, the researcher hopes that this has been achieved in the present research by providing a platform for young peoples' voices and experiences to be heard where they have perhaps been overlooked in the past.

Reflexivity

Conducting qualitative research is an intentionally personal endeavour in that the experiences and identity of the researcher will influence the findings that are produced (McLeod, 2011). On the condition that such personal opinions and insights are acknowledged, it can bring about valuable lines of enquiry (Malterud, 2001).

The researcher and the researched cannot be separated, a reciprocal relationship exists between the two (Douglas, Woolfe, Strawbridge, Kasket & Galbraith, 2016). This means that it is not possible for the researcher to position themselves outside the subject matter of their research and view it objectively (Finlay & Gough, 2003). Reflexivity is more than acknowledging personal biases, it invites the researcher to think about how their own reactions to the research context and the data actually make possible certain insights and understandings (Willig, 2008). There is greater recognition of the role of reflexivity in good science, and the Counselling Psychology profession endorses and seeks to incorporate the role of reflexivity into their identities as scientist-practitioners (Lane & Corrie, 2006).

While IPA aims to explore the participants' experiences from their own perspective, it recognises that such an exploration cannot easily be separated from the researchers' own view of the world, and the nature of the interaction between the researcher and the researched (Willig, 2011). It is therefore crucial that the researcher emphasises a commitment to reflexivity with respect to all aspects of the research process.

It is here that the researcher's reflexive role in the production of the material and analysis will be made explicit. This involves reflecting upon the ways in which the researcher's own values, experiences, interests, and beliefs have shaped the research process.

The researcher has a long-lived passion for empowering young people and enabling a platform for their voices to be heard and acknowledged. This passion stems from the researcher's own difficulties with mental health from early adolescence into her adult life. The challenges faced in everyday life were immense and triggered by a chaotic and traumatic parental separation. Experiences of anxiety, depression, low self-worth, and feeling lost and alone were daily battles. It was these early experiences as an adolescent that first drew the researcher to want to work with young people in supportive psychological environments.

The researcher has important clinical experience of working with young people in community and charitable counselling and psychotherapy settings, and believes that all young people deserve a supportive platform from which they can take charge of their lives and feel empowered to make decisions regarding their needs.

It was when the researcher began to work in adult and older adult NHS mental health settings that her eyes became open to the world of psychiatry and the impact that early diagnostic labels can have in later adult life. The researcher worked with individuals who were able to tell their stories of childhood diagnoses that had been persistent and enduring challenges that they felt unable to escape from and which impacted their lives in terms of career aspirations and relationships. Entering into mental health research, the researcher's view is that diagnostic labels are only truly helpful or unhelpful to the individual themselves in making sense of their experiences and as a gateway to support, and this is not for others to judge.

The researcher acknowledges that her experiences as a practitioner within both third sector mental health services and statutory NHS mental health services have provided valuable directions and changes in practice. Resources are often limited and demand is often high, yet finding even the smallest avenues to provide patient choice and to be completely transparent, is invaluable to enabling greater patient agency and autonomy over their health care.

Embarking on this research, the researcher wanted to make an impact to young peoples' lives and came to focus the research on a part of the mental health pathway for young people where there are multiple and significant transitions happening simultaneously. Leaving CAMHS at the age of 18 marks the end of being a child and entering the culturally defined age of adulthood. It is this transitional phase of life that the researcher is curious about.

The researcher acknowledges that the philosophy of Counselling Psychology as being rooted in humanistic principles and the exploration of the depth and complexity of human experiences, has influenced the methodology chosen and has understandably shaped the questions posed and subsequent analysis. In particular, the researcher admits to holding assumptions at conception of the research, firstly with regards to transitions into adulthood posing a potentially challenging and daunting experience, and secondly with regards to the importance of therapeutic relationships and support networks for young people. Regular supervision with a research team from different backgrounds in the fields of psychology, mental health, and social care, helped the researcher ensure that an appropriate topic guide was constructed which was open to hearing different understandings and perceptions.

The researcher had weekly psychotherapy throughout the professional doctorate programme, covering all stages of the research process, to explore and make sense of her own reactions to the participants' material. There were moments when the researcher really connected to participants' stories around loss and feeling lost in the world, and therapy was essential here for the researcher to 'bracket' her assumptions and experiences and truly hear what each participant was conveying (Smith, Flowers, and Larkin, 2009).

The researcher acknowledges that she is a white, well-educated woman who has experience of working in community mental health charities with young people. The researcher was aware as to how this may impact upon her relationships with participants. While striving to develop a collaborative partnership and recognising participants as experts on their experience, the researcher recognises the power differentials that are likely to be present in these relationships. Young people may be particularly eager to please the researcher and to give what they perceive is the 'right' answer.

Recruitment and data collection were a long process and at times the researcher felt frustrated by the pace of progress. The researcher was able to challenge these thoughts and to reframe this as needing to think more creatively in how to encourage participation in the research, and to work harder in the interviews to uncover meanings that might be more implicit. The interviews yielded varying degrees of richness of data, with some participants being able to talk about their experiences more articulately and more in depth than others. Given the researcher's own childhood struggles, she embedded herself into the spoken words of each and every participant and strived to truly hear the voice of every individual throughout the research, but most importantly through the analysis, whilst continuing to bracket her own experiences.

The researcher's reflective diary was a place where emotional expression could be made and brought to light, where thoughts and ideas could be played with, and where direction could be sought. The reflective diary, combined with the continued dialogue with the research supervisors and the open and reflective space of therapy, came together to support and guide the researcher through the research process.

It was at times a challenge for the researcher to engage in such an intense and immersive research process on a topic that she had a personal connection to with regards to mental health and developmental transitional stages. The three support areas of therapy, reflective diary and supervision were crucial to substantially restrict the researcher's unmindful skewing of the results from her own experiences.

The participants verbally reported that they had found the interviewing process a positive experience and were keen for the findings to play a part in shaping mental health services for young people. The researcher felt that participants had enjoyed being interviewed and having the opportunity to share their experiences on an important part of mental health care for young people.

RESULTS

The following section will give an overview of each superordinate theme accompanied with subsequent critical discussions and interpretations of meanings. The salient features of participants' accounts have been extracted and presented which highlight both commonalities and divergences in narratives. Three superordinate themes and multiple subordinate themes, and an overarching theme, emerged from the data following Interpretative Phenomenological Analysis, as summarised in table 2 below.

Superordinate theme 1: Power	**Theme 1.1:** Control and choice
	Theme 1.2: No transitional phase
	Theme 1.3: Multiple transitions
	Theme 1.4: Different approaches
Superordinate theme 2: Rejection	**Theme 2.1:** Abandonment
	Theme 2.2: Shock
	Theme 2.3: Alone with nowhere to go
	Theme 2.4: Loss of relationship
	Theme 2.5: Emotional pain
Superordinate theme 3: Identity	**Theme 3.1:** A child one day, an adult the next

	Theme 3.2: Fear of the adult world
	Theme 3.3: Wanting a diagnosis
Overarching theme	Quality mental health care

Table 2: Overview of superordinate themes and the overarching theme

Direct quotations from the interview transcripts are used to illustrate each theme. Quotations are taken from each participant transcript; however, some transcripts were richer in content than others and therefore some sections of the analysis draw more heavily on the responses of some participants than from others. The transcription key is shown in the table 3 below.

Transcription key	
[ ]	Indicates information that has been added to the transcript for clarity, or information that has been replaced for anonymity
{ }	Indicates an emotion or gesture of some kind, for example laughter or a sigh
Italics	Indicates where words or phrases have been stressed
(...)	Indicates that part of the transcript has been omitted
(-)	Indicates a pause in speech
//	Indicates an overlap or the absence of a gap between two consecutive utterances
(inaud)	Indicates part of the recording of the interview was inaudible

Table 3: Transcription key

Superordinate Theme 1: Power

One superordinate theme that arose from the data was concerned with participants’ awareness of where power lies between them as service users and the health professions and charity staff they were working with. In particular, this theme acknowledges the power imbalances and the challenges that come with this, but also brings light to instances where power is equal and the young person experiences greater autonomy over their mental health support. Figure 1 below shows the superordinate theme, the four themes within it, and the subordinate themes that make up these themes. The themes are presented in no particular hierarchical order of salience.

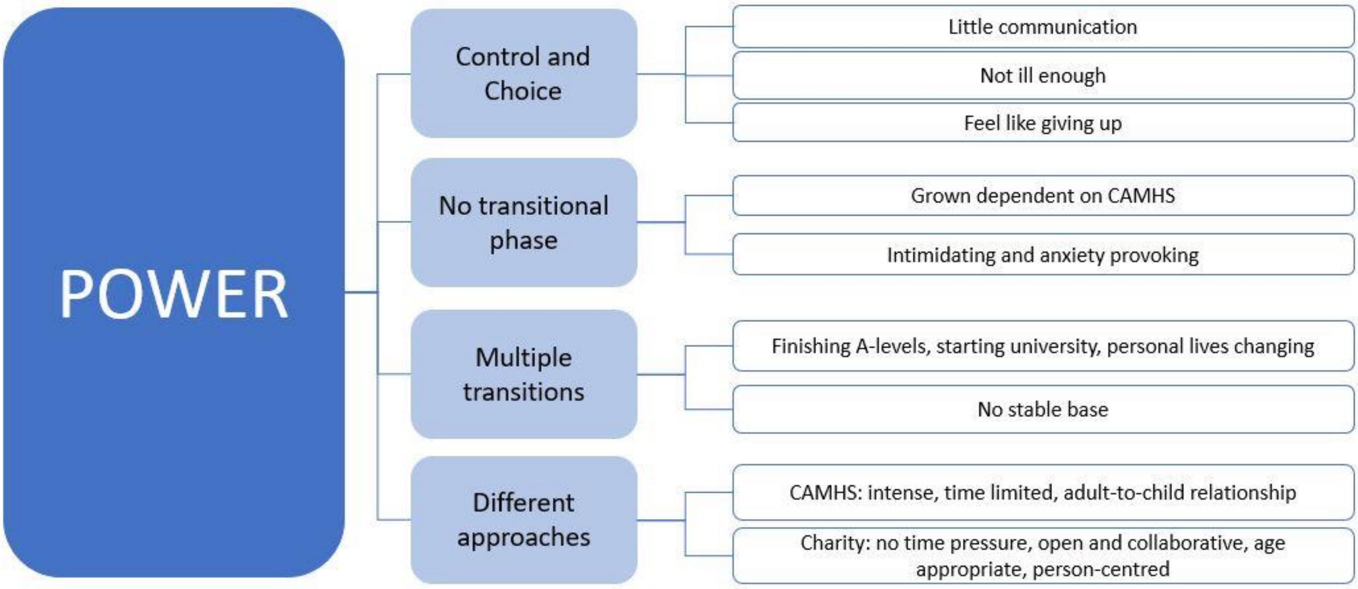

Figure 1: superordinate theme of ‘power’ and subordinate themes

Theme 1.1: control and choice.

The first theme to be discussed relates to participants’ experiences of control and choice. Participants felt that options and choices were not often provided from CAMHS regarding their treatment pathway, discharge and transition into further mental health support. Participants therefore felt they had little control or empowerment over their mental health care. Expressions of not feeling listened to or believed were reported.

> “There was little communication with me as to what *I actually wanted*. And I wasn't given the options, it wasn't laid out on the table like ‘what would you like to try?’ it was like {points in front} that’s what you [will] do (…) and I didn't know what other

> services I could have accessed because I was never told about any of them, and I found it quite hard to do my own research." (Frankie, 281)

> "With CAMHS I really felt like (-) a lot of the time I didn't have loads of choice, like they have power over like if they wanted to change my level of support or reduce my level of support or discharge me or whatever they wanted to do, although I would be part of the conversation at the end of the day they were the ones who had the control." (Natalie, 343)

> "It's about that power, that control over me (…) there's not a lot of choice about what you do and knowing that would suddenly finish was quite anxiety inducing." (Ali, 156)

Participants battled with coming to the end of their time with CAMHS and felt they had little control and choice, with minimal communication around the next steps. Participants therefore felt trapped in a position of powerlessness.

Some participants acknowledged a giving up when they had no power to change the situation, a sense of hopelessness was upon them. Being considered to be 'not ill enough' for access to further NHS support with AMHS seemed to be somewhat unacceptable and not how mental health provision should be.

> "Nothing I've ever said has been heard so I have no power to change anything. So I'll just let the people who don't listen to me do what they want and if they aren't going to do s**t then I can't do s**t because it's not down to me, never was down to me, so why try." (Joe, 353)

> "'Not ill enough' those were pretty much their exact words. (…) I was told I didn't need any more support {laugh}. I did. *I really did*. (…) [I was] told I wasn't ill enough to even try and get into adult services, so I was like 'oh why even try then'." (Frankie, 31)

Participants are active in pointing out the issues with CAMHS services, sometimes they may feel able to contest the issue, but they insist that the issues are wrong and that they should be addressed.

When finding charitable organisations for further support with their mental health difficulties following discharge from CAMHS, the control and choice gave a different experience. A positive experience of control and choice was reported, which participants experienced as empowering and engaging. A central difference from CAMHS was the plethora of options available to the participants, as well as the impression that therapists adjusted their agenda to the participants’ wishes.

> “I mean there's something different every week [at the charity] but typically there's a choice of different activities. It's quite empowering (-) I don't always like being told what to do, I need to be given a list of options but I think with [charitable organisation] yeah I think it's mainly empowering because it's something I can take control of.” (Ali, 193)

> “It was *brilliant* {laugh}. I walked into that room and it just felt *right*. He listened, he used to take a lot of notes which I found very reassuring as it felt like he was listening, taking it in and caring enough about it. (…) I felt very comfortable and I got to talk all about *me* {laugh} and *what I wanted* from the sessions and what I found helpful and he tailored my future sessions to me rather than just following through a booklet of pre-determined exercises.” (Frankie, 297)

> “I learnt how to verbalise what I want, I learnt that I can go into a room and say ‘this is what I want from this session’ and I can get it, I don't have to sit back and for someone to control my therapy experience, I'm allowed to speak up and say what I want.” (Frankie, 402)

> “I come here [charitable organisation] and it's like you’re picking chocolate, you've got a selection {laugh}” (Joe, 38)

Control and choice within the charitable organisation seem to be an empowering experience in which the participants are able to fully express themselves and have a voice with regards to their mental health.

As the young person moves into the culturally defined age of adulthood (18 years), previous power imbalances start to diminish, and experiences of control and choice appear. It is also possible that young people are experiencing a greater sense of respect and value which is regarded as important to them.

Theme 1.2: no transitional phase.

The second theme to be discussed relates to participants' experiences of lack of transitional support when leaving CAMHS due to turning 18 years old. Having no supported transitional phase when exiting CAMHS and no transitional support into further charitable organisations for continued mental health care, seemed to make transition an intimidating and anxiety provoking experience.

> "I guess the transition feels like intimidating, that maybe the service hasn't like prepared you enough" (Ali, 331)

> "You're over that age they can't treat you anymore, and they don't like even help you get into adult services either because like they didn't help me into adult services." (Lucie, 165)

> "Looking back now, I wish I would have like used [a charity] for that 3 month period [before starting university] but CAMHS didn't mention that, I don't think I even knew it was available at all. (…) Being in their hands for four years it became quite a big part of my life." (Natalie, 247)

There is an expression here of having grown dependent on the support provided by CAMHS which was a significant part of their life. The implied failure of CAMHS to prepare the young people for the next stages appears to place all the responsibility on the service providers. Yet it perhaps also highlights a neglect from services to encourage the young people to take charge of their own wellbeing when leaving such public services.

Participants were able to express what they would find helpful in relation to transitional support coming out of CAMHS. They expressed that a transition service between CAMHS and AMHS could be helpful; that individual maturity and circumstances could be taken into consideration, as opposed to an automatic discharge based on age when the service user turns 18; and more collaboration between CAMHS and AMHS.

> "Yeah well it's not really looking at the individual person (…) it would be so much nicer if they actually talk to the person and ask them what they wanted, I mean like some people might want to transition younger because it's too childish for them or something. (…) [also] more collaboration between adult mental health services and CAMHS maybe - if you're going to be seeing someone you bring them along [to] the last meetings at CAMHS so you get to meet them." (Ali, 273)

> "The thing is the waiting list for adult services is *6 months long*. I don't wanna feel like I'm being *sat on a waiting list* and then hopefully one day getting a letter saying *okay we're gonna help you now* or we're gonna see you, then you go and see them they're like *oh there's nothing we can do*. I'm just going back in that circle, waiting back on that waiting list, I'm just going back around in that loop, there needs to be something between it that people have, especially when they [are] coming out of the 17 into 18 there needs to be something between at least something waiting like doing group therapy or getting 18 year olds above the list, just something that is there to help them specifically because it's really hard if we've been kicked out at 18 and then being told right you've got to go back to the bottom of this list." (Lucie, 208)

For Lucie, there is a perception that waiting for public services is not acceptable and she feels able to express this. It is as if her understanding of a waiting list is being told that she is not 'good enough' which seems to feel rejecting for her. A waste of time, also, in that being on a waiting list only leads to being told she cannot be helped.

