Parent Experiences and Child Outcomes in Specialist Child and Adolescent Mental Health Programmes

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Thesis Portfolio Abstract

Background: Addressing the multifaceted mental health needs of children, adolescents, and their families requires flexible and adaptive approaches, particularly when first-line treatments have not yielded clinical change. This portfolio aims to explore caregiver experiences and child outcomes in specialist child and adolescent mental health programmes.

Method: A meta-analysis was conducted to determine the effectiveness of Acceptance and Commitment Therapy for children and adolescents from ill-health to thriving. An empirical paper qualitatively explored caregivers' experiences of joint admission to a children's mental health unit and its impact on their parenting approaches and relationship dynamics, utilising reflexive thematic analysis.

Results: The meta-analyses, including 28 studies, 89 outcome measures, and 1,643 participants, found significant effects for wellbeing/quality of life ($g = 0.99$), internalising/emotional difficulties ($g = 0.70$), externalising/behavioural difficulties ($g = 0.31$) and third-wave processes ($g = 0.26$). The empirical study identified four themes: (1) Acceptance and Exoneration, (2) Respite after Battle, (3) Understanding, Adaptation and Trust, (4) Navigating Control and Power Dynamics in Co-Parenting.

Conclusions: The meta-analysis displayed that ACT serves a valuable psychological treatment for enhancing mental health and promoting wellbeing amongst children and adolescents. The qualitative paper deepens understanding of the novel approach of joint admission and the significant impact on family dynamics through the lens of caregivers.

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Chapter One: Meta-Analysis

The Effectiveness of Acceptance and Commitment Therapy for Children and Adolescents: A Multivariate Meta-Analysis.

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Abstract

Objectives: There has been a recent surge in research exploring Acceptance and Commitment Therapy (ACT) for improving mental health, both in clinical and community contexts. This pre-registered (PROSPERO: CRD42023479014) meta-analysis aimed to determine the effectiveness of ACT for children and adolescents on internalising/emotional difficulties, externalising/behavioural difficulties, wellbeing/quality of life (QoL), and third-wave processes.

Methods: Literature searches were conducted across six electronic databases. Included studies employed either RCTs or randomised pre-post designs with a control group, utilising quantitative child-focused psychological outcome measures.

Results: The multi-level/multivariate meta-analyses, including 28 studies, 89 outcome measures, and 1,643 participants, found significant small effects for externalising/behavioural difficulties ($g = 0.31$, $p = 0.020$) and third-wave processes ($g = 0.26$, $p = 0.011$), a medium effect for internalising/emotional difficulties ($g = 0.70$, $p = 0.003$) and a large effect for wellbeing/QoL ($g = 0.99$, $p = 0.036$). Sensitivity analysis, only including studies rated moderate-high quality are discussed. Widespread heterogeneity raised concerns regarding generalisability.

Conclusions: This meta-analysis displays promising results for the use of ACT with children and adolescents. Further high-quality research is needed to explore maintenance effects and variations in efficacy across different mental health conditions.

Keywords: *Acceptance and Commitment Therapy, Child and Adolescent Mental Health, Meta-Analysis*

Introduction

Globally, it is estimated that one in seven (14%) 10 to 19 year olds experience a mental health disorder, and this rate is increasing (World Health Organisation, 2021). Within the United Kingdom (UK), 20.3% of eight to 16 year olds had a mental health disorder in 2023 (Newlove-Delgado et al., 2023). It is estimated that 50% of mental health disorders are established by the age of 14 and 75% by the age of 24 (Kessler et al., 2005).

Mental health disorders in childhood are commonly categorised in two broad types: internalising and externalising difficulties. Internalising difficulties are characterised by covert inward-focused challenges, involving problems with emotion regulation, low self-esteem, somatic complaints, and behaviours such as withdrawal or overcontrol (Achenbach, 1991). In the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V), internalising difficulties primarily encompass anxiety and depressive disorders (American Psychiatric Association; APA, 2013). On the other hand, externalising difficulties refer to behavioural problems characterised by negative actions directed outwardly, impacting the child's interaction with their external environment (Achenbach & Edelbrock, 1978). These difficulties commonly include challenges with impulse control, inattention, aggression, and may correspond to DSM-V disorders such as Attention Deficit Hyperactivity Disorder (ADHD) or Oppositional Defiant Disorder (ODD; APA, 2013).

Within the National Institute for Health and Care Excellence (NICE) guidelines, Cognitive Behavioural Therapy (CBT) is generally considered to be the “gold standard” psychological treatment for many mental health conditions in children and adolescents supported by its rigorous empirical basis (David et al., 2018). Meta-analyses demonstrate CBT to have a small to moderate effect for treating depression (Klein et al., 2007; Yang et al., 2017) and a moderate to large effect for treating anxiety disorders (Ishikawa et al., 2007; James et al., 2020) in children and adolescents.

More recently, there has been a growing emphasis on third-wave treatment approaches that are sometimes placed outside or opposed to CBT. Third-wave behavioural therapies are characterised by a transdiagnostic focus on the context, process and function of how a person relates to their internal experiences, encompassing concepts such as acceptance, metacognition, compassion and mindfulness (Hayes & Hoffman, 2021). Acceptance and Commitment Therapy (ACT), a prominent third-wave approach, challenges the CBT idea of ‘dysfunctional beliefs’, ‘faulty information processing’ and ‘distorted cognitions’ (Beck, 1993; Clark, 1995). Instead, they prioritise understanding the function of private experiences, rather than focusing on their content, and advocate for a process-based behavioural approach (Hayes, 2004; Zettle, 2005).

Conversely, many CBT researchers contest Hayes (2004) assertion that ACT represents a pioneering “third-wave” approach, instead arguing ACT may be more “old hat" than “new wave” (Hofmann & Asmundson, 2008). Despite theoretical contention, in clinical practice, ACT is predominantly used for children and adolescents experiencing chronic pain, supported by evidence of moderate certainty (World Health Organization, 2020), or when CBT treatment has been unsuccessful (Leveret et al., 2022). Some initial findings suggest that ACT may be as effective as CBT in reducing anxiety in children (Hancock et al., 2018) and more effective in some instances (Swain et al., 2015), whilst also showing greater effectiveness than CBT for depression in adolescents (Hayes et al., 2011).

The theoretical basis of ACT is rooted in Relational Frame Theory (RFT; Hayes et al., 2004) derived from a philosophical stance called functional contextualism (e.g., Gifford & Hayes, 1999). A fundamental premise of RFT posits the potency of evaluated feelings and bodily sensations is not solely determined by their form or frequency, but also by the context in which they occur. Problematic contexts arise when there is necessity to manage, control or explain these rather than directly being experienced (Hayes et al., 2004). To address experiential avoidance, ACT focuses techniques aimed to increase psychological flexibility, defined as "the ability to contact the present moment more fully as a conscious human being, and to change or persist in behaviour when doing so serves valued ends" (Hayes et al., 2006, p. 7).". The specific third-wave processes to reach this therapeutic goal include cognitive defusion, acceptance, being present, self as context, values and committed action, popularly referred to as the 'Hexaflex' (Hayes et al., 2006).

ACT has a growing evidence base on the treatment of adult psychopathology, with numerous reviews and meta-analyses demonstrating its efficacy (Powers et al., 2009; Öst, 2014; A-Tjak et al., 2015; Bai et al., 2020). However, there are comparatively fewer studies available regarding the application of ACT to children and adolescents. Given that the psychological flexibility model was originally designed for adults, it is essential to establish empirical validation with younger populations. While some ACT models consider developmental elements, such as the Discoverer, Noticer, Advisor – Values (DNA-V; Hayes & Ciarrochi, 2015), ACT for youths will be enriched when theories of development are integrated and validated within the six core processes of the psychological flexibility model (Petersen et al., 2022). Currently, within DNA-V, Hayes and Ciarrochi (2015) argue for avoiding imposing adult-orientated values, instead advocating for eliciting adolescents' passion for vitality and value. It has been purported that ACT may not only remediate, but also prevent, the emergence of rigid patterns of experiential avoidance in children, as they have had less time for adopted behaviours to become entrenched (Greco et al., 2005). ACT techniques emphasising experiential learning and values may complement developmental changes that occur during adolescence, such as an increased need to independence and autonomy (Hadlandsmyth et al., 2013). Together, this highlights the necessity for further empirical validation and standardisation of ACT interventions aimed specifically at children and adolescents (Greco et al., 2005).

To date, only two meta-analyses have been conducted on the efficacy of ACT (Fang & Ding, 2020; Parmer et al., 2021), and one meta-analysis on the efficacy of third-wave treatment approaches (Perkins et al., 2022) in children and adolescents. Fang and Ding (2020) conducted their literature search in 2018, yielding 399 results, with 14 randomised controlled trials (RCTs) meeting inclusion criteria. They found that ACT significantly improved anxiety, depression, and behavioural problems, compared to treatment as usual (TAU) and waitlist controls. On the secondary outcomes of quality of life (QoL) and wellbeing, subgroup analysis revealed ACT outperformed the untreated control group, but performed similarly to TAU. However, over the past five years, there has been a proliferation of studies within the ACT literature focusing on child and adolescent populations, which the current review aims to integrate.

A more recent meta-analysis conducted by Parmer et al. (2021) explored the efficacy of ACT for children with special health care needs. They found ACT to be more effective than no treatment for improving depressive symptoms, avoidance, and fusion, but not stress in children. However, this review was significantly underpowered, featuring only two studies per meta-analysis. Consequently, the precision of effect size estimates is dubious, with uncertainty regarding the true magnitude of effect. Again, the current review will synthesise the expanding pool of trials, thus offering a more accurate estimate of effect.

Lastly, Perkins et al., (2022) conducted a meta-analysis that explored the efficacy of third-wave approaches (e.g., compassion-focused therapy, mindfulness-based cognitive therapy [MBCT], ACT) in youths and found significant improvements in internalising problems, externalising problems, third-wave processes, wellbeing, physical health, and interference from difficulties. Subgroup analyses were conducted comparing ACT to MBCT. There was no significant difference between these subgroups, however ACT was found to have a significant effect for internalising, wellbeing, and third-wave processes. Since subgroup analyses are inherently observational and not grounded in randomised comparisons (Higgins & Green, 2011), this should be interpreted with caution. Nonetheless, these findings together merit further investigation, a gap this study seeks to address.

Overall, given the recent burgeoning body of research on ACT, this review seeks to keep analysis comprehensive and broad to provide an initial, sweeping overview and synthesis of current data. The aim of this review is to use a meta-analytic approach to determine the effectiveness of ACT for children and adolescents for the following outcome domains: (1) internalising/emotional difficulties, (2) externalising/behavioural difficulties, (3) wellbeing/QoL, (4) third-wave processes.

Materials & Methods

The meta-analysis was pre-registered on PROSPERO (registration number: CRD42023479014, 20/11/2023) and follows the Preferred Reporting Items for Systematic Reviews and Meta-Analyses checklist (PRISMA; Moher et al., 2009).

Search Strategy

Relevant studies were identified through systematic electronic searches of four databases: Medline, APA PsycInfo, Cumulated Index to Nursing and Allied Health Literature (CINAHL) and Scopus. To minimise potential publication bias and therefore risk of overestimating the true effects (McAuley et al., 2000), unpublished dissertations were searched on ProQuest (doctoral e-theses online library). The first 100 results of Google Scholar were also searched.

The search included studies from January 2000 to November 2023. This timeframe was selected because the official ACT treatment manual was published in 1999 which led to an increase in its use both clinically and in research (Hayes et al., 1999).

The final search was carried out on 7th November 2023 (Table 1.1). The search strategy encompassed terminology identified by the individual databases taxonomies (hierarchically structured controlled vocabulary thesaurus) to provide uniformity and consistency in searches by indexing and categorising literature (Table 1.2).

Table 1.1

Final Search Terms Used Across Databases

Term One	**Term Two**
Title or Abstract	All Fields
"Acceptance and Commitment Therapy"	*"parent*" or "caregiver*" or "mother*" or "father*" or "carer*" or "child*" or "adolescen*" or "teen*" or "paediatric*" or "pediatric" or "young pe*"*

Table 1.2

Search Terms Identified by Database Taxonomies

Database Taxonomy Name	**Search Terms**
Medline MeSH Terms	Acceptance and Commitment Therapy, Child, Parents, Mothers, Fathers, Adolescent, Acceptance and Commitment Therapy
APA PsycInfo Thesaurus of Psychological Index Terms	Acceptance and Commitment Therapy, Pediatrics, Caregivers, Parents, Mothers, Fathers, Adolescent Psychology, Youth Mental Health
CINAHL Subject Headings	Acceptance and Commitment Therapy, Adolescence, Parents, Child

Note. Scopus does not have taxonomies.

Inclusion Criteria

Inclusion criteria comprised the follow (1) primary empirical studies that utilised a RCT or randomised pre-post designs encompassing a control group, (2) investigated ACT compared to a control group (e.g., TAU, waitlist, CBT), (3) utilised a quantitative psychological outcome measure for children or adolescents 18 years or younger, (4) were reported in English.

This review included studies that used any measures related to four outcome domains (internalising/emotional difficulties, externalising/behavioural difficulties, wellbeing/QoL, and third-wave processes). These domains were identified in advance, as outlined in the protocol, based on pertinent literature, frequently employed outcome measures in child research, Perkins et al.’s (2022) categorisation of outcomes, and guidance from a member of the research team with expertise in this field of practice. The domain wellbeing/QoL was added later by reviewing mental health outcome measures from the included papers, which didn't align with the existing categorisation but naturally fitted together into the same theme. This was also in line with prior categorisation in research (Fang & Ding, 2020; Perkins et al., 2022). This outcome domain relates to positive psychology (Seligman & Csikszentmihalyi, 2000), including the promotion of human flourishing, positive emotions, and character strengths (Keyes et al., 2011). See supplementary Table 1.5 for outcome measures from included studies that did not fit the aforementioned criteria, and the reason for their exclusion.

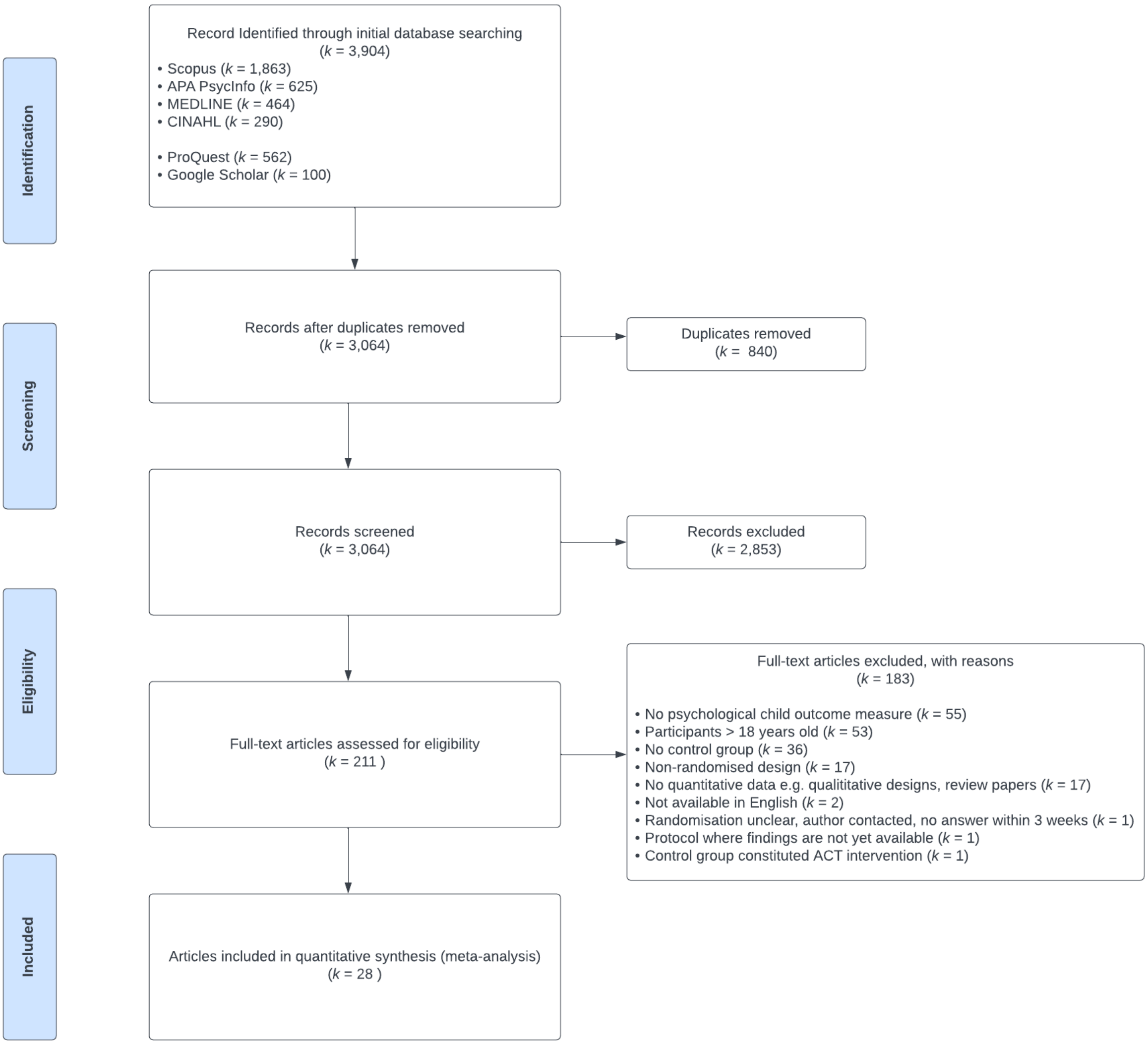
In line with the study’s aim to provide an initial, broad and comprehensive synthesis of current research, this review included studies conducted in any settings (schools, mental health clinics, general hospitals). Interventions delivered to children and/or via parents/caregivers were included, as long as there was a child-focused outcome measure. Diagnosis/presentation or delivery format (e.g., online, face to face, group, individual) did not serve as exclusion criteria. ACT interventions delivered both in isolation and in conjunction with another therapeutic modality were included to reflect the many ways clinicians flexibly adapt and implement ACT approaches in clinical practice (Hayes & Ciarrochi, 2015).

Screening Method

The initial search identified 3,904 results that were imported into EndNote (Figure 1.1). Duplicates were removed and all titles and abstracts were screened by the first author. In consideration of inter-rater reliability, a random 10% of studies were independently screened by an external reviewer with 99.74% agreement. The disagreement was discussed and resolved by consensus. A third reviewer was available for consultation however this was not required. The full text of eligible studies was also independently screened by the external reviewer, with 100% agreement.

Figure 1.1

PRISMA Diagram, Detailing Flow of Studies Retrieved from Searches Through to Inclusion



Note: k denotes number of studies for purposes of PRISMA diagram

Data Extraction

Information on the sample characteristics is outlined in Table 1.3, including the following categories: Author, Year of Publication, Country, Study Design, Age, Presentation/Diagnosis, Type of Control, Quantity of ACT sessions, Delivery Format, Parental Involvement and Treatment Condition. Included studies, outcome measures and number of participants in each meta-analysis (internalising, externalising, wellbeing/QoL, third-wave processes) are outlined in Supplementary Tables 1.6 to 1.9.

Data for meta-analyses was extracted following pre-determined rules: (1) post-intervention data was used for the calculation of effect sizes, (2) when a study was split by a subgroup (i.e., Beni. et al.’s, 2023 low, middle, and high income groups) a single mean and standard deviation was calculated utilising Cochrane’s formula for combining subgroups (Higgins & Green, 2011), (3) if there were multiple comparison groups, a non-active control was prioritised in line with the primary research aim to determine the effectiveness of ACT, not to compare it to other interventions, (4) if there were multiple post-intervention scores, the closest time point from completion of the intervention was chosen to maintain consistency, (5) data from intention-to-treat samples were utilised in analyses as preference, followed by data from treatment completers.

Table 1.3

Sample Characteristics of Included Studies

Author	**Year**	**Country**	**Study Design**	**Age (Years Old)**	**Presentation /Diagnosis**	**Type of Control**	**Quantity of ACT**	**Delivery Format**	**Parental Involvement**	**Treatment Condition**
Azadeh et al.	2015	Iran	Quasi-Experimental (Control group + Randomised)	15-16 y/o (Overall: *M* = 15.43, *SD* = 0.78)	Social Anxiety Disorder	Waitlist Control	10 sessions weekly, 90 mins	Group	No	Isolation
Beni et al.	2023	Iran	Quasi-Experimental (Control group + Randomised)	"Adolescents" (ACT: *M* = 14.11, *SD* = 0.68; Control: *M* = 14.10, *SD* = 0.7)	Non-Clinical (recruited from schools)	No Treatment Control	10 sessions weekly, 90 mins	Group	No	Isolation
Bernal-Manrique et al.	2020	Columbia	RCT	11-17 y/o (Overall *M* = 14.52, *SD* = 1.67)	Social and School Difficulties	Waitlist Control	3 sessions weekly, 75 mins	Group	No	Isolation
Burchkhardt et al.	2016	Australia	RCT	15-18 y/o (Overall: *M* = 16.37; ACT: *M* = 16.37, SD = *0.65*, Control: *M* = 16.34, *SD* = 0.64)	Non-Clinical (recruited from schools)	TAU (Pastoral Care Classes)	16 sessions over 3 months, 30 mins	Group	No	Conjunction (Positive Psychology)
Fang & Ding	2020	China	Quasi-Experimental (Control group + Randomised)	"Grade 7" 12-13 y/o (Overall: *M* = 13.23, *SD* = 0.55)	"Left behind children" Poverty-Stricken Area	School Education Course	10 sessions over 5 weeks, 60 mins	Group	No	Isolation
Ghorbanikhah et al.	2023	Iran	Quasi-Experimental (Control group + Randomised)	5-7 y/o (ACT: *M* = 5.93, *SD* = 1.18; Control: *M* = 5.93, *SD* = 0.92)	Depression / Anxiety	Waitlist Control	8 sessions weekly, 120 mins	Group	Yes (Only)	Isolation
Guerrini Usubini et al.	2021	Italy	RCT	13 - 17 y/o (ACT: *M* = 15.5, *SD* = 1.39; Control: *M* = 15.6, *SD* = 1.06)	Obesity	TAU (Multidisciplinary Rehab Programme)	3 sessions weekly, 60 mins	N/S	No	Conjunction (Multidisciplinary Rehab Programme)

Author	Year	Country	Study Design	Age (Years Old)	Presentation /Diagnosis	Type of Control	Quantity of ACT	Delivery Format	Parental Involvement	Treatment Condition
Hancock et al.	2018	Australia	RCT	7-17 y/o (Overall: *M* = 11, *SD* = 2.76)	Anxiety	Waitlist Control	10 sessions weekly, 90 mins	Group	Yes	Isolation
Hayes et al.	2011	Australia	Quasi-Experimental (Control group + Randomised)	12 -18 y/o (Overall *M* = 14.90, *SD* = 2.55)	Depression / Anxiety	TAU (Psychotherapy / CBT)	21 hours of sessions average	Individual	No	Isolation
Lappalainen et al.	2023	Finland	RCT	14-16 y/o (Overall: *M* = 15.01, *SD* = 0.15)	Non-Clinical (recruited from schools)	No Treatment Control	2 sessions, 45 mins with 1:1 student coach + 5 online modules OR 1 session, 15 mins with 1:1 student coach + 5 online modules	Online Written Content	No	Isolation
Livheim et al.	2015a	Australia	Quasi-Experimental (Control group + Females Randomised)	12.5-17.75 y/o (Overall: *M* = 14.6, *SD* = 1.03)	Mild-Moderate Depressive Symptoms	TAU (12 week monitoring support from school counsellor)	8 sessions weekly	Group	No	Isolation
Livheim et al.	2015b	Sweden	RCT	14-15 y/o	80th Percentile in Stress Scores	TAU (Individual support by school nurse / half had counselling - ranging 2 - 8 sessions)	6 weeks, 8 sessions, 90 mins (*M* = 5.8 sessions)	Group	No	Isolation
Marino et al.	2023	Italy	RCT	2-13 y/o (ACT: *M* = 6.9; Control: *M* = 5.8)	Autism Spectrum Disorder	Parent Group (24 sessions weekly, 90 mins)	24 sessions weekly, 90 mins	Group	Yes (Only)	Isolation
Moazzazi et al.	2015	Iran	Quasi-Experimental (Control group + Randomised)	7-15 y/o (ACT: *M* = 11.44, *SD* = 2.59; Control: *M* = 9.72, *SD* = 2.37)	Type 1 and 2 Diabetes	No Treatment Control	10 sessions weekly, 90 mins	Group	No	Isolation
Moghanloo et al.	2015	Iran	Quasi-Experimental (Control group + Randomised)	7-15 y/o (ACT: *M* = 10.35, *SD* = 2.91; Control: *M* = 10.59, *SD* = 3.16)	Type 1 and 2 Diabetes	No Treatment Control	10 sessions weekly, 90 mins	N/S	No	Isolation

Author	**Year**	**Country**	**Study Design**	**Age (Years Old)**	**Presentation /Diagnosis**	**Type of Control**	**Quantity of ACT**	**Delivery Format**	**Parental Involvement**	**Treatment Condition**
Nemati et al.	2022	Iran	Quasi-Experimental (Control group + Randomised)	"Under 12 Elementary School"; "Approximately 9 y/o"	Specific Learning Disability	No Treatment Control	8 sessions weekly, 40-60 mins	Group	No	Isolation
Petersen et al.	2023	USA	Quasi-Experimental Dissertation (Control group + Randomised)	"Adolescents" (Overall: *M* = 15.7, *SD* = 1.6; ACT: *M* = 15.6, *SD* = 1.1; Control: *M* = 15.8, *SD* = 2.0)	Anxiety	Waitlist Control	8 sessions weekly	Group	No	Isolation
Saliminezhad et al.	2022	Iran	Quasi-Experimental (Control group + Randomised)	13-14 y/o	Aggression	No Treatment Control	10 sessions weekly, 90 - 120 mins	Group	No	Isolation
Shabani et al.	2019	Iran	RCT	12-18 y/o (Overall: *M* = 14.96, *SD* = 1.47)	Obsessive-Compulsive Disorder	TAU (SSRI)	10 sessions weekly, 60 mins	Group	Yes	Conjunction (TAU - SSRI)
Simon et al.	2019	Holland	Quasi-Experimental (Control group + Randomised)	8-12 y/o (Boys: *M* = 9.50, *SD* = 0.97; Girls: *M* = 9.15, *SD* = 1.20)	Top 25% High Scores on Fear of Dark Questionnaire	CBT (Cognitive Restructuring, 30 mins Intervention)	1 session, 30 mins	Group	No	Isolation
Sveen et al.	2016	Sweden	RCT	ACT: *M* = 5.30, *SD* = 3.5; Control: *M* = 6.36, *SD* = 3.8)	Burns	Waitlist Control	6 modules, 1 per week	Online Written Content, with Feedback	Yes (Only)	Conjunction (CBT)
Talaeizadeh	2020	Iran	Quasi-Experimental (Control group + Randomised)	13-17 y/o	Depressive Symptoms (Referred to School Counselling)	No Treatment Control	8 sessions twice a week	Group	No	Isolation
Theodore-Oklota et al.	2012	USA	Quasi-Experimental (Control group + Randomised)	12-13 y/o (Overall: *M* = 12.45, *SD* = 0.51)	Non-Clinical (recruited from schools)	Waitlist Control	3 sessions over 2 weeks, 48 mins each (144 minutes total)	Group	No	Isolation

Author	**Year**	**Country**	**Study Design**	**Age (Years Old)**	**Presentation /Diagnosis**	**Type of Control**	**Quantity of ACT**	**Delivery Format**	**Parental Involvement**	**Treatment Condition**
White et al.	2022	Australia	RCT	13 - 14 y/o (Overall: *M* = 14, *SD* = 0.5)	Non-Clinical (recruited from schools)	TAU (Elective Subject of Choice)	5 hours per Fortnight for 20 weeks	Group	No	Conjunction (Physical Activity Elements, Self-Determination Theory)
Whittingham et al.	2016	Australia	RCT	2-12 y/o	Cerebral Palsy	Waitlist Control	2 x 120 mins ACT Stress Management; 6 x 120 mins Stepping Stones Triple P, 1 x 30 mins Telephone Consultation	Group	Yes (Only)	Conjunction (Stepping Stones Triple P)
Whittingham et al.	2022	Australia	RCT	2-10 y/o (ACT: *M* = 5y8m, *SD* = 2.36; Control: *M* = 5y 6, *SD* = 2.60)	Cerebral Palsy	Waitlist Control	3 x 2 hours, 1 x 1 hour over 10 weeks	Online Written Content	Yes (Only)	Isolation
Wicksell et al.	2008	Sweden	RCT	10.8 - 18.1 y/o (Overall: *M* = 14.8, *SD* = 2.4)	Longstanding Idiopathic Pain	TAU (Amitriptyline + MDT; MDT Sessions *M* = 11.7; SD = 11.9, Range = 7- 59)	10 sessions weekly (*M* = 10.3 sessions), 60 mins + 1-2 individual sessions with parents (*M* = 1.7 sessions), 90 mins	Group + Individual	Yes	Conjunction (Parent Sessions)
Zody	2017	USA	RCT Dissertation	"Child" (age range not specified; parent study)	Autism Spectrum Disorder	Waitlist Control	One Day Workshop	Group	Yes (Only)	Isolation

Quality Assessment

Risk of bias was assessed by the first author using the Cochrane risk-of-bias tool, version two (RoB-2; Sterne et al., 2019) with each component categorised as “high risk”, “some concerns” or “low risk” (Higgins & Green, 2011). The RoB-2 assessed six domains: randomisation process, derivation for intended interventions, missing outcome data, measurement of the outcome, selection of the reported results, and overall results. An external second reviewer independently assessed 20% of included studies (selected at random), with 83.33% agreement. Again, consensus was reached through discussion between the two reviewers.

