Title: '*What is 'crisis'?: A review of how 'crisis' is conceptualised in Children's Social and Mental Health Services in the UK'*

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1. Introduction

In the United Kingdom (UK), the Children Act (1989; 2004) states Local Authorities must ensure children and young people (CYP) are safe, appropriately looked after, and protected from physical and mental harm. Decisions on safeguarding and wellbeing interventions are led by Children's Social Care (CSC; Department for Education, 2023a) who work in close partnership with other agencies including Child and Adolescent Mental Health services (CAMHS) to provide services for children identified as not coping. Within these higher tier services, the term 'crisis' or 'in crisis' is often used in reference to CYPs and/or families who are not coping. These services provide multiagency or integrated care, but how 'crisis' is used across and between the services remains unclear. This review aims to explore the discourse of the term 'crisis' in these services to answer the following research question: How is the term 'crisis' used in the context of UK-based child-centred social care and mental health interventions with children and/or their families identified as experiencing difficulties with coping?

1.1. Overview of child-centred social care and mental health services

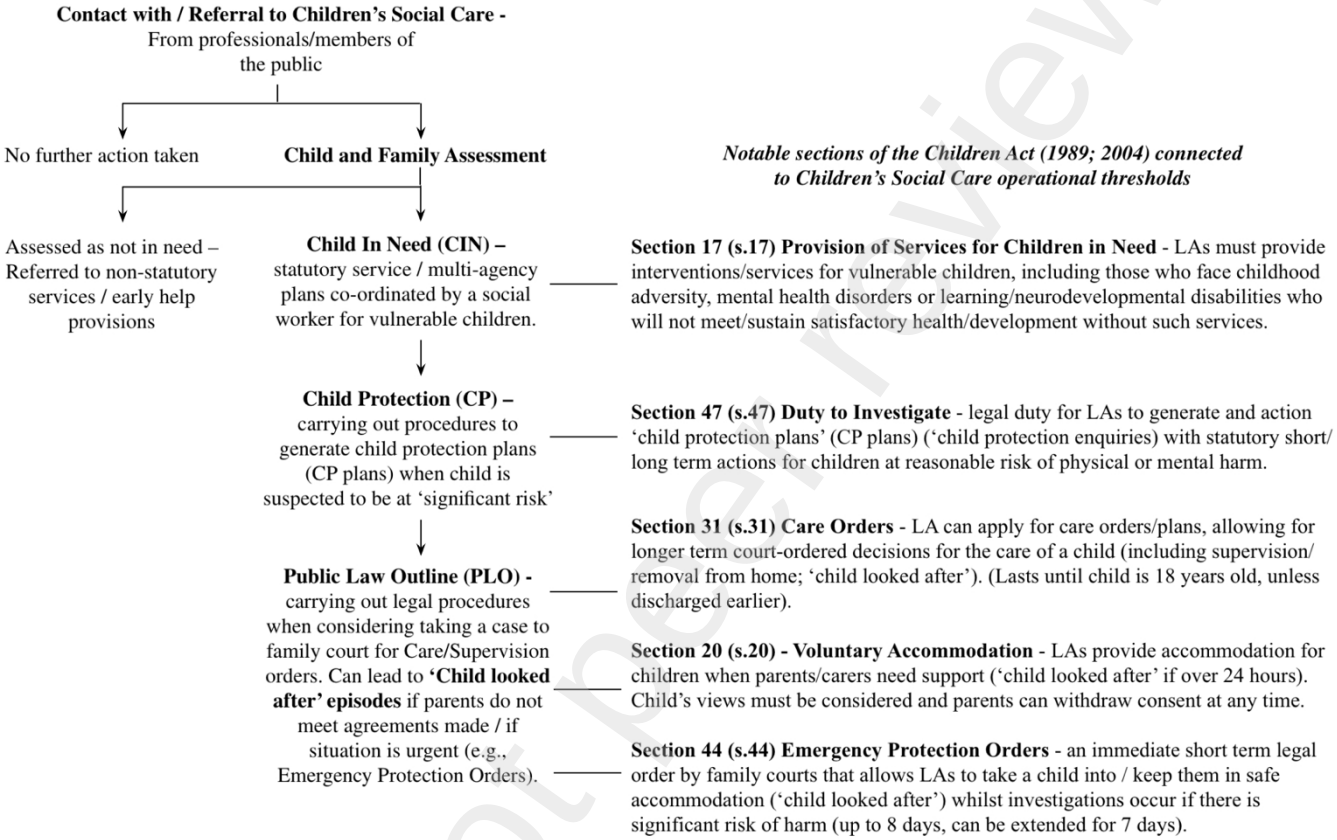
Children's Social Care (CSC) provide universal services (i.e., information and advice) and targeted and higher tier services to children and families. Targeted services and higher tier involvement is case-specific and involves various stages of screening, assessment and investigations and specific intervention services like early help, children's centres, child protection and out-of-home or looked after services (Department for Education, 2023a; Hood & Goldacre, 2021). CSC intervention is underpinned by the Children Act (1989; 2004) and supported by safeguarding laws and guidance, e.g., Children and Families Act (2014) and Children and Social Work Act (2017). To summarise operations, Hood and colleagues (2020; 2021) outlined principal thresholds of CSC, these being 'child in need', 'child protection plans', and 'looked after episodes' (see Figure 1 for overview). Initial child and family assessments are completed if CYP and/or their families are identified as vulnerable or not coping. CSC intervention should occur when families struggle to meet the needs of CYP due to complex needs or adversity (i.e., they meet the primary need codes or identifiable factors; see Appendix A), and higher intervention should occur when CYP are considered at risk of or experiencing 'significant harm' (e.g., sexual abuse, emotional abuse, physical abuse and neglect) (Department for Education, 2023b). Whilst operations are case-specific, CSC support families and CYP with a wide range of adverse situations and complex needs.

Children and Adolescent Mental Health Services (CAMHS) are part of the National Health Service (NHS) and work in multidisciplinary teams under section 17 (see Figure 1) alongside local authorities' social care, education, and healthcare services to provide support specific to management of CYP mental health conditions/concerns and neurodivergence. Whilst there has been movement towards other models (e.g., i-THRIVE, Pilling et al., 2019) CAMHS predominantly follow a stepped care approach (Garratt et al., 2024); a well-established care model, where support starts on the first 'step' and 'moves up' to higher intensity steps if required to meet needs (McLellan et al., 2022). This is operationalised via a four-tier system: (1) universal services; (2) targeted services; (3) specialist community CAMHs; (4) highly

specialist inpatient and outpatient services (Garratt et al., 2024). CAMHs professionals can be directly involved from tier 2 and CAMHs multidisciplinary teams are involved in tier 3 and 4 (The Association for Child and Adolescent Mental Health, n.d.).

Figure 1

CSC Thresholds and Operations Flow Chart



Note. Adapted from Hood and colleagues (2020; 2021) and the Children Act (1989; 2004).

1.2. Crisis discourse

In the 1960s Erich Lindermann and Gerald Caplan conceptualised 'crisis' as a state of 'disequilibrium' and 'disorganisation' (Eaton-Stull, 2022). However, more contemporary psychological theories of 'crisis' support the conceptualisation of 'crisis' as an event or difficulty that causes distress and exceeds coping mechanisms and abilities - leading to failure of coping mechanisms and lower capability to function (James and Gilland, 2001; Kanel, 2012). Reflecting this, The American Psychological Association (2018) explicitly define 'crisis' a situation or *"traumatic change"* that causes *"significant cognitive or emotional stress"* and *"instability"*.

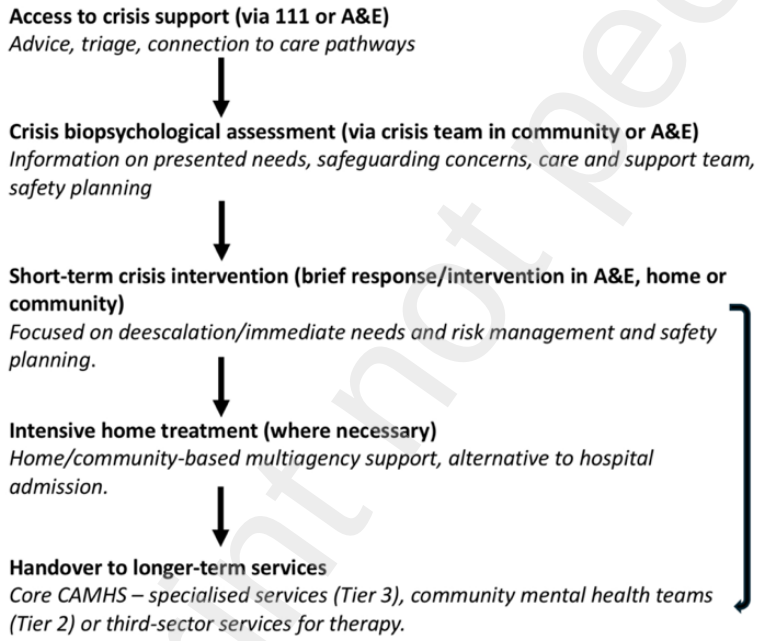
However, within social welfare, 'crisis' is perceptibly difficult to conceptualise, as it is used interchangeably with words of different meaning (e.g., stress, change and critical incident; Clark, 2007). Despite this, within higher tier children's services, 'crisis' and 'in crisis' are often used as blanket terms to describe CYP and/or their families who are not coping and require intervention (Holt & Kelly, 2020; Kanel, 2012; Lyons et al., 2023). In practice, 'crisis

support' and 'crisis services' are used across health, education and social care (Yeager & Roberts, 2015) by different clinical teams/settings (e.g., CAMHS, accident and emergency departments, school counsellors, youth services, community services; Clibbens et al., 2023). Ultimately, 'crisis' is not a protected term and is seen across varying contexts. Moreover, although community 'crisis' responses function better when services/agencies work together (Clibbens et al., 2023 Ofsted, 2023), there is still uncertainty surrounding how and when 'crisis services' operate within local care systems (Evans et al., 2023) and whether a similar understanding 'crisis' is shared between services.

Regarding mental health, the phrase 'mental health crisis' is often used to depict individuals experiencing a mental health episode, including children (Evans et al., 2023).Within CAMHS guidance, 'mental health crisis' is often defined as experiencing acute mental distress that leads to significant risk of harm towards themselves or others (Mind, 2020) and is connected to urgent and emergency mental health care (Healthy London Partnership, 2016; NHS England, 2024). Within guidelines, 'crisis' is operationalised via the Crisis Care Pathway that local teams utilise (see Figure 2).

Figure 2

Crisis Care Pathway Flow Chart



Note. Adapted from NHS England (2024).

Within crisis response and home treatment teams Tobitt and Kamboj (2011) proposed identifying factors of 'crisis': disruption to typical behaviour/psychological functioning; risk of harm to individual or others; further support needed. However, these are broad, and the authors also suggest 'crisis' is complex with varying definitions and conceptualisations and may cause confusion within communication (i.e, in teams/with referring agents). Moreover, research is lacking into practitioners understanding of crisis teams (Kusnierczak et al., 2025)

and there is ambiguity between services on what constitutes as a 'mental health crisis' despite common use (Edwards et al., 2023). Lyons and colleagues (2023) conducted an evolutionary concept analysis on 'mental health crisis', and found it lacks a universally accepted definition, and is 'multifaceted', 'fluid' and 'context-dependent' - impacting consistency in policies and practice.