For another participant, Natalie, it was a very different story. A clear plan was made for a gradual decline in contact with CAMHS to prepare for discharge at age 18. The plan was deemed helpful for the individual and had good intentions, however, difficulty in carrying out the plan led to difficulty coping with the transition.

> "We sort of started talking about my discharge a few months before it was going to happen and the plan was to like gradually reduce it [the contact] down so I wasn't having it as frequently, but every time I tried to do that I would get more anxious and then I'd start struggling more and then they'd end up having to increase it again so it didn't really happen. (..) so I was still having like twice weekly contact with them and it went from that to nothing." (Natalie, 126)

Despite the hope for a smooth transition out of CAMHS for Natalie, it did not work in practice and this posed a difficult period of adjustment to life without the level of support that she had been accustomed to.

Theme 1.3: multiple transitions.

The third theme for discussion relates to participants' experiences of having multiple transitions simultaneously and the difficulties that come with this. The time of discharge from CAMHS when turning 18 years old, also comes at a time when young people are transitioning from A-levels to University or finding a job, potentially leaving home or friends moving away. It is a period of significant change, and with a lot of change can also come considerable feelings of vulnerability and instability.

> "There was like loads of changes happening at the same time - so I was finishing sixth form and starting uni, I'm doing my A-levels and being discharged from CAMHS all at the same time. It was horrible, it just felt like everything was changing and just one of those things would have been stressful on its own {sigh} It's just rubbish." (Natalie, 31)

> "I dropped out of school like a few years early so through these transitions I didn't really have something that was constant. (…) A lot of people leave school when their 18 and at the same time they're leaving CAMHS or other services so that's a *lot* of change to adjust to." (Ali, 350)

> "I finished my A levels, I finished with CAMHS (…) then most of my friends went to university and I got a new job and I was not well. My [partner] dumped me as well so I was like very ill, I was not okay. I wasn't happy and I was missing everyone, and I didn't have anyone to talk to you anymore. (…) Lots of changes all in quick succession and I did not like that." (Frankie, 323)

There is a strong expression here of feeling unsettled and overwhelmed by so many changes at once. These changes are mostly determined by age, and thus the young person can be feeling powerless in this transition period. The timings of educational and career-based changeovers are held at political, societal, and even developmental levels, that the young person does not have the power to control or alter to fit their personal circumstances.

Theme 1.4: different approaches.

The final theme to be discussed under the superordinate theme of power relates to participants' experiences of the different approaches from CAMHS and the charitable organisations they attended. Participants speak of uncertainty and apprehension entering a new service and a new environment, as well as having to adjust to new ways of working.

The participants' experiences with CAMHS were described as intense, time-limited, focused on the here-and-now and the management of their condition, dominated by an adult-to-child relationship, and the buildings were described as clinical and more appropriate for young children. The charitable organisations were described as welcoming and friendly, trying hard to create pairings and small groups of service users, person-centred, focused on empowerment and individual expression, exploring childhood experiences and the causes of mental health difficulties, establishing of collaborative relationships, and environmentally directed towards young adults and their life stage. Participants found the more age-appropriate environment as well as the therapeutic and collaborative approach an engaging and empowering experience. Looking at these elements in more detail, in no particular order, a picture is developed of the importance these elements hold for these young people in making sense of the transitional experiences.

Frankie and Louise spoke of the importance of interactions with other young people experiencing similar difficulties, and the validation, understanding, and connection that they had from these interactions.

> "It [charitable organisation] felt very different from CAMHS. I suppose because it's more like family connections, everyone is just expected to get along with each other rather than the only interaction you have with those young people is talking about mental illness like sat around a table. In CAMHS, I didn't know much about the other people apart from their illness {laugh}, like I didn't really know what they were interested in or who they were as people, and that made it harder for me to open up." (Frankie, 150)

> "It is nice that they [charitable organisation] kind of get to know you as a person rather than with CAMHS you don't really have time to get to know them. (…) It was awkward in CAMHS as well because they wouldn't really let us talk. Me and this one girl would talk about how our upbringings had made us feel, and they didn't want us talking about that in case it triggered other people. I thought it was a bit annoying because I'd never met people who have had the same upbringing and have the same issues." (Louise, 173)

> "I met other young people [at the charitable organisation] who were so similar to me. (…) It was nice because I think that even though I know that there are other people who struggle, I didn't really know anyone. I felt like I was the only person stuck struggling and everyone else is getting on with their lives." (Natalie, 294)

There is a longing for personal connection and validation from others that seems an important part of making sense of their mental health difficulties. In transitioning from CAMHS, where interactions with other service users was limited or denied, to the charitable organisations, there were new opportunities for connection. Connection also came from being around others of the same age and from being ‘matched’ together.

> “It is hard for young people to get help, this place [charitable organisation] is for under 25’s so I think that's really good. At CAMHS I was like the oldest one there by far, so it's nice to have people my own age.” (Louise, 224)

> “[the charity] tend to pick people that are going to work well together and that have a similar background so that everyone can help each other, rather than it being like *you're gonna fit* and *you're gonna go there* and no-one actually having anything to do with each other. In CAMHS, none of us had been through similar stuff (…) That’s important to me, I like having people that understand how I feel (…) it makes it a lot easier and able to come every week.” (Lucie, 353)

In some interactions within CAMHS, there was a perception of being treated like a child, with little acknowledgement of individual needs, and in an environment that felt child focused.

> “I felt like it was very much an adult and child relationship, it wasn't two people working together, it was someone talking down to you and telling you what was wrong and what to do about it. (…) I was like I'm nearly an eighteen-year-old and I'm being treated the same as the eleven-year-old and there's a huge difference in how we are feeling and [our] behaviour. (…) I'm an individual who has different problems and needs to this other person and yeah I didn't feel like I was treated like an individual [in CAMHS], I felt like I was being treated like another child.” (Frankie, 348)

Moving from an adult-to-child relationship into a more adult-to-adult relationship was a difficult, yet freeing, transitional experience.

> "I think it was quite freeing and relieving to start at [charitable organisation] and it's really opened my eyes to what therapy should be like. Now I walk into a therapy room expecting it to be useful and helpful and supportive, whereas I did not have that expectation before with CAMHS, I was just like 'Oh I'll just hope it goes okay'." (Frankie, 359)

From a position of hoping for the best in CAMHS, Frankie moves into actively taking a lead in the therapy within the charitable organisation, which is seen as a new and empowering position.

> "my last session at [charitable organisation] I went in with paper and pencil and said I want to make something visual today and she [counsellor] was like 'okay here is the table' {laugh} and I don't think I ever could have done that with CAMHS." (Frankie, 345)

They are putting their toes into the water, trying on the position of power and control and finding it a positive experience, one that is embraced by the therapist. Perhaps this demonstrates feeling safe and contained within the therapy which may have allowed for adopting a new sense of agency. Louise also expresses empowerment within the context of therapeutic depth: she has chosen to stay away from the depth of the painful material that would have been necessary within CAMHS.

> "I was seeing a therapist here [charitable organisation] and like we didn't have to just talk, he let me paint or anything I wanted to do. I didn't even have to talk about my depressing stuff, I could talk about the happy stuff whereas with the CAMHS you can't really go in and be like 'Oh I did this today', you're there to get to the bottom of the issue." (Louise, 312)

Indeed, this depth and focus of therapy is acknowledged by other participants. Lucie acknowledges a distinction between focusing on underlying causes of mental health challenges within the charity compared to the focus within CAMHS being more in the here and now.

> "[the charity] tend to work more with your previous mental health and what's gone on in your life that has caused you to be this way, rather than the here and now like what's going on last week, they deal with your more like childhood stuff and I went over everything that I was going through and that I had been through. It really helped." (Lucie, 319)

Other participants note further differences in therapeutic approach. This relates to a more medical verses therapeutic approach. The impression of CAMHS is of a heavily medical and clinical approach, not just in the sense of the application of the medical model in the treatment of mental health conditions, but also in the very fabric of the environment in which therapy was taking place.

> "I only went [to CAMHS] because they put me on medication and 'cos I was under 18 they had to do regular check up's and prescriptions and stuff, so I think that was the only reason I ever really went in." (Ali, 209)

> "You go in [to CAMHS], through the corridors and it's like, this is intimidating. You go into sessions already feeling defensive. (…) You want environments for mental health support to be open, to be inviting, to be welcoming. CAMHS was just like claustrophobic, it showed no understanding of mental health - there was no separate areas, everything was open. Whereas [the charity] is calm, inviting and caring." (Joe, 222)

> "Even my therapist when we went into the room she was like 'You know these rooms are a bit too cold and clinical', you feel like you're at the doctors. Whereas you come here [charitable organisation] they've got artwork, they've got nice bright coloured things like the rug, just nice things to look at rather than going in and you've got all of these intimidating like doctors running around." (Louise, 316)

There is something important here about the environment in which mental health care is delivered for young people. Participants felt relaxed and comforted by warm and welcoming non-medical environments, where 'authority' is not dominant and intimidating. Transitioning into an environment that is more psychologically informed, seemed to be helpful for young people.

Another difference highlighted by the transition experience, was that of time and patience felt within the charitable organisations. Natalie speaks of a gradual introduction to the services offered within the charity, with time to get a feel of the organisation and to feel empowered in making a decision based on what for her felt the right fit.

> "I went to the [charitable organisation] drop-in sessions maybe like five times just getting used to it and I spoke with someone who went through all the options with me. We spoke through all of their one-to-one stuff and the group stuff as well." (Natalie, 281)

This lack of pressure within the charity is extended for Lucie who speaks of being in a position to determine herself when is the right time to stop attending, without any fixed time frames. From this experience there is a feeling of growth as an individual, an empowered young person making her own decisions in relation to her mental health and emotional stability in the context of all she is managing in life.

> "[At the charity] I don't feel like I need to be fixed in six weeks, there's no time pressure. Having someone that isn't just going to disappear after a certain amount of sessions, that was what kind of what made me change a lot more. In CAMHS, you're only allowed like 6 to 12 sessions and then they're gone, here [the charity] they're going to stay with you until you're able to say to them 'I don't need you'." (Lucie, 278)

Having looked at these different elements and approaches between CAMHS and the charitable organisations, it is interesting that there is a rejection of the lack of individuality in being treated like a child within CAMHS, yet participants hold on to a dependant mindset when they worry at the thought of not being held by a service. It possibly indicates a state of confusion for the young person in the longing for independence, but the reality is scary. Perhaps there is a lack of readiness to grasp responsibility for themselves. It also highlights a discomfort that is parallel in both the literal transition between services, and the developmental transition and the growth of the self. The latter will be explored in depth within the superordinate theme of Identify.

Superordinate Theme 2: Rejection

The second superordinate theme that arose from the data was concerned with participants experiences of rejection. This superordinate theme speaks to the experiences of shock and loss, and the emotional pain that comes with this. Figure 2 below shows the superordinate theme, the five themes within it, and the subordinate themes that make up these themes. The themes are presented in no particular hierarchical order of salience.

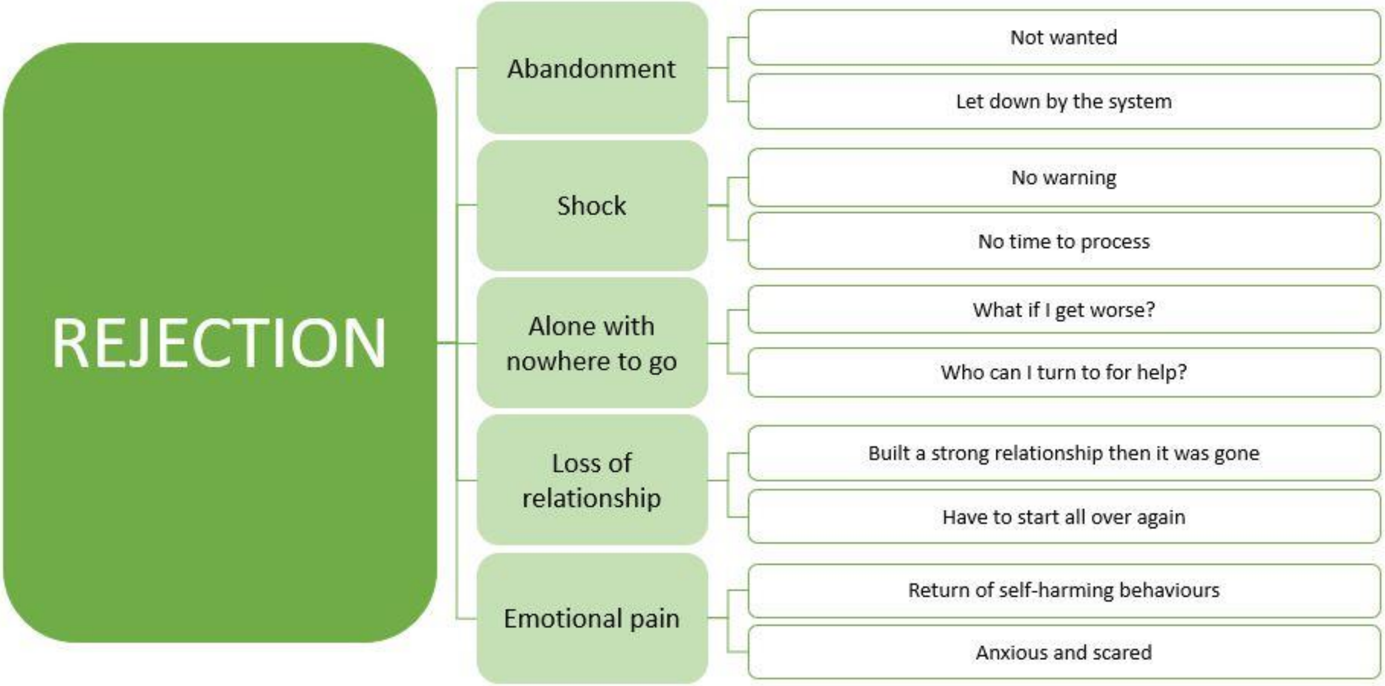

Figure 2: superordinate theme of 'rejection' and subordinate themes

Theme 2.1: abandonment.

The first theme to be discussed relates to participants' experiences of abandonment. Feeling unwanted and being disposed of, having to leave the service based on age (a factor they have no control over) and therefore feeling let down by the system, are all key elements to this theme.

> "When I was discharged, CAMHS basically said 'We're done with you now, we don't *care*!' {laugh; sigh} they didn't say that but it felt like they didn't care. It felt like they weren't taking me seriously (…) It was *frustrating*." (Frankie, 45)

> "So it was being let down and um just feeling rejected, so if I get let down that [is] a *massive thing* in my life, being treated like I wasn't enough or like I didn't deserve it. (…) When you're coming up to your 18th it doesn't feel like they're there to support you, it feels like 'right, now we *need to get rid of you* before you turn 18.'" (Lucie, 113)

There is both sadness and anger in their voices. Lucie speaks of feeling let down and un-supported, which is a difficult feeling for her to manage. She goes on to express that she felt like someone else's problem, failed by a system that has strict criteria of what mental health 'should' look like, leaving her feeling abandoned. This system is described as unfair on young people who fall between the gaps of child and adult services.

> "they very much brushed me under the rug and gave me to someone else, like made it someone else's problem and not theirs which is not how anyone should feel. (…) It was just never *their fault,* it was very much like we have to follow this guideline of not fitting this criteria of what mental health *should be* and we're not going to take them and that's *not fair*." (Lucie, 371)

Another participant, Joe, speaks of his feelings of abandonment having longer term effects, and struggling with feeling wanted by other people.

> "At the tender age of 18 I was abandoned by CAMHS, and that is where my issues of abandonment come from. Never had them before, but now I get easily attached to people and I get sad when I feel they are abandoning me." (Joe, 107)

This sense of abandonment speaks of CAMHS almost as a parental figure. There is a sudden drop of care with nothing to bridge the gap, leaving young people feeling vulnerable. This may highlight not only a lack of readiness and preparation for leaving CAMHS and sourcing alternative areas of support, but also the role CAMHS may play in attachment.

Theme 2.2: shock.

