"I think everybody's finding it a challenge to be honest"

The experience of mental health professionals working in Child and Adolescent Mental Health Services in Ireland

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Declaration

I declare that this thesis has not been submitted as an exercise for a degree at this or any other university and it is entirely my own work.

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Summary

This study explored the experience of mental health professionals working in Child and Adolescent Mental Health Services (CAMHS) in Ireland. Professionals in CAMHS work as part of a multidisciplinary team in order to provide high quality and effective services to children, adolescents and their families. Multidisciplinary teams in CAMHS are generally led by a consultant psychiatrist and can consist of professionals from the disciplines of social work, occupational therapy, nursing, speech and language therapy, social care, art/play therapy and clinical psychology.

CAMHS in Ireland has undergone significant development over the past decade. This development has largely occurred within the context of the publication of the national policy document *A Vision for Change* (Department of Health and Children (DOHC), 2006) which set out a framework for mental health services across the lifespan. While there has been a considerable focus on the number of referrals and waiting-lists in CAMHS, the experience of the professionals working within the services has been neglected. Little is known about how professionals make sense of their work in CAMHS and the nature of their experiences within these services.

A qualitative research design was employed in this study and semi-structured interviews were carried out with six multidisciplinary professionals working in CAMHS. The interviews were audio-recorded and the audio-recordings were subsequently orthographically transcribed. The data was analysed using interpretative phenomenological analysis. Three superordinate themes emerged from the data which indicate the challenging nature of working in CAMHS: *negotiating identity*, *power* and *the changing nature of CAMHS*. Participants described their unexpected journey to establishing a professional identity and being part of a multidisciplinary team. They also spoke about the hierarchical nature of the team and how their experience of the elevated status of psychiatry leads to participants having to battle for their voices to be heard. While participants acknowledged advantages and disadvantages of recent changes in CAMHS, the over-arching feelings were those of frustration, in addition to

pessimism about the future of the services, despite their motivation to engage in best practice with the clients and families that they work with.

Chapter One explores background literature on child and adolescent mental health in order to provide a context to this study. Key policy documents, including *A Vision for Change* (DOHC, 2006) are described while previous research studies exploring the views and experiences of professionals are also examined. The chapter concludes with an outline of the research questions.

Chapter Two describes the methodology used in this study and explains the research methods in detail.

Chapter Three explains the findings of the study and presents the main themes which emerged from the analysis of the data. Interview extracts the participants' accounts are presented along with a description and interpretation of the experiences of each of the participants.

Chapter Four discusses the findings of the study in relation to the literature and the main body of the discussion is divided into three sections: the mental health professional in CAMHS, the multidisciplinary team in CAMHS and the service provision in CAMHS. This study has number of implications for clinical practice, policy and education and it can also inform future developments in CAMHS.

The findings of this study highlight concerns about current practice in CAMHS and the complex nature of multidisciplinary team-working. Although efficiency and accountability are necessary, greater attention needs to be paid to the experiences of professionals working within services, as well as the quality of the services being provided.

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Chapter One: Literature Review

1.1 Introduction

This chapter will explore background literature on child and adolescent mental health. It will give an overview of previous research in order to provide a context for this study which seeks to explore the experience of mental health professionals working in child and adolescent mental health services (CAMHS) in Ireland. The chapter will first outline the current understanding of mental health in children and adolescents and the nature of mental health difficulties experienced by this population. It will then report on the development of mental health services for children and adolescents with a specific focus on the development of child and adolescent mental health services in Ireland. Recent research that has sought the views of different stakeholders in CAMHS, including young people and their families, will be discussed and this will be followed by an outline of research that has studied the views and experiences of professionals working within CAMHS. A summary of this background literature will then be provided and this chapter will conclude with an outline of the research questions for this study.

1.2 Child and Adolescent Mental Health

Mental health has been defined as "a state of well-being in which the individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community (World Health Organisation (WHO), 2014, p.1). Positive mental health empowers children and young people to lead satisfying and rewarding lives (Department of Education, 2015). Both mental health and social and emotional wellbeing have been identified as aims of the five national outcomes in the current policy framework for children and young people in Ireland (Department of Children and Youth Affairs, 2014).

Several studies have examined the prevalence of mental health difficulties in childhood and adolescence. Meltzer *et al.* (2003) found that 10% of children aged between five and fifteen years had a mental health disorder in Great Britain, while a review of a decade of literature by Costello *et al.* (2005) concluded that the figure was 12%. A recent meta-analysis of forty-one studies from twenty-seven countries around the world

indicated a prevalence figure of 13.4% (Polanczyk *et al.,* 2015). In Ireland, Lynch *et al.* (2006) reported that 15.6% of adolescents aged between twelve and fifteen years met criteria for a psychiatric disorder and a more recent study by Cannon *et al.* (2013) found that one in three young people have experienced a mental health disorder by the age of thirteen years. Studies investigating the epidemiology of mental health difficulties in children and adolescents tend to define mental disorder based on diagnostic classifications in documents, such as the Diagnostic and Statistical Manual (American Psychiatric Association (APA), 1994) or the International Classification of Diseases (WHO, 1993). However, it is important to note that children and adolescents can experience significant emotional distress without meeting diagnostic criteria for a mental health disorder (WHO, 2005). Within an Irish context, one in fifteen young people aged between eleven and thirteen years report to have engaged in deliberate self-harm and one in fifteen also report to have experienced suicidal ideation (Cannon *et al.,* 2013).

Children and adolescents with mental health difficulties are more likely to be in poorer general health, to miss time off school and to have a smaller network of family members and friends than children and adolescents without mental health difficulties (Green *et al.,* 2005). Mental health difficulties in adolescence can also impact on parental well-being and family life (Coyne *et al.,* 2015). Research has shown that over three quarters of mental health difficulties develop during childhood, adolescence and young adulthood (Kessler *et al.,* 2005) and mental health difficulties that emerge in adolescence in particular can lead to significant impairment into adulthood (Maughan & Coghill, 2011).

Research by Costello *et al.* (2011) has demonstrated trends in presentations of mental health difficulties from childhood to adolescence and adulthood. For example, Attention Deficit Hyperactivity Disorder (ADHD) and separation anxiety are common in early childhood but decrease with age, while depression and panic disorder increase in adolescence. Cannon *et al*. (2013) found that the most common mental health difficulty for eleven to thirteen years olds in Ireland was an anxiety disorder, followed by a mood disorder and a behavioural disorder. Anxiety and mood were also the main difficulties in young adulthood with psychotic disorders and symptoms also being reported (Cannon *et al.,* 2013).

1.3 Child and Adolescent Mental Health Services

Unlike difficulties in physical health, it is often not clear to the public how to recognise an emerging mental health difficulty or how to access appropriate services (Jorm, 2012). Jorm *et al.* (1997, p. 182) have defined mental health literacy as "knowledge and beliefs about mental disorders which aid their recognition, management or prevention." If a child or an adolescent has a temperature and a chesty cough, they and their parents are likely to know that they need to attend their general practitioner (GP) and will perhaps be on medication for a few days. Similarly, if a child or an adolescent seems to have a broken leg, they and their parents are likely to attend their local accident and emergency department and their expectation might be an X-ray to confirm the injury and a cast and crutches to aid their recovery. These pathways are not as clear when a child or adolescent is experiencing mental health difficulties and studies have repeatedly shown that many of the children and adolescents who are in need of a service are not accessing one. For example, less than one third of parents of young school-age children with a mental health difficulty have reported seeking professional help (Oh & Bayer, 2015) while many adolescents and young people who are experiencing mental health difficulties also report that they have not availed of support or intervention (Cannon *et al.,* 2013). As well as poor mental health literacy, stigma and embarrassment (Gulliver *et al.,* 2010) and the hidden nature of mental health difficulties (Buckley *et al.,* 2014) have also been identified as barriers to young people seeking help.

Globally, challenges exist in providing high quality and efficient child and adolescent mental health services. In addition to poor access to services, resources and waiting times are also of concern (Hindley & Whitaker, 2017). McGorry *et al.* (2013) have pointed out that CAMHS in Ireland, the United Kingdom and Australia have evolved from the child guidance model and are distinct from adult mental health services. However, many children and adolescents do not transition effectively from CAMHS to adult mental health services (Singh *et al.,* 2010) and McGorry *et al.* (2013) have called for a transformation of the design of mental health services for young people. Patel and Rahman (2015) suggest that universal interventions for child and adolescent mental health should begin in infancy and that schools are ideally placed to promote mental health in middle-late childhood and adolescence. Specialist mental health services can then provide interventions for those presenting with more severe mental health difficulties (Patel & Rahman, 2015).

1.4 The Development of Child and Adolescent Mental Health Services in Ireland

The recent development of CAMHS in Ireland has been guided and influenced by the publication of *A Vision for Change* (DOHC, 2006). This significant policy document set out a framework for the development of mental health services across the lifespan in Ireland and stated that "every citizen should have access to local, specialised and comprehensive mental health service provision that is of the highest standard" (DOHC, 2006, p. 2). Because of its significance and influence in the Irish context, the essence of this policy document will be described in detail in order to set the context and backdrop for this study.

Prior to the publication of *A Vision for Change* (DOHC, 2006), a number of other reports had been published on the development of child and adolescent mental health services in Ireland. A review of one such report, titled *Development Plan for Child and Adolescent Psychiatric Services* (DOHC, 1998) sheds lights on how far services have developed over the past two decades. This report from 1998 spoke about the objectives of child and adolescent mental health services as being of prevention and consultation, as well as assessment and intervention. Infant mental health, child abuse, conduct disorder, childhood encopresis, autism, toddlers with delayed communication development and children presenting with low mood in the context of other chronic medical conditions, were all considered as being within the remit of the services. The report advised ongoing flexibility in the operation of child and adolescent mental health services and highlighted the necessity of good working relationships between the services and other community services (DOHC, 1998). Of note, most of the contents of the report refer to 'child psychiatry' and 'child psychiatrists' but it also includes reference to the value of a multidisciplinary team. The specific disciplines included were psychiatry, clinical psychology, speech and language therapy, social work, childcare work/play therapy, community psychiatry nursing and administrative staff. The report suggested that the social worker in particular would ideally have postgraduate training in a relevant area of psychotherapy, although the reasons for this were unclear.

In 2006, there were very concerning gaps in mental health service provision for children and adolescents in Ireland which were outlined in *A Vision for Change* (DOHC, 2006). For example, the document highlighted that there were significant inconsistencies in

staffing and services across the country and adolescents often did not have access to any dedicated service. In addition, there was a lack of paediatric liaison services and a shortage of in-patient and day-hospital facilities for children and adolescents. *A Vision for Change* (DOHC, 2006) proposed a framework for child and adolescent mental health to include early intervention through families and schools, as well as community care services such as public health nursing and GPs. A number of recommendations were then made in relation to the development of specialist child and adolescent community mental health teams in order to meet the needs of children and adolescents who present with mental health difficulties. As well as providing assessment and interventions, the document called for each multidisciplinary team to establish links with local primary care services in order to be able to co-ordinate appropriate care for each child and adolescent.

A number of recommendations regarding the remit of CAMHS were also made in *A Vision for Change* (DOHC, 2006). For example, it suggested that CAMHS expand its remit to include adolescents aged sixteen to seventeen years. Until then, these adolescents attended adult mental health services. Furthermore, the development of further in-patient units was named as an urgent need, while a forensic child and adolescent mental health team was also recommended. In contrast, the document suggested a narrowing of the remit of CAMHS in relation to other groups of children and adolescents and stated that their needs should be met in other services. For children with autism, it stated that the role of CAMHS was (only) to provide consultation and specialist treatment for specific mental health difficulties. This marked a significant change in service provision for children with autism. Similarly, it was advised that the mental health needs of children in care could be best met by primary care psychological services. One criticism that can be levelled at *A Vision for Change* (DOHC, 2006) is that while it clarified the future remit of CAMHS, it failed to take the lack of development of other community services into account. Primary care psychology services, for example, continue to be under-resourced (Mental Health Reform, 2015) while access to services for those with Autism Spectrum Disorder are inconsistent and in need of review (HSE, 2017a).

A Vision for Change (DOHC, 2006) also outlined the composition of a multidisciplinary team in CAMHS and suggested that the governance of these teams should include three

aspects: clinical leadership, team co-ordinator and practice manager. In terms of clinical leadership, "in keeping with current legislation and contractual arrangements this role would be the remit of the consultant psychiatrist or psychiatrists attached to the team" (DOHC, 2006, p. 80), while the clinical co-ordinator could be any member of the multidisciplinary team. It was identified that multidisciplinary teams need to have a mix of skills and experience across the disciplines, and each team can have a unique mix of disciplines and skills depending on the needs and social context of its catchment area. In other words, flexibility around the composition of each multidisciplinary team was recommended. Additionally, the document proposed that the multidisciplinary team within CAMHS work within a model of recovery and involve both the young person and their family/carers in current and future service development.

The implementation of *A Vision for Change* (DOHC, 2006) was reviewed after three years by the Mental Health Commission (2009) and after nine years by the Mental Health Reform (2015). In the latter, a number of outstanding gaps were described in services for children and adolescents including the numbers of staff and multidisciplinary teams being far below the targets set out in the document. In addition, some multidisciplinary teams were continuing not to accept new referrals of children aged sixteen or seventeen years, while many children and adolescents continued to be admitted to adult in-patient units. The Mental Health Reform (2015) also commented on the absence of quality standards and guidelines specific to CAMHS, as well as a lack of a system for monitoring outcomes.

1.5 Current Child and Adolescent Mental Health Services in Ireland

The current purpose of CAMHS in Ireland is to "provide a specialist mental health service to those aged up to 18 years old who have a moderate to severe mental health disorders that require the input of a specialist multi-disciplinary mental health team" (Health Service Executive (HSE), 2015, p. 13). The mental health disorder is further described as having a significant impairment to the child or young person or others, and affecting aspects of their daily functioning and development (HSE, 2015). The demand for CAMHS in Ireland is growing as reflected in the increase in the number of referrals to services, with the most recent data available from the first quarter of 2017 showing that over 2,818 children and adolescents were on the waiting list for an initial appointment in CAMHS (HSE, 2017b). Of this figure, 279 children and adolescents

were waiting over twelve months for an initial appointment. In addition, only 69% of children and adolescents who required in-patient mental health services were admitted to child and adolescent in-patient units.

A series of five annual CAMHS reports were published by the HSE between 2009 and 2014. Most of these reports consist of quantitative data in the form of tables, percentages, bar charts and pie charts. This information is undoubtedly important but it contrasts starkly to a length qualitative description of different interventions and initiatives offered by each multidisciplinary team across the country. These descriptions are relegated to the appendices. A review of the appendix in the most recent annual report (HSE, 2014) indicates that many teams are offering training and consultation, and are engaged in research and audits. They are offering group as well as individual interventions and are continuing to develop their own skills and engage in professional development. Teams are also developing initiatives to seek and listen to the feedback from young people and their families. It is a pity that all of these practices are not given more attention. They too contain very important information and, in fact, resonate with some of the guidelines and suggestions set out in *A Vision for Change* (DOHC, 2006). However, it seems that quantitative measures and feedback have been prioritised over qualitative views and descriptions.

Standard operating procedures for CAMHS (HSE, 2015) were recently published in order to bring about increased transparency and consistency in the services across the country. Despite the earlier publication and implementation of some of the recommendations in *A Vision for Change* (DOHC, 2006), many inconsistencies between different CAMHS continued to exist. The Standard Operating Procedures (HSE, 2015) outlined a detailed model of child and adolescent mental health services including primary, secondary and tertiary services. Primary or tier one services consist of community-based services such as speech and language therapy, occupational therapy, clinical psychology and public health nursing, as well as educational psychology, teachers and school counselling. These services are co-ordinated through a child or young person's GP. If the child or young person is presenting with an increasing level of need, they can be referred to their local community CAMHS. Community CAMHS, therefore, make up the secondary or the second tier of services. If the child or young person continues to present with an increasing level of need, they can

be referred to tertiary or tier three services which consist of day hospitals, in-patient units, paediatric hospital liaison services, emergency departments and other sub-speciality services (HSE, 2015, p. 9). The Standard Operating Procedures also introduced a standard CAMHS referral form and made recommendations around individual care plans, multidisciplinary case reviews and the management of non-attendance in CAMHS.

While the three tiered model described above is impressive, the reality is that the first tier or primary care services continue to be under capacity and difficulties in communication and collaboration with CAMHS remain (Children's Mental Health Coalition, 2015). Professionals from different backgrounds report frustration in the apparent lack of co-ordination between services and they are concerned that some children and adolescents are missing out on appropriate mental health care (Children's Mental Health Coalition, 2015).

One development in the area of child and adolescent mental health services in Ireland that has received positive attention is the emergence of *Jigsaw*. Jigsaw is a service set up by the organisation *Headstrong* that provides early mental health intervention to young people aged between twelve and twenty-five years (O' Keeffe *et al.,* 2013). Based on needs analyses and feedback from young people, *Jigsaw* was set up in an attempt to bridge some of the existing gaps in mental health services. In particular, it aims to provide a timely service to those who are in distress but may not meet the criteria for a moderate to severe mental health disorder in CAMHS (O' Keeffe *et al.,* 2013). *Jigsaw* works at the level of the local community and involves young people in the design and plan of the service (Illback & Bates, 2011). Services provided by *Jigsaw* include a brief contact, individual case consultation, short-term and long-term interventions (Illback & Bates, 2011). Most of the young people attending avail of a short term intervention and are in the age range of fifteen to seventeen years, indicating that *Jigsaw* can offer a service to adolescents who are experiencing emerging or mild mental health difficulties and who may not be able to engage with CAMHS (O' Keeffe *et al.,* 2013).

1.6 Views and Experiences of Children, Adolescents and Parents

In a systematic review of studies of young people's views on mental health services in the United Kingdom, Plaistow *et al.* (2014) concluded that young people's views are central to the design of future services and the views of young people who disengage from CAMHS should also be sought in order to ensure that future services will meet the needs of everyone. *A Vision for Change* (DOHC, 2006) also emphasised the importance of listening to feedback from children, adolescents and their families and using this feedback to further develop services. Unfortunately, it seems that while such views have been sought both in Ireland and elsewhere, the extent to which they have been incorporated into the design of services seems limited. McGorry *et al.* (2013) point out that it can be difficult to challenge the status quo of existing services but the interests of young people need to be prioritised over those of managers and others who may have different interests.

Bone *et al.* (2014) studied the views of children aged between eight and twelve years of age that had been referred to CAMHS in England, as well as the views of their parents. Although the authors do not explain the kinds of questions and probes used, they elicited the opinions and experiences of children and parents on the services via semi-structured interviews and analysed the data using a thematic analysis. Children and parents both spoke about their initial uncertainty in relation to their attendance at CAMHS as they did not know what the first appointment was going to entail. They also both highlighted the importance of good communication with professionals in CAMHS and described ways in which the services could be improved for other children and families, such as increased accessibility and more child-centred services.

In Ireland, Coyne *et al.* (2015) explored the views of adolescents attending CAMHS and their parents through semi-structured interviews and focus groups. Similar to Bone *et al.* (2014), the data was analysed using a thematic analysis and the emergent themes were representative of both sets of participants. Adolescents and their parents spoke about the challenges in accessing CAMHS and the stigma of experiencing a mental health difficulty resulting in attendance at such services. They also drew attention to their struggles in having a voice and being able to express themselves during clinical sessions. The development of the therapeutic relationship with the professionals in CAMHS was described as being very important but this was often disrupted by staff

turnover. While participants in general expressed their satisfaction with CAMHS, the authors emphasised the need to include the views of adolescents and parents in service development in order to continue to improve the service and stated that "there is still much work to be done to promote true partnership in CAMHS" (Coyne *et al.,* 2015, p. 8).

In terms of the older adolescents who attend CAMHS, Harper *et al.* (2014) explored the experiences of sixteen to eighteen year olds attending mental health services in the UK. The ten young people who took part had previously attended CAMHS and were attending a specialist mental health service for older adolescents at the time of the study. Through semi-structured interviews, the participants gave detailed accounts of their experience of mental health services and their accounts were analysed using an interpretative phenomenological analysis. Five themes emerged from the data including power differentials between the participants and the professionals in CAMHS, the importance of developmentally attuned services and the value of therapeutic relationships. Of note, one of the recommendations made by the authors of this study was the exploration of the perspectives of mental health professionals in providing mental health services to older adolescents, an apparent gap in the literature.

In addition to researching views of children and adolescent on mental health services, it is also necessary and useful to explore their views on mental health. In a large study of over six thousand adolescents representing every county in the Republic of Ireland, Dooley and Fitzgerald (2012) used the *My World Survey* to examine the mental health profile of young people in Ireland and to understand more about the nature of their well-being. Adolescents identified school, family and friends as the main stressors in their lives while friends, talking and music were identified as ways of coping with such distress. Perhaps the most significant finding from this study and one which has continued to resonate in the literature was the finding about the importance of 'one good adult' in the lives of adolescents and young people. Having a close relationship with one adult was associated with life satisfaction, self-esteem, coping skills and a feeling of belonging. In contrast, adolescents and young people who could not identify 'one good adult' in their lives were at increased risk of self-harm and suicide (Dooley & Fitzgerald 2012). A similar finding was reported by McElvaney *et al.* (2013) who studied the views of young adults who had experience of being in care and being in the youth

justice system in Ireland. Reflecting on their experiences as children and adolescents, each of the participants spoke about the need to feel understood by at least one adult around them and the significance of this relationship. In terms of mental health services, they called for greater flexibility and more informal services to be available to young people in the future.

1.7 Views and Experiences of Professionals

The views of professionals on child and adolescent mental health services have also been explored and described in a number of studies. While studies with children, adolescents and families have tended to ask broad questions about views on services, studies with professionals working in CAMHS have been more specific in their research questions.

1.7.1 Working with particular groups of children and adolescents

Several studies have explored how mental health professionals describe their work with particular groups of children and adolescents. For example, Welsh and Tiffin (2012) studied the experience of mental health professionals working with young people at risk of psychosis. They conducted semi-structured interviews with six professionals working in CAMHS in North East England. While the study was open to various disciplines, all of the participants had a background in nursing and were experienced in working with young people presenting with at-risk mental state. Analysing the data using a thematic analysis, the authors reported that professionals spoke about the complex nature of the identification of young people at risk of psychosis and the difficulties in distinguishing between what could be considered typical adolescent development and an emerging psychosis. Professionals also discussed the nature of different interventions and highlighted a lack of agreement between different teams and services on how to work with this group of young people. These findings had implications for the development of future care pathways and guidelines in the management of young people at risk of psychosis. Welsh and Tiffin (2012) highlighted that their study provided a valuable understanding into the views and experiences of professionals working with young people at risk of psychosis, although the extent to which the ‘experience’ of the professionals was explored seemed somewhat limited.

Similarly, Hay *et al.* (2015) examined the views of mental health professionals on their role in working with young people who self-harm. Eighteen professionals consisting of seven psychiatrists and eleven community psychiatric nurses took part in semi-structured interviews and these interviews were subsequently analysed using thematic analysis. Findings showed that participants were clear on the role of CAMHS in working with young people who self-harm and they were also clear in their own role as a mental health professional in working with this group of young people. What was interesting about this study was that participants highlighted tension between different disciplines within their multidisciplinary team in relation to the management of young people who self-harm, in that some of their colleagues may not offer support and are reluctant to work with such young people. While it is acknowledged that it is natural for different professionals to have different views on their roles, this can nonetheless have implications for the service provided to the young people. The authors concluded that it is necessary for all professionals in CAMHS to understand and be clear in their roles, although a potential disadvantage of this is that roles become too rigid (Hay *et al.,* 2015).

Meanwhile, Reiss and Gannon (2015) used interpretative phenomenological analysis to examine the experiences of mental health nurses in working with adolescents who had a diagnosis of emerging personality disorder or personality disorder. The participants worked as part of a child and adolescent mental health team in an in-patient unit and their experience working in the setting ranged from eighteen months to eight years. Their accounts highlighted the emotional impact and the demands of working with this group of adolescents, as well as a lack of support and clinical supervision. Participants also spoke about conflict arising within the multidisciplinary team around how best to support the needs of the young people. Differences in opinion on the team appeared to be linked to differences in the amount of time spent working with the young people on a daily basis. As nurses, the participants spend long periods of time with the young people but it is often other members of the multidisciplinary team (i.e. the doctors) who make decisions about ongoing care. While some of the findings of this study were similar to those of mental health nurses working with adults with personality disorders, the authors highlighted that there are specific challenges in working with adolescents with this presentation and emphasised the need for further staff training and support. One

limitation to this study was that the interviews with the participants were very short in duration, with one interview lasting a mere twelve minutes.

Within the Irish context, McElvaney and Tatlow-Golden (2016) studied the experiences of a range of professionals who worked with children and young people in care or in detention. Through focus groups and a small number of individual interviews, the study focused on the professionals' opinions of the mental health needs of this group of young people. Twenty-six professionals from fourteen disciplines took part in the study and they worked in services including CAMHS, addiction services, child protection and residential care. The data was analysed using a thematic analysis and the authors conceptualised the overall experience of the professionals as "reflecting a traumatised and traumatising system" (McElvaney & Tatlow-Golden, 2016, p. 66). This was a powerful conceptualisation of the professionals' experiences of working with this group of young people with mental health needs. The participants highlighted the inadequacy of available services and the problematic nature of interagency working. In addition, they described the emotional impact of the work and similar to Reiss and Gannon (2015), the authors called for further training and support for professionals in working with this group of young people. They also raised concerns about the capacity of professionals to work effectively with young people with mental health needs if the professionals themselves are feeling over-whelmed by the nature of the work.

In another study exploring the experience of professionals working in Ireland, Webster (2016) used interpretative phenomenological analysis to analyse semi-structured interviews with eleven professionals working as part of a multidisciplinary team that provides a clinical service to children and adolescents in secure care centres. Under the heading of 'going the extra mile' to describe the overall phenomenon, three superordinate themes were identified during the analysis as *the journey*, *the path* and *the passengers*. Participants gave detailed accounts of the nature of their daily clinical practice (*the journey*), what works well and what may not work well (*the path*) and the people and services that they have regular contact with (*the passengers*). Webster (2016) suggested that the experience of the professionals was in some ways parallel to the experiences of the children and adolescents engaging with the service, and he advocated for further research into this area.

1.7.2 Working with other professionals and services

Other studies have explored the views of mental health professionals in relation to working with other professionals and services. Vostanis *et al*. (2010) examined the knowledge and confidence of staff in CAMHS in working with children with educational needs and with educational service. Ninety-six professionals representing six disciplines across four multidisciplinary teams completed questionnaires to measure their knowledge of educational needs, as well as their attitudes and experiences of working with educational services. The participants also reported on case vignettes and described the nature of assessment and intervention that the referrals in the vignettes might entail. Findings highlighted significant needs in training for professionals in CAMHS with many reporting that they did not feel that they were able to work effectively with a child with educational needs. Given the relationship between mental health difficulties and educational difficulties in childhood and adolescence (Masten *et al.,* 2005), these findings were of concern and the authors called for improved inter-agency working between CAMHS and educational services.

A number of studies have researched the experiences of professionals in CAMHS on working with other mental health professionals. For example, Kam and Midgley (2006) studied how five professionals in a multidisciplinary team in CAMHS referred a child for psychotherapy. Using an interpretative phenomenological analysis, they explored the lived experience of the professionals in deciding to make a referral to a child psychotherapist. Each of the five professionals was from a different discipline (i.e. counsellor, social worker, psychologist, family therapist and psychiatrist) and semi-structured interviews were conducted with each of the professionals. What was interesting about this study was that the researchers presented their preliminary analysis both to the multidisciplinary team and to an audience at a child psychotherapy conference in order to further develop and complete their analysis. They found that while some of their findings were specific to the five participants and the CAMHS team, their findings in general made sense to people working in other CAMHS teams. One of the main themes in the participants' accounts of making referrals to child psychotherapy was the idea of child psychotherapy as being 'precious'. This had both positive and negative connotations: child psychotherapy was seen to be a valuable intervention but also at times a rigid intervention. Participants also spoke about how they recognise what referrals might be appropriate for child psychotherapy and the

importance of the timing or the readiness of a child to engage in psychotherapy. The authors concluded that the challenge for child psychotherapists and perhaps also other disciplines is in achieving a balance between helping others understand their role and explaining the nature of their work, while also maintaining their specialism on the team. This study therefore has important implications for multidisciplinary teams in CAMHS and it underlined the need for each discipline to understand the roles and experiences of each other.

Also using an interpretative phenomenological analysis, Chance (2016) researched the experiences of nurses in working with adolescents transitioning from a secure in-patient unit to adult mental health services. There were some note-worthy findings in the participants' accounts which raised questions about the how mental health professionals working directly with children and adolescents experience organisational issues. Under one of the superordinate themes for example, the theme '*working in a business culture'* captured the participants' experiences of working in a service that can prioritise budgets and resources over the needs of young people. Participants also spoke about not having a voice in planning the transitions of young people from CAMHS to adult mental health services and emphasised that the young people themselves were also disempowered. Furthermore, the themes *'questioning your practice*' and *'feeling in limbo'* encompassed the uncertainty of practice in child and adolescent mental health services and how professionals can often feel powerless despite having considerable insight into the needs of young people.

Stanton *et al.* (2017) explored the views of community mental health professionals in referring children and adolescents to in-patient psychiatric units. Using a thematic analysis, they analysed semi-structured interviews with forty-eight mental health professionals representing a range of disciplines including psychiatry, nursing, occupational therapy, social work and psychology. All of the professionals worked in community out-patient mental health teams and had experience in working with young people who had been admitted to an in-patient unit. While a number of themes emerged from the data, a particularly interesting finding was the perceived power differentials between the referring mental health professionals (i.e. the participants) and the mental health professionals working in the in-patient units. Some participants also described the experience of discussing referrals and admissions of young people with staff in the

in-patient unit as being adversarial and somewhat bureaucratic. The authors identified a need for increased opportunities for communication between professionals and services and for services to develop a better understanding of each other.

1.7.3 Specific aspects of practice in CAMHS

Specific aspects of practice in CAMHS have also been the focus of research on the views and experiences of professionals working within the services. For example, Martin *et al.* (2010) studied the views of professionals in CAMHS on the use of standardised diagnostic assessments in routine clinical practice. The authors were particularly interested in the idea that referrals could be allocated to particular disciplines that might be best able to meet a child or adolescent's needs based on the findings of such initial standard diagnostic assessments. Fifty professionals from two multidisciplinary teams in CAMHS in London took part in semi-structured interviews discussing strengths and weaknesses in their training in relation to standardised assessments, as well as the advantages and disadvantages of using standardised diagnostic assessments with children, adolescents and their families. The professionals represented a range of disciplines including nursing, clinical psychology, family therapy, psychiatry, social work and occupational therapy. This is similar to the range of disciplines that form a multidisciplinary team in CAMHS in Ireland. A noteworthy finding of this study was that some professionals were concerned about the potential for standardised diagnostic assessments to impede their clinical practice and to impact on the engagement of young people and their families.

In addition, Norman *et al.* (2014) explored the attitudes of mental health professionals in CAMHS to the use of a particular system of measuring outcomes in CAMHS. Again, the participants represented a variety of disciplines in CAMHS including clinical psychology, family therapy, social work, psychiatry, nursing, psychotherapy and occupational therapy. Participants were asked about their views on the advantages and disadvantages of routine outcome measurement in CAMHS in semi-structured interviews and the data was analysed using qualitative and quantitative methods. One of the advantages identified by participants was routine outcome measurement could highlight the strengths of the work that they were doing and that services could be improved as a result of this. However, disadvantages included the possibility that outcome measures would not accurately represent the work in CAMHS and smaller

gains in therapeutic interventions would not be captured. In addition, professionals spoke about the potential depersonalisation of interventions that routine outcome measurement could cause. The authors emphasised the need for commissioners and managers of CAMHS to listen to the views of professionals working in CAMHS in order to support them in addressing perceived difficulties.

Meanwhile, Anderson *et al.* (2016) researched how mental health professionals in CAMHS experienced and made sense of young people and families missing appointments in the service. The emergent themes suggested that professionals engaged in formulations about the young people and their families and drew on their knowledge of organisational influences, therapeutic processes and frontline clinical work to make sense of how young people and their families attend and engage with CAMHS. The authors emphasised the value of reflective practice for professionals in order to continue to understand and meet the needs of young people and their families.

1.7.4 Responding and adapting to changes in practice

Finally, the views and experiences of mental health professionals on managing changes in practice have also been the subject of research. An interesting study by Fiddler *et al.* (2010) researched how a multidisciplinary team in an acute adult mental health service experienced a change in practice from having a lengthy ward round once a week, to having a daily one hour team meeting. Adapting a phenomenological-hermeneutical method, interviews with twenty-one staff were analysed and the mix of staff who participants in the study included social work, psychiatry, nursing and occupational therapy, as well as management. A note-worthy finding of this study was how the participants made sense of adapting to this new way of working and how they were '*bound by tradition'*. As part of this theme, participants spoke about the tension that existed in the traditional ward round as a result of different agendas and how each professional group viewed the traditional ward round as serving their own interests. Participants also referred to the hierarchy within the multidisciplinary team in that the medical model strongly influenced clinical practice and the care provided by the multidisciplinary team. Regarding the new way of working and the daily one hour meeting, participants generally welcomed the change and spoke about how they were adapting to same. The authors drew attention to the fact that contextual factors and the

structures of each multidisciplinary team need to be taken in account in order to bring about any successful change in clinical practice.

How mental health professionals viewed new national guidelines for psychosocial interventions for schizophrenia was the subject of a study by Sandstorm *et al.* (2014). Although based on clinical practice in adult mental health services, the study raised important questions about how guidelines are developed and implemented in services. As the authors pointed out, it is expected that mental health professionals will incorporate and implement guidelines into their practice once they have been published. The views of professionals on such guidelines and how they will be implemented are often ignored. In this study, group interviews with sixteen multidisciplinary professionals were carried out and the data was analysed by content analysis. Findings indicated that the participants viewed the guidelines as "a challenge to the practice of care as known" and viewed their implementation as "anticipating change to come from above" (Sandstorm *et al.,* 2014, p. 225). For these mental health professionals, the new guidelines were going to challenge their current practice and were likely to be implemented in a top-down approach. These findings have implications for the development and implementation of guidelines in other mental health services. The authors advocated for more in-depth interviews with professionals in order to ensure gain a better understanding of how to introduce changes in clinical practice.