Social workers are also often called 'crisis workers' (Eaton-Stull, 2022; Kanel, 2012), and CSC is often labelled as 'crisis-orientated' (Family Rights Group, 2018; MacAllister, 2022). However, in statutory social care guidance and frameworks 'crisis' is rarely explicitly used and when it is, it lacks explicit definition and consistent conceptualisation. In key frameworks including the 'Children's Social Care National Framework' (Department for Education, 2023c) and 'Working Together to Safeguard Children' (Department for Education, 2023a), 'crisis' is not explicitly used or defined. Under 'Every child matters' – a reform proposal (Department for Education and Skills, 2003), the common assessment framework (CAF) was developed for those working with CYP and families to identify those who need help earlier and intervene *"before things reach crisis point"* (Department for Education and Skills, 2008). This legislatively suggests social care should aim to be preventative rather than reactive to crises, which is supported in the Care Crisis Review (Family Rights Group, 2018). Furthermore, this conceptualisation of 'crisis' implicitly presents it as a state those not coping reach/enter (ie., 'crisis point'). Conversely, within the 'Child in need Consensus', 'crisis' is used only within the definition of 'Family in acute stress' (primary need code 'N4'):

> *"Children whose needs arise from living in a family that is going through a temporary* ***crisis****…where the parenting capacity is normally good enough, but they face circumstances, factors, or events that undermine that capacity."* (p.57, Department for Education, 2023b)

An explicit definition of 'crisis' is not given, but 'crisis' is implicitly linked to circumstances/events that undermine parenting capacity. Therefore, where 'crisis' is used in CSC guidance and statutory documents, the linguistic conceptualisation differs and there is a lack of clear operationalisation.

This review aims to expand on research by exploring how 'crisis' is utilised and conceptualised in the context of higher tier services for children identified as not coping. CSC and CAMHS work together, and both utilise 'crisis'. Therefore, records on both services will be included to allow for better analysis and comparison of how 'crisis' is used within and between services. Specifically, we will conduct a systematic review of relevant literature to answer the following research question: How is the term 'crisis' used in the context of UK-based child-centred social care and mental health interventions with children and/or their families identified as experiencing difficulties with coping?

2. Methods

A systematic review was conducted following PRISMA guidance (Page et al., 2021). The aim was to find and review relevant record to answer the following research question: How is the term 'crisis' used in the context of UK-based child-centred social care and mental health

interventions with children and/or their families identified as experiencing difficulties with coping?

2.1. Definitions utilised within inclusion-exclusion criteria

The phrase 'coping difficulties' will be used as an umbrella term to depict children and/or families experiencing difficulties that require social care and/or mental health services. This includes situations covered within the CSC primary need codes (e.g., child's disability/illness, parents disability/illness, family in acute stress, family dysfunction etc.) and the additional factors collected at initial assessment point (e.g., domestic abuse, learning disability, self-harm, alcohol/drug misuse, etc.) and the five categories for higher intervention ('significant risk of harm'; physical abuse, emotional abuse, sexual abuse, neglect, multiple) (see Appendix A for full lists). Moreover, the included research will focus on 'coping difficulties' impacting child welfare and subsequent intervention to safeguard them. Following Hood and colleagues (2021) thresholds of CSC operations (see Figure 1), this review will explore records focused on children who statutorily are considered a child in need (i.e., mental health issues, adversity, and/or complex needs; Children Act, 1989; 2004), or 'at significant risk' and thus in need of higher-level interventions (e.g., child protection plans and child looked after episodes).

As dictated by the Children Act (s. 17, 1989) and outlined in section 1.1, mental health support falls within the child welfare and social care bracket (i.e., 'Child in Need' threshold), and CAMHS are the primary service in supporting CYP mental health and wellbeing (NHS England, 2024). There is frequent multiagency cooperation between CSC and CAMHS – i.e., CSC social workers refer CYP to CAMHS (The Association for Child and Adolescent Mental Health Services, n.d.) and are involved in this care (Department of Health, 2004; Statham et al., 2006).

Notably, whilst police, health care professionals, support workers and educators form part of the wider UK social care system and multi-agency support/responses for vulnerable children and families, they are primarily reporters, referrers and implementors of agreed care plans (Department for Education, 2023b; 2023c; 2023d). As CSC and CAMHS are lead decision makers and interveners for higher tier safeguarding and welfare interventions for CYP, this review focuses on these services. Thus, any record focused on education, police or health services and other relevant agency interventions/services will not be included unless it is in the context of CSC or CAMHS intervention to ensure relevance to research question.

As 'crisis' is a term used by both services, including records focused on social care and mental health service interventions allows for a better analysis of how 'crisis' is used by those who are intervening to safeguard children and also allows for comparisons to be drawn between services. For ease, services will be referred to CSC and CAMHS when discussed separately and as 'higher tier services' and/or 'services for children identified as not coping' when discussed collectively.

2.2 Search Methods

Scoping searches were utilised initially to test search terms and strategies within different databases to identify the record they produced. We adopted a research strategy with five levels. These included sets of terms related to: child/children, services, social care, crisis, intervention, and the UK. Additionally, the final searches were further refined by language (English) and location (United Kingdom) if these options were available. The full search strategy can be found in Appendix B.

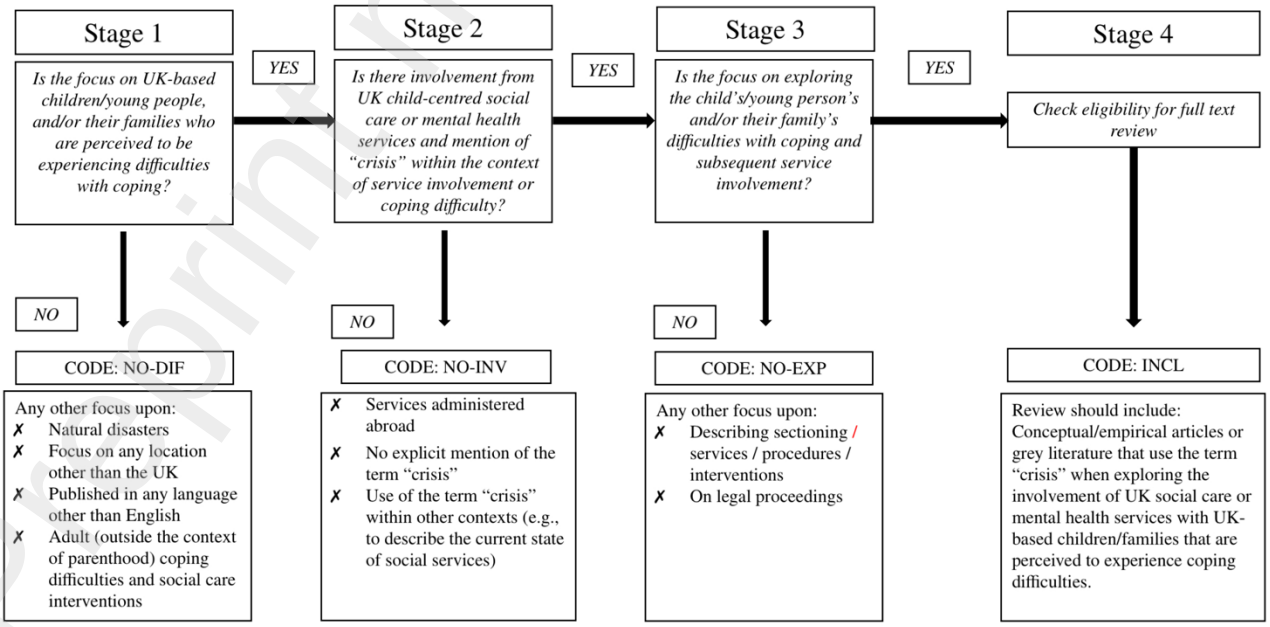
The finalised search strategy/protocol was utilised to conduct a systematic search of peer-reviewed articles and/or grey record within four e-databases; APA PsychArticles & eBook collection (via EBSCOhost; 10/12/2023), Scopus (10/12/23) and Web of Science (WoS; 10/12/2023), NSPCC database (27/12/2023). These searches produced k = 412 records - see Table 1 (Appendix C) for overview. Titles and abstracts were read to ascertain whether records met the inclusion criteria. From this, k = 34 records were included for full-text analysis.

2.3. Screening and document selection

In this systematic review we sought UK-based records exploring social care and mental health service interventions with UK children/families that mentioned the term 'crisis'. Explicit Inclusion-Exclusion criteria were discussed prior to screening by the full research team. Three stages were decided on, each containing individual inclusion and exclusion criteria. The stages were numerically labelled and had increasingly stricter criteria to more specifically meet the research question (see Figure 3) to ensure record included was relevant.

Figure 3

Eligibility/Selection Criteria Flow Chart



Screening was completed using REFworks (reference management software) by [author 1]. After importing all results, the REFworks duplicates tool was used on all references, and any duplicates found were removed (K = 48). Titles and abstracts were then screened to determine if they fit the predetermined inclusion-exclusion criteria (see Figure 3).

Records were assessed against the outlined eligibility/selection criteria of each stage. Explicitly, if record met stage 1 criteria, it would be examined against stage 2 criteria and then ultimately stage 3 criteria (see Figure 3). If record met all stages, it was included in stage 4 (eligibility screening). However, if record did not meet the inclusion criteria of stages 1, 2 or 3, it was excluded and consequently moved into the folder for that stage. Also, if record met any of the exclusion criteria of a stage it was excluded (regardless of whether it met inclusion criteria) and consequently moved into the e-folder for that stage. Records where no full text was available via university of [x] databases were excluded (k = 1), and any further duplicates that were not removed by the original tool function were excluded (k = 5). Where the country was not explicitly mentioned within the abstract or summary of the record, the tagged locations and/or the country of residence of the author/affiliation were utilised as determining factors on whether the study was UK-based and therefore excluded at stage 1.

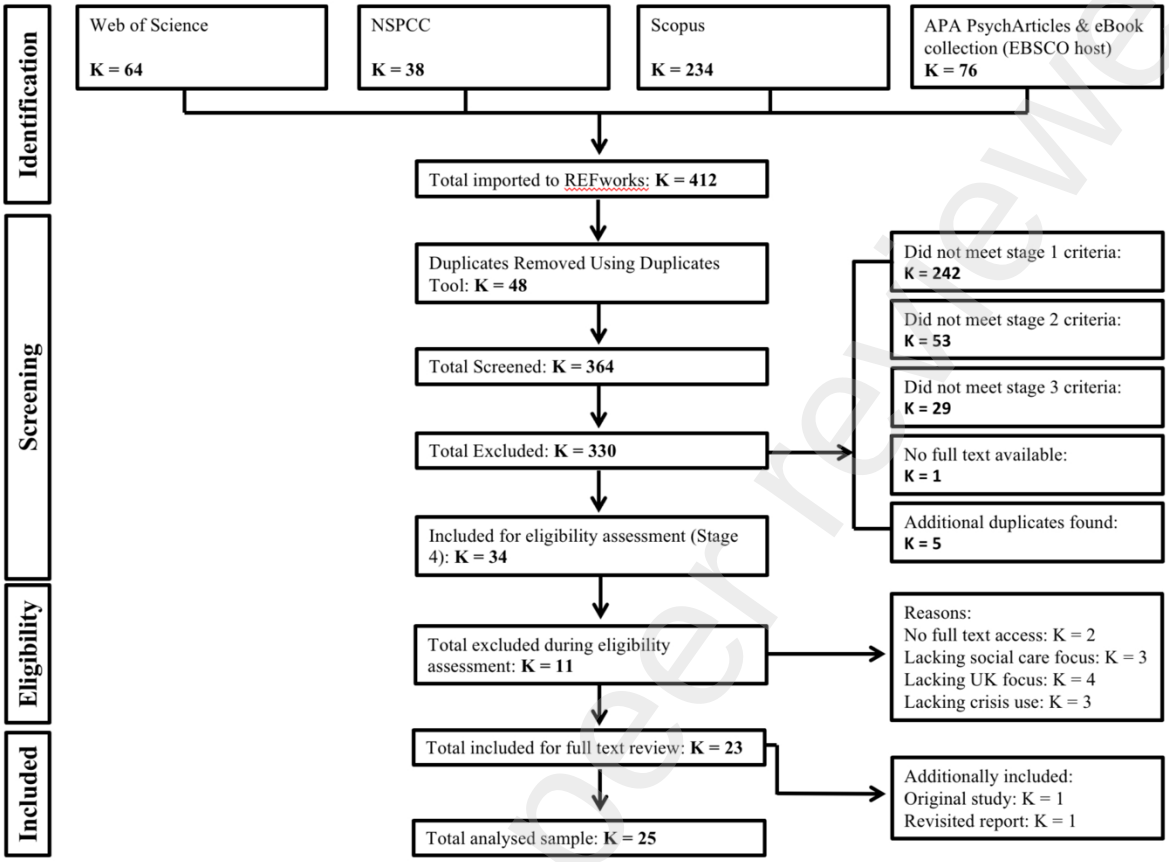
Once completed, the screening categorisation decisions were checked again to increase reliability. Also, any record the independent reviewer was indecisive on whether to include, and any discrepancies or further clarification on screening procedures were discussed amongst the research team.