The second theme relates to participants' experiences of shock. Despite the understanding that CAMHS services end at the age of 18 years, the suddenness of which they were discharged felt a shock to these young people. This shock ending appears to leave little room for young people to gain closure and come to terms with the ending of therapy in a supported way.

> "I knew you had to finish when you were 18 but I wasn't expecting it to be so sudden. Like I had one appointment, and the psychiatrist was like 'Oh this is your last appointment by the way'. Um, bit of a shock yeah. I think mainly just like it was unexpected. (…) It was like suddenly all support just stopped." (Ali, 6)

> "It was the last therapy session they would be like 'right okay, that's it, we're letting you go you're all good, sign a bit of paper, you're off'". (Lucie, 89)

Attending a regular session to then be told it is the last, understandably comes as both unexpected and a shock to these participants. Despite a little more notice for Louise, she nonetheless speaks of the lack of closure it gives her.

> "Like you only get a couple of weeks' notice to be told that you're finishing, so you don't really have the closure." (Louise, 310)

The suddenness of discharge for these young people is a challenge to them, and possibly explains and validates their experiences of abandonment and rejection.

Theme 2.3: alone with nowhere to go.

The third theme relates to participants' experiences of feeling alone and lost, not knowing where to go to for support. This theme speaks to a sense of being lost in the transition gap where young people feel vulnerable and alone sat between CAMHS and AMHS. Participants shared concerns over what would happen if their mental health deteriorated and they were without immediate or obvious support networks.

> "It's quite isolating, also a bit hopeless, because if CAMHS services can't help you who is actually going to be able to?" (Ali, 75)

> "I can remember being like 'Well if I can't access adult services like *what am I going to do* if I get ill or get worse, what am I going to do?' I just felt completely lost. (…) I felt like there wasn't anyone I could just go and talk to." (Frankie, 235)

> "Coming up to my 18th was like really scary. Like what if I go back into my whole like depression, like if I go back into it what do I do?" (Lucie, 161)

Having someone available and accessible to talk to seems important for these young people, and it cannot just be anyone: there is want for a network outside of family and friends, an independent and professional body of people. Professionals are seen as those in a position to give guidance, as described here by Louise and Frankie.

> "I had that thing once a week where I could talk to a professional, somebody not in the family, about stuff that had gone on and about how I feel, so I was worried when I finished. (…) you can talk to people at home but there are certain things I don't like talking about to people close to me." (Louise, 286)

> "I didn't have much support network outside of CAMHS I felt like I was kind of dropped on nothing. Like, I just felt a bit *lost* to be quite honest, without having anyone giving me any kind of guidance, it was difficult." (Frankie, 67)

Natalie had professional support from CAMHS for a long time and for her it was a question of being able to cope without them. There is an anticipation and belief that she is in a position of being 'unable'.

> "I was so scared like I'd had that support for so long and the thoughts of having all of that go and essentially be on my own, I convinced myself that I wasn't going to get back on and cope with it, I couldn't imagine like not having it." (Natalie, 23)

The expressions of feeling scared and worried by the prospect of being without any mental health support was a real concern and speaks volumes for these individuals. There is a detachment from the care provider here which conveys feelings of insecurity. There is an expectation of risk that these young people are voicing. These challenges are understood to fall within an overarching perception of rejection.

Little sense of self as an 'able' individual to take the learning from the service provider and apply to the external world is seen here. Perhaps this reflects on both individual and service level requirements in equipping young people for their 'adult' lives.

This theme overlaps with other themes, such as those within the superordinate theme of Power, and it is important to note here that feeling alone and at loss is associated with rejection within the participant narratives. It therefore forms part of the superordinate theme of Rejection.

Theme 2.4: loss of relationship.

The fourth theme under discussion relates to participants' experiences of loss of relationship with the CAMHS professionals. Time is spent with the CAMHS mental health professional where connection and trust is built. Participants experience loss from these relationships when it comes to being discharged from the service.

> "After CAMHS, with the therapist you feel like empty, you develop a relationship with this person and then you're like 'oh you're not there anymore, who am I going to talk to?'" (Louise, 354)

For Ali and Joe, it was a stark reminder that these relationships are in a professional capacity and they appear to also question the authenticity of the connection itself.

> "It was quite sad. I mean like you build up these relationships, you become like friends and then suddenly you have to leave and you are reminded that actually they are a professional and this is their job. I really struggled with that." (Ali, 134)

> "The young person can create a connection with the professional, and if they were to go then that person will feel sadness from that, in a way I feel like they didn't say goodbye to me. Everyone is a name and everyone has a story, but they will not feel that same emotional connection to you." (Joe, 480)

For some, like Ali, the thought of starting a new relationship with somebody else was difficult. It was not only upsetting but exhausting with the thought of the cycle repeating.

> "I had built up a relationship with my worker there, like I would have to start again with somebody new (…) it was quite upsetting (…) and you know that that [new relationship] will eventually end as well." (Ali, 129)

Relationships and connections are valuable to these young people, as explored in theme 1.4 'different approaches', and loss of such relationships is difficult for them to comprehend.

Theme 2.5: emotional pain.

The final theme to be discussed within the superordinate theme of Rejection relates to participants' experiences of emotional pain. Participants express feeling a range of difficult emotions following discharge from CAMHS, such as feeling upset and angry. The extracts below from Frankie and Ali express some of this emotional pain.

> "It [being discharged] didn't seem *fair*, it didn't seem right, it made me incredibly *angry* (…) my mum was also very angry because she could tell that like that service was not what I needed, it wasn't enough" (Frankie, 41)

> "It was upsetting. Yeah it hurt quite a lot to have to leave." (Ali, 139)

For Lucie, the emotional pain of discharge led to harmful behaviours, such as self-harming and attempting suicide.

> "After my last contact with them I went into hospital for self-harm and an OD [overdose], I was in and out of consciousness um they'd said to me 'do you want to be referred in [to CAMHS]?' and I said there's probably no point because I'm turning 18 in a couple of months, so what's the point of referring me back to CAMHS when they're literally going to say 'well you're 18 in a few months, what are we going to do? we'll have a chat and then tell you *like there you go! Out the door again!*'" (Lucie, 152)

> "Before I started exploring new places [charitable organisations] it just would be like 'F**k it, I'm going to commit suicide again', or attempt to. (…) it almost feels like a roller coaster my emotions." (Lucie, 402)

She articulates her story with such poignancy: the distress she felt was significant. With going back into CAMHS not feeling a viable option after her hospital admission, she was struggling to push herself to find a charitable organisation that could support her.

Superordinate Theme 3: Identity

The third and final superordinate theme that arose from the data was concerned with participants' identity. This theme speaks to the challenges of fitting into the social categorisations of being a child/adolescent and being an adult, and the struggles in making sense of their mental health difficulties in understanding what they are experiencing. Figure 3 below shows the superordinate theme, the three themes within it, and the subordinate themes that make up these themes. The themes are presented in no particular hierarchical order of salience.

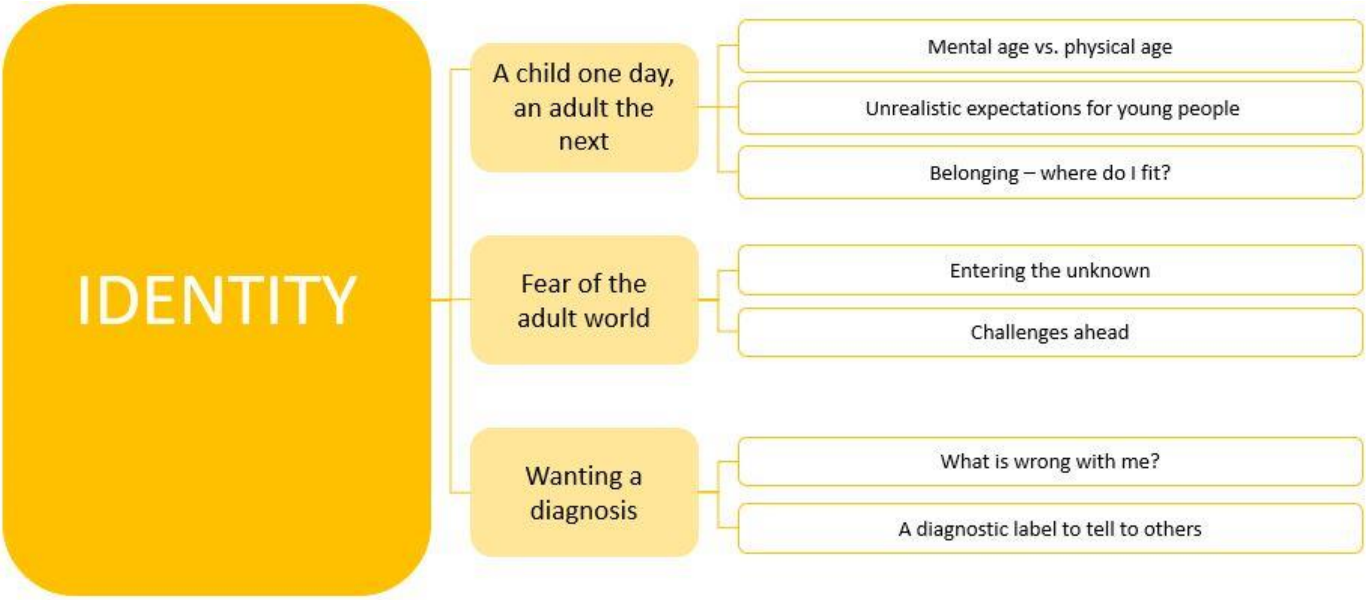

Figure 3: superordinate theme of 'identity' and subordinate themes

Theme 3.1: a child one day, an adult the next.

The first theme to be discussed relates to participants' experiences of feeling treated like a 'child' up to the age of 17, and then suddenly considered to be an 'adult' when turning 18, with little to no time for adapting. This theme speaks to the pressure and challenge of a sudden transition in their given identity and the social and cultural expectations. Natalie speaks of how this change of age triggers a very different system:

> "things can change so quickly - that one day you're 17 and the next day 18 and like *everything* changes (…) I think it's ridiculous how one day like the day before your 18th you're apparently like a child and can access CAMHS, and the next day you're suddenly an adult and having to access services with all ages, um yeah I think it's rubbish." (Natalie, 365)

For Frankie, the expectation to be an 'adult' was significant, and in being an adult it was believed that challenges and difficulties were therefore now possible to manage independently.

> "It felt like a lot of times I was seen as overreacting, or I was just like the *sensitive teenager*. They were like "You're an adult now, you can handle it" {laugh} and I *couldn't*." (Frankie, 53)

The change of age generates a different experience of the world, where the young person is no longer treated like a child and is now expected to understand themselves and their needs. Within the NHS mental health system, this sudden change in expectation feels unrealistic and unjustified. A call for an 'in-between' is made, as Ali and Lucie express:

> "when you've gone from a child focused service, suddenly you have to know all the answers, you have to know what you want. (…) the way the NHS works, just overnight you're an adult [and] that's just not realistic. (…) I feel like there's a gap definitely for that transition age (…) because I think young people do need something different like you can't just slot into adult services." (Ali, 255)

> "I hate that it's just like 18 is the cut off, you're either in this one or you're in that one, they need to make *a between*." (Lucie, 207)

Natalie calls for flexibility in the system, where a young person's readiness and level of maturity are assessed on an individual basis as to whether AMHS or third sector services are required.

> "people can be so different in terms of like how ready they are and their maturity at 18, so categorising everyone that they're ready for whether its adult services or any further support just because they turned 18 I don't think it's fair." (Natalie, 381)

This theme emphasises the social and cultural categorisation of age and how young people find these categorisations unhelpful, with unrealistic expectations. A gap seems to exist for young people as they do not feel ready to enter the 'adult' world, yet they have come to the end of the road in child services.

Theme 3.2: fear of the adult world.

The second theme to be discussed relates to participants' fear of entering the adult world. The responsibilities and challenges that lie ahead in the 'adult' world are seen as frightening and unknown. Being discharged from CAMHS means these young people are plunging into the deep end and feeling scared of what is to come.

> "They [CAMHS] were like "Okay we've taught you what to do, now off you go into the world" {laugh}. Very scary." (Frankie, 78)

> "It makes you not want to grow up. It makes you not want to get older, because as soon as you're an adult everything becomes harder, which is natural – adulthood is harder than childhood because you're no longer your parents' responsibility – but it's not a good feeling. Just because I'm 18 that doesn't mean I'm an adult mentally. (…) when I was discharged from CAMHS, I was sort of entering the unknown." (Lucie, 224)

These young people are speaking of a lack of readiness to adapt their identity. Their identity as a child or adolescent has been removed from them, and what lies beyond in their new identity as an adult is uncertain. There is a process here, for Lucie in particular, of trying to figure out what being an adult is and what it means.

Theme 3.3: wanting a diagnosis.

The third and final theme relates to participants' struggles with leaving CAMHS without a mental health diagnosis. This theme speaks to a feeling of not being able to understand themselves without a psychiatric diagnostic label and therefore feeling lost; where they have to try to make sense of themselves and what they need to do to help themselves. Generalised labels of anxiety or depression did not feel adequate for understanding what was happening to them, what it means for successful functioning in the world as an individual, and being able to provide this diagnosis to others who can support them.

> “I was searching for a label, just being like ‘Oh yeah, I have anxiety’, it never did any good (…) They [CAMHS] wouldn't label me as depressed, only anxiety-based depression. It's like, ugh (-) {tears in eyes, shakes head}.” (Joe, 200)

> “I was desperate to get a diagnosis. I really wanted to know what was going on in my head and no-one would give me that, they all just put it down to anxiety and bouts of low mood. Um, and that just never felt right with me. (…) I went in [to CAMHS] hoping someone could tell me what was going on in my head, for someone to tell me why I was ill, and I didn't really get that.” (Frankie, 183)

> “I always wanted a diagnosis. I've always wanted to know what was wrong, because [it] makes it easier for me to understand. If I know what's wrong, I know where I can get help and what sort of help I need. I said to them [CAMHS] ‘When you discharge me, set me up a diagnosis’, and then I can get some sort of closure. I just wanted a label so that I can work on that label, so I can do some research on it [and] I can learn what I can do to help myself.” (Lucie, 168)

These young people really stress the importance and reliance on the diagnostic label as a means to self-understanding and future direction. How these young people wanted their diagnosis to be understood by others varied considerably. For some, they were adamant that the diagnostic label was not an excuse or means of avoidance, and it was important for them to express this:

> “Like it's not an excuse, I'll never be like ‘Sorry I can't do that, I have depression’.” (Lucie, 177).

For others, a diagnostic label was seen as a way in which they can communicate their needs better to others:

> "I wanted a word I could use with my teachers, because I was about to go into university I wanted something that I could be like 'this is what is wrong with me, this is what I need from you.'" (Frankie, 428)

For Louise, a diagnostic label was given to her, and she valued this, however the diagnosis was kept from others in fear of receiving judgement or being treated differently. The extract below expresses this position:

> "my mental health nurse was the one that actually diagnosed me. All the symptoms fitted and I was good with it because I was like, right I know what I've got wrong with me now, I know what I can do. (…) I don't really tell anyone what I've got wrong with me I just say like 'Oh I've got anxiety and depression' because I want people to know me for me and not what I've been diagnosed with." (Louise, 193)

The identity of these young people seems to be as a person who is mentally unwell, that somehow they are not 'normal'. There is significant concern for them over leaving the containment of CAMHS and entering the adult world without a clear understanding of what is perceived as 'wrong' with them.

Overarching Theme: Quality Mental Health Care

An overarching theme of 'quality mental health care' emerged from the data. Participants actively reveal issues they consider to be present within the current NHS mental health service provision pathways for young people. Sometimes they may feel able to voice and contest these issues with the service in question, but they uphold that the issues are inadequate and that they should be addressed. Much attention is given to the details of how these services should suitably run, with a focus on the individual's needs. The thought of waiting for public services is considered unacceptable and not good enough for some participants.

Participants are clear in their views of what mental health support should look like, and they feel able to voice such opinions. The environment for delivering care, the connections and relationships held with professionals, and the ability to have anchors and stability in their lives are considered crucial for their psychological wellbeing. Such elements are deemed lacking in current NHS mental health service provision for young people.

These young people want to voice what makes mental health care effective for them, and they want to be heard. By involving the individual in decisions about their health care, health and wellbeing can potentially be improved, and individuals can make informed use of available healthcare resources.