1.8 Summary

Studies have estimated that the worldwide prevalence of mental health difficulties in childhood and adolescence is about 13.4% (Polanczyk *et al.,* 2015). Child and adolescent mental health services offer specialist services for children and adolescents experiencing these difficulties. In Ireland, these services have undergone a significant period of development in recent years and this development has been largely driven by the publication of the policy document *A Vision for Change* (DOHC, 2006). The demand for child and adolescent mental health services is continuing to grow and the ability of services to meet this demand is being monitored. Quantitative data regarding waiting-lists and numbers of referrals in readily available (HSE, 2017b) and the present focus in CAMHS in Ireland is on this kind of quantitative data. In contrast, little attention has been paid to the experience of mental health professionals working within CAMHS in Ireland. In a time of considerable change and development, as well as the

publication of a number of key documents, it remains unclear how professionals on the ground are experiencing working in child and adolescent mental health services.

A number of studies have demonstrated the importance of researching the views and experiences of mental health professionals. In addition, there is value in researching collective multidisciplinary views and having participants representing a mix of professional disciplines. Studies to date have focused on the experience of professionals in working with particular groups of children and adolescents, in working with other professionals and services, in specific aspects of practice in CAMHS and in managing changes in clinical practice. Working in CAMHS as a phenomenon in itself has been neglected and there is a gap in the literature around the experience of mental health professionals in these services.

1.9 Current Research Questions

In the context of the above, this study aims to explore the experience of mental health professionals working in CAMHS in Ireland. The research questions are:

1. What is the lived experience of mental health professionals working in CAMHS?
2. How do mental health professionals talk about and make sense of their work in CAMHS?
3. What are the implications of mental health professionals' accounts of their experience of working in CAMHS?

Chapter Two: Methodology

2.1 Introduction

This chapter will provide a description of the methodology of this study. The main aim of this study was to explore the experience of mental health professionals working in CAMHS in Ireland. The rationale for employing a qualitative research design will be discussed and this will be followed by an overview of different qualitative research methodologies. Interpretative phenomenological analysis was chosen as the methodology for this study and will therefore be explained in further detail. The chapter will then describe the specific research methods used in this study, including the recruitment of the participants, the data collection and the data analysis. As the researcher herself also has experience of working in CAMHS in Ireland, it will be necessary to refer to researcher reflexivity and discuss the advantages and disadvantages of what is often termed 'insider research'. A brief discussion relating to the evaluation of qualitative research will be provided and the chapter will conclude with a summary of the main points that are relevant to the methodology of this study.

2.2 Qualitative Research Design

Qualitative research is primarily concerned with meaning (Willig, 2013). While there is no universally accepted definition of qualitative research and many different methods of qualitative research exist, they "share the assumption that there is no 'objective' reality or universal truth" (Lyons, 2007, p.4). Instead, reality is understood to be constructed by each individual (Howitt, 2010). Qualitative research is interested in the nature of people's experiences of the world and how they make sense of these experiences (Willig, 2013). Rather than testing a predetermined hypothesis with a large number of participants, qualitative research seeks to engage a small number of participants in order to explore and to understand their experiences (Smith, 2008). It therefore seeks to *describe* rather than to *predict* (Willig, 2013).

In contrast to quantitative research, qualitative research asks open-ended research questions and is inductive in nature (Willig, 2013). It is interested in working with rich and deep data (Howitt, 2010) and involves textual rather than numerical analysis (Smith, 2008). Qualitative research rejects the traditional scientific approach to research (Howitt, 2010) and there has been an increased focus on qualitative research in

psychology over the past two decades (Smith, 2008). This is evident in the increase in the number of publications of qualitative research studies in the literature, as well as the large amount of publications of books on the topic and the inclusion of modules within university programmes that are dedicated to qualitative research design (Coyle, 2007).

As the aim of this study was to explore the experience of mental health professionals working in CAMHS in Ireland, a qualitative research design was employed. Consistent with approaches to qualitative research design, the researcher was interested in *exploring, describing, interpreting and understanding* the experiences of the participants (Smith, 2008). While there have been previous studies exploring specific experiences of mental health professionals as outlines in the previous chapter, none had explored the experience of working in CAMHS as a phenomenon in itself. The design of this study was therefore inductive in nature as it sought to develop an appreciation of the participants' lived experience and how they made sense of this experience. The study was concerned with people's meaning-making, which is consistent with the premise of qualitative research (Coyle, 2007).

2.3 Choosing a Qualitative Research Method

Qualitative research includes a variety of methods and approaches to data collection and analysis. In the initial stages of this study, the researcher was interested in pursuing a discourse analysis of how mental health professionals talk about CAMHS. The original research questions were in relation to the professionals' use of language in constructing accounts, or realities, of CAMHS. However, it was clear after data collection began that the participants' accounts of working in CAMHS were full of rich descriptions of their experiences *per se*.

Willig (2013) has previously emphasised the importance of being sensitive to the research data and adapting the approach as necessary. Consistent with her view that the process of research is more akin to an *adventure* than a *recipe*, it was decided to change the original research questions and approach to data analysis in this study. Instead of a discourse analysis, the researcher explored alternative approaches that would have more of a focus on the nature of the experience of the participants, rather than how they were using language to construct these experiences.

Thematic analysis is one approach to qualitative data analysis which looks for repeated patterns in the data and seeks to organise the data into themes (Braun & Clarke, 2006). While thematic analysis is an accessible and a popular approach to data analysis, it has been criticised for its variation in quality (Howitt, 2010) with some studies tending to present the data without much analysis (Braun & Clarke, 2006). On further review of the literature regarding thematic analysis, the researcher in this study was concerned that some of the nuances and the complexities of the participants' experiences would be lost. Additionally, she was concerned that the small sample size of participants would not lend itself well to thematic analysis.

Grounded theory is another approach to qualitative data analysis. It is interested in developing a theory that explains the basic social processes of a particular phenomenon (Glaser & Strauss, 1967). Key components of grounded theory including the coding of data and the method of constant comparative analysis (Glaser & Strauss, 1967) and different variations of grounded theory have been developed over the years. In terms of data analysis for this study, grounded theory was not an appropriate choice given the aims of this study and its research questions. This study was interested in exploring the experience of the participants in CAMHS and not in generating a theory which might explain how these experiences had developed.

Narrative analysis was also considered as an approach to analysing the data in this study. Given that the participants were giving accounts of their experiences of working in CAMHS, stories were a feature of these accounts. However, narrative analysis is primarily interested in how people construct stories to make sense of their experiences or events (Murray, 2008), and in the structure of these stories. It is less concerned about the nature of the experience in itself. Hence, narrative analysis was also excluded as an approach to data analysis for this study.

As Willig (2013) has pointed out, there are no right or wrong research methods; rather the methods need to *fit* the research question. As the research questions of this study sought to understand how participants experienced working in CAMHS in Ireland and how they made sense of these experiences, interpretative phenomenological analysis was subsequently chosen as the most appropriate approach to data analysis.

2.4 Interpretative Phenomenological Analysis

Interpretative phenomenological analysis (IPA) is an approach to qualitative research that is dedicated to the study of how people make sense of their experiences (Smith *et al.*, 2009). IPA is interested in exploring experience *in itself* and the ways in which people reflect on significant experiences in their lives (Smith *et al.,* 2009). IPA is not merely a description of people's experiences and sense-making; its aim is to understand and to contextualise these experiences and sense-making (Larkin *et al.*, 2006). The outcomes of an IPA study will therefore involve aspects of 'giving voice' and 'making sense' (Larkin *et al.*, 2006, Larkin & Thompson, 2012). There are three main theoretical foundations to IPA and these will be outlined in further detail below.

2.4.1 Phenomenology

The epistemology[1] of IPA is rooted in phenomenology or the philosophy of the study of experience (Smith *et al.,* 2009). Smith *et al.* (2009) describe how Husserl emphasised the importance and value of studying both experience and the perception of experience. Husserl "argued we should 'go back to the things themselves'… endeavour to focus on each and every particular thing in its own right" (Smith *et al.,* 2009, p. 12). He emphasised the need for reflection and to examine what might be otherwise taken for granted. Other philosophers including Heidegger, Merleau-Ponty and Sartre made further contributions to the development of phenomenology and the interpretative nature of knowledge (Smith *et al.,* 2009). Experience is a complex phenomenon and is never directly accessible (Smith *et al.,* 2009). Instead, IPA aims to get close to an individual's experience and explore the everyday lived experiences that are of particular significance to an individual.

2.4.2 Hermeneutics

Hermeneutics refers to the theory of interpretation (Smith *et al.,* 2009). In IPA, the researcher has an active role in interpreting and making sense of the participant's experience (Smith & Osborn, 2008). IPA involves a *double hermeneutic* as the researcher is attempting to make sense of the participant making sense of their experience (Smith & Osborn, 2003). Both empathic and questioning hermeneutics are used in IPA research (Smith *et al.,* 2009). While the researcher attempts to understand

[1] Epistemology is the theory of knowledge: how and what we can know

the experience of the participant and appreciate the phenomenon from their point of view (i.e. an empathic stance), the researcher also attempts to move away from what the participant said and adapt a more curious and critical style in their interpretation (i.e. a questioning stance).

2.4.3 Idiography

Idiography refers to "the particular" (Smith *et al.,* 2009, p. 29). IPA is idiographic in that it is concerned with the detailed analysis of a particular phenomenon, and how the phenomenon is experienced by a particular group of people in a particular context (Smith *et al.,* 2009). This is in contrast with other *nomothetic* approaches to research which look for findings that can be generalised and provide objective explanations (Coyle, 2007). Analysis in an IPA study involves an in-depth and close examination of the experience of one participant, before the researcher starts the analysis of the next participant's experience (Smith, 2004). Hence attempts to explore commonalities and differences in participants' experiences only occurs after the researcher has developed an understanding and interpretation of what the experience means for each individual participant and how each individual participant makes sense of their experience. In an important point, Smith *et al.* (2009) have emphasised a lack of a clear divide between the particular and the general. In others words, we may be better able to think about an experience and what we might share with an individual when their circumstances, at first, seem very different to our own. The detail of the individual often enables us to move closer to what might also be general (Smith et *al.,* 2009).

2.5 IPA Methodology

IPA studies tend to use small sample sizes (Smith & Osborn, 2008) in keeping with its idiographic focus (Reid *et al.,* 2005). This allows the researcher to engage in a detailed analysis of each of the participants' accounts and develop of an understanding of each of their experiences. IPA is a particularly useful approach when a complex or a novel experience is being researched, and its research questions are generally quite broad and open (Smith & Osborn, 2008). Semi-structured interviews are the most popular method of data collection in IPA studies (Reid *et al.,* 2005) and support the researcher and the participant in taking part in a flexible dialogue (Smith *et al.,* 2009). While interviews are often viewed as the 'go-to' option in qualitative research, there is a level of complexity and skill involved on behalf of the researcher, in order to ensure that the

participant feels comfortable and is able to give an account of their experience (Taylor, 2005).

2.6 Research Method

2.6.1 Ethical approval

Ethical approval for this study was granted by the Faculty of Health Sciences Ethics Committee in Trinity College Dublin (see Appendix 1). Although the researcher was a student in a school in the Faculty of Arts, Humanities and Social Sciences, it was necessary to seek ethical approval from the Faculty of Health Sciences given that the topic of the study was in relation to mental health services.

2.6.2 Participant recruitment

Once ethical approval had been granted, the researcher contacted the national representative bodies of professionals working in CAMHS. Professionals representing the different disciplines on a typical multidisciplinary team were sought. The researcher initially wrote to the chairpersons of the Association of Occupational Therapists Ireland (AOTI), the Irish Association of Social Workers (IASW), the Psychological Association of Ireland (PSI) and the Forum in Ireland for Nurses in Child and Adolescent Mental Health (FINCAMH). In the letter to the chairpersons (see Appendix 2), the researcher outlined the study and requested that the chairperson distribute the participant information leaflet (see Appendix 3) to its members. The chairpersons therefore acted as gate-keepers to the study. The researched delayed writing to chairpersons of the Irish Association of Speech & Language Therapists (IASLT) and the Faculty of Child and Adolescent Mental Health in the College of Psychiatrists of Ireland as she had previously had contact with both and wished to reduce potential bias in recruiting participants in the two professions.

Professionals who were interested in taking part in the study contacted the researcher directly and the researcher offered to answer any additional questions or provide clarification as requested. All of the professionals who expressed an interest in this study initiated communication with the researcher via email and this continued as the method of communication. A mutually agreeable time for data collection (i.e. a semi-structured interview) was agreed and the researcher ensured that this was scheduled for

at least seven days following the initial receipt of the information leaflet by the participant. This allowed the potential participants an opportunity to reflect on their decision to take part in the study.

2.6.3 Participants

Six professionals took part in this study. Three social workers and two clinical psychologists were recruited through the process described above. One speech and language therapist read the information leaflet in her social work colleague's office and contacted the researcher to express her interest in taking part. The researcher Table 2.1 below outlines basic demographic information about each of the participants. Additional information about their multidisciplinary team, the particular service and the local community was known to the researcher but has not been included here in order to protect the participants' anonymity.

Table 2.1 Information about Participants

No.	Name	Profession	Years Working in CAMHS	Level of Education
1.	Matthew	Senior Social Worker	5+	Masters Degree
2.	Caroline	Senior Speech & Language Therapist	5+	Bachelors Degree
3.	Ciara	Senior Social Worker	10+	Masters Degree
4.	Deirdre	Social Worker	5	Masters Degree
5.	Mary	Senior Clinical Psychologist	15+	Professional Doctorate
6.	Joanna	Clinical Psychologist	5	Professional Doctorate

Each of the participants met the following inclusion criteria:

- Must be a health professional in the area of Child & Adolescent Mental Health

- At least three years recent experience in CAMHS in general (as opposed to within one specific service)

None met the sole exclusion criteria:

- Those who have worked directly with the researcher in CAMHS.

2.6.4 Informed consent

Written consent from each of the participants was obtained on the day of their interview (see Appendix 4). Participants were reminded that they were free to withdraw their consent from the study at any time and that this would not lead to any adverse outcomes.

2.6.5 Data collection

Data was collected via semi-structured interviews. A topic guide was developed by the researcher in order to guide the interviews (see Appendix 5) and this was piloted with two professionals working in CAMHS who were not going to be taking part in the study. Feedback from this small pilot study allowed for further refinement of the topic guide. It also provided the researcher with the opportunity to practice interviewing mental health professionals about their experiences and to develop her interviewing style.

Semi-structured interviews were scheduled with participants at a time and a location that was convenient for them. With the exception of one, all of the interviews took place in the participants' place of work (i.e. their office or an adjoining quiet room). Ciara opted to meet in her house instead. The interviews lasted between fifty-six minutes and one hour and twenty-one minutes, with an average of one hour and six minutes.

Each of the participants enquired about the researcher's background and engaged in general conversation about CAMHS before the interview commenced. As stated in the information leaflet and consent form, the participants were aware that the researcher was a speech and language therapist and they assumed that she had prior experience, or knowledge, of working in CAMHS. While the researcher did not readily volunteer information about herself, it was clear that these 'getting to know each other'

conversations were an important part of the interview process and their main function seemed to be to put the participants at ease.

Participants were reminded at the start of the interview that the purpose of the study was to hear about their experiences working in CAMHS and their views on the services. The researcher reassured participants that she considered them to be the ones with the expertise; the interviews were not about examining professional knowledge or scrutinising individual practice. Most of the participants sought reassurance that any potentially identifying information about them would be removed from the interview transcripts.

Open-ended questions were asked in order to encourage the participants to express their opinions and talk freely. The initial questions were broad (e.g. *"How did you end up working in CAMHS?"*) and became more specific as the interview progressed (e.g. *"How would you describe the public's understanding of CAMHS?")*. The researcher did not rigidly adhere to the topic guide and instead followed the participant's lead during the interview. Probes such as *"Can you tell me more?"* and *"Do you mean…?"* were used for clarification and elaboration as required. Follow-up questions were asked based on the participant's responses in order to thoroughly listen to what they were saying and to understand the wider context of their views (Rubin & Rubin, 2012). The interviews were audio-recorded on an Olympus digital voice recorder VN-733PC.

When the interviews were finished, almost all of the participants commented to the researcher that they enjoyed the experience of taking part in the study. It seemed that they had not had the opportunity to take part in such a discussion before, and three of the participants gave feedback that the interview had provided them with a chance to reflect on their current clinical practice which they found helpful.

The interview data was transferred from the digital voice recorder to the researcher's computer and stored securely with password protection. Only the researcher and her supervisor had access to the data. The data was subsequently orthographically transcribed by the researcher and all potentially identifying information about the participants was removed or substituted. The researcher also borrowed some notation

from Jefferson (2004) to transcribe intonation, emphasis, laughter, pauses and other information that was deemed to be relevant to each interview.

Participants were also given the opportunity to access a copy of the transcript of their interview if they wished to do so. This would provide them with the opportunity to delete any wording that they were uncomfortable with, or any additional information that they perceived as potentially identifying them that the researcher had not already removed. Two participants sought to access copies of the interviews; neither requested the researcher to make any edits to the data.

2.6.6 Data analysis

The data was analysed according to the step-by-step approach described by Smith *et al.* (2009) and outlined below:

- Step 1: Each interview transcript was repeatedly read in order for the researcher to become very familiar with its contents and its structure. The researcher also listened to a number of audio-recordings of the interview and occasionally, she listened to the audio-recording at the same time that she was reading the transcript. This allowed her to become very acquainted with the interview and to develop an in-depth appreciation of the participant's account.

- Step 2: The researcher made initial notes and comments in the right-hand margins of the pages of the interview transcript. In order to structure these comments, she followed the suggestion of Smith *et al.* (2009) and distinguished between descriptive, linguistic and conceptual comments. Descriptive comments were straightforward and described the content of what was said in the interviews. Linguistic comments attempted to capture 'how' it was said and included notes related to the use of metaphors, hesitations, repetitions, sarcasm and the choice of vocabulary. As the researcher is a speech and language therapist, she was particularly interested in these linguistic comments and had to take caution not to favour them at the expense of the others. Conceptual comments were more questioning in nature than descriptive or linguistic comments and sought to comment on the overall sense of what was said.

- Step 3: Based on the initial notes and comments, the researcher looked for emergent themes or phrases to capture the general understanding, or the crux, of what the participant was saying. These emergent themes were more abstract than the initial notes and comments in step 2.

- Step 4: The researcher examined the emergent themes and sought to create connections and relationships between them. She listed all of the themes from an interview transcript in chronological order in a separate document, and moved them around until groups of clusters were formed based on their connections and relationships.

- Step 5: A table of themes was created based on the clusters of emergent themes. Each cluster of themes was given a name (i.e. a superordinate theme) and the table contained the names of each superordinate theme along with its cluster of themes.

- Step 6: The researcher began the data analysis of the next interview transcript and repeated steps 1-5. While she approached each interview transcript as 'new' data and remained true to the idiographic nature of IPA, she also kept in mind the analysis of the previous transcript(s).

- Step 7: When the data from all six interviews was analysed, a master table of superordinate and subordinate themes was created. The researcher continued to review the original interview transcripts and lists of emergent themes. The process was iterative in nature as she sought to determine patterns and relationships between clusters of themes across participants' accounts but also remain true to the particulars of each participant's account.

An examples of one of the interview transcripts and the data analysis is in Appendix 6 and the overall findings of the analysis are described in the next chapter.

2.7 Researcher Positioning and Reflexivity

Though often neglected in the literature, it is necessary to state the position of the researcher in this study. This will clarify the context of the research questions and the research design, as well as provide an understanding of the interpretative framework used in data collection and analysis (Coyle, 2007).

The researcher is a senior speech and language therapist who had been working in CAMHS for a period of seven years when this research was initially designed. She was interested in the nuances and in the details of professional life in CAMHS, and wanted to engage in a study that could capture some aspects of this. Having worked as a speech and language therapist on three different multidisciplinary teams in three different CAMHS settings, she had worked with a range of colleagues across different disciplines and with a variety of clinical experience and backgrounds. The researcher's areas of clinical interest were in the stories of young people and families attending the service, and the process of engagement between the professional and the young person and his/her family. As part of her practice in CAMHS, the researcher worked with her colleagues in providing general mental health interventions such as parenting programmes, as well as providing specific speech and language assessments and therapeutic interventions.

The researcher had always enjoyed her work in CAMHS but she left her post approximately halfway through the data collection and analysis phase of this study. Having started to work in CAMHS as a newly qualified clinician in 2006, the researcher was keen for a change and took up a post in a new national clinical service that was being developed for young people in care and in detention in Ireland. She continued to work as a speech and language therapist as part of a multidisciplinary team throughout the remainder of the data collection and analysis phase of this study and was still working in this service when this thesis was being written.

No researcher is ever on the 'outside' of a research study (Willig, 2013) and always has a role in how the research is shaped and develops. While there is often mention of researcher 'bias' in the literature, Willig (2013) argues that such biases do not, and cannot, be eliminated. Instead, she advocates that the researcher accepts them as being part of the research process. The approach of IPA is also clear that the researcher has an active role in the collection and the analysis of data (Smith *et al.,* 2009).

2.8 Insider Research

Related to the positioning and reflexivity of the researcher is the concept of 'insider research'. Insider research has been defined as "that which is conducted within a social

group, organization or culture of which the researcher is also a member" (Greene, 2014, p.1). There are a number of advantages and disadvantages associated with insider research. Blythe *et al.* (2013) outline how insider research may lead to easier access to participants and a lessening of potential power differentials between the researcher and the participants. In addition, the researcher is likely to have unspoken and implied knowledge about the topic being explored which may lead to a greater understanding of the research itself.

However, there are also a number of disadvantages associated with insider research. Participants may be less comfortable speaking with someone who is familiar with the topic being explored and both the participant and the researcher may engage in presumptions (Blythe *et al.*, 2013). The credibility of the study may also be questioned if the researched has not taken satisfactory steps to ensure that the findings of the study are accurate. A study by Coar and Sim (2006) also raised concerns about interviewing one's peers with many of the participants reporting that the interview felt like a test of their professional knowledge and competence.

Similar to Blythe *et al.* (2013), the researcher in this study took a number of steps to ensure that her positioning as an 'insider' did not adversely affect data collection and analysis. Before the interviews began, the researcher explained to the participants that she might ask them to clarify or explain particular comments at times in order to ensure that she understood exactly what they meant. The researcher also took hand-written notes before and after each interview to support her reflection and her ability to make sense of her experiences in interviewing the participants. When each interview had been transcribed and analysed, the researcher's supervisor also examined the transcripts in order to ensure their credibility. The process of supervision continued to involve frequent reflection and discussion between the researcher and her supervisor about the emerging themes and findings of each of the participants' accounts.

2.9 Evaluating Qualitative Research

While evaluation in quantitative research studies is typically concerned with validity and reliability (Coyle, 2007), the evaluation of qualitative research studies is not as straightforward. A variety of criteria to specifically evaluate qualitative research studies have been developed over the past two decades, including those of Elliott *et al.* (1999)

and Yardley (2000, 2008). Smith et al. (2009) focused on the criteria of Yardley (2000) in their influential IPA text; hence Yardley's criteria will be described below.

Yardley (2000) described four principles as a guide to assessing qualitative research: *sensitivity to context, commitment and rigour, transparency and coherence, and impact and importance. Sensitivity to context* includes the need for the researcher to be attuned to both the socio-cultural context of the study, and the relevant literature that has already been published. The researcher must also be attuned to his/her relationship with the participants and ensure that the necessary ethical procedures and standards have been adhered to. *Commitment and rigour* relates to thorough data collection and in-depth data analysis. The researcher must be fully engaged and invested in the research process. *Transparency and coherence* refer to the clarity in which the research process is presented, and the fit between the research questions and the research methods used. *Impact and importance* denote the need for the research findings to be useful and to have socio-cultural and theoretical implications.

In terms of the context of this study, the researcher ensured *sensitivity to context* by developing her knowledge and understanding of the relevant literature and policy documents, as outlined in the previous chapter. She also reflected on her own positioning in relation to the study and sought full ethical approval from the relevant university ethics board before any attempts were made to recruit participants. Regarding *commitment and rigour*, the researcher followed the step-by-step approach to IPA data analysis that was outlined by Smith *et al.* (2009). She engaged in regular supervision and reflection during the data collection and analysis phases, and also attended a number of short training courses on qualitative research methodologies in order to continue developing her research knowledge and skills. *Transparency and coherence* of this study will be particularly evident in the next chapter when the findings of this study are presented. The researcher has also provided a detailed account of her research methods in this chapter. Finally, the *impact and importance* (i.e. the 'So what?') of this study will be discussed in chapter four. The findings have a number of implications for clinical practice, policy and education in the future.

2.10 Summary

This chapter has provided a description of the methodology used in this study. In order to explore the experience of mental health professionals working in CAMHS in Ireland, a qualitative research design was employed and IPA was chosen as the method of data analysis. Participants were recruited primarily through the national representative bodies of the different professions. In total, six participants took part in this study and semi-structured interviews were used to collect the data. The researcher took care to ensure that her position as an 'insider' did not adversely affect the data collection. Each interview was transcribed and then analysed using step-by-step approach outlined by Smith *et al.* (2009). The findings of the interpretation of the participants' experiences, and their sense-making of these experiences, will be presented in the next chapter.

3.1 Introduction

This chapter will provide a description of the findings of this study and give an interpretation of the lived experience of working in CAMHS from a number of mental healthcare professionals' perspectives. Three superordinate themes emerged from the analysis: (1) *Negotiating Identity in CAMHS* (2) *Power in CAMHS* and (3) *The Changing Nature of CAMHS*. Each of these three superordinate themes was informed by three subordinate themes as summarised and shown in Figure 3.1 below. These themes will be described in detail and supported by relevant extracts from the participants' accounts. From the analysis, the general experience of working in CAMHS - or the phenomenon *per se* - can be understood as *"I think everybody's finding it a challenge to be honest."* This quote is taken from one of the participant's accounts and points to the overall sense of the phenomenon as experienced by the participants in this study. Table 3.1 at the end of this chapter illustrates the presence of the themes across each of the participant's accounts.

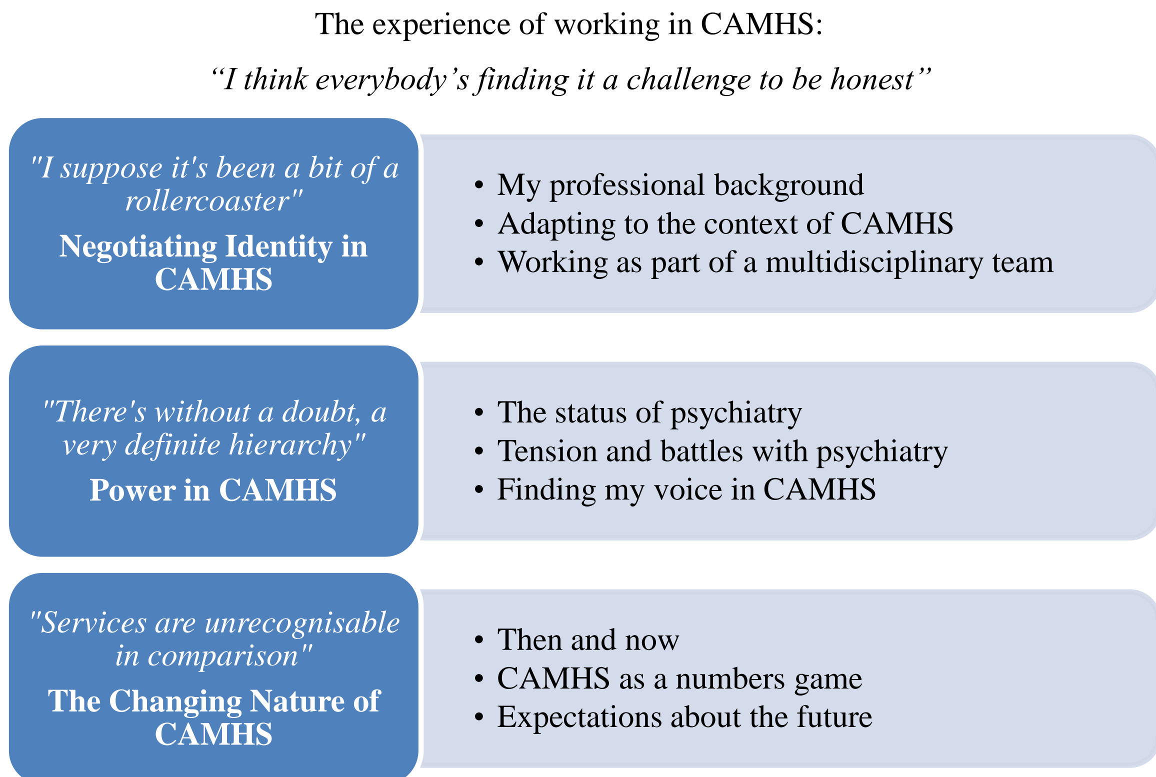

Figure 3.1 Overview of findings: The experience of working in CAMHS

3.2 Superordinate Theme I: Negotiating Identity in CAMHS

"I suppose it's been a bit of a rollercoaster"

Negotiating Identity in CAMHS

- My professional background
- Adapting to the context of CAMHS
- Working as part of a multidisciplinary team

This superordinate theme describes the journey to establishing an identity in CAMHS. Participants have trained in a specific professional discipline (i.e. social work, speech and language therapy or clinical psychology) and they each bring a set of skills and knowledge to the CAMHS setting. However, it seems from their accounts that they have had to adapt this set of skills and knowledge in order to 'fit' into CAMHS. This is not a straightforward task and is dependent on the individual participant and the service in which they are working. Participants are also part of a multidisciplinary team in CAMHS. The very nature of CAMHS means that they are not working in silos; they are one of a group of other professional disciplines.

3.2.1 My professional background

Each of the participants spoke about their professional background. They described their specific disciplines and reflected on what it means to be a social worker or a clinical psychologist or a speech and language therapist. Young people and families attending CAMHS often have different expectations about who they are going to meet and this can lead to participants initially having to '*explain*' themselves, as Caroline describes below:

> *And more often than not, I think it confuses people sometimes when they're coming in to the department and you know, their child might be, have severe anxiety, exceptionally bright and they're seeing a speech and language therapist? (laughs) They're going 'What's going on?' And then you have to explain yourself and once you explain it, it's fine. (L486-491)* [SLT][1]

Earlier in the interview, Caroline had described her previous role working with primary school-aged children with developmental communication difficulties. In that service,

[1] An abbreviation for the professional backgrounds of each of the participants i.e. speech and language therapist (SLT) , social worker (SW) and clinical psychologist (CP) is included after extracts in order to support the reader in this chapter

children were discharged from the speech and language therapy caseload before they transitioned to secondary school. She recalls a sense of there not being any benefit to further intervention for children after they left primary school, and contrasts this to her role in CAMHS. She now works with many adolescents with communication difficulties and recognises a need for speech and language therapists to upskill in this area of clinical practice. Caroline commented that she would be almost embarrassed to bring out *"nice little worksheets" (L899)* in clinical sessions and is clear that she would like to develop further expertise in working with adolescents. She believes that speech and language therapy as a profession has *"a huge piece of work to do I think (...) around kind of selling our goods in terms of what we could offer and what we could. And you know we could offer huge amounts" (L594-596).* The expression of '*selling our goods*' suggests that Caroline sees speech and language therapy as having to take more of an active role in emphasising their value in working with adolescents and in CAMHS.

Similar to Caroline, Deirdre also described others' confusion about her role in CAMHS. Sometimes this is evident amongst her colleagues and she gave an example of the occupational therapist on her team approaching her solely about obtaining an allowance for a family. As a social worker, there is a common expectation that she is part of the social welfare system and that she will complete relevant forms for allowances and other financial supports. She reports how parents may think that she is assessing their ability to look after their children and she is often greeted with an air of suspicion, as follows:

> *Eh so everybody has a different idea. I went out on a home visit last week and eh I clarified my role and all that they kept talking about was you know, 'We sort of, we don't want you to be kind of coming out to us because our kid isn't going to school' so they got me confused with an EWO[2]. Another eh, most other sessions when I mention when I'm doing an initial assessment eh here, most sessions they eh when you say 'I'm a social worker and this is the clinical nurse specialist,' they gravitate the eye-contact towards me and 'Oh'. So there's always that sense of 'Mmm social worker' you know? And then you you clarify that, you know that your role on the team is different and then you you balance it by clarifying that the clinical nurse specialist doesn't work with, you know this this and they work with their voice and they don't have. So you kind of try and kind of clarify it like that. (L194-207)* [SW]

[2]An EWO is an educational welfare officer who works with the Child & Family Agency (TUSLA) in order to ensure children are attending school regularly

It seems that in her attempt to explain her role to families and how it might be different to another kind of social worker, Deirdre compares her role to that of the clinical nurse specialist on her team. Both disciplines have what could be described as traditional and more widely understood roles (i.e. social work in child protection and nursing in medical settings/hospitals), but both also work in CAMHS. The nature of both of their roles in CAMHS is different to that in the other kinds of services.

For Deirdre, social work is not a discipline that is easily defined. She sees this as both an advantage and a disadvantage. She enjoys the creativity of social work, particularly in the CAMHS setting and she is clear that she could not work in a setting in which her practice might be very defined and restricted. She states that social work is an *"eclectic mix of all sorts of ideas and approaches and philosophies" (L230-231)* but acknowledges that this eclecticism can also lead to difficulties in others understanding their role.