Data Analysis

Separate meta-analyses were conducted to estimate effect sizes of ACT at post-intervention for each of the four primary outcomes utilising a random-effects model to account for heterogeneity. Analyses were performed using the Metafor package (Viechtbauer, 2010) in R 4.1.0 (Team R.D.C, 2010) to calculate standardised mean differences, which were converted to Hedge’s g (1981). Effect sizes of 0.2, 0.5 and 0.8 were interpreted as small, moderate, and large, respectively (Fritz et al., 2012).

Many studies included multiple relevant outcome measures, therefore a multi-level/multivariate model (Becker, 2000), fitted with the rma.mv function in Metafor (Vietchtbauer, 2010), was used to account for dependent, likely correlated estimates. Typically, meta-analyses deal with dependency by either choosing only one effect size from many, or average effect sizes to obtain a single effect sizes per study, however notable shortcomings have been associated with such approaches (Cheung, 2004; Vietchtbauer, 2021). Thus, this study utilised a three-level approach that permitted inclusion of all effect sizes derived from outcome measures from each study in a nonaggregate form.

For ease of interpretation, the polarity of effect sizes from the different outcome measures were homologised such that a positive effect size reflects a relative improvement, and a negative effect size reflects a relative deterioration, compared to the control group. A sensitivity analyses was conducted to exclude studies that were deemed as possessing a high risk of bias as identified by the RoB-2.

Heterogeneity of studies was assessed by the Cochrane Q-statistic; if significant ($p < .05$), it indicated that heterogeneity exceeded that expected by chance alone. I^2 (Higgins & Green, 2011) was generalised to the multilevel model (Vietchtbauer, 2010) to estimate the percentage of heterogeneity between studies that were not attributable to random sample error alone; percentages 30-60% may represent moderate heterogeneity, 50-90% may represent substantial heterogeneity and 75-100% may represent considerable heterogeneity (Higgins & Green, 2011).

Publication bias was explored only for outcome domains that do not have high levels of between-study heterogeneity. Multiple studies (e.g. Terrin et al., 2003; Peters et al., 2007) have illustrated that when studies do not share one true effect, it is likely that even large studies deviate substantially from the average effect even though it is unlikely that they are affected by publication bias, thus leading to invalid results. Visual inspection and trim-and-fill methods (Duval & Tweedie, 2000) were used to estimate whether there were any missing studies that account for significant asymmetric distribution. Pooled estimates were calculated per study, utilising the aggregate function within the Metafor package (Viechtbauer, 2010) in place of outcome measure estimates for ease of reading.

Subgroup analyses exploring study characteristics were not conducted. Metapower (a statistical package in R) was used to conduct power analyses for potential subgroups (Griffin, 2021). This revealed limited statistical power to detect significant differences between subgroups, likely due to low number of studies, high heterogeneity, and uneven division of study characteristics over potential subgroups (Cuijpers et al., 2021). Further, some researchers have argued that subgroup analyses are methodologically flawed as they are fundamentally observational and not grounded in randomised comparisons (Sun et al., 2012; Cuijpers et al., 2021).

Results

Study Characteristics

Twenty-eight studies were included in the meta-analysis, comprising 89 outcome measures and 1,643 participants. Studies were published between 2008 and 2023. Seventeen studies utilised an inactive control group (no intervention/waitlist) and 11 an active control group (TAU or other interventions). Intervention ranged from a single, 30 minute session to 2,160 hours over 24 weeks. Twenty-one studies were group interventions, three comprised online written content, one comprised both group and individual, one comprised individual therapy, and two did not report delivery format. Twenty-one studies delivered ACT in isolation, and seven studies delivered ACT in conjunction with different interventions such as positive psychology, CBT, parent sessions and self-determination theory. Twenty-one studies delivered the intervention directly to the child/adolescent, with nine studies including parents/caregivers. The age of children/adolescents ranged from five to 18 years old. Further details of the characteristics of included studies are outlined above in Table 1.3.

Study Quality

The overall risk of bias scores were highly variable, with 13 studies classified as having a low risk of bias, 10 studies classified as some concerns, and five studies classified as high risk of bias (Figure 1.2 & 1.3).

Domain four (measurement of the outcome) swayed the overall algorithm result to be “some concerns” for multiple studies. Domain four presents the dilemma of the unfeasibility of blinding participants in psychological studies with self-report measures, as treatment allocation is not concealed. This inevitably means there is a risk of response and social desirability bias. However, multiple meta-analyses have found that effect sizes based on self-report measures are more conservative than based on blinded clinician-rated measures (e.g., Greenberg et al., 1992; Lambert et al.,1996; Cuijbers et al., 2010). Thus, the lead researcher overwrote the overall algorithm result on the RoB-2 from “some concerns” to “low risk” where the above applied.

Figure 1.2

RoB-2 Bar Plot Displaying Author’s Judgement about each Risk of Bias Item Presented as Percentages Across all Included Studies

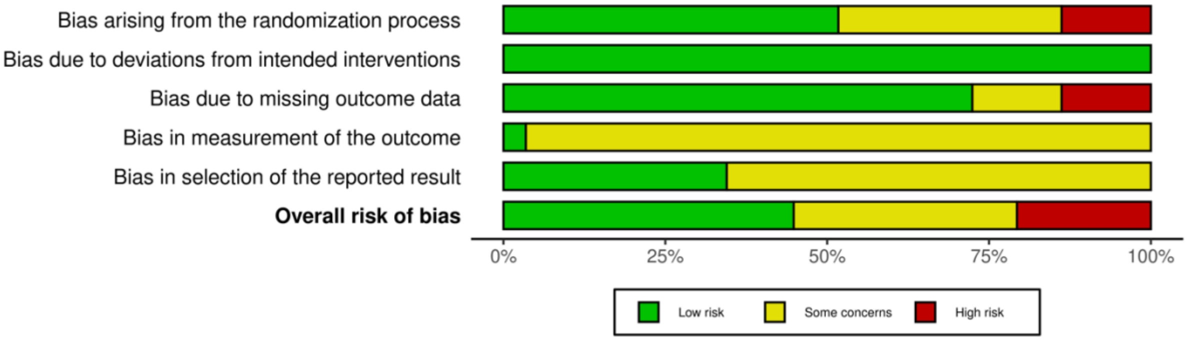
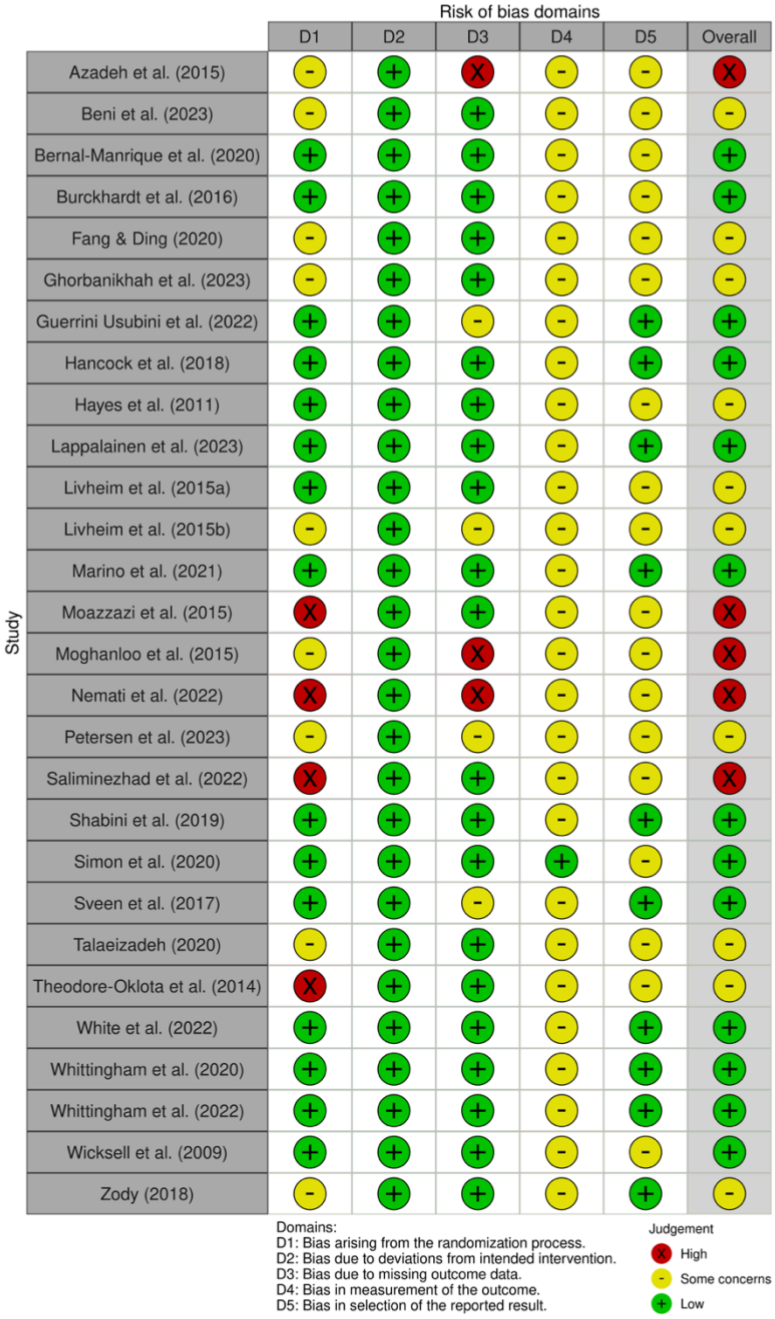


Figure 1.3

RoB-2 Summary Displaying Author's Domain Level Judgements of Included Studies Created Using the ***{robvis}*** *Package within R Studio (McGuiness & Luke, 2019; McGuinness et al., 2021)*



Risk of bias domains

Study	D1	D2	D3	D4	D5	Overall
Azadeh et al. (2015)	-	+	X	-	-	X
Beni et al. (2023)	-	+	+	-	-	-
Bernal-Manrique et al. (2020)	+	+	+	-	-	+
Burckhardt et al. (2016)	+	+	+	-	-	+
Fang & Ding (2020)	-	+	+	-	-	-
Ghorbanikhah et al. (2023)	-	+	+	-	-	-
Guerrini Usubini et al. (2022)	+	+	-	-	+	+
Hancock et al. (2018)	+	+	+	-	+	+
Hayes et al. (2011)	+	+	+	-	-	-
Lappalainen et al. (2023)	+	+	+	-	+	+
Livheim et al. (2015a)	+	+	+	-	-	-
Livheim et al. (2015b)	-	+	-	-	-	-
Marino et al. (2021)	+	+	+	-	+	+
Moazzazi et al. (2015)	X	+	+	-	-	X
Moghanloo et al. (2015)	-	+	X	-	-	X
Nemati et al. (2022)	X	+	X	-	-	X
Petersen et al. (2023)	-	+	-	-	-	-
Saliminezhad et al. (2022)	X	+	+	-	-	X
Shabini et al. (2019)	+	+	+	-	+	+
Simon et al. (2020)	+	+	+	+	-	+
Sveen et al. (2017)	+	+	-	-	+	+
Talaeizadeh (2020)	-	+	+	-	-	-
Theodore-Oklota et al. (2014)	X	+	+	-	-	-
White et al. (2022)	+	+	+	-	+	+
Whittingham et al. (2020)	+	+	+	-	+	+
Whittingham et al. (2022)	+	+	+	-	+	+
Wicksell et al. (2009)	+	+	+	-	-	+
Zody (2018)	-	+	+	-	+	-

Domains:
D1: Bias arising from the randomization process.
D2: Bias due to deviations from intended intervention.
D3: Bias due to missing outcome data.
D4: Bias in measurement of the outcome.
D5: Bias in selection of the reported result.

Judgement
X High
- Some concerns
+ Low

Study Findings

Overall effects for each outcome domain at post-intervention are presented in Table 1.4. Overall, a significant small effect was found for externalising/behavioural difficulties, and third-wave processes, a significant medium effect for internalising/emotional difficulties, and a significant large effect for wellbeing/QoL. Figure 1.4 depicts forest plots for overall effects across the four domains.

Impact of Study Quality

Sensitivity analyses excluding studies at high risk of bias were performed and presented alongside main effects in Table 1.4. Externalising/behavioural difficulties and third-wave processes remained a significant small effect. Internalising/emotional difficulties reduced from a significant medium effect to a significant small effect. Wellbeing/QoL reduced from a large effect to a medium effect and approached acceptance levels of statistical significance ($p = 0.054$). Supplementary Figure 1.6 depicts forest plots for the sensitivity analyses across the four domains.

Heterogeneity

The heterogeneity for externalising was non-significant ($Q = 18.49$, $p = 0.102$) suggesting the observed variation in effect sizes across the included studies could be due to random sample error. However, more likely, the Q statistic was probably biased by the low number of studies, and therefore should be interpreted with caution in the context of low power (Gavaghan et al., 2000). Further, in support of the latter hypothesis, the confidence intervals for the I^2 statistic were large, ranging from 0.00% – 85.87%. There was moderate-considerable significant heterogeneity for all other outcome domains (I^2 52%-97%).

Table 1.4

Overall Effects for the Four Outcome Domains, Inclusive and Exclusive of Low Quality Studies

	k	*nlvls*	*g*	95% CI	*p*-value	Heterogeneity I^2 (*Q* with *p*-value)
Internalising Difficulties						
Overall effect (*N* = 1,263)	**36**	**22**	**0.70**	**0.24 to 1.16**	**0.003**	93% (233.26, <.001)
Excluding low quality studies (*N* = 1,131)	**32**	**18**	**0.40**	**0.06 to 0.73**	**0.020**	86% (161.07, <.001)
Externalising Difficulties						
Overall effect (*N* = 477)	**13**	**8**	**0.31**	**0.04 to 0.57**	**0.022**	43% (18.49, 0.102)
Excluding low quality studies (*N* = 447)	**12**	**7**	**0.20**	**0.05 to 0.35**	**0.008**	0% (8.08, 0.706)
Wellbeing / QoL						
Overall effect (*N* = 734)	**20**	**12**	**0.99**	**0.07 to 1.91**	**0.036**	97% (121.23, < .001)
Excluding low quality studies (*N* = 700)	19	11	0.61	-0.01 to 1.24	0.054	92% (75.73, <.001)
Third-Wave Processes						
Overall effect (*N* = 855)	**20**	**12**	**0.26**	**0.06 to 0.46**	**0.011**	53% (94.50, <.001)
Excluding low quality studies (*N* = 825)	**19**	**11**	**0.23**	**0.03 to 0.44**	**0.025**	52% (91.95 <.001)

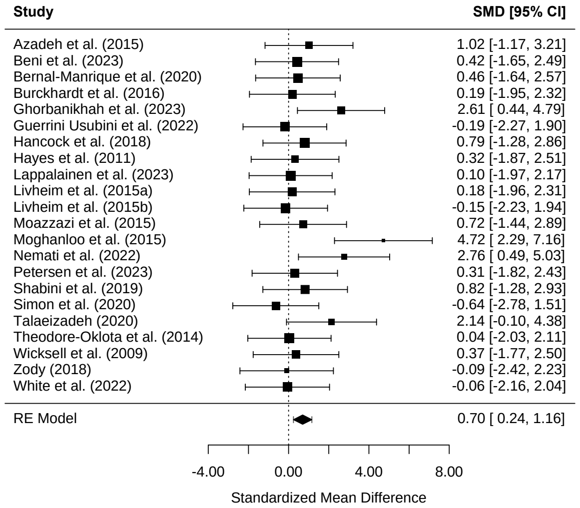
Abbreviations: *N*, number of participants; *k*, number of outcome measures; *nlvls*, number of studies; *g*, Hedge's *g*; *CI*, confidence intervals;

I^2, percentage of heterogeneity. A positive effect size favours the intervention group. Significant effect sizes ($p \leq 0.05$) are denoted in bold.

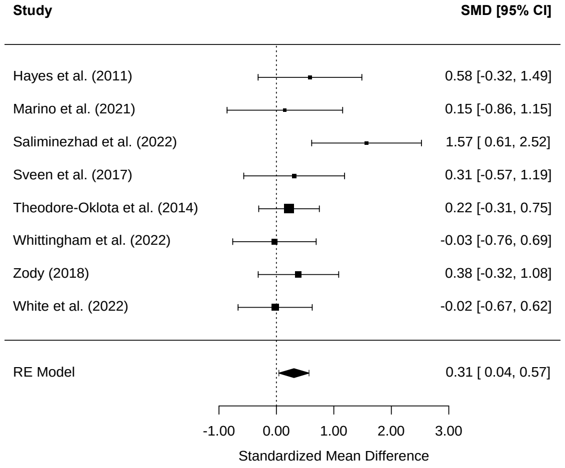
Figure 1.4

Forest Plots Detailing Effect Sizes with 95% Confidence Intervals for the Four Outcome Domains Including All Studies

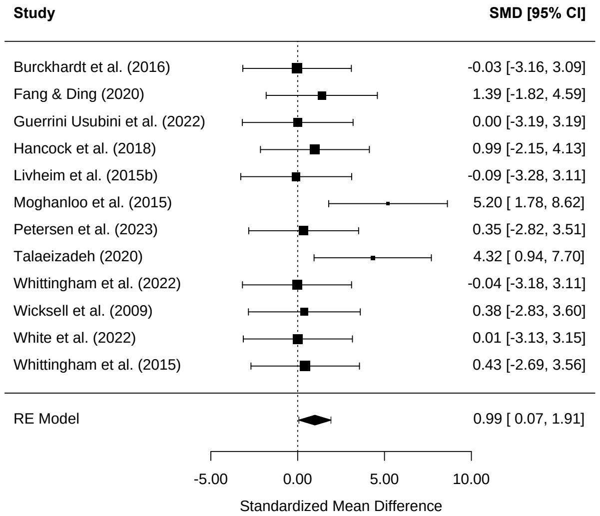
1. Internalising Difficulties



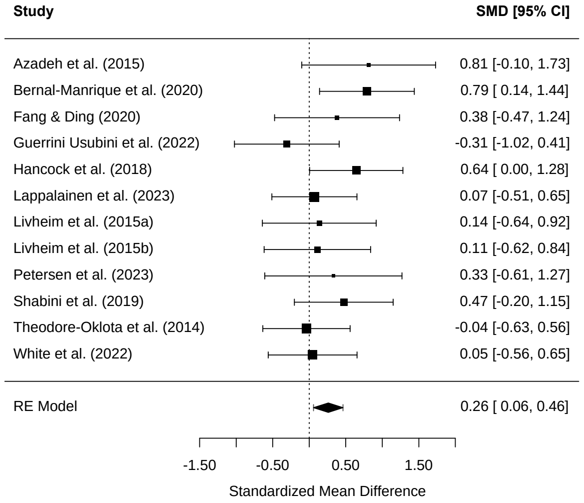
2. Externalising Difficulties



3. Wellbeing/QoL



4. Third-Wave Processes



Publication Bias

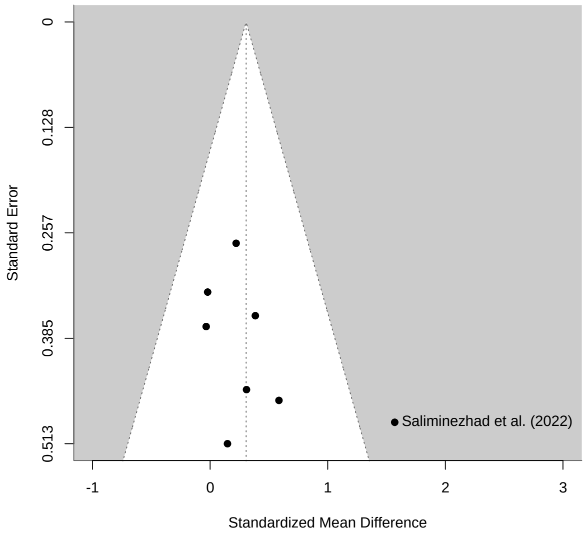
Publication bias was inspected through funnel plots for externalising difficulties and third-wave processes. Publication bias was not explored for internalising difficulties and wellbeing/QoL due to high between-study heterogeneity.

Inspection of the funnel plots displayed no imputed data points (based on the trim-and-fill method) and no asymmetry in the distribution of effect sizes for either externalising difficulties or third-wave processes, thus not affecting effect sizes (Figure 1.5).

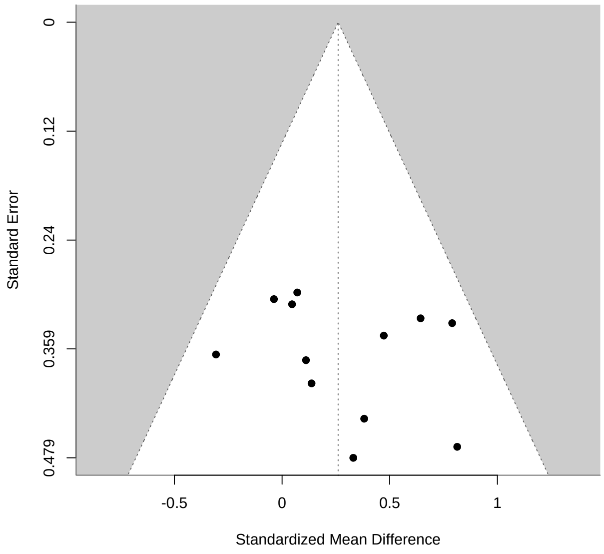
Figure 1.5

Funnel Plots Assessing Potential Publication Bias Utilising Trim-and-Fill Method

1. *Externalising Difficulties*



2. *Third-Wave Processes*



Discussion

This meta-analysis synthesised findings on the efficacy of ACT in children and adolescents from 28 papers, 89 outcome measures, encompassing 1,643 participants. Overall, findings yielded significant small effect at post-treatment in favour of ACT compared to control conditions for externalising/behavioural difficulties, and third-wave processes, medium effect for internalising/emotional difficulties, and a large effect for wellbeing/QoL. The results from the sensitivity analyses, excluding low quality studies, changed effect sizes for internalising/emotional difficulties (from a significant medium to a small effect) and wellbeing/QoL (from a large to a medium effect).

Overall, this adds to the existing meta-analyses (Fang & Ding, 2020; Parmer et al., 2021; Perkins et al., 2022) that found ACT to be a promising transdiagnostic intervention for children and adolescents on a range of outcomes from ill-health to flourishing. Since the goal of ACT is pursuing value-driven behaviour and increasing acceptance of experiences, symptom reduction is viewed as a by-product of treatment (Dindo et al., 2017).
For example, positive improvements in internalising/emotional difficulties, may be explained by shifting the relationship with anxiety, from one of struggle to acceptance, which has paradoxically been found to reduce symptoms of anxiety (A-Tjak et al., 2015; Dimidjian et al., 2016). Pragmatically, although symptom reduction is not the primary goal of ACT, the found decrease in internalising and externalising difficulties holds significance within the framework of treating mental health disorders within the National Health Service (NHS) context.

In addition to examining the usefulness of ACT within clinical practice, it is crucial to explore universal approaches that can be more widely applied for mental health prevention

(Department of Health & Education. 2018). The present review included studies with non-clinical samples, examining ACT interventions conducted in community settings and schools, many of which were relatively short group interventions. Additionally, ACT was found to have the largest effect on measures of wellbeing/QoL, the domain that is most generalisable to the wider population. Together, this offers promising prospects for group-based ACT interventions as a cost-effective and preventative measure that can be implemented within school settings to augment wellbeing. Future research should prioritise cost-effectiveness reporting and analyses.

The finding that third-wave processes exhibited the small effect sizes, both inclusive and exclusive of sensitivity analysis, was surprising given that these processes are the specific focus of ACT interventions. This result was in line with Perkin et al's. (2022) meta-analysis, also finding small effects, both inclusive and exclusive of sensitivity analysis, in the efficacy of third-wave therapies on third-wave processes. The statistically significant results support the ACT model's premise of facilitating individuals to reframe difficult thoughts or emotions as harmless, even if uncomfortable, transient psychological events (Dindo et al., 2017). However, the small effects raise the possibility that ACT may operate through a confluence of the small effects on the Hexaflex processes, alongside potential influences from effects not explicitly accounted for in the model, such as non-specific therapeutic effects or attachment-related processes. Alternatively, it's plausible that the measures for third-wave processes were insufficient in capturing ACT's impact on the Hexaflex processes. The aggregation of multiple components (e.g., self-compassion, psychological flexibility, acceptance) within this outcome domain complicates the assessment of the extent to which specific predictions from the ACT model are supported. Thus, given the expanding body of RCTs on ACT, future meta-analyses could assess the effectiveness of ACT on the six core processes outlined by the Hexaflex.

