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The social must be stabilised: How are the social needs of young people with social work involvement characterized in their mental health case notes?

Tessa Morgan [a,*], Francesca Crozier-Roche [a], David Graham [a], Jack Smith [a], Taliah Drayak [a], Sophie Mary [a], Jeanette Cossar [b], Julia Mannes [a], Dihini Pilimatalawwe [a], Pamela Parker [a], Barry Coughlan [a,c], Rick Hood [d], Dustin Hutchinson [e], Matt Woolgar [f,g], Robbie Duschinsky [a]

[a] Applied Social Science Research Group, Department of Public Health and Primary Care, The University of Cambridge, West Forvie Site, England, Cambridge, UK
[b] School of Social Work, University of East Anglia, Research Park, England, Norwich, UK
[c] National College of Ireland, Mayor Street Lower, International Financial Services Centre, Dublin, Republic of Ireland
[d] Department of Social Work and Social Care, Kingston University, Holmwood House, Grove Crescent, England, Kingston Upon Thames, UK
[e] National Children's Bureau, 23 Mentmore Terrace, England, London, UK
[f] Department of Child and Adolescent Psychiatry, Institute of Psychiatry, King's College London, DeCrespigny Park, England, London, UK
[g] National Adoption and Fostering Service, Michael Rutter Centre, South London & Maudsley NHS Trust, England, London, UK

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ABSTRACT

In Donzelot's landmark *The Policing of Families*, he traced the rise of the "social" sector in the 18th century, where institutions like social work, education, and healthcare regulated families, shaping norms of deviance to justify intervention. Social scientists continue to debate the impact of post-2008 austerity measures on the relationship between the social sector and family life in contemporary society. This study aims to contribute to these discussions through a critical discourse analysis of how the social needs of 70 young people with social work involvement have been characterised in their Child and Adolescent Mental Health Service case notes. This analysis was co-produced alongside three experts-by-experience with lived experience of both mental health and social care. Results of this analysis indicate that the social needs of our sample were a) *rejected* from mental health services for being too social, too chaotic and lacking a stable base; b) *accepted but secondary* to psychological concerns c) *outsourced* to other services or to families or young people themselves. Where young people's social needs were sufficiently high risk in the community they were d) *contained* in mental health facilities or under deprivation of liberty orders by social services. We contend that in the contemporary context, rather than the social comprising an ever-expanding entity designed to govern the conduct of family life, we identified ways in which the social sector was also governing through neglect and containment. This analysis offers important insights into inequalities faced by young people with social care involvement who seek mental health support.

1. Introduction

In *The Policing of Families*, Donzelot (1979, p. ix) outlined how from the 18th century the social emerged as "a particular sector in which quite diverse problems and special cases can be grouped together, a sector compromising specific institutions and an entire body of qualified personal". Donzelot was influenced heavily by Foucault's (1978) emerging account of governmentality, defined as the "conduct of conduct", which saw power shifting in the 18th century from disciplinary regimes centred on coercion to those based on pastoral, biopolitical forms of power targeted at promoting "life itself" and the productive capacity of the population. Donzelot (1979) saw the social as including social work, psychologists, educators and health care officials whose principal role was to offer pastoral care in the form of guidance, advice, mentoring, instruction and treatment. In its goal of regulating and normalising the home as a site for the medically, psychologically

* Corresponding author.
E-mail address: tlm32@medschl.cam.ac.uk (T. Morgan).

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and legally informed upbringing of children, the social also produced ideas of deviance and sickness which could justify intervention. Both Foucault (1978) and Donzelot (1979) highlight how psychology emerged in this period as a domain of knowledge used to privatise social problems by turning them into the responsibility for those affected based on norms of appropriate conduct. In this way, Donzelot (1979) argues psychology was used to control the rise of "delinquent" children who were "too numerous to be gotten rid of through prison, too shrewd and too 'wild' to be dealt with by charitable methods" (p.116) by making them the responsibility of the family or, failing this, psychiatric institutions. The 19th century ushered in development of the welfare state across Western Europe which was by no small part designed to tackle what Beveridge (1942) termed the 'five giants': Want, Disease, Ignorance, Squalor and Idleness. The welfare state consolidated the nation state's responsibility to provide social assistance and publicly funded goods/services including healthcare and education to all as well as more personalised forms of support such as social work with families, the development of children's services and mental health services for those with additional needs (Garland, 2016).

Sociologists contend that since the late 1980s new public management and neoliberal agendas, ushered in the United Kingdom (UK) by Thatcher's government, kickstarted the dismantling of the welfare state (Garland, 2016). Scholars are divided as to the impact of these neoliberal reforms on the relationship between social institutions and family life (Koch and James, 2022). Some have argued that neoliberalism has resulted in the withdrawal of the welfare state and the extension of the social's governing and moralising role throughout family life (Morgan et al., 2022). Most notably, Rose (1996) contends that neoliberal policies have refigured the territory of government from universal policies concerning all citizens to targeted policies directed at increasingly localized, heterogenous communities. Fundamental to this shift has been the growing emphasis on personal responsibility for social problems. As such there has been a shift from direct government intervention to "governing at a distance" through a range of entities including families who endeavour to "administer the lives of others in the light of conceptions of what is good, healthy, normal, virtuous, efficient or profitable" (Rose and Miller, 2010, p.273). Tyler (2013) considers how a new round of austerity cuts following the 2008 global financial crash has seen the intensification of stigmatizing discourses around "troubled families" which further demonises parents seeking direct state support. Featherstone and colleagues (2014) go further to illustrate how these discourses have resulted in the intensified surveillance of families viewed as deviant and has contributed to the increased number of child removals.