DISCUSSION

Semi-structured interviews were conducted with six young people who had transitioned from CAMHS into third sector charitable organisations. Interpretative Phenomenological Analysis was utilised to analyse the data where three superordinate themes emerged and an overarching theme. This discussion section will look at the results detailed above in the light of pre-existing literature, as well as new literature that has been highlighted by the findings. Indeed, Smith, Flowers and Larkin (2009) state that it is the nature of IPA for the interview and analysis to take the researcher into new and unanticipated areas. New areas include literature on power imbalances and shared decision making. Each superordinate theme will be presented in turn, commencing with Power, then Rejection, and then Identity, followed by the overarching theme.

Power

Power, as an unspoken dynamic between the young person and CAMHS services, emerged as a core component of the experience of transition for the participants. Their sense of power, autonomy and control over their mental health support was challenged in the final interactions with CAMHS which was felt to put them at a disservice.

Participants felt that options and choices were not available from CAMHS regarding their treatment pathway, discharge, and transition into further mental health support. Some participants described their position as hopeless when they had no power to change their situation. Participants were active in pointing out the issues with CAMHS services, some of which they felt able to contest, but they maintained that the issues are wrong and that they should be addressed. A central difference from CAMHS was the plethora of options available to the participants within the charitable organisations, as well as the sense that therapists were able to adjust their agenda to the participants' wishes.

The power dynamics between health professionals and young people in CAMHS reported in this research have been found in previous studies. Harper, Dickson and Bramwell (2014) report an 'us-and-them' dynamic between professionals and young people in CAMHS and experiences of being treated like a child. Bury, Raval and Lyon (2007) also reported that young people felt that they were not able to ask their therapist questions about issues that were concerning them or about decisions pertaining to their treatment. The maintenance and dominance of a service model in which the majority of decisions rest with a psychiatrist (Rethink & Adfam, 2004; Warner, 2005) has specifically been found to prevent other mental health professionals from practicing in an empowering way (Goodwin & Happell, 2006; O'Donovan 2007). The primary driver of service user involvement is thought to typically remain one of tokenism rather than genuine patient-centred care (Faulkner & Williams, 2005; Rose, 2001). The lack of recognition that has historically been afforded to the relational and hierarchical elements of health care has created a marked mismatch between client motivation and information exchange, such that service users' knowledge is often rendered insufficient for shared need assessments or care negotiation to occur (Bee, Price, Baker, & Lovell, 2015). Acknowledging the issue of power differences early on in the therapeutic encounter might go some way towards redressing this imbalance and increasing the level of therapeutic engagement (Hagan & Smail, 1998).

The research findings also speak to the literature around shared decision making in mental health services for young people. Shared decision making has been defined by The Health Foundation (2014) as a collaborative process through which a health care professional supports a patient to reach a decision about their care and treatment. Shared decision making is increasingly seen as the hallmark of excellent healthcare (The Health Foundation, 2012). The World Health Organization (2012) have called for the inclusion of young people in decisions when it comes to their care and treatment, and the UK Department of Health (2012) have made specific recommendations to include young people with mental health difficulties at a national level. It is now a decade from when the UK Government published a white paper on equity and excellence, setting a vision for the NHS where 'no decision about me, without me' was to become the norm (Department of Health, 2010). Yet unfortunately, power imbalances and a lack of shared decision making are significantly evident in the present research data.

A scoping review of the approaches for promoting shared decision making used in child and adolescent mental health suggests that six different approaches are commonly implemented to facilitate shared decision making (Cheng, Hayes, Edbrooke-Childs, Martin, Chapman, & Wolpert, 2017). These consist of: therapeutic techniques, decision aids, psychoeducational information, action planning or goal setting, discussion prompts, and mobilising patients to engage. Abrines-Jaume et al., (2014) argued that such approaches help to redress the power imbalance between young people and health professionals, to clarify different aspects of the treatment and decision-making process for both parties, as well as increase engagement. However, it is also established that trust, flexibility and effort are all essential to effectively facilitate shared decision making (Abrines-Jaume, et al., 2014).

In the present research, participants expressed having grown dependent on the support provided by CAMHS and felt there was little to prepare them for the next stages of service transition, or empower them to take charge of their own further wellbeing needs when leaving mental health services. Participants expressed what they would find helpful and this was regarded to be a transition service between CAMHS and AMHS, with good communication and collaboration; the individual's level of maturity and personal circumstances to be taken into consideration, rather than an automatic discharge based on age; and more age-appropriate settings for adolescents within CAMHS services. This finding speaks to Tanner's (2015) call for a developmentally informed model of mental health for emerging adults as essential for reducing the unmet needs of this age group within mental health services. Indeed, a developmental lens encourages understanding mental health needs from a multidimensional position.

There was strong expression of feeling unsettled and overwhelmed by multiple simultaneous transitions and changes in the present research findings. These changes are mostly determined by age, and young people often felt powerless. The timings of educational and career-based transitions are held at governmental and societal levels that the young person does not have the power to control or alter to accommodate their personal circumstances or developmental context. This finding is shared with Harper, Dickson and Bramwell's (2014) finding that transitioning into different services whilst in a stage of transitioning to adulthood is a difficult experience for young people. Indeed, the transition from adolescence to adulthood is a critical normative life transition as it typically involves pervasive and often simultaneous contextual and social role changes (Schulenberg, Sameroff, & Cicchetti, 2004).

For some young people, the relatively sudden drop in institutional structure can be debilitating, creating a mismatch between individual needs and contextual affordances (Schulenberg, Sameroff, & Cicchetti, 2004). This discrepancy can result in avoidance of life tasks during this time, creating a sense of floundering that can adversely affect their mental health (Mortimer, Zimmer-Gembeck, Holmes, & Shanahan, 2002).

Participants spoke of uncertainty and apprehension entering a new service and a new environment, as well as having to adjust to new ways of working following their transition from CAMHS. Many different approaches were reported, most notably was that of the more person-centred approach taken by the charitable organisations. This approach was experienced as initially very unfamiliar, but they felt it put them at ease and made the transition easier to adapt to.

The concept of person-centred care, closely related to that of shared decision making discussed above, is one which identifies the individual at the heart of all interactions and interventions. In person-centred care, the focus is on the person, as opposed to the condition or illness, and it promotes respect, dignity and compassion (Harding, Wait, & Scrutton, 2015; Leplege, Gzil, Cammelli, Lefeve, Pachoud, & Ville, 2007). Although there is ambiguity surrounding the core definition of person-centred care, it is generally understood to be a care system that is supportive of informed decision making, helps to navigate and manage a persons' own health and care, and delivers care with respect of individual abilities, preferences, personal circumstances and goals (Collins, Lead, & Somerset, 2014; Harding, Wait, & Scrutton, 2015).

Participants spoke of experiencing validating interactions with others, being able to take the lead in therapy, being able to control the 'depth' of the therapeutic intervention, and ultimately feeling their needs were being met. Feeling safe and having a therapist willing to adapt to their needs and wishes was experienced as empowering. Gondek et al. (2017) indeed argue that a greater focus should be put on the role of relationships in the process of person-centred care provision. Harper, Dickson and Bramwell (2014) also stress the importance of relationship continuity for young people with mental health problems.

What is also highlighted by the different approaches between CAMHS and the charitable organisations in the present research, is a discomfort for young people that is parallel in both the literal transition between services, and the developmental transition and the growth of the self. Participants rejected the lack of individuality in being treated like a child within CAMHS, yet they held on to a dependent mindset in their worries of not being fully supported by a service. It possibly indicates a state of confusion for the young person in the longing for independence, but the reality is frightening.

Despite the challenges with implementing person-centred care in young peoples' services, such as having complex conversations with highly stressed or vulnerable individuals (Wolpert et al., 2012), and the possibility of introducing safeguarding issues (Abrines-Jaume et al., 2014), person-centred care can have a positive impact on self-esteem, self-management, self-efficacy, transitions into adulthood, patient empowerment and treatment outcomes (Asarnow et al., 2009; Edbrooke-Childs et al., 2016; Joosten, De Jong, de Weert-van Oene, Sensky, & van der Staak, 2011; Richardson, McCauley, & Katon, 2009; Westermann, Verheij, Winkens, Verhulst, & Van Oort, 2013).

Nonetheless, evidence suggests that young people are rarely involved in decision-making regarding their care or treatment and their preferences and goals may be often unheard (Coyne, Hayes, Gallagher, & Regan, 2006; Wolpert et al., 2012). This can make them feel lonely, ignored and betrayed (Coyne et al., 2006). There is an urgent need to improve the information provision for service users and carers within mental health services, as this is considered one of the most predominant barriers to person-centred care reported by young people in youth services (Gondek et al., 2017).

Rejection

The ending of mental health treatment with CAMHS was experienced by participants to be a personal rejection, an abandonment. Rejection, and the emotional elements of this – shock, loss of relationship, being alone, and emotional pain – emerged as another core component of the experience of transition for participants.

Abandonment, the feeling of being unwanted or being disposed of, left many participants feeling let down and unsupported. The system is considered to have strict criteria of what mental health 'should' look like, which was experienced as unfair on young people who fall between the gaps of child and adult services, leaving them to feel abandoned and vulnerable. This may highlight not only a lack of readiness and preparation for leaving CAMHS and sourcing alternative areas of support, but also the role CAMHS may play in attachment. This feeling of abandonment speaks of CAMHS almost as a parental figure.

The suddenness of discharge for these young people was a challenge for them, and possibly explains and validates their experience of abandonment and rejection. This shock ending appears to leave little room for closure and coming to terms with the ending of therapy in a supported way. Participants experienced feeling alone and lost in the transitional gap, not knowing where to go for support and feeling vulnerable and insecure. Participants spoke of concerns over what would happen if their mental health deteriorated and they were without immediate or obvious support networks. Having someone available and accessible to talk to seemed important for young people, and it cannot just be anyone: an independent and professional body of people is called for, outside of the network of family and friends, who can give support and guidance. Anticipation and belief of being 'unable' is noted; little sense of self as an able individual to take the learning from the service provider and apply to the external world, which perhaps reflects on both individual and service level requirements in equipping young people for their 'adult' lives.

Time is spent with the CAMHS mental health professionals where connection and trust is built. Participants experience loss from these relationships, for some it was a stark reminder that these relationships are in a professional capacity and even questioned the authenticity of the relationship itself. It was felt to be upsetting and exhausting to think of having to start new relationships and the cycle repeating itself. From this, participants express feeling a range of difficult emotions following discharge from CAMHS, such as feeling upset, angry, scared, helpless. For one such participant, the emotional pain of discharge from CAMHS led to harmful behaviours, such as self-harming and attempting suicide.

These findings speak to the attachment literature and the literature around experiences of termination of therapy. We cannot talk about experiences of abandonment and the emotional impact of loss of relationship and connections with others without referring to the understandings of attachment. The presumed biological function of the attachment system is to protect a person from danger by assuring that proximity is maintained to caring and supportive others (attachment figures), especially in risky or dangerous situations (Mikulincer & Shaver, 2016). Human beings inherently seek connections and relationships, and are naturally inclined to seek proximity to familiar, comforting figures, especially in times of threat, pain, or need. The loss of such contact is a natural source of distress and psychological dysfunction. Bowlby (1969/1982) claimed that the attachment behavioural system is activated by environmental threats that endanger a person's perceived survival. Encounters with such threats arouse a need for protection provided by other people and automatically activate the attachment system.

Theorists have developed a 'prototype approach' to attachment that leaves room for both stability and change in attachment patterns (such as Fraley, 2002; Owens, Crowell, Pan, Treboux, O'Connor, & Waters, 1995). According to this approach, infant attachment patterns are the templates of attachment patterns throughout the lifespan, however, prototype-discrepant and prototype-consistent experiences during childhood, adolescence and adulthood can reduce or increase the degree of continuity observed. Revisions of attachment representations due to life events or environmental changes throughout development result in further updating the working-model.

Early attachment relationships may therefore be triggered in the ending of mental health service provision and therapeutic relationships, providing understanding of the challenges young people in the present research are voicing. Indeed, Bury, Raval, and Lyon (2007) argue that some of the difficulties associated with ending therapy relate back to feelings associated with separation and loss. At the end of therapy, these feelings may be reactivated as the young person loses the support of the therapist. This can be seen as a transitional period when the young person attempts to adjust to a new situation without the structure and routine of therapy. Expressions of difficult emotions associated with this process have been found in studies exploring therapy termination, many of which support the finding of the present research in uncovering feelings of sadness, loss and rejection (such as Baum, 2005; Bury, Raval, & Lyon, 2007).

Many emotional reactions following termination have been identified in the literature as stemming from the degree to which the client and therapist have: reached the goals of therapy, engaged in a gradual process of termination, had the opportunity to explore feelings surrounding termination, and engaged in future orientated discussions (Baum, 2007; Knox et al., 2011; Marx & Gelso, 1987; Roe, Dekel, Harel, & Fennig, 2006). It is questionable as to the extent of which, if at all, participants in the present research have experienced such ending processes prior to leaving CAMHS and may explain the emotion that is felt.

Quintana and Holahan (1992) assert that the termination of therapy is a complex stage, and the way termination occurs can determine whether the gains of therapy are consolidated or damaged. Furthermore, Mirabito (2006) found that the developmental tasks of adolescence influenced the ways that young people engaged in, and terminated, treatment. Developmental challenges, such as separation, individuation, and autonomy, made forming and ending therapeutic relationships emotionally demanding.

Identity

The identity of the young people, as understood in the context of society and service provision, emerged as another core component of the experience of transition for the participants. Their sense of self was understood in relation to the expectations, categorisations, and labels defined by others. Elements of who they are and what they were experiencing was sometimes rejected, such as being treated like a child, and sometimes wanted, such as being provided with a psychiatric diagnostic label.

Participants spoke of feeling treated like a 'child' up to the age of 17, and then suddenly considered to be an 'adult' when turning 18, with little to no time for adapting or developing. There are pressures and challenges of a sudden transition in their identity and thus the social and cultural expectations. The change of age suddenly generates a different experience of the world, where the young person is no longer treated like a child and is expected to understand themselves and their needs, to advocate for themselves and the taken on responsibilities. Within the NHS mental health system, this sudden change in expectations was considered unrealistic and unjustified by the young people, calling for a transitional period to be acknowledged and respected. Once again, participants expressed that readiness for transition and level of development/maturity are important considerations for mental health services.

Returning to the literature on development and maturation in young people, it provides a critical foundation for the argument of developmental/maturity based considerations for mental health services. Cognitive capacity, which underpins logical thinking, is thought to reach adult levels around age 16, whilst psychosocial maturity, which comprises individuals' ability to restrain themselves in the face of emotional, exciting, or risky stimuli, is thought to not reach adult levels until after age 18. This creates what has been described as a 'maturity gap' between cognitive and psychosocial maturity for young people (Icenogle et al., 2019). Differential maturation in the structure and function of brain systems associated with these systems leaves adolescents particularly vulnerable to socio-emotional influences and risk-taking behaviours (Smith, Chein, & Steinberg, 2013).

The social and cultural categorisation of age is apparent in the present research and how these categorisations are unhelpful, with unrealistic expectations. A gap seems to exist for young people as they do not feel ready to enter the 'adult' world, yet they have come to the end of what they feel is considered a 'child'. Culturally based, age-related expectations shape transitions by providing a normative timetable and agenda (Neugarten, 1979), which for participants in the current research found to put significant pressure on individuals to develop and behave differently within an unrealistic timeframe.

The responsibilities and challenges that lie ahead in the 'adult' world are seen as frightening and unknown to participants in the current research. Being discharged from CAMHS means these young people are plunging into the deep end and feeling scared of what is to come. These young people are speaking of a lack of readiness to adapt their identity to fit within the opposing categories that are on offer in NHS services - child/adolescent or adult. Their identity as a child or adolescent has been both removed from them and has also been rejected, and what lies beyond in their new identity as an adult is uncertain.

These findings support the literature around emerging adulthood and the stages of adaptation. Emerging adulthood is a period in which young people can feel lost between the identities of adolescence and adulthood and experience a desire for self-exploration and experimentation; a time that is comparatively independent from traditional social roles and normative expectations, instead of a time characterised as settling into traditional adult roles (Arnett, 2000; Baggio et al., 2017; Nelson & Barry, 2005). Arnett (2004a, 2004b) proposed five dimensions related to psychological states in emerging adulthood. The dimension labelled 'feeling in-between' describes the uncertainty of individuals as they gradually become adults, that is, no longer identifying as an adolescent although not yet feeling fully adult. The expressions of the participants in the current research speak to this state of 'feeling in-between'.