Strengths, Limitations and Future Research

This was a comprehensive review encompassing a large range of outcomes and a high number of participants across a range of settings. It provided a thorough investigation into the effectiveness of ACT for children and adolescents, from the treatment of symptomatology to the promotion of wellbeing, as well as a rigorous evaluation of study quality. It is acknowledged that the diverse range of studies incorporated (i.e. variety of settings, presentations, age groups/developmental stages, delivery formats and level of parental involvement) means that it is not possible to determine effectiveness for specific presentations, diagnoses, or situations; however, this review aimed to adopt an initial broad and exploratory perspective on the efficacy of ACT in supporting children and adolescent mental health and wellbeing.

Despite the promising overall results, it is important to highlight that the substantial heterogeneity within four out of the eight meta-analyses, raised questions regarding the generalisability of the findings. Additionally, for the externalising difficulties outcome domain, the wide confidence intervals resulting from heterogeneity and the comparatively smaller sample size suggest the possibility that greater statistical power was necessary to detect effects. Given the transdiagnostic nature of ACT and the limited existing literature, there are insufficient homogeneously conducted studies to provide adequate statistical power for meta-analyses on distinct mental health conditions. Therefore, future RCTs should explore the effectiveness of ACT across different presentations and diagnoses in children and adolescents. This will provide a foundation for research at a later date to begin exploring the effectiveness of specific ACT components for young people and provide an understanding of how ACT can be more precisely adjusted across the developmental spectrum (Petersen et al., 2022).

Although studies included in this review offer international representation across most continents, the scope remains limited. There is a notable scarcity of research focusing on ACT with diverse and underserved populations, both in adult and child literature. Preliminary evidence suggests positive outcomes for African American and transgender youth undergoing ACT interventions (Petts et al., 2017; Bennett & Dillman Taylor, 2019). However, there is a clear need for further investigation into the feasibility, acceptability, and efficacy of ACT for a broader range of populations (Petersen et al., 2022).

Another limitation of this review was that the categorisation of outcome measures by domain was unable to consider individual items within each questionnaire. Instead, it focused on the overall theme, leading to some unavoidable ambiguity in classification. For example, the Strengths and Difficulties Questionnaire (Goodman, 1997) was classified within the externalising domain as this reflected the overarching measure of the questionnaire, however it includes a subset of items related to emotional symptoms which would more appropriately align with the categorisation of internalising difficulties.

Finally, post-intervention data was collected from the closest timepoint from completion of the intervention to maintain consistency. As only a small number of studies included follow-up data, maintenance effects were not evaluated. Considering adolescence is a period of rapid development and change, there is a need for studies incorporating longitudinal measurements to explore potential long-term impacts (Petersen et al., 2022).

Conclusions

In summary, this is the largest and most comprehensive meta-analysis to date synthesising the effectiveness of ACT for children and adolescents. Significant small effects were found for third-wave processes and externalising/behavioural difficulties, with more promising, stronger effects found for internalising/emotional difficulties and wellbeing/QoL. Whilst further high-quality research is necessary to explore heterogeneity and maintenance effects, this review suggests that ACT serves as a valuable psychological treatment for enhancing mental health, as well as a public health tool for promoting wellbeing, amongst children and adolescents.

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Supplementary Tables

Supplementary Table 1.5

Excluded Child Outcome Measures from Included Studies with Reasons Noted

Study	Excluded Outcome Measure	Reason for Exclusion
Azadeh et al. (2015)	Social Anxiety Scale for Adolescents	Only used for inclusion purposes, not used as an outcome measure
Beni et al. (2023)	Study Skills Inventory	Not a psychological outcome measure
Beni et al. (2023)	Social Skills Inventory	Not of interest
Bernal-Manrique et al. (2020)	Interpersonal Conflict Resolution Assessment	Performance test - not a questionnaire
Fang & Ding (2020)	Utrecht Work Engagement Scale (Chinese Version)	Not a psychological outcome measure
Hancock et al. (2018)	Anxiety Disorder Diagnosis and Clinical Severity	Interview data
Hancock et al. (2018)	Child Health Questionnaire (Physical Subscale)	Physical health subscale of questionnaire, not a psychological outcome measure
Moazzezi et al. (2015)	Special Health Self-Efficacy Scale	Physical health measure, not psychological measure
Nemati et al. (2022)	Student-Life Stress Inventory	Focused on school/academic stressors mainly, not of interest
Nemati et al. (2022)	School Burnout Inventory: Pessimism Subscale	Inaccurate reporting of SDs
Nemati et al. (2022)	School Burnout Inventory: Efficiency Subscale	Not psychological outcome measure
Saliminezhad et al. (2022)	Fundamental Value Scale	Measures wisdom, spirituality and problem solving, not strictly a psychological outcome measure
Saliminezhad et al. (2022)	Buss-Perry Aggressiveness Questionnaire	Only used for inclusion purposes, not used as an outcome measure
Shabani et al. (2019)	Therapeutic Alliance Scale for Children-Revised	Measurement of therapeutic alliance - Not of interest /not a psychological outcome measure
Shabani et al. (2019)	The Credibility/Expectancy Questionnaire-Parent Version	Measurement of parental expectations of therapy - not of interest / not a psychological outcome measure
Simon et al. (2019)	Darkness Toleration Measure	Not a questionnaire; measurement of exposure time
Theodore-Oklota et al. (2012)	Revised Peer Experiences Questionnaire (Externalising)	Measures victimisation of aggression, not of interest/ psychological outcome measure

Study	Excluded Outcome Measure	Reason for Exclusion
Theodore-Oklota et al. (2012)	Responses to Stress Questionnaire	Only used subscale relating to problem solving / not psychological outcome measure
Whittingham et al. (2022)	Emotional Availability Scale	Naturalistic Observational Data / Not questionnaire
Whittingham et al. (2022)	Cerebral Palsy Quality of Life Scale (Child) Subscales: Feelings about Function; Participation & Physical Health; Access; Pain & Impact; Family Health	Not a psychological outcome measure
Monghanloo et al. (2015)	Eysenck Feeling of Guilt Scale	Unable to obtain the paper referenced by author
Wicksell et al. (2008)	Functional Disability Inventory	Measures severity of physical illness, not a psychological outcome measure
Wicksell et al. (2008)	The Multidimensional Pain Inventory	Measures pain related functioning, not solely psychological outcome measure
Wicksell et al. (2008)	The Pain and Impairment Relationship Scale	Measures beliefs about pain and functioning despite pain, not solely psychological outcome measure
Wicksell et al. (2008)	The Short Form-36 Health Survey - Physical Component Scale	Measure physical functioning, not solely psychological outcome measure
Wicksell et al. (2008)	Tampa Scale of Kinesiophobia	Kinesiophobia scale, not solely psychological outcome measure
White et al. (2022)	Behavioural Regulations in Exercise Questionnaire-II	Measures motivation for physical activity, not of interest
White et al. (2022)	Adolescent Sedentary Activity Questionnaire	Measures screen-time, not a psychological outcome measure

Supplementary Table 1.6

Internalising/ Emotional Difficulties Meta-Analysis: Table of Included Studies, Outcome Measures and Number of Participants Across Conditions

Study	Outcome Measure	*N* (ACT)	*N* (Control)
Azadeh et al. (2015)	Inventory of Interpersonal Problems (IIP-60)	15	15
Beni et al. (2023)	Emotion Regulation Questionnaire for Children and Adolescents Revised Form (ERCQ-CA): Expressive Suppression	61	61
Beni et al. (2023)	Emotion Regulation Questionnaire for Children and Adolescents Revised Form (ERCQ-CA): Cognitive Reappraisal	61	61
Bernal-Manrique et al. (2020)	Perseverative Thinking Questionnaire- Children (PTQ-C)	21	21
Bernal-Manrique et al. (2020)	Depression Anxiety and Stress Scale - 21 (DASS-21)	21	21
Burckhardt et al. (2016)	The Depression Anxiety and Stress Scale Short Form (DASS-21)	24	22
Ghorbanikhah et al. (2023)	Revised Child Anxiety and Depression Scale - Depression Subscale	16	16
Ghorbanikhah et al. (2023)	Revised Child Anxiety and Depression Scale - Anxiety Subscale	16	16
Guerrini Usubini et al. (2022)	The Depression Anxiety Stress Scale (DASS-21) - Depression Subscale	17	17
Guerrini Usubini et al. (2022)	The Depression Anxiety Stress Scale (DASS-21) - Anxiety Subscale	17	17
Guerrini Usubini et al. (2022)	The Depression Anxiety Stress Scale (DASS-21) - Stress Subscale	17	17
Guerrini Usubini et al. (2022)	The Dutch Eating Behaviour Questionnaire - Emotional Eating Subscale	17	17
Hancock et al. (2018)	The Multidimensional Anxiety Scale for Children	68	62
Hancock et al. (2018)	Children Anxiety Life Interference Scale - Parent Interference	68	62
Hayes et al. (2011)	Reynolds Adolescent Depression Scale-2	19	11
Lappalainen et al. (2023)	Spielberger State-Trait Anxiety inventory short form	73	64

Study	Outcome Measure	*N* (ACT)	*N* (Control)
Lappalainen et al. (2023)	Depression Scale	73	64
Livheim et al. (2015a)	The Reynolds Adolescent Depression Scale-2	32	19
Livheim et al. (2015b)	The Perceived Stress Scale	15	17
Livheim et al. (2015b)	Depression, Anxiety and Stress Scale: Anxiety Subscale	15	17
Livheim et al. (2015b)	Depression, Anxiety and Stress Scale: Depression Subscale	15	17
Livheim et al. (2015b)	General Health Questionnaire-12	15	17
Moazzazi et al. (2015)	Perceived Stress Scale	18	18
Moghanloo et al. (2015)	Reynolds Child Depression Scale	17	17
Nemati et al. (2022)	School Burnout Inventory: Exhaustion Subscale	16	16
Petersen et al. (2023)	Screen for Child Anxiety and Related Disorder - Child Report	13	13
Petersen et al. (2023)	Center for Epidemiologic Studies Depression Scale	13	13
Shabini et al. (2019)	Childrens Yale-Brown Obsessive Compulsive Scale	17	22
Shabini et al. (2019)	Childrens Depression Inventory	17	22
Simon et al. (2020)	The Fear of Dark Questionnaire & Thermometer	22	21
Talaeizadeh (2020)	Beck Depression Inventory - 13 Items Version	15	15
Theodore-Oklota et al. (2014)	Youth Self Reported Child Behaviour Checklist	105	105
White et al. (2022)	Rumination Scale - Adolescent Version	47	42
Wicksell et al. (2009)	The Center for Epidemiological Studies Depression Scale for Children (CES-DC)	13	11
Wicksell et al. (2009)	The Pain Coping Questionnaire (PCQ)	13	11
Zody (2018)	Nisonger Child Behavior Rating Form, Parent Version - Insecure / Anxious Subscale	9	5

Supplementary Table 1.7

Externalising/Behavioural Difficulties Meta-Analysis: Table of Included Studies, Outcome Measures and Number of Participants Across Conditions

Study	**Outcome Measure**	***N* (ACT)**	***N* (Control)**
Hayes et al. (2011)	Strengths and Difficulties Questionnaire - Student Version	19	11
Marino et al. (2021)	Home Situation Questionnaire ASD	10	10
Saliminezhad et al. (2022)	Matson Social Skills Questionnaire	15	15
Sveen et al. (2017)	Strengths and Difficulties Questionnaire - Parent Rated	13	17
Theodore-Oklota et al. (2014)	Peer Experiences Questionnaire - Revised - Physical Aggression Subscale	105	105
Theodore-Oklota et al. (2014)	Peer Experiences Questionnaire - Revised - Relational Aggression Subscale	105	105
Whittingham et al. (2022)	Strengths and Difficulties Questionnaire - Parent Rated	25	29
Zody (2018)	Nisonger Child Behavior Rating Form, Parent Version - Conduct Problems Subscale	9	5
Zody (2018)	Nisonger Child Behavior Rating Form, Parent Version - Hyperactive Subscale	9	5
Zody (2018)	Nisonger Child Behavior Rating Form, Parent Version - Self-injury / Stereotypic Subscale	9	5
Zody (2018)	Nisonger Child Behavior Rating Form, Parent Version - Self Isolated / Ritualistic Subscale	9	5
Zody (2018)	Nisonger Child Behavior Rating Form, Parent Version - Overly Sensitive Subscale	9	5
White et al. (2022)	Strengths and Difficulties Questionnaire	47	42

Supplementary Table 1.8

Wellbeing/QoL Meta-Analysis: Table of Included Studies, Outcome Measures and Number of Participants Across Conditions

Study	**Outcome Measure**	***N* (ACT)**	***N* (Control)**
Burckhardt et al. (2016)	Flourishing Scale	115	102
Fang & Ding (2020)	Positive Psychological Capital Questionnaire	18	17
Guerrini Usubini et al. (2022)	Psychological Wellbeing Scales (Italian Version)	17	17
Hancock et al. (2018)	The Child Health Questionnaire - Psychosocial Subscale	68	62
Livheim et al. (2015b)	Satisfaction with Life Scale	15	17
Moghanloo et al. (2015)	Satisfaction with Life Scale	17	17
Petersen et al. (2023)	Mental Health Continuum Short Form	13	13
Petersen et al. (2023)	Student Subjective Wellbeing Questionnaire	13	13
Talaeizadeh (2020)	Oxford Happiness Questionnaire	15	15
Whittingham et al. (2022)	Cerebral Palsy Quality of Life Scale - Child - Social Wellbeing & Acceptance	20	23
Whittingham et al. (2022)	Cerebral Palsy Quality of Life Scale - Child - Emotional Wellbeing & Esteem Subscale	20	23
Wicksell et al. (2009)	The Short Form-39 Health Survey - Mental Component Scale	13	11
White et al. (2022)	Psychological Flourishing Scale	47	42
Whittingham et al. (2015)	Cerebral Palsy Quality of life-Child: Parent Version: Social Wellbeing & Acceptance	21	19
Whittingham et al. (2015)	Cerebral Palsy Quality of life-Child: Parent Version: Feelings about Functioning	21	19
Whittingham et al. (2015)	Cerebral Palsy Quality of life-Child: Parent Version: Participation and Physical Health	21	19
Whittingham et al. (2015)	Cerebral Palsy Quality of life-Child: Parent Version: Emotional Wellbeing & Self-Esteem	21	19
Whittingham et al. (2015)	Cerebral Palsy Quality of life-Child: Parent Version: Access to Services	21	19
Whittingham et al. (2015)	Cerebral Palsy Quality of life-Child: Parent Version: Pain and Impact of Disability	21	19
Whittingham et al. (2015)	Cerebral Palsy Quality of life-Child: Parent Version: Family Health	21	19

Supplementary Table 1.9

Third-Wave Processes Meta-Analysis: Table of Included Studies, Outcome Measures and Number of Participants Across Conditions

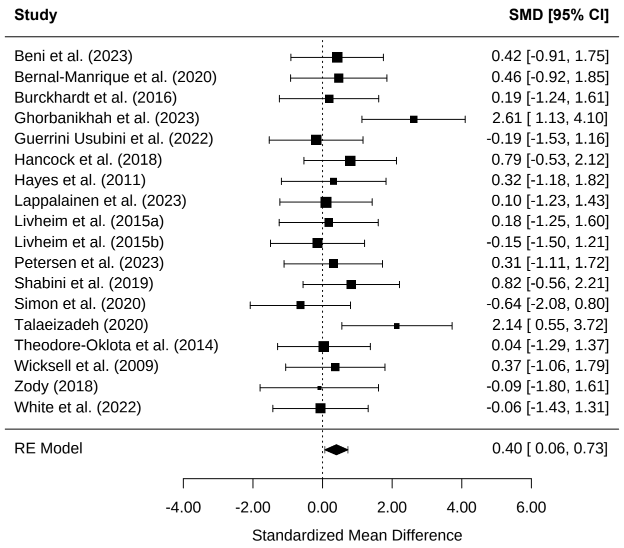
Study	**Outcome Measure**	***N* (ACT)**	***N* (Control)**
Azadeh et al. (2015)	Acceptance and Action Questionnaire II	15	15
Bernal-Manrique et al. (2020)	Valuing Questionnaire - Progress	21	21
Bernal-Manrique et al. (2020)	Valuing Questionnaire - Obstruction	21	21
Bernal-Manrique et al. (2020)	Avoidance and Fusion Question - Youth 8	21	21
Fang & Ding (2020)	Acceptance and Action Questionnaire-II (Chinese Version)	18	17
Guerrini Usubini et al. (2022)	Avoidance and Fusion Questionnaire - Youth	17	17
Guerrini Usubini et al. (2022)	The Difficulties in Emotion Regulation Scale	17	17
Hancock et al. (2018)	The Avoidance and Fusion Questionnaire-Youth	68	62
Lappalainen et al. (2023)	Comprehensive assessment of Acceptance and Commitment Therapy (Psychological Flexibility) Processes	73	64
Lappalainen et al. (2023)	The Self-Compassion Scale - Short Form	73	64
Livheim et al. (2015a)	Avoidance and Fusion Questionnaire for Youth (Short Form)	32	19
Livheim et al. (2015b)	Mindful Attention Awareness Scale	15	17
Livheim et al. (2015b)	Avoidance and Fusion Questionnaire -Youth	15	17
Petersen et al. (2023)	Avoidance and Fusion Questionnaire - Youth	13	13
Shabini et al. (2019)	The Avoidance and Fusion Questionnaire - Youth	17	22
Shabini et al. (2019)	The Valued Living Questionnaire - Persian Version	17	22
Shabini et al. (2019)	Child and Adolescent Mindfulness Measure	17	22
Theodore-Oklota et al. (2014)	Avoidance and Fusion Questionnaire for Youth	105	105
White et al. (2022)	Child and Adolescent Mindfulness Measure	47	42
White et al. (2022)	Self-Compassion Scale	47	42

Supplementary Figures

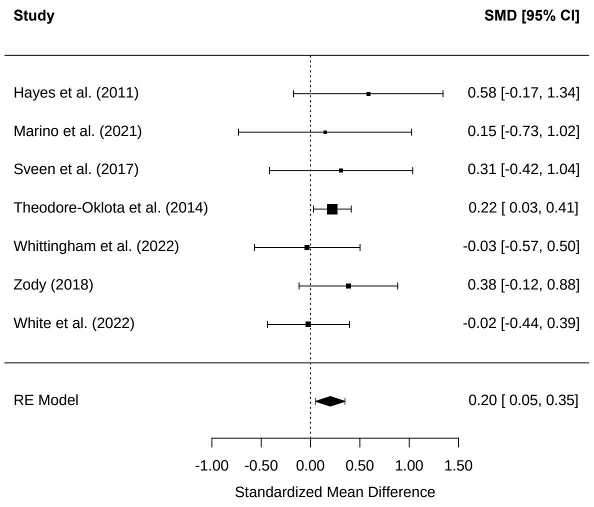
Supplementary Figure 1.6

Forest Plots Detailing Effect Sizes with 95% Confidence Intervals for The Four Outcome Domains - Sensitivity Analyses

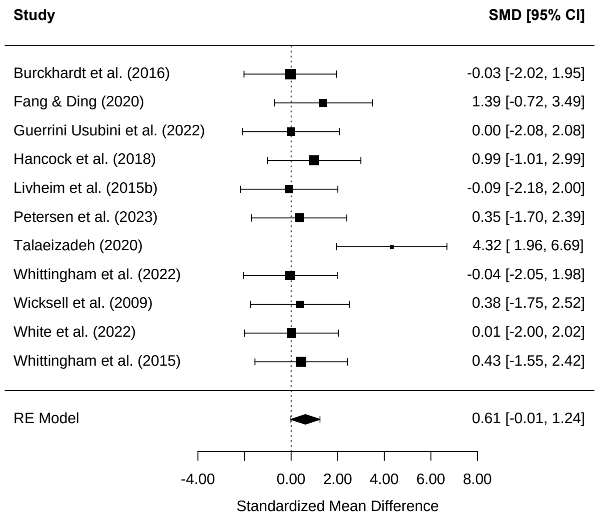
1. Internalising/Emotional Difficulties



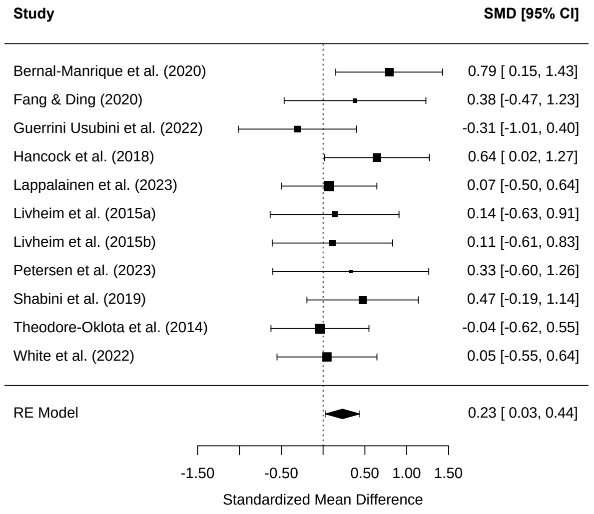
2. Externalising/Behavioural Difficulties



3. Wellbeing/QoL



4. Third-Wave Processes



Chapter Two: Bridging Chapter

The preceding chapter synthesised the efficacy of ACT for children and adolescents. Following this exploration, the subsequent chapter will explore caregivers' experiences of joint admission to a children's mental health unit and its impact on their parenting approaches and relationship dynamics with their child.

Whilst ACT and joint admission to children's mental health units represent two very distinct interventions, their exploration collectively underscore the diverse and comprehensive approaches necessary within CAMHS to address the multifaceted needs of children, adolescents, and their families. Both interventions offer unique avenues for intervention within a stepped-care model, particularly when first-line approaches have not yielded clinical change. This highlights the necessity for flexible and adaptive approaches to navigate the complexities of challenging cases within CAMHS.

The role of parental and caregiver involvement, along with a broader systemic approach, is a central theme throughout this thesis portfolio. The meta-analysis incorporated both child-focused and parent-focused interventions to reflect clinical practice within CAMHS, where interventions frequently integrate direct methods targeting the child with indirect strategies aimed at supporting the family. The following chapter, which explores joint inpatient admission, underscores the systemic approach as the core component of its intervention strategy. Joint admission recognises the whole family as a cohesive unit for exploration and focus of change. The systemic approach is vital within a holistic framework to facilitate both first-order and second-order changes.

Research into both ACT and joint inpatient admission within CAMHS is still in its early stages. In the realm of ACT, there has been an exponential surge of RCTs, necessitating updated meta-analyses to consolidate findings regarding its efficacy in children. However, the volume of research remains relatively limited compared to more established interventions such as CBT. Similarly, research on joint admission is currently characterised by only seven units globally. Methodologically, studies predominantly lean towards uncontrolled within-subject designs, with some initial qualitative explorations delving into the perspectives of clinicians and caregivers. Consequently, both ACT and joint inpatient admission are emerging practices within the landscape of CAMHS. Despite their potential, there is a significant gap in understanding about their effectiveness and implications for clinical practice.

This bridging chapter emphasises the importance of further research and exploration in both ACT and joint admission within CAMHS. By deepening our understanding of these interventions and their impacts, we can strive towards more holistic and effective approaches for supporting the mental health and wellbeing of children, adolescents, and their families.

Chapter Three: Empirical Paper

Caregivers' Experiences of the Impact of Joint Admission to a Children's Mental Health Unit on their Parenting Practices and Relationship with their Child.

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(Prepared for submission to Journal of Clinical Child & Adolescent Psychology – Appendix B)

Abstract

Objective: Globally, there is a dearth of research exploring the novel approach of joint caregiver-child admission to children's mental health inpatient units. This study aims to investigate caregivers' experiences of the impact of joint admission on their parenting practices and relationship with their child.

Method: 10 caregivers ($M_{age} = 49.4$, 60% female, 80% Caucasian) who had undergone joint admission at a specialist inpatient mental health unit for children under 13 years old completed qualitative semi-structured interviews. Data was analysed according to the principles of reflexive thematic analysis.

Results: Four themes were identified as follows: (1) Acceptance and Exoneration, (2) Respite after Battle, (3) Understanding, Adaptation and Trust, (4) Navigating Control and Power Dynamics in Co-Parenting.

Conclusions: Through the lens of caregivers, this study deepens our understanding of the novel approach of joint admission and the significant impact on family dynamics, providing a valuable contribution to the Tier 4 CAMHS evidence base.

Introduction

Child and Adolescent Mental Health Services (CAMHS) in the National Health Service (NHS) operate on a four-tiered stepped care model, with tier four providing specialised inpatient services for a minority of children facing severe and complex mental health challenges that pose a risk to themselves or others (CAMHS Tier 4 Report Steering Group, 2014). At present, there are just eight inpatient units within the United Kingdom (UK) that admit children under the age of thirteen (Cousin & Holmes, 2021).

Within these inpatient services, a family-centred, systemic approach is embraced, emphasising collaboration with caregivers (NHS England, 2018). Working "in partnership with parents" stands as a cornerstone principle of the Children Act 1989, serving as the legal framework that shapes the operations of all child-focused agencies in the UK, including CAMHS (UK Government Legislation, 1989). A systemic approach seeks to understand the relationship between family processes in the development and maintenance of childhood mental health difficulties by recognising that children are embedded within a wider system around them (Gopalan et al., 2010).

A systemic approach is underpinned by attachment theory (Bowlby, 1973) and family systems theory (FST; Bowen, 1966) that both posit relational factors play a role in determining a child’s emotional and behavioural patterns. Specifically, FST views families as an interconnected system of interdependent individuals, or an emotional unit, where understanding the psychology of one individual requires consideration of the entire system. This consideration might involve exploring various aspects of the system, such as the pushes and pulls, competing emotional demands, role definitions and expectation, coalitions and collusions, family culture and belief systems (Bowen, 1966). According to attachment theory, children are more likely to develop a sense of relational security and robust mental health when their caregivers are emotionally responsive and sensitive to their needs (Dunst & Kassow, 2008). Hence, research has shown that involving caregivers in treatment positively impacts outcomes within CAMHS (Pfeiffer & Strzelecki, 1990; Haine-Schlagel & Walsh, 2016). Further, the therapeutic alliance between the child, their family, and the inpatient team, along with family participation in the therapeutic process, have been identified as key predictors of positive outcomes within inpatient settings (Green et al., 2007).

Despite the adoption of the systemic approach, the prevailing method in most CAMHS inpatient services, compromising seven out of the eight units in the UK, involves admitting the lone child that is displaying mental health difficulties in isolation, often a significant distance away from their family and home (Cousins & Holmes, 2021). In practice, caregiver involvement and systemic exploration typically involves weekly evidence-based family therapy or parental education groups on an outpatient basis (NHS England, 2018). This is often complicated by caregivers having to travel considerable distances for short appointments, which is further exacerbated by caregivers existing histories with services and relational dynamics (Johnson, 2000). Although the practice of admitting lone children and focusing predominantly on individual work has been found to be effective (e.g., Jacobs et al., 2004; Tulloch et al., 2008), there has been limited research examining potential negative consequences or comparing it with alternative inpatient treatments (Green et al., 2007).