Another body of literature focuses instead on how austerity measures across different neoliberal nations have resulted in varied forms of state neglect. In the UK, scholars have focused on how funding cuts to public services have resulted in the widespread reduction of early help interventions which has meant families are often left without support until they are deemed at acute, immediate risk (Bergen et al., 2023; Webb and Bywaters, 2018). Anthropologist Joao Biehl has powerfully argued that these socioeconomic conditions have produced *zones of social abandonment* where socially undesirable subjects are concentrated outside of social life altogether (Biehl and Eskerod, 2013). As an example, Biehl documents *Vita*, an outskirt area in Brazil where psychiatric patients deemed terminally "hopeless" or "unwanted" were cast out by their families and medical professionals to fend for themselves (Biehl and Eskerod, 2013). More recent ethnographical work with marginalised communities, including isolated black communities in the U.S. and those living in *Yoseba* (day labour acution markets) in Tokyo agree that these zones of state neglect may originally arise through the discriminatory withholding of essential services (Archer, 2024; Han, 2024). Scholars suggest, however, that these zones can also be experienced as places of solidarity, collectivism and mutual aid outside of normative structures (Archer, 2024; Han, 2024). Crucially, these empirically informed cases disrupt the "ever expanding gaze" narrative of the social offered in the theoretical accounts of Foucault (1978, 1991), Donzelot (1979) and Rose (1998). They also support a critique made of these theorists who routinely "describe without examining how agents put [ideas] into practice" (Pestaña, 2012, p. 133; Koch and James, 2022). This paper aims to make a contribution to governmentality studies by focusing empirically on mental health access for young people who also have social work involvement. As these young people exist at the coal face of changes to multiple care organisations, we contend they present an emblematic case study of neoliberal care in contemporary Britain.

1.1. Context

A unified Child and Adolescent Mental Health Service (CAMHS) was finally created within the NHS in 1987. Drivers for its establishment include the shift in psychiatry from the mid-1950s to view child and adult mental health as distinct domains. This was coupled with a growing concern that mental health care was increasing disjointed across community and hospital settings and that the later was not keeping up with demand from young people (Barrett, 2019). Neoliberal economic ideologies from the 1980s also played a central role in the deinstitutionalisation of mental health care underpinned by the belief this was a more cost-effective to shift the moral responsibility of psychological care back onto families (Rose and Miller, 2010).

National guidelines for the service were developed in 1995 which saw CAMHS arranged into four tiers with ascending levels of need (Table 1). From the beginning of the 21st century, it has become increasingly apparent that CAMHS is in crisis (Barrett, 2019). Repeated independent reports have concluded that CAMHS faces a range of serious problems, which has been accredited to systematic underfunding, such as long waiting times, post-code lottery of service provision and lack of emergency services (Children's Commissioner for England, 2024). Cuts have been accredited to the significant reduction in early intervention Tier 1–2 services (British Medical Association, 2016). Evidence indicates that austerity has resulted in unequal access to CAMHS. Supporting this contention, the Children's Commissioner for England (2024), reported that during the 2022-23 period, of the 949, 200 children and young people who had active referrals to CAMHS, 373, 000 children (39 %) had their case closed before accessing treatment, with a further 270,300 children (28 %) currently on a waitlist. An analyses of over 71,000 records from a large NHS Trust found children from the most deprived areas and young people with social service

Table 1
Description of CAMHS Tier system.

CAMHS Tier Level	Description	Who is responsible
Tier 1	Universal service aimed to promote good mental health.	Supported by non-mental health specialists such as G.P.s, health visitors, school nurses, teachers, social workers and youth justice workers.
Tier 2	Short-term, early intervention for those with mild to moderate mental health problems.	Supported either within a specialised CAMHS clinic or an out-reach basis, for example in G.P. surgeries or schools.
Tier 3	Longer term care and treatment for severe, complex or persistent difficulties including moderate to severe mental health difficulties (e.g. PTSD, depression, OC) or complex neurodevelopmental disorders.	The service is provided by a team of specialists in a community mental health clinic or hospital outpatient clinic.
Tier 4	Highly specialised services for the most complex cases.	Typically hospital-based and include both day units and in-patient units

Note. Adapted from Lambeth CAMHS eligibility criteria. https://slam.nhs.uk/lambeth-camhs.

involvement were around two to three times more likely to have their referral rejected from CAMHS than their peers (Mannes et al., 2024).

Inequitable access to mental health services is stark given young people with social service involvement are six times more likely than their non-social service involved peers to experience mental distress (McKenna et al., 2024). Some of the mental distress may be explained by experiences of trauma and adversity before entering the social care system, with abuse or neglect identified in 57 % of child-in-need referrals in the UK (Office for National Statistics, 2024). It may also be a feature of social care involvement. Multiple placement shifts, for example, have been found to be especially detrimental to young people's mental health (Ford et al., 2007; Hiller et al., 2021). Qualitative evidence suggests that this unequal access to CAMHS may relate to stigmatizing assumptions made by professionals about young people's social lives. For example, an analysis of 100 CAMHS case notes found that adopted and fostered children are over-diagnosed with attachment disorders rather than other common mental health conditions (Woolgar and Baldock, 2015). Connecting this health service literature with wider sociological debates has the potential to help clarify mechanisms sustaining such inequities and therefore deepen our understandings of how to best address them.