The results from the screening process are outlined within Figure 4, which is based off the PRISMA flowchart model (Page et al., 2021). After applying the selection criteria, 330 records were excluded (see Figure 4 for breakdown). Consequently, 34 records were included for eligibility screening (stage 4) for full-text analysis.

Within eligibility screening, the stage 4 records were scanned and assessed more thoroughly for eligibility against the selection criteria. During this, a further 6 record sources were excluded; as upon further investigation they did not fully meet the eligibility/selection criteria (see Figure 3). Specifically, k = 3 records were excluded due to lacking explicit focus on UK data/context, k = 2 records were excluded due to lack of full text access, k = 3 records were excluded due to lacking focus on the CSC or CAMHS involvement and k = 4 records were excluded as lacked use of ‘crisis’ in the context wanted (i.e., crisis was only used in the names of the service, not as a choice of language or they lacked association of crisis with service involvement). Additionally, during full-text analysis, an additional k = 2 records were reviewed as they were the original/revisited work of included records and deemed relevant to include. Consequently, after exclusions and additions, the final analysed sample was K = 24, consisting of journal articles (K=13), book chapters (K=2) and reports (K = 3) and serious case reviews (K=6).

Figure 4

Flow Chart of Included-Excluded Record



Updated searches using the same search strategy were conducted on August 1st 2025 via Scopus and Web of Science to review records published between December 2023 and August 2025. The updated Scopus search produced k = 5 records, but these did not meet eligibility/selection criteria. The updated Web of Science search produced k = 22 records, of which k = 1 record met all eligibility/selection criteria. This record (i.e., Ashworth et al., 2025) is a journal article. A full-text analysis was conducted, and the findings of this review were updated.

2.4. Full-text analysis

All records were read for understanding and context, then sections containing the term ‘crisis’ (or ‘crises’) were read in their entirety and analysed line-by-line by author 1. Regular meetings were held with members of the research group to discuss salient patterns in the data. Information was collected for the following research question relevant items: coping difficulty outlined; intervention used; explicit definitions of ‘crisis’; context ‘crisis’ is used. Exemplar quotes from analysed sections were also collected. Other information and the record type was included in a residual category titled ‘other comments’, the number of times ‘crisis’ (or ‘crises’) was used in each record was also recorded. Each source was

independently analysed, and the information items were collected then inputted directly into a table (see Supplementary Materials) which was then used to conduct the analysis.

Narrative syntheses are used in systematic reviews to analyse qualitative or quantitative data collected in included studies to analyse effectiveness or implementation of interventions and make empirical claims on certain populations. Instead, the current review analyses conceptualisation of a certain term, and thus is unconventional in its approach. Arguably, this review merged the concept of a narrative synthesis with that of a content analysis approach to find patterns in how the concept of crisis is communicated in the included literature. Therefore, after collecting the data in the full-text analyses, a hybrid narrative synthesis/content analysis of the collected data was conducted. Content was extrapolated via inclusion-exclusion criteria and then more specifically via sections containing the term 'crisis'. Then, guided by the research question, the information collected was used to generate low level sub themes (see Supplementary Material). These themes were then grouped to form overarching themes and used to detect patterns and relationships in how the concept is communicated.

3. Results

3.1. Preliminary summary

Within the text of the included records, the term 'crisis' (or 'crises') was used between two and seventy-eight times specifically alongside either social service involvement or the coping difficulties leading to the social service involvement. However, in four records, 'crisis' was also used in other contexts to describe the state of; finances (Stalker et al., 2018), the pandemic / housing shortages (Galloway, 2020), the rate of mental health issues (Staite et al., 2022).

Within the included literature, 6 records have a predominant CAMHS focus, 14 records have predominant social services focus and 4 records are serious case reviews where care involved both social services and mental health services – and at times other agencies (e.g., police).

3.2. Crisis definition

Within the records, no explicit definition of 'crisis' was given. However, one explicit definition of 'mental health crisis' was given. Explicitly, Staite and colleagues (2021) stated, *"a mental health crisis is an emergency that poses a direct and immediate threat to physical or emotional well-being."*. In other records, 'crisis' was treated synonymously to phrases depicting acute risk / needs. Including: *"emergency"* (Staite et al., 2021; NICCY 2018; Mackenzie & Holden, 1972; Hatfield et al., 1997), *"tipping point"* (Stalker et al., 2018), *"significant harm"* (Delaney, 2004), *"immediate risk/harm"* (Staite et al., 2021; NICCY 2018), *"traumatic experience(s)"* (Blank, 1975). Other words such as "complex", "vulnerable" and "at risk" were associated with individuals/family units experiencing a crisis. For example, Stalker and colleagues (2018) defined *"complex cases" "in terms of a child's level of impairment and its impact on the family, or else where children were "at risk" or a family at "crisis point".* They also state families who need level 4 (the level tied to being *"in*

crisis") intervention *"will have identified complex needs".* Additionally, Byrne (2017) stated *"…crisis care and joined up support for the most complex and vulnerable young people in the future".* O'Connor and colleagues (2014) stated *'the complex interwoven nature of their needs"* after crisis intervention *"are likely to have ongoing repercussions",* they also specified *"attachment complexity".* Regarding 'mental health crisis', the following phrases were used in records: *"Very vulnerable young people talked about their mental health deteriorating, for some to a crisis point"* (NICCY, 2018); *"Patients of high acute mental health complexity were admitted [to mental health crisis ward]"* (Gorny et al., 2021);*"Professionals involved in mental health crisis should be aware of the complexity of need in family units with children…"* (Hatfield and colleagues, 1997); *"…majority of young people accessing the CAMHS Crisis Team consistently have complex difficulties…"* (Staite et al., 2022). Some specified "complex difficulties" lead to / precipitate a 'crisis'. For example, NICCY (2018) stated "*Young people who present to A&E during a mental health crisis often have a wide range of complex needs that have precipitated the crisis".*

3.3. Crisis intervention

All records focused on intervention at a 'crisis' point, often termed *"crisis intervention"* (Staite et al., 2022; NICCY, 2018; Leigh & Miller, 2004; Mackenzie & Holden, 1972; O'Connor et al., 2014; Forrester et al., 2008; Griffin, 2023), but also: *"crisis management"* (Galloway, 2020; Griffin, 2023; Wate, 2021); *"crisis care"* (Griffin, 2023; Byrne, 2017; NICCY, 2018; Gorny et al., 2021); *"crisis-led"* support / services (Galloway, 2020; Griffin, 2023); *"crisis consultation"* (Blank, 1975). 'Crisis' also featured in the explicit names of services, but predominantly in records focused on mental health coping difficulties. Two records focused on parental mental health interventions featured explicit crisis service names, Kalifeh and colleagues (2009) used *"crisis resolution team"* and *"crisis house"*, whilst Mackenzie and Holden (1972) used *"family-crisis intervention unit".* Five records focused on children's mental health interventions – specifically CAMHS, used numerous crisis service names. NICCY (2018) focused on *"CAMHS crisis intervention services"* and alongside using *"crisis intervention"* and *"crisis care"*, they also used the following terms: *"crisis intervention teams", "crisis mental health support", "crisis support", "crisis residential care", "community-based crisis assessment and intervention teams".* Gorny and colleagues (2021) also focused on *"crisis pathways"* within CAMHS and alongside *"crisis care"* they used; *"crisis service", "crisis hub", "crisis teams", "crisis community services".* Other records with similar focuses used the terms; *"crisis team"* (Stalker et al., 2018), *"CAMHS crisis team", "crisis service"* (Staite et al., 2021; Staite et al., 2022), *"crisis resolution team"* and *"crisis resolution and home treatment team* (Staite et al., 2021). Therefore, it appears there is a pattern where records focused on mental health coping difficulties and CAMHS used crisis intervention more explicitly and specifically, while social services focused records used it more generally.

Forrester and colleagues (2008) describe *"Intervention at the crisis point"* to be *"shaped by crisis intervention theory and focuses on immediate, intensive and short-lived intervention".* When discussing crisis intervention, other records also featured one or multiple of the terms

(or synonyms of them): 'immediate' (NICCY, 2018; Staite et al., 2021; Staite et al., 2022; Khalifeh et al., 2009; Blank, 1975); 'intensive' (NICCY, 2018; Khalifeh et al., 2009; Scullin & Galloway, 2014; Staite et al., 2021); 'short-term'. (Mackenzie & Holden, 1972; Blank, 1975; Staite et al., 2021). Some records also metaphorically illustrated 'crisis intervention' as *"fire fighting"* (Byrne, 2017; Griffin, 2023). Some records gave explicit short term time frames, but these differed, for example, Staite and colleagues (2022) focused on CAMHS interventions for CYP experiencing mental health crises and stated *"…crisis intervention will be across 72 hours. However, this is flexible and can be extended if needed".* Whereas O'Connor and colleagues (2014) focused on home-based interventions for children at risk of CP plans and stated *"…intensive crisis intervention services in the family home over a brief (4–6 weeks) period".* This again shows differences in operationalisation of 'crisis' between CAMHS and social services intervention, specifically CAMHS crisis intervention is much shorter than social services based – but this cannot be generalised across the records due to their lack of specification.

Some records highlight crisis intervention as an ineffective model of intervention in acute social care scenarios. For example, Forrester and colleagues (2008) stated "*…brief interventions are unlikely to be an effective way of reducing the need for public care. In general, children enter care because of complex and chronic problems, rather than a precipitating crisis".* Also, within the included serious case reviews the crisis management / crisis led intervention approaches were often criticised and recommended against. Griffin (2023) stated *"The unintended consequence of this crisis mode was that, too often, the urgent drove out the important. This resulted in important actions/interventions that were needed being missed, especially if they fell outside statutory or procedural requirements…",* and Shelton (2015) stated "*Too many of the interventions were responses to a crisis and, as such, were not an efficient or effective use of resources"* and described crisis-led intervention as "*reactive rather than a proactive approach to assessing and planning".* Notably, whilst crisis intervention is overwhelmingly conceptualised as short-term immediate support, some argue this should be in collaboration with longer term care. For example, Forrester and colleagues (2008) stated *"…findings raise questions about whether a short-term, crisis intervention model is appropriate for all of the families worked with. Indeed, for the families we consider most likely to have children enter care —those with complex and long-standing problems — effective prevention may require longer term or episodic work".* O'Connor and colleagues (2014) specify *"Children and young people may benefit from brief interventions during a period of crisis and longer-term interventions which address cumulative effects and attachment complexities and promote sources of resilience."* This indicates intervention should be brief at time of crisis ('crisis intervention'), but complex issues associated with 'crisis' need to be solved through longer term intervention.