Leaving CAMHS without a psychiatric diagnosis consequently left participants struggling to understand themselves and their further direction. Generalised labels of anxiety or depression did not feel adequate for understanding what was happening to them, what it means for successful functioning in the world as an individual, and being able to provide this diagnosis to others who can support them. How these young people wanted their diagnosis to be understood by others was for very different reasons. For some, they were adamant that the diagnostic label was not an excuse or means of avoidance, for others, a diagnostic label was a way in which they can communicate their needs better to others. The identity of these young people seems to be as a person who is mentally unwell, that somehow, they are not 'normal'. There is significant concern for them over leaving the containment of CAMHS and entering the adult world without a clear understanding of what is perceived as 'wrong' with them.

Experiences of psychological pain and distress can arguably be understood as a normal and natural part of human existence, and like all other experiences, experiences associated with distress are bound up with social, cultural and material conditions, and with personal biographies, relationships, and life events (Bentall, 2003; Cromby, Harper, & Reavey, 2013). Distress does not form a separate, singular category of symptoms that can be understood in isolation from everything else (Cromby, Harper, & Reavey, 2013). The BPS (2011) considers individuals and the general public to be negatively affected by the continued and continuous medicalisation of natural responses to life experiences; responses which undoubtedly have distressing consequences which demand helping responses, but which do not reflect illnesses so much as normal individual variation. Diagnostic classification systems, such as the DSM and ICD, are constructed on identifying problems as located within the individual, bypassing the relational context of problems and the undeniable social causation of many such problems (BPS, 2011). The BPS (2011) also state their concern at the increasing use of diagnostic criteria and of the increasing use of medication for children and young people.

It is interesting to find in the present research, that participants were not satisfied with understanding their mental health difficulties to be anything other than something that is 'wrong' with them, for which they need a diagnostic label. Making sense of psychological and emotional experiences without a diagnostic label to guide them, seemed impossible for some participants. This seems to reflect what commonly remains the social and cultural understanding of human emotion and suffering and it could be argued that there is still a long way to go in terms of detaching from the medical model of distress.

Overarching Theme: Quality Mental Health Care

The overarching theme, of 'quality mental health care', is presented as a boarder interpretation of the data.

Issues with NHS mental health service provision for young people were revealed by participants, and the provision of quality free mental health care, and continuation of such services beyond the current capacity, was insisted. Attention was given to the lack of service provision for young people and the idea of waiting for public services was considered unacceptable and not good enough.

Participants revealed specific issues with the way CAMHS services were run. Sometimes participants feel able to voice and contest these issues with the service in question, but they uphold that the issues are inadequate and that they should be addressed. Much attention is given to the details of how these services should suitably run, with clear views of what mental health support should look like. The environment for care delivery, the relationships held with professionals, and the ability to have anchors and stability in their lives are considered crucial for their psychological wellbeing. Such elements are deemed lacking in current NHS mental health service provision for young people.

Access to NHS services is an undeniable privilege that living in the UK provides. These young people want to voice what makes mental health care effective for them, and they want to be heard. Indeed, as previously discussed, by involving the individual in decisions about their health care, health and wellbeing can potentially be improved, and individuals can make informed use of available healthcare resources.

The voice of young people in this present research with regards to what NHS mental health care should look like, accompanies the limited literature surrounding what young people find most helpful when it comes to navigating the mental health service transition. Burnham-Riosa et al. (2015) captured the factors that young people consider important in order to achieve a successful transitional process. These are: to receive detailed information regarding the transition process and the subsequent service; to continue in an engaging, open and client-centred relationship with health professionals; and to have open communication between child and adult health professionals through the transitioning period. Burnham-Riosa et al. further argue that young people often clearly articulate the preparation they require to leave CAMHS with the confidence to take responsibility for their own healthcare. They want to be included and play an active role in the transition process, and to feel empowered as agents of their own mental health journey. It can therefore be argued that health professionals, services and commissioning bodies have a duty of care to listen and acknowledge the views of young people in order to make service transitions most effective and successful.

Implications for Counselling Psychology

The current research can be said to have important implications for the field of Counselling Psychology. Counselling Psychology is orientated to the meanings, beliefs, context, and processes that are constructed both within and between people and which affect an individual’s emotional and psychological wellbeing (BPS, 2018). Douglas, Woolfe, Strawbridge, Kasket and Galbraith (2016) describe Counselling Psychology as having important links with humanistic thinking with its emphasis on viewing human beings holistically. Counselling Psychology emphasises the subjective experience of clients, collaborative relationships, and seeking to understand inner worlds and individual constructions of reality. The present research explores these constructions for young people within the context of transitions from statutory to third sector mental health services.

The relational challenges and disruptions revealed in the present research, speaks to the very foundations of Counselling Psychology and what, as a profession, it strives to achieve. This is deeply relevant to Counselling Psychologists working with this vulnerable population of young people who, at their core, are seeking connection and understanding. Counselling Psychologists are well placed to advocate for young people with mental health difficulties who find themselves struggling to adapt and fit into the socially and culturally defined age groups. There is a depth and complexity to young people experiencing mental health difficulties that far exceeds any possible psychiatric diagnostic label or social category that requires consideration and validation.

Speaking to the social justice ethos of Counselling Psychology, there is opportunity here to strengthen the wellbeing and empowerment of young people who fall between the gaps of service provision. Mental health and inequality are interrelated. Indeed, mental health strategy is considered both a public health strategy and a strategy for social justice and change (Department of Health, 2011). The fundamental structures of the NHS and the overall organisation form the foundation on which professional practice is built, providing policies and guidance on the overall direction services take. The increasing complexity of the current economic and mental health climates provoke an array of ethical, social, and political debates relevant to the Counselling Psychology profession. The challenge is to maintain a principle-driven ethical practice in a rule-driven world, where alignment between core professional values and the demands of one’s work is under regular threat (Douglas, Woolfe, Strawbridge, Kasket and Galbraith, 2016).

Limitations of the Research

Whilst the present research has provided a wealth of rich and detailed information and understanding of young peoples’ experiences of transitions from CAMHS to charitable voluntary organisations, it is not without limitations. Such limitations need to be acknowledged.

IPA: the role of language in data collection.

One possible limitation of IPA is its reliance on the use of language for data collection. Collecting data via interviews indicates that language is the means by which participants attempt to communicate their experiences to the researcher (Willig, 2008). Since phenomenological research is interested in the actual experience itself, it must assume that language provides participants with the necessary tools to capture that experience – it relies upon the representational validity of language. However, it could be argued that language constructs, rather than describes, reality, in that the words we choose to describe a particular experience always construct a particular version of that experience. Language adds meanings that reside in the words themselves and, therefore, makes direct access to someone’s experience impossible. An interview transcript may well tell us more about the ways in which an individual *talks about* a particular experience within a particular context, than about the *experience* itself.

IPA: explanation versus description.

IPA aims to gain a better understanding of how participants perceive and experience the world. It is concerned with *how* the world presents itself to participants as they engage with it in a particular context and with particular intentions. It cannot make, and does not make, claims about the nature of the world itself. It could be argued that a focus on appearances, without regard for their cause or origin, limits our understanding of phenomena (Willig, 2008).

Homogeneity.

Homogeneity is an important criterion of IPA research and it is plausible that the present research can be criticised for its lack of homogeneity in the sample. Participants recruited to the study were all young people who had left CAMHS and had subsequently sourced further mental health support from a charitable organisation within the specific regions of Bristol and Gloucestershire. However, they varied considerably in terms of: their treatment interventions and length of time in CAMHS; their level of support from the charitable organisations; their mental health difficulties; and the time between leaving CAMHS and starting at the charity. This lack of homogeneity perhaps reflects the diversity of people, problems and services available.

Checking the findings with participants.

The findings of any IPA are the researcher's analysis of the participants' accounts, and as such may not be an analysis that is agreed to by the participants. However, there are plans in place to contact each individual and provide a summary of the salient findings, and if the responses indicate useful material for the methodology or the findings of the study, additional publication of such material will be considered.

Biased sample.

The findings of the present research is by definition the result of a biased sample. A number of young people were approached by staff members of the charitable organisations and posters were displayed in waiting areas and other visible locations, but unfortunately several people declined and many did not step forward to take part. It may be that these young people had more positive or alternative experiences which were not able to be voiced in this research.

Suggestions for Further Research

The present research was an attempt to explore the experiences of transitioning from CAMHS into third sector mental health organisations from the point of view of the young people who find themselves in the gap between CAMHS and AMHS. The research points to the complexities and challenges around the loss of therapeutic relationships and valued systems of support at a crucial age where multiple other transitions are taking place.

Further research is needed to understand these issues in more depth. A possible fruitful avenue to explore could be clinicians' views of the governments' drive for better partnership working between CAMHS and charitable organisations in local areas. Perhaps with the use of focus groups, exploration could specifically focus on *how* more collaborative relationships between services could be achieved, and ultimately *how* the relational and person-centred aspects of service provision can be provided.

Clinician and patient views on the governments' offer of a comprehensive service for 0-25 year-olds could also be explored, in particular, what both parties would like to see in the finer details of such a service. This could further explore the views expressed in the present research with regards to quality and appropriate therapeutic environments for young people. It will also be important for recommendations to be made to commissioning bodies in light of these findings with respect to what clinicians' and patients' require to achieve effective and quality service provision for young people.

It is also considered important for future research to incorporate the use of participant and public involvement across key stages from research design to publication. This is deemed particularly valuable when researching within the area of young peoples' mental health, given the challenges and complexities young people can face.

CONCLUSION

This research thesis has contributed to building an understanding of the ways in which young people can experience transitions in mental health support and services. It highlights the importance of acknowledging power imbalances, engaging in shared decision making, and empowering young people to develop independence, identify needs, and to make informed decisions. Autonomy, agency, and control over their mental health support is challenging for young people, especially in the final interactions with CAMHS, which was felt to put them at a disservice. Young people develop a dependency on the support provided by CAMHS, with little to prepare them for the next stages of service transition, or empower them to take charge of their own further wellbeing needs when leaving statutory mental health services. When venturing into the unfamiliar world of local third sector charitable organisations, a more notable person-centred approach put them at ease and made the transition easier to adapt into.

The research also points to the complexities and challenges around the loss of therapeutic relationships and valued systems of stability at a crucial age where multiple other transitions are taking place. The importance of relationships for young people was a significant finding, and speaks to the role of attachment in the loss of relationships and stability from services. As human beings, we inherently seek connections and relationships with others, and we are naturally inclined to seek proximity to comforting and familiar people in times of threat, pain, or need. The loss of such contact is a natural source of distress.

The challenges for young people in understanding the self and their identity have also been emphasised in this research. Young people no longer identify as an adolescent yet do not feel fully adult, indeed experience a state of 'feeling in-between' (Arnett, 2004a, 2004b). Entering the 'adult' world is felt to be disenabling and overwhelming. This is mirrored in young peoples' struggles to receive a psychiatric diagnostic label in order to understand their inner experiences. Without such labels, they felt unable to understand themselves and were left without further direction. Psychological pain and distress can arguably be understood as a normal and natural part of human existence, and perhaps reflects what commonly remains the social and cultural understanding of human emotion and suffering. This perhaps reflects how society largely remains fused to the medical model of distress.

Finally, the research stresses how young people have clear ideas and visions for making improvements to young peoples’ mental health services and transitional processes that can enhance the quality of service provision. It is argued that health professionals, services and commissioners can all play a vital role in improving mental health service transitions for young people.

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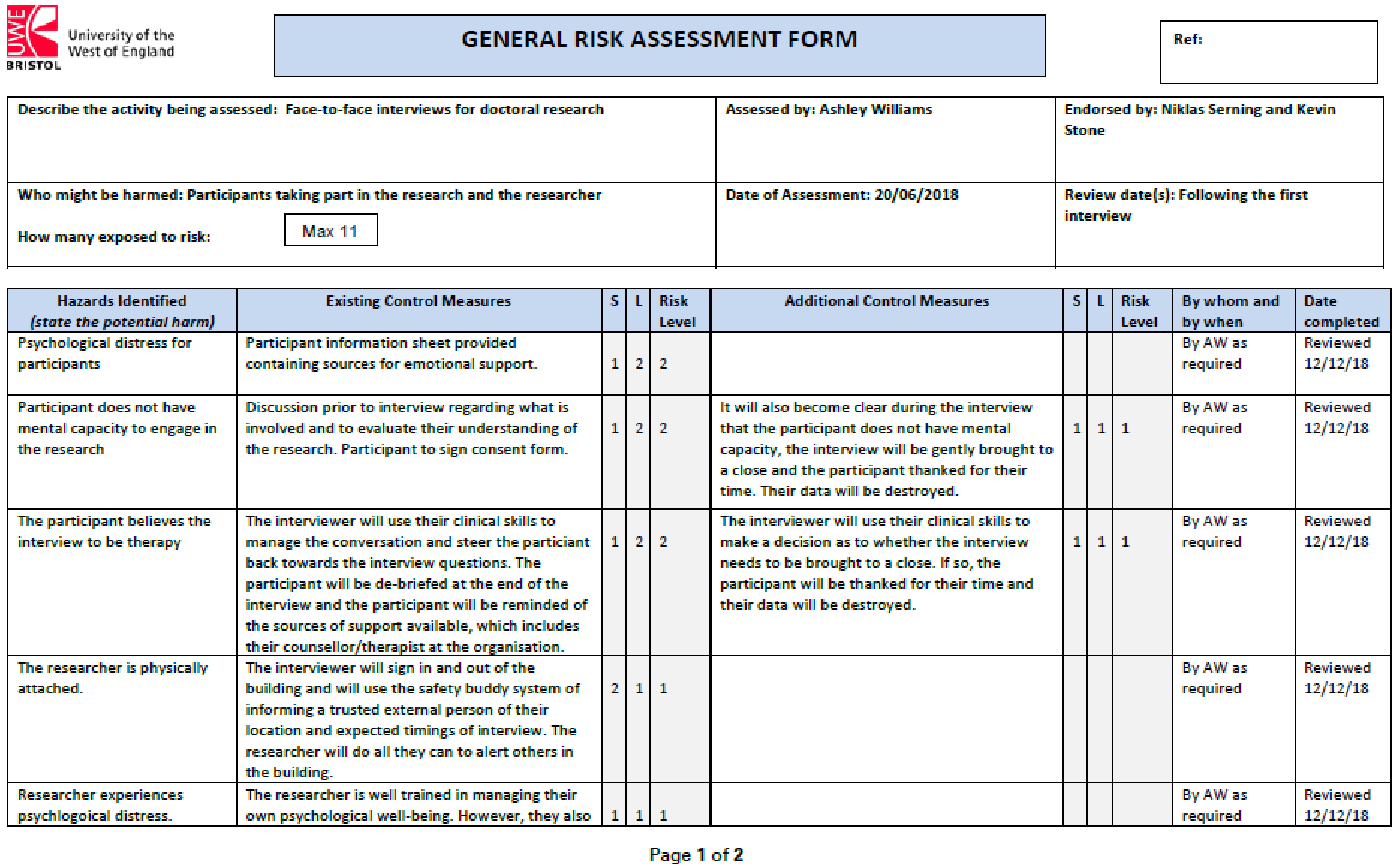
APPENDICES

Appendix 1: Risk Assessment



UWE BRISTOL University of the West of England

GENERAL RISK ASSESSMENT FORM

Ref:

Describe the activity being assessed: Face-to-face interviews for doctoral research	**Assessed by: Ashley Williams**	**Endorsed by: Niklas Serning and Kevin Stone**
Who might be harmed: Participants taking part in the research and the researcher **How many exposed to risk:** Max 11	**Date of Assessment: 20/06/2018**	**Review date(s): Following the first interview**

Hazards Identified ***(state the potential harm)***	**Existing Control Measures**	**S**	**L**	**Risk Level**	**Additional Control Measures**	**S**	**L**	**Risk Level**	**By whom and by when**	**Date completed**
Psychological distress for participants	Participant information sheet provided containing sources for emotional support.	1	2	2					By AW as required	Reviewed 12/12/18
Participant does not have mental capacity to engage in the research	Discussion prior to interview regarding what is involved and to evaluate their understanding of the research. Participant to sign consent form.	1	2	2	It will also become clear during the interview that the participant does not have mental capacity, the interview will be gently brought to a close and the participant thanked for their time. Their data will be destroyed.	1	1	1	By AW as required	Reviewed 12/12/18
The participant believes the interview to be therapy	The interviewer will use their clinical skills to manage the conversation and steer the particiant back towards the interview questions. The participant will be de-briefed at the end of the interview and the participant will be reminded of the sources of support available, which includes their counsellor/therapist at the organisation.	1	2	2	The interviewer will use their clinical skills to make a decision as to whether the interview needs to be brought to a close. If so, the participant will be thanked for their time and their data will be destroyed.	1	1	1	By AW as required	Reviewed 12/12/18
The researcher is physically attached.	The interviewer will sign in and out of the building and will use the safety buddy system of informing a trusted external person of their location and expected timings of interview. The researcher will do all they can to alert others in the building.	2	1	1					By AW as required	Reviewed 12/12/18
Researcher experiences psychlogoical distress.	The researcher is well trained in managing their own psychological well-being. However, they also	1	1	1					By AW as required	Reviewed 12/12/18

Page 1 of 2

	have very supportive partner and will make use of the external support available from the Samaritans and their own counsellor.									