1.2. Aim

To understand how the social needs of young people with social work involvement are characterised in their Child and Adolescent Mental Health Service (CAMHS) case notes.

2. Methodology

2.1. Theoretical framework

This analysis seeks to analyse mental health case notes using Fairclough's (1995) three-dimensional framework for critical discourse analysis. This approach analyses text on the level of text, discourse practice, and sociocultural practice. From this perspective, case notes do not merely represent what has happened but "they also evaluate it, ascribe purposes to it, justify it" (Van Leeuwen, 2008, p. 6). They do so in relation to the discursive, institutional and sociocultural practices in which they are embedded. Douglas (1986) contends that institutions produce texts that reflect ritually cultivated thought styles that lead people to act in ways that reinforce their form of social organization. Such texts tend to "naturalise and normalise prevailing ideologies" (Van Leeuwen, 2008). Foucault contends that case notes operate as a technique of "hierarchical observation" and surveillance designed to suppress deviance and cultivate normalised and individuated behaviour. He contends that case notes link individuals into "a network of writing" that "engages them in a whole mass of documents that capture and fix them" as individuals with marked characteristics (1991, p. 189).

Social scientists have shown how medical case notes normalise through a "cutting out operation" by elevating the significance of some information whilst rejecting others; and filling in the blanks of unobserved actions and relations (Hov et al., 2022; Smith, 1978). These 'factual' accounts then have the power to attribute acts and persons as 'deviant' or otherwise (Kelly et al., 2024). This labelling process has a meaningful impact on patients' lives by influencing patients' diagnoses and treatment pathways as well as reinforcing hierarchical relations between professionals and their patients (Berg, 1996). As such, professionals may also knowingly disobey the generic requirements of the case notes, by adding or omitting information to protect their patients or to influence their care pathways (Hov et al., 2022).

2.2. The social in mental health research

In recent years there has been a decided shift to considering the role social elements play in mental health (Cruwys et al., 2023). Both the biopsychosocial model and social determinants models have become increasingly common models used in conceptualising mental health (Cruwys et al., 2023). Mental health research has also increasingly recognised the ways that mental distress itself is a historically, culturally, and politically situated experience (O'Reilly and Lester, 2017). The extent to which these models have proliferated into practice is debatable. Moreover, definitions of the social and its relationship with mental health remain undertheorized, varied and contested (Bemme and Béhague, 2024). Contributors in a recent special issue about the role of the social in mental health research diversely conceptualised it as social support, social inclusion, social construction of need, social risk factors, social environment, social status, and social discrimination (Bemme and Béhague, 2024). Authors in this special issue aptly advocated for setting mental health amidst wider power structures including historical processes of marginalisation such as racism, colonialism, capitalism, and welfare policies (Irvine and Haggar, 2024). There remains a need to extend these arguments to consider the ways wider biopolitical regimes designate something social. To do so we draw on the ideas of Donzelot, Foucault, and Rose who view the social as a zone of governmentality in which the boundaries of the specific social institutions (social work, psychology) are (re)produced in the service of promoting "life itself" and the productive capacity of the population. By taking this approach we allow room to explore how multiple different conceptualisations of the social (support, context, status) are used in practice to negotiate boundaries between public and private life.

2.3. Experts-by-Experience

This paper addresses longstanding epistemic injustices which have seen people with lived experience left out of mental health research (Bemme and Béhague, 2024). This research was co-produced by a core team of three experts-by-experience (EbyE) with lived experience of both mental health and social care, alongside one charity sector leader and an experienced researcher; each with their own experiences of mental health services. Reflecting a high level of co-production (Hemming et al., 2021), we worked together weekly for the duration of the project to conceptualise, analyse and write this paper. This process involved the sharing of different kinds of unique experiential and theoretical knowledges (e.g. sociological theory) which we carefully applied to the case notes. The process required a high level of on-going reflexivity and discussion about the validity of interpretations (Hemming et al., 2021). This research could often be emotionally distressing so clinical psychological supervision was provided to individual members These findings have been informed by wider stakeholder consultation. Co-authors include clinicians who have worked directly with young people in care and who offered invaluable insights into how our findings could be useful in improving rather than merely critiquing current service provision. Two advisory groups (one including academics and another with social work and mental health professionals) reviewed our findings at different stages of development to support their theoretical and practical validity (Varpio, 2023).

2.4. Data collection

Case notes were sourced from the *Clinical Record Interactive Search (CRIS)* dataset based in the South London and Maudsley (SLAM) NHS trust. Half of the young people accepted by this NHS Trust have identified safeguarding needs and a fifth have social care involvement (Coughlan et al., 2024). This project has been approved for secondary data analysis by the University of Oxford (23/SC/0257). All patients have consented for their anonymised notes to be used for research purposes. These notes include unstructured fields, referral documents, correspondence, progress notes and demographic data. These case notes are principally produced by CAMHS professionals but also include notes from G.Ps., A&E doctors, educators, social workers, police officers, and occasionally young people and their guardians. Case notes span from

2007 to present, capturing a period slightly before the introduction of austerity measures following the 2008 global financial crisis. They also include information from the COVID-19 pandemic where services had to shift almost exclusively to online consultations.