Some argue that handing over the care of a child to a clinical team might strengthen the medicalisation of the child’s difficulties (Volk, 2004). Cousins and Holmes (2021) suggest that it could promote a family’s belief that the child needs to be “fixed” by professionals, potentially disempowering caregivers, particularly if symptomology improves during inpatient stay. Separation, especially during times of distress when the child may need caregiver support the most, can be traumatic and painful for both the caregiver and child (Volk, 2004). Additionally, after discharge, the family might find themselves lacking the skills or resources needed to effectively adjust and establish alternative methods of connecting to their child (Gross & Goldwin, 2008). This could result in the dynamics within the home environment remaining unchanged, potentially leading to a cycle of "recovery" followed by readmission (Brendler, 1987). This underscores the importance of offering alternative inpatient care packages that prioritise intensive caregiver engagement, providing flexibility for varied treatment approaches on a case-by-case basis.

In recognition of the disadvantages of the predominant lone child admission approach, a novel treatment of admitting a family or child and caregiver was created. This approach recognises the whole family holistically as a unit for exploration and focus of change, as opposed to just the individual child in isolation (Holmes et al., 2011). Holistic family work promotes second-order change, which involves altering the environment and family system rather than attributing the problem solely to the child (Hanrahan, 1986). Clinicians are able to assess parenting styles and attachment patterns directly and utilise caregivers as a resource in treatment (Rimehaug et al., 2012). For example, the clinical team can observe difficult parenting situations directly and help caregivers identify individual sources of stress, develop stress management skills, and enhance positive parenting practices (Von Wirth et al., 2023). Additionally, it is common in this population for caregivers to have their own mental health challenges and histories of trauma that will understandably impact on the family system (Ghanizadeh, 2008). Joint admission enables such difficulties to be explored during their inpatient stay (Ise et al., 2015). From an attachment perspective, this affords caregivers to become more emotionally available and nurturing, strengthening relational security for their child, conducive to long-term change (Dunst & Kassow, 2008).

At present, there are only seven known CAMHS inpatient units worldwide that admit the caregiver with the child. This is predominately due to the lack of research in this novel model, alongside higher costs associated with admitting several family members. One such unit, The Croft Centre, is located in the UK. Given the scarcity of joint admission units, there has been a dearth of research within this area. Globally, initial evidence indicates that inpatient family units positively influence family functioning (Ickel et al., 2004). In terms of parental outcomes, family inpatient units in Sweden (Hansson et al., 1992), Germany (Ise et al., 2015), and Norway (Rimehaug et al., 2012), have reported reduced parental strain and improved parental mental health, self-efficacy and warmth following joint admission, maintained at twelve-month follow up. In terms of child outcomes, admission to a family unit in Australia led to reduced child emotional and behavioural difficulties at discharge (Volk, 2004). Additionally, Ise et al. (2015) found improved teacher ratings of children's disruptive behaviour at school in the German family centre. Within this centre, Von Wirth et al. (2023) explored predicators of treatment outcomes and found family inpatient treatment was particularly effective for children in families with lower parental education and a history of harsh parenting. This study illustrates the bidirectionality of child and caregiver relations and these findings collectively offer promise for the effectiveness of joint admission on caregiver, child, and family outcomes. However, it is important to acknowledge that these studies utilised pre-post within-subject designs, without a control group, thus, causal inferences should be made with caution.

Volk (2004) conducted qualitative interviews focused on the theoretical orientation, practices, and outcomes of clinicians. Thus, there remains a notable gap in the literature concerning the experiences of caregivers. Recently, Shilton et al. (2023) conducted interviews with parents who had undergone a one-week joint admission to a child psychiatry inpatient unit in Israel. Themes around (1) initial ambivalence and confusion of parents, (2) gradual process of separation from child during joint stay at ward, (3) building confidence and trust toward the staff, were identified. While this provides an initial exploration of caregivers' experiences during brief joint admissions, the current study aims to expand on this by investigating the impact of longer admissions specifically on the caregiver-child relationship.

Therefore, the current study will employ a qualitative design to hear first-hand caregiver experiences of joint admission to a Tier 4 CAMHS inpatient unit. The research focuses on the caregiver-child relationship dynamics, aiming to answer the research question: What are caregivers’ experiences of the impact of joint admission to a children’s mental health unit on their parenting practices and relationship with their child?

Methods

Ethical Approval

Ethical approval was gained from the NHS Health Regulation Authority (Ref: 23/WA/0195; Appendix C). Principles of the Code of Human Research Ethics, provided by the British Psychological Society (BPS, 2021), were adhered to.

Design

The study adopted a qualitative design, frequently utilised to explore the intricacies of service user experiences, particularly amongst underserved communities. This approach provides a means to articulate the voices and narratives of this unique group, thereby granting them agency and visibility within the scholarly research discourse (Smith, 1996).

The researcher ascribes to a critical realist philosophical stance. Critical realism espouses a realist ontological stance positing that reality exists independent of our perceptions and theories (Archer, 2007). However, it acknowledges the inherent challenge in directly capturing reality due to its interpretation through the lenses of our brains, language, and culture (Wiltshire & Ronkainen, 2021). Therefore, critical realism adopts a relativist epistemological stance, asserting that knowledge is obtained by interpreting meaning to explain elements of reality (Wynn & Williams, 2012). This framework aims to foster a mediated reflection of reality through perspectival and contextual truths (Bhasker, 1979). Thus, it is discerned that the understanding attained in this study is an amalgamation of both interviewee and interviewer experiences, perspectives, and the broader social context. A critical realist approach aligns with the research question as it presupposes a shared reality whilst accommodating diversity in experiences based on various aspects of parental and family social contexts.

Participants

Participants comprised caregivers who had undergone admission at The Croft Child and Family Unit within the past three years, have been discharged from the service, and are in a position to reflect upon their journey. The term caregiver is utilised throughout this paper to inclusively refer to both parents and guardians who have the responsibility of raising children.

The Croft is an eight-bed unit that offers time-limited assessment, formulation, and treatment, for children under the age of thirteen and their caregivers. Admission criteria include:

- children with severe and complex developmental or psychiatric disorders associated with significant safeguarding or safety risks to themselves, or others, to a degree where they are no longer able to be managed safely in the community.
- children requiring specialist intensive mental health support rehabilitation under close observation away from their home environment.

Over the past three years, the main recorded reasons for admission have been eating disorders (51.28%), followed by challenging behaviour (encompassing emotional dysregulation, verbal and physical aggression; 20.51%), OCD (7.69%) and Pervasive Arousal Withdrawal Syndrome (PAWS; 7.69%).

All caregivers receive family therapy, drama psychotherapy group, and behavioural management support during their admission. Many caregivers also engage in dyadic developmental psychotherapy. In addition to family-focused interventions, children receive a range of input including psychology, arts-based therapies (such as music, drama, and art), and a dialectical behavioural therapy skills group.

A total of 10 caregivers were recruited for this study, utilising a volunteer purposive sampling method. In line with reflexive thematic analysis (RTA), this sample size enabled significant reflection and depth of engagement with each transcript, enabling situated and reflexive interpretation (Braun & Clarke, 2021). There was a high information power (Malterud et al., 2016) as each caregiver holds rich, multi-faceted experiences of this novel treatment approach. RTA does not subscribe to the notion of data saturation as research is viewed as a reflexive, situated, and theoretically embedded practice of knowledge generation, with limitless potential for new insights (Saunders et al., 2018). The sample is homogeneous regarding the common factor of joint admission with a child with significant mental health difficulties, however this research also aims to capture the heterogeneity of the sample, encompassing the different socio-demographic lenses through which participants experience and articulate their reality (Braun & Clarke, 2006).

Measures

Data was collected utilising semi-structured interviews, providing a loose structure within which topics of interest were explored. The interview schedule (Appendix D) was developed collaboratively with (1) the research team, (2) The Croft’s multidisciplinary team (MDT; including a ward manager, nurse, healthcare assistant, occupational therapist, consultants, clinical psychologists, and family therapists), (3) a caregiver with prior admission experience at The Croft.

Procedure

The gatekeeper at The Croft had collected a list of caregivers who expressed interest in research participation at discharge. The gatekeeper sent the study poster (Appendix E) and the permission to contact form (Appendix F) to these caregivers. Researchers sent caregivers the information sheet (Appendix G), consent form (Appendix H), and demographic sheet (Appendix I) via email. Caregivers engaged in an initial telephone conversation with one of the researchers to discuss the study details, address any queries, and arrange a mutually convenient time for the interview.

Semi-structured interviews took place on Microsoft Teams, lasting approximately ninety minutes. The interview comprised two parts, aligning with two separate doctoral research projects (Appendix J). The first part addressed another researcher’s project, exploring caregivers' experiences of undergoing their own therapeutic work and their wellbeing. The second part focused on the parenting practices and the caregiver-child relationship, the focus of the present study. The two researchers conducted half of the interviews each, that were video recorded, transcribed, and anonymised. Below, the data is presented verbatim, although pseudonyms have been used to protect participants' identities. Ellipses have been used to indicate pauses, omitted interjections, or brief tangents. Circular parentheses have been used to protect potentially identifiable information. Square parentheses have been used to provide important context for isolated participant quotes. Participants were sent a debrief form (Appendix K), offered a summary of the study's findings, and a £10 voucher as a token of gratitude.

Data Analysis

Data was analysed using RTA adhering to Braun and Clarke's (2021) six-phase process. RTA was chosen as it considers individual subjectivity and groups experiences into something broader that represents themes across caregivers' lived experience of this novel systemic treatment approach as a whole (Braun & Clarke, 2006; Appendix L).

An experiential orientation and inductive approach to analysis was adopted, whereby data was open-coded to explore meaning ascribed by caregivers (Braun & Clarke, 2013). Yardley's (2008) principles for evaluating the quality of qualitative research was adhered to, including sensitivity to context, commitment and rigour, transparency and coherence, and impact and importance. Furthermore, Lincoln and Guba (1986) criteria of credibility, transferability, dependability, and confirmability were considered. Consistent with a critical realist theoretical perspective whereby reality is captured indirectly, the subjectivity of the researcher should be acknowledged and therefore investigator triangulation was deemed unnecessary (Denzin, 1978). The researcher kept a reflexive journal (Appendix M) to align with the central tenet of RTA, which underscores the significance of the researcher's position and contribution as integral components of the analytical process (Wagstaff et al., 2014). RTA appreciates that knowledge generation is inherently subjective and situated and this is treated as a resource for doing analysis (Gough & Madill, 2012).

Results

Demographics

The 10 caregivers were aged between 39 and 62 years old (*M* = 49.4, *SD* = 8.25), including six females and four males. 80% of caregivers (*N* = 8) described their ethnicity as White-British or White-Other, with 20% (*N* = 2) identifying as other ethnicities (due to the small sample, further details are not presented to protect participant anonymity). Of the six caregivers who provided socio-economic information (via free text entry), there was a mix of responses, predominantly self-identifying as middle class, however ranging from working class to upper-middle class. Of the seven caregivers who provided sexual orientation descriptors, 100% identified as heterosexual. Three caregivers had one child, five had two children, and two had three children. The gender of the index child was predominantly female 70% (*N* = 7), and 30% (*N* = 3) were male. The length of admission ranged between 10 to 31.29 weeks (*N* = 10, *M* = 19.01, *SD* = 6.68). The length of time since discharge ranged from 44.86 to 150.86 weeks (*N* = 10, *M* = 91.52, *SD* = 44.80).

Summary of Themes and Subthemes

Four themes were identified as follows: (1) Acceptance and Exoneration, (2) Respite After Battle, (3) Understanding, Adaptation and Trust, (4) Navigating Control and Power Dynamics in Co-Parenting. The themes and their respective subthemes are outlined in Table 3.1.

Table 3.1

The Summary of Themes and Subthemes

Theme	Subthemes
Acceptance and Exoneration	• Self-Approval • Blame and Guilt • Journey to Validation
Respite After Battle	
Understanding, Adaptation and Trust	• Parental Cognizance • Parenting Tools • "He Knows He is Not on His Own"
Navigating Control and Power Dynamics in Co-Parenting	• Regaining Control • "Broad Brush Approach" – Power Imbalance

Theme 1 Acceptance and Exoneration

The first theme consisted of three subthemes: ***Self-Approval, Blame and Guilt,*** and ***Journey to Validation***. This theme captured participants' journey from feeling at fault for their child's difficulties, to a place of acceptance, recognising their strengths and resilience amidst challenging circumstances.

Self-Approval

Caregivers expressed that their perceptions of themselves, and their parenting abilities, shifted from a place of self-doubt prior to admission, to self-assurance during admission.

> *I probably learnt that actually I'm doing a really good job. That actually, I have been doing quite a lot of things right and not a lot wrong. -Lydia*

This self-approval helped participants shift towards having more trust in their own parenting ability.

> *I am a better parent than I thought that I was… it taught me to trust myself that I do actually know. -Neha*

Caregivers reflected on their coping abilities whilst enduring adversity, describing an awareness of their resilience.

> *I did definitely learn that I'm much tougher than I realised. Because I think if you can come through that still standing, I think you're doing alright… I think I learned a certain humility when faced with things that are bigger than you. -Noah*

> *When we went in, I felt very responsible for it was for me to sort these things out, to fix these things, and if I did the right things, we wouldn't have been in The Croft in the first place. The staff sort of explained to me that actually wasn't the case, that I'm not responsible for everything and you know things happen and I haven't got to fix everything. -Canyon*

Caregivers articulated releasing a self-perception of sole control and responsibility for their child's wellbeing and acknowledging forces larger than oneself. This recognition of larger contextual forces was perceived as influential in fostering a sense of acceptance within their caregiving experiences.

Blame and Guilt

Caregivers grappled with intense feelings of blame, attributing, and internalising their child's struggles to parental shortcomings.

> *I felt like I had done something wrong, which was why she got ill. So, her getting better was massively linked to my own sort of feelings of self-worth and success, like oh my goodness, I'm just a rubbish mum. -Juniper*

Throughout admission, caregivers reported gaining new insights into the complexities of their child's condition and the broader multifaceted context of mental health and neurodiversity.

> *It's my fault, everything is my fault, I can't do nothing, nothings right, what is wrong, she hates me, I can't win, I can't manage her, into coming into The Croft, it's ok, let it go, let it be. -Lydia*

Noah explained how releasing himself of the burden of blame allowed him to shed pressure of being a *"hero dad"*, which paradoxically led to his relationship with his child becoming *"stronger than ever"*. Caregivers implied that they experienced a clearer sense of their own values, less clouded by emotionality, leading to what was described as a more balanced emotional connection with their child. Recognising their dedication and care for their child appeared to contribute to a newfound sense of confidence in their parenting abilities.

> *I think before I went just thought I'm a failed parent whose child has become unwell... I felt guilt or unhappiness in myself as well. But now I think, I felt that admission gave*

> *me perspective to think, you know, how caring and how loving I have been towards her… I'm not a bad parent and it's not because of me… which has helped me to develop confidence as a parent and continue to improve and learn. -Rima*

There were nuanced variations in caregivers' experiences and interpretation of guilt and blame. Some caregivers internalised blame, linking it to their own sense of self-worth, others viewed it primarily as a parenting issue, rather than a reflection of their intrinsic worth.

Journey to Validation

Caregivers highlighted that joint inpatient admission provided validation, offering a sense of understanding and empathy in their journey. They noted that receiving positive recognition, reassurance, and feedback affirmed their parenting abilities and practices.

> *I think (wife's name) would look back on and say that possibly one the most important things for her was that it gave her validation that you know things what she was doing was right. -Summit*

> *(Family therapist at The Croft) would just say one very small sentence which showed that he felt that I wasn't going mad… I think being heard is more important than being validated, the latter often follows the former. -Noah*

Validation provided by both inpatient staff and fellow families served as a stark juxtaposition to the sense of stagnation and hopelessness that caregivers experienced prior to their child's admission.

> *I just feel like completely exonerated. It's just like I was going to be serving a life in prison and someone came along with a magic wand and said its ok we have the answer. -Lydia*

Theme 2: Respite After Battle

This theme encapsulates the journey of many caregivers from a state of relentless battle to secure support for their child's mental health needs. Caregivers had experienced feelings of despair and entrapment in the community due to trauma and systemic disempowerment within the healthcare system. This led to profound relief and much-needed reprieve upon admission. The distress felt by many caregivers prior to admission was notably traumatic, evident in the tone of anguish in their voices.

> *And they turn up and then say in front of him, oh we are going to have to consider sectioning him and, you just like, excuse my language here, are you ****ing kidding? We've been asking for help for three months now. -Noah*

> *It was almost like a lightning strike in that respect because I know there's only six beds there and that's the only place in the whole of the UK, I don't regard myself as a particularly lucky person and to find we actually got a place there, you know, I don't want to look at it in a kind of fateful fashion, but God knows what we'd have done. -Jacob*

Upon admission, a significant burden was alleviated, creating space to reflect on alternative methods to assist their child. This transition was perceived as a move from feeling overwhelmed and stagnant to adopting a more flexible and proactive parenting approach.

Moreover, receiving support and validation enabled some caregivers to feel closer to their child and less isolated in their challenges.

> *For years and years and years it's been me fighting the battle and me fighting the corner and me advocating for her and trying to get things done and things right, you know, banging your head on a wall… it's been lovely [The Croft] because I feel like you're holding my hand… you come somewhere that does listen to you. -Lydia*

> *Going into The Croft just relieved that massive pressured burden that we had, and also allowed us to look after our other child... it was just like a huge weight had been lifted… it allowed us to just to take a step back and look at different way of actually supporting (index child's name). -Summit*

Summit's insight highlights the significance of creating a reflective space, not only for the immediate caregiver-child relationship but also for the broader family dynamic. This emphasises the interconnectedness of family systems, where changes in one aspect can reverberate positively throughout the entire unit.

Theme 3: Understanding, Adaptation and Trust

The third theme consisted of three subthemes: ***Parental Cognizance***, ***Parenting Tools***, and ***"He knows he's not alone"***. This comprises caregivers improved knowledge, understanding and adaptation to their child's idiosyncrasies, leading to a reported increased perceived trust from the child towards the caregiver.

Parental Cognizance

Caregivers reported that joint admission facilitated awareness and greater sensitivity to their interaction styles with their child. This fostered an environment where their child felt more at ease in seeking support and being listened to by their parents.

> *What was highlighted was my very sunny positive character and (child's name) doesn't seem to be able to cope with that very well… my always finding positive solutions to things... so I learned that this is something that is not always helpful, so I try to tone that down a bit for (child's name) benefit and you know that's something I'm constantly aware of. -Canyon*

> *I came more understanding if there is anything you know they wanted to share with me or I want to share with them, I'm a bit more you know I think calm listener now compared to coming to giving them solutions… when the children are sharing with you, how important it is to check upon them or giving them that confidence that you are here to listen. -Rima*

Caregivers recounted the usefulness in their child receiving diagnoses as this provided them with an explanatory framework to understand their child's presentation. Armed with this understanding, caregivers engaged in reflective practices and sought guidance to tailor their parental approaches according to their child's unique needs. This encouraged a deeper and more meaningful bond between caregiver and child. This adaptive approach not only enhanced the caregiver's ability to meet the child's specific requirements but also facilitated a more responsive and supportive caregiving environment.

> *It's almost like education isn't it really, how you deal with someone with severe OCD and autism… stop your sense of humour…cause (family therapist at The Croft) said (child's name) probably won't be able to decipher what you really mean… you just got to be very black and white with him. -Jacob*

> *I think I've got a better understand now of (child's name) condition and you know the autism, the impact its hard without doubt…things like being much more aware of the time it takes to process things and to do things, so you've got to be thinking ahead, whereas I never really sort of thought like that…You can't talk them out of it once it's sort of like emotion you know they have to…as long as they're safe, they have to be able to almost like self-regulate themselves… It was OK for her to have that time, to then recalibrate. -Summit*

Caregivers commented on the usefulness in externalising the disorder as it helped their understanding and compassion toward their child's struggle. This enabled both the caregiver and child to work as a team to challenge the disorder collaboratively.

> *It gave me the breathing space to be able to work out what is an appropriate response to somebody with an eating disorder and try and understand it a bit more… not losing your temper with her but knowing and talking about it [eating disorder] as a separate thing from her… like this is an illness. This is not you. -Randa*

Joint admission facilitated a deeper understanding amongst caregivers of their child's presentation, encouraging parental validation and adjustments, that together reportedly cultivated a supportive environment where the child was perceived to be more comfortable in seeking help.

Parenting Tools

Caregivers commented that joint admission increased their parenting practical strategies and metaphorical tool kit. The acquisition of new tools and techniques led to caregiver reporting to feel more able to intervene effectively in family interactions and address underlying issues that might contribute to relational challenges. Caregivers highlighted the advantage of adopting new strategies with the aim of achieving short-term goals, noting how this gradual process resulted in significant changes in their child's presentation over time.

> *It gave me some new tools as to how to manage situations. And certainly, the family therapists work on this principle of small shifts…. I soon began to understand that a tiny shift leads to a tiny shift. And then suddenly you look two weeks and there has been ten shifts and you can actually track those… you know what (The Croft family therapist names) preach "you can't resolve a situation in a fell swoop" you can only be patient and create small shifts and then eventually you might reach the holy grail of second order change so that really was a life lesson that I tried to do with my children. -Noah*

Caregivers acknowledged the inherent difficulty of this endeavour, however highlighted the benefit of "live" observation and support from inpatient staff in implementing the new strategies. This collaborative partnership between caregivers and inpatient staff appeared to play a pivotal role in facilitating positive changes in their relationship with their child.

> *I have some new techniques that I now implement. However, if someone had just taught me, that wouldn't have worked, we had to be there, I had to walk it through. -Lydia*

> *I think the professionals I could check upon and I could get feedback and I think that was a really important thing so that I thought my parenting actually got really better. -Rima*

"He Knows He is Not on His Own"

Caregivers expressed that joint admission and enduring adversity together (caregiver-child) perceivably helped their child to realise that they are not alone in their struggles, instilling a sense of reassurance in their caregiver's unwavering support.

> *What has helped him is that he knows he is not on his own. He realised mummy and daddy were all the way with him to understand and everything they go through and all these therapies. -Charles*

> *The trust between me and (child's name) is even stronger than ever now. Like if he has a problem whatever, I told you I will be there, it's a journey I did with you, I never lie, I was there, and he knows he can depend on his mum and dad more than ever. -Jacob*

Caregivers noted that their reliability and dependability during challenging times were acknowledged by their child, resulting in perceived heightened trust, mutual understanding, and a stronger caregiver-child relationship.

> *She knows that I was there looking after her... You can tell a child that "I do all of this for you" but (child's name) knows that. (Child's name) knows that I work hard for her. So, in that respect it's changed, because she kind of like values me a little more and trusts me to do the right thing for her. -Lydia*

Theme 4: Navigating Control and Power Dynamics in Co-Parenting

The fourth theme encompassed the subthemes ***Regaining Control*** and ***"Broad Brush Approach" - Power Imbalance***. It explores caregivers' journey to regain authority within the caregiver-child relationship, amidst navigating power dynamics with co-parenting. It highlights some caregiver frustrations with externally imposed boundaries and underscores the imperative for a nuanced comprehension of their child's behaviour.

Regaining Control

This theme depicts caregivers' efforts to regain authority and boundaries within the caregiver-child relationship. Caregivers expressed feelings of being overwhelmed and lacking authority before joint admission, but during their inpatient stay, they regained a sense of control with the support of staff members. Further, caregivers reflected on lowering their threshold of what they would tolerate in terms of externalising difficulties.

> *You have to remember that I am the parent here, not you, and no matter what you think, I do have the say at the end of the day. -Lydia*

> *How to deal with the caveman or a tiger… (child's name) was in charge and we had to regain some control… we are mummy and daddy, and whatever happens on the*

> *tantrums and the distress, there is still a child in there, and where to regain control as parents. -Charles*

Caregivers commented on how joint admission allowed them to not be scared of their child, or by concealing their fear, they were more able to implement boundaries. By adopting a more assertive stance, caregivers were able to maintain their own emotional equilibrium whilst effectively managing the dynamics in the family system.

> *If you are imposing boundaries, you keep doing that until the penny drops and that consistency is very important. It also taught me not to be scared of my children…they talk a lot about holding the line at The Croft…so it was just those sort of little refreshers that reminded me that's how I had to be. -Noah*
>
> *Keeping some of the fears that I felt back was very important for us in moving forward… it was like actually before I'd be too worried about her wellbeing… like well "if I can't go to football, I might cut myself", and actually it was like you've got to stop being scared of that or just hide the fact and not be so open with your emotions and you know just follow through. -Juniper*

"Broad Brush Approach" – Power Imbalance

Some caregivers noted that co-parenting with the inpatient team posed a challenge, as they felt external imposition of rules and boundaries deprived them of decision-making agency, leading to a sense of disempowerment.

> *I definitely came out feeling very disempowered, because at The Croft other people had put the rules and boundaries in place, and I was sort of trying to support those boundaries, but it was somebody else's choice. -Juniper*

Caregivers expressed frustration at the imposition of one-size-fits-all behavioural management techniques by the inpatient team. Caregivers highlighted the need for a more nuanced, idiosyncratic understanding of their child’s behaviour, particularly in the context of neurodevelopmental diagnoses.

> *There’s a sort of broad brush approach…something called 123 Magic... it’s just sort of rewarding good behaviour and not that especially complicated anyways, you know, it’s fine if you’ve got a child that responds to that…but when you throw in an illness or the diagnosis of say autism or something like that, I think it becomes a bit more complicated than that. -Randa*

> *Whatever was wrong, you have the 123 magic and sometimes I think you do have to understand that you're dealing with a quite an ill child and also an autistic child and has like significant other issues with it as well, it's just sometimes I think you know that probably wasn't the best and could have dealt with it differently. -Summit*

Further, Neha highlighted that as a parent she was not looking to impose strict control and boundaries onto her child, but rather trying to understand that unmet needs of her child, in line with attachment parenting principles. However, she felt unsupported by the inpatient team in this approach, speaking to the broader issue of power dynamics. She conveyed how the professional perspective was given precedence over her lived experiences, recognising that in matters concerning her son, she holds the expertise.

> *Then one meeting they told me that I needed to empower myself as a mother and I said “I am not disempowered. I’m unsupported”. They’re two very different things. -Neha*

Neha's unwavering advocacy paradoxically engendered a sense of validation and fortified her confidence in her parenting approach.

> *There's this frustration because I'm like, if you listen to me, the impact that the collaboration between them and me could have had would be so much greater…What happened was in this kind of conflict with the ward, it made me even more secure in the parenting style that I've chosen…Afterwards he [son] would say thank you or he would express like, you know, they were so stupid because they didn't get it, even though you're explaining it to them, so there has been a strengthening in our relationship -Neha*

Neha reported a schism in co-parenting dynamics, with Neha and her son on one side, and the staff on the other. Feeling united on the 'same side' cultivated greater reported trust from her son.

This underscores the rich tapestry of attitudes amongst caregivers regarding the notions of control and authority, likely related to differing socio-demographic lenses, histories, education, existing parenting practices and stances. While some articulated a keen appreciation for these attributes and demonstrated proactive efforts to cultivate associated skills, others advocated for a collaborative, less authoritarian approach. This spectrum of perspectives illustrates the nuanced landscape of parenting ideologies and the diversity of approaches taken by caregivers in navigating the complexities of parenting.