RISK MATRIX: (To generate the risk level).

Very likely **5**	**5**	**10**	**15**	**20**	**25**
Likely **4**	**4**	**8**	**12**	**16**	**20**
Possible **3**	**3**	**6**	**9**	**12**	**15**
Unlikely **2**	**2**	**4**	**6**	**8**	**10**
Extremely unlikely **1**	**1**	**2**	**3**	**4**	**5**
Likelihood (L) ↑ Severity (S) →	**Minor injury – No first aid treatment required** **1**	**Minor injury – Requires First Aid Treatment** **2**	**Injury - requires GP treatment or Hospital attendance** **3**	**Major Injury** **4**	**Fatality** **5**

ACTION LEVEL: (To identify what action needs to be taken).

POINTS:	RISK LEVEL:	ACTION:
1 – 2	NEGLIGIBLE	No further action is necessary.
3 – 5	TOLERABLE	Where possible, reduce the risk further
6 - 12	MODERATE	Additional control measures are required
15 – 16	HIGH	Immediate action is necessary
20 - 25	INTOLERABLE	Stop the activity/ do not start the activity

Appendix 2: Research Scoping Meeting with 'Mentality' Group

2nd November 2017

RESEARCH SCOPING

OTR 'Mentality' Group

Area of exploration:
Experiences of mental health service transitions for young people

Direction of exploration:

1. Transitions between Child and Adolescent Mental Health Services (CAMHS) and charities such as Off The Record Bristol (OTR): - i.e. NHS to community charitable organisation. Mapping onto the NHS Five Year Forward View policy document published 2014 which incorporates improves to the partnership between the NHS and local, community-based voluntary/charitable organisations across the lifespan.

OR

2. Transitions between one-to-one and group therapy/treatment within mental health charitable organisations such as at OTR.

Methodology and research design:
Data collection:

1. face-to-face 1:1 semi-structured interview

OR

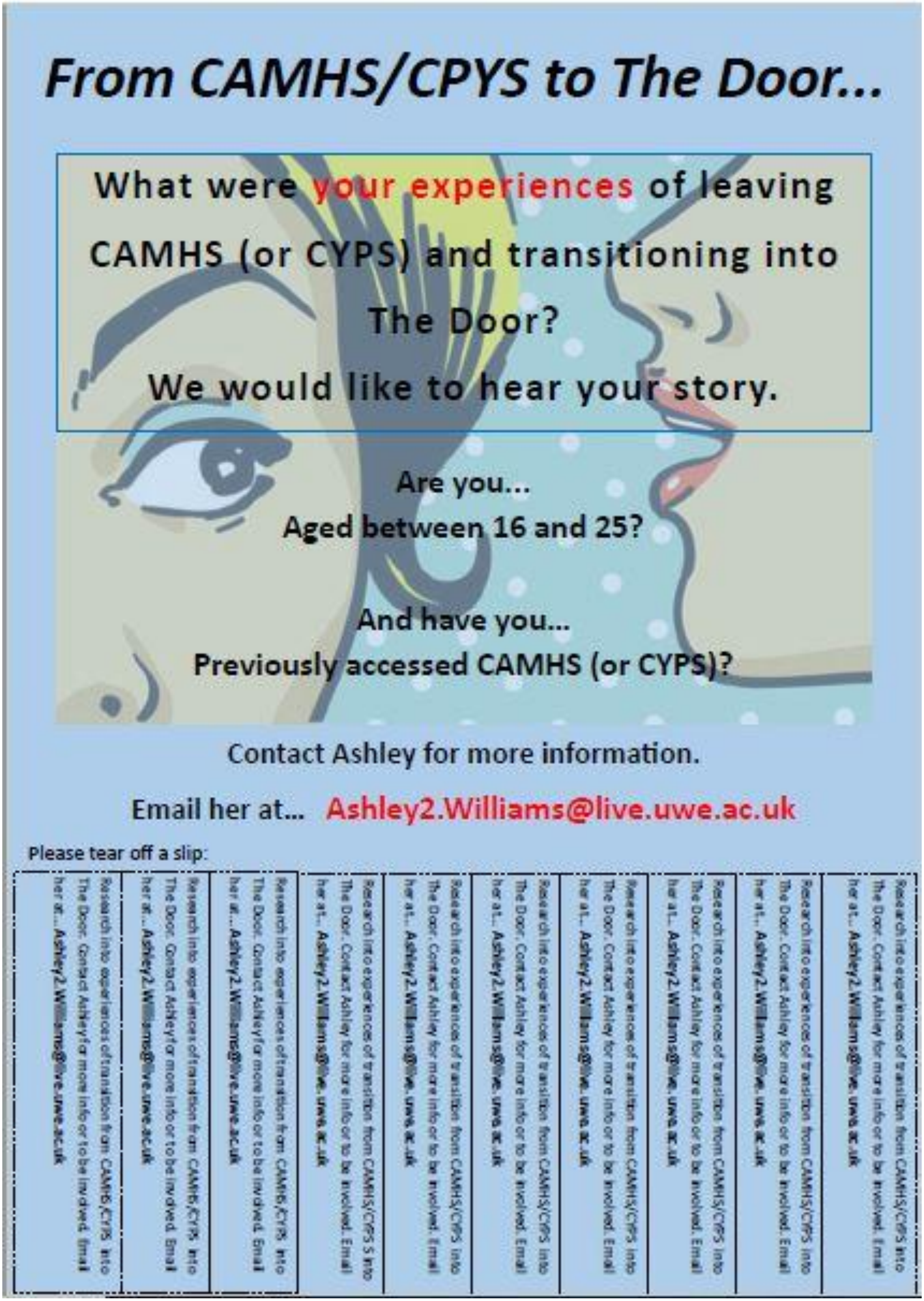
2. focus groups

- Qualitative study – capturing themes
- Interviews to be audio recorded then transcribed verbatim

Participants:

- Service users of mental health charitable organisations
- Experienced a transition (possibly within a set time frame)
- Participants will be anonymised

Appendix 3: Recruitment Poster (size A3)



From CAMHS/CPYS to The Door...

What were your experiences of leaving CAMHS (or CYPS) and transitioning into The Door?

We would like to hear your story.

Are you...
Aged between 16 and 25?

And have you...
Previously accessed CAMHS (or CYPS)?

Contact Ashley for more information.

Email her at... Ashley2.Williams@live.uwe.ac.uk

Please tear off a slip:

Research into experiences of transition from CAMHS/CYPS into The Door. Contact Ashley for more info or to be involved. Email her at... **Ashley2.Williams@live.uwe.ac.uk**

Research into experiences of transition from CAMHS/CYPS into The Door. Contact Ashley for more info or to be involved. Email her at... **Ashley2.Williams@live.uwe.ac.uk**

Research into experiences of transition from CAMHS/CYPS into The Door. Contact Ashley for more info or to be involved. Email her at... **Ashley2.Williams@live.uwe.ac.uk**

Research into experiences of transition from CAMHS/CYPS S into The Door. Contact Ashley for more info or to be involved. Email her at... **Ashley2.Williams@live.uwe.ac.uk**

Research into experiences of transition from CAMHS/CYPS into The Door. Contact Ashley for more info or to be involved. Email her at... **Ashley2.Williams@live.uwe.ac.uk**

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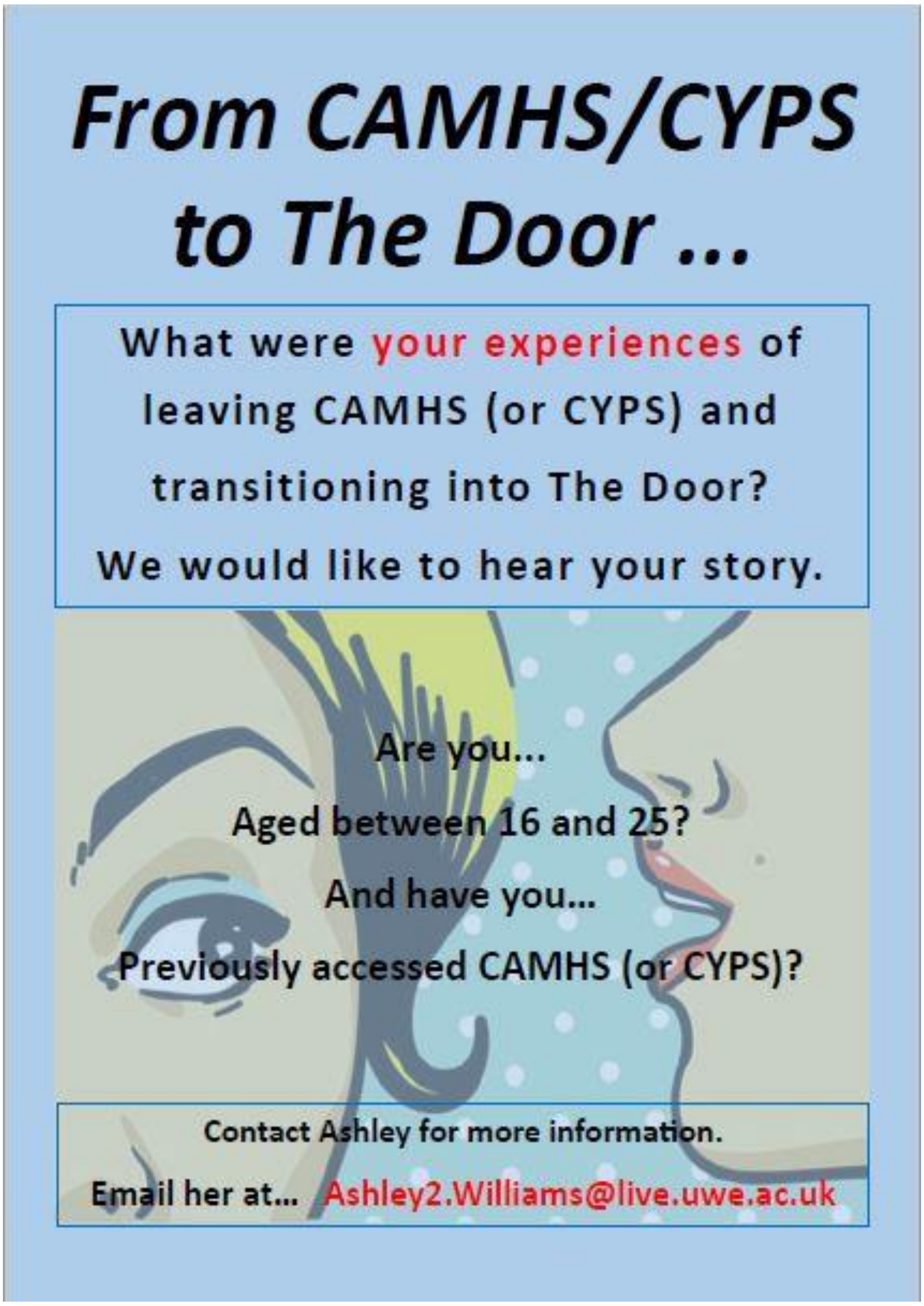
Research into experiences of transition from CAMHS/CYPS into The Door. Contact Ashley for more info or to be involved. Email her at... **Ashley2.Williams@live.uwe.ac.uk**

Appendix 4: Recruitment Flyer (size A5)



From CAMHS/CYPS to The Door ...

What were your experiences of leaving CAMHS (or CYPS) and transitioning into The Door?
We would like to hear your story.

Are you...
Aged between 16 and 25?
And have you...
Previously accessed CAMHS (or CYPS)?

Contact Ashley for more information.
Email her at... Ashley2.Williams@live.uwe.ac.uk

Appendix 5: Participant Information Sheet

Participant Information Sheet

How do young people experience the transition from Child and Adolescent Mental Health Services (CAMHS/CYPS) into voluntary mental health services?

Who are the researchers?

Thank you for your interest in this research. My name is Ashley Williams and I am a psychology doctoral student in the Department of Health and Social Sciences, University of the West of England, Bristol. I am completing this research for my Professional Doctorate in Counselling Psychology thesis. My research is supervised by Dr Niklas Serning (see below for his contact details).

What is the research about?

The number of young people being referred to CAMHS/CYPS is increasing. Young people have to stop accessing CAMHS/CYPS services when they reach a certain age, and those who need continuing support after they leave CAMHS/CYPS may not always be accepted into adult mental health services (AMHS). The government is recognising the need for better partnership working between CAMHS/CYPS and voluntary mental health services in order to continue to support young people with their mental health problems. Listening to young people’s experiences of their transition between CAMHS/CYPS and voluntary services outside of the NHS is important so that we young people can be better supported through this necessary and inevitable transition phase.

What does participation involve?

You are invited to participate in a qualitative interview – a qualitative interview is a ‘conversation with a purpose’; you will be asked to answer questions in your own words. The questions will cover what your experiences of your transition from CAMHS/CYPS into [*Name of voluntary organisation*] have been like. The interview will be audio-recorded and I will transcribe (type-up) the interview for the purposes of analysis. On the day of the interview, I will ask you to read and sign a consent form. You will also be asked to complete a short demographic form. This is for me to gain a sense of who is taking part in the research. I will tell you what is going to happen in the interview and you will be given an opportunity to ask any questions that you might have. You will also be given another opportunity to ask questions at the end of the interview.

Who can participate?

Anyone between the age of 16 and 25 years who is interested in taking part. You must have previously accessed CAMHS/CYPS and completed a referral to [*Name of voluntary organisation*].

How will the data be used?

Your interview data will be anonymised (i.e., any information that can identify you will be removed) and analysed for this research. This means extracts from your interview may be quoted in my thesis and in any publications and presentations arising from the research. The demographic data for all of the participants will be compiled into a table and included in my thesis and in any publications or presentations arising from the research. The information you provide will be treated confidentially and personally identifiable details will be stored separately from the data.

The personal information collected in this research (e.g., the interview audio-recording and transcript, and the demographic form) will be processed by the University in accordance with the terms and conditions of the 2018 Data Protection Act. We will hold your data securely and not make it available to any third party unless permitted or required to do so by law. Your personal information will be used/processed as described on this participant information sheet.

What are the benefits of taking part?

You will get the opportunity to participate in research on an important social and psychological matter. It is an opportunity for your voice to be heard regarding your experiences of the inevitable transition between services which may have potential to influence how transition processes are managed and supported.

How do I withdraw from the research?

If you decide you want to withdraw from the research please contact me via email [Ashley2.Williams@live.uwe.ac.uk]. Please note that there are certain points beyond which it will be impossible to withdraw from the research – for instance, when I have submitted my thesis. Therefore, I strongly encourage you to contact me within a month of participation if you wish to withdraw your data. I would like to emphasise that participation in this research is voluntary and all information provided is anonymised where possible. In addition, there is no obligation for you to answer any question that you do not wish to answer.

Are there any risks involved?

We do not anticipate any particular risks to you with participating in this research; however, there is always the potential for research participation to raise uncomfortable and distressing issues. For this reason, we have provided information about some of the different resources which are available to you. The Samaritans provide a 24hr free and confidential listening service to people in distress, you can call them on 116 123 (freephone). For more details, visit their website at www.samaritans.org. Should you feel it necessary, you are also able to access the services you are enrolled in within [*Name of voluntary organisation*].

How do I take part in this research?

If you would like to take part in this research please contact me directly via email at Ashley2.Williams@live.uwe.ac.uk. We will then arrange a convenient time to meet at [*Name of voluntary organisation*] to carry out the research interview.

If you have any questions about this research please contact me via email at Ashley2.Williams@live.uwe.ac.uk. Alternatively, you can contact my research supervisor Dr Niklas

Serning via email at Niklas.Serning@uwe.ac.uk or via post to Department of Health and Social Sciences, Frenchay Campus, Coldharbour Lane, Bristol, BS16 1QY.

Appendix 6: Consent Form

Consent Form

How do young people experience the transition from Child and Adolescent Mental Health Services (CAMHS) into voluntary mental health services?

Consent

Please read the following statements carefully, and if you consent please write your initials beside each statement.