We familiarised ourselves with the data before selecting our sample. As this was an exploratory qualitative study we used a maximum diversity purposive sampling strategy (Liamputtong, 2020). One analyst, guided by conversations with the wider EbyE team, selected 70 cases which aimed to reflect the diversity of the sample by including a variety of genders, ages, ethnicities, mental health diagnoses and difficulties, and levels of social work involvement. Social work involvement was based off any young person having one or more social work flag registered on their CAMHS record (Supplementary 1). Low social work involvement related to one-two flags and high social work involvement related to three or more flags. Our final sample was extracted on February 1, 2023 by the SLAM data manager into an Excel spreadsheet, along with demographic data and each young person's most recent CAMHS risk assessment. The 70 cases included 20,166 unique case notes. Young people had between 33 and 2672 case notes (mean = 288). The demographic data of this diverse sample is outlined in Table 2.

2.5. Analysis

We began our critical discourse analysis with one analyst creating a pen portrait of each young person's set of case notes (Hollway and Jefferson, 2013). Each portrait included a timeline of service provision, along with extended quotes that reflected important and/or recurring topics in each case note (Hollway and Jefferson, 2013). Together at weekly analysis we read excerpts from these pen portraits, focusing closely on what language professionals used, how assessments and clinical reflections were structured, how young people and their families were represented and what happened. Experts-by-experience related these accounts to their own experiences which was how we shifted our focus to how these case notes were reflective of wider socio-cultural practices they themselves had experienced. Over nine months, EbyE and academic co-Is discussed 40 cases, which was the point at which we felt we had reached information power (Malterud et al., 2016). Through discussion we identified four distinct ways that CAMHS handled social needs. Supporting the trustworthiness of our analysis, themes were compared to notes made about the remaining 30 cases to ensure they were supported in the wider dataset (Hollway and Jefferson, 2013; Lincoln and Guba, 1985). EbyE co-researchers also reflexively compared findings with their own lived experience to further support the trustworthiness of the overall analysis. To ensure anonymity, quotes were approved by the CRIS team. Each young person is referred with a pseudonym and also identified by their number in their social work group, their gender and ethnicity.

Table 2
Sample demographics.

Characteristic	*N*
Ethnicity	
Black British	21
White British	21
White other	5
Mixed Heritage	9
Asian	6
Other	8
Gender	
Female identifying	30
Male identifying	30
Gender diverse	10
Age	
12–15 years old	20
16–18 years old	50
Safeguarding needs	
High (2+ safeguarding need)	35
Low (1 safeguarding need)	35

3. Results

Social needs were not viewed within CAMHS's remit. Where young people's problems were identified as 'social', or where their social situation was not deemed sufficiently stable, requests for care were typically rejected by CAMHS. Where social needs were viewed as warranting CAMHS attention, they were subordinated to psychological diagnoses that typically met the formal DSM psychological criteria. Sometimes young people with social needs were outsourced to other services. In other circumstances young people and families were required to attend to their mental health concerns themselves. Finally, where social needs escalated to a level that made them too risky, they were then contained within psychiatric wards or under deprivation of liberty orders in social care settings.

3.1. Rejected

3.1.1. Too social

Young people whose emotional distress or behavioural challenges were identified as principally relating to "social" or "contextual" stressors almost always had their CAMHS referral rejected. Young people who were living in foster or residential care often had their CAMHS referral rejected for being too social. In a typical example, Alex, a 12-year-old was brought into A&E after having taken a suspected overdose and running away from their new foster placement which they had recently shifted to due to "complex family dynamics." Nevertheless, because their presentation was deemed "substantially social" they were rejected by mental health services on the basis that they "need [social service] intervention and generic support with emotional regulation" (33HSWOWB).

In another case, Benedict, a 16-year-old unaccompanied asylum seeker was rejected from CAMHS on the basis that "Although he was expressing distress, it was primarily in the context of him being very unhappy in his foster placement" (34HSWMBB). Crucially in situations where young people's assessments were indeterminate, the existence of any social factors could be the reason for the rejection of their referral. For example, Coulson, a 13-year-old who was referred to CAMHS by school for soiling and disruptive behaviour was assessed for ADHD. Despite the findings of this assessment being inconclusive, his CAMHS referral was ultimately rejected on the basis that social factors might be underlying his presentation:

> Coulson does not meet the criteria for a moderate to severe mental health difficulty and initial assessments around possible underlying neurodevelopmental difficulties have been inconclusive…Coulson's lack of contact from his father and bereavement of his grandmother may be predisposing factors to his emotional dysregulation (12HSWMWB)

3.1.2. No stable base

Acute contextual crises had to be resolved for CAMHS to accept a young person into the service. For example, case notes explicitly state that the legal ramifications of physical or sexual abuse had to be resolved prior to therapeutic input, despite legal edicts to the contrary (The Crown Prosecution Service, 2022). Two separate entries stated: "CAMHS would not be able to act in this matter until it is clear that safeguarding issues are dealt with, and the [sexual abuse] allegations have been properly investigated" (29HSWO; 1LSWFMR). The caveat to this was situations where CAMHS was already substantially involved in a young person's care exhibited in the case of Freddie, a 7-year-old who had been involved in CAMHS since aged 2. Him and his siblings were actively offered support by their care co-ordinator during court proceedings relating to their custody. The care coordinator wrote that they had been "working with the family for several years on and off" and

"spoke to the family about continuing to support the children through this uncertain time, seeing the children fortnightly" for Art Therapy (03HSWMMR).

The requirement to have a "stable base" to begin therapy presented a barrier for young people in foster or residential care placements who were often denied care because their home setting was viewed as inherently unstable. This is chronicled in a discharge note from 2021 for Gwen, a 17-year-old who was deemed unable to achieve a stable base to begin therapy:

> Gwen has been open to [the service] since her referral in 2018, she has not had the opportunity to experience a stable placement on a consistent basis… Gwen has not been in a settled enough placement to allow her to engage in any therapeutic process (06HSWFMR).