3.4. Coping difficulties linked to crisis

An extensive range of coping difficulties were associated with 'crisis' across the records. Due to the range of coping difficulties and demand drivers for CSC intervention acknowledged in the literature, records were categorised by coping difficulty. These

categories are similar to previously used categories of factors associated with social care use (see Fitzsimons et al., 2022) but are more specific to our findings. These are displayed in Table 2 below alongside the number of records in each category, and the specific coping difficulties/demand drivers referenced across records which are listed on a spectrum of increasing severity. Some records arguably overlapped categories but were grouped into the most fitting/prominent category based on the focus (see Supplementary Materials for details).

Table 2

Coping difficulties associated with 'crisis' and depicted as demand drivers for intervention

Coping difficulty category	Examples given	Records in category
Child's (or young persons) mental health issues/disabilities or child beyond control	***Focus on child exhibiting distressing behaviour and child and/or family unit are not coping due to this.*** ***Including;*** non-attendance at school, special education needs and disorders, isolation, behavioural issues beyond coping ability of parent (e.g., physical/verbal aggression and disruptive behaviour), mental health concerns (anxiety and low mood, depression, psychosis), criminal behaviour, eating disorders, substance abuse, self-harm and suicidal behaviour.	8
Parental mental/physical health and parenting struggles	***Focus on parent exhibiting distressing behaviour and not coping and therefore not able to parent successfully.*** ***Including;*** mental health concerns (depression, affective psychosis, psychotic episodes), substance abuse, suicidal episodes/behaviour, breakdown in parenting (i.e., inconsistency, issue maintaining boundaries, upheaval, chaotic parenting lack of emotional connection, 'parentification' of child), exposing children to distressing behaviour, relationship breakdowns, difficulties in meeting child's physical needs, neglect, abandonment (physical/psychological) disappearance/death/hospitalisation, mistreatment, domestic abuse, child abuse (real/threatened violence).	8
Child facing complex/multiple psychosocial difficulties	***Focus on child experiencing mental health issues alongside/due to multiple adversities and not coping.*** Mental health concerns and/or behavioural concerns making them 'beyond parental control' (e.g., emotional dysregulation, aggression, risky behaviour, criminal acts, substance misuse, self-injurious/suicidal behaviour) due to/alongside; bereavement, parental separation, parental	5

	mental health issues (inc. substance abuse), parenting breakdowns, parental criminal behaviour, neglect/needs not met, CSC intervention, foster placement breakdowns, upheaval, criminal involvement (child exploitation), homelessness, incarceration, sexual exploitation.	
Family unit facing adversity	***Focus on family unit experiencing adversity and not coping.*** Including; exclusion from community/school, relationship breakdowns, cost of living, poverty (and destitution), chronic stress, parental mental health issues, bereavement, parenting struggles, housing insecurity/homelessness, domestic abuse.	3

To sum, from the records, parent mental health and breakdowns in parenting and child's mental health/child beyond parental control are the most associated with 'crisis' and social services intervention, then child facing multiple/complex psychosocial difficulties, then family unit facing multiple adversity. Notably, six of the records in the child's mental health/child beyond parental control category did have a predominant focus on CAMHS intervention, rather than social services directly. It is also evident that 'crisis' is associated with a spectrum of severity of coping difficulties experienced (see Table 2). Reinforcing this spectrum, CAMHS focused records associated 'crisis' with depression and also suicidal tendencies, and social services focused records associated 'crisis' with relationship breakdowns/parenting struggles as well as abuse/neglect.

In records focused on mental health coping difficulties, crisis was often made more specific at the point of use. Explicitly, "mental health crisis" was often used. This was seen in 3 records focused on parental mental health concerns (Hatfield et al., 1997; Khalifeh et al., 2009; Tudor, 2022). It was also seen in four of the CAMHS focused records (Staite et al., 2021; Staite et al., 2022; Gorny et al., 2021; NICCY, 2018). Two CAMHS focused records further specified their conceptualisation of crisis, Stapley and colleagues (2017) stated *"the crisis of their teenage child's depression",* and Ross and Dodds (20230 specified *"in crisis"* to *"young people with an intellectual disability"* who caregivers reported to be showing *"increased arousal…and unpredictability of behaviour".* Therefore, in records focused on mental health coping difficulties and CAMHS involvement, 'crisis' was overwhelming tied to a singular coping difficulty and was more specifically conceptualised. However, dissimilarly, in records focused on CSC intervention there is often a focus on multiple/a wide range of coping difficulties, and the situation/coping difficulty not specified when 'crisis' is actually used. Instead, it is used more like a blanket term for experiencing coping difficulty and requiring intervention.

3.5. Linguistic differences in conceptualisation - State vs. situation

Within the included literature, many records present 'crisis' as a state one enters into and use it as a blanket term to depict this state of overwhelm. For example, Forrester and colleagues (2008) use "in crisis" to depict the state one enters after reaching a "crisis point" (*"…intervention at the crisis point. Families are considered to be 'in crisis'…"*). Moreover, Blank (1975) described being "in crisis" as when *"people are confronted by serious and unavoidable problems which they seem unable to solve with existing coping and defence mechanisms. Unless they can mobilise additional forces within themselves, or be helped to do so, depression, anxiety, personality disorganisation and disintegration are threatening"*. Other records used phrases such as; *"in crisis"* (e.g., NICCY, 2018; Staite et al., 2021); *"period(s) of crisis"* (O'Connor et al., 2014; Ross & Dodds, 2023); *"families in crisis"* (Stalker et al., 2018); *"parenting while in crisis"*; (Khalifeh et al., 2009); *"in a state of mental crisis"* / *"when in crisis"* (Griffin, 2023); *"Services report that more families are presenting in a state of crisis"* / *"tipping more families into crisis"* / *"working with children and families who are already in crisis"* (Scullin & Galloway, 2014); *" people in crisis"* / *"families in crisis"* (Galloway, 2020). Some records emphasised 'crisis' as a transient state, one that one can enter when they are not coping and leave when they are coping again. For example, Byrne (2017) used the phrases *"when children are in crisis"* and *"a child in crisis"* and also interviewed service users involved in a serious case review child and asked, *"what was MM like when not in crisis?".* Also, Blank (1975) used the phrases *"in crisis"* and *"emerge from the crisis"*.

Others use 'crisis' as synonymous to, or to depict acute or adverse situations one experiences that they struggle to cope with. For example, Stapley and colleagues (2017) described children experiencing depression as a 'crisis' via the phrase *"dealing with the crisis of their teenage child's depression"*. Additionally, Barratt and Granville (2006) depict 'crisis' situationally, as they state, *"kinship family is often constructed quickly in response to a crisis."* Situational examples given are: *"disappearance, death or hospitalisation of birth parents"; "abandonment and mistreatment"; "physical or psychological absence"; "neglectful and chaotic parenting from adults who have major problems with drug and/or alcohol abuse"*. They also state that in most cases *"…the major issue that has led to the children needing an alternative placement has been parental drug and/or alcohol misuse. There are often accompanying issues of adult mental health difficulties, domestic violence, child abuse, and neglect".* Furthermore, rather than using 'crisis' as a blanket term for a state of not coping, Shelton (2015) use 'crisis' to refer to individual adverse situations for example, they state *"Staff focused their attention on the individual crises with which Ryan regularly presented them"* and *"…dealt with the regular crises in his life, in particular his homelessness and offending."* They also used phrases such as; *"repeated crises in Ryan's life"; "placements were all responses to crises"; "crisis situations"*. NICCY (2018) used similar terms, (e.g., *"crisis incidents", "in a crisis situation" and "life threatening crisis situations")* and associated these with self-harm, suicide, and substance abuse. Tudor (2020) states that *"…when a teenager takes their own life, stress factors can combine and increase over time and may be triggered by a crisis, for example, a relationship breakdown",* which depicts 'crisis' situations (e.g., relationship breakdowns) act as a 'trigger' to stress factors and suicide.

Some records feature both linguistic conceptualisations of 'crisis'. Notably, Khalifeh and colleagues (2009) appear to attempt to differentiate by depicting the problematic/distressed individual (i.e., the parent) as in a state of crisis (*"in crisis"*), and those surrounding the problematic/distressed individual who are dealing with the situation as experiencing *"a crisis"* (i.e., the family unit).

3.6. Crisis on a scale

Some records also used language that conceptualises 'crisis' as scalable. Meaning in some records 'crisis' is depicted as a state that you can be more or less in or can experience at different intensities – which diverges from the use of 'crisis' as a blanket term and opens the term up to more subjectivity. For example, Forrester and colleagues (2008) stated the *"degree of crisis"* experienced is the risk at which the child is likely to enter care. Further explained intervention is only given to families considered the most 'at risk' and thus with the highest *"degree of crisis"*, but there were no details clearly given explaining this scale. Others elude to a 'crisis scale' in the language used, for example; *"Major mental health crisis"* (Staite et al, 2021); *"Deeper in crisis"* (Scullin & Galloway, 2014); *"Period of acute crisis"* and "*escalating crisis"* (Byrne, 2017); "*in times of serious crisis"* (McKenzie & Holden, 1972); *"severe acute mental health crisis"* (Khalifeh et al., 2009); *"…escalated to life threatening crisis situations"* (NICCY, 2018). Galloway (2020) also emphasise that even when 'in crisis', families need to reach a *"tipping point"* to obtain support as they state *"…the bureaucracy is frustrating because you've got families in crisis, but not yet at tipping point.".* Interestingly, regarding CAMHS, Staite and colleagues (2022) offered less intensive support (telephone rather than face to face) to those determined *"low risk"* after a *"crisis assessment"*, as they state *"All crisis assessments were face to face; however, if the young person was indicated as low risk from the assessment, the follow up appointment would be offered via telephone".* NICCY (2018) also reference a *"crisis assessment and intervention team"* which suggests a level of standardisation to the 'scale of crisis' that individuals are facing in via an assessment; however, no details are given.

3.7. Risk association

As aforementioned 'crisis' is tied to acute and complex needs requiring "immediate" and "intensive" care. In addition to this, both CSC and CAMHS focused records converge on the association of crisis with higher level intervention and thus higher levels of need / risk – when a child is at 'significant risk'. Three records associated crisis with emergency care/departments (Gorny et al., 2021; Wate, 2021; NICCY, 2018). Four records explicitly associated 'crisis' with 24 hours/out of hours services (e.g., CAMHS crisis teams; Staite et al., 2021; Staite et al., 2022 and Extended Hope Service; Byrne, 2017). In terms of mental health, NICCY (2018) stated *"currently the only statutory community based 'out of hours' service for mental health is crisis response",* and Staite and Colleagues (2021) stated *"the intervention(s) delivered by the CAMHS Crisis Team had the aim of immediately attending to the mental health needs of young people in crises."* Moreover, six records associated 'crisis' with in-patient care/hospitalisation of a child (i.e., Tier 4 CAMHS; Byrne, 2017; Griffin,

2023; Ross & Dodds, 2023), or of a parent (McKenzie & Holden, 1972; Hatfield et al., 1997; Tudor, 2022). Also, five records focused on family focused/preservation services as an alternative to hospitalisation of parents during 'crisis', for example, home treatment (O'Connor et al., 2014; Forrester et al., 2008) and residential family unit ('family crisis unit'; Mackenzie & Holden, 1972). Three records additionally connected 'crisis' to police-level incidents (Scullin & Galloway, 2014) and intervention (Byrne, 2017; Ross &. Dodds, 2023; Shelton, 2015). Consequently, 'crisis' is often linked to a sense of emergency / urgency and by implication high risk cases.