Discussion

The aim of this study was to explore caregivers' experiences of joint inpatient admission, specifically the influence on both parenting approaches and the caregiver-child relationship. Thematic analysis identified four overarching themes: (1) Acceptance and Exoneration, (2) Respite After Battle, (3) Understanding, Adaptation and Trust, (4) Navigating Control and Power Dynamics in Co-Parenting.

The first two themes identified were congruent to Shilton's (2023) findings, depicting the desperation and helplessness of caregivers at the point of admission, after a history of feeling let down by services, and their child's behaviour escalating to a point of feeling stuck and trapped in the situation. Many caregivers had internalised this, and experienced feelings of guilt and responsibility for their child's presentation. These findings resonate with broader literature on caregivers of hospitalised children, as highlighted in Weller et al.'s (2015) systematic review on the effects of psychiatric hospitalisation on caregivers that found stigma manifested in caregivers' self-devaluation and feelings of shame. Within FST (Bowen, 1966), caregiver internalisation might be understood as increased fusion, or a lack of differentiation (a sense of intense responsibility for another's reactions within a relationship), thus creating a cycle of reciprocal anxiety. The current study highlights the potential benefit of joint admission in understanding and changing parental distress to support second-order change (Hanrahan, 1986).

Within the analysis, many caregivers reported that psychological techniques that specifically targeted self-blame, such as normalisation and validation, were particularly useful for them. Perlick et al. (2011) examined interventions designed specifically for parents of people with serious mental disorders and found that family members' voices in leading peer-led discussion groups are more effective in reducing family self-stigma than clinician-led psychoeducation. This aligns with findings from the current study, whereby caregivers shared that augmented parental acceptance and validation, was aided through both the provision for shared caregiver support and psychological guidance from the inpatient team.

Many caregivers reported increased parenting skills, understanding, and regained control in the caregiver-child dynamic following joint admission. This is aligned with prior quantitative research (Hansson et al., 1992; Rimehaug et al., 2012; Ise et al., 2015), with caregivers' voices providing a deepened understanding of the possible context of this shift. Caregivers identified pivotal factors that they perceived led to a strengthened caregiver-child relationship and an improvement in their child's presentation. These included setting graded goals, acknowledging small behavioural shifts, shared formulation of child's difficulties, shared awareness of family dynamics, reimplementing family roles, maintaining parental emotional equilibrium and collaborative co-parenting. The nature of joint admission supports these mechanisms through intensive MDT guidance and hands-on observation and support, viewing the whole family as a unit for change. The guidance happens 'live' in the moment, rather than caregivers receiving feedback on a weekly basis, as would be standard in traditional under 13 inpatient units. Despite some commonality amongst caregivers, it is crucial to acknowledge nuances in caregivers' experiences and parenting styles, influenced by individual, societal and cultural contexts.

In acknowledgement of this diversity, some caregivers articulated that the more challenging elements of joint admission were predominantly around power imbalances between professionals and caregivers. Power imbalances are well-documented within inpatient literature (e.g., Cleary, 2003; Scholz et al., 2018). Qualitative research serves as a vital mechanism for inclusively engaging with marginalised, underserved communities in terms of experiential expertise. By heeding caregivers' recommendations, scholarly discourse can advance strategies to redress these disparities. Caregivers voiced the need for the joint inpatient unit to adopt a more nuanced, individualised approach and to promote collaboration by encouraging professionals to actively learn from caregivers’ lived experiences and expertise of their child. These narratives enrich our understanding of power dynamics, particularly within the milieu of joint admission where co-parenting complexities might have the potential to intensify power dynamics (Foster & Whitehead, 2017).

Moreover, while many caregivers articulated feelings of gratitude for finally receiving adequate support and the opportunity to accompany their child during admission, it is essential to recognise the nuanced nature of this emotion. Gratitude, although often perceived as positive, may also signify deeper states of chronic desperation, reflecting underlying feelings of disempowerment, shame, and frustration (Galvin, 2004). Caregivers voiced feeling let down by services, feeling abandoned and stuck prior to admission, highlighting the importance of considering the broader political and social context of the NHS when interpreting narratives.

Limitations

Firstly, in terms of credibility (Lincoln & Guba, 1986), the researcher who conducted interviews and analysed the data is not part of the clinical team at The Croft. This might have offered the advantage of neutrality so that participants’ felt more freely able to express their honest view. However, it must be acknowledged that some contextual knowledge may not represented due to reduced familiarity with the phenomenon and research context (Miles & Huberman, 1994). Secondly, in terms of transferability (Lincoln & Guba, 1986), the study utilised a volunteer purposive sampling strategy, that holds the risk that caregivers who are more passionate or opinionated on the subject of joint admission, or possess certain demographics, may be more likely to participate and therefore might be overrepresented in the sample (Stukas et al., 2015 Consequently, caution should be exercised when generalising the findings to the broader population of caregivers, as the sample may not fully capture those with more moderate or diverse experiences.

Finally, caregivers' reflections may be influenced by the duration of time elapsed since discharge, which varied greatly within the sample. This study captured caregivers' reflections at a single time point; however, it must be recognised that caregivers may be at different stages of processing their experiences, which are likely to be fluid and subject to change over time. Additionally, there is a potential for recall bias in retrospective interviews, as reliance on memory may affect the depth of the reflections provided.

Future Research

This study offers a springboard for future research to further investigate this novel approach. Future research could include a longitudinal measurement with a comparison group to compare experiences and outcomes between joint admissions and traditional lone child admissions. It would also be advantageous from an economical perspective to conduct a cost-benefit analysis on these two approaches. Bornstein et al. (1985) highlighted that the costs associated with inpatient family treatment need to be balanced against the usual alternative costs of long admission of the child alone and sustained involvement by multiple agencies.

The present study focused on caregivers' experiences as this was deemed best served to answer the research question directly relating to parenting practices and caregiver-child relationship dynamics. Their adult perspective might have allowed for deeper reflections that contextualise and interpret the impact of joint admission on family dynamics, capturing broader relational and emotional patterns. Additionally, caregivers’ narratives provided valuable indirect insights into the hypothesised experience of their child. However, future studies are needed to qualitatively explore the child’s perspective on joint admission; an area with no literature, to the author’s knowledge, to date. To gain this valuable insight, research materials would need to be designed in a child-appropriate way, as well as tailored to neurodiversity. The inclusion of the child’s perspective would complement the current study’s findings by providing a more rounded understanding of the joint admission experience from both sides of the caregiver-child relationship.

Finally, the sample was limited to caregivers from the UK who attended The Croft. Therefore, future research could encompass participants from other joint inpatient units around the world, inclusive of a more diverse range of ethnicities and cultures, to increase the global discourse and transferability of this novel approach. Specifically, research could examine how marginalisation and systemic trauma interact with cultural frameworks to influence experiences of co-parenting and power dynamics within joint admission.

Conclusions

To the author’s knowledge, the current study is the first to qualitatively explore caregivers’ perspectives of joint inpatient admission on parenting approach and the caregiver-child relationship. The voices of this underserved group are represented, identifying themes around acceptance, exoneration, a chance to step back from a position of feeling stuck, augmenting trust, parenting understanding, cognizance, control, and challenges of power dynamics.

Through the lens of caregivers, this study deepens our understanding of the novel approach of joint inpatient admission.

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Chapter Four: Overall Discussion and Critical Evaluation

This chapter provides a discussion and critical evaluation of the entire thesis portfolio. It begins with describing the overall aim of the portfolio, followed by a discussion of the findings of the meta-analysis and empirical paper. Strengths and limitations are then discussed, followed by theoretical and clinical implications, and suggestions for future research. The chapter ends with an overall conclusion of the portfolio.

Thesis Overall and Summary of Findings

The overarching aim of this thesis was to explore caregiver experiences and child outcomes in specialist child and adolescent mental health programmes. The meta-analysis synthesised the efficacy of ACT for children and adolescents from ill health to thriving. The empirical paper explored caregivers' experiences of joint admission to a children's mental health unit and its impact on their parenting approaches and relationship dynamics with their child.

The exploration of these two distinct interventions contribute to the broader aim of advancing understanding of alternative therapeutic interventions, with a growing evidence base, within the stepped-care model of CAMHS. Research into ACT and joint admission within CAMHS is still in its early stages. This portfolio aimed to advance existing research in these areas, contributing to academic discourse on the efficacy and experiences of these interventions for children and caregivers. This understanding holds significance in clinical practice, enabling the delivery of holistic and comprehensive care to children, adolescents, and families grappling with complexity, especially when initial treatment approaches have failed to generate clinical improvements.

To the authors knowledge, this is the largest and most comprehensive meta-analysis to date synthesising the effectiveness of ACT for children and adolescents. Literature searches were conducted across six electronic databases, including studies that employed either RCTs or randomised pre-post designs with a control group, utilising quantitative child-focused psychological outcome measures. The multivariate meta-analyses, including 28 studies, 89 outcome measures, and 1,643 participants, found significant small effects at post-treatment in favour of ACT compared to control conditions for externalising/behavioural difficulties, and third-wave processes, a significant medium effect for internalising/emotional difficulties, and a significant large effect for wellbeing/QoL. Overall, results suggest that ACT may be a promising intervention for children and adolescents across a range of outcomes, to varying effects.

An empirical study followed from the meta-analysis, that, to the authors knowledge, is the first study to qualitatively explore caregivers' experiences of the impact of joint admission on their parenting practices and relationship with their child. 10 caregivers completed qualitative semi-structured interviews and data was analysed utilising reflexive thematic analysis. Four themes were identified as follows: (1) Acceptance and Exoneration, (2) Respite after Battle, (3) Understanding, Adaptation and Trust, (4) Navigating Control and Power Dynamics in Co-Parenting. Through the lens of caregivers, this study deepens understanding of the novel approach of joint admission.

Strengths and Limitations

The meta-analysis offered a comprehensive and broad sweeping overview and synthesis of the efficacy of ACT, inclusive of a variety of settings (e.g., schools, clinics, hospitals), presentations (e.g., non-clinical, developmental, mental and physical health) and delivery formats (e.g., parent interventions, group, individual). This enabled assessment of ACT as a universal intervention applicable across diagnostic categories and along the spectrum from ill health to thriving. The adoption of a multi-level/multivariate random-effects model permitted the inclusion of all effect sizes derived from outcome measures from each included study, whilst modelling the dependence between effect sizes that arose when multiple outcome measures were use on the same sample (Vietchtbauer, 2021). Separate meta-analyses were conducted for distinct outcome domains, that were clinically informed, to increase homogeneity. Study quality was assessed utilising the Cochrane Rob-2 which is based on both empirical evidence and theoretical considerations (Higgins & Green, 2011). Additionally, sensitivity analyses, excluding studies identified as high risk of bias, were reported, and discussed.

It could be argued that prioritising the results and conclusions derived from sensitivity analysis might have enhanced the clarity of the most robust evidence, particularly considering that low-quality studies appeared to inflate effect sizes and heterogeneity. However, the researcher chose to report sensitivity analyses alongside main analyses a priori, as stipulated in the study protocol. Following Thabane et al.’s (2013) recommendations, transparency was maintained by meticulously interpreting and discussing the extent to which low-quality studies impacted the results and robustness of the study.

The inclusion of studies across various settings, diagnoses, and delivery formats aligns with the study's aim of offering an initial, broad, and comprehensive synthesis of the efficacy of ACT for children and adolescents. Additionally, this approach also effectively mirrors the multifaceted ways in which ACT is implemented in clinical practice. The limitations of the meta-analysis largely result from the scarcity and quality of the existing RCTs available for synthesis. Currently, there is an insufficient number of homogeneously conducted studies to provide adequate statistical power for meta-analyses focused on specific mental health conditions, developmental age stages, or types of intervention. Therefore, it is acknowledged that the diversity of included studies precludes the determination of ACT's effectiveness for specific diagnoses, presentations, developmental stages or situations. For example, interventions were included regardless of whether they were delivered directly to children or indirectly via parents or carers, provided the child was the focus of the intervention and a child-focused outcome measure was utilised. Whilst this reflects clinical practice, where interventions for children and adolescents often combine direct and indirect methods, caution is required when generalising these findings to specific contexts. Additional limitations, including issues of sample representation, outcome measurement, heterogeneity, statistical power, and maintenance effects have been considered and discussed.

As discussed above, quality assessment is an integral step of the review process, which has vital implications for the conclusions drawn (Cuijpers, 2016). The use of Cochrane RoB-2 is widely advocated (Eldridge et al., 2016, Sterne et al., 2019), but it has been critiqued for focusing exclusively on research processes (e.g., blinding, randomisation), whilst ignoring clinically important information that is relevant to quality. It might be argued that the NICE quality appraisal checklist for quantitative intervention studies (NICE, 2012) would have been more clinically relevant, allowing for assessment of quality of reporting, sampling, and intervention quality. Further, intervention quality is particularly important to consider as the psychological flexibility model was originally designed for adults, and there is less research and guidance on effective applicability with child and adolescents. Hayes and Ciarrochi (2015) express concerns that ACT has often been poorly applied to children and adolescents, consequently not considering this in the meta-analysis when aiming to determine effectiveness is an area of weakness.

The empirical paper adopted a thorough and comprehensive approach throughout the research process, including designing the methodology of the study. The choice of semi-structured interviews facilitated adherence to the interview topic guide, ensuring that the gathered information remained pertinent to the research question. It also allowed flexibility to capture nuanced and salient information unique to each participant's experience, whilst also facilitating rapport-building (Patton, 2002, Prior, 2018). The researcher also facilitated rapport by utilising clinical skills within interview, displaying warmth, curiosity, and unconditional positive regard (Rogers, 1957), in addition to integrating learnings from qualitative research courses attended (e.g., summarising, reflecting, utilising participant’s own words and phrases).

One of the reasons that thematic analysis was chosen was because it considers individual subjectivity as well as aiming to group lived experiences into something broader that represents themes across caregivers who have undergone this novel systemic treatment approach as a whole (Braun & Clarke, 2006). This analytical approach provided a platform to hear the dominant, as well as less heard voices, listening out for untold stories (Riessman, 2005). The data was coded in accordance with the semantic (explicit, surface level) meaning communicated by the parents, and the latent (implicit, assumptions under the surface) meaning interpreted by the researcher (Patton, 1990). This is reflective of the underlying theoretical assumption of the analysis acknowledging the impossibility of accessing incontrovertible and decontextualised truth (Willig, 2013). Consistent with a critical realist theoretical perspective whereby knowledge generation is inherently subjective and situated and treated as a resource for doing analysis, member checking and investigator triangulation was not deemed appropriate (Denzin, 1978; Gough & Madill, 2012).

Lincoln and Guba's (1986) four-dimension criteria for ensuring trustworthiness in qualitative research was considered. To ensure dependability of the study, the researcher ensured their process was traceable and clearly documented (Tobin & Begley, 2004). This included ensuring a clear audit trial including keeping the records of the raw data and transcripts to help cross referencing data (Halpren, 1983). Transparency of the process was reflected in the appendix of the report including example extracts of the coding and theme development (Nowell et al., 2017). Credibility and confirmability were considered by ensuring prolonged engagement with the data (including rewatching all interviews, reading transcripts), and keeping a reflexive journal (Stahl & King, 2020). The journal included personal, functional, and disciplinary reflexivity, viewing the researcher as an active participant in the research (Wilkinson, 1988). The researcher critically reflected on the analytic process, acknowledging their lenses and positions that influenced interpretations. For example, the following factors related to positionality that might influence unconscious bias and thinking were identified at the beginning of the research, and reflected on throughout the research process:

- Non-parent, Trainee Clinical Psychologist, thereby occupying an 'outsider' perspective. This might hinder ability to ask meaningful or insightful questions (due to no a priori knowledge). However, this might offer the advantages of an external perspective, reduced bias, and a more naïve approach, that together might enable caregivers to feel more comfortable in sharing sensitive information.
- Growing up with an attachment parenting style, with the belief that a child displaying suffering / difficulties is generally a sign of an unmet need.

- Growing up observing and experiencing the impact of mental health difficulties amongst family members leading to an inclination toward a systemic psychological approach.
- Having experience of significant ill physical health throughout adolescence and feeling let down by NHS services.
- White, European, non-religious, female might influence outlook to various topics.

Limitations of the empirical paper, including investigator's authority and sample considerations have been considered and discussed. Alternative analytic approaches, such as Interpretative Phenomenological Analysis (IPA; Smith & Osborn, 2009), were considered. With groundings in phenomenology, hermeneutics and ideography, IPA might have allowed for a more in depth exploration of individual narratives through detailed case-by-case analysis (Zahavi, 2003). Consequently, it is acknowledged that utilising RTA might have resulted in some potential loss of depth and uniquity of each individual participant's experience. However, RTA was selected for its aptness in addressing the overarching research question, particularly considering the novel nature of the population and intervention. RTA's emphasis on discerning overarching patterns and themes corresponds with the objective of encapsulating the multifaceted experiences of caregivers regarding joint admission, including the intricacies and nuances inherent in the dataset (Braun & Clarke, 2021).

Implications and Future Research

ACT has been increasingly used within CAMHS, and more widely across school and community settings. Nonetheless, evidence regarding its efficacy has been lacking. It is imperative to consider the aforementioned limitations, particularly those associated with the availability and quality of current RCTs, when interpreting findings. Consequently, conclusions should be approached with caution, as they may undergo revision in light of the emergence of more robust trials. Nonetheless, the current meta-analysis provides initial support for the effectiveness of ACT for targeting internalising/emotional difficulties, externalising/behavioural difficulties, wellbeing and third-wave processes in children and adolescents. It offers valuable insight into the efficacy of ACT for children and adolescents, relevant for informing best practice guidelines for clinical practice.

ACT was found to have the largest effect on wellbeing/QoL. This outcome domain relates to the promotion of human flourishing, that can be widely applied in non-clinical samples in community setting in the pursuit of mental health prevention. This is particularly relevant in the context of the NHS long term plan, whereby the Children and Young People's Mental Health Green Paper outlines recent increased funding for Mental Health Support Teams to aid preventative strategies in schools and colleges (Department of Health & Education, 2018). This paper offers promising prospects for group-based ACT interventions as a cost-effective and preventive measure that can be implemented within school settings to augment wellbeing.

ACT was found to have a medium effect size for internalising/emotional difficulties, displaying promise for treating anxiety and depressive disorders with CAMHS. Future research should prioritise high quality RCTs on specific diagnostic-specific outcomes, so that future meta-analyses have enough power and homogeneity to differentiate evidence of the efficacy of ACT on different DSM-V disorders.

Similarly potential hypothesis for small effect sizes on third-wave processes have been discussed in relation to the aggregation of multi constructs within this outcome domain. Future research should assess the effectiveness of ACT on the six core principles of the Hexaflex and the overarching concept of psychological flexibility distinctly to assess the extent to which specific predictions from the ACT model are supported. Initial findings have found support that the constructs of experiential avoidance, acceptance, and mindfulness account for variance in ACT treatment for adolescents' wellbeing (Ciarrochi et al., 2011; McCracken et al., 2010). However, studies are predominantly uncontrolled, thus given the developing state of this literature, any inferences regarding efficacy of specific mechanisms of ACT with children and adolescent are premature (Coyne & Mchugh, 2011).

The themes identified and discussed in the empirical paper contribute to a deeper comprehension of first-hand caregiver experiences, enriching our understanding of joint inpatient admission. Moreover, the identified diverse experiences of caregivers discern potential areas of strength and improvements, enriching clinical practice across joint admission units. For example, narratives contribute to a nuanced comprehension of navigating power dynamics inherent in the milieu of co-parenting between caregivers and the inpatient team. More broadly, this study contributes to the nascent evidence base for the novel model of joint inpatient admission. This evidence base collectively contributes to developing scholarly understanding of this unique model, that can be utilised to inform evidence-based recommendations for CAMHS inpatient units.

This study offers a springboard for future research to further investigate this novel approach. As discussed, future research could include a longitudinal measurement with a comparison group to compare experiences and outcomes between joint admissions and traditional lone child admissions. It would also be advantageous from an economical perspective to conduct a cost-benefit analysis on these two approaches. Additionally, future studies are needed to qualitatively explore the child’s perspective on joint admission; an area with no literature, to the author’s knowledge, to date.

Overall Conclusions

Addressing the multifaceted mental health needs of children, adolescents, and their families requires flexible and adaptive approaches, particularly when first-line approaches have not yielded clinical change. This thesis portfolio contributes to scholarly understanding of two emerging practices within the landscape of CAMHS. The meta-analysis determined the effectiveness of ACT for children and adolescents on internalising/emotional difficulties, externalising/behavioural difficulties, wellbeing/QoL, and third-wave processes. The empirical paper explored caregivers' experiences of joint admission to a children's mental health unit and its impact on their parenting approaches and relationship dynamics with their child. This deepened understanding of these two interventions, contribute to the wider goal of augmenting holistic and effective approaches in supporting the mental health and wellbeing of children, adolescents, and their families.

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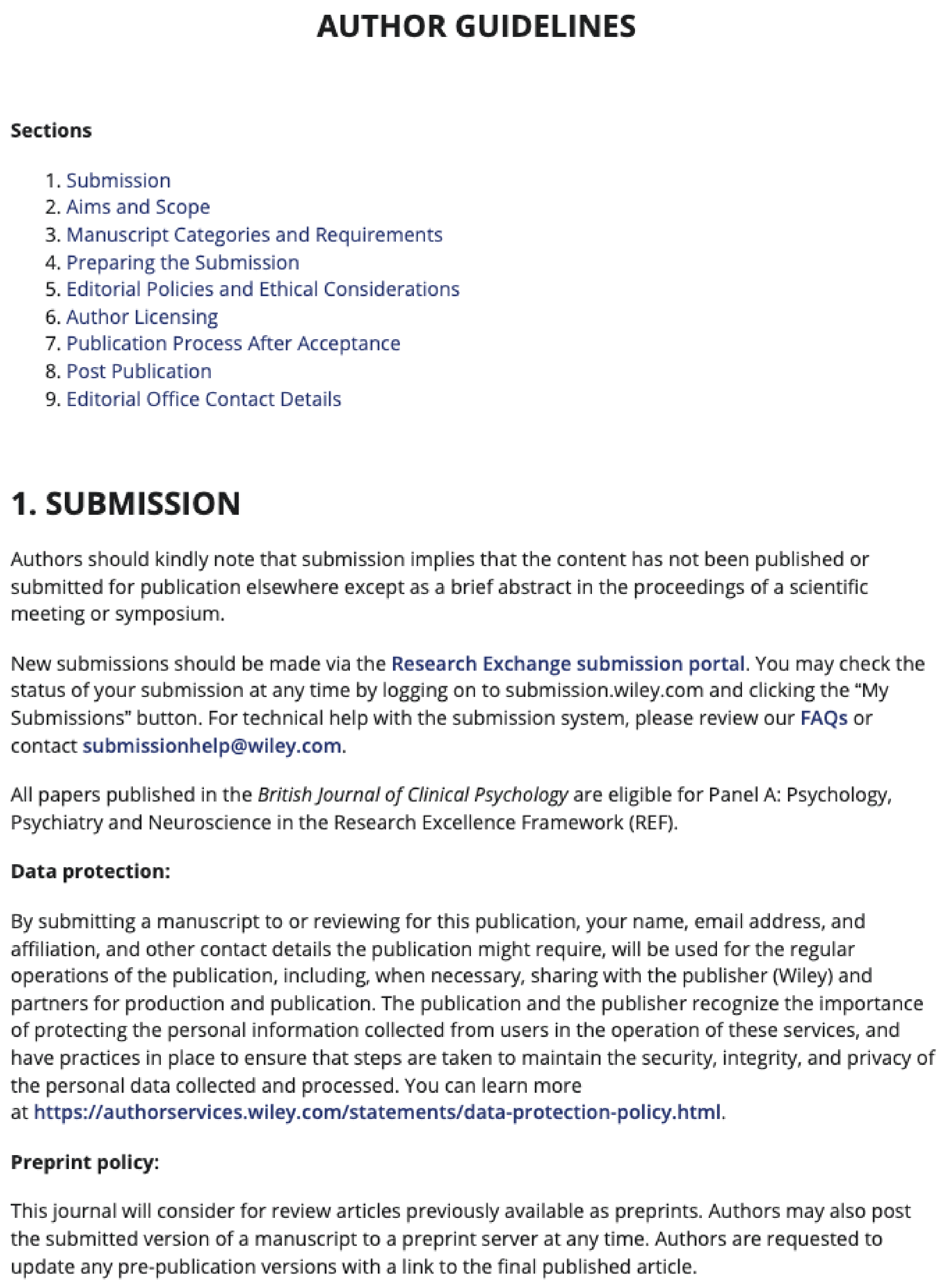
Appendices

Appendix A: Author Guidelines for British Journal of Clinical Psychology (Meta-Analysis)



AUTHOR GUIDELINES

Sections

1. Submission
2. Aims and Scope
3. Manuscript Categories and Requirements
4. Preparing the Submission
5. Editorial Policies and Ethical Considerations
6. Author Licensing
7. Publication Process After Acceptance
8. Post Publication
9. Editorial Office Contact Details

1. SUBMISSION

Authors should kindly note that submission implies that the content has not been published or submitted for publication elsewhere except as a brief abstract in the proceedings of a scientific meeting or symposium.

New submissions should be made via the **Research Exchange submission portal**. You may check the status of your submission at any time by logging on to submission.wiley.com and clicking the "My Submissions" button. For technical help with the submission system, please review our **FAQs** or contact **submissionhelp@wiley.com**.