Requests by social workers for CAMHS to intervene in order to stop placement breakdowns were frequently rejected by CAMHS on the grounds that the young person was not in a stable social environment. Such interprofessional correspondence also linked to funding disputes around whose responsibility it was to pay for mental health care in these instances. In a typical example, a foster carer asked for therapeutic input for their child, Hayley, to prevent their placement from breaking down. The carer's request was rejected due to a funding disagreement between CAMHS and social services. Five months later the foster carer handed in her notice citing Hayley's "deteriorating behaviour" (07HSWFBB). It is important to note that earlier case notes from 2007 to 2010 suggest that CAMHS used to fund a service to support children at risk of placement breakdown prior to Austerity cuts (09HSWMBB). Without such a service the case notes indicate a number of young people with service-identified "trauma" and a high level of behavioural and/or mood concerns experiencing a high number of placement breakdowns without any direct therapeutic support. Worryingly, a lack of a "stable base" was the reason provided to refuse treatment to Juliette, a young woman who had shifted five placements in one year, despite explicit and repeated acknowledgement of her trauma from parental neglect and familial sexual abuse (13HSWFBB). Left unsupported, Juliette's case notes chronicle her escalating forms of self-harm and suicidality resulting in multiple A&E admissions in one year.

This principle also applied to young people who were living with their family of origin. In one case Kevin, an 11-year-old boy "referred to CAMHS following significant behavioural difficulties at home and concerns regarding his emotional wellbeing" (18HSWMWB) had his assessment delayed until he could prove that he was not living with the "contextual stressor": his mother. The service noted this separation was "crucial in establishing and maintaining therapeutic progress" (18HSWMWB). On moving in with his father his referral was accepted by CAMHS and he was diagnosed with social anxiety and ADHD.

3.1.3. *Too chaotic*

Where the needs of young people and/or families were deemed too "chaotic", seemingly employed as a synonym for difficult and/or too complex, they were often rejected from the CAMHS service or their treatment was stopped. Often this would happen subtletly whereby a family and/or young person would miss one or two appointments and their case would be closed as a "did not attend". Sometimes such judgements were made more explicitly in the notes. For example, direct therapy was stopped for a family on the basis that mum would not have capacity as "things might be a bit too chaotic at the moment" (31HSWOWB). Notably the CAMHS coordinator remained involved in the multidisciplinary network around the child and provided evidence to support a Child in Need order. In another case, a mother was advised that CAMHS would be closing her two children's cases because it was apparent that she needed to attend to their "social" needs first and that it was "particularly important as we believe therapy sessions should not take priority over important health checks, child protection conferences and other family emergencies" (30HSWOO). In notes, their family was framed as a "chaotic environment" which "had to be tackled before any further diagnoses could be explored". Indeed, the mother was instructed during a family therapy session to "develop prioritization and organization skills" to ensure her children attend CAMHS on time. This is despite her documented limitations such as her other caring responsibilities and her very precarious financial situation which meant they often could not afford to take public transport (30HSWOO). This decision also seems to be taken separately from the needs of the two children.

In a handful of examples, young people identified as being in extremely complex situations were left without any therapeutic input despite having no consistent social support structure to contain their risk. In a stark example, Michelle, a 12-year-old living in residential care who had enter CAMHS at 7 due to a suicide attempt was deemed too complex to receive Tier-4 national service specialist support. It was thought that her high level of daily risk should be supported locally. As her discharge note states:

> in view of her history of complex traumatic experiences, Michelle would also benefit from a tailored intervention to support emotional regulation and emotional literacy to reduce the severity of her maladaptive externalising behaviours and risk of self-harm (13HSWFBB)

3.2. *Accepted but secondary*

Young people's social needs were accepted by the service where they were viewed as elevating the risk of clearly diagnosable psychological/neurological conditions. The clearest examples of this were where significant, and clearly defined adverse social experiences had culminated in post-traumatic stress disorder, such as in the case of Nicholas, a 16-year-old unaccompanied asylum seeker:

> Nicholas is at risk of post-traumatic stress disorder having lived in a war zone, the sexual assault he reports and other experiences on his journey which he may not have spoken about. There should be a low threshold for offering him emotional and psychological support (16HSWMO).

More typically, social factors met high service thresholds where they could not be distinguished from psychological factors in moments of acute distress, for example during A&E admissions following an attempted suicide or instance of "significant" self-harm. Such a combination of "psycho-social stressors" is clearly outlined as culminating in Onyx's, a 14-year-old, suicide attempt which led to their A&E admission.

> Voice-hearing has coincided with increasing anxiety and in response to several pscyho-social stressors: starting new school, father leaving…two sexual assaults, and increasing confusion … regarding gender identity (07LSWFWB)

While social factors were accepted, there remained a clear hierarchy with psychological symptoms always noted prior to the social or contextual stressors exacerbating them. This hierarchy was also evident for treatment provision. For example, Onxy was referred to a clinic a month later to determine the psychiatric nature of their voices. During this assessment serious mental health was ruled out and they were therefore referred to CBT for their emotional distress which took over a year to access and a gender clinic referral that was never offered.