Overwhelmingly, records associated 'crisis' with higher levels of CSC intervention – this being care plans (CP) and removing a child from their parents (CLA episode). For example, Forrester and colleagues (2008) state *"For all referrals a decision is made about whether it* [crisis intervention] *is 'appropriate'. Appropriate referrals require the child to be at risk of coming into care (with a minority being considered at risk of being placed on the Child Protection Register…"* and *"Families are considered to be 'in crisis'—with this crisis generally being linked to the possibility a child entering public care".* Furthermore, Galloway (2020) utilises the Hardiker model and consistently associates crisis with Level 4 intensive intervention– children in need of rehabilitation (CLA episodes), where *"families will have identified complex needs and children may be in a state of care"*. Below this is level 3 which is defined as children in need in the community (CIN). Therefore, they operationalise crisis as cases requiring the highest level of intervention and featuring complex needs/high risk. Scullin & Galloway (2014) also link crisis to CLA as they state *"Services were selected for inclusion in the survey if they provided intensive support to families at levels 3–4* [Harkinder model of prevention]… *if they provided services to children in need in the community, or to children who are already in crisis and require rehabilitation. Some of these children may already be looked after or accommodated".* Therefore, specifically linking those at risk of CLA (level 4) with 'crisis', and CIN with the level below this. Two records also associated 'crisis' with placing a child in the care of relatives through special guardianship (Hingley-Jones et al., 2020) and Kinship care (Barratt & Granville, 2006).

Regarding mental health and CAMHS involvement, NICCY (2018) utilised *"The Stepped Care Model for Child Adolescent Mental Health"* and referenced it as the *"preferred regional model for the organisation and delivery of mental health services and support for children and young people in Northern Ireland".* Within this model, 5 steps to support are outlined, these being: *"prevention, early intervention, specialist intervention services, crisis intervention and inpatient and regional specialist services."*. Stage 4 was also explicitly titled *"Integrated Crisis Intervention Child and Family Services"* and the interventions at this stage were listed as *"CAMHS resolution and home treatment teams, crisis residential care, intensive day care support services"*. Therefore, they also conceptualised crisis as a higher level of intervention. This highlights that a CSC focused and a CAMHS focused record operationalised 'crisis' within a model specifically within a higher level of intervention. However, these models are not used universally across other records, highlighting a lack of standardisation. Moreover, NICCY (2018) also states *"There is no consistent, region-wide*

crisis response service for children and young people, resulting in unacceptable variations in care and outcomes."

Few records associated 'crisis' with lower-level social care intervention, for example, preventative services (Blank, 1975; Leigh & Miller, 2004; Stalker et al., 2017; Stapley et al., 2017). However, some of these records also emphasise that service users do not get the support needed, and that support is not given until a 'crisis point'. For example, Stalker and colleagues (2018) stated *"Both carers and providers reported that families with disabled children were only helped when they reached crisis point, but the research also heard from families who appeared to be at "tipping point" yet were not receiving the type or level of help needed"* and *"A view shared by many was that social work focused almost wholly on families with child protection concerns, at the expense of those with disabled children, despite the latter's high support needs and stress levels…so long as they did not mistreat their disabled children, these families would get limited support…".* Further, Leigh and Miller (2004) focused on social care enquiries for 'low risk' referrals from parents but differentiated *"low risk"* from crisis, which they depicted as *"high risk"* cases needing *"crisis intervention"*. For example, they stated *"If social workers are denied the opportunity to develop such skills in relation to 'low-risk' work they will not only be unprepared to respond to high-risk situations but will find that such circumstances do not readily allow them to do so. Actual or potential crisis interventions do not often provide the basis for establishing empathic understanding and trust".* They also stated, *"potential service users have to demonstrate that the child either is at a high level of risk or presents as a high risk to others in order to receive any service at all",* which reinforces the connection of high risk and intervention.

3.8. Crisis as a threshold point

Many records highlight higher tier to be based on crisis management / intervention, leading to the loss of preventative care. For example, Galloway (2020) stated *"...we've lost the capacity to be preventative as much as I would hope and a lot of services are crisis led…Services across a range of different authority areas also referred to a change in the role of children and families social work. It was described as 'crisis-led', or 'crisis-management".* Also, Stalker and colleagues (2018) referenced *"Action for Children (2013)"* who *"found that service infrastructures were fragmenting with a loss of early intervention work and a move towards dealing only with families in crisis"* and *"both carers and providers reported that families with disabled children were only helped when they reached crisis point".* 'Crisis', and the high level of needs tied to it, has become an operational threshold marker to the point that many do not receive help until they reach a critical point. For example, Scullin & Galloway (2014) state "*As Social Work thresholds increase, referrals made to Services via the Social Work route may have already reached crisis point…the direction of travel…is towards working with children and families who are already in crisis. The implication is that the "gap in the middle" around children and families below the threshold for statutory intervention is widening".*

Moreover, the updated searches provided a study by Ashworth and colleagues (2025). In which, survey results from parents of autistic children experiencing mental health difficulties and accessing CAMHs highlighted 'crisis' as a threshold point. For example, *"We had to be in crisis before we got any help. Kept being told that we didn't meet threshold' (P38)"* and *"Common responses included their child not meeting the threshold of need ('I was told she doesn't meet the criteria as she isn't in crisis or harming herself' (P103)"*.

This conceptualisation of 'crisis' as a threshold to higher tier service intervention is depicted to be created by both top-down and bottom-up causes. Regarding top-down causes, Scullin and Galloway (2014) argue *"As Social Work thresholds increase, referrals made to Services via the Social Work route may have already reached crisis point…"*. Moreover, some records highlight governmental funding issues are pushing care to be 'crisis led'. For example, Griffin (2023) stated *"With increasing demand at the acute end of the system, the costs of children's social care are spiralling and shifting towards crisis management"*. Also, Scullin and Galloway (2014) stated *"In some Local Authority Social Work Departments the lack of additional resources has meant cases are increasingly not picked up until they reach crisis point…"* and "*gave concrete examples of cases where neglect or abuse had not been picked up due to pressures on Social Work departments"*. Additionally, Stalker and colleagues (2018) stated *"Several added that funding was now only available for "complex" cases…where children were "at risk" or a family at "crisis point". Certain children, including those with learning disabilities or with autism, were identified as "not getting any help"*. They also found funding issues were an issue service users are aware of, as they quote a service user who stated *"It always comes down tae [to] money and it seems in a lot of situations that they only, if they do anything they only do it when somebody gets to crisis point"*. Regarding CAMHS, NICCY (2018) also stated *"In the absence of sufficient investment in the full range of services across the Stepped Care Model, specialist services can become crisis services, with children and young people being seen only when their condition has deteriorated"*. They also stated, *"There needs to be a fundamental shift to early intervention and prevention, rather than a system which only reacts when a child or young person is already in crisis"*.

Regarding bottom-up causes, some records suggest fear of services and losing custody and a lack of help seeking behaviour from service users/potential service users is leading to crisis being a threshold for care. For example, Leigh and Miller (2004) stated *"For many, only a crisis could prompt the need for outside support"*. Further, Khalifeh and colleagues (2009) stated "*Currently a major impediment to parents' seeking help with child care during a mental health crisis is fear of losing custody"* and "*When parents are treated at home for an acute mental health crisis, both parents and children struggle to cope, but they are reluctant to seek*". Supporting this, Barratt and Granville (2006) started *"Referral or asking for help can be feared as signifying that carers are not managing and may raise the possibility that children could be removed"*.

The operationalisation of crisis as a threshold to social care and the focus on crisis cases is depicted in records to be leading to delays in care – associating crisis-led intervention with

late intervention. For example, Scullin and Galloway (2014) state "*'we seem to be going backwards', in that the service often receives referrals at a late stage…*[service] *managers highlighted the fact that in terms of referral processes there needs to be an 'incident' before they are referred such as a domestic violence or a police incident…Another Manager argued that they often get cases after things have already gone badly wrong".* Galloway (2020) argued intervening at a 'crisis point' is *"too late"* and this is occurring due to the high number of individuals "in crisis", as they state *"…there is still a lot of unmet need. Although we're trying very hard to provide an element of early intervention, because there are so many people in crisis there are people who will fall through the cracks unfortunately in the wider system and then we probably are catching them too late".*

Moreover, in a CAMHS focussed review, NICCY (2018) highlight delays in care by stating *"Children and young people in crisis were being failed by a system that could not respond to their needs quickly enough".* They further suggest delays increase the 'crisis level' of the situation, for example they state *"…the delay in access to support had escalated to life threatening crisis situations"* and *"…an escalation in their crisis situation, due to the delay in being able to access appropriate and timely help".* They also suggested this encourages individuals not to seek help when future difficulties arise by stating *"Very vulnerable young people talked about their mental health deteriorating, for some to a crisis point* [stage 4]*, as a direct result of the delay in being able to access services* [stage 3] *being dissuaded from seeking services in future due to a lack of timely interventions".* They further highlighted issues with diagnoses encouraged crisis-led care and thus delays as they stated, *"Significant delays in being diagnosed with a learning disability and/or mental health problems means that access to essential support services and specialist advice is often crisis driven rather than offered as a form of early intervention".*

The updated search result record by Ashworth and colleagues (2025) also found delays in mental health care for autistic CYP as stated they are "*accumulating trauma and experiencing worsening mental health along the care pathway, waiting for inevitable crisis"*. However, they also highlighted that this is nonspecific and part of wider CAMHS issues and referred to delays as *"wait-to-fail models"* which are *"resulting in many CYP reaching crisis".*

3.9. Summative interpretations

There were 11 key summative interpretations from the narrative synthesis:

1. Crisis lacks explicit definition but is tied to complexity, vulnerability and higher risk ('acute' cases).
2. Crisis intervention is defined as short term, intensive, immediate care for when parents, children or family units are not coping. Longer-term care should follow this.
3. Records focused on mental health coping difficulties/CAMHS used crisis intervention more explicitly (e.g., within names of services and teams) while social services focused records used it more generally (e.g, in association with thresholds of

intervention). Potentially exposing issues with co-ordinated care conceptualisation and thresholds.

4. Coping difficulties associated with 'crisis' can be categorised. The categories most associated with crisis were parental mental/physical health and parenting struggles (inc., substance abuse) and child's mental health/disabilities or child beyond parenting control (inc., substance abuse), then child facing complex/multiple psychosocial difficulties and family unit facing adversity.
5. Within each coping difficulty category, a variety of coping difficulties varying in severity/risk of significant harm were linked to 'crisis'.
6. Within mental health focused/CAMHS focused records, 'crisis' is mostly directly associated with a singular coping difficulty/category of need when it is used – 'mental health crisis'. Whereas in social services intervention 'crisis' is often used to refer to multiple psychosocial coping difficulties/categories of need and more so used as a blanket term to depict non-coping / adverse situations.
7. 'Crisis' is linguistically depicted as a state of overwhelm of a child's/guardian's/family's coping / functioning capabilities ("in crisis"), but 'Crisis' is also used in reference to numerous adverse situations/experiences ("experiencing a crisis").
8. 'Crisis' is linguistically depicted as scalable, but without clear standardisation or measurement for what the scale is.
9. 'Crisis' appears to be associated with higher risk/higher-level intervention rather than lower risk/lower-level intervention, by academics, professionals and service users (children and families). Explicitly, those perceived as 'in crisis' are seen to be at a more critical point and need urgent care / more support.
10. Crisis intervention appears to be the current approach used in higher tier services for children identified as not coping, but this is also critiqued as late intervention and to be delaying care.
11. 'Crisis' is depicted as a 'threshold' to higher tier service intervention, and this is reinforced and encouraged by top-down causes (i.e., professionals/services and funding) and bottom-up causes (i.e., service users).