Ciara is also a social worker and similar to Deirdre, she spoke at length about the identity of social work and how she makes sense of this. She sees social work as having a strong ethical background but perhaps being less defined in terms of its therapeutic background. In the extract below, her comparison of a social worker to *'a cuckoo'* conveys the idea of social work not having its own set of interventions:

> *It's kind of, eh I mean social work borrows from all over the place, it's kind of a bit of a, a bit of a cuckoo. Is it a cuckoo going around stealing other birds' eggs? (laughs) (...) It's a little bit like that, borrows from all over the place. So we have a strong social work position but when you're going into therapeutic social work, it's all a bit kind of, well you can kind of pick and choose. (L159-167)* [SW]

Ciara later describes the nature of this 'woolliness' of social work and similar to Deirdre, she embraces this wooliness and welcomes it. For Ciara, this 'woolliness' is the true value of social work. Being a social worker also means being 'uncertain' and being confident in holding this uncertainty according to Ciara. However, not all social workers and certainly not all other professionals understand this. Later in the interview, Ciara explained that she is involved in teaching undergraduate and postgraduate social work students. She recognises that uncertainty can be difficult for students and newly-qualified practitioners, and that many social workers prefer working in settings where

the work is more easily defined. Reflecting on CAMHS, Ciara emphasised that the role of social work is in its ability to bring a '*position*' to the team and this is what is special and unique about social work in CAMHS. Social work sees the child or adolescent in the context of their family and the overall system around them. Being a social worker in CAMHS is therefore *"probably less about what you do and more about where you come from" (L217-219).*

Some of the participants reflected on their clinical education/training and how this continues to manifest in their current role. For example, Matthew spoke about his earlier experience of education and adulthood before becoming a social worker. As a younger man, he explained that he dropped out of his original academic course in university and worked in a variety of unskilled jobs throughout his early to mid-twenties. While he always enjoyed working with young people, his decision to become a social worker developed from his interest and appreciation of social constructionism. He viewed social work as *"kind of like the meeting point between philosophy and eh human services" (L49-50)* and he contrasted this philosophical background of social work to that of other disciplines in CAMHS. The background of other disciplines do not resonate as well with him and his use of an air quote gesture in the extract below suggests a sense of ridicule or his lack of belief in these alternative ideas:

> *A lot of eh, other forms of therapy would be based upon more objective, in inverted commas [makes air quotes gesture] 'scientific modernist ideas', where there's a belief in an absolute truth, in truth in reality in things like that, eh which don't fit for me. (L73-77)* [SW]

Matthew later described how he managed to gain experience in CAMHS during one of his social work student placements. Though he was meant to have a placement in child protection, he instead discussed the option of a placement in CAMHS with his supervisors. He had become increasingly interested in mental health and therapeutic interventions over the course of his studies and it seemed that he was keen to pursue this in clinical practice. Matthew was successful in his pursuit of a placement in CAMHS and he recalled an immediate sense of *"This is it, this is what I want to do" (L97-98)* when he started his placement there.

Joanna is a clinical psychologist and she also described how her experiences and her clinical placements shaped her interest in working in child and adolescent mental health.

She described how different clinical psychology trainee programmes tend to have an emphasis on different aspects of clinical psychology, and the programme on which she studied had a focus on attachment in childhood. One of her clinical placements was on a specialist community psychology team which worked with children in care. Joanna explained how this placement "*left a deep imprint in terms of the work and the approach that they took" (L28-29)* and ultimately led her to taking her current post in CAMHS. As part of her clinical training, Joanne also completed research on the relationship between social disadvantage and mental health. Given that she now works on a CAMHS team in an area of social deprivation, she described how she is able to use this background knowledge and experience to make sense of her work with families. Ideally, Joanna would like to see more of a focus on the parent-child relationship in CAMHS and she linked this focus to her clinical training and her experience as a trainee psychologist. She reflected that while attachment behaviours are frequently discussed in CAMHS, she does not think that the equivalent interventions are provided very often.

Like Joanna, Mary is a clinical psychologist. She has worked in CAMHS for over twenty years and she recalled how she first developed an interest in working in child and adolescent mental health. As a young adolescent herself, she described how she read a book about a boy who had autism and how well he responded to psychological intervention. While she somewhat poignantly states *"my reality hasn't matched the book but yeah (sighs)" (L32)*, Mary is clear that one of her main interests has always been in the therapeutic relationship and the connection between the clinician and the service-user. She was keen to work in a profession that would give her the opportunity to '*get to spend time with people*':

> *I knew I never wanted to do medicine or GP because I thought you never get to spend time with a person you know, it's in and out so I kinda was more interested. If I wouldn't have done psychology, I was thinking of social work or or nursing because I'd get to spend time with people. (L37-41)* [CP]

Mary gave an account of her journey to becoming a clinical psychologist. This was a long struggle due to the high demand and low supply of placements on the clinical training programmes. When she completed her training, she worked for a short period in locum positions and an adult mental health service before moving to CAMHS. She works with complex cases in CAMHS (i.e. '*the chronic ones*') and identified

psychology as the discipline which is viewed as having the skills and the expertise to do so:

> *Whereas now, well certainly for psychology you'd be getting the chronic ones, you wouldn't getting the easy ones. If there was an easy one, usually the nurse or another discipline would often take those. (L311-314)* [CP]

Mary subsequently gives an example of a 'chronic one' as a young person who is engaging in repeated self-harm and an example of an 'easy one' as a child with developmental difficulties. Her role as a psychologist is therefore more specialised than that of her colleagues.

In summary, all of the participants have a specific professional background and a set of experiences which they have brought to CAMHS. Their background has a significant bearing on how they currently work and continues to be part of how they negotiate their identity in the service.

3.2.2 Adapting to the context of CAMHS

Each of the participants also spoke about adapting their professional background to the context of working in CAMHS. Participants described a process of familiarising themselves with CAMHS and making some changes to their practice or their role in order to 'fit' in. For some participants, this is an ongoing endeavour.

The three social workers in this study have all pursued postgraduate study in psychotherapy and have trained as family therapists while working in CAMHS. Ciara explained how she had always had an interest in working with families and had always done this kind of work but she was keen to obtain a formal qualification in same. When she started working in CAMHS, she recalled her surprise at being told that her role was to work with parents of children attending the service, and not with directly children. Given that Ciara had decided to move to CAMHS from adult mental health services in order to spend more time working with children, she was very taken aback at this idea. While she did end up also working with children, Ciara describes lacking in confidence as a social worker in CAMHS and she was '*hungry*' for further training:

> *You know I did get to do the work I wanted to but I did feel kind of underqualified, I didn't know what I was doing and I really appreciated the support of my line manager and. And again I was hungry for the*

> *training so I got into that quite quickly, into doing family therapy training which was incredibly useful in the job. I sort of felt I was really gaining skills that I needed. (L144-150)* [SW]

It seems that this 'hunger' for training was a basic need in Ciara that had to be met. The qualification in family therapy did meet her expectations and she developed specific therapeutic and counselling skills that were relevant to her work in CAMHS. Commenting on the training, Ciara reflected "*it was a fit, the right fit" (L534)* and it gave her confidence in her role as a social worker in CAMHS. Now, she sees herself as both a social worker and a family therapist and she does not think that she can separate out what she does as "*anything that's purely social work or anything that's purely family therapy" (L564).*

Similarly, Matthew also describes how he made the decision to pursue a family therapy qualification. As a student, he had really enjoyed his clinical placement in CAMHS and had decided at that point that he wanted to work in the services when he was fully qualified. Therefore, little adaptation was going to be necessary for Matthew as he already had experience of working in CAMHS and was clear that he wished to return there. However, he was aware that many social workers in CAMHS had a qualification in family therapy and thought that if he was to pursue the same qualification, it might increase his chances of getting a post in CAMHS as he describes below:

> *And I also realised that if I wanted to work in CAMHS that the vast majority of social workers have additional psychotherapy training. In fact at the time when I came here on placement, I don't think there was any social worker that wasn't a psychotherapist as well. So I realised long term in terms of if I aspired to work here, I needed psychotherapy training. (L57-62)* [SW]

Such was Matthew's desire and determination to return to CAMHS as a fully qualified social worker, he started his qualification in family therapy before he had completed his social work studies.

Deirdre reported how she and her social work colleagues initially experienced significant uncertainty and doubt about their role in CAMHS. As a consequence, they adopted temporary identities and "*turned into mini-regs and mini-nurses and mini-whatever until we got some sense of where we might fit" (L363-364).* Over time and with the support of a new line manager as well as developing some key documents

about social work in CAMHS, they developed a stronger sense of themselves and felt more able to their own work. In the context of reviewing her role in CAMHS and trying to broaden her skill set and expertise, Deirdre also decided to pursue a qualification in family therapy. Three years later, this decision causes her some upset and she wonders why social workers in CAMHS feel a need to pursue further training. In the following extract, there is a sense of social work not being 'good enough' (i.e. '*hasn't got the value*') to work in CAMHS and Deidre and her social work colleagues having to address this sense of deficiency by pursuing further training:

> *Eh so yeah, it saddens me because I just feel like you know that social work should have. Like what is it about social work that hasn't got the value on its own you know?(...) Like you know, what is it that? So like eh you know for example a nurse or a psychiatrist can come in here with their title and you know there's not the same, you know (sighs) level of retraining you know? Cause it's, cause they do psychiatric nursing but for social work, I think again it's around that general term. But like, that's the value, that's the best thing about social work. And then we try and pare it down, by you know cause we don't fit. So then when we don't fit, how are we going to fit? So we put a psycho-something before our name or after our name, you know? And then, then people might appreciate. (L634-647)* [SW]

For Deirdre, additional therapeutic qualifications are seen as being more useful on the multi-disciplinary team than the core social work qualification. She lamented that social workers *"have to sexy it up a bit" (L663)* in CAMHS and she is dismayed that the true value of social work has been '*lost*':

> *Eh what's our core bit? Don't forget the core bit, that's the value. That's the real value for me and I feel that, that's what saddens me. I think 'Where, where is it all? (laughs) Where is it, where is it?' It got lost. (L 668-671)* [SW]

Unlike Ciara, Deirdre is very definite that she is first and foremost a social worker, and not a family therapist. She stated that she will remain true to her social work role and while family therapy will inform and add value to her role as a social worker, it will certainly not replace it.

As a speech and language therapist in CAMHS, Caroline explained how working and adapting to CAMHS has led to her developing another professional identity as *"a mental health worker" (L384)*. While Caroline is unsure if she will continue to live in

Ireland in the future due to personal circumstances, she is aware that speech and language therapists do not work as part of CAMHS in many other countries. She does not wish to ever return to working in community speech and language therapy services and she predicted that she would find such a return very challenging. Even though Caroline thinks she had become deskilled in some of her core speech and language therapy skills, she has embraced this new identity as a 'mental health worker'. She described it as a natural consequence of her role in CAMHS because *"the working life of a clinician on a CAMHS team isn't, it's not straightforward, it's not sort of compartmentalized. It's not neat, you know" (L210-212).* However, Caroline also spoke about some difficulties she has experienced in adapting this identity of a 'mental health worker'. She gave an example of applying for funding to attend a short training course on loss and bereavement. Her application was queried by the management team because she is a speech and language therapist and it was not clear to them why she would be interested or needed to attend a course on the topic of loss and bereavement. It seems that while Caroline sees herself and her colleagues as being 'mental health workers', the management team may not share this understanding. Caroline pointed out that *"it's really hard to kind of explain to somebody who doesn't understand our remit that we're not just speech and language therapists, we're not just psychologists. We have two hats; we are mental health workers" (L204-206)* [SLT].

Participants also spoke about the demands of CAMHS and having to adapt their practice to keep up with the pace of the work, as well as administration demands. For Mary, this is an ongoing challenge. She described how she has recently moved to a different clinical psychology role within CAMHS which means that she is using new formal assessments and working with an older group of adolescents. While she is managing to offer appointments to all the young people that are in need, she is struggling to keep up to date with the corresponding paperwork. She explained how she has tried different ways to manage this better but to little avail. She is *"resigned to the fact that I might never be up to speed with it" (L690)* and describes a sense of guilt at these outstanding reports. Mary referred to having brought work home with her on occasion in her attempts to try and be 'up to speed'. Mary has also recently trained in dialectical behavioural therapy (DBT) as part of a service-wide initiative to start offering adolescent DBT group programmes. While she is happy to have had the opportunity to develop these skills, being a qualified DBT clinician is going to lead to further demands

being placed on her. This is already causing her some distress and she described her difficulties in managing the demands of being a qualified DBT clinician as well as being the clinical psychologist on the team. Mary feels a duty towards her colleagues and it can be '*hard to say no*':

> *It reduces my time here and I still have the same work really, so it puts more pressure because in effect I'll be here three days a week you know. But there's only one psychologist so if there's stuff to be done it's like, it's hard to say no and then it's hard to fit stuff in. And people just, they see you there so you know, they're not thinking 'Oh well, sure you're only here three days.' (L580-586)* [CP]

Adapting to CAMHS is therefore an ongoing task for Mary as she tries to manage the different demands on her role and perhaps achieve a balance between 'saying yes' and 'saying no'.

While most of the participants moved to CAMHS from different areas of clinical practice, Joanna came straight from her clinical psychology training to working in CAMHS. Unlike Matthew, she did not have a placement in CAMHS and while she was keen to work in CAMHS, she had no prior experience of same. Joanna described being quite taken aback when she first started in CAMHS and it took her a while to settle into her role. In the extract below, she contrasts her role as a clinical psychology trainee to that of a full-time clinical psychologist:

> *I suppose when you're out of training (...) you have ideas, you're enthusiastic, you've all different ways of thinking of how things work. When you, you know, you're in there working in the field and I suppose it's been a bit of a rollercoaster, I have to say. In that initially thought thinking I had quite a shaped identity of what of eh of how I might work and how I wanted to work. That I was quite thrown when I first started in CAMHS. (L 70-78)* [CP]

The comparison of her initial experience in CAMHS to that of a '*rollercoaster*' suggests a journey of ups and downs, of highs and lows and perhaps the unexpected. It was clear from Joanna's account that transitioning to a fully qualified clinical psychologist in CAMHS was a challenge and part of this was a result of the context of the team on which she was working on. As a trainee, Joanna recalled how she had a small caseload and was usually based in the same building all day. When she started working in CAMHS, she had to manage working with a large number of children and adolescents

with less time to prepare for and reflect on sessions. She also had to move between different locations as the CAMHS team did not have a set base. For Joanna, supervision and an increased familiarity of the team and the service enabled her to develop confidence in herself and to work more in line with how she initially expected. Over time, she started *"fine-tuning sort of my skills for CAMHS settings" (L122-123)* and became more comfortable in her role and on her team.

In summary, each of the participants has recognised the need to adapt to the context of CAMHS. While they attempt to remain true to their professional background, they have also developed ways to adjust to working in CAMHS and to negotiate their identity accordingly.

3.2.3 Being part of a multidisciplinary team

Many of the participants spoke about being part of a multidisciplinary team in CAMHS and how this also shapes their practice. While it can take a while to get to know their colleagues and to get used to working together, participants generally spoke about their positive experiences of being part of a multidisciplinary team. Mary explained that her decision to continue working in CAMHS was largely influenced by her experience of working on her team. She recalled that she initially did not intend to stay working in CAMHS and had planned to leave after a year or two but she ended up staying in the service as she got on really well with her team. Her current team work very well together but she does not take this for granted. Mary repeatedly commented that she and her colleagues are '*lucky*' as evident in the short extracts below:

> *Yeah I mean I suppose eh (pause) we're very lucky here in that have a really nice team touch a bit of wood [touches item beside her]. (L850-852)* [CP]
>
> *So I mean we do say that we're very lucky (...) I would hate to think what it would be like if we didn't get on, we just couldn't work I think. (L860-863)* [CP]
>
> *We're very lucky to have that, eh. You know, we've a few straight-talkers (...) Including the Consultant, so that's great. You know, people kind of call a spade a spade. (L885-890)* [CP]

Mary later gives an account of a negative experience she had while working as part of a different team. People were not 'straight-talkers' and she was very unsure of herself and

in her work. This culminated in her taking some time off on sick leave before transferring to her current team. Perhaps this is why she now considers herself '*lucky*'. Mary described the nature of joint-working on her team in further detail later in the interview and explained how the team set aside a regular time to reflect on how they are functioning and the service that they are providing together.

Deirdre also reported that her team does a lot of joint-work together and for the most part, this works very well. In her service, the multi-disciplinary team conduct initial assessments with young people and their families in pairs of two clinicians (e.g. a social worker and a nurse, or a nurse and a psychologist). They also provide interventions together and co-work cases on an ongoing basis. Deirdre commented that her colleagues on the multi-disciplinary team have *"gorgeous skills" (L765-766)* and can do *"gorgeous work" (L807)*. This work is clearly welcomed and valued by Deirdre as evident in her repeated use of the adjective 'gorgeous'. For Deirdre, everyone on the team has the same goal in offering a quality service to young people and families presenting with mental health difficulties. While the team can sometimes disagree about each other's roles and '*get into debates*' about what the other is doing, the team work on Deirdre's team is generally '*excellent*' as she concludes in the following extract:

> *And eh the the, the the team complement each other. When we work well, we really complement each other. Like when we work really, when we, when we work well together, we actually get down to the bones of it and just do it, you know? When we get into debates about what we do and who's bit is this bit; that's what I kind of mean about maybe when you get down to it (….) the actual doing is excellent. (L776-783)* [SW]

Ciara has always worked as part of a multidisciplinary team. Prior to joining her current CAMHS team, she worked in a multidisciplinary team in adult mental health services and a number of multidisciplinary teams in other CAMHS services. Her current team is small in comparison but they are nonetheless *"quite an efficient little team" (L1022)*. According to Ciara's account, there are limited opportunities for joint-work due to different work schedules and the small size of the building. Ciara stated that she misses joint-work as she did a lot of this on her previous CAMHS team. However, she believes that multidisciplinary teams can still function well in spite of not being able to spend much time together and she quoted the number of open cases and the number of whole time equivalents on her team at present. While some participants described a process of

learning to be part of a team in CAMHS, this was true for Ciara and she attributed this to her past experience and her confidence in her role on the team:

> *You know there's a bit about how you come in. I'm relatively new on that team and you know you need to sort of, I suppose come in and convince people that you're competent and able to do the work, do you know like? At my stage, you know that wasn't hard to do really because I do feel like, competent and I know the work and I know, you know I kind of know what I'm doing at this stage. (L421-427)* [SW]

Ciara continued to describe how in her experience, it is important to have a mix of experienced and novice clinicians on a team. She explained that if too many new clinicians join at the same team at one time, it can cause confusion and considerable difficulty in the team.

For Joanna, she joined her current CAMHS team as a newly qualified clinical psychologist and she spoke at length about being part of a multidisciplinary team in CAMHS. She recalled how it took a while to feel comfortable on the team and to understand the different roles of her colleagues. Many of her colleagues had additional therapeutic training and this initially caused her confusion. She explained that she now sees this as evidence that the team have a common goal and she has realised that *"we were all, in essence I've felt over time, doing the same thing, similar things, but we were looking at it in slightly different ways through different lenses" (L106-109)*. Joanna also described the process of the development of trust between her and her colleagues in that she had to take time to get to know her colleagues and vice versa (i.e. '*learning to trust*'). Joanna's colleagues seem to have taken care to ensure that she had a gradual introduction to the work in CAMHS and as she became more familiar with the work, she was able to do more work as part of her team. The nature of this team-work was captured in the extract below:

> *I think it was sort of the gradual process of the team starting to trust me?↑ On the one hand it was not, I didn't think that they didn't trust me, but they were actually supportive in not throwing me in the deep end in working you know, with high risk cases or you know doing kind of intakes you know, of sort of you know high risk or urgent appointments. So I felt I was being supported, I wasn't pushed into it and I could go at it at my own pace (...) So I think yeah it was a process between learning to trust, you know my colleagues and my, and my colleagues trusting me and then just starting to take on a caseload and to see if I can get them from the get go. (L124-148)* [CP]

Similar to Ciara, Joanna explained that she and her colleagues do not always have the opportunity to do joint-work together as they are often working in different locations. However, they committed to supporting and helping each other out when the need arises and in relation to difficult cases. Joanna continued say that she feels a greater loyalty and *"allegiance" (L1036)* to her multidisciplinary team than she does to her colleagues in the department of psychology. She also reflected that she is able to have a better understanding of other disciplines based on her experience of working on the multi-disciplinary team.

Meanwhile Caroline was clear that being part of a multidisciplinary team is one of the main reasons why she enjoys working in CAMHS. She had earlier described how her previous role as a speech and language therapist involved working with developmental communication difficulties and visiting schools as part of her typical working day. This led to her working primarily out of her car and in quite an isolated way. In contrast, she is surrounded by colleagues on the multidisciplinary team in CAMHS and spoke highly about this:

> *But what I really liked about CAMHS was just being part, part of the multidisciplinary team, learning from colleagues, and just the whole new area. And the fact that you know it was…it was quite different to core SLT work. (...) Learning from colleagues was something I really enjoyed and continue to enjoy. (L22-29)* [SLT]

In summary, participants are individual clinicians working in CAMHS and they are also clinicians working as part of a multidisciplinary team. Working as part of a multidisciplinary team appears to bring challenges as well as rewards, and is another way in which participants negotiate their identity in CAMHS.

3.2.4 Summary of Superordinate Theme I: Negotiating Identity in CAMHS

The participants' experiences of negotiating identity in CAMHS can be understood as a process in which they recognise their professional background and adapt this background to the particular context of CAMHS. While there are some similarities in the participants' journeys to negotiating an identity, it is also clear that each participant's journey is unique to them. In addition to their professional background and attempting to 'fit' into CAMHS, participants also familiarise themselves with their

colleagues and learn how to work as part of a multidisciplinary team. Negotiating identity is therefore *"a bit of a rollercoaster" (Joanna L75).*

3.3 Superordinate Theme II: Power in CAMHS

"There's without a doubt, a very definitie hierarchy"

Power in CAMHS

- The status of psychiatry
- Tension and battles with psychiatry
- Finding my voice

The second superordinate theme that emerged from the participants' accounts of working in CAMHS describes the concept of power within the services. Participants work as part of multidisciplinary teams which are led by consultant child and adolescent psychiatrists. Psychiatry is therefore the discipline that holds clinical governance and makes decisions about the nature of service delivery. It seems from the participants' accounts that this can sometimes lead to conflict within teams. Participants attempt to respond to this conflict and to have their say in the delivery of the service despite the existing power of psychiatry.

3.3.1 The status of psychiatry

Almost all of the participants reported that psychiatry have an enhanced position on the multidisciplinary team in CAMHS. Their accounts seem to suggest that there is a kind of pecking order of disciplines within CAMHS and psychiatry is at the top. For example, Matthew stated that psychiatry *"have the power and the status and they maintain it. Ruthlessly" (L473-474).* He also identified that clinical psychology are next in line to psychiatry in terms of status while the remaining disciplines (i.e. social work, occupational therapy, speech and language therapy) have the least status and the least influence. In his experience, these three disciplines are at the very bottom of the pecking order and the imagery invoked in the comment below is illustrative of this:

> *Clinical psychology are the eh, the kings elect. So there's psychiatry, then clinical psychology, then the rest of us in the gutter, scrambling around. (laughs) (L206-208)* [SW]

Matthew lamented that psychiatry are automatically in a position of clinical lead on the multidisciplinary team. He does not agree that a consultant psychiatrist necessarily has the skills or the relevant experience to lead a group of disciplines in CAMHS and believes that a position of clinical lead should be based on merit instead of professional discipline. Furthermore, he explained that psychiatry is the only discipline that has a say in the planning of services at a senior management level. Matthew attributed this in part to the publication of *A Vision for Change* (DOHC, 2006). While multidisciplinary practice was emphasised in the document, multidisciplinary decision-making was not:

> *All of the decisions about services are made by clinical directors, always psychiatry. Team leads - always psychiatry. Advisors to government - always psychiatry. So all significant decisions are made by psychiatry and then essentially the multidisciplinary working is just that thinnest piece at the interface with the public. (L464-469)* [SW]

Ciara also spoke about the status of psychiatry in CAMHS and like Matthew, she linked this in part to the publication of *A Vision for Change* (DOHC, 2006). Psychiatry hold clinical governance and are therefore the *"dominant discipline" (L745)* in CAMHS. Further evidence of this dominance for Ciara lies in the fact that different grades of posts were only specified for the discipline of psychiatry in *A Vision for Change* (DOHC, 2006). While the document referred to social workers, speech and language therapists, psychologists and occupational therapists on the multidisciplinary team, it referred to the inclusion of 'Consultant' psychiatrists, 'Senior Registrar' psychiatrists and 'Registrar' psychiatrists. Ciara emphasised that it is not appropriate to have one dominant discipline in any service and that all disciplines should have a role in leadership and in decision-making. Otherwise, what can happen is that psychiatry "*tend to assert their own (pause) model eh (pause) in a way that's kind of dismissive of the other positions" (L367-369)* [SW] and Ciara recalled her initial experience in CAMHS, whereby the psychiatrist was *"kind of dictating on the team, you know, what people were doing" (L142-143)*. Psychiatry 'dictating' to the team suggests a sense of absolute rule and power.

Deirdre had a similar experience to Ciara when she first started working in CAMHS and she too recalled a sense of being 'dictated to' by the consultant psychiatrist on the team. At the time, Deirdre did not have a specific social work line manager and psychiatry was therefore akin to being her line manager. She compared the dynamics between

psychiatry and the rest of the multidisciplinary team to that of a parent and a child, a powerful comparison which demonstrates the nature of their relationship:

> *You were dictated to by the by the Consultant and then they would say 'Do a do a mental state' and you're like (whispers) 'Is that what I'm meant to do on CAMHS? Is that what is okay? Well if that's what I'm meant to do…' (...) Yeah you just 'Was that what I'm meant to do? Oh!' and because of that dominance, it's like you almost get into child-mode, child- and parent-mode where (whispers) 'I'll just do what I'm told.' (L373-382)* [SW]

It seems that Deirdre felt that she had to do as she was told, like the way a child obeys his or her parents. While Deirdre later spoke about her discipline of social work no longer simply doing as psychiatry say, there continues to be a hierarchy within in team. She and her colleagues "*can't jump without psychiatry saying 'Yes, how high?'" (L1495)*. Deirdre wonders if the status of psychiatry on the multidisciplinary team can be explained by its origins. She described how the team on which she is currently working initially consisted of a nurse and a psychiatrist. Other disciplines have joined over time but in Deirdre's experience, the medical model continues to dominate. Psychiatry has a stronger voice than other disciplines on the team and it can override other voices as Deirdre described below:

> *And then even how you get your voice, like that idea of 'one person, one vote' doesn't always stand through when you're kind of talking about maybe a case formulation and you try to bring in the social idea, the social work ideas around you know, the possibilities that have been over-looked. And it's it's I suppose it's that kind of like you know, just maybe the dominance and the the the the difficulties to get that kind of view or that perspective eh in. (L329-336)* [SW]

There is an apparent lack of equality on the team (i.e. it is not '*one person, one vote*') and this means that psychiatry have the ultimate say in the clinical formulation of a young person who is attending the service.

For Caroline, recent changes in the management the service have led to psychiatry having a greater status on the multidisciplinary team. Previously, Caroline reported that other disciplines on the team also had some power and, for example, were able manage the assessment and intervention plan for young people presenting with at-risk behaviour. Now, each child or adolescent attending the service has a named psychiatrist on their file regardless of whether they are in need of psychiatry or not. As a speech and

language therapist, Caroline explained that managing immediate at-risk behaviour is not within her remit and she can see some benefits in one discipline having overall responsibility on the team. However, it has been difficult for some of Caroline's colleagues in social work and psychology to adapt to these changes and Caroline has no desire for psychiatry to direct multidisciplinary practice on the team:

> *So I certainly don't want a CAMHS where I'm told what to do, I think we should all remain autonomous and you know, fluid. You know our work needs to be fluid and you know, we need to listen to each other. We need to listen to what our colleagues. I don't want it to become top-down, you know. (L886-890)* [SLT]

Meanwhile, Joanna's experience of the status of psychiatry is different to that of the other participants. While her colleagues in psychology are keen to stress that they are not 'answerable' to the discipline of psychiatry, Joanne stated that she can see some benefits in psychiatry being the leader on the team. If there are difficulties in a case she is working on, she explained that she is able to approach the psychiatrist on the team for support and guidance, and she is unlikely to approach other colleagues for this support as she described in the extract below:

> *I eh you know keep hearing you know, and this is even broader, but kind of at psychology team meetings that you know psychology as such is independent, is an independent discipline on a CAMHS team that's not directly answerable to a psychiatrist. And yet again having experience of being on a CAMHS team, I also see the other I see the value of having an individual you know that leads a group that provides support and guidance, you know. I I see positive elements you know and you know I'm currently working with an individual who's very supportive, who is available if you know you're stuck or when you're concerned about something, so there's many benefits. (L363-373)* [CP]

Joanna's experience of psychiatry may be related to her having joined her team as a newly qualified clinical psychologist. As referred to in the previous section, Joanna was quite thrown by the heavy workload and by the demands of some of the cases that she was expected to work with when she started working in CAMHS. For her, it is likely that having a named lead and a 'go-to' person is helpful and reassuring to her practice.

In summary, it seems from the participants' accounts that the discipline of psychiatry has an elevated status on the multidisciplinary team in CAMHS. As default clinical

lead, psychiatry have a greater say in how the service is delivered and this has an impact on how participants maintain their independence and have their own say.

3.3.2 Tension and battles with psychiatry

Unsurprisingly, the status of psychiatry can lead to tension and battles within the multidisciplinary team in CAMHS. It seems that working in a dominant medical model does not sit easy with the participants and it is inconsistent with some of their professional backgrounds and values. While Caroline stated that she was keen not to create a sense of 'them and us', she acknowledged that there is a division between psychiatry and the other disciplines on the team. Psychiatry seem to have a different view of what CAMHS is and the kind of service they are aiming to provide to young people and their families, compared to that of the rest of team. Caroline referred to psychiatry and nursing (i.e. 'the medics') as having *"a very black and white way of working" (L609),* whereas she and other disciplines (i.e. 'the therapists') see mental health intervention as being *"every colour under the sun" (L610-611).* These two phrases signify a great contrast between the two sets of disciplines. Caroline sees the value in having these different views on the multidisciplinary team but she emphasised that these views need to be married neatly together, rather than one view always taking precedence. She recalled an experience she had in relation to a particular case which led to conflict between her and the psychiatrist on the team. The child had attended the service for an assessment and it was recommended that she avail of intervention in local community services. However, no such community services existed and Caroline continued to follow-up with the child's parents. She outlined what happened next in the extract below:

> *Eventually I brought it back to team and begged the psychiatrist to allow this child to be taken back and offered long-term play therapy (...) I just thought you know, 'We know we're not possibly the number one port of call, we're not the right service but we're the best there is out there for this child'. So my, my thinking was, I mean the psychiatrist was saying 'This child doesn't have a mental health disorder'. And I was like (pause) 'Okay, she has a severe attachment disorder, she has severe emotional and behavioural difficulties, she probably has ADHD' you know. She's you know, the type of child that walks into a room and up ends everything you know. Very disturbed child. But because she didn't have an Axis 1 diagnosis you know, they weren't going to allow her to be seen here again. So anyway I argued the toss with them and eventually got the child in and she's accessing this service but that was a battle, you know I had*

> *to fight and really advocate for this child (...) My, my argument was okay she doesn't have an Axis 1 diagnosis now but let's wait until she's ten when she's cutting her wrists and then we'll see her, you know. (L629-649)* [SLT]

Caroline had to 'beg', 'argue' and 'fight' in order to advocate for this child and to have her own professional opinion valued. The difference and the tension between her opinion and that of the psychiatrist appeared to lie in the distinction between '*a mental health disorder*' and '*severe emotional and behavioural difficulties*'. Caroline was ultimately successful in advocating for this particular child to attend the service but it took a considerable effort and was essentially a '*battle*' between her and the psychiatrist.

Joanna spoke of similar experiences to Caroline in that she does not always agree with the principles of psychiatric assessment and intervention in CAMHS. In particular, she disagrees with the emphasis on diagnosis and the use of deficit-led questionnaires in CAMHS. She believes that mental distress can often be understood in the context of a young person's experiences and does not necessarily have to lead to a conceptualisation of 'abnormal' emotion or behaviour. Similarly, she questions the value of ADHD clinics. Though there is evidence that other interventions such as parenting support programmes and behavioural management can be effective, a biological approach to the management of ADHD is often prioritised in CAMHS. Children attend ADHD clinics for a trial of medication and regular reviews, and Joanna stated that she has *"a strong resistance (...) of taking part in that way of working within CAMHS" (L268-269).* Indeed Joanna commented that as a clinical psychologist, she can struggle with *"the whole dialogue" (L218)* in CAMHS and she would prefer to see more of an emphasis on attachment and relationships within the family. There is also tension between Joanna and the consultant psychiatrist on the team in relation to how Joanna manages her caseload. While the consultant would like her to work with new cases more frequently, Joanna cannot do this. If she did, the quality of her work would be affected and she has to stay true to her role as a psychologist, as she explains below:

> *And as a psychologist or working as an individual in mental health, I feel that there's always that tension where I feel I am trained to work as a psychologist you know with psychological therapies and a psychological way, but you can't speed that, you can't do quicker, you can't you know*

> *(sighs) (...) you can't speed that up and make that faster or split yourself in half. That's a natural process and you know, it takes time. (L389-398)* [CP]

The other participant who is a clinical psychologist reported a similar experience to Joanna. Mary too has felt under pressure by the psychiatrist on the team to manage her caseload differently and she lost some of the autonomy that she previously had. She referred to sometimes not feeling able to her work as she wished and a sense of being checked on in that others are "*coming tapping on your shoulder" (L207)*.