The lower status of social needs was clearly expressed in bullying cases. Emotional distress due to bullying rarely met service thresholds. In one case it did: Peter, a 13-year-old boy was deemed to meet psychological criteria of "depressive illness in the context of social stressors". This is because his bullying was connected to his onset of seeing visions and hearing voices, and persistent "suicidal thoughts by hanging". Nevertheless, because a CAMHS assessment determined that "as risk is low and difficulties indicated as mild-moderate in range, consider for Tier 2 services. brief intervention… possibly by trainee psychologist." (32LSWMWB).

Other forms of common lower tier interventions for young people with significantly socially-disruptive behaviour was medication. Multiple young people were diagnosed with ADHD and Hyperkinetic Conduct Disorder and prescribed medication. In one case this process took place despite the psychologist's concern that a young person's, Quinn, behaviour was "difficult to unpick …from complex social background without further assessment" (22HSWFMR). While it is not to dispute the validity of the diagnosis, it is to note that rarely were these interventions offered alongside psychological interventions to address these young people's acknowledged underlying trauma (13HSWFBB). Group parenting interventions based around behavioural management strategies or psychoeducation were another widely prescribed low-tier intervention where the perceived problem was parental figures' ability to manage their young person's risk. Such interventions were often supported by attachment discourses which located the solution to a young person's attachment problem (especially if they were living in foster or residential care) as providing "reliable, available and consistent care" which could be achieved through "intensive parenting to stabilize" (18HSWMWB). Parenting interventions did not extend to psychological work with parents which was problematic in cases where the principle challenge was identified as parent's mental health. In an extreme case despite "mum's low mood" being identified as the "key factor in Quinn's recent behavioural difficulties, rather than showing something inherent in Quinn", Quinn's mother was prescribed a "parenting intervention" rather than direct mental health care. Without support, Quinn's mum attempted suicide some months later and resulted in Quinn being taken into care (22HSWFMR).

3.3. Outsourced

CAMHS often rejected referrals of young people with social presentations by outsourcing their needs to other services. One note explicitly stated that this practice was preferable as it was in the patient's best interests to avoid multiple interventions. Occasionally young people were signposted to other charities where health care professionals felt that CAMHS treatment would not be effective, for example in the case of bereavement or specialised sexual violence services. There also appeared to be a resource saving motivation, with CAMHS outsourcing to other organisations where they could. This was clearest in cases where the CAMHS assessments were inconclusive as in the following excerpt that shows that school was identified as best place to take responsibility:

> Following CAMHS extended assessment, evidence was not conclusive to warrant a diagnosis of ADHD. Instead specific recommendations have been made for school around exploring specific learning difficulties and working with SENCO (32LSWMWB)

Indeed, the choice to frame young people's needs as social rather than psychological was most prevalent where young people's needs could be met by lower-level interventions through social care, school counselling or bereavement services. Practices of outsourcing were potentially influenced by CAMHS practitioners' assumptions that other services would have more resources to better support a young person for a longer period of time. For example, young people who had recently been bereaved were framed in terms of grief and they were signposted to a non-for-profit bereavement service, despite their self-reported concerns with anxiety and depression. In another case, Russell, a 10-year-old boy's CAMHS assessment mentioned a history of self-harm, restrictive eating, hearing voices, and aggression to others. Nevertheless, because his difficulties were located with mother's cultural difficulties of accepting his sexuality, he was deemed to not have "any significant mental health issues". This assessment was also made on the basis that he was also already engaged with a counselling charity and his CAMHS case was closed (2LSWMB). While such cases could both also be read as examples of good signposting, the fact that many of these young people were rereferred to CAMHS with escalating need indicate otherwise.

For teenagers who did not meet high thresholds of risk, the expectation was that they would care for themselves; reminiscent of Foucault's 'technologies of self'. This emphasis on taking responsibility for oneself was explicitly outlined in a safety planning resource distributed to young people following an A&E admission for self-harm or suicide. The one-page sheet outlined the need to reduce their own "difficult feelings" and "increasing coping resources" through strategies such as breathing, distraction techniques and lifestyle changes. In emergencies, young people were advised to use online applications such as Headspace and Stayalive a suicide prevention application or call emergency services. While this could be seen as a way of promoting young people's coping skills; often the outcome was young people's readmission to A&E for suicide or self-harm, with no indication, as the sheet stated that "things will get better." (30HSWOO; 07LSWFWB; 23HSWFWO; 31HSWOWB).

3.4. Contained

A final group of young people were deemed to present risks "too great to manage in the community" (02HSWFBB). Young people in this category were deemed unable to care for themselves and their wider care network was deemed unable to contain their risk. Young people's liberty was usually restricted under sectioning orders within a Tier 4 in-patient mental health care facility from A&E following a "serious" suicide attempt. Case notes from these in-patient admissions were extensive, including multiple entries per day. These detailed how unresolved social factors, particularly relating to not feeling safe at home or in their neighbourhood, resulted in their increasing feelings of not wanting to be alive.

These social factors also made it difficult to discharge them home. For example, following a third suicide attempt, Victoria, a 14-year-old girl was admitted into a Tier 4 facility as "she could not guarantee her safety" (02HSWFBB). During her initial assessment Victoria described self-harm as "a long-standing coping mechanism … to self-soothing in the context of chronic emotional neglect". This led to her being placed on a child protection plan which in turn made it difficult to discharge Victoria. After a month, professionals raised concerns about her "institutionalization/bed blocking" despite Victoria stating that she continued to have "3 & 4 panic attacks a day". Victoria was eventually discharged seemingly against her wishes to her mother, whom Victoria had explicitly stated she did not want to live with.