4. Discussion

This systematic review aimed to explore the following research question: How is the term 'crisis' used in the context of UK-based child-centred social care and mental health interventions with children and/or their families identified as experiencing difficulties with coping?

We found no formal definition of 'crisis' in the included records. However, we identified general convergence on the association of 'crisis' with complex and acute cases where children/families are vulnerable and experiencing coping difficulties. However, there was divergence in conceptualisation of 'crisis' and how it is perceived, used, and standardised within and between higher tier services for children identified as not coping.

Records associated 'crisis' (and 'acute' and 'complex') with a range of coping difficulties. We categorised the coping difficulties linked to 'crisis' into categories (see Table 2). Records focused on CSC involvement, 'crisis' associated numerous psychosocial coping difficulties with 'crisis' and often used it as a 'blanket term' for non-coping. Dissimilarly, within records focused on mental health difficulties or CAMHS, 'crisis' was often tied to a singular coping difficulty via the phrase 'mental health crisis'. This makes logical sense as CAMHS are more specialised and focus solely on mental health support, whilst CSC support a wider range of needs (see Appendix A). Whilst no records explicitly defined 'crisis', one did explicitly define 'mental health crisis' as *"an emergency that poses a direct and immediate threat to physical or emotional well-being"* (Staite and colleagues, 2021, p.162). This supports consistent definitions of 'mental health crisis' seen in statutory guidance (NHS, 2025; NHS England, 2024) and prominent reviews (Care Quality Commission, 2018). This phrase is widely used in health and social care (Evans et al., 2023; Lyons et al., 2023) and it adds more clarity to 'crisis' as the coping difficulty is identified at the point of use (i.e., mental health). However, whilst CAMHS/mental health focused records conceptualised 'crisis' more specifically ('mental health crisis'), coping difficulties ranged in severity across categories (see Table 2). This supports conclusion made by Lyons and colleagues (2023) who argue 'mental health crisis' lacks universal definition and is 'multifaceted', 'fluid' and 'context dependent'.

Moreover, the frequency in which the 'coping categories' were associated with 'crisis' (see Table 2) does not match the use of 'crisis' in key statutory social care documents. Specifically, within primary need code 4 definition within the 'child in need consensus'. Within this, 'temporary crisis' is explicitly linked to cases where previous functioning was adequate, but an adverse event/situation has disrupted this. Examples of adverse situations/events given are temporary relationship challenges, financial challenges (e.g., homelessness, loss of employment), death of parents/family members or inability to meet needs of children (Department for Education, 2023b – see Appendix A). Arguably, 'family unit facing adversity' (see Table 2) best fits this conceptualisation, yet we found this featured the smallest number of records. The 'Child's (or young persons) mental health issues/disabilities or child beyond control' and the 'Parental mental/physical health and parenting struggles' categories featured the highest amounts of records. Whilst debatably this data is skewed as CAMHS-focussed records were included – a specialised mental health service. Only six records with this direct focus were included and regardless of these records, mental health concerns in the family unit were still largely associated with 'crisis'. Moreover, the results presented in Table 2 suggest records fitting these categories focused on coping difficulties beyond that described in primary need code 4 (Department for Education, 2023b). Arguably, situations/experiences we found to be more associated with 'crisis' better fit other primary needs codes (whose definitions do not feature "crisis"). For example, mental health concerns of CYP better fits 'Child's disability/illness' (code 2) and abuse / neglect better fits 'Abuse or neglect' (code 1; see Appendix A). Additionally, records often linked 'crisis' to acute situations, care plans and instances where children are removed from their parents. This arguably links more to code 5 ('Family dysfunction') where ***"****parenting capacity is chronically inadequate",* than code 4 where the family *"generally functions adequately"* (Department for Education, 2023b). Consequently, there is divergence in what constitutes a 'crisis' between this review's findings and statutory documents.

'Crisis intervention' was more defined across records, with many converging on explicitly and implicitly defining it as immediate and intensive short-term care – that should be followed by longer-term intervention. This definition is multidisciplinary and well-

established (Roberts, 2005; Yeager & Roberts, 2015). Regehr (2011) defines 'crisis intervention' as *"a short-term intervention technique that is grounded in crisis theory"*, that attempts to restore balance – or 'homeostasis' (Caplan, 1964) or a 'functional baseline' (Ahmad, 2019). We also found across higher tier services, 'crisis' was frequently associated with higher risk/higher-level intervention by academics, professionals and service users. However, again, records focused on mental health coping difficulties and CAMHS used 'crisis intervention' more specifically, whilst CSC focused records used it more generally.

Explicitly, across CSC records 'crisis intervention' was commonly tied to care plans and child looked after episodes – inherently tying 'crisis' to higher level intervention. However, clear operationalisation and 'crisis' pathways were not identified. Some records explicitly associated 'crisis intervention' within social care models and associated it with a higher-level intervention. Explicitly, Scullin and Galloway (2014) and Galloway (2020) used the Hardiker model of prevention and associated 'child in need' status with level 3, and 'in crisis' with level 4 – tying 'crisis intervention' with higher-level intervention. This model is widely used by UK and Irish governments as a planning framework (Owens, 2010). But again, other records did not use this model in relation to 'crisis'. Further, wider research does not use 'crisis' when outlining this model (e.g., Flynn, 2019), and some link level 4 to other terms such as 'complex' (Gillen et al., 2013) or describe families reaching this level as *"broken down"* (Owens, 2010). This suggests a lack of consistent association of 'crisis' and reinforces our finding of a tendency to view/use 'crisis' interchangeably with other vague terms - which as argued by Clark (2007), makes defining 'crisis' difficult.

Regarding CAMHs, records explicitly associated 'crisis intervention' within care models and associated it with a higher-level intervention. NICCY (2018) referenced The Stepped Care Model for Child Adolescent Mental Health and it's 5 stages to intervention and presented level 4 as 'crisis intervention' – depicting it as higher-level CAMHs intervention, above and beyond early intervention and specialist services. Whilst not all research on the CAMHs stepped care approach features the term 'crisis' (e.g., McDermott & Cobham, 2014), in practice, 'crisis intervention' is given as an example of intensive intervention (Step 4 of 5) (Health and Social Care, 2018). The standardised tiered system to mental health intervention is based on a stepped care model (Garratt et al., 2024), within which 'crisis intervention/care' has been explicitly linked to tier 3 (specialist) and tier 4 (highly specialist) – when CAMHS teams are directly involved (The Association for Child and Adolescent Mental Health, n.d.). Alongside general terms (i.e., 'crisis care / support'), records focused on mental health interventions and CAMHS referenced 'crisis' in multiple names of teams (e.g., 'crisis teams' / 'crisis resolution teams') and services (e.g., 'crisis service / hub'). These teams and services are operationalised within the CAMHS 'crisis care pathway' (see Figure 2; NHS England, 2024), but only one record clearly referenced this pathway (Gorny et al., 2021). Moreover, whilst records concluded the need for and effectiveness of CAMHS crisis care/teams, they also critiqued 'crisis care' for prolonged waiting times, variation within availability and quality of services, and lack of co-ordinated pathways. Although not included due to a lack of focus on UK-based records, supporting this Edwards and colleagues (2023) concluded CYP 'crisis care pathways' are underdeveloped, poorly co-ordinated and are highly variable. Therefore, 'crisis intervention' and the 'crisis care pathway' operationalisation of 'crisis' within CAMHS appears to lack consistency rather than standardisation.

Our findings highlight linguistic divergences in 'crisis'. Many records linguistically depicted 'crisis' as a state one enters when not coping (*"in crisis"*). This links to original crisis theory where a crisis state (being "in crisis") is conceptualised as experiencing circumstances which

overwhelm individual coping abilities (Caplan, 1964) – which has been upheld over time and across handbooks (Clark, 2007; Eaton-Stull, 2022; Kanel, 2012; Regehr, 2011). Alternatively, some records linguistically used 'crisis' to describe the adverse situations an individual/family unit may experience. Within social care, Clark (2007) argued 'crisis' has merged with 'critical incident' - events/situations that overwhelm coping abilities and response capacity which are unexpected and time-limited. Arguably, 'critical incident' can readily be seen as synonymous to 'precipitating events' – adverse situations leading to 'crisis' (Kanel, 2012). However, other factors impact whether 'crisis' is experienced. For example, alongside an adverse situation ('precipitating event') and an inability to return to a functioning state via coping mechanisms, individuals must perceive the event realistically and as a cause of distress (Kanel, 2012; Cutler et al., 2013). Therefore, adverse situations are a factor that "*may*" overwhelm an individual and lead to a 'crisis' which suggests 'crisis' is more complex than a descriptor of adverse situations leading to intervention. These linguistic divergences may be contributing to confusion around what 'crisis' means within higher tier services for children identified as not coping. If services are intervening when a family unit/child experiences 'a crisis', the distinction between crisis state and crisis situations is important as having 'crisis' linguistically mean both may encourage variation in practice. Explicitly, do services intervene when a family is overwhelmed and 'not coping' (i.e., 'crisis'), or when they are experiencing an adverse (i.e., 'crisis') situation?

Encouraging a lack of standardisation, we found across services records linguistically presented 'crisis' as scalable yet did not present objective measurements. For example, records used phrases such as *"deeper in crisis", "serious crisis"* and "*…escalated to life threatening crisis situations"* - suggesting endangerment to life is on the higher end of a 'crisis scale'. Forrester and colleagues (2008) used *"degree of crisis"* and specifically associated this with the risk of a child entering care – where a higher *"degree of crisis"* was associated with those more at risk, but no objective measure was given. Being 'more in crisis' is therefore perceived as a higher amount of danger and risk, but there is a lack of clarity and objectivity to meeting this criterion. Notably, in two CAMHS records, *"crisis assessments"* were referenced. Yet, no details on these 'measures' were given. We also found two CSC focused record emphasised that when 'in crisis', families need to reach a *"tipping point"* to obtain support (Galloway, 2020; Stalker et al., 2018). This furthers the conceptualisation of 'crisis' as scalable and begs the concerning question of what a *"tipping point"* looks like, when 'crisis' is associated with 'acute' needs. Therefore, our findings suggest a lack of a standardised, measurable archetype of what 'crisis' is within higher tier services - inherently minimising construct and inherent validity.

Within their social care handbook, Clark (2007) states 'decisions' about whether individuals are 'in crisis' are made by social workers. Without a standardised archetype of 'crisis', social workers may have different perceptions of what constitutes a 'crisis' – especially as perceptions of acute cases will naturally differ due to influence from agencies or previous cases (Hardiker et al., 1991). Moreover, like other professions, there is evidence that social workers too engage in cognitive bias (Featherston et al., 2019) and are sometimes influenced by (or choose to ignore) socio-economic information (Morris et al., 2018). In the UK social workers have also highlighted that they are not permitted to spend enough time with children (Murphy, 2023) and are perhaps too overworked, understaffed and overwhelmed (Family Rights Group, 2018; Leigh & Miller, 2004). Mirroring this, a recent evaluation of staff views of CAMHs crisis and home treatment services highlight they are understaffed for the demand and further training is still needed (Kusnierczak et al., 2025). These pressures make acting

from non-standardised concepts even more concerning. Ultimately, lack of standardisation of 'crisis' may be encouraging families/individuals to 'fall through the cracks'.