Meanwhile, Matthew also gave an account of the tension that can exist between psychiatry and other disciplines and he believes that this is not unique to his team. Matthew explained that he attends regular special interest group meetings with other social workers working in in CAMHS around the country and he has concluded from these meetings that many social workers share his experiences of battles and conflict with psychiatry. In his opinion, *"sometimes psychiatry doesn't allow space for other views" (L202)* even though other disciplines do allow space for psychiatry. Matthew welcomes a diversity of opinion and views in CAMHS and believes that such diversity is necessary, as he described below:

> *Because I think that difference is really important. I think that if you have too much consensus, I would worry about a CAMHS team where there's consensus all the time. I would think that team isn't functioning properly. So you have to find this balance between allowing for difference and diversity, which is good for the clients I think, where there's different perspectives but not allowing those differences (pause) destroy the team or stop you working together. So it's a really fine balance so you just have to take a little bit of care in how you differ and in how you manage differences. (L323-332)* [SW]

Differences therefore need to be managed effectively - they have the potential to 'destroy' a multidisciplinary team but are nonetheless essential to the functioning of a team. Ciara echoed this point and spoke about differences between psychiatry and other disciplines as potentially complementing one another. She added that tension in itself is not necessarily negative as it can encourage debate and conversation between disciplines. However, she suggests that if this debate and conversation is not managed or contained, it can have profound consequences for the team:

> *And you know you get, conflict in the team, where people are you know, people are bullied. And (pause) you know, maybe leave because of it, because it can't be resolved eh. And that's really just about different ways*

> *of working and I think, I think to myself, 'How ridiculous is this?' (...) it's not about, it shouldn't be about our, our own kind of power battles, pettiness and. It should, it should just be about trying to do the best job for the service user and, you know. So that, so that's kind of your worst case scenario I guess and (...) I've been there and I've been on a team where, you know maybe the team, the person who's leading it, the clinical lead is, is maybe a bit eh, untrusting of their colleagues and you know, gets into kind of the micro-management and it just doesn't work. And you feel like you're not trusted, you feel like your opinions aren't valid and you're, and even your discipline is being criticized for not being as good as another discipline and that just, it's really uncomfortable, it's really difficult and you just kind of have to try and work through that. (L390-409)* [SW]

One way in which social work may not be 'as good as' psychiatry for example, is in its evidence base. According to Ciara, her intervention as a social worker and a family therapist is relationship based. It is not set out in a manual and is different for every young person and their family. She sees her such therapeutic intervention as being more akin to art than science and points out that it can never be researched in the same way as other interventions such as medication or cognitive behavioural therapy. It will therefore never be considered 'the gold standard.' Reflecting on what is considered evidence-based practice, Ciara commented *"I'm very Foucault[3] about this" (L1180)*, suggesting that psychiatry has a position of both power and knowledge.

For Deirdre, tension and battles have occasionally led to *"bad practices" (L441)* on her team. In fear of being *"shunned off the team" (L443)*, it seems that clinicians have been coerced into engaging in tasks as specified by psychiatry, but at the expense of being inconsistent with their own professional values. Deirdre did not give specific examples of poor clinical practice but had earlier referred to her and her social work colleagues completing mental state examinations with young people. She was clear that she no longer does this kind of work and spoke about taking time to reflect on what she is being asked to do by the psychiatrist on her team before making a decision as to whether or not she is in agreement with the psychiatrist. It was initially difficult to do so as she outlined below:

> *So you you had that you know that sense of 'Mmm' all of the time and then then you had to try come up against it: 'That's not something that I'm prepared to do'. And then it's like that fight then that comes with 'You will do it, you will do it.' (L396-399)* [SW]

[3] Foucault refers to Michel Foucault (1926-1984)

Like the other participants, there was an overall sense of being in conflict with psychiatry and having to almost stand her ground. In general, Deirdre sees conflict on the team as arising out of this confusion and a lack of understanding about each other's roles.

In summary, it seems that the status of psychiatry in CAMHS leads to tension on the multidisciplinary team. Differences between the practice of psychiatry and the other disciplines mean that participants often end up engaging in battles in order to stay true to their values and maintain their own standards of clinical practice.

3.3.3 Finding my voice

In context of the status of psychiatry and the battles that ensue on the multidisciplinary team, some participants have found ways to ensure that they have a stronger voice. They attempt to resist and 'fight back' against the status quo. Joanna described finding her voice over time as she became more familiar with the service and more confident in how she wanted to work. As mentioned earlier, Joanna was initially quite thrown when she started working in CAMHS and it took her a while to settle into her role. Over time, she has reflected on clinical practice in CAMHS and asked herself questions in order to clarify how she would like to continue working as a clinical psychologist in CAMHS:

> *That's a long process. It took a while you know, to kinda of follow that, and I suppose witness it happening and then maybe making the decision like 'Oh was that the way I wanted to work in this place?' or 'Was that helpful in terms of helping people move forward and bring about change?' or you know, improve their relationships with the child? (...) It's just all of that was kind of a journey really to find, you know, back to a place where I felt 'Well no, I actually work in this way' and you know 'This is also evidence based.'(L239-248)* [CP]

Joanna reported that she now feels that she has more of a part in shaping what the service is about and that she has more to contribute to multi-disciplinary team discussions. She makes suggestions based on her clinical background and her areas of interest (e.g. the importance of the parent-child relationship) and this has led to her being *"authentic to the way I wanted to work" (L145).*

Ciara also pointed out that having her voice heard is a lot easier than it used to be due to her being more experienced and having more confidence in her role in CAMHS. As well as being more confident in her position, she stated that she is also *"more confident in holding it" (L353)*. Being able to hold her position is crucial in the context of the tension and battles that can take place with psychiatry as described earlier. It is not sufficient to solely recognise her position; it seems that Ciara has learned that she must be able to withstand any potential threats to same. As a result, Ciara reported that she feels her opinion on the team is valid and she now has a sense of autonomy in her work (i.e. *"I kind of get just to do my own thing really" (L380-381)* [SW]).

For Matthew, taking on a role of clinical co-ordinator on the team has enabled to him to have a stronger voice on the team. He explained the role of a clinical co-ordinator is to manage referrals and the waiting-list, and liaise with external agencies as necessary. According to Matthew, it is a role that has been frequently referred to in the literature but had not been introduced in CAMHS. Perhaps as a response to psychiatry being the default clinical lead on the team, Matthew suggested that the role of clinical co-ordinator be introduced on his team and he volunteered to take on the role himself. As a result, he makes decisions about referrals on behalf of the team and this has given him *"quite a bit of say in things" (L287-288)*. He may get heard *"a little bit differently at the team meeting" (L288-289)* although he believes that this difference is somewhat minimal. In addition, Matthew reported that he tries to sit down and talk with the psychiatrists on his team whenever difficulties are starting to arise between disciplines. Matthew was clear that it is important to invest time into these working relationships and this can lead to good collaboration on the team. Overall, Matthew reflected that he tends to 'push himself forward' on the team and this has led to him being able to respond to the power of psychiatry.

The introduction of statutory registration with CORU[4] has given Deirdre and her social work colleagues a position from which they can respond to the power of psychiatry in CAMHS. Deirdre referred to CORU registration having ethical and legal implications in terms of professional conduct. As a result, she is increasingly able to speak back to psychiatry and feels more confident in doing so. In addition to CORU, Deirdre

[4] CORU is the statutory regulatory board for health and social care professionals in Ireland

identified having a new social work line manager as having a significant impact on her ability to have a voice within CAMHS. Her department have developed a set of policies and procedures about the role of social work in mental health services and these documents acts as a 'power tool' in the battle with psychiatry:

> *It gives you something to come from, yeah* (…) *It's, it's almost like that power tool (...) It is a bit like the power tool because you know (...) other people have power tools of their own. (L505-510)* [SW]

Another way of trying to reclaim some power is by recognising that there is strength in numbers. As a department, Deirdre commented that social workers are now *"all kinda talking from the same hymn sheet" (L430-431)*. Rather than taking a passive position as she might have done in the past, Deirdre spoke about her ability to assert herself now and to ensure that she is heard on the multidisciplinary team. She also described her attempts to understand the voices of other disciplines and being open to hearing what they have to say, even if it differs to her own voice. Over time, Deirdre has been able to develop a better understanding of other disciplines on the team and she makes sense of this in the extract below:

> *I suppose I could sit here and say 'I don't get heard' and 'I don't have the voice' and 'I don't, they don't understand'. But that kind of, that also goes both ways in that I have to understand what other voices mean or what they might mean to them (...) So like that's opened, I suppose because of my experiences, opened up how I relate to other people on the team as well and what their experiences are, their, what their position is and I think that puts you in a way better position not to battle and not to struggle and not to try and 'My voice, my voice, listen to me.' (L468-478)* [SW]

Being able to have a better understanding other disciplines has meant that she is less likely to be drawn into battles. She respects that there are different voices on the team and she endeavours to maintain good working relationships with her colleagues in spite of these differences.

In summary, participants have developed strategies to respond to the status of psychiatry and to ensure that their voice is heard. Working as part of a multidisciplinary team in CAMHS means that there can be differences in clinical opinion and participants attempt to manage these differences effectively.

3.3.4 Summary of Superordinate Theme II: Power in CAMHS

The participants' experiences of power in CAMHS is that of psychiatry having a higher status on the multidisciplinary team and ultimately having a greater say in the delivery of the service: *"There's without a doubt, a very definite hierarchy" (Matthew L183-184)*. Although they are not in a managerial position per se, psychiatry is the clinical lead of the team in CAMHS. They often try to direct the practice of others and this leads to conflict within the team. Participants must therefore find ways to cope with and respond to this conflict.

3.4 Superordinate Theme III: The Changing Nature of CAMHS

"Service are unrecognisable in comparison" **The Changing Nature of CAMHS**	• Then and now • CAMHS as a numbers game • Expectations about the future

The final superordinate theme describes the participants' experiences of changes in CAMHS over the past number of years. Many of the participants have been working in CAMHS for a period of between five and ten years and during this time, both the remit and the operation of the service have evolved. Participants compare past and present CAMHS, and identify the current focus on numbers (i.e. number of appointments being offered per week, number of referrals and discharges) as a potential barrier to good practice. In light of these changes, many of the participants are uncertain about whether they have a role to play in CAMHS in the future, and what this future might look like.

3.4.1 Then and now

Almost all of the participants spoke about the differences between CAMHS in the present compared to CAMHS in the past. One of these differences is in the presentation of young people attending the service. For Mary, this has been the most significant change that she has experienced in the twenty years that she has been working as a clinical psychologist in CAMHS. She reported that the presentations of children and adolescents are now much more 'complex', and that there are many more of them. Mary described some examples of young people that she has worked with over the

years. While she acknowledged that some presentations in the past were also '*complex*', she was clear that some presentations were '*simple problems*':

> *Well I suppose they're totally different like, you know it was so much easier back then because I suppose, like you know you'd get bed-wetters. I mean you'd never see a bed-wetter now, you might get encopresis, you'd get simple problems back then. Now, I mean the public health nurse would deal with that - we'd never see anything like that…You know it was just so easy back then, whereas now I suppose it's much more complex and multi-layered and (...) Yeah, very different really. Much more complicated now. (L136-146)* [CP]

Upon further discussion, Mary identified self-harm, suicidal ideation and difficulties in family relationships as factors that contribute to the complexity of presentations of children and adolescents. She wondered if the increased complexity in presentations can be attributed to changes in how young people and families are living in the twenty-first century. According to Mary, there has been a loss of community and a loss of supports for many families over the past two decades and this has had a knock on effect on people's sense of belonging and their well-being (L412-415 and L427-431).

Caroline also spoke about changes in the presentation of young people attending CAMHS. Compared to when she first started in CAMHS, the age-range of children and adolescents attending the service has reduced significantly. For example, she outlined how the team used to have a dedicated preschool team but this has since been disbanded. Caroline commented that she always enjoyed working on the preschool team and she believed that the service being provided by the team was '*really good*' compared to what is currently being provided:

> *We were very good at whenever a pre-schooler came into the service, or an under six, they would be allocated one of the teams so that would be an SLT, a psychologist and a social worker (…) So they always got a really good service from us you know, they did (pause). And now, it's not, it's a little bit more ad-hoc. (L431-437)* [SLT]

There have also been changes in personnel on Caroline's team and while new staff have joined, there are fewer opportunities to work together. Caroline stated that she now often does initial team assessments of young people on her own, *"which isn't great" (L438)* in her opinion. Two heads are better than one and two disciplines are better than one, as she later pointed out (L485). Given that one of the things Caroline most enjoyed

about starting in CAMHS was working with her colleagues and not being on her own, it seems that she has come full circle and is now working alone again, similar to her previous job when she was travelling between schools and working out of her car. Caroline reflected that it is a time of *"huge change in the service, there's so much change going on" (L54-56)* and there was an overall sense of loss in her account of working in CAMHS over the past seven years.

Joanna has been working in CAMHS for five years and she too has witnessed changes in the remit of the service. CAMHS now accept referrals of young people aged sixteen and seventeen years of age. Previously, these young people had to attend adult mental health services and Joanna seemed to welcome this development. Unfortunately, she described some difficulties in the logistics of extending the service to sixteen and seventeen year olds in that additional resources and staffing have not been provided to cope with these extra demands. As a result, the team currently accept referrals of young people aged sixteen years but not aged seventeen years. The other change in the remit of CAMHS that Joanna has experienced is in relation to service provision for young people with an Autism Spectrum Disorder (ASD). Rather than attending CAMHS for a range of interventions as they may have done in the past, children and adolescents with a diagnosis of ASD are currently offered a service if they have additional mental health needs:

> *Eh I suppose from compared to when I started to now there seems to be more clear distinction around children with ASD, in terms of you know CAMHS approach yes eh involvement in, you know differential diagnosis of. Are there are co-morbid mental health difficulties? Tease out what's going on, what's triggering this, what's contributing to this child, you know eh not manging or getting you know, eh (pause) easily upset or you know just having emotional outbursts. So being involved in that way yes, but very very clear boundaries regarding not being involved to all lengths, not very clear but a clearer boundary around what, what our remit is, and what not, what's not our remit. (L616-626)* [CP]

In other words, CAMHS will currently work with children and adolescents with a diagnosis of ASD if they are experiencing '*co-morbid mental health difficulties*' but not if they are '*just having emotional outbursts*'.

For Matthew, there has been considerable change in the operation of CAMHS as a result of a national drive for the standardisation of services. Matthew spoke about

changes that have been introduced on his team such as referrals only being accepted from GPs and not from other allied health professionals or professionals working in education and youth services. This poses a dilemma for Matthew: his clinical experience to date and his knowledge of existing literature emphasise the importance of engaging difficult-to-reach adolescents but GP-only referrals are going to hinder this engagement. While Matthew acknowledged that there can be some advantages in services being standardised and sharing similar processes, standardisation also comes at a cost. He lamented how standardisation leads to a service not being able to have its own identity as *"innovation, uniqueness gets lost" (L133-134).* Matthew explained that there seems to be a push by senior management in CAMHS for the service to adapt processes akin to adult mental health services. This *"really jars" (L170)* for him as he believes there are fundamental differences between how a service meets the needs of children and adolescents, and how a service meets the needs of adults. Like Caroline, there was an overall sense of loss, as well as anger, in Matthew's account of his experience of working in CAMHS over the past seven years. Put simply, his service has undergone massive change:

> *So there have been a lot of structural changes, organisational changes, personnel changes, all of which I think has changed the nature of the service. Probably inevitably. (L142-144)* [SW]

Ciara on the other hand spoke mainly about the positive changes that she has experienced working in CAMHS over the past ten years. In particular, she described a significant decrease in the length of time that young people wait for an initial assessment in the service. When she started working in CAMHS ten years ago, the waiting list was *"like a millstone around my neck and other people as well" (L661-662)* and this feeling of being burdened did not ease for a number of years. Ciara explained that despite many initiatives, nothing seemed to work and the waiting list continued to grow. Now, services are much more organised and she emphasised the difference between then and now in the following extract:

> *Services are unrecognizable in comparison. They're so much more structured and organised. Eh, much less wishy-washy. (...) So we used to these incredibly long waiting lists. When I started, I think our waiting list was like three and half years or something. Awful. So you constantly had a sense of guilt for the kids who weren't being seen. (L650-655)* [SW]

Ciara attributed the change in services being 'less wishy-washy' to the publication of *A Vision for Change* (DOHC, 2006) and new consultant child and adolescent psychiatry posts. She explained that when new consultants took up their posts, they were aware of the long waiting-lists and they were committed to introducing changes. For example, Ciara recalled her team offering one initial assessment appointment per week in the past. This initial assessment involved all disciplines on the multidisciplinary team and therefore lasted a number of hours. Ciara commented that this was a kind of '*precious idea*' and again compared it to current practice:

> *You know, so it was this really, really intense input and this is, kind of quite precious idea in CAMHS – 'Oh yeah we have to do it this way, we can't do it any other way, and everybody on the team has to be involved in every case' and just team meetings would go on forever because everybody would have their tuppence worth about every family. It just felt really stuck. So now it doesn't feel stuck. It feels like there's this turnover and there's movement and that's great. (L676-683)* [SW]

While Ciara clearly welcomes the above changes in CAMHS, she referred to other colleagues not being as welcoming of these initiatives. Many of her social work colleagues have therefore left their posts in CAMHS as they were seemingly unable to manage in the 'new' service.

In summary, participants have been working in CAMHS for a number of years and they report considerable changes in services during this time. Their experience is that there have been benefits to some of these changes but other changes have proven to be more challenging for participants and their practice.

3.4.2 CAMHS as a numbers game

Many of the participants talked about the increased focus on the number of appointments offered by each clinician in CAMHS and on the number of re-referred children and adolescents attending the service. There was a collective feeling of frustration in their accounts as they described how this focus on numbers has affected their individual clinical practice as well as the quality of the service being provided to young people and their families. For example, Deirdre commented there is a need for speed on her team: *"Literally that like, you know, 'Quick, quick'. We get in, see as many as we can and close as many as we can" (L820-821).* While she acknowledged that some measurement is helpful and necessary, she was clear that the current focus on

numbers in CAMHS is having a detrimental impact on how her team are functioning. It appears to her that the more '*focused*' clinicians are on numbers, the less focused they are on the care plans for young people attending the service:

> *That some people are so focused on, that's the only thing people want is new referrals, see the person, see more people, you know? Eh cause we'll meet KPIs*[5] *and I just think 'Where is the recovery piece in that? Where is the client in that? Where is the, what say do they get?' Eh you know, all of that stuff. (L900-904)* [SW]

The care of the young people continuing to attend the service perhaps gets lost as clinicians strive to prioritise referrals and re-referrals.

The other challenge that Deirdre experiences as a result of the focus on numbers is that her appointments with young people and families are generally longer than those of her colleagues. As an example, she contrasted the complexity of a social work intervention to that of an ADHD review clinic. During a typical day, she may have four appointments with families whereas the nurse on her team may have twice as many appointments in less than half a day. This was illustrated in the following extract:

> *Like we see complex cases and it could take, I say complex case; whatever that means, and it could take maybe one hour for a tiny piece of work (...) Whereas the nurse might see eight people in in in fifteen minutes to do height and weight at an ADHD clinic. So your stats as a nurse eh, so it would be the same for like GP you know, somebody doing a mental state you know 'Quick, [clicks fingers] fire buzzer round' and you know 'Okay I've got enough out of you, now leave'. So it's like that deductive way of working and you know 'That's a very quick, you know, that's a very quick case'. So your stats are, so a nurse is seen as being more useful or or a reg or whatever cause you you meet the KPIs, but a social worker? 'What is it that that woolly stuff that they do? And they take an hour, so they really only see four people a day.' (L338-352)* [SW]

It seems that Deirdre feels judged on the team by her ability to meet the key performance indicators ('*the KPIs*'). Her references to nursing working akin to a '*fire buzzer round*' conveyed a sense of ridicule and perhaps anger.

Caroline also spoke about the impact that the increased focus on numbers have had on her practice as a speech and language therapist. She explained that one of the targets

[5] KPIs are key performance indicators

that management have communicated to the team is that each clinician successfully offers sixteen appointments per week. If young people and families miss their scheduled appointments, the appointment does not count towards the clinician's target of sixteen. In addition, Caroline stated that group interventions only count as one appointment no matter how many young people might attend the group. Indirect intervention such as school liaison does not count towards the target of sixteen either. Caroline outlined that she did not meet the target of sixteen appointments during a recent audit on the team and she is concerned that she will have to adapt her practice in order to meet the target in the future. Regrettably, this will come at a cost and it means a potential loss of what she sees as very valuable clinical intervention, as follows:

> *So to give you an example I was out last week or the week before. I took the best part of the day, visited four schools in relation to six clients. Really productive day, lots of, you know meeting with teachers but because I didn't clap eyes on any of those six children, none of those contacts are counted even though I think that was a really valuable piece of work. Certainly around how teachers can support young people in schools, making sure that resource hours are used effectively with the young people that are attending. I mean, I think that piece of work is invaluable and I'd be really sad to see that piece of work go, eh, just because I need to get my numbers up. (L134-146)* [SLT]

Caroline predicated that she and her colleagues may *"have to start boxing clever" (L174)* in order to meet the target of sixteen appointments per week and she gave a hypothetical example of what 'boxing clever' looks like. Caroline works in an area of high social deprivation and she described how she tends to offer appointments that are double the length of standard appointments in order to reduce demands on young people and their families. Longer appointments can mean less frequent appointments and therefore reduced pressure on young people and their families. Caroline outlined how she may now have to break up these double length appointments into two separate appointments in order to '*get her numbers up*'. This is a dilemma for her as she is aware that many young people and their families already struggle to attend appointments for reasons including not being able to afford transport to the service. Caroline stated that the target of sixteen appointments per week is therefore not in the best interests of young people and their families and she instead dismissed it as *"just bums on seats and ticking boxes and saying 'Yes we're meeting that criteria'" (L234-235).*

Mary also emphasised that current practice in CAMHS is very focused on the number of appointments being offered by each clinician and the number of new referrals and re-referrals attending the service. She described that she is now less likely to provide a long-term clinical psychology intervention to a young person. Instead, she provides shorter interventions and a young person can be re-referred to the service if they are in need of further intervention. This *"looks better on the books" (L164)* according to Mary but she was clear that she is not in agreement with this kind of practice. Like Deirdre and Caroline, Mary also spoke about clinicians adapting their practice in order to increase the likelihood that they will meet the targets that have been set out regarding numbers of appointments and numbers of new referrals and re-referrals being seen in the service. Mary pointed out that the wrong measures are being taken in CAMHS and there is a lack of interest in how much progress a young person makes or how they respond to intervention in CAMHS. As a clinical psychologist, she frequently uses pre- and post- measures in order to capture therapeutic change but it seems that these kinds of numbers are not of interest to others. Appearances can therefore be deceiving:

> *So it looks good - loads of people are being seen and going back out. What are they learning? What's really changing? But it looks good on paper so people are getting seen faster, going through the books quicker, but is there like eh (long pause) not an emphasis, an emphasis on stats and numbers rather than the quality of the work really, so people are being measured on how many they're seeing, rather than on what they're doing. (L076-1083)* [CP]

Ciara also echoed this point and identified the emphasis on the number of appointments and the number of referrals (i.e. quantity) as eclipsing any emphasis on the value of these appointments (i.e. quality). While she agreed that attempts to improve service delivery and efficiency are welcome, she is worried about the current concept of efficiency in CAMHS. She commented that *"there's an assumption that quality just happens and quality doesn't just happen in my experience" (L1061-1062).* According to Ciara, young people will be at increased risk for mental health difficulties in adulthood if they cannot attend a high quality service in childhood and adolescence. In other words, what looks like an efficient service now may not be that efficient in the long run. For Ciara, there is a sense within her team that it does not matter what kind of appointments are offered to young people as long as the appointments are limited in number per young person and a total of sixteen take place per week:

> *So we're definitely getting a clear message that it doesn't really matter what you do in your sessions as long as you only offer eight (...) it doesn't matter how long your sessions are, once you have at least sixteen a week of them. So if you're just seeing, clocking someone for fifteen minutes and checking in how they are, that's okay, as long as you're doing it sixteen times a week. As opposed to maybe offering something that's really quality (...) we're definitely getting that message and how that is affecting is people are saying, in our service 'Ah well you know what, I'm just going to, you know offer, offer shorter appointments and actually not, you know offer the kind of sessions that I would like to offer because you're not getting any credit for it and I'm under pressure to.' (L1087-1102)* [SW]

'*Clocking someone for fifteen minutes*' is deemed to be more efficient than '*offering something that's really quality*'. Given that Ciara is a social worker and a family therapist, she is unlikely to offer any fifteen minutes appointments and her work therefore may not be considered efficient.

In summary, CAMHS has become a 'numbers game' to the participants over the past few years. The emphasis on the number of appointments being offered and the number of referrals being seen has led to significant changes in service delivery. For participants, this has resulted in a decrease in the quality of the service being provided by their multidisciplinary team and a sense of frustration that there is less value placed on the quality of their work.

3.4.3 Expectations about the future

Perhaps unsurprisingly, participants expressed uncertainty about the future of CAMHS. In the context of recent changes and the increased pressure on their performance in terms of numbers as outlined in the previous section, participants are considering what is in store for the future of CAMHS as well as what is in store for their own future in CAMHS. There was a sense of pessimism in Matthew's account and he predicted that the remit of CAMHS will continue to narrow and become increasingly medicalised. He highlighted the recent disbandment of the multidisciplinary CAMHS advisory group as evidence of this and stated that the multidisciplinary aspect of CAMHS *"is being eroded" (L622)*. The team is being worn away over time and many of Matthew's original colleagues have left their posts in CAMHS. Earlier in the interview, Matthew had recalled his excitement and his passion about transitioning from a student social

worker on placement to a fully qualified social worker on the team. This was in stark contrast to how he spoke about the future of CAMHS. In particular, he predicted that there will be further changes in personnel as clinicians seek to escape and to '*get out*' of CAMHS:

> *I see an awful lot of people leaving CAMHS. I see an awful lot of very very experienced, brilliant clinicians and therapists looking to get out, feeling that they don't want to do the kind of work that CAMHS services are allowing them do. Eh, I see a lot of people who very demoralised, eh disenfranchised, trying desperately to focus on their clinical work because all else feels like it is (pause) going very badly. (L603-607)* [SW]

The above extract suggests that clinicians do not have permission to work as they would like in CAMHS. It appears that they are disheartened and marginalised and eventually have no other option but to leave.

Caroline would like to stay working in CAMHS and was clear that she continues to enjoy her work in spite of recent changes. She outlined that while she sometimes considers returning to her native country, she knows that speech and language therapy posts are not common in CAMHS there. This would affect her decision-making about returning home or staying in Ireland, such is her wish to continue working in CAMHS. However, Caroline was also clear that she is worried about the future of CAMHS and like Matthew, she predicted that the remit of the service will become increasingly narrow (i.e. *"very dogmatic, very black and white" L766*). She has no desire to work in a service that is too prescriptive and if further changes are on the horizon, she stated that all disciplines on the multidisciplinary team need to have a voice and be heard.

In addition, Caroline also spoke of her concern about the future of speech and language therapy in CAMHS. In the context of the changes in the ages and the presentations of young people attending the service, she sees the possibility of speech and language therapy not having as much of a role in CAMHS as it did in the past. This poses a potential threat to the inclusion of the discipline on the multidisciplinary team as she described below:

> *I see it being very medicalised, I see even SLT being phased out of CAMHS, you know or we will be working in a very different way. I think there's a bit of a panic with speech and language therapists around our roles on teams*

> *and what we can offer because we don't have that fundamental piece that we would have had previously. (L583-587)* [SLT]

Meanwhile Mary would also like to remain working in CAMHS but she shares concerns similar to the other participants about the future of the service. She is worried that the service will continue to focus solely on the quantity of appointments rather than the quality, and be less effective as a result. Mary wondered if CAMHS will then *"come full circle in twenty years' time and decide all this was wrong and go back to maybe where we were" (L1085-1087)* [CP]. In terms of her own future in CAMHS, she would like to stay working on the multidisciplinary team that she is currently a part of and stated that she is keen to further develop her own skills and knowledge. She outlined her plans for her own professional development and she identified that she would like to work on managing her daily routine and her administrative demands. Over time, she predicted that she will be more comfortable and more competent in her role and *"it won't be causing me the time and the stress it is at the moment" (L1012-1013).*

Joanna too is looking forward to developing to her skills further and continuing her journey to "*grow-up professionally a bit" (L964).* She is more optimistic than other participants about the future of CAMHS and commented that she is excited about some of the new approaches and therapies that are being introduced, such as Dialectical Behaviour Therapy (DBT). Joanna explained that she would like to continue working in CAMHS but probably not on a full-time basis. Working as a full-time clinical psychologist in CAMHS is intense and it can be difficult to cope with the demands of the role. Working part-time in a private practice could provide Joanna with a balance to her part-time practice in CAMHS with an opportunity to experience *"more of a choice and control" (L978-979)* [CP] over how she would like to work with young people and their families.

Finally, Ciara spoke about being unclear as to whether she will continue to work in CAMHS or not. Like Joanna, she referred to working in CAMHS at times as being intense and difficult. She pointed out that working in CAMHS involves listening to and being with young people who are in considerable distress. This can be emotionally draining for clinicians. At present, there is no funding available for training and ongoing professional development for Ciara and her colleagues which makes it difficult *"to kind*

of keep your head above the water" (L960). Perhaps this quest for survival eventually takes its toll on clinicians. While Ciara explained that she has always worked in mental health services and continues to have a strong interest in mental health, she is now considering other options for her future. She already has started working part-time in a private practice and she is also involved in teaching social work students in third level education. There was a sense of disillusionment and pessimism in Ciara's account of the future of CAMHS. She seemed somewhat resigned to the idea that CAMHS is moving further away from what it once was and in parallel, she may also have to move away from CAMHS (i.e. '*the jury's out*') and the extract below captured her current uncertainty:

> *But eh (pause) I think I feel a little bit, maybe pessimistic or maybe it's realistic eh, about realistic change. Maybe I do and maybe I don't, I don't know. Sometimes I think yeah, CAMHS is for me and sometimes I think maybe I should you know, look at other, look at other things. I don't know, the jury's out Eimear. Maybe I'll stay, maybe I won't. (L828-834)* [SW]

In summary, participants are considering the future of CAMHS. The service has already undergone a significant process of change and there is an expectation that this process of change may continue. Some participants are optimistic about the future of CAMHS and committed to continue working as part of the service while others are less hopeful about its future.

3.4.4 Summary of Superordinate Theme III: The Changing Nature of CAMHS

The participants' experiences of the changing nature of CAMHS are complex and consist of positives as well as negatives. Compared to five to ten years ago, *"services are unrecognisable in comparison" (Ciara L650)*. While some changes have been embraced by participants such as the reduction in waiting-lists, many changes have challenged the core of the participants' clinical practice. It seems to them that the remit of CAMHS has narrowed and CAMHS has become a 'numbers game' in that appointments are scheduled to suit the needs of clinicians rather than the needs of the young people and families attending the service. Participants must therefore consider the future of CAMHS and how they are going to manage to continue being a part of the service.

3.5 Summary

This chapter presented the findings of this study which sought to explore the lived experience of working in CAMHS. This experience or phenomenon can be best understood in the context of a quote from Caroline: *"I think everybody's finding it a challenge to be honest" (L275).* There are three main components to the challenging nature of the experience of working in CAMHS. Firstly, participants have to engage in efforts to negotiate an identity in CAMHS. They are already qualified as clinicians, and are sometimes experienced clinicians, when they start working in CAMHS but they nonetheless must learn to adapt to the service and become part of a multidisciplinary team. Also central to the experience of being part of a multidisciplinary team in CAMHS is that psychiatry is the default clinical lead and is therefore in a position of power. This gives rise to tension and battles as participants attempt to find ways to respond to the hierarchy on the team. Finally, participants have experienced a considerable amount of change in CAMHS over the past number of years. Many of these changes do not sit easy with the participants and they weigh up their expectations about the future of CAMHS.

Table 4.1 on the next page illustrates the presence of the themes across each of the participant's accounts. The following chapter provides a description of the findings of this study in the context of existing literature.

Table 4.1 Presence of subordinate themes across participants' accounts

	Matthew	*Caroline*	*Ciara*	*Deirdre*	*Mary*	*Joanna*
Negotiating Identity in CAMHS						
My professional background	✓	✓	✓	✓	✓	✓
Adapting to the CAMHS context	✓	✓	✓	✓	✓	✓
Working as part of an MDT		✓	✓	✓	✓	✓
Power in CAMHS						
The status of psychiatry	✓	✓	✓	✓		✓
Tension and battles with psychiatry	✓	✓	✓	✓	✓	✓
Finding my voice in CAMHS	✓		✓	✓		✓
The Changing Nature of CAMHS						
Then and now	✓	✓	✓		✓	✓
CAMHS as a numbers game		✓	✓	✓	✓	
Expectations about the future	✓	✓	✓		✓	✓

4.1 Introduction

In this final chapter, the findings of this study will be discussed in the context of existing literature. The main research question of this study was to explore the lived experience of mental health professionals working in CAMHS in Ireland. Findings have indicated that this experience is best understood as a challenge, captured in one of the participant's comments: *"I think everybody's finding it a challenge to be honest"*. Analysis of the phenomenon of the experience of working in CAMHS shows that participants have to negotiate a professional identity, respond to the power of psychiatry on the multidisciplinary team and adapt to changes in practice that have taken place over the past number of years.

In order to structure the chapter and to effectively contextualise the findings, the main body of the discussion has been divided into three sections: the mental health professional in CAMHS (section 4.2), the multidisciplinary team in CAMHS (section 4.3) and the service provision of CAMHS (section 4.4). Implications for clinical practice, policy and education are discussed and this will be followed by an identification of the limitations of the study. Suggestions are also made for future areas of research.

4.2 The Mental Health Professional in CAMHS

4.2.1 Professional roles and identity

It was clear from the participants' accounts that professional identity is not something that is taken for granted in CAMHS. Instead, it has to be developed within the context of the individual multidisciplinary team and the individual service. This pursuit for professional identity has been documented elsewhere in the literature as "a culture of self-questioning and self-monitoring" (Crawford *et al.*, 2008, p. 1061). As the findings of this study have demonstrated, mental health professionals in CAMHS have to negotiate an identity for themselves and this is characterised by uncertainty and a variety of efforts to 'fit' into the service.

Boundaries within roles and the positioning of disciplines on the multidisciplinary team have been found to contribute to the challenge of establishing professional identity in youth mental health services (Hardaker, 2011). The roles of mental health professionals in CAMHS can involve a mix of specific and general work and similar to Hardaker (2011), participants interviewed for this study found it hard to identify and clearly express their role within CAMHS. It has been suggested that it is harder to define roles of different disciplines in mental health and in CAMHS multidisciplinary teams, than it is in other areas of healthcare (Baldwin, 2008); this could explain some of the findings of this study. While the participants were clear that they had a role in CAMHS, it was evident that many of them viewed some aspects of their role as being similar to that of their colleagues. Caroline spoke about being 'a mental health worker' as well as a speech and language therapist, while Joanna spoke about her realisation over time that everyone on her team is 'doing the same thing'. In contrast, professionals working as part of a multidisciplinary team in a hospital setting are likely to have clearer and more easily defined roles with less generic practice between disciplines (Baldwin, 2008).