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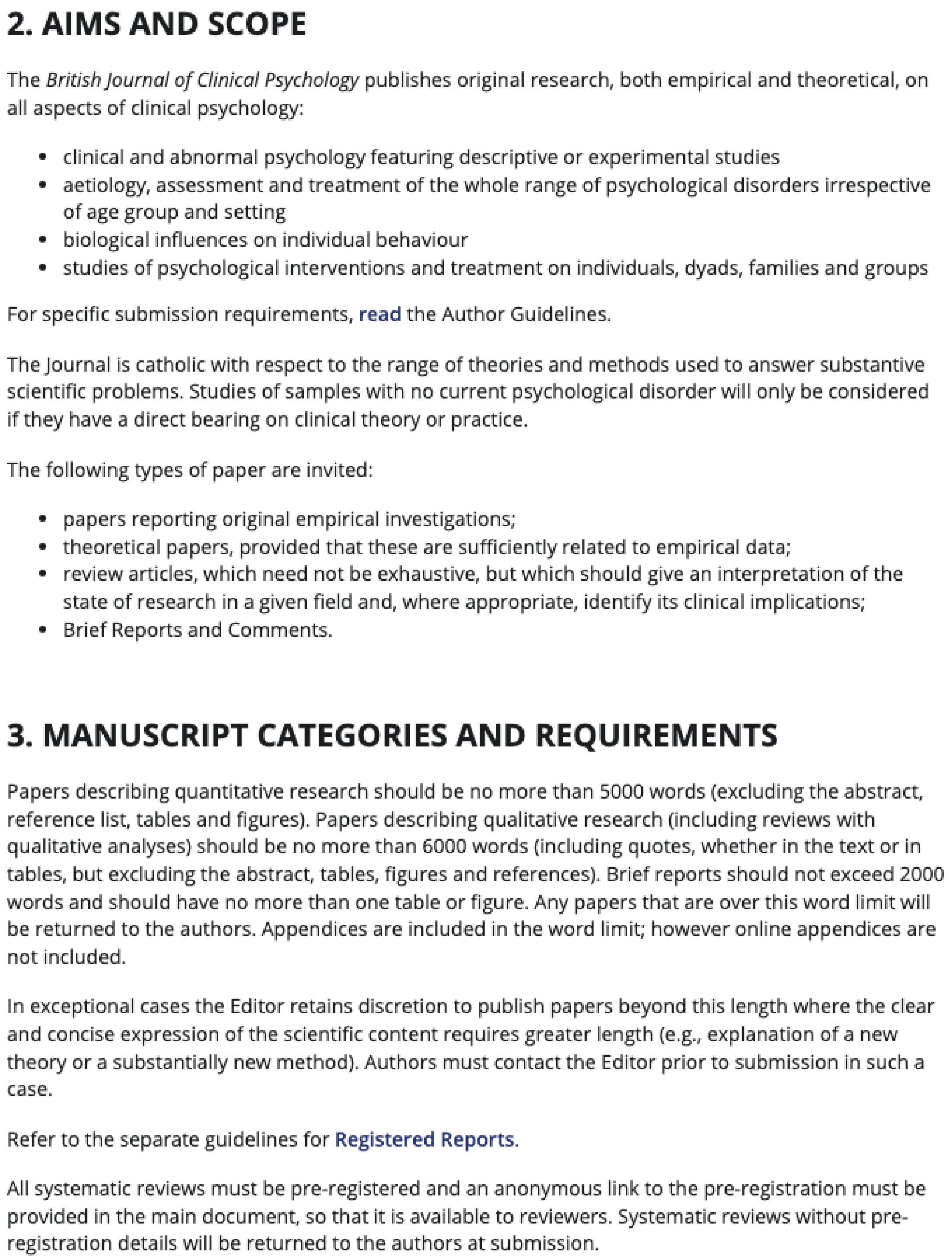

2. AIMS AND SCOPE

The *British Journal of Clinical Psychology* publishes original research, both empirical and theoretical, on all aspects of clinical psychology:

- clinical and abnormal psychology featuring descriptive or experimental studies
- aetiology, assessment and treatment of the whole range of psychological disorders irrespective of age group and setting
- biological influences on individual behaviour
- studies of psychological interventions and treatment on individuals, dyads, families and groups

For specific submission requirements, **read** the Author Guidelines.

The Journal is catholic with respect to the range of theories and methods used to answer substantive scientific problems. Studies of samples with no current psychological disorder will only be considered if they have a direct bearing on clinical theory or practice.

The following types of paper are invited:

- papers reporting original empirical investigations;
- theoretical papers, provided that these are sufficiently related to empirical data;
- review articles, which need not be exhaustive, but which should give an interpretation of the state of research in a given field and, where appropriate, identify its clinical implications;
- Brief Reports and Comments.

3. MANUSCRIPT CATEGORIES AND REQUIREMENTS

Papers describing quantitative research should be no more than 5000 words (excluding the abstract, reference list, tables and figures). Papers describing qualitative research (including reviews with qualitative analyses) should be no more than 6000 words (including quotes, whether in the text or in tables, but excluding the abstract, tables, figures and references). Brief reports should not exceed 2000 words and should have no more than one table or figure. Any papers that are over this word limit will be returned to the authors. Appendices are included in the word limit; however online appendices are not included.

In exceptional cases the Editor retains discretion to publish papers beyond this length where the clear and concise expression of the scientific content requires greater length (e.g., explanation of a new theory or a substantially new method). Authors must contact the Editor prior to submission in such a case.

Refer to the separate guidelines for **Registered Reports**.

All systematic reviews must be pre-registered and an anonymous link to the pre-registration must be provided in the main document, so that it is available to reviewers. Systematic reviews without pre-registration details will be returned to the authors at submission.

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- The title page of the manuscript, including a data availability statement and your co-author details with affiliations. *(Why is this important? We need to keep all co-authors informed of the outcome of the peer review process.)* You may like to use this template for your title page.

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If you are invited to revise your manuscript after peer review, the journal will also request the revised manuscript to be formatted according to journal requirements as described below.

Revised Manuscript Submission

Contributions must be typed in double spacing. All sheets must be numbered.

Cover letters are not mandatory; however, they may be supplied at the author's discretion. They should be pasted into the 'Comments' box in Editorial Manager.

Parts of the Manuscript

The manuscript should be submitted in separate files: title page; main text file; figures/tables; supporting information.

Title Page

You may like to use **this template** for your title page. The title page should contain**:**

i. A short informative title containing the major key words. The title should not contain abbreviations (see Wiley's best practice SEO tips);
ii. A short running title of less than 40 characters;
iii. The full names of the authors;
iv. The author's institutional affiliations where the work was conducted, with a footnote for the author's present address if different from where the work was conducted;
v. Abstract;
vi. Keywords
vii. Data availability statement (see Data Sharing and Data Accessibility Policy);
viii. Acknowledgments.

Abstract

Please provide a structured abstract under the headings: Objectives, Methods, Results, Conclusions. For Articles, the abstract should not exceed 250 words. For Brief Reports, abstracts should not exceed 120 words.

Articles which report original scientific research should also include a heading 'Design' before 'Methods'. The 'Methods' section for systematic reviews and theoretical papers should include, as a minimum, a description of the methods the author(s) used to access the literature they drew upon. That is, the abstract should summarize the databases that were consulted and the search terms that were used.

Keywords

Provide appropriate keywords.

Acknowledgments

Contributions from anyone who does not meet the criteria for authorship should be listed, with permission from the contributor, in an Acknowledgments section. Financial and material support should also be mentioned. Thanks to anonymous reviewers are not appropriate.

Practitioner Points

All articles must include Practitioner Points – these are 2-4 bullet points, following the abstract, with the heading 'Practitioner Points'. These should briefly and clearly outline the relevance of your research to professional practice.

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As papers are double-anonymous peer reviewed, the main text file should not include any information that might identify the authors.
Manuscripts can be uploaded either as a single document (containing the main text, tables and figures), or with figures and tables provided as separate files. Should your manuscript reach revision stage, figures and tables must be provided as separate files. The main manuscript file can be submitted in Microsoft Word (.doc or .docx) or LaTex (.tex) format.

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LaTex Guidelines for Post-Acceptance:

Please check that you have supplied the following files for typesetting post-acceptance:

- PDF of the finalized source manuscript files compiled without any errors.
- The LaTeX source code files (text, figure captions, and tables, preferably in a single file), BibTex files (if used), any associated packages/files along with all other files needed for compiling without any errors. This is particularly important if authors have used any LaTeX style or class files, bibliography files (.bbl, .bst. .blg) or packages apart from those used in the NJD LaTex Template class file.
- Electronic graphics files for the illustrations in Encapsulated PostScript (EPS), PDFor TIFF format. Authors are requested not to create figures using LaTeX codes.

Your main document file should include:

- A short informative title containing the major key words. The title should not contain abbreviations;
- Abstract structured (objectives/methods/results/conclusions);
- Up to seven keywords;
- Practitioner Points: Authors will need to provide no more than 2-4 bullet points, written with the practitioner in mind, that summarize the key messages of their paper to be published with their article;
- Main body: formatted as introduction, materials & methods, results, discussion, conclusion;
- References;
- Tables (each table complete with title and footnotes);
- Figure legends: Legends should be supplied as a complete list in the text. Figures should be uploaded as separate files (see below).

Supporting information should be supplied as separate files. Tables and figures can be included at the end of the main document or attached as separate files but they must be mentioned in the text.

- As papers are double-anonymous peer reviewed, the main text file should not include any information that might identify the authors. Do not mention the authors' names or affiliations and always refer to any previous work in the third person.
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This journal uses APA reference style; as the journal offers Free Format submission, however, this is for information only and you do not need to format the references in your article. This will instead be taken care of by the typesetter.

Tables

Tables should be self-contained and complement, not duplicate, information contained in the text. They should be supplied as editable files, not pasted as images. Legends should be concise but comprehensive – the table, legend, and footnotes must be understandable without reference to the text. All abbreviations must be defined in footnotes. Footnote symbols: †, ‡, §, ¶, should be used (in that order) and *, **, *** should be reserved for P-values. Statistical measures such as SD or SEM should be identified in the headings.

Figures

Although authors are encouraged to send the highest-quality figures possible, for peer-review purposes, a wide variety of formats, sizes, and resolutions are accepted.

Basic figure requirements for figures submitted with manuscripts for initial peer review, as well as the more detailed post-acceptance figure requirements.

Legends should be concise but comprehensive – the figure and its legend must be understandable without reference to the text. Include definitions of any symbols used and define/explain all abbreviations and units of measurement.

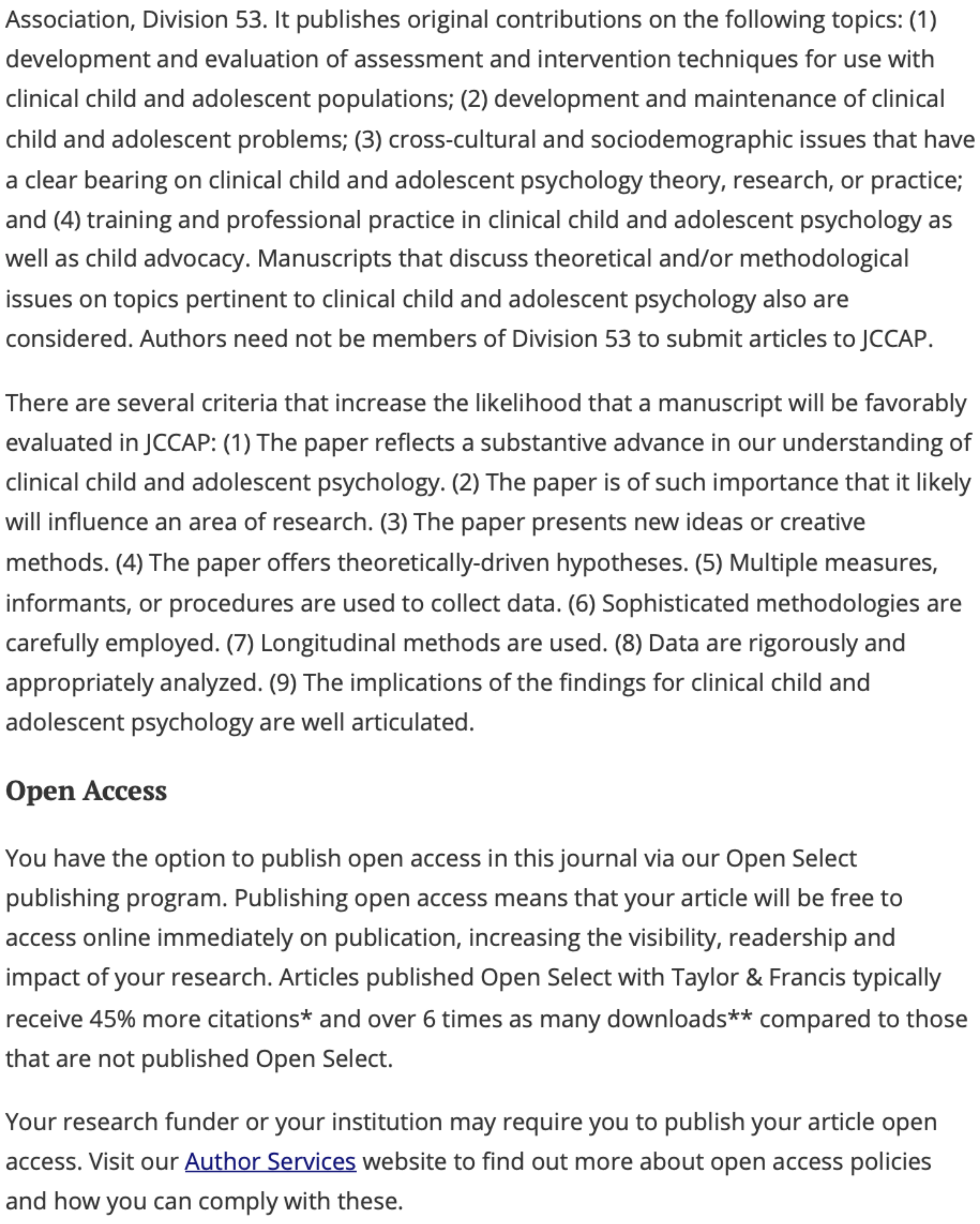
Supporting Information

Supporting information is information that is not essential to the article, but provides greater depth and background. It is hosted online and appears without editing or typesetting. It may include tables, figures, videos, datasets, etc.

Wiley's FAQs on supporting information.

Note: if data, scripts, or other artefacts used to generate the analyses presented in the paper are available via a publicly available data repository, authors should include a reference to the location of the material within their paper.

Appendix B: Author Guidelines for Journal of Clinical Child & Adolescent Psychology (Empirical Paper)



Association, Division 53. It publishes original contributions on the following topics: (1) development and evaluation of assessment and intervention techniques for use with clinical child and adolescent populations; (2) development and maintenance of clinical child and adolescent problems; (3) cross-cultural and sociodemographic issues that have a clear bearing on clinical child and adolescent psychology theory, research, or practice; and (4) training and professional practice in clinical child and adolescent psychology as well as child advocacy. Manuscripts that discuss theoretical and/or methodological issues on topics pertinent to clinical child and adolescent psychology also are considered. Authors need not be members of Division 53 to submit articles to JCCAP.

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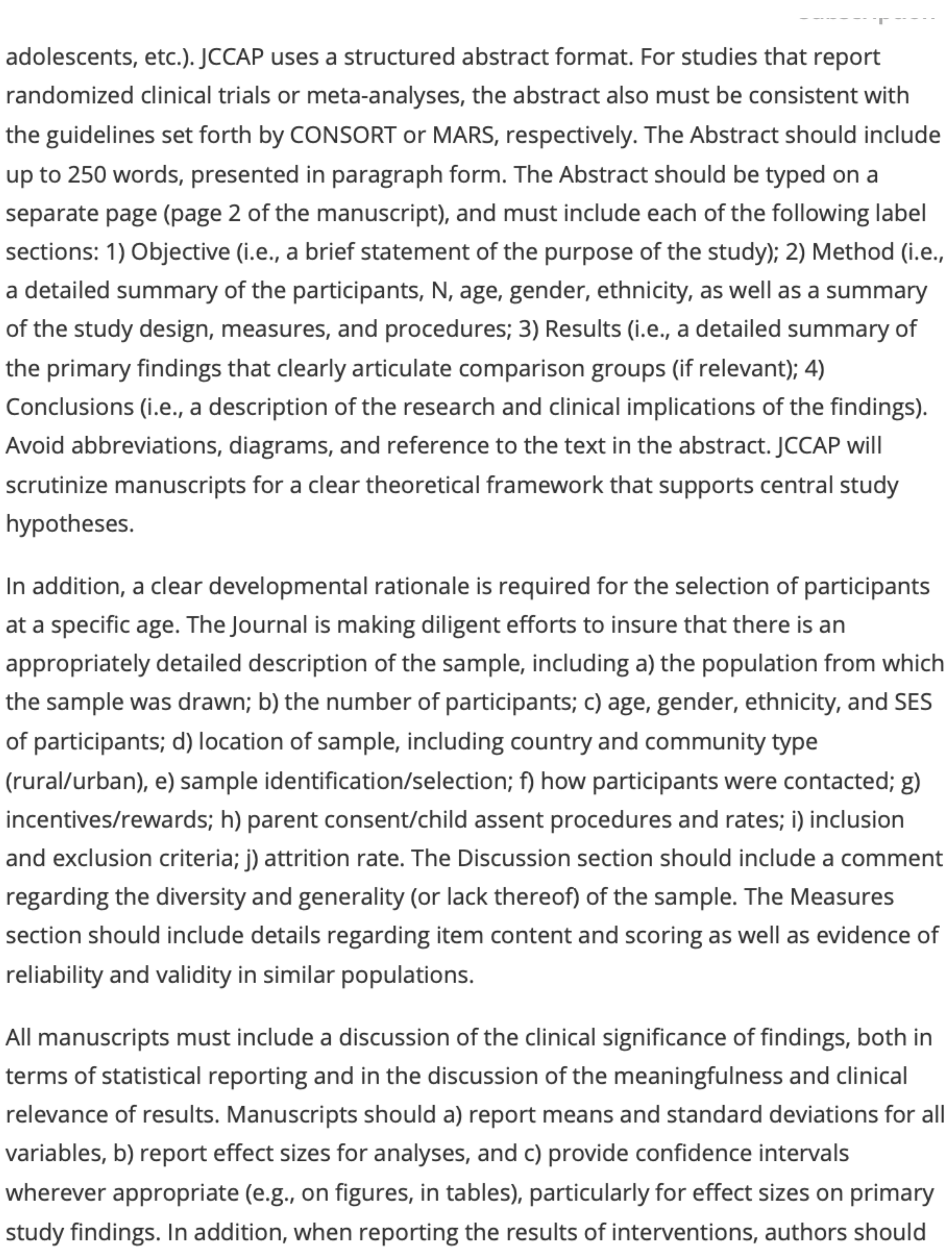
- Should contain a structured abstract of 250 words.

Read making your article more discoverable, including information on choosing a title and search engine optimization.

- A Regular Article may not exceed 11,000 words (i.e., 35 pages), including references, footnotes, figures, and tables. Brief Reports include empirical research that is soundly designed, but may be of specialized interest or narrow focus. Brief Reports may not be submitted in part or whole to another journal of general circulation. Brief Reports may not exceed 4,500 words for text and references. These limits do not include the title page, abstract, author note, footnotes, tables, and figures. Manuscripts that exceed these page limits and that are not prepared according to the guidelines in the Manual will be returned to authors without review. Future Directions submissions are written by



adolescents, etc.). JCCAP uses a structured abstract format. For studies that report randomized clinical trials or meta-analyses, the abstract also must be consistent with the guidelines set forth by CONSORT or MARS, respectively. The Abstract should include up to 250 words, presented in paragraph form. The Abstract should be typed on a separate page (page 2 of the manuscript), and must include each of the following label sections: 1) Objective (i.e., a brief statement of the purpose of the study); 2) Method (i.e., a detailed summary of the participants, N, age, gender, ethnicity, as well as a summary of the study design, measures, and procedures; 3) Results (i.e., a detailed summary of the primary findings that clearly articulate comparison groups (if relevant); 4) Conclusions (i.e., a description of the research and clinical implications of the findings). Avoid abbreviations, diagrams, and reference to the text in the abstract. JCCAP will scrutinize manuscripts for a clear theoretical framework that supports central study hypotheses.

In addition, a clear developmental rationale is required for the selection of participants at a specific age. The Journal is making diligent efforts to insure that there is an appropriately detailed description of the sample, including a) the population from which the sample was drawn; b) the number of participants; c) age, gender, ethnicity, and SES of participants; d) location of sample, including country and community type (rural/urban), e) sample identification/selection; f) how participants were contacted; g) incentives/rewards; h) parent consent/child assent procedures and rates; i) inclusion and exclusion criteria; j) attrition rate. The Discussion section should include a comment regarding the diversity and generality (or lack thereof) of the sample. The Measures section should include details regarding item content and scoring as well as evidence of reliability and validity in similar populations.

All manuscripts must include a discussion of the clinical significance of findings, both in terms of statistical reporting and in the discussion of the meaningfulness and clinical relevance of results. Manuscripts should a) report means and standard deviations for all variables, b) report effect sizes for analyses, and c) provide confidence intervals wherever appropriate (e.g., on figures, in tables), particularly for effect sizes on primary study findings. In addition, when reporting the results of interventions, authors should

Appendix C: NHS REC & HRA Ethical Approval

Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

Ariennir gan Lywodraeth Cymru
Funded by Welsh Government

Wales Research Ethics Committee 4
Wrexham

Mailing address:
Health and Care Research Wales
Castlebridge 4
15-19 Cowbridge Road East
Cardiff, CF11 9AB

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

05 September 2023

Ms Freya Lenton
11 St Bartholomews Court
Riverside
Cambridge
CB5 8JB

Dear Ms Lenton

Study title:	**Exploring Parents' Experiences During Joint Admission to a Children's Mental Health Unit: A Thematic Analysis.**
REC reference:	**23/WA/0195**
Protocol number:	**320767**
IRAS project ID:	**320767**

Thank you for your letter of 23 August 2023, responding to the Research Ethics Committee's (REC) request for further information on the above research.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

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

Good practice principles and responsibilities

The UK Policy Framework for Health and Social Care Research sets out principles of good practice in the management and conduct of health and social care research. It also outlines the responsibilities of individuals and organisations, including those related to the four elements of research transparency:

1. registering research studies
2. reporting results

3. informing participants
4. sharing study data and tissue

Conditions of the favourable opinion

The REC favourable opinion is subject to the following conditions being met prior to the start of the study.

Confirmation of Capacity and Capability (in England, Northern Ireland and Wales) or NHS management permission (in Scotland) should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements. Each NHS organisation must confirm through the signing of agreements and/or other documents that it has given permission for the research to proceed (except where explicitly specified otherwise).

Guidance on applying for HRA and HCRW Approval (England and Wales)/ NHS permission for research is available in the Integrated Research Application System.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of management permissions from host organisations

Registration of Clinical Trials

All research should be registered in a publicly accessible database and we expect all researchers, research sponsors and others to meet this fundamental best practice standard.

It is a condition of the REC favourable opinion that **all clinical trials are registered** on a publicly accessible database within six weeks of recruiting the first research participant. For this purpose, 'clinical trials' are defined as:

- clinical trial of an investigational medicinal product
- clinical investigation or other study of a medical device
- combined trial of an investigational medicinal product and an investigational medical device
- other clinical trial to study a novel intervention or randomised clinical trial to compare interventions in clinical practice.

Failure to register a clinical trial is a breach of these approval conditions, unless a deferral has been agreed by the HRA (for more information on registration and requesting a deferral see: Research registration and research project identifiers).

If you have not already included registration details in your IRAS application form you should notify the REC of the registration details as soon as possible.

Publication of Your Research Summary

We will publish your research summary for the above study on the research summaries section of our website, together with your contact details, no earlier than three months from the date of this favourable opinion letter.

Should you wish to provide a substitute contact point, make a request to defer, or require further information, please visit: https://www.hra.nhs.uk/planning-and-improving-research/applicationsummaries/research-summaries/

N.B. If your study is related to COVID-19 we will aim to publish your research summary within 3 days rather than three months.

During this public health emergency, it is vital that everyone can promptly identify all relevant research related to COVID-19 that is taking place globally. If you haven't already done so, please register your study on a public registry as soon as possible and provide the REC with the registration detail, which will be posted alongside other information relating to your project. We are also asking sponsors not to request deferral of publication of research summary for any projects relating to COVID-19. In addition, to facilitate finding and extracting studies related to COVID-19 from public databases, please enter the WHO official acronym for the coronavirus disease (COVID-19) in the full title of your study. Approved COVID-19 studies can be found at: https://www.hra.nhs.uk/covid-19-research/approved-covid-19-research/

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

After ethical review: Reporting requirements

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study, including early termination of the study
- Final report
- Reporting results

The latest guidance on these topics can be found at https://www.hra.nhs.uk/approvalsamendments/managing-your-approval/.

Ethical review of research sites

[Omit this sub-section if no NHS sites will be taking part in the study, e.g. Phase 1 trials in healthy volunteers]

NHS/HSC sites

The favourable opinion applies to all NHS/HSC sites taking part in the study, subject to confirmation of Capacity and Capability (in England, Northern Ireland and Wales) or management permission (in Scotland) being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Non-NHS/HSC sites

I am pleased to confirm that the favourable opinion applies to any non-NHS/HSC sites listed in the application, subject to site management permission being obtained prior to the start of the study at the site.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
Copies of materials calling attention of potential participants to the research [Study Poster]	2	14 July 2023
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Indemnity Cover]	1	01 August 2022
Interview schedules or topic guides for participants [Interview Schedule]	1	01 May 2023
IRAS Application Form [IRAS_Form_26062023]		26 June 2023
Letter from sponsor [Sponsor Cover Letter]	1	02 June 2023
Other [FW CV]	1	26 May 2023
Other [Permission to share contact details form]	1	26 May 2023
Other [Indemnity Cover]	1	01 August 2022
Other [Debrief form]	2	14 July 2023
Other [Demographic Information Sheet]	2	14 July 2023
Other [Debrief form TC]	2	27 July 2023
Other [Demographic Information Sheet TC]	2	27 July 2023
Participant consent form [Consent Form]	2	14 July 2023
Participant information sheet (PIS) [PIS]	2	14 July 2023
Research protocol or project proposal [Research Protocol]	2	14 July 2023
Response to Request for Further Information [Response to Request for Further Information Following Provisional Opinion]		20 July 2023
Response to Request for Further Information [Response to Request for Further Information]		02 August 2023
Response to Request for Further Information [Response to Request for Further Information Following Provisional Opinion]		23 August 2023
Summary CV for Chief Investigator (CI) [FL CV]	1	26 May 2023
Summary CV for student [AM CV]	1	26 May 2023
Summary CV for supervisor (student research) [FG CV]	1	26 May 2023

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: http://www.hra.nhs.uk/about-the-hra/governance/qualityassurance/

HRA Learning

We are pleased to welcome researchers and research staff to our HRA Learning Events and online learning opportunities– see details at: https://www.hra.nhs.uk/planning-and-improvingresearch/learning/

IRAS project ID: 320767   Please quote this number on all correspondence

With the Committee's best wishes for the success of this project.