This ambiguity in standardisation and the issues stemming from this links to the concept of 'floating signifiers' – constructs/terms that are ambiguous, open to interpretation and lack fixed meaning. Conversely, 'boundary objects' have interpretive flexibility but have enough shared structure across to allow consistency, co-operation and collaboration between groups (Chandler, 2007; Star, 2007). We argue 'crisis' is more akin to a 'floating signifier' (or 'buzzword'; Bensaude-Vincent, 2014) as there is ambiguity on what 'crisis' actually looks like and lacks stable meaning within and across services. Therefore, this term may mean *"different things to different people"* – a distinctive trait of 'floating signifiers' (Chandler, 2007, p.78). Considering 'crisis' as a 'floating signifier' or 'buzzword' builds on the argument that the term lacks standardisation and may be leading to confusion.

Despite this, we also found 'crisis' is operationalised as a threshold point to higher tier service intervention. Supporting this, the All Party Parliamentary group found thresholds are rising to the point where *"children and families often have to reach crisis before they can get help"* (2018, p. 5). Considering we found 'crisis point' was conceptually linked to acute needs, complexity and emergency care – when "*things have already gone badly wrong"* (Scullin & Galloway, 2014). 'Crisis' being an operational threshold to intervention contradicts the overarching ideology of social care - to prevent harm to children. Under s.17 of the Children Act (1989; 2004) social services are tasked statutorily to intervene when a child present as 'in need' (i.e., mental health concerns, neurodivergence and childhood adversity), and the Common Assessment Framework (CAF) states professionals should *"identify these children [with additional needs] earlier and help them before things reach crisis point"* (Department for Education and Skills, 2003). Therefore, the operationalisation of 'crisis' as a threshold encourages disparity between statutory aims and actual intervention. Unlike 'crisis', 'Child in need' and 'child protection plan' thresholds do have standardised criteria via threshold documents. However, between local authorities, there is also variation in these documents and how thresholds are met - leading to children who experience similar needs and risks obtaining different support (All Party Parliamentary Group for Children, 2018). Therefore, arguably operationalising 'crisis' (which lacks standardisation or consistent criteria) as a threshold may be leading to more variation in care. This finding also suggests 'crisis', and its lack of standardisation, may be contributing to the blurring of thresholds leading to an *"erosion of section 17 provisions"* (Hood et al., 2019; MacAlister, 2022). We also found records criticised 'crisis' as a threshold and depicted intervening at a 'crisis point' as 'late intervention' or 'delayed care' leading to a *"widening of the gap in the middle"* (Scullin & Galloway, 2014). This supports consistent arguments where the focus on crisis/late intervention, and the reduction of early/preventative intervention criticised in social services (All Party Parliamentary Group for Children, 2018; Hood et al., 2019; MacAlister, 2022;) and CAMHs (Children's Commissioner, 2024; Healthy London Partnership, 2016). Additionally, recent research has highlighted issues with eligibility threshold criteria for CAMHs crisis services (Edwards et al., 2023) and the importance of consideration of CYPs need for support prior to crisis and needing crisis and home treatment teams (Kusnierczak et al., 2025).

We suggest 'crisis' as a threshold may be encouraged by top-down and bottom-up factors. Regarding top-down issues, findings suggest funding issues may be encouraging 'later intervention' (i.e., at 'crisis point'). In UK social care there is *"rising demand and decreasing resources"* due to austerity (Murphy, 2023). Additionally, inquiries highlight governmental

funding cuts to local authorities for early prevention services – especially in deprived areas (Webb and Bywaters, 2018). Early intervention services are fragmented, uncertain and underfunded, and spending on early intervention (e.g., family support services) has decreased whilst later intervention (e.g., child protection) has increased (Elliot, 2024). Explicitly, intervening later (at 'crisis point') costs more money, which is taken from preventative services in a *"vicious cycle"* (Action for Children, 2017). These funding issues were also seen in CAMHS-records as NICCY (2018) highlight a lack of funding in all steps of the stepped care model, leading to 'specialist services' becoming 'crisis services' and late intervention when conditions have 'deteriorated'. Supporting this, CAMHs reviews highlight CYP struggle to gain access to service until they decline to a 'point of crisis' (e.g., Evans et al., 2023). Regarding bottom-up issues perpetuating 'crisis' as a threshold point, records suggested service users were more likely to seek support during 'crisis' – which Golan (1978) originally argued. Records also suggested potential service users may not seek help prior to 'crisis' due to fear of service involvement or belief services cannot help them due to previous incidences of feeling 'let down'. Fearing social services is well-known to encourage families to avoid or show negativity towards support services - encouraging *"hard to reach"* families (Boag-Munroe & Evangelou, 2012). Fear and negativity are perhaps encouraged by how the media negatively present social workers – i.e., referring to them as *"child/baby snatchers"* (Leedham, 2023; Goddard, 2022). What perhaps antagonises this – especially in deprived areas – is the 'top-down' issue of funding, which we found service users are aware of (i.e., Stalker et al., 2018). If social services are predominantly intervening in cases at a later point (i.e., crisis point), 'failure' to help a family back to a functional point and removal of a child is naturally a higher possibility – which negatively skews public views towards involvement. Consequently, top-down and bottom-up issues within the operationalisation and conceptualisation of 'crisis' are not independent concerns, rather they are intertwined.

5. Conclusion

There was convergency in conceptualisation via implicit association leading to the following general assumptions: 'crisis' and 'crisis intervention' is associated with high-risk, acute and complex cases where families/individuals need urgent and higher-level intervention from higher tier services for children identified as not coping. However, findings suggest a lack of an explicit standardised definition and archetype of 'crisis', linguistic divergence in its use, and inconsistency across and between higher tier services in use and conceptualisation. Notably, CSC literature used 'crisis' more generally (i.e., as a blanket term), whilst CAMHs literature use was more specific via the term 'mental health crisis' - was more defined but lacked consistent use. Thus, conceptualisation of 'crisis' can differ between services, so when children require both services this may encourage issues in co-ordinated care. This flexibility, lack of robust definition, and inconsistency across within and between services impacts the terms construct and inherent validity and presents 'crisis' as a 'floating signifier' – putting it at risk of lacking standardisation and causing confusion (Chandler, 2007).

Despite this, findings also suggested 'crisis' is perceived and operationalised as a threshold point which may be leading to 'late intervention' – perhaps contributing to the *"erosion of section 17"* (Hood et al., 2019). Findings also suggested both top-down issues (e.g., funding) and bottom-up issues (e.g., service user help seeking behaviour) are encouraging this. This supports inquiries highlighting the lack of funding in services and the rise of demand, and the call for the government to better invest in preventative services (Elliott, 2024) and investigate variations and 'diverging perceptions' in practice (All Party Parliamentary Group for Children, 2018).

6. Future Directions

Standardising 'crisis' is arguably fundamental within re-building a system that understands how to support CYP and families before they reach 'crisis' and experience significant harm. Further research is therefore essential to understand how 'crisis' is being used in practice (e.g., case notes) and work towards standardising its use. This should be conducted in line with enquiries exploring variations in intervention. Also, with enquiries arguing for systematic changes towards better preventative and early care and away from crisis intervention-based higher tier services. How can services intervene preventatively before 'crisis', when 'crisis' lacks standardisation?

7. Limitations

This review is limited by the potential impact of researcher bias on the validity of results. The PRISMA model dictates best practice requires the use of numerous coders (Page et al., 2021). However, within this review, although discussion of inclusion-exclusion criteria and its application occurred, only one author fully completed the screening and data collection/coding. Whilst having inclusion-exclusion criteria increases inter-rater reliability, ultimately decisions could have involved biased interpretation and subjectivity in analysis. This is especially due to the interpretive-based nature of some of the inclusion criteria and subjective nature of narrative summaries.

Importantly, crisis theory and intervention are an interdisciplinary field (Roberts, 2005). This review looked at crisis specifically in the scope of child-centred social work and mental health services in the UK, and the results and discussion are therefore focused to this area. The results and discussion cannot be generalised across other areas of crisis research or the operations of other country's social care systems. Moreover, this review analysed records focussed on interventions – not actual practice data. Further research should be conducted to establish the use of crisis in documents used within actual practice.

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9. Appendices

Appendix A

Information on primary need codes and identifiable factors for intervention, from 'children in need census' government document (Department for Education, 2023b)

Primary Need Codes

- (N1) **Abuse or neglect**: children experiencing, or at risk of, abuse or neglect; also includes domestic violence.
- (N2) **Child's disability/illness**: main service need is child's disability, illness or intrinsic condition.
- (N3) **Parent's disability/illness**: main service need is capacity of parent(s) (or carer(s)) to care for child/children impaired by the parent's (or carer's) disability, physical or mental illness, or addictions.
- (N4) **Family in acute stress:** needs arise from living in a family that is going through a temporary crisis that diminishes parental capacity to adequately meet some of the children's needs.
- (N5) **Family dysfunction:** needs primarily arise from living in a family where parenting capacity is chronically inadequate.
- (N6) **Socially unacceptable behaviour:** need for services primarily arise out of the child's behaviour impacting detrimentally on the community.
- (N7) **Low income:** needs primarily arise from being dependent on an income below the standard state entitlements.
- (N8) **Absent parenting:** needs for services arise mainly from having no parents available to provide for them.
- (N9) **Cases other than children in need:** children who have been adopted and, despite no longer being a child in need, receive adoption support from social services immediately after adoption. Should not be used where a child receives an adoption payment.
- (N0) **Not stated:** when reference data is not completely entered on the system and need code is yet to be determined, or the case is a referral that has been closed following assessment.

Five categories for higher intervention decisions ('significant risk')

- **Physical abuse; sexual abuse; emotional abuse; neglect; multiple**.

Factors identified during initial/statutory assessment

- **Alcohol misuse**: concerns about alcohol misuse by the child (1A), parent (1B) or by another person living in the household (1C).
- **Drug misuse**: concerns about drug misuse by the child (2A), parent (2B) or by another person living in the household (2C).

- **Domestic abuse**: concerns about the child being the subject of domestic abuse (3A), the child's parent(s)/carer(s) being the subject of domestic abuse (3B) or another person living in the household being the subject of domestic abuse (3C).
- **Mental health:** concerns about the mental health of the child (4A), of the parent(s)/carer(s) (4B), or health of another person in the family/household (4C).
- **Learning disability**: concerns about the child's learning disability (5A), the parent(s)/carer(s) learning disability (5B), or another person in the family/household's learning disability (5C).
- **Physical disability or illness**: concerns about a physical disability or illness of the child (6A), of the parent(s)/carer(s) (6B), or of another person in the family/household (6C).
- **Young carer**: concerns that services may be required or the child's health or development may be impaired due to their caring responsibilities (7A).
- **Privately fostered**: concerns that services may be required or the child may be at risk as a privately fostered child - overseas children who intend to return (8B), overseas children who intend to stay (8C), UK children in educational placements (8D), UK children making alternative family arrangements (8E), other (8F).
- **UASC**: concerns that services may be required or the child may be at risk of harm as an unaccompanied asylum-seeking child (9A).
- **Missing**: concerns that services may be required or the child may be at risk of harm due to going/being missing (10A).
- **Child sexual exploitation**: concerns that services may be required or the child may be at risk of harm due to child sexual exploitation (11A).
- **Trafficking:** concerns that services may be required or the child may be at risk of harm due to trafficking (12A).
- **Gangs**: concerns that services may be required or the child may be at risk of harm because of involvement in/with gangs (13A).
- **Socially unacceptable behaviour**: concerns that services may be required or the child may be at risk due to their socially unacceptable behaviour (14A).
- **Self-harm**: concerns that services may be required or due to suspected/actual self-harming child may be at risk of harm (15A).
- **Abuse or neglect – 'NEGLECT':** concerns that services may be required or the child may be suffering or likely to suffer significant harm due to abuse or neglect (16A).
- **Abuse or neglect – 'EMOTIONAL ABUSE'**: concerns that services may be required or the child may be suffering or likely to suffer significant harm due to abuse or neglect (17A).
- **Abuse or neglect – 'PHYSICAL ABUSE':** concerns that services may be required or the child may be suffering or likely to suffer significant harm due to abuse or neglect by another child (child on child - 18B) or by an adult (adult on child - 18C).
- **Abuse or neglect – 'SEXUAL ABUSE':** concerns that services may be required or the child may be suffering or likely to suffer significant harm due to abuse or neglect by another child (child on child - 19B), or by an adult (adult on child - 19C).
- **Other** (20).