Despite being qualified in a particular discipline and being hired to practice in this discipline as a member of a multidisciplinary team in CAMHS, it seemed that participants in this study have to persuade and almost prove to their colleagues that they can add value to the team. This finding resonates with the work of Beddoe (2013) with regard to social workers in particular. In her study of the professional identity and knowledge of social work in New Zealand, Beddoe (2013) highlighted the marginalisation of social work in institutions and reported that further education was one way in which social workers attempted to improve their status and earn respect on the multidisciplinary team. In addition, social workers frequently compared themselves to other disciplines and spoke about engaging in 'battles' as they attempt to measure up to other professionals. Beddoe (2013, p. 26) stated that "the development of professional identity within contestable territory is highly complex" and based on the accounts of all of the participants in this study, it appears that CAMHS is one such example of 'contested territory' within health services.

The findings of Beddoe (2013) could therefore be extended to the other disciplines in CAMHS in order to understand the collective and shared experience of the participants in trying to establish a professional identity. An added challenge to this contested

territory is that stereotypical ideas of roles of disciplines, such as speech and language therapy and social work, persist. Participants may have to explain themselves to colleagues and to young people and their families, as was evident in both Caroline and Deirdre's accounts. Caroline reported not using 'nice little worksheets' like other speech and language therapists might, and Deirdre was clear she did not view filling out allowances for social welfare payments as being part of her role.

Brennan (2009) has explored 'a snapshot' of the role of social work in CAMHS in Ireland and her findings are also mirrored in those of this study. Using thematic analysis, Brennan (2009) analysed semi-structured interviews with ten social workers working in multidisciplinary CAMHS teams. She concluded that there was no common role for the discipline and that the role of each social worker was affected by factors, including their particular area of interest and skill set, as well as whether or not they had pursued further postgraduate education. Her findings echo the experiences of the three participants who were social workers in this current study who had all decided to train in family therapy in order to carve out a more defined role and to add weight to their opinions on the team. They did not feel confident or 'good enough' to practice as a social worker in CAMHS without also being qualified in family therapy.

Also of interest in Brennan's (2009) study was that participants expressed concern about future clinical practice in CAMHS in the context of the focus on the numbers of appointments being offered and the length of waiting-lists. They queried whether they would be able to continue engaging in long-term work with young people and families. The findings of this current study indicate that this concern has become the unfortunate reality for many in that almost all of the participants, including the disciplines of speech and language therapy and clinical psychology, spoke about their experience of being encouraged to only offer short-term interventions to children and adolescents.

One of the benefits of having clear roles and responsibilities in mental health services is its association with higher level of job satisfaction (Goetz *et al.,* 2017). It could be true, therefore, that the *loss* of clear roles and responsibilities also affects job satisfaction, as suggested in some of the participants' accounts in this study. Participants spoke about specific tasks, such as supporting school liaison, assessing preschool-aged children and running group programmes that are currently under threat in CAMHS as a result of the

shifts in practice. The current focus is on the number of appointments being offered and the length of waiting-lists, and this has led to changes in practice that have impacted on the roles and responsibilities of particular disciplines. For the two clinical psychologists in this study, the emphasis on short-term intervention and quicker throughput contradicts or, is at odds with, their professional background. Baldwin (2008) has emphasised that the nature of clinical psychology training is crucial in determining their professional identity and this is clearly supported in the findings of this study. Both Mary and Joanna referred to their background training and being trained in particular therapeutic approaches which may not always be in harmony with practice in CAMHS.

4.2.2 Burnout and well-being

Burnout is a significant difficulty amongst mental health professionals (Morse *et al.,* 2012) and while this study did not explore burnout directly, it was clear that many of the participants seemed to be struggling to manage their role in CAMHS and to cope with the demands currently being placed on them. Burnout has been defined as "a stress-related syndrome that often affects mental health professionals and may have serious consequences on personal well-being as well as on the quality of provided psychiatric care" (Volpe *et al.,* 2014, p. 774).

Evans *et al.* (2006) have explored stress, burnout and job satisfaction in social workers working in mental health services. In addition to the demands of the role, feeling undervalued, as discussed above, was associated with high levels of emotional exhaustion and stress. Restricted freedom to make decisions and concerns about how the discipline was recognised within the team were also linked to stress and burnout. These findings could also be extended beyond the role of social work and are similar to the experiences of each of the disciplines in this study. Evans *et al.* (2006) suggest that if employers do not recognise the challenging nature of these working environments, difficulties in staff recruitment and retention will occur. Indeed some of the participants in this study hinted at the possibility of leaving their respective posts in CAMHS, such is their experience at present and the challenges that they are facing.

Participants described their frustration, their disappointment and their exasperation with current service delivery in CAMHS and reported feeling powerless in the context of ongoing changes. They do not feel valued or listened to by management and have to

work hard to have their voice heard even within their own team. Having to fight to have a voice resonates with the views of adolescents and their parents attending CAMHS (Coyne *et al.,* 2015). Coyne *et al.* (2015) describe how parents have spoken about not feeling involved in decisions and fighting to receive information their child's progress, while adolescents also report feel disempowered and silenced in the CAMHS setting. Similar to Webster's (2016) study of professionals working with young people in secure care, some aspects of the experiences of mental health professionals in CAMHS therefore also appear to mirror or parallel the experiences of those attending the service. Children and adolescents attending the service are presenting in distress and it seems that the professionals themselves may also be experiencing distress. McElvaney and Tatlow-Golden (2016) have previously raised concerns about the ability of professionals to provide an effective service when they are experiencing distress themselves. Burnout is likely to affect the overall therapeutic environment of CAMHS (Volpe *et al.,* 2014).

Resilience has been highlighted as a potential coping strategy for mental health professionals in responding to difficult experiences and persisting through these (Edward, 2005). Self-care, insight into roles and having a sense of self (i.e. including factors such as expertise, confidence and autonomy) have been linked to the concept of resilience in mental health professionals (Edward, 2005). However, it was evident in this study that participants often did not feel very confident or autonomous in their work. It appeared from their accounts that their performance is being judged and measured in methods that do not capture its true value. Participants frequently compared themselves to psychiatry and nursing in this regard, as it appears to be easier for those disciplines to prove their worth and to meet the key performance indicators. While the disciplines of social work, speech and language therapy and clinical psychology have insight into their own respective roles, this insight is limited to them as individuals and to others within their specific discipline. It is not shared by their colleagues.

Finally, a related point to the experience of burnout could be the participants' views of the increasing complexity in presentations of young people, which is in contrast to the findings of a recent study (Thompson *et al.,* 2013). While professionals in CAMHS in the United Kingdom also report that cases have increased in complexity over time, a comparison of standardised measures of case complexity between 1996 and 2006

revealed no such significant trends. Thompson *et al.* (2013) suggested that the validity and sensitivity of the standardised measure used in their study might have affected the results but they also queried if the perception of increased complexity of cases amongst staff could be a result of other pressures and general dissatisfaction in working within the services. This could also be true for the participants in this study. While Mary, for example, gave specific examples of complex presentations of young people, it was also clear from her account that the pressures of the emphasis on numbers of appointments and managing administration demands were contributing to her workload and perhaps the overall ‘complexity’ of her caseload.

4.2.3 Moral distress

The experience of participants in this study and the overall phenomenon of working in CAMHS appears to involve significant moral distress. *Moral distress* is a term that was originally coined by Jameton (1984) in relation to the discipline of nursing but has since been extended other disciplines. It refers to situations “when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action” (Jameton, 1984, p. 6). Perception is key to the experience of moral distress (Austin *et al*., 2008) in that one professional may not experience something as morally distressing, whereas another professional will.

Participants in this study spoke about specific situations that seemed to invoke feelings of moral distress. Adjusting the scheduling of appointments in order to meet targets, rather than the needs of young people and their families, or neglecting parent training programmes for children with ADHD, were two such examples from the participants’ accounts. Austin *et al.* (2005) have studied the experience of moral distress in psychologists working in mental health services. Institutional demands were noted as a source of moral distress, as well as conflict within the team. Austin *et al.* (2005) outlined how the psychologists responded to moral distress in different ways, including staying silent, acting in secret and taking a stand. Each of these actions were evident in the participants’ accounts in this current study, in that sometimes participants stayed quiet and accepted the way things were, sometimes they pursued a particular practice unknown to others, and sometimes they stood up to institutional constraints and demanded something different. One such example of the latter was the description given by Caroline of advocating for a particular child to be offered long-term play therapy on

her team. The conflicting agendas of different systems around young people have also been identified in the literature as a considerable source of moral distress (Musto & Schreiber, 2012).

Similarly, Manttari-van der Kuip (2016) explored moral distress among social workers in a variety of services and found working with limited resources was a key contributing factor. A lack of resources in other services, increased demand on workload and restraints on budgets were also associated with moral distress. Those experiencing moral distress were less likely to stay in their posts and had higher levels of sick leave. Meanwhile, Kalvemark *et al.* (2004) have suggested that moral distress tends to occur when there is conflict in the goals of the health professional, such as acting in the best interests of the person attending the service or acting in the best interests of organisation. This seems particularly relevant for the professionals working in CAMHS in this study. While they can often identify the needs of children and adolescents and their families, they are often not able to provide assessments or interventions to meet these needs. Due to a drive within CAMHS to prioritise throughput, to increase discharges and re-referrals and to standardise referrals, participants have to adapt their practice despite such adaptations potentially having negative effects on the service being provided to some young people and their families. The participants effectively highlighted a lack of person-centred care in that the needs of the service and the organisation seem to take priority over the needs of the young people and their families.

"*Doing the best I can do*" was a conceptualisation of the process whereby adolescent mental health nurses make sense of experiences that lead to moral distress, in a study by Musto and Schreiber (2012, p. 139). Talking with someone (e.g. a colleague, a supervisor) was key to working through and resolving the experience of moral distress. When participants had a positive experience of engaging in such dialogue with others, they were able to accept that they had done the best that they could and could identify incidents of moral distress as existing within the broader context of service delivery. Unfortunately, the participants in this study reported that they do not see their colleagues very often and opportunities for joint-work are limited. Therefore it is likely that they cannot engage in dialogue with colleagues about their experiences of moral distress and as a result, may struggle to resolve these experiences. For example, for Matthew, it is unclear if he has been able to discuss the impact of GP-only referrals with

his colleagues, while Ciara refers to frequently working in isolation and 'doing her own thing'. One example of engaging in dialogue with colleagues was given by Deirdre. She described her department of social work reflecting on their role together and devising a document to further establish what areas of practice they were comfortable with and felt were appropriate to be a part of. This is consistent with Musto and Schreiber's (2012) study in that talking with colleagues and supervisors can support professionals in resolving their experiences of moral distress.

4.3 The Multidisciplinary Team in CAMHS

4.3.1 Conflict within the team

One of the main findings of this study was the participants' experiences of working on a multidisciplinary team in CAMHS and their relationships with their colleagues. The often adversarial nature of multidisciplinary working was evident throughout the participants' accounts and this is consistent with the literature in that "conflict is inherent in team work" (Brown *et al.,* 2011, p. 11). Conflict in multidisciplinary teams has been well documented in other areas of health services, such as stroke care (e.g. Baxter & Brumfitt, 2008) and paediatrics (Forbat et *al.,* 2016) and is not restricted to mental health contexts.

Byrne and Onyett (2010) have suggested that multidisciplinary teams pass through stages of development similar to Tuckman's (1965) model of group development and that conflict is part of the 'storming' phase[1]. However, all of the participants in this study had been working in CAMHS for at least five years. Even allowing for changes in personnel, their experience suggests that conflict in teams can persist. It is also possible that changes in the practice of CAMHS have led to some of this conflict as participants spoke about particular struggles arising out of the increased focus on numbers and the shift in the remit of CAMHS towards working with young people with moderate to severe mental health disorders. In his qualitative study of thirty-two members of multidisciplinary teams in adult mental health services in Ireland, Deady (2012) found a complete lack of consensus on the *structure, formulation and practice* of

[1] According to Tuckman (1965), 'storming' is the second phase of the group development and is characterised by disagreement as group members begin to express their negative views of each other and of the group

multidisciplinary teams. This could also be true for members of multidisciplinary teams in CAMHS.

Brown *et al.* (2011) identified *role boundaries issues*, *scope of practice* and *accountability* as the main sources of conflict in their large qualitative study of over one hundred and twenty professionals working in primary health care teams. Each of these sources of conflict was mirrored in the findings of this study. Linked to establishing professional identity as previously discussed above, participants described their struggles in determining the remit and the boundaries of their professional practice. For example, Mary emphasised that as the clinical psychologist on the team, she now works solely with 'chronic' presentations, whereas 'easy' presentations are within the remit of other disciplines. Deirdre also explained how she and her social work colleagues engaged young people in mental state examinations when they initially started working in CAMHS before they were able to make it clear to the consultant psychiatrist that this task was not within their scope of practice. In addition, there were differences in opinion in this study in terms of whether or not the consultant psychiatrist was ultimately accountable for the care of those attending the service. Caroline described this as being a source of tension amongst her colleagues, although she herself sees advantages in one person having overall responsibility on the team.

One of the consequences of tension or conflict on multidisciplinary teams is disjointed and fragmented intervention (Byrne & Onyett, 2010). Professionals may return to working in silos because it feels safer and they can work independently (Hall, 2005). Again, this was echoed in the accounts of the participants in this study with many referring to working alone as a way of coping, or avoiding, conflict on the team. Teamwork then becomes rather tokenistic with pretence of co-operation (Byrne & Oynett, 2010) and Matthew in particular mentioned the 'thin veneer' of multidisciplinary practice on his team.

Unsurprisingly, good relationships with colleagues are associated with higher job satisfaction amongst mental health professionals (Goetz *et al.,* 2017). The opposite may also be true in that poor relationships with colleagues negatively affect job satisfaction and there was evidence of this in the findings of this study. Participants spoke about their frustration and sometimes even their anger towards colleagues. Ciara, for example,

referred to being criticised on her team and her feelings of discomfort while Deirdre referred to the possibility of being ‘shunned’ off her team if she did not agree with particular colleagues.

If disciplinary groups do not get the opportunity to share their views about their roles, negative consequences for team work can result, as Bailey (2012, p.26) explains:

> where these respective value systems of disciplinary groups remain unexplored and unacknowledged they have the potential to hinder effective communication, disempower team members, increase resistance to change and foster conflict rather than collaboration.

In addition, different values amongst professionals can cause tension and block communication on the multidisciplinary team (Hall, 2005). For example, a social worker might be more interested in hearing the story of a young person and their family and a psychiatrist might be more interested in obtaining clear information about factors that could contribute to an at-risk mental state. Hall (2005) also highlights how communication skills’ modules at university tend to focus on communication with the people and families attending services, rather than communication with colleagues. As a result, graduates often leave university with an understanding and appreciation of their own profession and associated values, but not of other professions. This does not prepare them for the reality of multidisciplinary clinical practice. However, recent moves to embed interdisciplinary learning at undergraduate level on professional courses go some way to address this reality in the working world (e.g. Guinan *et al.,* in press).

4.3.2 Dominance of the medical model

The findings of this study suggest that the medical model dominates practice in CAMHS. Participants described their experiences of consultant psychiatrists ‘dictating’ to the team and it was evident in their accounts that the psychiatrist on the team is in a position of power and makes decisions on behalf of the team. While *A Vision for Change* (DOHC, 2006) set out that psychiatry is the clinical lead of community mental health teams in CAMHS and adult services, it seems that this role of clinical lead has blurred into that of a manager and a kind of team co-ordinator. Participants gave

examples of psychiatrists on their teams deciding whether referrals were accepted or not, delegating specific tasks to disciplines and not taking multidisciplinary views on case formulations into account.

The findings of this study are very much supported by those of Maddock (2015). In his recent study of a multidisciplinary team in an adult mental health service, Maddock (2015) conducted semi-structured interviews with five professionals and also observed four weekly clinical meetings. Analysis of the data showed that the consultant psychiatrist was in charge of decision-making and there was a clear hierarchy within the multidisciplinary team. The community psychiatric nurse was closely aligned to the consultant psychiatrist leading to a split within the team between the 'medical' and the 'psychosocial' parts. The occupational therapist, social worker and psychologist remained on the periphery of the team and their ability to contribute to the weekly clinical meeting varied according to the presence of the community psychiatric nurse. One particularly interesting finding was that when all five disciplines were present at the meeting, 73% of the total input into case discussions was from the consultant psychiatrist and the community psychiatric nurse.

The participants in this study did not refer to the status of psychiatric nursing in CAMHS although there was some mention of the practice of nursing being similar to that of psychiatry. For example, Deirdre spoke about the ability of nursing to easily meet the target number of appointments per week as a result of the ADHD clinic. She described what she sees as a quick 'fire buzzer round' and high turnover of young people in the ADHD clinic and how this compares to the nature of her practice. Similarly, Caroline referred to nursing being part of the 'medics' and having a rigid view of mental health compared to other disciplines on the team.

Also raised in Maddock's (2015) study were the different models of understanding mental health among disciplines. He reported the use of medical, psycho-social and psychological models of mental health, with the medical model tending to rule. Debates about associated interventions tend to accompany debates about different models of mental health (Byrne & Onyett, 2010) and there was evidence of these debates in this study. Joanna, for example, spoke about her struggle with 'the whole dialogue' in CAMHS and she was clear that she would prefer a greater emphasis being placed on

attachment and parent-child relationships in services. Similarly, Matthew spoke about his interest in social work - stemming from social constructionism - and contrasted this with ‘scientific modernist ideas’ that may be present in other mental health interventions.

Hall (2005) has pointed out that doctors are generally trained to be in charge and to be responsible for decision-making in clinical settings. They are usually expected to take on the role of a leader and this could explain why it is difficult for them to share this role, or in the context of CAMHS, to be a clinical leader but not have the authority to direct the practice of other disciplines. Related to this is a point made by Reese and Sontag (2001) in that doctors tend to focus on action and outcomes, whereas other disciplines may prioritise the therapeutic relationship. This could explain some of the findings of this study and the participants’ experiences of the differences between their practice and that of the consultant psychiatrists.

4.3.3 Factors supporting multidisciplinary teamwork

As mentioned earlier, conflict in multidisciplinary teams and the dominance of the medical model have been well documented in the literature. Similarly, suggestions on how to overcome these difficulties and ideas on ‘what works’ in teams have been outlined in a number of studies and policy documents (e.g. Molyneux, 2001; Robinson & Cottrell, 2005; Byrne & Onyett, 2010). Brown et al. (2011) lament that team functioning nevertheless continues to be affected by the same sources of conflict as ever.

A study by Molyneux (2001) suggested three key components that are necessary for positive team functioning. These are the *personal qualities and commitment of staff*, *communication* and *creativity* in the development of models. One particular facilitator of communication is when all members of the team are working in the same location (Molyneux, 2001). This is very relevant to the findings of this study as almost all of the participants referenced working part-time, not seeing colleagues very often, struggling to find physical space in the building and working across different locations. Therefore it seems reasonable to suggest that poor communication in teams for participants in this study was affected by members not consistently being at one base. In addition, many of the participants spoke about the limited opportunities for joint-working with colleagues

due to their different schedules and these further reduced opportunities for communication.

The 'nurturing' of teams has also been highlighted as a factor that contributes to effective multidisciplinary team working (Mental Health Commission, 2006). Relationships between colleagues take time to develop and getting to know one another and one another's style of working is not a process that happens instantaneously. Indeed a number of the participants in this study spoke about feeling more comfortable and more able on their team as time progressed. However, the passage of time alone does not lead to teams being nurtured and functioning without difficulty. Formal team building programmes and a true commitment to team development from management and the overall organisation have also been called for (Mental Health Commission, 2006). Unfortunately, these do not seem to have been incorporated into practice.

Barriers to conflict resolution have been identified as *a lack of time and workload, people in less powerful positions, lack of recognition or motivation to address conflict* and *avoiding confrontation for fear of causing emotional discomfort* (Brown *et al.,* 2011, p. 4). Similar to the findings of this study, there are a number of ironies in some of these barriers. Firstly, it could be true to say that a lack of time and heavy workloads, as well as power dynamics on the team, are the causes of conflict on the team. If they also become barriers to resolving the conflict, then the cycle of conflict and lack of conflict resolution will continue. In addition, mental health professionals in CAMHS work with young people and their families in distress and difficulties in relationships can be part of this distress. Each of the disciplines represented by participants in this study have skills in supporting children, adolescents and their parents in working through conflict and in communicating effectively with each other. It is therefore quite perplexing that the participants seem unable to use the same skills to resolve differences and improve relationships within the context of their multidisciplinary team. As both Matthew and Ciara pointed out, there can be some advantages to conflict and differences amongst disciplines in the multidisciplinary team but these need to be managed very carefully.

An interesting idea put forward by Garven (2011) suggests a *reflecting team process* as one way in which can teams can successfully discuss and co-ordinate their different

approaches. Based on an idea that originated in supervision in systemic family therapy, a reflecting team process creates a context for dialogue between disciplines. When a case is identified as being in need of a clinical discussion or consultation, one professional interviews the other in front of the rest of the team and gently probes the interviewee's ideas and expectations about the case. Afterwards, the remaining professionals discuss the consultation in front of the interviewer and the interviewee, before the interviewer and interviewee then reflect on the contents of the team discussion. Based on her work to date with multidisciplinary teams in CAMHS, adult mental health services and substance misuses services, Garven (2011) reports that this reflecting team process means that there is less focus on professionals' ideas being in competition with each other and less promotion of different agendas. Instead, teams engage in more negotiation and shared dialogue with one another, and show more curiosity and creativity in case consultations.

4.4 Service Provision in CAMHS

4.4.1 Remit of CAMHS

Participants in this study raised a number of concerns about the remit of CAMHS and this is echoed elsewhere in the literature. Caroline, for example, spoke about her view of the mental health needs of a particular child who was presenting with severe emotional and behavioural difficulties. Her view was in contrast to that of the consultant on her team who was keen instead to point out that the child did not have a mental health disorder. Similarly, Joanna spoke about the need to clarify whether a child with an autism spectrum disorder (ASD) is presenting with co-morbid mental health difficulties or difficulties that could be best understood within the context of ASD. Professionals in a study by McElvaney *et al*. (2013) also shared their confusion and frustration with the differences in the concept of mental health across services for young people in Ireland. They emphasised that mental health does not merely mean the absence of mental illness and suggested that mental health needs for young people, in care and in detention in particular, should extend beyond the presence of a psychiatric diagnosis and include general emotional well-being.

The findings of this study also suggest that there is an increasing emphasis on short-term interventions in CAMHS. This contradicts existing literature which has shown that

adolescents' engagement in therapeutic intervention is best understood as a continuum and a process which develops over time (Donnellan *et al.*, 2012). Such engagement is unlikely to develop under strict time limits. Additionally, the therapeutic relationship between the young person and the professional has been repeatedly emphasised as being of value by younger children and their parents (Bone *et al.,* 2014). Both adolescents and their parents have also highlighted the importance of building rapport and learning how to trust a mental health professional (Coyne *et al.,* 2015). If the duration of interventions in CAMHS are restricted to eight sessions as Ciara mentioned, this will challenge the formation of strong therapeutic relationships and impact on the ability of young people and their families to engage with the service. It is also unclear how the needs of children and young people with complex mental health presentations will be met by short-term interventions.

A similar point about the remit of CAMHS based on the findings of this study relates to the provision of indirect and group interventions. As Caroline explained, indirect interventions such as school visits are not counted as appointments according to the current key performance indicators in CAMHS. Furthermore, a group intervention is only counted as one appointment, no matter the number of attendees. As a consequence, it is possible that professionals will offer less of these interventions in the future, particularly if they are under pressure to meet the target figure of sixteen appointments per week. Given that there is evidence that group intervention can be effective for a range of presentations of children and adolescents in CAMHS (e.g. Sharkey *et al.*, 2008; Coughlin *et al.*, 2009; Van Vliet *et al.*, 2017), the potential loss of such interventions in CAMHS is a cause for concern.

4.4.2 Process of change and organisational culture in CAMHS

There have been significant developments in CAMHS in Ireland over the past number of years and many of these developments occurred on foot of the publication of *A Vision for Change* (DOHC, 2006). While participants outlined the impact of these changes on clinical practice in CAMHS, it was also clear from their accounts that this process of this change and development, in itself, has been very difficult. For example, Matthew spoke about his colleagues feeling demoralised and disenfranchised, and he was very clear that most disciplines did not have the opportunity to contribute to decision-making about the development of services. Similarly, Caroline referred to

‘huge’ changes on her team and there was a sense that perhaps too many changes were introduced at the one time.

While standardisation and consistency in services is welcome, the changes that have been introduced in CAMHS do not seem to have taken the variety of contexts of each team and service into account. Instead, it appears that a ‘once size fits all’ approach has been adopted. Similar to research by Sandstorm *et al.* (2014), it is clear from this study that greater attention needs to be paid to clinicians who are working directly with young people and their families, and who are expected to implement changes into their practice. Sandstorm *et al.* (2013) also made the point that out that any new guidelines or policies need to be converted and adapted into local practice in order to be effective. *A Vision for Change* (DOHC, 2006) advocated for each mental health team to adapt to the context of its community but the findings of this study suggest that this is not happening in reality. Participants spoke the over-arching drive for services to be standardised and the lack of flexibility and choice that has been afforded to them in their practice. While national guidelines are helpful in defining some aspects of service delivery (Hay *et al.*, 2013), individual teams need be allowed to make specific decisions about the design of their service.

The findings of this study also suggest a number of features of the current organisational culture in CAMHS in Ireland. Organisational culture is “manifest in patterns of behaviour underpinned by beliefs, values, attitudes and assumptions, which can influence working practices” (McLaren *et al.*, 2013, p. 254). Firstly, there is a clear focus on the quantity, rather than quality, of appointments being offered to young people and their families. Deirdre referred to this as a ‘need for speed’ while Mary referred to the prioritisation of what ‘looks better on the books’. This increasing sense of bureaucracy in CAMHS is leading to some professionals adapting practices that prioritise their own needs and the needs of the organisation (i.e. HSE) over the needs of the young people and their families who are attending.

There is also a significant discrepancy between how the professionals and management or the organisation are evaluating CAMHS. While the increased performance of the services might be impressive in terms of the number of appointments being offered and the reduction in the length of waiting-lists, the findings of this study suggest that the

quality of the service is under threat. Twomey *et al.* (2013) have proposed an interesting model to evaluate mental health services based on their work in the West of Ireland. As well as measuring the efficiency of the service and economic evaluations, they propose an inclusion of clinical outcomes and measures of satisfaction among those attending the service and their GPs. It is reasonable to suggest that such a model might also suit an evaluation of CAMHS. For the participants in this study, measures of satisfaction and clinical outcomes would be warmly welcomed as alternative or additional ways of evaluating CAMHS.

Burnout was discussed earlier in this chapter in relation to mental health professionals in CAMHS but it is worth a brief mention again in the context of the organisation of CAMHS. In their review of burnout in mental health services, Morse *et al.* (2012) pointed out the irony in mental health services paying little attention to the mental health and well-being of its own staff. Factors relating to the organisation and the workplace environment tend to be more powerful predictors of burnout in staff than individual characteristics (Morse et *al.,* 2012) and there is a need for mental health services to implement interventions at the level of the organisation in order to improving staff well-being of staff and reduce burnout. One striking feature of the findings of this study was that the participants did not refer to any difficulties in working directly with young people and their families. While Mary referred to some complex mental health presentations, there was generally little mention of challenges in working with children and adolescents who are in distress. Instead, the challenges of working in CAMHS seem to arise out of difficulties at the level of the multidisciplinary team and of the service.

4.5 Implications of Study

The findings of this study have a number of implications for clinical practice, policy and education.

It is no secret that CAMHS in Ireland is subject to much public criticism for its long waiting-lists and low staffing numbers. There are repeated calls for increased numbers of staff and multidisciplinary teams (Mental Health Reform, 2017) in order to meet the growing demand on services. However, the findings of this research study suggest that

increased staff and team numbers may not be appropriate at this time. Instead, the remit and the core processes of CAMHS need to be addressed. There are very concerning underlying deficiencies in how multidisciplinary teams and the services of CAMHS are operating at this time. It is the researcher's opinion that these deficiencies need to be addressed before further staff are recruited.

Firstly, there is a clear need for professionals working in multidisciplinary teams in CAMHS to develop a better understanding of each other's roles and sets of values. Improved communication and working relationships with colleagues would be likely to lead to improved staff well-being, and this could reduce the possibility of professionals leaving their posts due to difficulties in working as part of a multidisciplinary team.

Additionally, there is a very obvious need for formal team building activities and team development programmes. While there are some comprehensive documents (e.g. Byrne & Onyett, 2010) available to all professionals and multidisciplinary teams in CAMHS in Ireland, such literature needs to be brought to the fore in order for teams to be able to reflect on how they are functioning and translate some of the suggestions and recommendations into action. Furthermore, such team reflection and development programmes needs to be prioritised at the level of the organisation. Given the high demands and the hectic schedules of professionals working in CAMHS, it is crucial that specific time is set aside for team reflection and development and all members of the team buy into its importance. It may be helpful to have an external facilitator to support this work, particularly for teams that may be experiencing frequent conflict.

A Vision for Change (DOHC, 2006) recommended that each community mental health team has a unique set of skills and adapts to the context of its local community. As mentioned earlier, this does not seem to be the case for multidisciplinary teams in CAMHS at present. Instead, there appears to be an overwhelming drive for standardisation and the potential for each CAMHS team to have a unique identity and to tailor to the needs of young people and their families has been stifled. Teams need to be able to create their own ways of working and to be given permission and encouraged to do so (Molyneux 2001). As well as professionals feeling empowered and committed, this would also likely lead to increased partnership between professionals and the young people and families attending the service (Molyneux, 2001).

The role of the ‘primary mental health worker’ has been introduced in England in recent years in order to address the gap between primary care services and CAMHS (Bradley *et al.,* 2009). While the primary mental health worker engages in some clinical work with children and families, they are also involved in case consultations, service-liaison and training for professionals working in primary care services (Gale & Vostanis, 2003). It may be worth considering introducing this role as part of future mental health service developments in Ireland. A primary mental health worker could be based in each primary care centre and their goal would be to liaise with the local CAMHS team as well as local primary care services. They would be able to provide training and consultation to both, and this would improve collaboration and co-ordination between the services, ultimately in the best interests of young people and their families.

Finally, the findings of this study suggest that there is value in attempts to embed interdisciplinary learning at undergraduate level (e.g. Guinan *et al.,* in press) and that such learning is likely to better prepare students for multidisciplinary practice in CAMHS and in other settings. It would be helpful to explore opportunities to embed similar interdisciplinary learning to professionals who are already practising.

Based on the findings of this study and the discussion outlined in this chapter, a model for the development of, or a future ‘vision’ of CAMHS, is proposed on the next page.

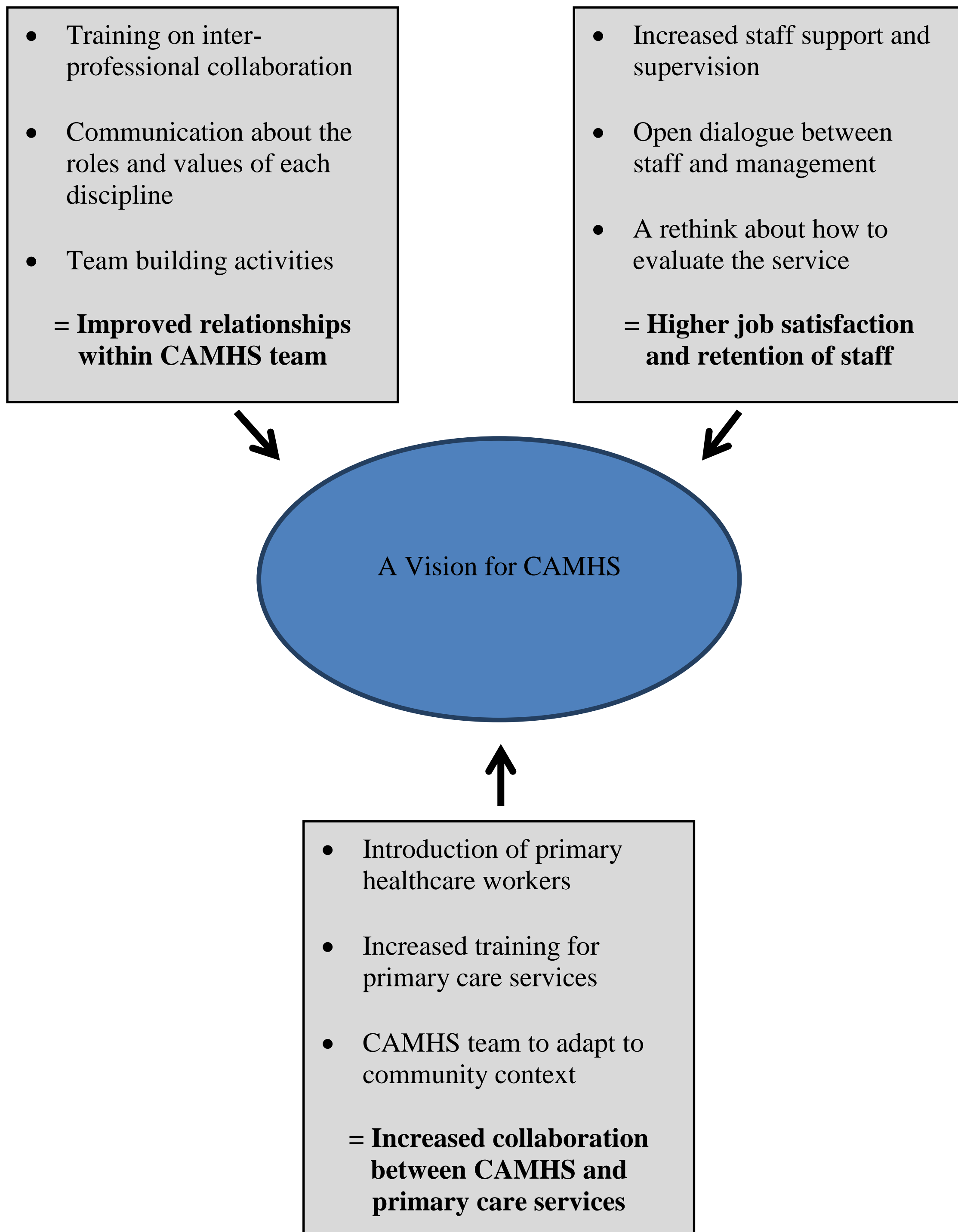

Figure 4.1 A suggested model of development of CAMHS

4.6 Limitations of Study

The findings of this study may not be representative of other professionals working in CAMHS and the small number of participants means that the findings cannot be generalised to others. However, the small size was in keeping with the practice of qualitative research in that a low number of participants allowed for an in-depth exploration and understanding of the participants' experiences. Of note, many of the participants referred to colleagues either on their multidisciplinary team or within their disciplines during the interviews and they seemed to suggest that their experiences were similar in nature. This was best captured in Caroline's comment and the title of this study: *"I think everybody's finding it a challenge to be honest"*.