I confirm that I have read and understood the information sheet for the above research. I have had the opportunity to consider the information, ask questions and have had these answered to my satisfaction.	__________
I am aware that my answers to the interview questions will be recorded and later analysed in generating research findings.	__________
I understand that my participation is voluntary and that I am free to withdraw by contacting the researcher within two weeks of the interview. I also understand that my health care and legal rights will not be affected should I decide to withdraw.	__________
I am aware that the findings of the research may be presented in future research reports, conferences and/or research journals. However, the information I provide for the research will remain confidential.	__________

I agree to take part in the above research. __________

Please sign this form to show that you have read the contents of this form and of the participant information sheet and you consent to participate in the research:

Participant name (print):

Signature:

Date:

Researcher name: Ashley Williams

Signature:

Date:

Thank you for your participation in this research.

Appendix 7: Demographics Form

Demographics Form

How do young people experience the transition from Child and Adolescent Mental Health Services (CAMHS) into voluntary mental health services?

In order for us to learn about the range of people taking part in this research, we would be grateful if you could answer the following questions. All information provided is anonymous.

Please either write your answer in the space provided, or circle the answer/s, that best apply to you.

1	How old are you?			
2	I am:	Male	Female	Other
3	I am:	Full-time employed	Part-time employed	Full-time student
		Part-time student	Other: ___________________________	
4	How would you describe your sexuality?	Heterosexual Bisexual Lesbian Gay Other: ____________________		
5	How would you describe your racial/ethnic background? (e.g., White; Black; White Jewish; Asian Muslim)	__________________________		
6	How would you describe your social class? (e.g., working class; middle class; no class category)	__________________________		
7	Do you consider yourself to be disabled?	Yes	No	
8	How would you describe your relationship status?	Single Partnered Married/Civil Partnership Separated Divorced/Civil Partnership Dissolved Other: _____________________		

Appendix 8: Interview Schedule

Semi-Structured Interview Schedule

The transition from statutory Child and Adolescent Mental Health Services into third sector voluntary and charitable services: An Interpretative Phenomenological Analysis of young peoples' experiences

Briefing and Introduction

Thank you for meeting with me today. I am interested in hearing about your experiences of your transition from CAMHS into [*Name of voluntary organisation*]. I will be asking you some questions and I would like to look at the flow from the point of preparing to leave CAMHS through to settling into [*Name of voluntary organisation*]. The interview should last approximately one hour and I would like to audio-record our conversation using this encrypted dictaphone.

Anonymity and confidentiality

All information that you give today will be kept confidential. When I type up the interview I will anonymise any identifying information, including names and places that may identify you.

There are some circumstances where, by law, I would have to break this confidentiality. These situations are:

1) If you tell me that you are going to seriously harm yourself or others, and
2) If you told me about safeguarding concerns that were not on record

In these situations, I would be required to share what you had told me to other organisations, such as the police or social services.

Withdrawing from the research

Your participation in this research is completely voluntary and you have already been asked to sign a consent form. If you decided that you do not want to continue with the research, you are free to stop the interview at any point. You are also free to withdraw your data up to two weeks from today. Please let me know by email if you wish to withdraw from the research.

Are you happy to continue with the interview?

Semi-Structured Interview

What interested you to want to participate in this research?

What has the transition from CAMHS into [*Name of voluntary organisation*] been like for you?

What was it like for you when starting to think about moving away from Child and Adolescent Mental Health Services (CAMHS)?

- Thoughts, feelings, concerns?
- What age were you?

What was your last contact with CAMHS like?

- Thoughts, feelings, concerns?

How was it like for you to stop having contact with CAMHS?

- Thoughts, feelings, concerns?

How did you experience not being under a mental health service?

- Thoughts, feelings, concerns?
- How long was this period of time?
- How did you cope/what were your needs?

How did you come to be in contact with [*Name of voluntary organisation*]?

- What were you looking for and why?

What has it been like for you to be in contact with [*Name of voluntary organisation*]?

- What were your expectations?
- What has been the reality?

Overall, what would you say are the main positive and negative experiences of your journey from leaving CAMHS and entering [*Name of voluntary organisation*]?

Do you have anything else you would like to tell me about your experiences of your journey of transition that we have not already covered?

Debriefing and Close

We have come to the end of the interview. Thank you very much for taking part. I will now turn the recording equipment off.

Are you okay? How do you feel about what we have talked about today? Have you found what we have talked about distressing? [If yes, identify whether the person would like to be given information about support agencies].

Remember that everything that you have told me today will remain confidential. Do you have any final questions or comments?

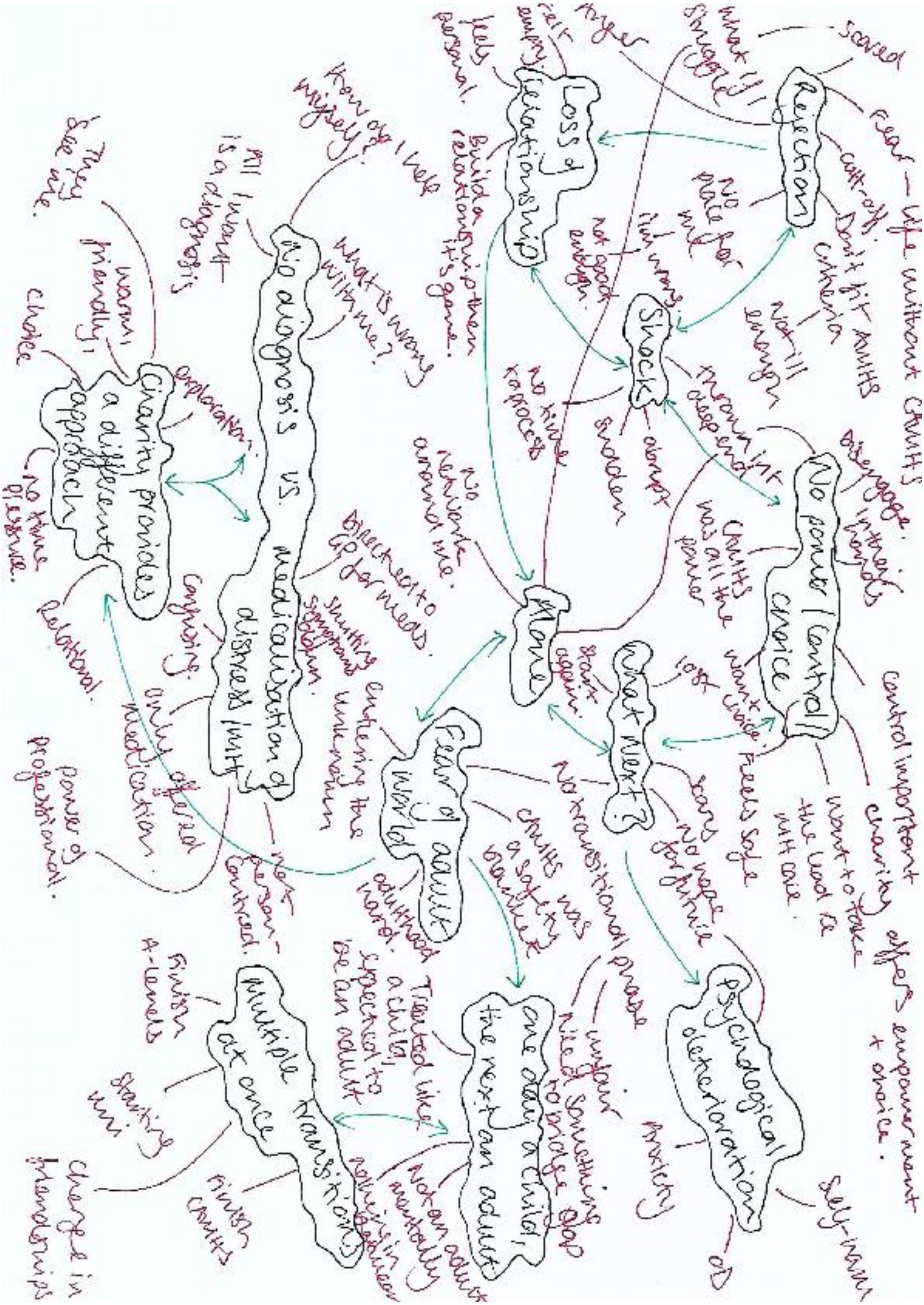
Thank you again for taking part in this research.

Appendix 9: Interview Checklist

Interview Checklist

	Positive +	Negative –	Experiences	Practicalities
CAMHS/CYPS				
Transition period				
Charity Organisation				

Appendix 10: Diagram of Emerging Themes



Appendix 11: Journal Article

Journal Article

THE TRANSITION FROM STATUTORY CHILD AND ADOLESCENT MENTAL HEALTH SERVICES INTO THIRD SECTOR VOLUNTARY AND CHARITABLE SERVICES: AN INTERPRETATIVE PHENOMENOLOGICAL ANALYSIS OF YOUNG PEOPLES' EXPERIENCES

Ashley Mai Dawson, Dr Niklas Serning, and Dr Kevin Stone
University of the West of England, Bristol

Word count: 4,980 (excluding references and appendices)

ABSTRACT

Young peoples' experiences of transitioning from Child and Adolescent Mental Health Services (CAMHS) into charitable services were explored. Semi-structured interviews were conducted with six young people aged 18-23 years. Interpretative Phenomenological Analysis was utilised to analyse the data. Three superordinate themes emerged of: Power, Rejection, and Identity. The research highlights the importance of acknowledging power imbalances, shared decision-making, and empowerment. The importance of relationships and stability for young people, and the challenges of entering the 'adult' world were also significant findings with implications for practice.

INTRODUCTION

NHS services for young people in the UK are split between Child and Adolescent Mental Health Services (CAMHS) and Adult Mental Health Services (AMHS). The time point when a young person transfers to AMHS differs according to local service design (such as locality and diagnosis-specific services), and can occur between the ages of 16 and 18 years (Singh et al., 2008). Transitional care refers to the co-ordination and continuity of healthcare between different sub-locations or levels of care within the same general location, and describes a process that begins with preparing a service user to leave one setting and is complete when the service user is accepted into the next setting (Coleman & Berenson, 2004).

Half of all adult mental health disorders begin in adolescence (Jones, 2013), affecting young people just when they require transition into adult services (Paul et al., 2015). Although many health professionals view transitions within the healthcare system as a necessary and inevitable component of a patients' pathway (Carroll, 2013), mental health services can underestimate the anxiety that experienced when transitioning between services (Dunn, 2017). Young people and their families can feel ambivalent towards their unknown future, as well as unsettled, anxious, abandoned, and confused about the transition process, and often express a lack of regard for their preferences regarding the planning of their healthcare (Burnham-Riosa, Preyde, & Porto., 2015; Carroll, 2013).

Historically, only 23% of mental health services in the UK have had specific arrangements for transition from CAMHS to AMHS (Audit Commission, 1999). Although a few regions of the UK have since transformed young peoples' mental health services to offer provision up to 25 years-old, most still require young people to transition to an adult service for ongoing mental health problems, or to be discharged at age 18 (Department of Health, 2004; Dunn, 2017). From the mental illness and social adjustment perspectives, this age cut-off is considered an artificial boundary, creating a system which is "weakest where it needs to be strongest" with risks to ongoing treatment and care (McGorry, Bate, & Birchwood, 2013, p30), and still often leads to a "cliff-edge of lost support as young people with mental health needs reach the age of 18" (Department of Health, 2014, p26). Transition occurs during a period of increased risk for onset of mental health difficulties and young people are negotiating complex physical and psychosocial changes and demands, and the current system offers little flexibility to account for individual differences in maturity, readiness, functioning, wellbeing, or life context (Dunn, 2017).

Consensus is growing that this age-based cut-off, albeit convenient for service providers, is not in the best interests of young people (McGorry, Bate, & Birchwood, 2013). Inefficiencies and weaknesses in the current system have been highlighted and have triggered renewed focus in exploring services for 14–25 year-olds, which includes looking at cross-service approaches to better manage this period of incident risk for mental illness and personal adjustment into more independent adult living (Department of Health, 2014).

An estimated 25,000 young people transition from CAMHS to AMHS each year (Health Safety Investigation Branch, 2018). Although there is national policy, guidance and legislation in place to support the process, only 4% of young people received an 'ideal' transfer and three quarters of the transition protocols have no provision for ensuring continuity of care for cases not accepted by AMHS (Singh et al., 2008). Since only a small proportion of these cases continue to receive care from CAMHS beyond the transition boundaries, Singh et al. (2008) argue that the outcome for the rest, who slip through the net, is area of urgent attention.

The literature on transitions between CAMHS and AMHS highlights that young people who have received a service from CAMHS may continue to experience a high degree of mental health problems that do not clearly fulfil diagnostic criteria, but are nevertheless not referred or accepted into AMHS (Islam et al., 2016; Lamb, et al., 2008; Lamb & Murphy, 2013; Memarzia et al., 2015; Singh et al., 2010). The ageist structure of mental health services results in vulnerable young people losing access to stable support and entering an unfamiliar and highly variable system of care (Memarzia et al., 2015).

The planning and management of transitions is a key element in the organisation and delivery of healthcare (National Mental Health Development Unit, 2011; Reiss & Gibson, 2002). Significant discontinuity exists between CAMHS and AMHS services, primarily due to poor planning and lack of co-ordination (Paul et al., 2015; Singh, 2009). Successful transition is believed to require high mental health self-efficacy and self-confidence (Burnham-Riosa et al., 2015). An individual's readiness for transition is also thought to be a key factor for the success of the transition and should take priority (Dimitropoulous, et al., 2012; Delman & Jones, 2002).

Burnham-Riosa et al. (2015) captured the underpinnings of the transition process that is of importance to young people for its success: a gradual transition process; to receive detailed information regarding the transition process and the subsequent service; to continue a client-centred relationship with health professionals; and to have open communication between child and adult health professionals through the transitioning period. Young people often have clear ideas about the preparation they require to leave CAMHS with the confidence to take responsibility for their own healthcare; they want to be included and play an active role in the transition process, and feel empowered as agents of their own mental health journey (Dunn, 2017; Burnham-Riosa et al., 2015). However, these needs are met with difficulties due to lack of funding and rigid policies and procedures that create barriers to the implementation of young peoples' ideas and wishes (Dunn, 2017).

Mental health disorders in children and young people continue to rise in the UK, with one in eight (12.8%) 5 to 19-year-olds having at least one mental health problem (NHS Digital, 2018), and many young people are slipping through the gap between mental health service provision. The importance of providing more efficient and effective services for child and adolescent mental health has risen up the political agenda (Frith, 2016). The NHS England (2015) taskforce report, 'Future in Mind', provides a vision making mental health support more visible and accessible for young people. It is recognised that the charitable sector can be especially effective in providing support in non-stigmatised, accessible, and welcoming environments, thus NHS services should form stronger partnership working with the charitable sector.

More recently, publication of the NHS Mental Health Implementation Plan 2019/20-2023/24 (NHS England & NHS Improvement, 2019) provides guidance for local areas on how to deliver the mental health ambitions. By 2023/24, 345,000 additional children and young people aged 0-25 years will have access to support via NHS-funded mental health services and school or college-based Mental Health Support Teams. These NHS plans are much welcomed and it is hoped that they help to provide a transparent, workable and valued transitional pathway for young people.

Aims and Objectives

The study aims to explore how young people, aged 18-23, experience the transition from CAMHS into the charitable sector in Bristol and Gloucestershire. The study aims to generate insight to assist health professionals to enter into the service users' lived experiences, and to offer a relational experience and empower young people to be involved in the decision-making processes regarding their healthcare. Extending knowledge in this area may also further inform NHS policy and the charitable sectors in helping to establish greater partnership working.

METHODOLOGY AND METHOD

Methodology

The research was undertaken using an explorative qualitative methodology. Interpretative Phenomenological Analysis (IPA) is committed to the examination of how people make sense of their lived experiences (Smith, Flowers, & Larkin, 2009). Analysis was conducted from a critical-realist ontological perspective, assuming the existence of an ultimate reality while acknowledging that our understanding of this reality is characterised by external factors such as culture, language, and political interests (Braun & Clarke, 2013). The epistemology was broadly contextualist which assumes that meaning is related to the context in which it is produced (Braun & Clarke, 2013).

Procedure

Ethical approval was gained through The University of the West of England. Four charitable organisations for young peoples' mental health in Bristol and Gloucestershire were approached and became collaborators for the research. Participants were recruited from the collaborating organisations through posters and flyers displayed in communal areas.

Potential participants contacted the researcher directly via email and were subsequently emailed a participant information sheet. Interviews took place on the premises of the charity where the participant was recruited. Participants signed a consent form and completed a demographics form prior to interview. Data were collected through semi-structured audio-recorded interviews. Participants subsequently received a £10 voucher for their participation.