Young people's liberty could also be restricted through Deprivation of Liberty (DOL) orders used in three cases in this sample for already looked-after children. DOLs orders involve a young person being placed under 24/7 surveillance in a secure social care setting with a limited number of other young people. These were justified in situations when "a subject lacks capacity and to present serious deterioration. DOL necessary for life-sustaining treatment …. Or doing 'any vital act'" (03HSWMBB).

CAMHS played an important role in advising social services around these orders though they did not provide direct therapeutic support to these detained young people. An explanation for this is that containment was principally about protecting young people from themselves and others rather than remedying the root cause of their distress. A DOL was framed as the only way to keep Ziva, a 16-year-old gender-diverse autistic young person safe from themselves after they were admitted to A&E 9 times in one week (31HSWOWB). In another case the DOL was used by social services as a "back door" means to shift a young person named Isaac into a new placement given reluctance from any residential facilities to take him after his psychological review deemed him as having "psychopathic" qualities alongside Autism (09HSWMBB). While three separate CAMHS professionals advised he be placed in a 52-week therapeutic placement to help off-set some of his early childhood trauma, he was instead placed in accommodation where he was monitored 24/7 by staff, but with no therapeutic input. After 6 months on this order, Isaac received another CAMHS psychological review which

determined that the "provision of care in a secure setting would not be in his longer-term best interests". Isaac himself noted that "it is not helping him develop into a mature man". Shortly after this, Isaac allegedly physically assaulted a residential care staff member and was sent down the "criminal justice route".

4. Discussion

This empirical account of Child and Adolescent Mental Health Services aims to further sociological understandings of the relationship between the social and the family under austerity in the England. Whilst identifying ways in which the social continues to permeate the conduct of family life, in line with the governmentality scholarship, we have also identified co-occurring patches of neglect and containment. In line with previous research, we therefore offer a more fractured picture of the social (Koch and James, 2022). Governing through neglect has analogies with the empirical evidence around "zones of social abandonment" whereby young people with social needs were being rejected from mental health care for being *too* social (Biehl and Eskerod, 2013). These decisions appear to be underpinned by assumptions that other services, or indeed family, were better suited to managing these young people's risk. An issue with this logic was that often young people's social stressors made them "too chaotic" or too complex to be accepted by other services. In line with other scholars (Barrett, 2019), we view this tendency to exclude "complex" cases as underpinned by wider austerity logics whereby resource limited services were increasingly reluctant to take on resource intensive clients. Similar forms of gatekeeping have been identified in Adult Mental Health services, with adults denied support on the basis they were too complex because they faced both substance and mental health challenges (Bergen et al., 2023). Our finding also chimes with an analysis of government policies after 2010 which identified a shift towards a biological interpretation of mental health in order to exclude socio-economic causes and therefore underplay the effects of austerity on wellbeing (Callaghan et al., 2017).

This analysis has important implications for what constitutes legitimate mental health problems under Austerity. Contrary to the growing academic and policy literature on the social determinants of mental health, this analysis reveals that in practice services are operating on a strict biomedical, diagnostic-led approach to mental health (Callaghan et al., 2017). While it is important to recognise that not all young people's social needs can or should be attended to by mental health services, nor should their emotional or behavioural concerns be understood a priori as mental health problems. Our concern, however, is that due to these strict remits we identified many cases where young people's needs appeared to be characterised as social to justify their rejected referral despite their notes documenting underlying psychological or trauma-related concerns. Our finding aligns with a recent interview study with CAMHS practitioners who felt they could justify less involvement if social care needs were framed as the immediate priority as this framing meant that young people could hopefully receive support from another service (Beale, 2022). As such our analysis highlights the ways that resource limitations in mental health care impact care pathways. The practitioners' groups consulted in the process of this analysis similarly felt that systematic underfunding had meant they routinely faced difficult, morally challenging decisions around whether to accept young people with social work involvement whose needs were on the cusp of service thresholds.

Compounding matters, we identified an imperative that the social must be stabilised for young people to be able to receive mental health support. What constituted social stability was unclear and appeared to relate to a myriad of domains such as home environment, legal standing, economic security, social conduct and relationships. The lack of consistency with which stability was deployed aligns with the absence of agreement about what stability constitutes amongst mental health professionals (Kirkman, 2019). This finding helps us to further understand why young people with social work involvement continue to experience inequitable access to mental health services given they are likely to be viewed as lacking stability in multiple domains and therefore not suitable for mental health care. This particularly concerning given evidence that young people in residential care with the most significant mental health difficulties are the most likely to be in unstable placements (Hiller et al., 2023). Our findings indicate the need to reconsider social stability as the basis of receiving mental health care (Kirkman, 2019). To do so, further research is required to systematically understand how stability is conceived of by mental health practitioners.

"Governing through neglect" resulted in young people and families having to manage high levels of risk, a finding that accords with insights by Donzelot and Rose. This notion of the family as a 'stabilising' force that neutralised its own social risk is precisely why Donzelot, Rose, and Foucault viewed social organisations as seeking to govern through families, based on an assumption that families (read mothers, daughters) would always be there to provide care. Concerningly, our analysis revealed very little support in the way of parents' own mental health needs. This suggests that the original promise of the social to provide extra familial support when needed, is increasingly limited in scope (Donzolet, 1979). These findings indicate the need for greater integration of child and adult mental health services if the family is to remain a stabilising force to support young people's development. Our analysis identified the need for exploring alternative ways of organising services that centre need rather than shoehorning young people into pre-existing pathways (Farr et al., 2020). There is also further need to design and better fund holistic, interprofessional ways of attending to young people's challenges.