There was an over-representation of social workers in the study and all three had pursued postgraduate training in family therapy. It is also worth considering that the professionals who expressed an interest and took part in this study were biased. They perhaps came forward because they were in distress and felt that they had something to say to the researcher.

4.7 Ideas for Future Research

It would be useful to explore the experiences of other disciplines working in CAMHS that were not included in the group of participants in this study (e.g. occupational therapy, psychiatric nursing and social care). The experiences of consultant psychiatrists would also be an interesting topic of research and the research question could focus in particular on their experience of being the clinical lead of the multidisciplinary team in CAMHS. This could lead to further interpretation and act as an extension to the findings of this research study.

All of the participants who took part in this study had been working in CAMHS for a number of years. It would be interesting to explore the experiences of professionals who have recently joined the service and see in what ways their experiences are similar and different to the participants in this study.

4.8 Conclusion

In conclusion, this study paints a gloomy picture of the experience of working in CAMHS in Ireland. The experience of working in CAMHS, as a phenomenon in itself,

had been neglected in the literature to date and consistent with the aims of IPA research, this study has ‘given voice’ to these professionals and ‘made sense’ of their experiences (Larkin *et al.,* 2008).

Behind the measures of appointments, waiting-lists and numbers of staff, it is clear that multidisciplinary teams are not functioning well in CAMHS and are in need of significant development. While the framework set out in *A Vision for Change* (DOHC, 2006) brought about changes in the structure and operation of CAMHS, it seems that many of these changes have not been welcomed by professionals working in the services. In order to preserve and to truly promote the multidisciplinary nature of service delivery for children and adolescents with mental health difficulties, the unique value and role of each discipline needs to be acknowledged and promoted. This may mean re-examining the purpose of clinical leader and team co-ordinator on the multidisciplinary team, as well as a re-evaluation of the current system of performance measures.

The experiences of the professionals in this study were characterised by struggles, frustration, sadness and a sense of despair. Given that each of the professionals chose to work in CAMHS and is inherently committed to meeting the needs of children and adolescents who are in distress, it was very striking to listen to their accounts of working in the services at present. The initial passion and enthusiasm that many of them brought when they first started in their posts seems to have disappeared; perhaps worn away by the frequent battles and conflict that they have to manage within their own service. If this continues to occur, CAMHS will face a different crisis in the near future – the mass loss of very skilled, competent and committed staff. Ultimately, it will be children and adolescents with mental health difficulties who will face the brunt of this crisis.

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Appendix 1:
Ethical Approval

COLÁISTE NA TRÍONÓIDE, BAILE ÁTHA CLIATH

Dámh na nEolaíochtaí Slaínte,
Foirgneamh na Ceimice,
Colaiste na Tríonóide,
Baile Átha Cliath 2, Éire.

TRINITY COLLEGE DUBLIN

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T:-+353 (0)1 8964255

Eimear Ryan

XX,

XX,

XX

Dublin 6.

23 September 2013

Study: The emerging identity of child and adolescent mental health services via discourse analysis

Dear Applicant(s),

Further to a meeting of the Faculty of Health Sciences Ethics Committee held in June 2013, we are pleased to inform you that the above project (as amended) has been approved without further audit.

Yours sincerely,

pp. Caroline Rooney

____

Dr. Ruth Pilkington

Chairperson

Faculty Research Ethics Committee

Supervisor: Dr Irene Walsh

Appendix 2:
Letter to Chairpersons of Professional Associations Seeking Co-operation with the Study

Department of Clinical Speech & Language Studies
University of Dublin,
Trinity College,
7-9 South Leinster Street,
Dublin 2.

15th January 2014

Name of Chairperson,
Name of Association,
Address.

Dear *Name of Chairperson*,

I am a postgraduate student in the Department of Clinical Speech and Language Studies at Trinity College Dublin (TCD). I am writing to seek your co-operation in recruiting participants for my research study entitled: *The Emerging Identity of Child & Adolescent Mental Health Services (CAMHS) via Discourse Analysis.* I am conducting this research under the supervision of Dr. Irene Walsh who is an Associate Professor in the Department.

Please find enclosed an information leaflet that outlines the study in detail. Briefly, participating in the research would involve your members agreeing to participate in an interview exploring their professional role and involvement in CAMHS in general.

I would be very grateful if you could distribute the information leaflet to members in your association. If any of your members are interested in participating, they can contact me directly for more information or if they wish to schedule an interview.

If you have any questions about the study, please do not hesitate to contact me at ekryan@tcd.ie.

Thank you for reading this letter and I hope that you will consider distributing the information leaflet to your members.

With every best wish,

____

Eimear Ryan
Department of Clinical Speech and Language Studies, TCD

Appendix 3:

Participant Information Leaflet

Department of Clinical Speech & Language Studies
University of Dublin,
Trinity College,
7-9 South Leinster Street,
Dublin 2.

20th January 2014

Dear Sir/Madam,

I am a postgraduate student in the Department of Clinical Speech and Language Studies at Trinity College Dublin (TCD). I am writing to invite you to participate in a research study entitled: *The Emerging Identity of Child & Adolescent Mental Health Services (CAMHS) via Discourse Analysis.* I am conducting this research, as part of my postgraduate studies, under the supervision of Dr. Irene Walsh who is an Associate Professor in the Department.

The purpose of this study is to explore how mental health professionals working in child and adolescent mental health services (CAMHS) talk about these services; that is, what they have to say about their experiences and how they see their role within such services. The aim is, that through discourse analysis, these accounts will lead to a construction of the current identity of CAMHS via professional discourse. I am interested in hearing the different 'voices' of professionals currently working in CAMHS and who have had at least three years of experience in that context.

Back in 2006, 'A Vision for Change' was published as a report of the expert group on mental health policy. Since then, there has been lots of development in CAMHS, affecting both practice and roles. While there are frequent quantitative reports of processes and outcomes in CAMHS (e.g. Fourth Annual Child and Adolescent Mental Health Service Report 2012) , I am interested in exploring professionals' experiences of CAMHS using qualitative data analysis and building a descriptive picture - or identity - of these services.

I would like to invite you to participate in a semi-structured interview which will take up to an hour (maximum).This will be scheduled at a time and location that is convenient for you. The purpose of the interview is to listen to you talk about your experiences of working in CAMHS; it is not an examination of professional knowledge or a scrutiny of practice. I will be interviewing professionals from psychiatry, psychology, social care, speech and language therapy, occupational therapy, social work and nursing. This study has the potential to build a multidisciplinary representation of CAMHS and inform future practice.

I will audio-record the interview and transcribe it for analysis. Your identity will remain confidential as you will be assigned an anonymous code. Your name and any

identifying information will not be published and will not be disclosed to anyone. If you wish, I can give you a copy of the transcript and you will have the opportunity delete any wording that you perceive as identifying you or that you are uncomfortable with. The data will be stored securely and only my supervisor Dr. Irene Walsh and I will have access to it. If you decide to volunteer to participate in this study, you may withdraw at any time.

This study has Research Ethics Committee approval from the Faculty of Health Sciences in TCD and is covered by standard institutional indemnity insurance. Nothing in this document restricts or curtails your rights.

Please let me know if you are interesting in participating in this study by contacting me on 087 XXXXXXX or ekryan@tcd.ie. If you would like more information or answers to your questions about the study, do not hesitate to contact me.

Thank you for reading this letter and I very much hope that you will consider your participation.

With every best wish,

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Eimear Ryan
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Appendix 4:

Informed Consent Form

Project Working Title:
The Emerging Identity of Child and Adolescent Mental Health Services (CAMHS) via Discourse Analysis

Principal Investigator:
Ms. Eimear Ryan - under the supervision of Dr. Irene Walsh
Department of Clinical Speech & Language Studies, TCD, Dublin 2.

The purpose of this research is to work towards a description of an identity of CAMHS via a discourse analysis of in-depth interviews with mental health professionals working in these settings.

I will participate in a semi-structured interview with Ms. Eimear Ryan. This will take up to an hour (maximum) and has been scheduled at a time and location that is convenient for me. I understand that the interview will be audio-recorded and transcribed for analysis. If I wish, I can ask for a copy of the transcript.

I understand that my details will be anonymized at the commencement of the study by allocations of a code number and this number will be used in all subsequent stored data records. If there is any other identifying information in the data, it will be removed. I understand that the data will be stored securely on a password-protected computer. Hard copies will be stored in a locked cabinet. Only Ms. Eimear Ryan and Dr. Irene Walsh will have access to the data.

I am aware that the anonymised data may be used in future studies by Ms. Eimear Ryan without additional consent. The results of this study and future studies may be presented at conferences or published in journals but no identifying information will appear. I also understand that my participation in this study is voluntary and I can withdraw my consent at any time.

Declaration:
I have read, or had read to me, the information leaflet for this project and I understand the contents. I have had the opportunity to ask questions and all my questions have been answered to my satisfaction. I freely and voluntarily agree to be part of this research study, though without prejudice to my legal and ethical rights. I understand that I may withdraw from the study at any time and I have received a copy of this agreement.

Participant's Name: ________________________________

Contact Details: ________________________________

Participant's Signature: ________________________________

Date: ________________________________

Statement of investigator's responsibility:
I have explained the nature and purpose of this research study, the procedures to be undertaken and any risks that may be involved. I have offered to answer any questions and fully answered such questions. I believe that the participant understands my explanation and has freely given informed consent.

Investigator’s Signature: ___________________________________

Date: ___________________________________

Appendix 5:

Interview Topic Guide

Topic Guide for Main Questions

- Orientation – factors/events leading to participant working in Child & Adolescent Mental Health Services (CAMHS)
- Touring questions – talk about a typical 'week in the life of …' in CAMHS
- Role of participant's profession in CAMHS compared to other areas of clinical practice
- Working in a multidisciplinary team
- Participant's overall experience of working in CAMHS – highs and lows
- Description of CAMHS to someone who is not familiar with the service
- Public understanding of CAMHS
- Creating an ideal CAMHS
- How CAMHS has evolved over time
- Potential areas of development for CAMHS in the future

Appendix 6:

Sample Interview and Analysis - Deirdre

		Transcription	Exploratory Comments			Emergent Themes
			Semantic	Linguistic	Conceptual	
1 2	R	Eh so maybe to start off can you tell me how you ended up working in CAMHS?				
3 4 5	P	CAMHS? Eh I was working in eh disability services beforehand, eh outside of the HSE and eh. I eh did my panel interviews then, when they came up, social work panel interviews.	Previously worked in disability serv. Did SW panel interviews		Transition from disability services to CAMHS	
6	R	Oh yeah.				
7 8 9 10 11 12	P	And eh, I eh I had, I had put in eh all areas, you can confine it down to one particular area of work so it could be primary care, disabilities, mental health, child and family. Eh I put down all and eh, yeah a job offer came up in Richmond in CAMHS mental health services and eh eh I took it. So that was eh that was eh four and a half years ago, February in 2010 yeah, yeah.	Put in all areas in panel interview Job offer in CAMHS Started in 2010	*Confine it down* – restrict	SW roles in different areas of practice	
13	R	Okay, okay.				
14	P	So that's how basically.				
15 16	R	And had you put all the areas down just in terms of more opportunities for a job or did you have a preference?				
17 18	P	More opportunities for a job and I certainly had had a preference for what I didn't want to do.	Preference for what area she didn't want			
19	R	Which was?				
20 21 22 23 24 25 26 27	P	So if one came up in child and family, I wouldn't have taken it. Eh I had some reservations about taking a primary care social work position eh although that kinda changed as I, as my time moved on. Eh and I'd a particular interest in eh disabilities and had access in the last job eh to mental health services and eh also cases where mental health was quite present. Eh mental health needs were quite present so I would have been, like I was delighted when I got the eh the post came up in CAMHS.	Wouldn't have taken job in child & family Unsure about primary care Interest in disability Contact with MH services Delighted with job offer	*MH was quite present* – it existed *Delighted* – very happy	SW in child& family agency not attractive to her Uncertainty about SW in primary care Past contact and experience with MH services as a reason for pursuing this area	SW in CAMHS as her choice
28	R	Yeah so=				
29	P	=It was something I never did before directly.	No direct experience in CAMHS			
30 31	R	Yeah but you had, so you you were in learning, a learning disability service?				

32 33 34	P	Learning disability. I worked in eh, I I worked in. I I don't know whether this service name will be put into the research or not, will it?	Worked in learning disability before CAMHS	Checking confidentiality, sense of disclosing	Looking for reassurance about confidentiality	
35	R	No it won't.				
36	P	Eh Laurel View Services, Laurel View School.				
37	R	Oh yes, yes in Oldtown.				
38 39 40 41	P	So I was there for a while in Oldtown, yeah and then before that I was always disability as well. So I would have worked with the Rockingham Services before that and elder care then as well, so yeah.	Also worked in care of elderly			
42 43	R	Okay so while you were in Laurel View, then there were you'd some interface with CAMHS was it?				
44 45 46 47 48 49 50 51	P	There was a huge, well with Silverdale CAMHS eh services and eh and then also some adult services, where children would have had parents who were accessing some of the Laurel View adult services eh and then I would have worked with eh, eh as a social care worker. When I was working as a social care worker, I would have worked with eh with the residential side of things and again there would have been a lot of access to mental health services eh through Laurel View.	Had contact with MH services Parents of children attending adult MH services Working in residential care: contact with MH services	*The residential side of things* – general, vague term	She had contact with both CAMHS and adult MH services Contact with adult MH services from residential care	Contact/Experience with CAMHS as an outsider first
52	R	Okay.				
53 54 55	P	Eh so yeah, we would have done a lot of eh joint working with eh particularly Silverdale Services, eh and eh yeah there was kind of a good strong link there between us all, so yeah.	Joint working Link between disability & MH services	*A kind of a good strong link* – unclear, then clear expression		
56	R	And how how was that for you, that?				
57 58 59 60 61 62 63 64	P	The link? Eh (pause) yeah like, I I guess I mean I would have, I would have kind of (sighs). I'm probably going into a bit of a problem talk more than more than I should, even in response to that straightaway but like what come to mind is eh. Yeah there wasn't, there wasn't maybe a huge link between mental health services and schools eh and I kind of felt that because we were linked in terms of the umbrella, we were under Laurel View Services, that maybe that kind of forced us into thinking we'd a better relationship than we	Going into problem-talk Not a huge link between MH services and schools Forced to think relationship was better than it	Sighs – weary, exhausted? *I'm probably going into problem talk* – monitoring her expression, concept of problem talk	Why is she commenting on 'going into problem talk'? So lots of contact with MH services but not an actual link or relationship?	CAMHS talk as problem talk Weak link between CAMHS and schools

65 66 67		actually did. Eh cause I I've kind of, I have and I suppose I'd have the same experience here, that eh maybe there isn't that connection as strong as maybe I would have felt, think it should be.	was Connection not strong in current service		How does she think it should be?	
68	R	Between schools?				
69 70 71 72 73 74 75 76 77 78 79	P	Between schools and mental health services. But like I suppose we would have had that kind of, it would have been that access point so or that referrals point. We would have got a lot of referrals from eh Silverdale or we would have sent a lot to them, eh some of our kids would be diagnosed with ADHD, others with Asperger's eh and others with mild learning disabilities which they would have kind of supported eh around behaviour and emotion, emotional concerns. Eh so we would have had a lot of access around you know (sighs) supporting appointments and 'God is he, did he change his medication?' and sending a new school report and maybe family via, or to Silverdale via family, that sort of stuff.	Had access point to CAMHS Referrals to/ from disability & CAMHS Children with diagnoses of ASD, ADHD Disability services supporting family attending CAMHS	Direct speech to explain her point	Schools as a source of referrals to CAMHS and vice versa School as a way of supporting children and families engaging with CAMHS	CAMHS supporting schools and schools supporting CAMHS
80	R	Yeah.				
81 82 83 84 85 86 87 88	P	But I mean a lot of it would have been kind of, maybe driven. This is terrible, this mightn't be what, how anybody else would see it, but maybe driven by the school to to to link up with services and because we were Silverdale. I think the the over-arching managers would have tried to make you know make it a little bit more positive in terms of the communication so they did lots of things to try and eh encourage communication between the different services; disability, mental health, school, you know, whatever other services.	Contact with CAMHS driven by school Managers trying to support communication between different services	*This is terrible* – commenting on what she is saying, negative evaluation	Onus on schools to make contact with CAMHS, not the other way around – why?	Recognition by management of need for improved communication between CAMHS and schools
89	R	Sure.	Stronger link than on current team	*I think, probably, maybe* – uncertain language		
90 91	P	They had, so I think because of that, it was probably stronger than maybe the link I would see happening here.				
92	R	Okay, okay.				
93	P	Yeah.				
94 95	R	So you had that that kind of that eh introduction if you like to to mental health, adult and child?				
96	P	Yes, adult and child actually, yes.	Wasn't running away from			
97	R	You thought then, maybe this is something you'd like to work at?				

98 99 100 101	P	I I definitely wasn't running away from it. When I got the, when I got the post I was delighted. I thought 'This is wonderful a new experience'. I had a sense of, eh but not in any ways a detailed sense of what a social worker might do in CAMHS, so eh yeah.	CAMHS Delighted when she got the post Had a sense of SW role in CAMHS	*Wasn't running away from it* – not afraid, avoiding it Quoting herself here	Do other people run away from working in MH or CAMHS?	Embracing the offer of a post in CAMHS
102 103 104	R	Yeah. And you mentioned on the panel that you were clear that you didn't want to work in community or child protection, or what was the first you said, child and family?				
105	P	Eh yes, child protection.				
106	R	Oh child protection, yeah=				
107	P	=Is child and family.				
108 109 110	R	Because eh I think what you're maybe saying is that the social worker role is very different in CAMHS to what it is in say, child protection or?				
111 112 113 114 115 116 117 118	P	It certainly is and I sort of, I eh. If if you were asking me kind of what I think about the difference, I felt I would have been a little bit eh. I do, I I sort of feel that maybe the child protection and welfare eh social work role is is quite confined and I I just. I I struggle when I'm confined to a particular you know 'one thing and one thing only' and I think lots of social workers are creative and wonderful in their role in child protection and welfare but that it's quite limiting in lots of ways because of, because of the statutory piece I suppose.	Role of SW in child protection is confined Struggles when confined to one thing only SW are creative but limited role in child protection	*I struggle* – difficult *One thing and one thing only* – restricted, inflexible	SW in child protection as restricted Legal system in child protection hinders creativity and flexibility of SW	SW in CAMHS not as restrictive Restrictions on practice as a struggle
119	R	Yeah.				
120 121 122 123 124 125 126 127	P	And and other pieces as well, resources and things like that. But eh yeah eh. I I I would have felt that maybe there would be more scope in in other areas. Primary care, I wasn't so sure because I I felt at the time the role hadn't really been defined enough and I didn't get the sense that it would be a good time to move into that position, even though there was lots of primary, primary care was the thing at the time. But I just felt that the social work role wasn't defined enough at the time so.	Lack of resources in child protection SW role in primary care was unclear Didn't want to move there at the time		SW role in primary care wasn't defined; SW role in CAMHS was?	SW in other areas of practice as more unknown than SW in CAMHS
128 129 130	R	Mmm. And eh I noticed you you used the word creativity cause somebody else has also spoken about this eh social work, about create creativity is is, it's an important or it's part of the it's really				

131		part of the job and=				
132	P	=It is. I I don't know whether I I need to be talking about my role		Commenting on the content of her expression		
133		now or like, what's most helpful or just in general like in CAMHS?			She thinks I have an agenda?	
134	R	In general.				
135	P	Or in general?				
136	R	Anything at all.				
137	P	Yeah eh. Yeah like I know here, like you know, I feel like you get to	Get to use elements of yourself			
138		use that that element of yourself.				
139	R	Great.				
140	P	Eh hugely. Eh and if you didn't have those elements of yourself to	Otherwise would be limited		Importance of creativity in working with children	
141		use, I think you'd be quite limited. Eh yeah, it's hugely important.				
142		Like I think particularly with the, with the little ones we serve and as		*Serve* – verb choice		
143		you will see the room is pretty eh disturbed when it comes to	Important to use elements of yourself	*Disturbed* – very wrong, troubling		
144		thinking that this is a playroom. There's nothing really to play in it			CAMHS building not appropriately equipped	
145		or around it.	Room is not suitable for play and young children			
146	R	Sure.				
147	P	Eh so you do have to be creative in in the use of yourself. So like in				
148		lots of different and lovely bits that you'd be able to bring in. Eh	Be creative			
149		like speech and drama and you know that sort of stuff that you did	Bring in speech & drama		Different ways of being creative in working with children	SW as a creative role
150		yourself as a kid, that you bring in some of that and eh you know.				
151		Eh (sighs) the miracle ways of looking at problems, what in terms of	Miracle ways of looking at problems			
152		looking at solutions and eh you know, lots of different kind of eh				
153		you know, pretending and if you were a, you know if there was a				
154		connection would the child have with the dog but it wouldn't talk to	Pretence			
155		anyone else, you know, that you might kind of think about eh yeah	Imagination	Giving example of hypothetical dialogue with child		
156		how you might bring that in. So 'If you were, if I was a dog, what				
157		would I be saying? Or if you were a dog what you would be doing?'	Support a young person to engage			
158		or you know, and that might help a a little one to talk. And eh even		*A little one* – repetition from earlier, referring to children	Importance of informal and flexible style in working with children	
159		being creative to the point that you're you're not limiting yourself to	Not being limited to sitting and looking at young person			
160		sitting here with somebody on a chair eh looking eyeball to eyeball				
161		at a young person, that you say 'Okay where can I extend my role?		*Looking eyeball to eyeball* – intense, formal		
162		Can I do some work in the school? Can I link in with eh the				
163		swimming instructor and you know go to the kid's, take an interest	Extend your role	Quoting herself	Questioning what is	The extension of SW role for each

164 165 166 167		and go to the kid's whatever?' You know, and and engage at that level. 'Can I eh can I wide widen it out a bit from from kinda just you know sitting in the room here with?' You know, so they're the kind of lovely opportunities that I think are available to…	Link in with others around the child Widen out what she's doing	and her own questioning here	meaningful in each child's context	child & context
168	R	And and here you can do that?	Opportunities			
169 170 171 172 173 174 175 176 177 178 179 180 181 182	P	Yeah (sighs) I think so. I think, again you have to be creative about how you are being creative you know so. Because it's quite limiting in lots of ways or you can see the limitations and not move beyond them. So for example KPIs eh you can see it all about being 'Who, who' and 'How many did you see per year?' and 'What light you get into, the red one or the green one or the amber one?' and eh and I mean you can just limit yourself to then just, 'Okay how many people, new assessments did you see?' And I think those in in themselves are really limiting, you know, those KPIs and even people's idea of you know eh (pause). People's idea of what staff should do on on on teams, you know and you know you can become quite limited with that as well, and I I I think you know it's about how you don't limit yourself within those ideas, about what you're limited to do.	Be creative about being creative Limitations KPIS – how many seen, what light result Can limit yourself to new assessment for KPIs People's ideas about what staff do on MDT Also limiting Don't limit yourself	Sighs – again, weary? Tired? *Limiting, limitations* – restricted Example of direct speech: questions asked Repetition: *Limiting* *Limited* *Limit*	KPIs impacting creativity and flexibility KPIs focusing on numbers and quantity Having to respond to KPIs	KPIs as a threat to core qualities of SW The need to extend beyond KPIs
183 184	R	And when you say people's ideas about what you do on the team, do you, who are you referring to exactly?				
185 186 187 188	P	Eh I think, I think even on the team, I think you know as Linda almost said when she went out there, I think eh people's idea of what you do might be very different to your own idea of what you do.	Ideas on MDT about role can differ to own idea		Differing understandings of roles on team, lack of communication?	Contradiction in own and team understanding of role
189	R	Sure.				
190 191 192	P	Just like maybe it's different for a family's idea what you do, just like it's very different what social workers in child and family think you do.	Family's idea about role can also differ SW in CFA idea can also differ		What leads to all these different ideas, and how can they be managed?	
193	R	Okay.				
194 195 196	P	Eh so everybody has a different idea. I went out on a home visit last week and eh I clarified my role and all that they kept talking about was you know, 'We sort of, we don't want you to be kind of coming	Everybody has a different idea Recent home	Direct speech to explain this	SW in CAMHS	

197 198 199 200 201 202 203 204 205 206 207		out to us because our kid isn't going to school' so they got me confused with an EWO. Another eh, most other sessions when I mention when I'm doing an initial assessment eh here, most sessions they eh when you say 'I'm a social worker and this is the clinical nurse specialist,' they gravitate the eye-contact towards me and 'Oh'. So there's always that sense of 'Mmm social worker' you know? And then you you clarify that, you know that your role on the team is different and then you you balance it by clarifying that the clinical nurse specialist doesn't work with, you know this this and they work with their voice and they don't have. So you kind of try and kind of clarify it like that.	visit Family confused her with EWO Families surprised when she mentions she's a SW Questioning this Clarify her role as SW in CAMHS Clarify role of nurse in CAMHS	example *Gravitate the eye-contact towards me* – sense of suspicion?	seen as a threat to families? Suspicion around SW in CAMHS Differing role of SW in CAMHS as compared to differing role of Nursing in CAMHS	The need for clarification of SW role in CAMHS with families
208 209	R	What do you think they're thinking when you say social worker initially?				
210 211 212 213 214 215 216	P	Eh well they've clarified what they're thinking on on several times which is confirmed and then also disconfirmed. When I thought I was thinking or what I thought they were thinking, eh 'I'm going to take my children your your children into care.' Eh 'I'm going to bring you to Court for not eh having your child in school. I'm going to give you eh a benefit or an allowance. Eh I'm your social eh welfare officer.'	Families think SW in CAMHS as SW taking children into care, school non-attendance, social welfare		Confusion around role of SW in CAMHS	SW in CAMHS viewed as SW in TUSLA
217	R	Okay.				
218 219 220 221 222	P	Eh 'You're my social welfare officer or community welfare officer. Eh you're going to get me a house. Eh actually I've got four children and I I eh, you know I'm I'm on eh single parent's allowance. Is there any other allowances that I should get?' Eh (pause) yeah all that sort of stuff.	Families think SW in CAMHS as SW to get benefits	Direct speech and listing of ideas of SW in CAMHS	Cliché expectations of SW	SW in CAMHS viewed as social welfare
223 224	R	Okay okay. And why do you think social work as a profession has such a, I mean why do you think people think those ways?				
225 226 227 228 229	P	Things eh (pause). I think it's one of the, one of the, not the only, but I do think it's one of the, and I see, loads of people wouldn't probably say this about their own profession too. OT would probably say it as well, eh SLT would probably say it as well. Eh I think it is one of the professions that kind of like would almost pride	Other disciplines may not say it OT, SLT would say it		Comparing SW to OT and SLT	

230		themselves in being eh an eclectic mix of all sorts of ideas and	SW prides itself	*An eclectic mix of all sorts* – a variety of things		
231		approaches and philosophies and eh there would also probably,	in being an eclectic mix,		SW as a mix of all sorts	Pride in SW's eclectic mix
232		social work would also probably pride themselves in being holistic.	being holistic			
233		And that's like the social approach in that you don't limit to one	Social approach as not limiting			
234		possibility, that you look at, look and think about you know other			What's unique about SW can also lead to restrictions?	
235		opportunities and possibilities to work. And maybe that kind of is is	This can limit SW in tying SW down	*Tying it down* – being clear		Acknowledgement of disadvantages in SW's eclectic mix
236		what kind of, you know maybe limits us in terms of tying it down.				
237	R	Yeah.				
238	P	What we actually do, eh. And then the other piece I think is that				
239		predominantly, you know I did my my Masters training in social				
240		work in UL and, and predominantly the language was child	Focus on child protection in her Master		Different 'languages' (or discourses?) in different SW courses	
241		protection. Eh I think UCD would kind of talk to that and social				
242		policy would be their main piece but they talk to child protection as				
243		well. Cork I think has a kind of a, eh I I can only speak for what I	Social policy in different course			Variety of SW discourses
244		kind of understood at the time. I think they have a you know, they				
245		probably have a little bit more of a broad, you know idea of	Other course with broader focus			
246		themselves. And I think again, I think eh Galway is different. So I				
247		think you know but I think predominantly the role of social work			Child protection as dominant language in much of SW education	
248		was eh. People's idea of it is that, you know that you'd protect	Variety in course			
249		children in one form or another from their, from their parents or	People's idea of SW is protecting children			
250		from society. And I think that's just because you know. And we're				
251		still, we're quite a new profession as well and even though you				
252		know, it's not that new anymore. But it is, it's still, it's something	SW as a new profession			
253		that's evolving and changing. And these roles like primary care, as I			Changing roles of SW	
254		said, that wasn't something that was out there you know, eh from a	SW still evolving & changing	*Out there* – available, known		Evolving role of SW
255		social work point of view. Disability, we still don't have disability				
256		social workers in this area as such eh. Mmm so disability social	No SW in disability			
257		work like are, you know. They're, I think the the main staffing has				
258		been put into child and family and again because of that statutory	↑SW in child & family			
259		piece. And so mental health and things like that have been				
260		overlooked in terms of, but it's only now we're starting to get with	SW in MH overlooked			
261		the Vision for Change and all of that, that we're getting eh more			Vision for Change as a mandate for ↑SW staffing	
262		staff and then there's a stronger voice. Like when I started there was	Starting to change as a	*A stronger voice*		

263		eh me and the principal social worker and a senior social worker,	result of Vision ↑SW in MH in her department since she started	– increasingly being heard		SW having a voice in CAMHS
264		and eh now there is. And there was adults, who was like maybe one				
265		or two in adult eh and now, there's eh there's twenty-two staff.				
266	R	Wow.				
267	P	Social work staff, you know. There's still more to come in line with			Vision for Change continues to be a mandate for ↑SW staffing	
268		what they said was going to come you know with the, with the eh	More SW posts in MH to come on foot of Vision	*what they said* – who are 'they'?		
269		with the Vision for Change recommendations and whatever else, but				
270		so the things are. It's it's it's like, it's a new kind of, almost like a				
271		new position for social work.	New position for SW			
272	R	Yeah.				
273	P	And and yet there's been social work in mental health for years but				
274		it's just, I think the voice has been kind of quieter than maybe child	SW in MH for years		SW having a quiet voice in MH compared to child protection – a result of lower staffing and less focus in education?	Quieter voice of SW in MH in the past
275		protection and our you know. I think it's it's it's it's. And it has been		*Voice has been quieter* – not heard? Silenced?		
276		difficult to bring that to the position that you want it to to be, you	But voice has been quieter than other areas			
277		know, that that the difference. I'm, it is a different, and yet we do				
278		have expertise in terms of knowledge around child protection and	Difficult to bring position			
279		welfare issues cause that's part of our training.				
280	R	Yeah.	Expertise around child protection			
281	P	Eh so like that piece is still very important.				
282	R	Yeah and you mentioned, you mentioned eh you know your role and	Important			
283		what you do and people, and you were saying families and the, you				
284		said also on the team?				
285	P	Yeah.				
286	R	On the team here, that sometimes your role can be maybe=				
287	P	=Yeah I didn't answer that one=				
288	R	=Unclear is it?				
289	P	Eh yeah. I think eh again it's about, eh I think it can be about the eh	Role can be unclear on team			
300		(sighs). I think it can be about the dominance in terms of the				
301		different models and approaches. So again the medical model gets		*Dominance* – power, authority	Power of medical model in MH	
302		eh you know, and has eh politically got a lot of eh eh you know, has	Dominance of models & approaches			Power in MH
303		been the ((the attention)) in terms of mental health and I think for				
304		legislative reasons and risk reasons and everything else, the	Medical model as the main		Attributing this to risk and legal issues	Power of medical model
305		psychiatrist is the kind of seen as the, you know, and even even with	Risk and			

306		the Mental Health Act, the psychiatrist is the referring person even	legislation		Visibility of psychiatrist compared to rest of MDT	
307		though there’s a team behind. So the whole clinical governance	Psychiatry makes referrals			
308		thing and everything else. So there’s that, there’s that piece about				
309		you know, the medical model being quite strong eh and yet there’s	Psychiatry with clinical governance	*Lip-service* – talked about but doesn’t happen		
310		kind of lip service paid to a multi-disciplinary team approach in all			MDT approach not real, only in writing	False impression of MDT in MH
311		the documents that we read but there hasn’t been a flattening out of	Lip-service to MDT	*Flattening out* – not equal		
312		the hierarchy on the ground eh. And so eh it’s it’s eh it’s (pause).				
313		What was the, what was the, bring me back to the question for a	Hierarchy on ground has not flattened	*Hierarchy* – order of merit?	Hierarchy is still present	Hierarchy needing to change
314		second?				
315	R	No I just saying you mentioned something about the team and your				
316		role?				
317	P	And not knowing your role, yes. Eh so so I think sometimes it’s				
318		about like you know I I eh social work or other roles outside of the			MDT as unknown to psychiatry	
319		medical model might be seen as you know, ‘I don’t know what you	SW role outside medical model			
320		do because it’s it’s alien to me, I’ve not worked’. Cause I think	Not known	*Alien* – foreign, unknown	Origins of current MDT as psychiatry and nursing	SW as alien to others in CAMHS
321		initially this team started with a nurse, nurse and a, and a	MDT: nursing and psychiatry at start			
322		psychiatrist.				
323	R	Sure.				
324	P	Eh on a ward.	MDT on ward at start			
325	R	Yeah.				
326	P	Eh so ‘I it’s it’s alien, I don’t really get that.’ So and ‘All these new		Direct (hypothetical) speech from others		
327		social workers coming in who, well what will we do with these	Questions about SW on team		Introduction of other disciplines in MDT as unknown, baffling to psychiatry?	
328		ones? What good are they on a mental health team?’ Eh ‘What what				
329		would they do? What would they have to offer?’ And then, and then	What do SW do?			The questioning of the value of SW in CAMHS
330		even how you get your voice, like that idea of ‘one person, one vote’		*One person, one vote* – equality, representation		
331		doesn’t always stand through when you’re kind of talking about	‘One person one vote’ doesn’t stand			
332		maybe a case formulation and you try to bring in the social idea, the			Power in MDT	
333		social work ideas around you know, the possibilities that have been	Try bring in social idea			Lack of equality on MDT in CAMHS
334		over-looked. And it’s it’s I suppose it’s that kind of like you know,				
335		just maybe the dominance and the the the the difficulties to get that	Dominance on MDT		Not being able to be heard, have a say	
336		kind of view or that perspective eh in. And I suppose we’re new in				
337		lots of ways on this team and eh we’re also, so I think we’re also	Difficulties getting views in			
338		seen as eh. Like we see complex cases and it could take, I say	New on this		Trying to make sense of the reasons	Dominance, power in MDT