Yours sincerely

MJR

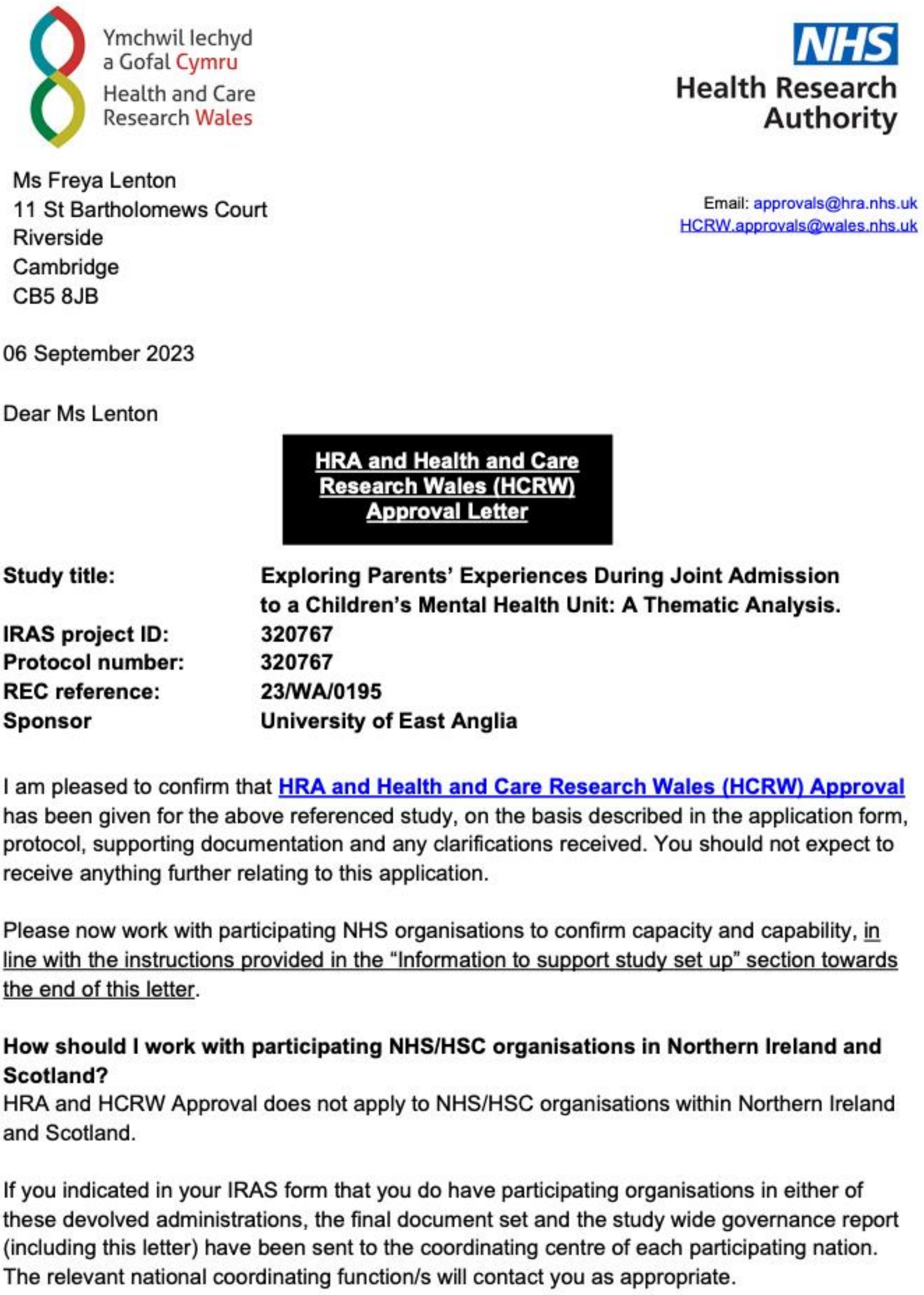
pp Mr Martin Rawson- Approvals Administrator
Dr Julie Latchem-Hastings Chair

Email: Wales.REC4@wales.nhs.uk

Enclosures: "After ethical review – guidance for researchers" **Non CTIMP Standard Conditions of Approval**

Copy to: Ms Tracy Moulton

Lead Nation England: approvals@hra.nhs.uk



Ymchwil Iechyd
a Gofal Cymru
Health and Care
Research Wales

NHS
Health Research
Authority

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

Ms Freya Lenton
11 St Bartholomews Court
Riverside
Cambridge
CB5 8JB

06 September 2023

Dear Ms Lenton

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

Study title:	**Exploring Parents' Experiences During Joint Admission to a Children's Mental Health Unit: A Thematic Analysis.**
IRAS project ID:	**320767**
Protocol number:	**320767**
REC reference:	**23/WA/0195**
Sponsor	**University of East Anglia**

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

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

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

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

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

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

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

What are my notification responsibilities during the study?

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

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

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

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

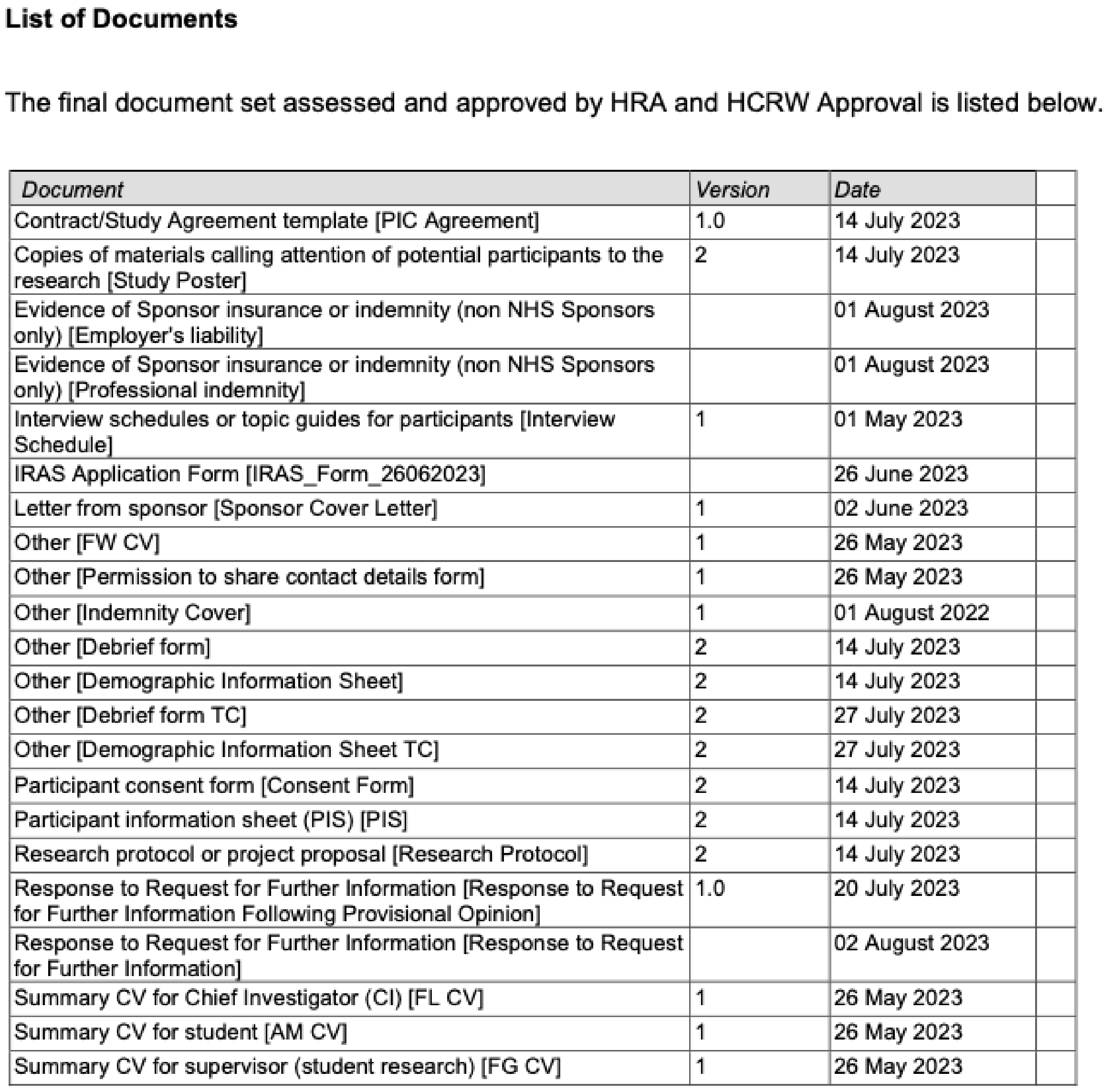
Your IRAS project ID is **320767**. Please quote this on all correspondence.

Yours sincerely,
Gurmel Bhachu

Approvals Manager

Email: HCRW.approvals@wales.nhs.uk

Copy to: *Ms Tracy Moulton*



List of Documents

The final document set assessed and approved by HRA and HCRW Approval is listed below.

Document	*Version*	*Date*	
Contract/Study Agreement template [PIC Agreement]	1.0	14 July 2023	
Copies of materials calling attention of potential participants to the research [Study Poster]	2	14 July 2023	
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Employer's liability]		01 August 2023	
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Professional indemnity]		01 August 2023	
Interview schedules or topic guides for participants [Interview Schedule]	1	01 May 2023	
IRAS Application Form [IRAS_Form_26062023]		26 June 2023	
Letter from sponsor [Sponsor Cover Letter]	1	02 June 2023	
Other [FW CV]	1	26 May 2023	
Other [Permission to share contact details form]	1	26 May 2023	
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Response to Request for Further Information [Response to Request for Further Information]		02 August 2023	
Summary CV for Chief Investigator (CI) [FL CV]	1	26 May 2023	
Summary CV for student [AM CV]	1	26 May 2023	
Summary CV for supervisor (student research) [FG CV]	1	26 May 2023	

Appendix D: Interview Schedule

Parent Interview Schedule v1 May 2023 IRAS Project ID: 320767

University of East Anglia

NHS
Cambridgeshire and
Peterborough
NHS Foundation Trust

PARENT INTERVIEW

ID NUMBER:

INTERVIEWER:

INTERVIEW DATE:

PART ONE: Parent/carer mental health and experience of therapeutic work

I'd like to start by asking you a bit about what you knew about the croft before being admitted with your child.

1. A) What were you told about the croft before the admission?
   B) How helpful was this information in preparing you for the admission?
   C) Is there anything that could have been done to better prepare you?

2. Have you ever received any type of therapeutic support before coming to the croft?
IF YES: What kind of therapy? What was your experience of this?
[distinguish whether they received therapy for themselves or as part of care for their child (eg family therapy as parent]

The next few questions are about the therapeutic support you received while at the Croft.

3. Can I just check - during your time at the croft, did you meet with anyone for 1:1 support? Or did you only receive support alongside your child? (i.e. family therapy)

   IF 1:1: Can you tell me about your experience of this?

   IF no 1:1: Would you have liked to received 1:1 therapy? If so, what would you have liked from this 1:1 therapy?

4. What was it like to explore your own experiences (and challenges?) at the same time as your child's difficulties? (For example in family therapy sessions)

5. What, if anything, did you learn about yourself through the support you received at the croft?

6. What was *most helpful* and what was *most challenging* about the therapeutic work you did at the croft? (For example, family therapy or, if applicable, the 1:1 support you received?)

7. Are there any ways that the staff at the croft made this process easier/harder?

8. Are there any ways that the therapy experience could be improved?

For the next couple of questions, I'd like you think about your experience of the admission as a whole (i.e. not just of therapy).

9. What impact do you think the time spent at the croft had on your wellbeing/mental health?
    A) At the time/during the admission
    B) In the longer term/after discharge

10. Has your experience of admission impacted on the wellbeing/mental health on your child? Wider family members? Grandparents? Friends? If so, in what ways?

11. Was your partner involved in the admission? In what ways do you think this has impacted their wellbeing?

12. If I asked your partner/child/family, what might they tell us about how your mental health changed during and after your admission?

The next couple of questions focus on the end of your time at the Croft and your experience of being discharged from the service.

13. What was the experience of discharge like? What helped with this transition? Is there anything that you think could help support the wellbeing of parents and families during this process?

14. At the end of the Croft admission, was it suggested to you to seek further/longer-term support (therapeutic) for yourself/for you and your partner?

15. Did you receive therapeutic support (eg family therapy) after you left the Croft?

If YES: How helpful did you find this support?

IF NO: Would you have liked to access further/longer-term support (therapeutic) for yourself/for you and your partner? What would have been helpful?

16. In what ways do you think CAMHS services (like the Croft) can best support the wellbeing of parents and families?

PART TWO: The changing relationship between the child and parent from admission to discharge and beyond

I will start by asking a bit about how the croft has impacted your parenting

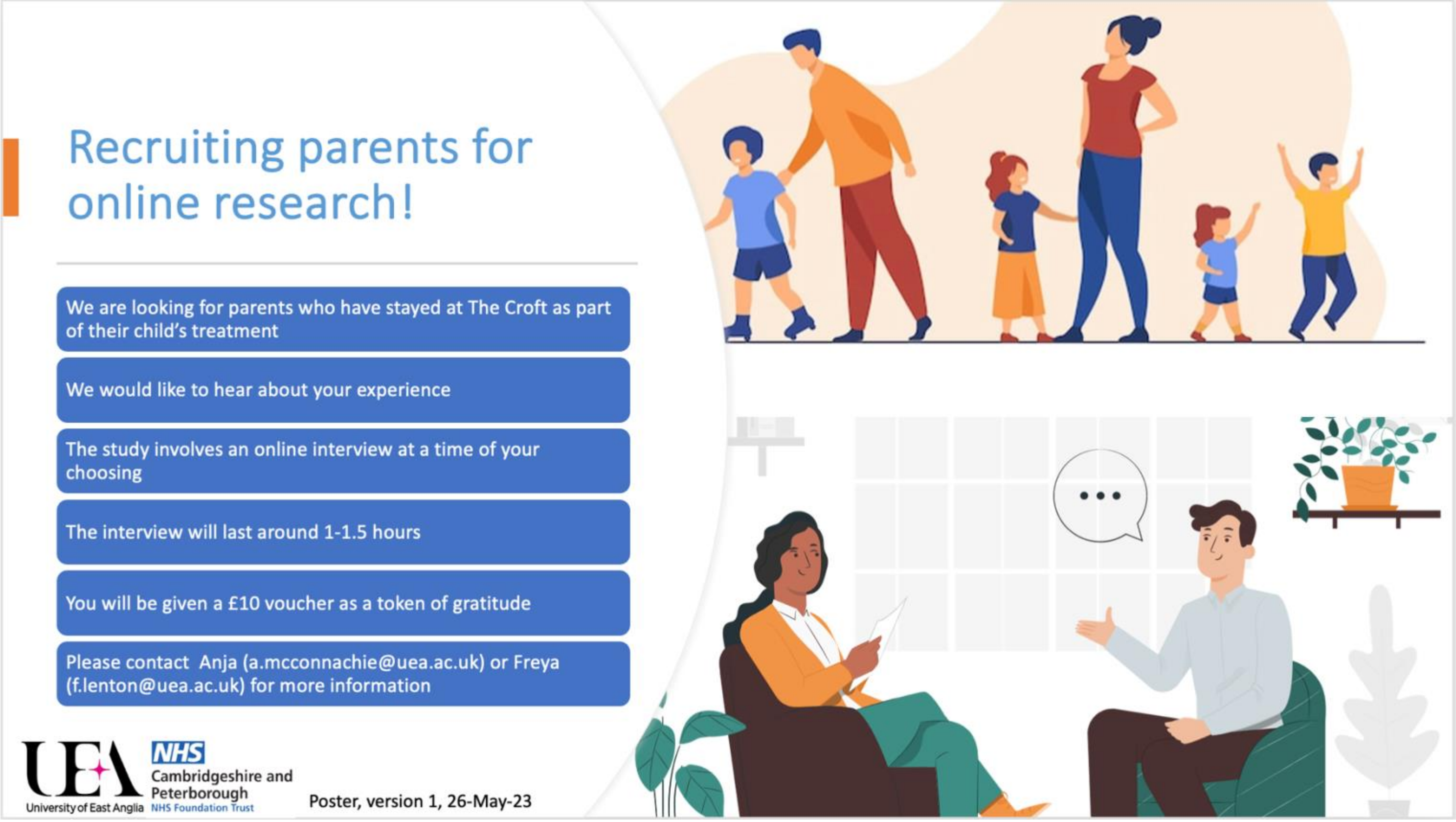
Did you feel that The Croft had an impact on your parenting style?

1. Did you feel that The Croft had an impact on your parenting style?
2. Did you feel that The Croft had an impact on how you play and have fun with your child?
3. Did you feel that The Croft had an impact on how you emotionally relate to your child (and when s/he is distressed)?
4. Did you feel that The Croft had an impact how you show affection with your child?
5. Did you feel that The Croft had an impact on your behavioural control/ boundaries/ discipline?
6. Did you feel that The Croft had an impact on how much pressure / expectations of yourself / confidence / acceptance in yourself as a parent?
7. What was the impact, if any, of admission on your child's mental health needs/behavioural needs?
8. Do you feel that The Croft changed communication between you and your child?
9. How was your experience of parenting your child alongside staff?

I will now ask a bit about others in your life and impact of admission on family life

10. What was the impact of admission at The Croft on relationships within the family (e.g. partner, siblings, grandparents)
11. What was the impact of admission to reintegration/adjustment back to family life at home?
12. Would others in your family say your relationship with child has changed, and if so, how? What have they observed?

Appendix E: Study Poster



Recruiting parents for online research!

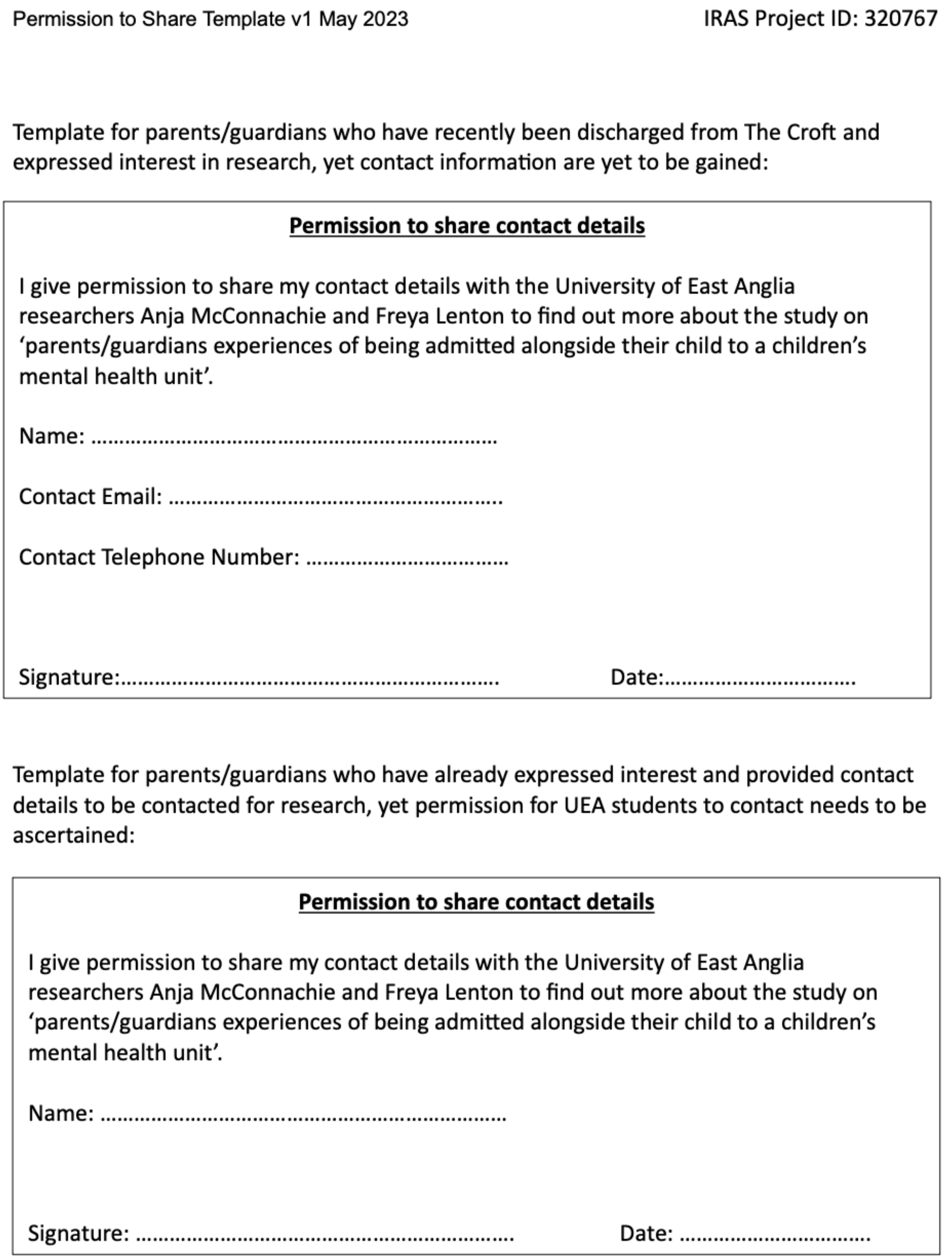
- We are looking for parents who have stayed at The Croft as part of their child's treatment
- We would like to hear about your experience
- The study involves an online interview at a time of your choosing
- The interview will last around 1-1.5 hours
- You will be given a £10 voucher as a token of gratitude
- Please contact Anja (a.mcconnachie@uea.ac.uk) or Freya (f.lenton@uea.ac.uk) for more information

UEA University of East Anglia

NHS
Cambridgeshire and Peterborough
NHS Foundation Trust

Poster, version 1, 26-May-23

Appendix F: Permission to Contact Form



Permission to Share Template v1 May 2023

IRAS Project ID: 320767

Template for parents/guardians who have recently been discharged from The Croft and expressed interest in research, yet contact information are yet to be gained:

Permission to share contact details

I give permission to share my contact details with the University of East Anglia researchers Anja McConnachie and Freya Lenton to find out more about the study on 'parents/guardians experiences of being admitted alongside their child to a children's mental health unit'.

Name: ………………………………………………………………

Contact Email: …………………………………………………..

Contact Telephone Number: ………………………………

Signature:………………………………………………………… Date:……………………………

Template for parents/guardians who have already expressed interest and provided contact details to be contacted for research, yet permission for UEA students to contact needs to be ascertained:

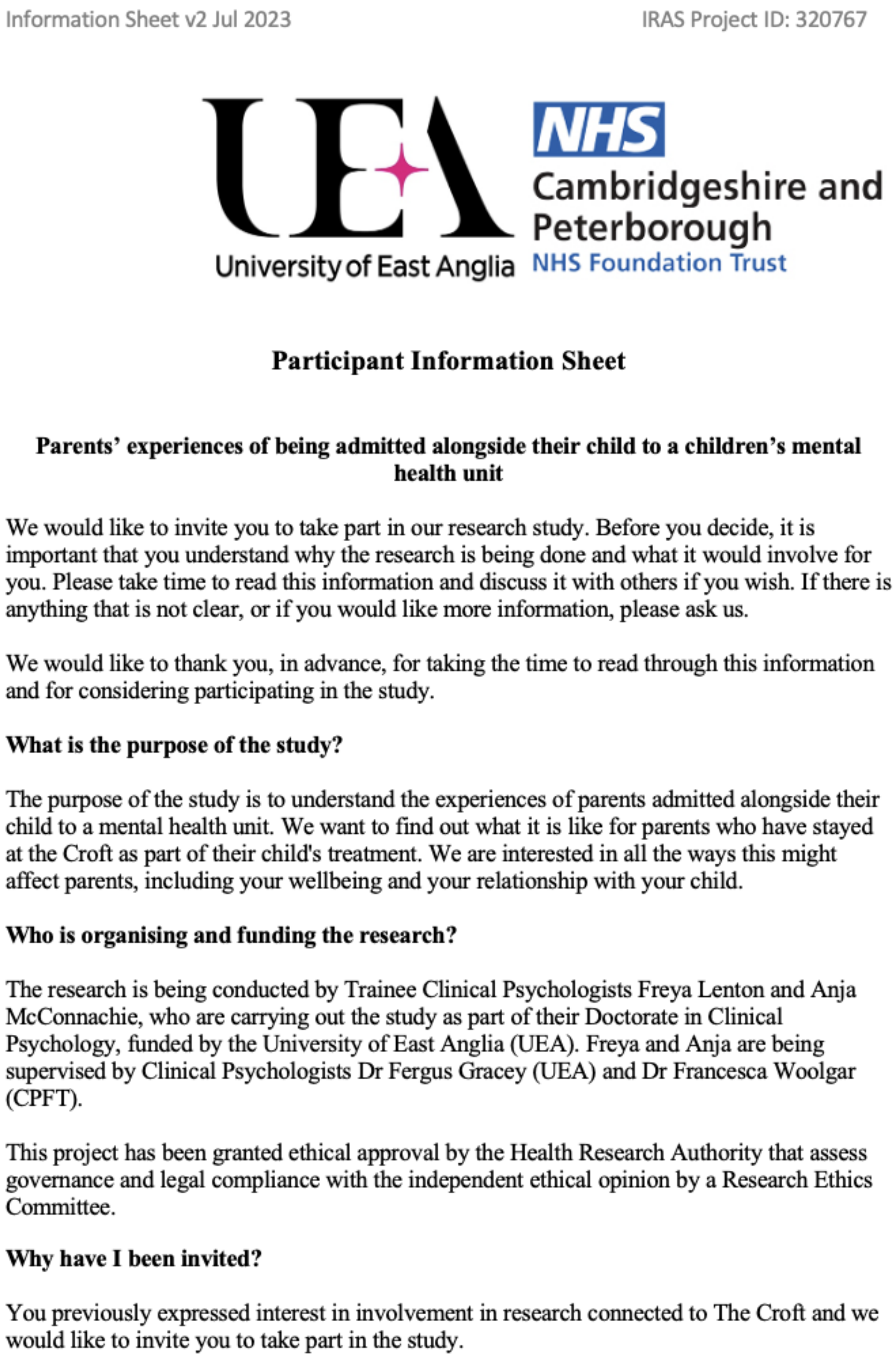
Permission to share contact details

I give permission to share my contact details with the University of East Anglia researchers Anja McConnachie and Freya Lenton to find out more about the study on 'parents/guardians experiences of being admitted alongside their child to a children's mental health unit'.

Name: ………………………………………………………………

Signature: ………………………………………………………… Date: ……………………………

Appendix G: Information Sheet



Information Sheet v2 Jul 2023 IRAS Project ID: 320767

University of East Anglia

NHS
Cambridgeshire and Peterborough
NHS Foundation Trust

Participant Information Sheet

Parents' experiences of being admitted alongside their child to a children's mental health unit

We would like to invite you to take part in our research study. Before you decide, it is important that you understand why the research is being done and what it would involve for you. Please take time to read this information and discuss it with others if you wish. If there is anything that is not clear, or if you would like more information, please ask us.

We would like to thank you, in advance, for taking the time to read through this information and for considering participating in the study.

What is the purpose of the study?

The purpose of the study is to understand the experiences of parents admitted alongside their child to a mental health unit. We want to find out what it is like for parents who have stayed at the Croft as part of their child's treatment. We are interested in all the ways this might affect parents, including your wellbeing and your relationship with your child.

Who is organising and funding the research?

The research is being conducted by Trainee Clinical Psychologists Freya Lenton and Anja McConnachie, who are carrying out the study as part of their Doctorate in Clinical Psychology, funded by the University of East Anglia (UEA). Freya and Anja are being supervised by Clinical Psychologists Dr Fergus Gracey (UEA) and Dr Francesca Woolgar (CPFT).

This project has been granted ethical approval by the Health Research Authority that assess governance and legal compliance with the independent ethical opinion by a Research Ethics Committee.

Why have I been invited?

You previously expressed interest in involvement in research connected to The Croft and we would like to invite you to take part in the study.

As The Croft is the only children's inpatient unit in the UK to admit parents alongside their child, we would like to learn what it is like for parents to be part of the inpatient stay. We hope to speak to around 12 parents, and we would like to hear from parents with a wide range of experiences.

Do I have to take part?

You do not have to take part in the study – participation is entirely voluntary. If you do take part and then later change your mind, you can withdraw from the study without giving a reason until the point of analysis. Whether you decide to take part or not, it will not impact on the clinical care you and your family receive. If you decide to withdraw from the study this will also not impact yours and your family's clinical care.

What will happen if I decide to take part?

If you decide to take part, you will be interviewed at a time of your choosing by one of two Trainee Clinical Psychologists – Anja McConnachie or Freya Lenton. The interview will take place online over Microsoft Teams and will last around 1-1.5 hours. Alternatively, if you prefer, the interview can be carried out over the telephone. All interviews, whether online or via telephone, will be video/audio recorded and transcribed using Microsoft Teams software.