- **No factors identified:** no evidence of any of the factors listed and no further action is being taken (21).
- **Female genital mutilation (FGM)**: concerns that services may be required or the child may be at risk due to female genital mutilation (22A).
- **Abuse linked to faith or belief**: concerns that services may be required or the child may be at risk due to abuse linked to faith or belief (23A).
- **Child criminal exploitation**: concerns that services may be required or the child may be at risk of harm due to child criminal exploitation (24A).

Appendix B

Finalised Search strategy

- Where necessary, searches initially refined by category featuring 'abstract'.
- Searches built upon by progressively adding sets of search terms using Boolean Operators as follows:

    - Set 1 = Child* OR Youth OR Adolescent* OR Teenager* OR "Under 18" OR Family OR Families
    - AND Set 2 = "Social Care" OR "Social Work" OR Safeguarding OR Service*
    - AND Set 3 = Crisis OR Crises
    - AND Set 4 = Section* OR Refer* OR Assess* OR Intervene OR Intervention*
    - AND Set 5 = "United Kingdom" OR England OR British OR English OR "Northern Ireland" OR Irish OR Scotland OR Scottish OR Wales OR Welsh

- Where possible final results filtered by language (English)
- Where possible final results filtered by country (United Kingdom).

Appendix C

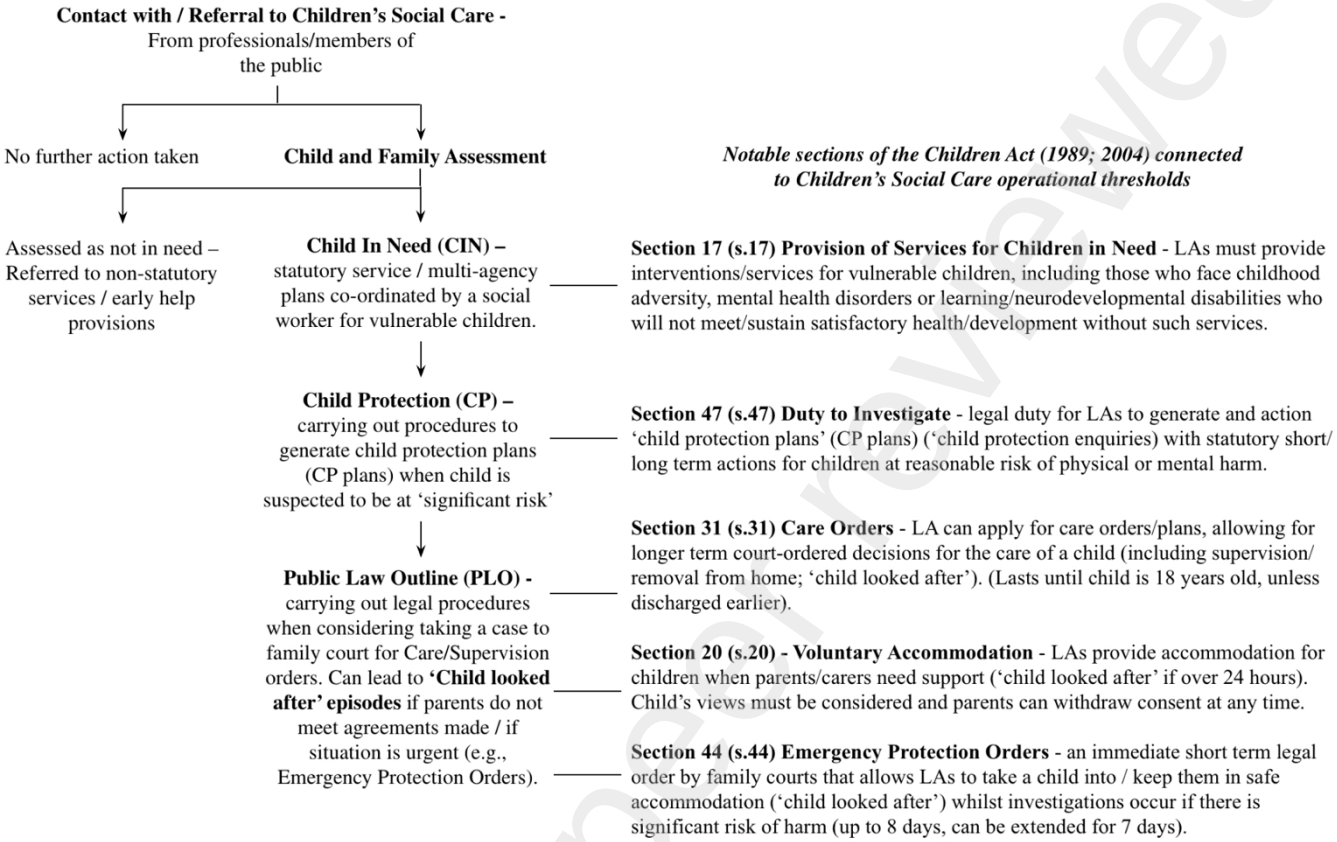
Table 1

Initial search results

	Search refine category and record type(s)	**Set 1**	**Set 1 AND Set 2**	**Set 1 AND Set 2 AND Set 3**	**Set 1 AND Set 2 AND Set 3 AND Set 4**	**Set 1 AND Set 2 AND Set 3 AND Set 4 AND Set 5**	**Results filtered by language : English**	**Results filtered by country: United Kingdom**
Web of Science	Topic (title, abstract, author keywords, and Keywords Plus) Peer-reviewed articles and book extracts.	4,152,135	205,251	4,153	2,012	126	125	**64**
NSPCC database	All fields. Articles, books, case reviews, journals, online reports, ebooks.	44,575	18,188	180	89	**38**	Option unavailable (UK database)	Option unavailable (UK database)
Scopus	Article title, Abstract, Keywords. Peer-reviewed articles.	7,073,805	502,483	9,064	4,902	426	377	**234**
APA PsychArticles & eBook collection (via EBSCOhost)	Abstract. Peer-reviewed articles and book extracts.	44,055	3,283	131	76	76	**76**	Option unavailable

Figure 1

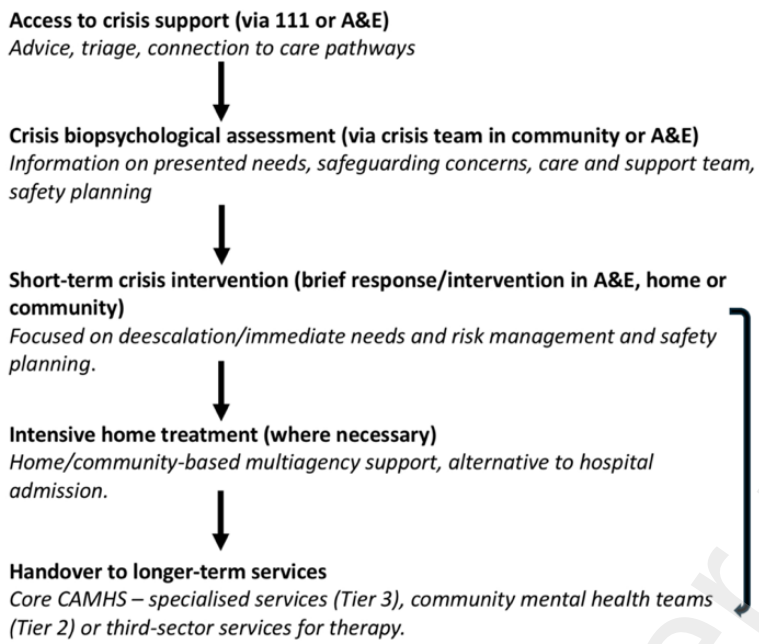
CSC Thresholds and Operations Flow Chart



Note. Adapted from Hood and Goldacre (2021) and The Children Act (1989; 2004).

Figure 2

Crisis Care Pathway Flow Chart



Note. Adapted from NHS England (2023).

Figure 3

Eligibility/Selection Criteria Flow Chart

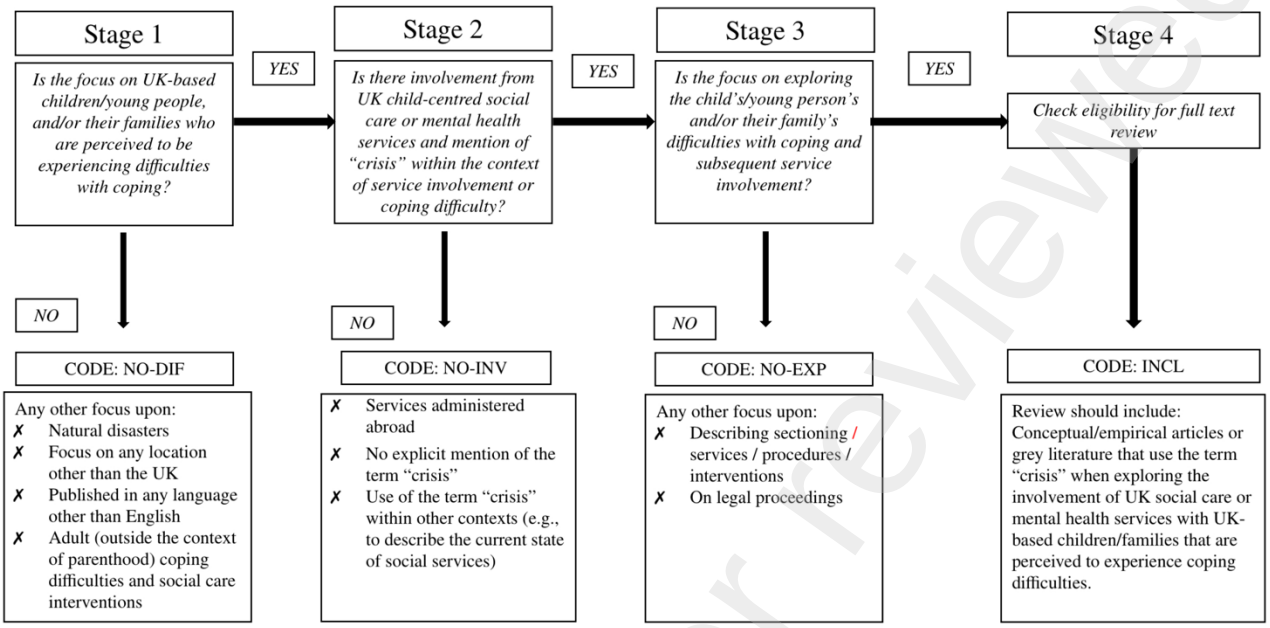


Figure 4

Flow Chart of Included-Excluded Record