Participants and sample

Participants were aged 18-23 who had previously accessed services within CAMHS and were accessing mental health support from charitable organisations within Bristol and Gloucestershire. A purposive homogenous sample of six participants was recruited.

Analysis

Interviews were transcribed orthographically, participants were anonymised and pseudonyms were given. IPA was used to analyse the data. The production of key themes which best illustrate the data, as well as in-depth examination of the data, supported the interpretation of processes as experienced and understood by participants.

RESULTS

Three superordinate themes and multiple subordinate themes emerged. The salient features of participants' accounts are presented, highlighting both commonalities and divergences in narratives.

Superordinate Theme 1: Power

This theme acknowledges the power imbalances between young people and CAMHS health professions. In contrast, it highlights instances where power feels equal and greater autonomy is experienced.

Theme 1.1: control and choice.

Participants felt that options and choices were not provided from CAMHS regarding their treatment pathway, discharge, and transition into further mental health support. Participants felt little empowerment or agency and had little communication around the next steps.

> "There was little communication with me as to what *I actually wanted*. (…) and I didn't know what other services I could have accessed because I was never told about them." (Frankie)

Participants acknowledged giving up as they could not change the situation. Being considered to be 'not ill enough' to access further with AMHS seemed somewhat unacceptable.

> “‘I was told I didn't need any more support {laugh}. I did. *I really did*. (…) [I was] told I wasn't ill enough to even try and get into adult services, so I was like ‘oh why even try then’.” (Frankie)

Participants actively pointed-out the issues with CAMHS, sometimes they felt able to contest the issues, but they maintained that the issues are wrong and that they should be addressed.

When finding charitable organisations for further support following discharge from CAMHS, greater control and choice was experienced. A central difference from CAMHS was the plethora of options available, as well as the experience of therapists adjusting the agenda to their wishes.

> “I felt very comfortable and I got to talk all about what *I wanted* from the sessions and what I found helpful, and he tailored my sessions to me rather than just following a booklet of pre-determined exercises.” (Frankie)

Control and choice within the charity was an empowering experience in which participants were able to have a voice. As the young person moves into these more person-centred approaches, previous power imbalances started to diminish.

Theme 1.2: transition upon transition

Participants experienced a lack of transitional support, at a time when many other transitions were taking place. Having no transitional support into charitable organisations was intimidating and anxiety provoking. Participants grew dependent on the support by CAMHS and there was little to encourage them to take charge of their wellbeing when leaving public services. Yet the implied failure of CAMHS to prepare them for the next stages appears to place all responsibility on service providers.

Participants expressed what they would find helpful in their transition: a transition service between CAMHS and AMHS; individual maturity and circumstances to be taken into consideration; and more collaboration between CAMHS and AMHS.

> “Yeah well it's not really looking at the individual person (…) some people might want to transition younger because it's too childish (…) more collaboration between adult mental health services and CAMHS is needed.” (Ali)

> “There needs to be something in between that people have, something like doing group therapy or getting 18 year-olds above the list.” (Lucie)

The time of discharge from CAMHS comes at a time when young people are transitioning from A-levels to University or finding a job, leaving home or friends are moving away. It is a period of significant change, and with this comes feelings of vulnerability and instability.

> “I was finishing sixth form and starting uni and being discharged from CAMHS all at the same time. It was horrible.” (Natalie)

> “I didn't really have something that was constant. (…) A lot of people leave school when their 18 and at the same time they're leaving CAMHS or other services so that's a *lot* of change.” (Ali)

Participants expressed being unsettled and overwhelmed by so many changes and thus feeling powerless in this transition period.

Superordinate Theme 2: Rejection

This theme explores the experience of rejection when leaving CAMHS, in particular, feeling alone, in shock, and experiencing loss.

Theme 2.1: abandoned and alone with nowhere to go.

Participants' experienced feeling abandoned, almost disposed of, in having to leave CAMHS based on age and consequently felt let down by the system.

> "[I was] treated like I wasn't enough or like I didn't deserve it. (…) When you're coming up to your 18th it doesn't feel like they're there to support you, it feels like 'right, now we *need to get rid of you* before you turn 18.'" (Lucie)

There is both sadness and anger in their voices. Lucie speaks of feeling let down and un-supported, and felt like someone else's problem, failed by a system that has strict criteria of what mental health 'should' look like. This system is described as unfair on young people who fall between the gaps of services.

> "they very much brushed me under the rug and gave me to someone else, like made it someone else's problem and not theirs. (…) It was just never *their fault,* like we have to follow this guideline, not fitting this criteria of what mental health *should be* and that's *not fair*." (Lucie)

Another participant, Joe, speaks of his experience of abandonment having longer-term effects, and struggles with feeling unwanted by others.

> "I was abandoned by CAMHS, and that is where my issues of abandonment come from. Never had them before, now I get easily attached to people and I get sad when I feel they are abandoning me." (Joe)

This speaks of CAMHS as a parental figure. There is a sudden drop of care with nothing to bridge the gap, leaving young people feeling vulnerable. This highlights not only a lack of readiness for leaving CAMHS, but also the role CAMHS may play in attachment.

Participants felt lost in the transition gap. Concerns were shared over what would happen if their mental health deteriorated and they were without support networks.

> "If I can't access adult services like *what am I going to do* if I get ill or get worse, what am I going to do?!" (Frankie)

> "I was so scared, I convinced myself that I wasn't going to cope with it, I couldn't imagine like not having it." (Natalie)

The prospect of being without any mental health support was concerning. There is a detachment from the care provider here which conveys insecurity. There is little sense of self as an 'able' individual to take the learning from the service provider and apply to the external world. Perhaps this reflects on both individual and service level requirements in equipping young people for their 'adult' lives.

Theme 2.2: loss of relationship.

Connection and trust is built with CAMHS health professionals and participants experience a loss from these relationships when being discharged. It was a stark reminder that these relationships are in a professional capacity and participants question the authenticity of the connection itself.

> "It was quite sad. I mean like you build up these relationships, you become like friends and then suddenly you have to leave and you are reminded that actually they are a professional and this is their job. I really struggled with that." (Ali)

Relationships and connections are valuable to these young people and loss of such relationships are difficult to comprehend.

Superordinate Theme 3: Identity

This theme describes the challenges of fitting into the social categorisations of being a child/adolescent and being an adult, and the struggles in making sense of their mental health difficulties without diagnostic labels.

Theme 3.1: a child one day, an adult the next.

Participants' experienced being treated like a 'child', then suddenly considered to be an 'adult' when turning 18, with no time to adapt. There is pressure of a sudden transition in identity and expectation, which feels unrealistic and unjustified.

> "when you've gone from a child focused service, suddenly you have to know all the answers, you have to know what you want. (…) just overnight you're an adult, that's just not realistic." (Ali)

This emphasises the social and cultural categorisation of age and how young people find these unhelpful, with unrealistic expectations. The responsibilities and challenges that lie ahead in the 'adult' world are frightening and unknown.

> "It makes you not want to get older, because as soon as you're an adult everything becomes harder. Just because I'm 18 that doesn't mean I'm an adult mentally. (…) when I was discharged from CAMHS, I was sort of entering the unknown." (Lucie)

These young people speak of a lack of readiness to adjust their identity. There is a process here of trying to make sense of what being an adult is.

Theme 3.2: wanting a diagnosis.

Participants were unable to understand themselves without a psychiatric diagnostic label. Generalised labels of anxiety or depression were not adequate for understanding what was happening to them, what it means for successful functioning in the world.

> "I was desperate to get a diagnosis. I really wanted to know what was going on in my head and no-one would give me that." (Frankie)

> "I always wanted a diagnosis. I've always wanted to know what was wrong, because [it] makes it easier for me to understand. If I know what's wrong, I know where I can get help." (Lucie)

There is significant reliance on a diagnosis as a means to self-understanding and future direction. The identity of these young people is of a person who is mentally unwell, that somehow they are not 'normal'. There is concern over leaving the containment of CAMHS and entering the adult world without a clear understanding of what is perceived as 'wrong' with them.

DISCUSSION

Power

Power, as an unspoken dynamic between the young person and CAMHS services, emerged as a core component of the experience of transition. Power, autonomy and control over their mental health support was challenged in the final interactions with CAMHS which was felt to put them at a disservice. A central difference from CAMHS, however, was the plethora of options available to participants within the charitable organisations, as well as the therapists more able to adjust their agenda to their wishes.

These power dynamics have been found in previous studies. Harper, Dickson and Bramwell (2014) report an 'us-and-them' dynamic between professionals and young people in CAMHS and experiences of being treated like a child. Bury, Raval and Lyon (2007) also reported that young people felt that they were not able to ask their therapist questions about issues that were concerning them or about decisions pertaining to their treatment. The primary driver of service user involvement is thought to typically remain one of tokenism rather than genuine patient-centred care (Faulkner & Williams, 2005; Rose, 2001).

Shared decision-making is a collaborative process through which a health care professional supports a patient to reach a decision about their care and treatment, and is increasingly seen as the hallmark of excellent healthcare (The Health Foundation, 2012, 2014). The Department of Health (2012) have made specific recommendations to include young people with mental health difficulties at a national level. Cheng et al.'s (2017) scoping review of approaches for promoting shared decision-making used in child and adolescent mental health suggests that six different approaches are commonly implemented: therapeutic techniques, decision aids, psychoeducational information, action planning or goal setting, discussion prompts, and mobilising patients to engage. Such approaches help to redress the power imbalance between young people and health professionals, to clarify different aspects of the treatment and decision-making process for both parties, as well as increase engagement (Abrines-Jaume et al., 2014).

Multiple simultaneous transitions are experienced as unsettling and overwhelming. These changes are mostly determined by age, for which young people feel powerless. This finding is shared with Harper, Dickson and Bramwell's (2014) finding that transitioning into different services whilst in a stage of transitioning to adulthood is a difficult experience for young people. Indeed, the transition from adolescence to adulthood is a critical normative life transition as it typically involves pervasive and often simultaneous contextual and social role changes (Schulenberg, Sameroff, & Cicchetti, 2004).

The concept of person-centred care, closely related to that of shared decision-making discussed above, is one which identifies the individual at the heart of all interactions and interventions. The focus is on the person, as opposed to the condition or illness, and it promotes respect, dignity, and compassion (Harding, Wait, & Scrutton, 2015; Leplege et al., 2007). A therapist willing to adapt to their needs and wishes was experienced as empowering for participants. Person-centred care can have a positive impact on self-esteem, self-management, self-efficacy, transitions into adulthood, patient empowerment and treatment outcomes (Asarnow et al., 2009; Edbrooke-Childs et al., 2016; Joosten et al., 2011; Richardson, McCauley, & Katon, 2009; Westermann et al., 2013). There is an urgent need to improve the information provision for service users and carers within mental health services, as this is considered one of the predominant barriers to person-centred care reported by young people (Gondek et al., 2017).

Rejection

The ending of mental health treatment with CAMHS was experienced as a personal rejection which consequently led to feeling let down and unsupported. The system has strict criteria of what mental health 'should' look like, which was experienced as unfair on young people who fall between the gaps of service provision. This highlights a lack of readiness and preparation for leaving CAMHS and sourcing alternative areas of support, and also the role CAMHS play in attachment processes.

The suddenness of discharge for these young people was challenging. It leaves little room for closure and coming to terms with the ending of therapy in a supported way. Participants experienced feeling alone and lost in the transitional gap, not knowing where to go to for support and feeling vulnerable and insecure. Concerns were raised as to what would happen if their mental health deteriorated and they were without professional support. Anticipation and belief of being 'unable' was also noted. There was little sense of self as an able individual, reflecting on both individual and service level requirements in equipping young people for their 'adult' lives.

Connection and trust is built with CAMHS mental health professionals, and participants experience loss from these relationships. These findings speak to the attachment literature and the literature around experiences of termination of therapy. The presumed biological function of the attachment system is to protect a person from danger by assuring that proximity is maintained to caring and supportive others (attachment figures), especially in risky or dangerous situations (Mikulincer & Shaver, 2016). Humans inherently seek connections and relationships, and are naturally inclined to seek proximity to familiar, comforting figures, especially in times of threat, pain, or need. Loss of such contact is a natural source of distress.

Early attachment relationships may be triggered in the ending of service provision and therapeutic relationships, providing understanding of the challenges young people are voicing. Indeed, Bury, Raval, and Lyon (2007) argue that some of the difficulties associated with ending therapy relate back to feelings associated with separation and loss. At the end of therapy, these feelings may be reactivated as the young person loses the therapist's support. Difficult emotions associated with this process have been found in studies exploring therapy termination, many of which support the findings of the present research in uncovering feelings of sadness, loss, and rejection (Baum, 2007; Bury, Raval, & Lyon, 2007).

Identity

The identity of the young people, as understand in the context of society and service provision, emerged as another core component of the experience of transition for the participants. Their sense of self was understood in relation to the expectations, categorisations, and labels defined by others.

Participants spoke of feeling treated like a 'child', then suddenly considered to be an 'adult' when turning 18, with no time for adapting. There are expectations for them to understand themselves and their needs, to advocate for themselves and the take on responsibilities. This was considered unrealistic and unjustified. Readiness for transition and their individual level of development and maturity are important considerations for mental health services. Culturally based, age-related expectations shape transitions by providing a normative timetable and agenda (Neugarten, 1979), which for participants in the current research found to put pressure on individuals to develop and behave differently within an unrealistic timeframe.

These findings support the literature around emerging adulthood and the stages of adaptation. Emerging adulthood is period in which young people can feel lost between the identities of adolescence and adulthood and experience a desire for self-exploration and experimentation; a time that is comparatively independent from traditional social roles and normative expectations, instead of a time characterised as settling into traditional adult roles (Arnett, 2000; Baggio et al., 2017; Nelson & Barry, 2005). Arnett (2004a, 2004b) proposed five dimensions related to psychological states in emerging adulthood. The dimension labelled 'feeling in-between' describes the state of no longer identifying as an adolescent although not yet feeling fully adult.

Leaving CAMHS without a diagnosis left participants feeling unable to understand themselves and without direction. Generalised labels of anxiety or depression did not feel adequate for understanding what was 'wrong' with them. Experiences of psychological pain and distress can arguably be understood as a normal and natural part of human existence, and like all other experiences, experiences associated with distress are bound up with social, cultural, and material conditions, and with personal biographies, relationships, and life events (Bentall, 2003; Cromby et al., 2013). The British Psychological Society (BPS, 2011) considers individuals and the general public to be negatively affected by the continued medicalisation of natural responses to life experiences; responses which undoubtedly have distressing consequences which demand helping responses, but which do not reflect illnesses so much as normal individual variation. The BPS (2011) also state their concern at the increasing use of diagnostic criteria and of the increasing use of medication for young people.

It is interesting to find in the present research, that participants were not satisfied with understanding their mental health difficulties to be anything other than something that is not 'normal', for which they need a diagnostic label. This reflects what commonly remains the social and cultural understanding of human emotion and suffering.

Limitations of the Research

Homogeneity is an important criterion of IPA research and it is plausible that the present research can be criticised for its lack of homogeneity. While participants were all young people who had left CAMHS and had subsequently sourced further mental health support from a charitable organisation within specific regions, they varied considerably in terms of: their treatment interventions and length of time in CAMHS, their level of support from the charitable organisations, their mental health difficulties, and the time between leaving CAMHS and starting at the charity. This lack of homogeneity perhaps reflects the diversity of people, problems and services available.

The findings of the present research may also be the result of a biased sample. Posters were displayed in communal areas for many months, but unfortunately many did not step forward to take part. It may be that these young people had more positive or alternative experiences which were not able to be voiced.

Suggestions for Further Research

The research points to the complexities and challenges around the loss of therapeutic relationships and valued systems of support at a crucial age where multiple transitions take place. Further research is needed to understand these issues in more depth. A possible avenue to explore could be clinicians' views of the governments' drive for better partnership working between CAMHS and charitable organisations. Exploration could specifically focus on *how* more collaborative relationships between services could be achieved, as well as the relational aspects of service provision.

Conclusion

This research has contributed to building an understanding of the ways in which young people experience transitions in mental health services. It highlights the importance of acknowledging power imbalances, shared decision-making, and empowering young people.

The challenges for young people in understanding the self and their identity have also been emphasised. Young people no longer identify as an adolescent yet do not feeling fully adult. This is mirrored in young peoples' struggles to receive a psychiatric diagnostic label in making sense of their experiences. Without such labels, they felt unable to understand themselves and were left without direction.

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