At any point during the interview, you have the right to withdraw. You can withdraw after the interview up until the point of analysis. During transcription, your data will be pseudonymised (i.e., assigned a fictional name, rather than your real name).

The researchers will keep a separate spreadsheet which will link your pseudonym with your participant ID so that we can contact you if you would like to be involved in checking our analyses. Once the data has been analysed, you can receive a summary of the research findings and will have the opportunity to give feedback.

After this, the spreadsheet linking your pseudonym and participant ID will be deleted to ensure your anonymity. The information collected from the interviews will be written up and will be presented in quotes with all identifying information removed.

Are there any disadvantages or risks from taking part?

As the interview will cover topics relevant to mental health and parents' experiences of undergoing therapy, some interview questions may bring up strong emotions for you. If you do feel distressed at any point during the interview, you can take a break or withdraw from the study at any point. If there are any questions you would prefer not to answer you can skip the question. The interviewer will also provide a list of support services that you can contact if you would like further support after taking part.

What are the possible benefits of taking part?

Taking part in the study will help to provide valuable information to wider Child and Adolescent Mental Health Services (CAMHS) about the experiences and support needs of parents and families. We hope that parents' will find it helpful to have the interviewer listen to their experience, but please note that we cannot guarantee this.

Will I be reimbursed for taking part?

To thank you for your time and participation in the study you will be given a £10 shopping voucher.

Will my taking part in the study be kept confidential?

Your participation in the study will be kept confidential, unless you tell us something which raises a serious concern about your safety or the safety of others. If you tell us something which raises serious safety concerns, we would be required to break confidentiality to ensure the safety of all persons linked to the study.

All information will be kept on the secure network at University of East Anglia (UEA) which only the research team will be able to access. Although one of the supervisors (Dr Francesca Woolgar) works at the Croft, please note that the data is not connected to you or your child's care. All data collected will be kept confidential and cannot be accessed by the clinical team. In any written reports, data will be presented as pseudonymised quotes and all identifying details will be removed.

How will we use information about you?

We will need to use information from you for this research project. This information will include your name and contact details. We will use your name and contact details only to help stay in touch with you while you are in the study. After that we will delete all identifiable information.

We will also gather demographic information and information from you during our interviews. Interviews will be recorded digitally and stored on the UEA secure password-protected encrypted network that only the research team can access. During transcription, all names and identifying information will be changed to protect participant identity. The pseudonymised research data will be stored separately to any identifiable information we have like your name and contact details. We will handle this information and write our reports in a way that no-one can work out that you took part in the study. After publication of the research findings, the anonymised research data will be stored for at least 10 years in line with UEA data management policy.

What are your choices about how your information is used?

You can stop being part of the study at any time, without giving a reason, but it will not be possible to withdraw the data after the analysis has begun. We need to manage your records in specific ways for the research to be reliable. This means that we won't be able to let you see or change the data we hold about you.

Where can you find out more about how your information is used?
You can find out more about how we use your information

- at www.hra.nhs.uk/information-about-patients/
- our leaflet available from www.hra.nhs.uk/patientdataandresearch
- by asking one of the research team
- by contacting the UEA's Data Protection Officer at dataprotection@uea.ac.uk

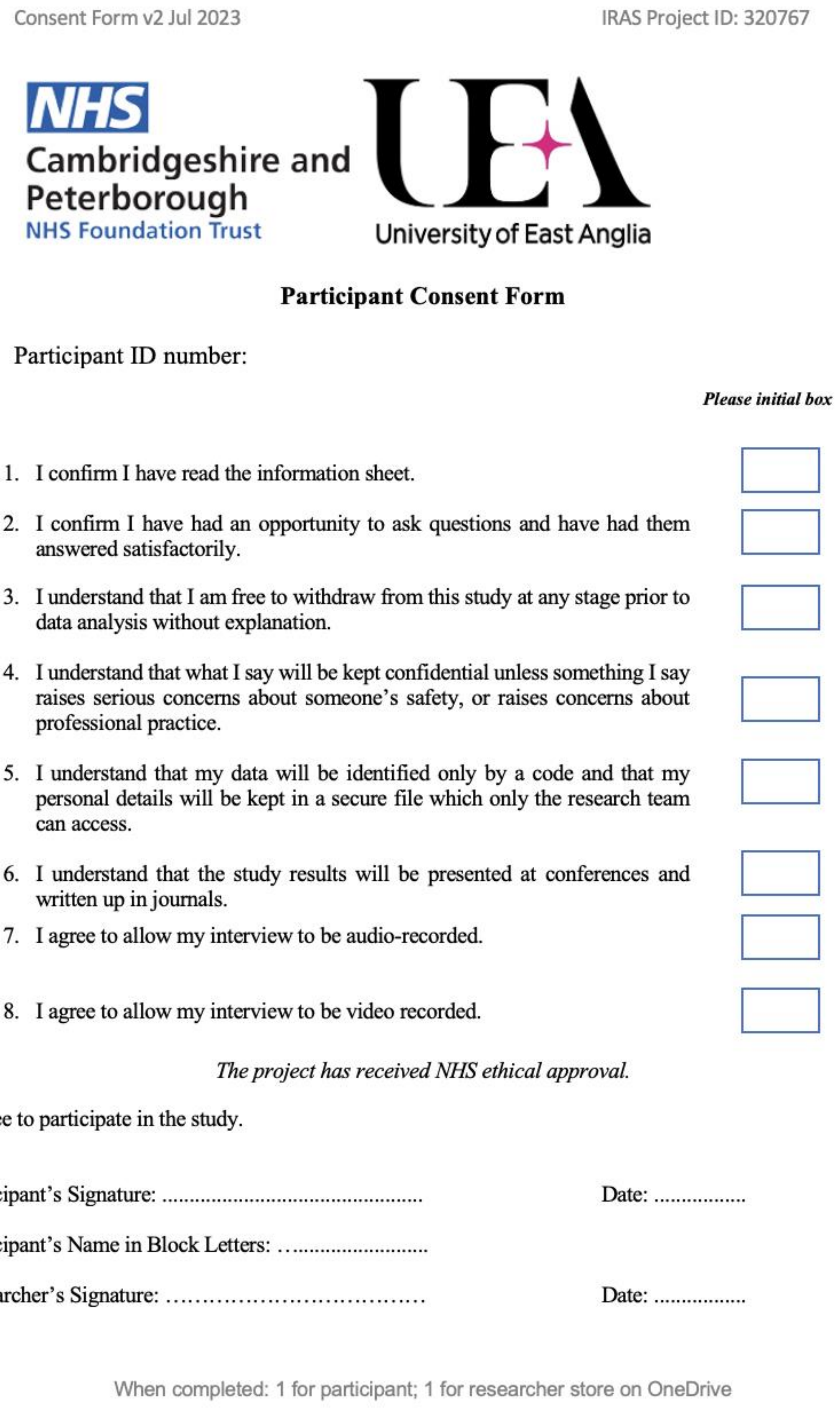
What should I do if I have any concerns or complaints about the study?

If you wish to make a complaint about the research or investigators, then please contact Professor Sian Coker, Acting Programme Director, Professor of Clinical Psychology, (s.coker@uea.ac.uk). Professor Coker is separate from the research team.

How do I take part?

If you would like to take part in the study, please reply to Anja McConnachie (a.mcconnachie@uea.ac.uk) or Freya Lenton's (f.lenton@uea.ac.uk) email and they will contact you to set up a brief initial telephone conversation to answer any questions, explain consent and set up a convenient interview time.

Appendix H: Consent Form



Consent Form v2 Jul 2023

IRAS Project ID: 320767

NHS
Cambridgeshire and
Peterborough
NHS Foundation Trust

University of East Anglia

Participant Consent Form

Participant ID number:

Please initial box

1. I confirm I have read the information sheet. ☐
2. I confirm I have had an opportunity to ask questions and have had them answered satisfactorily. ☐
3. I understand that I am free to withdraw from this study at any stage prior to data analysis without explanation. ☐
4. I understand that what I say will be kept confidential unless something I say raises serious concerns about someone's safety, or raises concerns about professional practice. ☐
5. I understand that my data will be identified only by a code and that my personal details will be kept in a secure file which only the research team can access. ☐
6. I understand that the study results will be presented at conferences and written up in journals. ☐
7. I agree to allow my interview to be audio-recorded. ☐
8. I agree to allow my interview to be video recorded. ☐

The project has received NHS ethical approval.

I agree to participate in the study.

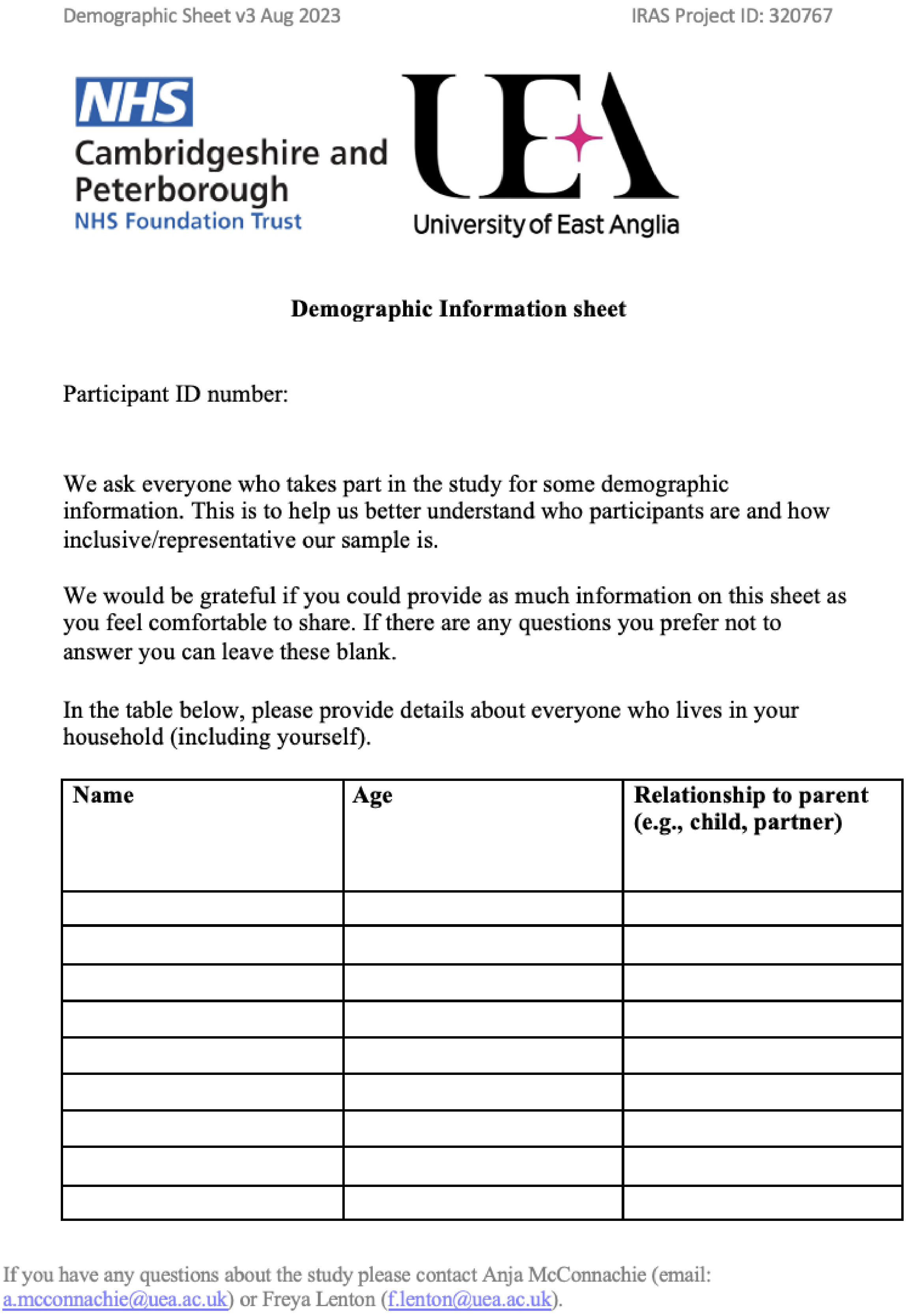
Participant's Signature: .... Date: ....

Participant's Name in Block Letters: …........................

Researcher's Signature: ……………………………… Date: ....

When completed: 1 for participant; 1 for researcher store on OneDrive

Appendix I: Demographic Information Sheet



Demographic Sheet v3 Aug 2023 IRAS Project ID: 320767

NHS
Cambridgeshire and Peterborough
NHS Foundation Trust

UEA
University of East Anglia

Demographic Information sheet

Participant ID number:

We ask everyone who takes part in the study for some demographic information. This is to help us better understand who participants are and how inclusive/representative our sample is.

We would be grateful if you could provide as much information on this sheet as you feel comfortable to share. If there are any questions you prefer not to answer you can leave these blank.

In the table below, please provide details about everyone who lives in your household (including yourself).

Name	**Age**	**Relationship to parent (e.g., child, partner)**

If you have any questions about the study please contact Anja McConnachie (email: a.mcconnachie@uea.ac.uk) or Freya Lenton (f.lenton@uea.ac.uk).

Demographic Information continued

Please answer the following questions in your own words. If there are any questions you prefer not to answer you can leave these blank.

1. How would you describe your gender?

2. Is your gender different to the sex you were assigned at birth? Y/N (circle)

3. Would you consider yourself to have a disability? If so, please describe:

4. How would you describe your ethnicity?

5. How would you describe your sexual orientation?

6. How would you describe your social class?

If you have any questions about the study please contact Anja McConnachie (email: a.mcconnachie@uea.ac.uk) or Freya Lenton (f.lenton@uea.ac.uk).

Appendix J: Division of the Research Project

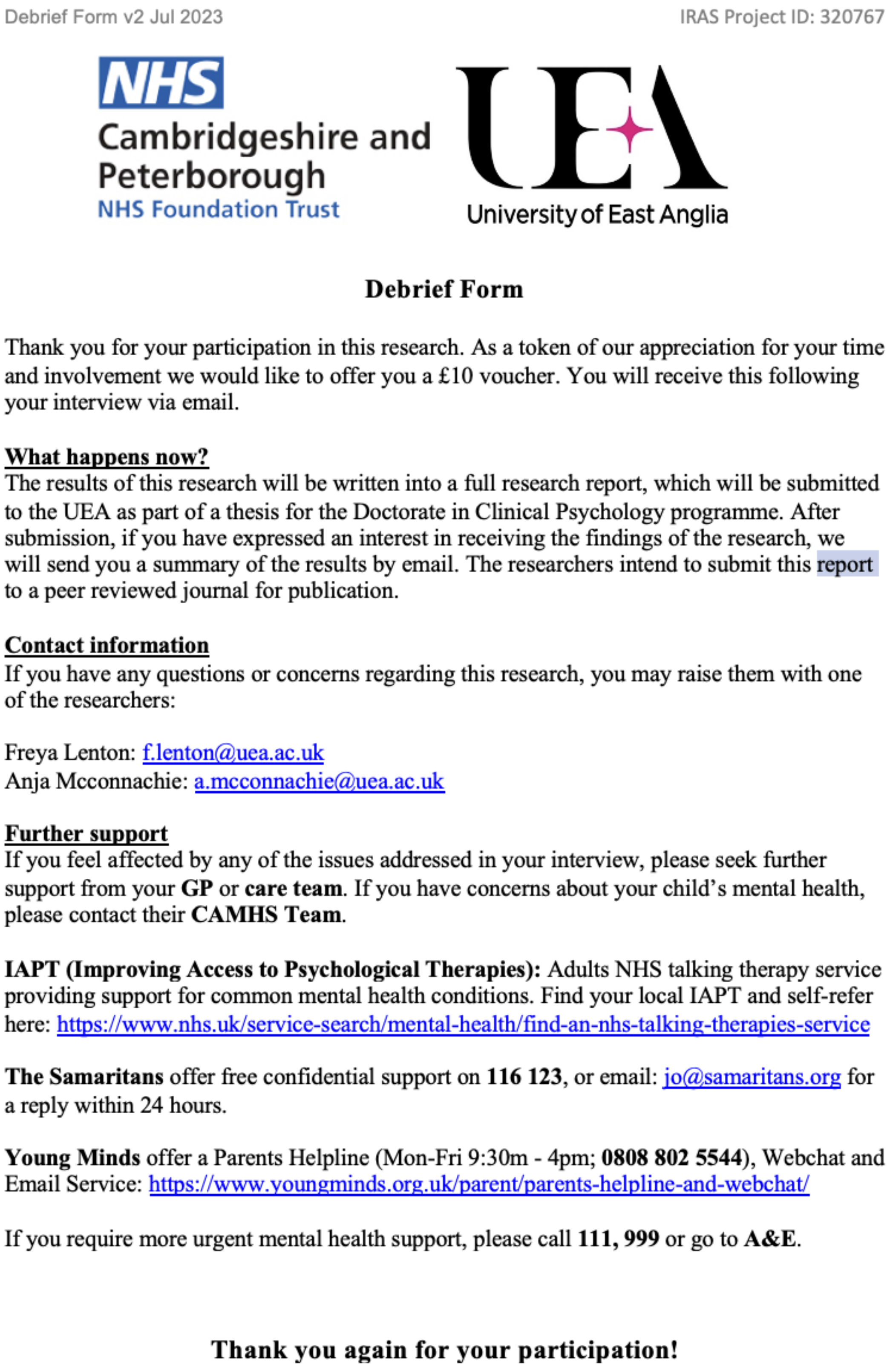
The research at The Croft formed two separate doctoral theses, with the overarching aim to explore caregivers' experiences during joint admission to a children's mental health unit. The current study focused on caregivers' experiences on parenting practices and the relationship with their child. The other trainee focused on caregivers' experiences of undergoing therapeutic work alongside their child and the influence on their wellbeing. The table below displays how tasks were divided between researchers throughout the research project. In terms of data collection, researchers conducted half of the interviews each. Both researchers watched all video recordings and read full transcripts from all interviews to ensure deep engagement with the data.

Table Appendix J

Division of Tasks Between the Two Researchers Relating to The Current Research Project

Project Task	Joint Workload (i.e. 50/50)	The Current Project
Composing Study Materials (i.e. consent to contact, study poster, consent, demographic, information, debrief forms)	X	
Gaining Ethical Approval	X	
Development of Interview Schedule (including conducting focus groups and interviews)	X	
Data Collection (including initial calls, exchanging documentation sharing, conducting interviews)	X	
Transcription	X	
Analysis		X
Write Up		X

Appendix K: Debrief Form



Debrief Form v2 Jul 2023 IRAS Project ID: 320767

NHS
Cambridgeshire and Peterborough
NHS Foundation Trust

UEA
University of East Anglia

Debrief Form

Thank you for your participation in this research. As a token of our appreciation for your time and involvement we would like to offer you a £10 voucher. You will receive this following your interview via email.

What happens now?

The results of this research will be written into a full research report, which will be submitted to the UEA as part of a thesis for the Doctorate in Clinical Psychology programme. After submission, if you have expressed an interest in receiving the findings of the research, we will send you a summary of the results by email. The researchers intend to submit this report to a peer reviewed journal for publication.

Contact information

If you have any questions or concerns regarding this research, you may raise them with one of the researchers:

Freya Lenton: f.lenton@uea.ac.uk
Anja Mcconnachie: a.mcconnachie@uea.ac.uk

Further support

If you feel affected by any of the issues addressed in your interview, please seek further support from your **GP** or **care team**. If you have concerns about your child's mental health, please contact their **CAMHS Team**.

IAPT (Improving Access to Psychological Therapies): Adults NHS talking therapy service providing support for common mental health conditions. Find your local IAPT and self-refer here: https://www.nhs.uk/service-search/mental-health/find-an-nhs-talking-therapies-service

The Samaritans offer free confidential support on **116 123**, or email: jo@samaritans.org for a reply within 24 hours.

Young Minds offer a Parents Helpline (Mon-Fri 9:30m - 4pm; **0808 802 5544**), Webchat and Email Service: https://www.youngminds.org.uk/parent/parents-helpline-and-webchat/

If you require more urgent mental health support, please call **111, 999** or go to **A&E**.

Thank you again for your participation!

Appendix L: Summary of Individual Participant Brief Themes

Lydia
- Validation through diagnosis
- Confidence
- Doing a good job
- Child more trusting
-Gained respect
-New techniques
-Back in control
-Lower threshold of what's tolerated
-It's a partnership

Rima
-listened to without judgement
-New strategies
-Control back
-Struggle other child at home
-Supported from prof
-Calm approach
-Listening > solutions
-Power of diagnosis
-Child feeling understood
-Exonerated
-Looking after self to look after child

Charles
-Control (tiger analogy)
-Child trusting parent
-adversity faced together
-Looking after self to look after child
-Respite - understood after years of battling
-Reflect & take step back from stuckness
-Big family at The Croft
-Power in community - connections with others
-Family reliance

Neha
-Validation in diagnosis
-All or nothing
-Difference in parenting style
-Battle led to more self-confidence in style
-conflict on ward
-blanket rules - not accounting for idiosyncraties / neuro divergence
-Feeling unsupported
-Reaffirmed parenting position
-Taking care of self
-Child trusting mum
-Advocating for child

Randa
-Blanket rules
-No allowance for neurodivergence
-Respite/breathing space
-Step back from stuckness
-Extra reading + understanding
-Child feeling safer
-New skills
-Calmer in parenting
-Coparenting diff views

Jacob
-Trauma being croft - let down by services
-Lower expectations of child
-Having support after struggles
-Being alongside importance
-Understand neurodivergence
-Building tools
-Stopping pulling ourselves to pieces as parents
-Expectations vs resignation

Noah
-Tougher than expected
-Reinforced boundaries
-You are the parent
-New tools
-Acknowledging small changes
-Heard and validated
-Acceptance of self
-Not afraid being disliked
-Closer connection
-Stripped back bare
-Break all cycles

Juniper
-Disempowered as parent
-Power imbalance
-Who had control
-Alongside importance
-Tiredness and feared not showing best
-Coparenting responsibility
-Control back
-Concealing emotions benefit
-Trauma as parent
-Reflecting of reflection
-Codependence

Canyon
-Learning about self
-Seeing family patterns
-Unmuddling picture
-Validation in diagnosis
-Piecing the puzzle
-Better understanding
-Reduced pressure
-Guilt - acceptance
-Bigger picture of responsibility
-Teamwork in coparenting
-Not knowing all answers

Summit
-Relief
-Reduced burden
-Pressure lifted
-Space to de-stress
-Take a step back
-Baby analogy at discharge
-Neurodivergence ignored
-123 Magic blanket implementation
-Awareness and understanding through diagnosis
-Validation as parent
-Codependency - family patterns
-Wider family - impact on sister

(Note: Themes are not exhaustive, but brief notes to display evidence of engagement)

Appendix M: Example Extracts from Reflexive Journal

All extracts were written by free hand in a notebook to allow for natural flow of writing thoughts, feelings and decisions. It also made it accessible enabling the recording of reflections in the moment.

An example of an entry after conducting an interview:

It is important to acknowledge personal factors that might shape my interpretation to this interview. This is particularly important in this interview, because I came away with a feeling a strong sense of responsibility to ensure that this parent's view is strongly represented in my paper. I reflected on why this feeling was particularly strong after this interview and think it's for a few reasons. Firstly, her sense of desperation and anguish permeated our conversation, evoking in me a profound sense of empathy and compassion as I listened. I think sharing a similar lived experience in terms of desperation for help within paediatric services as a child myself, perhaps influenced my feelings of heightened responsibility to share her views. Finally, I think we shared similar views around parenting approaches, that led me to feel more aligned personally with her perspectives. It's crucial to remain mindful of these influences and ensure a balanced representation of voices in my analysis. While amplifying the perspectives of caregivers like xxx, I equally value the viewpoints of those with different experiences or less assertive opinions. This balance is key to fostering a comprehensive understanding of family dynamics and child mental health.

The next few entries are included as an example of how journal entries aided key decisions throughout the research process. This example, expanding across three journal entries, related to making a key decision around theme generation during analysis:

Entry 1:

I am exploring the way certain themes fit together, trying different options, and also being transparent to myself that there is not a right answer. Maybe this feels slightly uneasy to me, being a person that likes objective reasoning and explanations. I am trying to sit with the discomfort and also remind myself that my perspective is acknowledged in analysis by interpreting meaning to explain elements of reality. I currently have many provisional subthemes around topics of acceptance, exoneration, space for reflection, respite, overcoming battle in CAMHS services, blame and guilt. While it is useful to consolidate all this information under one overarching theme at this point, it is evident that this theme is very dense and unwieldy. To do justice to the subthemes and narratives, further revision and delineation is required.

Entry 2:

This morning I came up with an initial thematic map that categorised subthemes under overarching themes, however reviewing codes I realised that a couple of themes seemed blurred, and a different categorisation might promote clarity and further exploration. For example, I am now thinking that within initial subthemes of acceptance and validation, there are further areas to explore, such as caregivers' journeys from a place of blame, self-criticism and stuckness to self-approval. I want to capture differences between caregivers within the concept of self-approval - some said this approval was encouraged by The Croft, whereby a strong view by another caregiver explained that self-approval came from a battle of differing perspectives of parenting to the service whereby the conflict led to them feeling more confident in their own parenting ability. I am aware of my own position of one that feels aligned to the parenting views of the latter caregiver, who opposed parenting practices such as 123 magic, a practice encouraged by the services that feels different to an approach I *would take. Acknowledging my own perspective allows me to remain open to all perspectives and ensuring that my analysis reflects the diversity of caregivers' experiences.*

Further, I have been reflecting on the complexities of being supervised by a staff member at The Croft whilst simultaneously listening to and analysing the narratives of caregivers, some of whom have critical perspectives of the service in some areas. This dual role presents a unique challenge. I recognise this supervisory relationship might subconsciously influence my analysis whilst also recognising my commitment to honouring the authenticity and narratives of the lived experiences of caregivers. However, I don't think these two areas are mutually exclusive, and the aim is not an evaluation of The Croft but rather to explore the nuanced and multifaceted caregiver experiences, focused on their relationship with their child. There is no right or wrong experiences, but rather a spectrum influenced by individual circumstances and histories. I think it is important to reflect on this for transparent documentation, acknowledging my own biases, and aiding a more balanced representation.

Entry 3:

I made two revisions of the thematic map, I started writing up in line with the first version, however as I was writing I decided to change the categorisation of subthemes between these two overarching themes again. I think the only reason that I didn't do this sooner was because I wanted my thematic map to be evenly balanced. However, I spent a while reading Braun and Clark's (2021) book and they highlight how thematic maps can be asymmetrical. Also, the works of Patton (1980) on 'dual criteria for judging categories' (i.e. internal homogeneity and external heterogeneity) allowed me to see that the heterogeneity between theme one and two related to caregiver's view of themselves and the influence of this on their relationship with their child, whereas theme two related more to the sense of much-needed *respite after relentless battles with services to get support for their child. This heterogeneity between themes and homogeneity within themes supported revision two. This resulted in a revised thematic map, with theme two established as a standalone theme without subthemes, allowing for a more comprehensive and in-depth exploration of its complexity and nuances.*

References

Braun, V., & Clarke, V. (2021). *Thematic analysis a practical guide*. SAGE Publishing.

Patton, M. (1980) *Qualitative evaluation methods*. Sage Publications.