339		complex case; whatever that means, and it could take maybe one	team		for this	
340		hour for a tiny piece of work.	See complex			
341	R	Yeah.	cases			
342	P	Whereas the nurse might see eight people in in in fifteen minutes to	Work takes time			
343		do height and weight at an ADHD clinic. So your stats as a nurse eh,	Nurse can see 8		SW apts/work	
344		so it would be the same for like GP you know, somebody doing a	people quickly	Clicks fingers,	compared to	
345		mental state you know 'Quick [clicks fingers] fire buzzer round' and	Nurse like a GP	*fire-buzzer round*	Nursing apts/work	CAMHS as a
346		you know 'Okay I've got enough out of you, now leave'. So it's like	Fire-buzzer	– ridicule?		numbers game
347		that deductive way of working and you know 'That's a very quick,	round Deductive way	anger? *Deductive* – top		
348		you know, that's a very quick case'. So your stats are, so a nurse is	of working	down approach	Medical model as	
349		seen as being more useful or or a reg or whatever cause you you	Cases as quick		deductive	
350		meet the KPIs, but a social worker? 'What is it that that woolly stuff	Stats of nurse	*Woolly stuff* –		Being valued on
351		that they do? And they take an hour, so they really only see four	and reg seen as	ambiguous		MDT according to
352		people a day.' But between you know, so there's there's that kind of	more useful, meet KPIs		Being seen to be useful on MDT,	KPIs
353		I think, there's there's also a kind of a cop out, a bit eh 'I don't want	Cop-out	*A cop out* – an	judgement by	
354		to know what you do because if I had to actually step outside of my	Others don't	excuse	colleagues?	
355		kind of medical ways of add addressing the world, that would kind	want to know			
356		of leave me quite vulnerable and my power would be quite	role of SW,		Psychiatry and	MDT as threatening
357		vulnerable as well'. Eh so I think there's that kind of, that the good-	outside of medical model	Commenting on	nursing not interested in MDT?	to psychiatry & nursing
358		will isn't there. Am I, I'm probably speaking very controversially?	Lack of good-	her expression		
359	R	No no no no. There's, yeah.	will			
360	P	Eh but also I think, not to be passive about it. I think you know we	Speaking			
361		probably didn't do a huge amount of work initially on ourselves in	controversially			
362		terms of understanding what we do in in this, in this job. And so we	Didn't do much			
363		just turned into mini-regs and mini-nurses and mini-whatever until	work on own	*Mini-regs*	Mirroring of	
364		we got some sense of where we might fit. So I think there's a there's	understanding	*Mini-nurses*	nursing and doctors	
365		a growth going on there as well for ourselves and we've stepped up	Turned into	*Mini-whatever*	to try fit into MDT	Attempts to fit into
366		to that. And we've kind of you know did some key documents that	mini-regs and	- descriptive,		MDT
367		describe who we are to ourselves so as we can work at that level	mini-nurses	trying to copy		
368		first, in terms of conforming, eh having some common ground for	Growth Key documents	others		
369		all the social workers on the team, as to what is it you do on this		*Conforming* –	Strength in SW	
370		team eh.	Common	being the same	unity & numbers	Attempts to
371	R	At the start, you said you were mini-regs mini-nurses. What, what	ground for all SW on teams			establish role on MDT

372		do you mean by that, you were?				
373	P	So you just, you just so you you you were dictated to by the by the		*Dictated to* – ordered, imposed		
374		Consultant and then they would say 'Do a do a mental state' and	Dictated to by Consultant		Power of psychiatry	
375		you're like (whispers) 'Is that what I meant to do on CAMHS? Is		Whispers to signify weakness and lack of a voice		Psychiatry having authority in CAMHS
376		that what is okay? Well if that's what I'm meant to do…' And this	Questioning what meant to do		Being quietened by psychiatry	
377		was before registration came in which makes a big difference as				
378		well, the CORU registration has really shifted things but eh. Yeah so				
379		you'd, cause you'd no leg to stand on otherwise almost, so you just	Before CORU Registration has shifted things	*No leg to stand on* – not able to justify action		
380		eh. Yeah you just 'Was that what I'm meant to do? Oh' and because				
381		of that dominance, it's like you almost get into child-mode, child-	No leg to stand on otherwise			
382		and parent-mode where (whispers) 'I'll just do what I'm told,' you			Following direction of psychiatry as not able to challenge it	Being weakened by power of psychiatry
383		know. And and you didn't, there was, the leadership wasn't there or	Dominance	Whispers again		
384		it wasn't respected if it was, or 'Who are you?' and it was all, it all	Child-parent mode			
385		happened too fix too quick for people I think, you know. Maybe	Do what you're told			
386		they didn't believe it was going to happen anyway eh.			Change on MDT was too quick for some	
387	R	And how did CORU change all that?	Happened too quick			
388	P	Eh (pause) yeah. CORU eh gave us a legal eh and an ethical eh				
389		position and you know, I think you eh you can have those. I know				
390		when I came in, I have a very strong and I really think that's this	CORU: legal and ethical position		CORU as a way to respond to direction of psychiatry	CORU as standing up to power of psychiatry
391		what was, that I have a very strong ethical eh understanding in				
392		relation to how I work. So when I'm told to do an MSE, I I sit in a				
393		room and I think at the beginning (sighs) 'This isn't how I work. So	Strong ethical understanding about work			
394		I don't know, this doesn't feel that right, I feel.' So you think about		Sighs twice here	Trusting her gut feeling	
395		self-determination, you go back to your core values and you think.	Being told to do MSE – doesn't feel right			Reflective practice as a way to stand up to power of psychiatry
396		(sighs) So you you had that you know that sense of '<u>Mmm</u>' all of		*Mmm* – questioning self, unsure		
397		the time and then then you had to try come up against 'That's not				
398		something that I'm prepared to do'. And then it's like that fight then	Core values			
399		that comes with 'You will do it, you will do it' and we had no	Fight	*Come up against* – an opposing pressure	A struggle to resist psychiatry	
400		supervisor that was, we weren't, we were seen as being supervised	Being told to do it			
401		by the Consultants at the time and that that was their job to manage				
402		us. And without CORU, even though we had our own ideas and	No supervisor			Negotiating the power of psychiatry
403		IASW ethics and all of this, and our our I suppose our our training,	Consultant as manager			
404		that you know, our voice was weakened by you know, I think more	Own ideas and	Language of power:		

405		dominant and more power powerful positions. And so we could	IASW ethics	*More dominant*		
406		have got supervision but it would have been, a lot of it would have	Voice was weakened	*More powerful*	Power of psychiatry would have been stronger than SW supervision	
407		been over-ridden by you know 'No this is what we say happens.' So	Dominant &	*Over-ridden*		
408		you were, lots of things might have happened around that. So with	powerful positions			
409		CORU now we have supervision and that's by law you know,				CORU as the start of a journey to a stronger voice
410		supervision is within in it and it's eh we've dominate, we've got a	Being over-ridden			
411		super supervision policy from that.				
412	R	And that's with your line manager social worker?	CORU has supervision policy			
413	P	We made that yes eh. And then you know as part of our ethics, we				
414		we we have to, you know in terms of the regulation, you have to be			Legal implications of CORU	
415		very careful about the work that you you know, agree and whether				
416		that's within your code of ethics and so you're not kind of going	Regulation: careful about work & code of ethics			CORU as a mandate for ethical practice
417		(sighs) 'Sure I have to, they're making me'. So you're less passive		Pair of contrasting descriptions: *less passive, more proactive*		
418		and more proactive in the way that you work. And it's also you can			Referring to CORU regulations in response to psychiatry	
419		talk back to the dominance with 'Well actually by law…' and it's	Be less passive and more proactive			
420		just like, that's almost the voice that gets heard the most in the HSE				
421		in terms of risk and and eh law.				
422	R	And is it working?	What's by law			
423	P	Absolutely.	Voice of risk/law gets heard in HSE			
424	R	Is it a year CORU has come in, a year now?				
425	P	Yes, just a year to register by. It's that and it's also like our our line				
426		manager position changed, eh so she has really you know eh brought			Impact of line manager on her SW practice in CAMHS	
427		a lot of efficiency to social work and brought some of those gaps	Change in line manager position			
428		and identified needs for social work, in terms of how we can				Role of line manager
429		actually do our jobs on CAMHS eh teams into. So we've we've got	Efficiency in SW	*Talking from the same hymn sheet* – all in agreement		
430		our own policies and procedures and we're all kinda talking from			Importance of consistency amongst SW	
431		the same hymn sheet and we have eh more of a sense of ourselves.	Address gaps and needs			
432		So she's done a lot of work on that with us in terms of continued	Own policies and procedures			
433		professional development and what our role is and we've set up a				Establishing professional identity of SW
434		key document that says what we do for everybody on the team you	Sense of selves			
435		know, so the social workers. And then leaflets have been designed	Work done on CPD		Documents and leaflets re SW practice – written communication	
436		'What do social workers do?' and when you've initial contact with				
437		eh somebody now, we're thinking of the consent policy because	Key document re role on team			

438		we've talked at it at team, at social work team meetings and the	Leaflets re SW			
439		consent policy is real, it's a legal document. It's it's eh, it's eh it's	Considering consent policy			
440		you know. It's an important thing to, so everybody is clear and			Pressure on MDT affecting quality of practice	
441		aware and bad practices won't continue because somebody else here	Consent policy as legal document, important	*Twisting your arm* – being coerced into it, with pressure		
442		kind of twisting your your arm into, or 'You have to' or else you'll				
443		be shunned off the team or you know. All this sort of stuff, yeah.				
444	R	Yeah yeah. And eh I know from other interviews I've done as well,	Bad practice can continue otherwise	*Shunned off the team* – ignored?		Resisting the pressure in MDT
445		this is a very similar idea that people, you know this idea of eh				
446		almost being in in a fight or in a battle on with your colleagues?			Change in being assertive> passive	
447	P	Yeah yeah and there is. And I I think it's important that you know.				
448		(sighs) Like I I do take the position of assertiveness around that				
449		now, whereas I wouldn't have before.				
450	R	Mmm.	Take a position of assertiveness now			Developing assertiveness on MDT
451	P	Eh I would have kind of felt very like eh you know. I would have		*Under the power* – power can be overwhelming	Learning how to respond to power over time	
452		probably eh went under the power of it, you know as opposed to				
453		kind of, you know or else met the power without any power eh	Went under the power before			
454		which had its own implications. So now I kind of think 'Okay,' you				
455		know. I don't take a passive position on anything else so I kinda	Met the power without any power		Developing strategies	
456		think you know I'm not getting, I I I don't think about it, the battle				Negotiating and responding to power on MDT
457		anymore. I think more about you know 'Okay come back, what	Don't think about battle anymore			
458		are?' and I just always come back then.				
459	R	Okay.				
460	P	And actually the code of ethics has kind of brought me there, where		Lots of examples of quoting herself and her sense-making	Documents are important to her? Something in writing is more definite, clearer?	
461		I kinda of come back to that and I say 'Right, well what are my core	Come back to?			
462		values? What are my core ethics?' And in the document that we did	Code of ethics			
463		on the social work role, that was like, 'Okay, what is it that eh, what				
464		is our position? Let's remember what is it, our position' and so I	SW document			
465		don't get into that because I appreciate other people have different	Consider position again			SW as a position
466		ideas.	Others have different ideas			
467	R	Mmm mmm				
468	P	And I think that's the most important thing that I don't, I. I suppose			She has a responsibility to have her voice heard?	
469		I could sit here and say I don't get heard and I don't have the voice				
470		and I don't, they don't understand. But that kind of, that also goes	Could sit here			

471		both ways in that I have to understand what other voices mean or	and say she's not heard			Taking action to have a stronger voice
472		what they might mean to them and that. So I don't get into that				
473		monologue idea or that dictatorial kind of 'My voice is better than	Works both ways, she needs to understand others' voices	*Monologue idea* – only concerned with self, speaking at length		
474		your voice' kind of stuff. So like that's open, I suppose because of			Importance to be open-minded about others' roles on MDT	
475		my experiences, opened up how I relate to other people on the team				
476		as well and what their experiences are, their, what their position is				
477		and I think that puts you in a way better position not to battle and	Relating to others on MDT and their position			
478		not to struggle and not to try and 'My voice, my voice, listen to me.'				Making sense of MDT
479		That it's like 'We are a multi-disciplinary team, we all have voices		Again, quoting herself and some hypothetical speech here		
480		and they're all of value and that's why we are a multi-disciplinary	Not to battle and struggle		Reflecting on MDT and value of all roles	
481		team for children who are attending here'. That is just, that's seen as				
482		the best way forward that we're and that we're balanced out and that	MDT: all have voices, all of value			
483		we kind of all 'one person one voice'. I keep saying it, eh that we all				
484		have eh an input into into how somebody is care-planned for or	One person, one voice			
485		cared for on this team.				
486	R	Mmm mmm.	All have input into care-planning			
487	P	So and I think that's taken me out of that struggle for voice where I		*A victim* – a target, suffering?		
488		feel 'Oh I'm such a victim' you know? So I kind of think 'Look,			Taking action> being a victim	
489		what what experiences did I have and what what responsibility have				
490		I here as well?' Like we would have done a huge amount of work on	Taken out of struggle			
491		all the, all the key documents, the recovery pieces, the like. We we,	No longer feel like a victim			A responsibility to have a voice on MDT
492		our principal social worker would have brought us to the team	Did work on key documents			
493		working document, brought us through all the eh important policies				
494		and that. CPD, CPD stuff has been hugely influential on then how			Presenting self to the team	
495		we present ourselves on the team and eh as less of a victim and more	CPD has been influential			
496		of a 'Let's see what we can do to improve ourselves so as we can	Less victim, more what can we do to improve			
497		improve the service so as the children and families can get a better				A quest for improvement in SW
498		service'.				
499	R	Mmm so it's it's kind of eh, it's been a mix of kind of maybe your				
500		own experiences eh having other colleagues social work colleagues				
501		eh a good principal worker and then this I suppose other documents				
502		that are available?				
503	P	Yeah absolutely.				

504	R	It gives you a bit of confidence maybe?				
505	P	It does it gives you something to come from, yeah.			Need to have ways to respond to power	
506	R	Yeah.				
507	P	It's, it's almost like that power tool.	Something to come from	*Power tool* – something to have, to hold onto Symbolic image		
508	R	Yeah yeah.				Being equipped to respond to power on MDT
509	P	It is a bit like the power tool because you know there's the, other	Power tool			
510		people have power tools of their own.				
511	R	Exactly yeah.	Others have own power tools			
512	P	And without the power tool, it's it's really, I I feel like you don't				
513		have=				
514	R	=Yeah.				
515	P	You know, and what do you talk to? Only you hold your own and				
516		you know…				
517	R	Yeah and who else is on your team here then, you have?				
518	P	Eh okay. So eh we have, we have one OT, we've one and half SLT.				
519		Eh we have three eh whole time clinical nurse specialists. Eh we	OT, SLT, clinical nurse specialists, psychologist, social care, admin, SW on team			
520		have eh, one of those is a is a family therapist as well but that's,				
521		she's not employed as a family therapist. Eh we have eh one eh				
522		whole time psychologist. Eh we have two admin staff, we have one				Make-up of MDT
523		social care worker. Eh we have eh three eh social workers, one just				
524		newly started eh and one on maternity leave. And then our principal				
525		is for all Acorn, Laurel, Oakview, Sandford adult, child and older				
526		age	Nurse also qualified in family therapy			
527	R	Ah okay.				
528	P	Yeah, mental health.				
529	R	And then one Consultant is it?				
530	P	Eh two Consultants.				
531	R	Oh two Consultants here as well, so it's kinda like two teams is it?	Consultants X2			
532	P	Yeah and two regs. Eh well no and actually that's very interesting				
533		that you just said that.				
534	R	Oh okay.				
535	P	But that's the idea that people think, that eh and I think that's where				
536		changes are going to come.				

537	R	Okay.	Changes to come		Will this split be welcomed?	
538	P	Eh so there'll probably be eh an eventual split of the teams but no		*Split* – a division		
539		we're seen as all of Acorn, all of Laurel, a multidisciplinary team:				
540		one.				
541	R	Yeah.	Probable split of team			
542	P	One but there's=				
543	R	=And are you always here or?				
544	P	Well there's a satellite clinic in Sandford and a satellite clinic in		*Satellite clinic* – a separate, smaller one		
545		Oakview as well.	Satellite clinics			
546	R	Ah yeah, yeah.				
547	P	Yeah, yeah and here is the base.				
548	R	Here is the base yeah, so you probably have a big catch catchment				
549		area, yeah?	Base			
550	P	Yeah, oh it's huge. I don't know exactly what the population is but			Visibility and appearance of team, gives misleading picture	
551		it's like, it's. And I think that's that's a major issue in terms of	Huge population in catchment area			
552		staffing and because we're all grouped in together, we don't look				Insufficient staffing on MDT
553		like we're under-resourced.				
554	R	Mmm.	Don't look under-resourced			
555	P	Cause we're really only seen nationally as one team.				
556	R	Mmm.	Seen as one team			
557	P	But I think if we were grouped, like we're down two psychologists		*We're down* – missing in action		
558		in terms of Vision for Change and we're down like eh one,				
559		absolutely one at least OT, one at least SLT, eh yeah, so yeah.	Down on staffing as per Vision for Change			
560	R	Yeah yeah. And you mentioned eh you were a social care worker				
561		initially was it?				
562	P	Yeah yeah.				
563	R	Okay, for the first few years?				
564	P	I did eh I did social care in SIT and I was working for seven years as			Transition from social care to social work	
565		a social care worker, mostly in disabilities, a little bit in elder care as	Studied social care initially			
566		well. And eh then I went back to UCM in 2005 to do my Masters.				
567		Eh I did that in two years.	Worked in disability			
568	R	And was that always the plan, to do social work or what was it that?				
569	P	Eh (pause). Yeah I think what happened was eh education is, I like it	Back to do SW Masters		Further education as	

570		eh but I think one of the things, eh again it's it's probably similar to			a means to overcome restrictions and limitations as a social care worker	
571		my experience here is around that kind of, you know, what you can.	Like education	Language of being confined: *Limitations* *Restrictions* *Limited* *Restricted*		
572		The limitations to what you can do eh and the restrictions that are				Further education as a means to an end
573		sometimes put in because of maybe how you're seen by other				
574		people, in terms of the work that you do eh. And so yeah, I kind of	Limitation and restrictions on what you can do			
575		felt a little bit limited and restricted in, as I got to a stage in social				
576		care and I I I wanted to get into, eh more possible work eh.	Got to stage in social care, wanted to do more			A quest for 'more'
577	R	Yeah yeah.			Comparison between SW and social care	
578	P	And I couldn't do that. So I I I always wanted, like I had that kind of				
579		social care, social work. I always wanted to stay within that. They're				
580		very different and yet some of the same values.	Social care & SW: very different, some shared values			
581	R	Yeah.				
582	P	And so yeah I I went back and did that and when I got here, I eh		Quoting herself and her decision-making around FT	Family therapy in response to role of SW in CAMHS	
583		worked for a few years and again eh. 'How how is social work seen				
584		on the team, and then what might be useful, and for me and for my	SW on team here			
585		work and the clients and the team, and how might I eh (pause) bring				
586		it on a little?' And then I went and did the Masters in family	Questioning how to bring it on			Family therapy as extending her role in CAMHS
587		therapy, yeah.				
588	R	Okay so you're three quarters of the way.	Masters in family therapy			
589	P	I have one more year to go.				
590	R	And has that met your, you know?				
591	P	Expectations?				
592	R	Yeah, yeah.				
593	P	Eh…				
594	R	In terms of wanting to bring it on and?				
595	P	Yeah it has. It has in lots of ways and I think I probably when I'm		*Stand more ground* – maintain her position, ideas	Family therapy as another 'power-tool'?	
596		finished, will stand a little bit more ground here.	Stand some more ground here when finished			
597	R	Yeah.				Family therapy as strengthening her voice on MDT
598	P	Yeah which is quite sad in some ways and that's probably for		*Quite sad* – sense of regret here?		
599		another, another thesis. But in other ways I feel very very eh true to			Sadness about impact of having FT Masters	
600		my social work role and that's what I'm employed as you know?	Sad in some ways			
601		And I think it can it can only add to that, it will inform that eh and	Feel true to SW role		FT complimenting SW, not	
602		eh. Yeah it's definitely added to the value of work that I I deliver to		*Deliver* – work		Identity as SW &

603		eh children with mental health difficulties, cause particularly the	Add to that role Add to value Focus on MH	as something being given to others	substituting it?	Family Therapist
604		focus is quite on, you know mental health. Like I did it in				
605		Bridgevale CAMHS and Bridgevale family therapy department and				
606		like we take most of our referrals from CAMHS. So it's certainly				
607		informed and you know, that's been hugely beneficial. And even in		Use of quantifiers: *Huge* *So much more*		
608		the work like you could just, like some of the approaches you know	Hugely beneficial Approaches she takes are more informed by FT		Impact of FT on her SW role	
609		that I take are just, you know so eh much more informed than they				
610		would have been without the course.				Family therapy as informing SW practice
611	R	Sure.				
612	P	Cause I think I would have kind of, probably got the bones of some				
613		of the work in UL, even though there was a mental health module				
614		but I still, even working directly with children, you got the bones of	Had bones of work from Masters FT course has helped to flesh it out Also experience of being on team longer	*The bones of* - an outline, the main parts	FT & experience on team extending earlier skills	
615		the thing and the bones of the work. But this kind of really has				
616		helped to, to flesh flesh that out. Eh and the experience as well of				
617		being on the team a little longer and being a little kind of clearer				
618		about what I do and that, yeah.				Experience leading to ↑clarity in role
619	R	And can I ask you why you might be sad or you mentioned				
620		something about?				
621	P	Eh to think that. Yeah cause I I (sighs). My colleagues as well				
622		would eh have started on the team, and and even here a colleague		Monitoring what she is saying and checking with me, seeking permission to continue?	Comparing herself to colleagues	
623		has started on the team and she has like two other qualifications.				
624		One in, I I. Again I I don't know whether this is okay and this is all	Colleagues recently started on team, has other qualifications			
625		mine?				
626	R	Yeah, yeah.				
627	P	But eh and hopefully it will be useful eh to you. Like something in				
628		psycho-something something, you know? Psycho-something and		*Psycho-something*: made up term, ridicule?		
629		psycho-something stands weight to people here, psycho-something				
630		so eh…	Qualifications in psycho-something		Value placed on extra training in psychological therapies	Perceived value of further training on MDT
631	R	It stands?				
632	P	Weight, it bears weight.		Emphasizing this point		
633	R	Oh I beg your pardon.				
634	P	Eh so yeah, it saddens me because I just feel like you know that	Has weight			
635		social work should have. Like what is it about social work that			SW not enough, not	

636		hasn't got the value on its own you know?	Why can't SW		values on its own	SW in isolation as
637	R	Okay.	not have values			insufficient
638	P	Like you know, what is it that? So like eh you know for example a	on his own?			
639		nurse or a psychiatrist can come in here with their title and you				
640		know there's not the same, you know (sighs) level of retraining you	Nurse and		Comparison	
641		know? Cause it's, cause they do psychiatric nursing but for social	psychiatrist		between further	
642		work, I think again it's around that general term. But like, that's the	don't have same		training in SW and	
643		value, that's the best thing about social work. And then we try and	level of retraining		other disciplines	A quest for SW to
644		pare it down, by you know cause we don't fit. So then when we	SW as general	Repetition and		fit on MDT
645		don't fit, how are we going to fit? So we put a psycho-something	Best thing about	emphasis on *fit*	SW not fitting on	
646		before our name or after our name, you know? And then, then	it		MDT	
647		people might appreciate. So when this new person came in, eh they	But pare it	Direct		
648		didn't hear the social work bit cause it was like 'Oh Jesus, what are	down because SW doesn't fit	(hypothetical) speech to explain		Further training as an attempt to fit on
649		we going to do with another social worker? We're going to have to	How to fit?	team's response	Response to SW	MDT
650		see more people' but then when they heard she had psycho-	Psycho-	to new colleague	with further	
651		somewhere; you know what I mean by psycho-?	something		qualification vs SW	
652	R	Psychoanalysis yeah, yeah I probably do know.	New SW on		without	
653	P	Psychoanalysis, psychodrama, whatever. Eh and CPD, C continuous	team – need to			
654		eh not continuous, eh cognitive behavioural therapy, eh two other	see more people			
655		qualifications.	Psychoanalysis			
656	R	Yeah, yeah.	CBT			
657	P	'Oh now we're interested' you know? So that saddens me because I				
658		think where have we, you know? It's lost. Where, where has the role	Interest when	*Lost* – gone	SW is lost	
659		eh you know, where do we have to get to? Where do we have to go	SW has other			
660		to? You even if you go to the IASW website, the way we define our	qualifications			Loss of SW identity
661		role talks to that kind of 'Oh but we're, it's more of a therapeutic'.	Loss of SW role			on MDT in
662		So like yes, we can we have therapeutic skills and yes, we can use				CAMHS
663		them but we don't have to sexy it up by saying you know 'Oh well	IASW: therapeutic role	*Sexy it up* – make it look more	SW trying to change their role?	
664		we're trained in'. Because if you look at the website, we're trained	of SW	attractive		
665		in oh family therapy and C C eh…	Don't have to			
666	R	CBT?	sexy it up with			
667	P	CBT and this, and this. So and it names that there and again I feel	extra training			
668		like, it's like you know. Eh what's our core bit? Don't forget the				

669		core bit, that's the value. That's the real value for me and I feel that,	Where is core SW?		Value of SW is in its core, not any extra training	
670		that's what saddens me. I think 'Where, where is it all? (laughs)	Core SW has value	Repetition of *Where is it?*		Loss of value in SW role
671		Where is it, where is it?' It got lost.		Repetition of *lost*		
672	R	And is it that you feel this new clinician will end up doing, working	Saddens her			
673		more as a pscyho-whatever and as a CBT as, yeah?	Core SW lost			Sadness at loss in value of SW role
674	P	Yeah and, and being seen to be useful because of that, as opposed to				
675		be because of her social work roots, and…	Useful because of other qualifications, not as SW		Need to be seen as useful on MDT	
676	R	Okay and again be seen to be useful, is it be, by psychiatry, is that?				
677	P	Yeah and maybe even other team members as well, yeah. I don't				
678		think, I don't think it's just psychiatry eh. Yeah I, I think. Yeah				
679		somebody walked in the other day and said 'Oh social workers' and	Not just psychiatry with this view		Role of SW misunderstood amongst all of MDT, not only psychiatry	
680		this was another team member, eh. 'Oh social workers, eh a Mother		Direct speech to explain her point		
681		wants her like domiciliary care allowance.' Eh you know and you				Role of SW as understood by MDT
682		know, that's that's an OT who came in. Eh (sighs) yeah, eh nurses	Team member recently asking SW about care allowance			
683		would, would be delighted, 'Like I can't, I can't,' you know. They				
684		would, they would not do that type of work, so anyone with			Nursing not feeling able to do therapeutic work with children and families?	
685		cognitive behavioural therapy you know, eh 'Give it to them,' you	Nurses don't want to do some types of work			
686		know? And not like. Yeah, not just psychiatrists, no I think.				
687	R	And when you have your qualification in eh family therapy=				
688	P	=Yeah.				
689	R	Is it that you see then getting all these referrals for family therapy, is				
690		it?				
691	P	Eh like it's interesting what happens here, you'll talk to Emma				
692		herself and she'll talk to you about it, but yeah. I think it would be	Need to manage her work and role when finished FT course, still working as SW		Employed as a SW, not a FT	
693		kind of, eh yeah. I think yeah and, and I need to, I will need to				
694		manage that because I will be. Eh I am employed as a social worker.				Identity as SW
695	R	Yes.				
696	P	But I will be informed eh hugely by my family therapy and I will, I			Planning to balance SW and FT	
697		will be taking social work referrals.				Potential difficulty in managing SW/FT referrals
698	R	Yes.	Will be hugely informed by FT			
699	P	Eh and in my. But I mean, I'll think more about that as I go along.				
700	R	It's kind of, eh I suppose it's eh (pause). It's almost like eh maybe, I				
701		don't know. Eh like you you wanted to do the extra family therapy	For further thought			

702		because you said you wanted to bring something on, do something,				
703		but yet in some ways by doing that, you'll have to almost work				
704		harder to keep=				
705	P	=To own your bit, absolutely.				
706	R	Mmm.				
707	P	But, but I think, I think actually depending on how you look at it and				
708		how you behave within it, eh. That's going to be the most important	Will depend on how she looks at it & how she behaves		Balancing SW & FT is mainly down to her?	
709		thing. So like I I've, I think this informs my, and compliments my,				Sense of agency in establishing professional identity
710		eh social work practice.				
711	R	Yeah.	FT informs & compliments			
712	P	And it's it's all about what people, how people view it, eh you				
713		know, what you do. And once you know what you do and what you				
714		contribute, that's a very important thing how you describe it to other	All about how people view it			
715		people, you know. I think people are going to hear you know from	Know what you do & what you contribute		Others will follow her lead on SW & FT, learn by doing	
716		maybe the experience of working with you, as opposed from what				
717		you say you do.				
718	R	Yeah.	People will hear from experience			
719	P	And how do you actually language it. Like it's a very difficult thing		*Language* as a verb		
720		to tie down, what you actually do as a social worker because there is		*To tie down* – to be certain about	How roles are talked about is important	
721		loads of bits you do.	Also about how you language it			SW as hard to define
722	R	Yeah.				
723	P	So you know, that's the whole (sighs). That's the whole difficulty I				
724		think, you know. So like I think sometimes it's about like somebody			Others on team learning about each other by 'doing'	
725		learning what you do, from the experience of being with you but the	People learning from what you do, the experience of being with you			Identity of SW as established through 'doing'
726		the family therapy thing will certainly add to it, and I think it's		*Credibility* – the integrity, value of SW?		
727		probably added to the credibility of social work on the team, yeah.				
728		Yeah.			SW is not as credible on its own?	
729	R	Okay. And I I've spoken to a few social workers, a lot of social	FT adding to credibility of SW			
730		workers they do seem to have an extra=				
731	P	=Qualification.				
732	R	Like you said, either CBT or family therapy or mainly those two				
733		actually so far, yeah.				
734	P	Yeah and I wonder about, I wonder about even going back. I think at				

735		the time, I wonder now if I had had more experience and felt less			Reflecting on her decision to do FT course	
736		powerless and more clear about myself and what I did, and more,	Wonder about decision to do FT, would she make same decision with experience and confidence now?			
737		more eh. Like I'd a little bit more, eh what's the word? Eh				Making sense of her decision to do FT
738		confidence in what I do, would I have went back, you know?				
739		Because family therapy wasn't always, like I I worked with families,				
740		like that's what I, that's what social work, you know do well.				
741		Obviously family therapists do it in a different way but eh like I			Working with families vs family therapy	
742		work brilliantly with with, social work with eh families, I work with				
743		with. I don't see the client as just the person who comes in the door	Always worked with families			
744		with the, with the referral letter from the GP. I see a client as that	Work brilliantly in this way			Child/adolescent as part of a wider system
745		person, their family, their neighbours, their school, their church,				
746		their, you know. And that's who I see my client as. So I would have				
747		done that work very well. But I wonder looking back now if I, if I	Client as family, community		Decision to do FT course was made in the pursuit of confidence?	
748		had the confidence that I I have now, would I have went back to do				
749		it, or would I have the confidence now that I have, if I didn't go	Wonders about decision to do FT, and effect on confidence			
750		back to do it? So you know, it's…				
751	R	Yeah yeah yeah. It could have worked both ways.				
752	P	So it's all of those bits, exactly. I think, I think I've a very strong				
753		sense of social work though and I I sort of feel like it eh you know.		Repetition of FT *informs* SW	FT informs SW, does not replace it	
754		This just adds to it and informs, informs it as well yeah.	Strong sense of SW			Making sense of being a FT and a SW
755	R	Yeah and do you do a lot of work eh in terms of your sessions,				
756		would they be on your own or with the other professions or?	FT adds to it and informs it			
757	P	Eh both. Like we do our initial assessments with a different, it's				
758		called a multi-disciplinary team assessment. So we do one social				
759		work, one nurse, one nurse, one psychologist, one. So it mixes				
760		mixes up and then you consult with the Consultant eh and with the	MDT assessments		Joint assessments and joint therapeutic work in MDT	
761		family as well eh. And then if I was doing joint pieces of work, it				
762		might be like something that might complement. So if there was a	Joint pieces of work as complementing each other			Nature of MDT tasks and joint-working
763		child with an eating disorder, I might kind of do some joint pieces of				
764		work with the psychologist cause I'd have that more systemic lens				
765		around broadening it out, whereas she would have the gorgeous		*Gorgeous* – choice of adjective to describe work		
766		skills of being able to kind of look at that kind of core belief stuff				
767		with the little one, or even with the parents. And we'd we'd	e.g. eating disorder			

768		complement each other well eh or we might do joint work without				
769		being in the room together. So I might take, I might take eh a chance		*Take a chance* –		
770		at working with the siblings you know, just to try and strengthen	Joint work without being in	risk involved, the		
771		that that group and maybe eh eh look at conflict stuff with the	the same room	unknown		
771		parents, depending on what the issue was. And then the somebody				
772		else would work with an individual and then we'd come together	Then come			
773		and review, and all that sort of stuff. So yeah it depends, it can be	together and			
774		both and actually we do get a lot of variety.	review It depends,			
775	R	Yeah.	Variety of cases	*Fabulous* –		
776	P	Which is fabulous. And eh the the the the team complement each		choice of		
777		other. When we work well, we <u>really</u> complement each other. Like		adjective,	MDT works well	
778		when we work really, when we, when we work well together, we	Fabulous work	extraordinary	together despite talk	
779		actually get down to the bones of it and just do it, you know? When	Team complement	Emphasis on	about roles and	MDT complements
780		we get into debates about what we do and who's bit is this bit; that's	each other	*really* – the truth	ownership of work	each other
781		what I kind of mean about maybe when you get down and do it.	Can work really	*Get down to it*		
782	R	Like the team meetings almost, but then the actual setting?	well together	*Get down and do*		
783	P	The actual doing is excellent. It's just that that kind of like tension	Less getting into	*it* – less talk, the		
784		that comes with power and you know, boundaries and role	debates	action?	Tension around	
785		confusion and all that stuff that kind of blurs it a bit, but yeah.	The 'doing' is	*Tension* – strain	roles can distort the	Power/tension can
786	R	Did ye, did that take you by surprise when you started?	excellent	on the team	work being done	affect MDT
787	P	No no that was, that's everywhere though.	Tension can			functioning
788	R	It's everywhere?	blur it			
789	P	On any MDT, yeah I think it is. I think in mental health maybe a			MDT working in	
790		little bit more because of its roots. I think its its roots have been		*Roots* – where	CAMHS as similar to other settings	Historical
791		more like, the whole roots of it has been in the medical or the idea	On all MDTs	MH has grown		construction of MH
792		that this is an exact science.	More in MH	from	History of MH in	
793	R	Mmm.	because of root		medical model	
794	P	Well of course it's not, eh and. But yet its roots and the whole DSM	in medical			
795		and the power and the money is behind that, and then eh. Yeah and	model		DSM as a document	
796		then eh the growth because of the Vision for Change and even a	Power and		with power	Power in
797		little, you know the growth in the, in the MDTs and we're	money behind			psychiatric
798		haemorrhaging at the seams and you know like, just. I think a lot, a	DSM			document DSM
799		lot of things in the last eight years have happened and I don't know	Growth in MDTs, Vision	*Haemorrhaging* *at the seams* –	Too much growth in MDTs?	