This analysis also identified a high demand placed on young people themselves to respond to their emotional and behavioural issues despite being in crisis. This seems to reinforce wider expectations that contemporary social life comes with a relatively high level of distress, which Berlant has termed previously as "crisis ordinary", that individuals themselves are expected to bear (Helms et al., 2010). We contend that this sets problematically high expectations on young people to exert their agency and "care for themselves" in circumstances where their ability to take decisions are "thinned" by their context, particularly for young people without consistent adult support (Hutchby & O'Reilly, 2010). Concerningly, a similar experience has been documented for young adults whose presence of mental capacity was used as justification to reject requests for formal help as it was perceived they could choose to care for themselves (Bergen et al., 2023).

On the other end of the spectrum this analysis also identified a pattern of "governing through containment". By highlighting the deployment of secure units and deprivation of liberty orders, this paper problematised the assumption that community care has so decisively replaced asylums and other forms of institutional care (Bolton and Bhugra, 2021). This analysis reveals how this shift back from community to institution occurred when young people's social needs became too complex to be attended to in the community or contained by themselves and family. These young people could be understood in Foucauldian terms as a residue of disciplinary power systems which always produce some subjects "inassimilable to all of a society's educational, military, and police disciplines" (Foucault, 2006, p. 54). Nevertheless, this analysis identified how it was precisely because these young people's social and mental health challenges were not attended to earlier that their ability to care for themselves became compromised. Our finding is in line with the few contemporary studies that consider how asylums remain places where people "end up when kinship ties fall to pieces" (Pinto, 2014). This description aptly captures young people with social care involvement, whose lack of social support appears a core reason for their admission. This finding supports calls for earlier intervention that takes account of the holistic needs of the family (Webb and Bywaters, 2018). Concerningly, our finding about the use of deprivation of liberty orders was illustrative of a wider trend; whereby the use of such orders for people aged under 18 has increased 462 % between 2018 and 2022 (Nuffield Family Justice Observatory, 2022).

We argue that this reflects a wider tendency born out of austerity (Leppo and Perälä, 2017) that where neoliberal subjects are framed as acutely risky and complex, a logic of force enters that prioritises containment and control and impedes compassion and care for our society's most vulnerable.

4.1. Limitations

These qualitative findings are not generalizable although the large qualitative evidence base enhances their robustness. Second, EbyE acknowledged variation in service provision in CAMHS in different NHS trusts and therefore a comparison between services would be beneficial. Stakeholder consultation with professionals across multiple trusts, however, reported that these findings were "all-too familiar". This analysis is limited to textual representations and therefore cannot capture the whole host of actions occurring around the text which may indicate other kinds of service response. Future observational or interview studies with service providers and young people themselves would complement these insights.

5. Conclusions

This empirical account of Child and Adolescent Mental Health Services offers a contribution to furthering sociological understandings of the relationship between the social and the family under austerity in the UK. Rather than the social comprising an ever-expanding entity design to govern the conduct of family life, we offer an account of the social being distorted by austerity owing to the diminished resourcing of such services. High thresholds meant that young people with social work involvement were often rejected by mental health services for their needs being *too* social. This resulted in the dual process of "governing through neglect" whereby young people and their families had to fend for themselves precisely because there were no other services available. On the other hand, we identified the tendency to "govern through containment" where young people's social needs escalated to the point that made them too risky to themselves or others. Recommendations for service provision include the need for greater financial investment in CAMHS, a move away from requiring the social to be stable ahead of therapeutic input, more parental mental health support and increased provision of early intervention services.

CRediT authorship contribution statement

Tessa Morgan: Writing – review & editing, Writing – original draft, Supervision, Project administration, Methodology, Investigation, Formal analysis, Data curation, Conceptualization. **Francesca Crozier-Roche:** Writing – review & editing, Writing – original draft, Validation, Methodology, Investigation, Formal analysis, Conceptualization. **David Graham:** Writing – review & editing, Writing – original draft, Validation, Methodology, Investigation, Formal analysis, Conceptualization. **Jack Smith:** Writing – review & editing, Writing – original draft, Validation, Methodology, Investigation, Formal analysis. **Taliah Drayak:** Writing – review & editing, Writing – original draft, Validation, Methodology, Investigation, Formal analysis, Conceptualization. **Sophie Mary:** Writing – review & editing, Validation, Methodology, Investigation, Conceptualization. **Jeanette Cossar:** Writing – review & editing, Validation, Supervision, Investigation. **Julia Mannes:** Writing – review & editing, Validation, Investigation, Formal analysis, Conceptualization. **Dihini Pilimatalawwe:** Writing – review & editing, Validation, Investigation. **Pamela Parker:** Writing – review & editing, Supervision, Conceptualization. **Barry Coughlan:** Writing – review & editing, Validation, Investigation, Data curation. **Rick Hood:** Writing – review & editing, Supervision, Funding acquisition, Conceptualization. **Dustin Hutchinson:** Writing – review & editing, Supervision, Funding acquisition, Conceptualization. **Matt Woolgar:** Writing – review & editing, Supervision, Investigation, Funding acquisition, Conceptualization. **Robbie Duschinsky:** Writing – review & editing, Writing – original draft, Supervision, Project administration, Funding acquisition, Conceptualization.

Ethical approval

This project has been approved for secondary data analysis by the University of Oxford (23/SC/0257).

Declaration of competing interest

Authors confirm that they have no competing interests.

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Appendix A. Supplementary data

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Data availability

The authors do not have permission to share data.

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