800		that there's been a lot there to support. Like for a consultant	for Change	overflowing, uncontained		
801		psychiatrist to have all of us, who are so different, our views. It must	Lots has happened			
802		be so difficult for them, you know to to to have to, even 'Oh my	Query level of support		Psychiatry needed support to manage the changes?	Making sense of how psychiatry makes sense of MDT and new colleagues
803		God, how how can I think this way? How can I even think about,				
804		how I manage the thinking of this?' You know, cause their stuff gets	Difficult for consultants to manage			
805		challenged you know in terms of the certainty, eh and never mind			Some sympathy here for psychiatry?	
806		that eh. Yeah just, just the general issues that go on. Like there's				
807		some gorgeous work family work that the nurses do, like they do	Being challenged	Repetition of *gorgeous*		
808		gorgeous family work, you know and eh. Like eh you know that's,	General issues			
809		that's fabulous but in some ways sometimes we think we do family	Gorgeous family work		MDT doing similar but different work to each other?	
810		work as well and it's just that we think we do different types of				Sharing roles on MDT
811		family work, or maybe they're quite the same, and you know.	Nursing, SW			
812		There's that kind of you know, there's that. That tension is there and	Different types of work, or maybe the same			
813		I think you know eh. Yeah just that general multidisciplinary team			MDT confusion leads to MDT tension	Confusion on MDT about roles
814		kind of confusion around you know what we all do and how we	Tension			
815		complement each other and best serve the client, eh.	MDT confusions about role and how to work together			
816	R	And how has the, eh you mentioned KPIs and eh (pause) that				
817		general, as you said changes in the last couple of years where it's				
818		more focused on appointments and numbers, eh. How has that come				
819		into play in your actual work?				
820	P	Literally that like, you know, 'Quick, quick'. We get in, see as many		*Quick, quick –* go, go		
821		as we can and close as many as you can. And what's being counted?			Pressure of KPIs, need for speed	
822		Three things eh, three things are being counted. I can't remember	KPIs: be quick			CAMHS as a numbers game
823		exactly, tell you but any of the, the how many you see, the waiting	See and close as many as possible			
824		time and eh (pause).			Interesting that she's unsure of all KPIs	
825	R	Is it re-referrals I think or something?				
826	P	Is it? There's three and like that, that comes into play usually like eh	Three measures			
827		you know, so how many referrals and and the, the eh. I think the	Referrals being counted			
828		boundaries of what CAMHS teams do has changed within that,				
829		because with KPIs you know (pause). CAMHS teams have, I think	Changes in how CAMHS works due to KPIs		Shift in remit of CAMHS	KPIs as changing the remit of CAMHS
830		they've shifted their focus, some eh some to the lesser extent, where				
831		they see, where they're less kinda clear and more 'Sure we'll see a				
832		bit of that, cause we have feic all key, you know people' you know,	Shift in focus	*Sure we'll* *Bit of that*	Seeing children and families ?flippantly	

833		‘We’ve feic all people’ or ‘We didn’t see enough’ or ‘We’re in	Less clear in who to see See people to make numbers	*Feic all* - informal decision-making	in order to meet KPIs	Adapting practice to suit KPIs
834		the…’ you know, whatever.				
835	R	Oh, okay.				
836	P	Eh and then others, then too too tight and then they’re not seeing		*Too tight* – fixed		
837		any and you know, what, where does that leave them? Eh (pause).				
838	R	Another person mentioned to me about sometimes even changes in	Others not seeing people at all			
839		practice. Like that, you know on paper you could have, instead of				
840		doing an hour and half appointment, do an hour this week and an				
841		hour next week, cause it looks better on paper.				
842	P	Absolutely and that’s that whole thing about like you know we				
843		would have, we would have, we would. I would have been seeing				
844		families for like two hours you know and like I might do, I might				
845		have done my significant intervention at that stage where I could	Sessions with families lasting two hours			
846		have had seen a few together, a few separate and then brought		Direct (hypothetical speech) to explain impact of KPIs on her work		Quantity>quality in CAMHS
847		everybody in together kind of stuff. I worked hard at that cause there				
848		was a momentum going and then that idea of ‘Well now good luck	Working hard		Her work not satisfying KPIs	
849		to you, but that’s not how we do it’ and ‘Eh statistically, this is what	Momentum going			
850		will work out best for us’ you know? So and and that even, the more	But not how done on team, not best statistically		Measure of intervention in numbers>quality?	Working for KPIs
851		you can. Like the ADHD clinic that runs here like, you know, the				
852		more you can pack into that, the better, cause you’ll have to do no		*The more...the better* – numbers matter		
853		work for the rest of the week kind of thing, you know? So it’s like I				
854		I I feel that, you know there’s a wonderful piece to it in lots of ways,	ADHD clinic: the more, the better			
855		but like the client care gets lost and that’s the main thing. And it’s		Client care as *lost* – gone, missing, left behind	Loss of client care	
856		completely gotten lost. It’s all about numbers and fundings and you	Some advantages but client care gets lost			↓Quality of service
857		know, eh who gets seen and how many get seen and wait. That’s				
858		important that people don’t wait too long for a service and that				
859		there’s some measurement around that, and dynamics around that,			Emphasis on numbers	
860		but you know I just. I find sometimes, I feel sometimes that eh	All about numbers, funding & W/L			
861		patient care gets lost you know? And I I I work hard trying not make				
862		that happen but you’re working within those constraints, so you also	Important but patient care gets lost	*Constraints* - restrictions		
863		have to work you know within those constraints.				Trying to resist the influence of KPIs on practice
864	R	Yeah.				
865	P	And that’s, and that’s where services have got different, whereas	Try not to make that happen			

866		like really we can't, we actually can't see the guidance, the child		Emphasis on *guidance* here		
867		guidance people anymore, you know. So the territory has changed	Services are now different		Shift in remit of CAMHS	
868		and like that's not even, it's meant to be a national kind of an		*Territory* – what is owned by CAMHS		Identity of CAMHS – guidance/MH
869		arrangement. I don't know is it, actually I don't know why I said it's	Can't see the guidance			
870		meant to be, but I get a sense that you know, nationally we're all	Change in territory			
871		doing different things and we're seen in different ways. So CAMHS			Differences in practice in CAMHS across the country	
872		here do this, but 'You're not serious enough for that CAMHS team'.	Query if national or all doing different things			Variation in remit of CAMHS nationally
873		And then there's huge friction going to happen because social work		*Friction* – resistance, difficulty		
874		and child and family services will say 'Oh our kids are never serious				
875		enough, you know for ye to see; and then it's like, you know. Cause	Friction will happen with child & family SW		Friction as a result of these differences	
876		the the boundaries are different for different areas, you know. I don't				Consequences in variation in remit of CAMHS
877		know whether they are meant to be or whether they are, but anyway				
878		that's my sense.	Different boundaries in different areas			
879	R	Yeah.				
880	P	So yeah it's and it's, it's changed the type of work you do as well in				
881		terms of the referrals you see and eh…				
882	R	What changes are, are they?				
883	P	The the the KPIs I think changed the type of work, you know. We're				
884		only meant to be seeing, meant to be (pause) you know (sighs) re-	KPIs have changed the type of work in CAMHS		Emphasis of KPIs on re-referrals	
885		referrals. I mean is it good to let them go early eh so that you can get		Asks rhetorical question		KPIs as changing practice in CAMHS
886		a few more re-referrals? Or it depends on who's looking at it. Like I				
887		mean the thinking around it is so, is so different and the constructs			Different people view this differently – different interests or agendas?	
888		that people around have around it are so different. Like 'Oh we we	See re-referrals			
889		have to see, we have to keep them open or have them open' or you	Different thinking around it, and constructs			
890		know, eh and…				
891	R	You mean on the team, sorry?				
892	P	On the team, yeah. And what does that mean, like? And if we got			KPIs have been introduced as the gold standard, but impact of results afterwards are unclear	
893		into the red or the green, what does that mean? What does that				
894		mean, like? What would be the worst thing about that? That we're	What will happen after results of KPIs?	Listing of questions about KPIs		
895		highlighting a need, that we're saying that 'Actually this probably				Unknown consequences of KPIs measurements
896		isn't the best way forward' or if it is, you know. I don't know.				
897		There's all sorts of different ideas about it but people's ideas about it	What does will mean?			
898		eh are so different.	Very different			

899	R	Yeah.	ideas about it			
900	P	That some people are so focused on, that's the only thing people			Different responses by colleagues to KPIs target	
901		want is new referrals, see the person, see more people, you know?				
902		Eh cause we'll meet KPIs and I just think 'Where is the recovery	Some people only focused on referrals for KPIs			
903		piece in that? Where is the client in that? Where is the, what say do		Quoting her own questions and her sense-making	KPIs overshadows client-centred care	KPIs>recovery and person
904		they get?' Eh you know, all of that stuff yeah.				
905	R	And eh you mentioned eh in your previous job, the the working with	Where is recovery?			Quantity>quality
906		schools and I was going to come back to that. Because again this has				
907		come up in other interviews, that eh links with schools are can vary				
908		and then eh I suppose some people are very favourable and others				
909		then not so bothered not so much?				
910	P	Yeah.				
911	R	How are things here?				
912	P	Yeah and I don't I think. I think everybody has like, everybody has		*Goodwill* – meaning well		
913		goodwill like to the best of their ability here and like there's huge			All on MDT do their best	
914		limitations on people since all the cuts and everything else. So	Everybody has goodwill re schools			
915		people's goodwill has kind of changed a little bit but everybody tries				
916		their best I think, just to say that cause I'm sounding very critical, I		Again, commenting on her expression, negative evaluation?		Reflecting on her criticism of MDT and CAMHS
917		can hear myself sounding very critical [coughs]. But I think it's	Huge limitations on people		Speaking honestly means speaking critically?	
918		about the value of. Some people wouldn't see it as being valuable				
919		and sometimes I think that's just down to training. And other people	She sounds very critical?			
920		then would, and again I think sometimes that's down to training. It's				
921		also down to like you know, other things outside of training and I	Some people see school liaison as valuable, others less so			Role of background training on MDT views
922		don't know what what I can talk to about that now but I I'm sure			Attributing different perspectives on school liaison to background training	
923		there are other factors. But like I think we do great work. OTs, SLT		*Fabulous* – repetition of this adjective to describe some work on team		
924		do fabulous eh school liaison work around, after assessment around				
925		looking at kind of you know what might be helpful for the child in	Down to training and other factors			
926		their daily activities in school. And then the piece eh that I think				
927		that social work have great strengths in, is around kind of				
928		connecting with the school, as in, so if there's a mental health issue	Team do great work			
929		you know that they're dealing with it five days a week, or if they're	SLT, OT working with school s after assessment			Role of SW in school liaison
930		not, they need to be. Or if the permission is there, it would be useful				
931		perhaps to have them to be aware so as it could, so there's, they're				

932		the second most important connection that a child will have you	SW can also			
933		know and the second most spent place that a child will have outside	connect		School having a	Importance of
934		of home usually. And there's usually if there's conflict at home or	School is second most		role in child's well-being	school in child & adolescent MH
935		damaged relationships at home, there's usually a mentor in school	important			
936		who can really connect and really make a difference in a child's life	connection for			
937		in terms of their mental health. So I feel it's very very important. So	child			
938		yeah but around permission and things like that, sometimes parents	Often someone			
939		won't allow it and don't want it and things like that. So that can be	who connects with child in		Parental consent to	Seeking consent
940		an issue and a barrier, and parents do gate-keep that piece. And also	school	*Gate-keep* – let it	liaise with schools	from parents to
941		you have to be careful about what permission you've been given.	Need parental	in/out, in control	can vary	liaise with school
942		What do you want? What do they want us to say? What's you, what	permission to			
943		would be useful? And you've to be very clear about get getting	connect			
944		informed consent around that, but we're excellent. At the outset, we	Some parents don't allow it			
945		do send eh a consent form to both parents to agree to the initial	Type of			
946		assessment and to a school eh eh liaison, but it's an indirect school	permission			
947		liaison. So what that means is that we have a a [coughs] we have a a	given			
948		a report, it's like a school report form and we send that to the school.	Send out			
949	R	Okay, yeah.	consent to liaise			
950	P	And they fill it out and they send it back and we don't share	indirectly at outset, school			
951		anything with their, the school. So again there's a consent piece	report form			
952		around that, what would be most useful and we have a dialogue with			Negotiating consent	
953		the parents and the child around that, and we can sometimes. I think			with child and	
954		social work do more of that, whereas eh other people would kind of.	Dialogue with parents & child		parents	
955		Like SLT and OT would see it as part of their job, that when they	about consent			
956		have you know if particularly if there's a learning kind of need or a	SW do more of			Comparison
957		communication and social need, eh or like dyspraxia or dyslexia or	this			between different
958		some of that stuff, eh. They then would see that there's eh eh it's,	SLT & OT also			disciplines on MDT
959		it's almost a necessity to advocate for the child and the family with	see it as part of role		Role of SLT & OT in school liaison	and role in school liaison
960		the school. And we would also liaise then with and they would liaise	SLT & OT see			
961		a lot with us, and we would liaise a lot with them around resources	school liaison as			
962		and things like that. And I think sometimes a lot of the drive around	almost a			
963		diagnosis is because of the shifts and the changes in the Department	necessity			
964		of Education around what they're requiring to have resources firmed	Liaison around resources	*Firmed out* – set,		

965 966 967 968 969 970		out. And that's been a huge impact on CAMHS, major. Like there's more people seeking a diagnosis and less people wanting interventions. They just want the letter eh and schools want it as well, but then there's a, there's a new thing around that where you have to eh follow-up. So the schools are looking for that piece in the letter too or NEPS are, or the Department of Education.	Changed in Dept of Ed re resources Huge impact on CAMHS People seeking a diagnosis	fixed *They just want the letter* – minimal	Diagnosis is necessary to access supports in school Parents seeking a diagnosis as a result	Diagnosis as a means to an end – school resources
971 972	R	Like for there to ongoing attendance and that sort of thing? Yeah, yeah.	Just want the letter Now also need follow-up			
973 974 975 976 977 978	P	Things like that, but yeah. No I think we do have a great and like lots, we do school observations so it would to see the child in their own environment, to get more a better sense of, a social sense of how the child behaves and what their struggles or their strengths are and what their needs might be, as well as part of the assessment process. And schools ring us all of the time.	School observations Better sense of child Strengths & needs		Information gathering from school	Role of school in assessment of child & adolescent MH
979	R	Yeah.				
980 981 982 983 984 985 986	P	Like all of the time, when parents would have given them that kind of permission. So we would get school calls of the time and there's a really good sense, cause I think we've done a lot of work in the community around if a school has a concern about somebody self-harming, they'll say 'Look I just want to run this by you'. A bit like maybe eh you'd ring a duty social worker about a child protection concern to get a sense of 'What next?'	When parents give permission, schools make contact all the time Work done with schools in managing self-harm and	*Run this by you* – check it out, seek reassurance	Contact between schools and CAMHS – queries, questions, reassurances	CAMHS as a support to schools
987	R	Yeah.				
988 989 990	P	So they'd ring us and we'd kind of respond to that, about 'Okay this is, it sounds, you know this and this' so we have got good links and eh.	Schools ring CAMHS, CAMHS offer advice		CAMHS responding to queries from schools	
991 992 993 994	R	I wonder what it's like for you being on the other side? I know the school in Kilclough was a learning disability but you've kind of been on the other side of it, you've been in the school trying to connect with CAMHS and now you're in the CAMHS?				
995 996 997	P	Yeah and I think that's why I really kind of consider schools as much as I do, and I do think my training as well with that whole, you know systemic lens, and all trying to kind of connect out and				

998		broaden the story out, and bring more possibilities for the child and	Her training			
999		solutions and eh. And yet I think the Kilclough school piece would	Systemic lens		Past experience	
1000		have been eh the reason why I have that, that kind of real sense of	Connect and broaden out,		working in a school, as well as her sister	Insider SW and Outsider SW
1001		having to connect with. And also my sister is a teacher and that	solutions		being a teacher has	experience with
1002		makes a difference too, because she would often say ‘This kid, like	Past experience		led to her interest in	schools
1003		he tried to kill himself and like nobody told us, and if we had a	with schools has		improving links	
1004		known.’ Cause you, you know they they, school have guidance	led to her		between schools &	
1005		counsellors and supports as well and like you know, we have to be	current interest Also F/B from	*In our little*	CAMHS	Bringing past experience into
1006		aware of those instead of. I feel that we sit here like in our little	sister: a teacher	*bubble* – on their		current role
1007		bubble, creating sort of you know, orchestras around how we think	Schools can	own, not in real	Information sharing	
1008		people need to behave in this system. And we forget about other	have own	world	from CAMHS, to	Need for
1009		systems outside who have, you know the ability to carry on when	supports	*Creating sort of..*	be part of a system	↑communication
1010		you know norm, in normal environments. The the work that a young	Need to be aware of those	*orchestras* – ridicule?	around child & adolescent MH	from CAMHS
1011		person has done, a family has done and maybe we have done here as	CAMHS can			CAMHS not in
1012		well, and we forget about them.	forget about			isolation
1013	R	Yeah, yeah. And eh I wanted to ask you as well about eh	other systems			
1014		transitioning to adult services. I’m not sure, I know you said your	Can forget			
1015		your line manager is is kind of connected to all services. Eh would	about work already done			
1016		you have any experience yourself with children or adolescents				
1017		attending who move on to adult mental health services?				
1018	P	Mmm (sighs). I’m stuck on something I didn’t say about schools.				
1019	R	Oh sorry, I beg your pardon.				
1020	P	Can I just I’ll say that and then I’ll go back to that?				
1021	R	Yeah yeah yeah.				
1022	P	No you don’t have to be sorry but just so at least I was finishing				
1023		what I thought. Eh I also amn’t sure that schools know what we do.	Schools do not		Lack of	
1024		I think that makes a big big difference as well. I don’t know whether	understand		understanding of	
1025		that’s that’s? It seems like it’s important to me at the minute.	CAMHS		CAMHS in schools	CAMHS as the
1026	R	Yeah, that that they’re not sure about CAMHS or?			– despite their current links and	unknown to schools
1027	P	Yeah and I think eh. Or or even what mental health, you know and	Schools do not		contact?	
1028		how to respond. Cause I think in some ways, mental health to	understand MH			
1029		somebody is, like it could be emotional behavioural stuff and that’s	and how to			
1030		not necessarily ‘Oh holy shit, we have to go to CAMHS and declare	respond Could be EBD	Direct	What is mental health?	Concept of MH as the unknown to

1031		you know, declare at a crisis or an emergency.' So I I and I think	Not a crisis and having to attend CAMHS	(hypothetical) speech to explain her point here		schools
1032		that that filtering sometimes doesn't happen, because eh I think you				
1033		know we don't get, we're. I feel that you know filtering doesn't	Lack of filtering, not just with schools	*Filtering* – remove the extras, unwanted	CAMHS viewed as only service for MH	Anxiety around MH in children & adolescents
1034		happen, very rarely, not just with schools but yeah. That sense of				
1035		what, what mental health=				
1036	R	=Communication between CAMHS and, is it?				
1037	P	Yeah maybe that or even that idea of 'What eh, what does this, what				
1038		does this mean?' So somebody then says 'I'm really upset you	Meaning of distress		Lack of normalization and context of expressions of distress?	
1039		know, I fought with my you know. I feel like life isn't worth living.'	Not straight to CAMHS or A&E	*Direct, quick* Clicks fingers - emphasizing crisis nature		Identity of CAMHS
1040		(pause) 'Direct, quick,' [clicks fingers] you know, 'Get to CAMHS,				
1041		go to A&E.'				CAMHS seen as the first port of call
1042	R	Yeah.				
1043	P	You know and it's like, 'Hang on, there's a. Let's, let's stall the ball	Hang on	*Stall the ball* – calm, take it easy		
1044		for a minute.' So that's what I kind of mean, well if that's, in any				
1045		ways makes sense in that.				
1046	R	Yeah, yeah. I understand what you mean eh (pause). Yeah yeah.				
1047	P	Yeah.				
1048	R	And maybe, would you say that's also true for other maybe services				
1049		or agencies, not just?				
1050	P	Oh yeah.				
1051	R	Schools.				
1052	P	Not just schools. And I just thought, I actually thought of a case.				
1053		That's why I was talking about the school when I thought about it. I	Similar amongst schools, community services, SW departments, youth organizations, parents			
1054		I was thinking school and that, yeah. I would say absolutely				
1055		community services, even child and family services, social work			The above not just in schools, in other settings too	
1056		department, you know. And not as bad as it was, but certainly but				Lack of understanding of CAMHS amongst community services
1057		yeah all community, even just youth organizations and you know				
1058		even parents themselves, all of that. Now I think it's appropriate				
1059		when somebody says life isn't worth living, I appreciate the	Appropriate to respond when someone says life not worth living, but can block other			
1060		appropriateness of it, of standing up and taking that seriously.				
1061	R	Yeah, yeah.				
1062	P	But I think it can block lots of eh referral avenues for other people				
1063		where you have, like here you know, maybe you're dealing with			Inappropriate referrals affecting	Impact of

1064		inappropriate kind of you know eh referrals.	referrals		progress of appropriate referrals	inappropriate referrals in CAMHS
1065	R	Okay. And you were thinking of a case specifically where it was				
1066		something like that, was it?				
1067	P	Around schools and then, the the tension they brought. And then	Recent case: tension, things being catastrophized	*Catastrophized* – turned into a disaster		
1068		they came and the the, oh my God, it was catastrophized. And then			Over-reaction and inappropriate referrals – but maybe these referrals have to come to CAMHS for their appropriateness to be determined?	
1069		when they came eh. And all of that takes a lot of working time and				
1070		for the families as well, what that, what that means for them coming				
1071		in, sharing their story and then to say (sighs). You know and maybe	Takes a lot of time			
1072		'No it doesn't make sense that you remain here, but yet you've told	After initial ass, case not appropriate for CAMHS			
1073		the story' and then that. Then you know, you start 'Oh I heard the		*Crazy things happen* – nonsensical, without clear reason		Inappropriate referrals continuing to attend CAMHS
1074		story now and yeah, you do need some supports,' even though it				
1075		could be probably primary care. So then then crazy things happen				
1076		cause.	But may continue attending			
1077	R	And with that case, is that how?				
1078	P	Well with that particular case they stayed and like (sighs). Yeah for		Sighs here		
1079		me (pause) you know from an ethical point of view, I struggle with	Ethical point of view: child thinks "I'm psychiatric"	Stating label on child		
1080		that. Like you know a child has this idea of 'I'm psychiatric' cause			Labelling around psychiatry, stigma?	Impact of inappropriate attendance at CAMHS
1081		that's the sign that's still on the door.				
1082	R	Sure.				
1083	P	'I'm psychiatric' and what, where do they take that story for the rest	What story is that?	*That's my bias* – an attempt soften her opinion a little?		
1084		of their life? And that's my bias eh.				
1085	R	I did notice the sign eh. Cause at reception I'd asked for CAMHS				
1086		team and then she was asking what exactly, and I=	Different names, child guidance for some			
1087	P	=That's that's changed in people's language, on the headed letter				
1088		that's changed forever. But like it's not, we're still called child			Child guidance as an outdated term in services in Ireland	The language of CAMHS
1089		guidance for some people.				
1090	R	But your headed letter is?				
1091	P	Our letter head is is child and family, child CAMHS eh.	CAMHS on headed letters			
1092	R	Yeah, just the signs on the door?				
1093	P	But the sign on the door.	Sign on door different			
1094	R	You've got two on the door, yeah.				
1095	P	Yeah, and and even people don't language it like that, psychiatry,				
1096		you know? I I would be very careful not to call it child psychiatry	Use of language Avoid			

1097		but people don't language it. Like as you said child psychiatry you	'psychiatry' CAMHS as too long-winded		What's in a name?	
1098		know, that they wouldn't know it was CAMHS. 'What does that,				Discourse of CAMHS and Psychiatry
1099		what's that? That's too long-winded, we'll go with psychiatry' and			How mental health is talked about	
1100		that then, that changes people's idea and perception. And again I	Name changes people's ideas			
1101		think that's why difficult, it's sometimes difficult for social work on	Difficult for SW on 'child psychiatry' team	Emphasis on *psychiatry* to explain her opinion		
1102		a child psychiatry team you know, <u>psychiatry</u> team? Anyway.				
1103		(laughs)				
1104	R	It's it's a moving more (pause) serious or medical?				
1105	P	Yeah, <u>psychiatry</u>.				
1106	R	Or than mental health?				
1107	P	Psychiatry, psychiatry yeah. Mental health just to me says	Different meanings in 'psychiatry' and 'mental health'		Comparison between psychiatry and mental health	
1108		something different.				Construction of MH/Psychiatry through language
1109	R	Which is?				
1110	P	It's a normal eh you know, piece of somebody's eh presence. So				
1111		we've got physical health and we've got mental health and	MH is a normal part of being			
1112		<u>psychiatry</u>. Psychiatry is just such a, a disabling word.		*Disabling* – weakening		
1113	R	Yeah.	Psychiatry as a disabling word			
1114	P	You know? Or at least you know you're you're, you're. It it has the			Psychiatry implies a need for a cure?	
1115		language of eh needing to be fixed.	Needing to be fixed			
1116	R	Yeah.				
1117	P	Whereas mental health is a positive, you know approach to thinking.	MH is positive approach to thinking			
1118		Mental health you know, everybody has it. When it goes wrong,			MH as a positive construct	
1119		there's a there's a place that you can check it out and then, you		*Check it out* – informal		Normalization of MH and difficulties
1120		know. And then there's other places too you know but just to, just	Everybody has MH, can check it out when needed			
1121		to. Yeah and I. Yeah (laughs).				
1122	R	And that sign why is it still there do you think or?				
1123	P	Eh…				
1124	R	Is there any mention of just?				
1125	P	Yeah. It's it's a bit like accommodation. Since I've started here, it's				
1126		been mentioned.				
1127	R	Okay.				
1128	P	Eh I don't think that anyone. I think the the, there's. I really really				
1129		feel that there's a resistance to moving to modern psychiatry and	Resistance to moving to	*Resistance* – people don't		

1130		modern ways of of addressing mental health and looking at mental	modern practices in MH Too scary for some people Have to look at things again Requires a move, a departure	want it *Scary* – daunting *Get out of your nest... fly somewhere else* – idiom, to leave the unknown *Real* – valid?	Move away from medical model as frightening for some on MDT Change can be difficult	
1131		health reform because it's it's just scary, I think. It's just scary for				
1132		people who have worked in a different model and it's like 'Oh God				Potential threat of shift from medical model to some disciplines
1133		look at these ones coming in, this is way too…' Cause you, I think				
1134		you have to look at things that maybe you haven't looked at before				
1135		and just you have to get out of your nest and go and fly somewhere				
1136		else and that's just. That's just how I think and maybe that's not real				
1137		at all, maybe that's not real at all.				
1138	R	But like you said, it doesn't matter. Eh nothing is real, it's just sort				
1139		of=				
1140	P	=It's just your idea.				
1141	R	Yeah.				
1142	P	Exactly, yeah. But the the adult thing, sorry to to bring you back to		*Little ones* – repetition from earlier, description of children Emphasis on *absolutely* *Blessed* – lucky?		
1143		that. Eh the adult thing, yeah we'd have we'd have eh have had	Experience in transitioning young people to adult MH SW have been blessed in Principal SW			
1144		loads of eh little ones. I'd had experience of eh transitioning eh little				
1145		ones over to adult services and I think we have been <u>absolutely</u>,			SW discipline as distinct from others in transitioning young people to adult MH?	
1146		particularly our discipline have been absolutely blessed in lots of				Successful SW transition of young people from CAMHS to Adult MH
1147		ways. And I'm sure the principal social worker wouldn't see it,				
1148		because she was sort of eh made to do that, because of money made				
1149		change you know eh…				
1150	R	To look after all of you is it?				
1151	P	I can't find the language today, I'm really sorry.				
1152	R	No you're okay! (laughs)				
1153	P	I'm so tired.				
1154	R	No, you're okay.				
1155	P	Eh she was made move. So she used to be principal for just	Principal SW was only for CAMHS, then for other areas			
1156		CAMHS, so because of money and people retiring and things like				
1157		that, she was. What's the, re- re-?				
1158	R	Re-deployed, maybe?				
1169	P	She was redesigned. Eh her role was redesigned or whatever yeah.	Role of principal SW was redesigned			
1160		So she took on all of these people, child, adult and older age.				
1161	R	And that's the twenty-two in total you were saying?				
1162	P	Yes yes.				

1163	R	That’s a lot, yeah.				
1164 1165 1166 1167 1168 1169 1170 1171 1172 1173 1174 1175	P	It is, and it’s a lot for her. But I think that has had huge benefits for us as a, as a social work in mental health. Like it’s just like across the board, we all now understand our role in the same way, pretty much, with lots of variations. And gorgeous variations, which is very appropriate and important, eh but also we have connections to each other so we can kind of liaise and we also know each other’s role. We know what they do, we know the differences and the similarities, and we’re able to prepare then young people and families for that much more than we would have before. Because I wouldn’t have had any sense of a link otherwise. It used to be psychiatrist to psychiatrist and it still is; you can’t transfer, social work can’t transfer.	Huge benefits for SW in MH Understand their role in same way Appropriate variations Connections, can liaise Can prepare YP better for adult MH services No link otherwise	Emphasis on *huge* *In the same way, pretty much, with lots of variations* – description of SW role	Line manager had no choice to take current role, but it has led to significant changes for SW department No permission for SW to transfer young people to adult CAMHS	Role and benefits of SW manager Shared knowledge in SW department Restrictions on MDT referrals between CAMHS and adult MH
1176	R	No?				
1177 1178	P	It’s psychiatry to psychiatry, as it is doctor to psychiatrist here. You can’t=	Only psychiatry can transfer to each other			
1179	R	=Yeah.				
1180 1181 1182 1183 1184 1185 1186 1187 1188 1189 1190 1191 1192 1193 1194	P	Other people can’t refer. Now other teams are different. The Acorn/Laurel team take from social workers, from child and family. It’s not doctor-doctor, eh but here, no. And the same for adult, it has to be psychiatrist to psychiatrist to transfer over. But now we have that lovely opportunity where there’s a sense of understanding what the, what the differences is and to prepare a young person for those differences, to promote their kind of independence around, and. And to maybe just shift our way of working towards the end, cause we know they’re not going to get this and then they’re going to relapse. So it’s that idea of really kind of getting a sense of our how we organize our work and tapering it at a particular time, knowing that they might, this is what they’re going to land into and the difference. And also the very appropriate piece around moving from child to adult in just in the in the basic sense of it, without a mental health piece to look at.	Others can’t refer to CAMHS Different across teams Now sense of understanding of adult MH Can shift thinking Prepared Know how adult MH works Basis sense of transitioning between services	*Tapering it* - decreasing	Shared knowledge between SW in CAMHS and adult MH, and benefits for young people transitioning Better knowledge of adult MH leads to better preparation for young people	Difference between CAMHS and adult MH Preparing young people to adapt to adult MH
1195	R	Yeah yeah.				

1196 1197 1198 1199 1200 1201 1202	P	So I I will say that that's really been huge for us, eh. And I think we've, I've felt stronger because of that. I've felt stronger in my voice here and how I then transfer over. So I used to, it used to be just a transfer letter, you know: 'Mary Jones is transferring to you know, because she's this, she needs to be reviewed, thanks very much.' And then they would see her in two weeks' time in a review clinic, they've got really speedy, very quick. So that's good eh.	Huge for SW Feel stronger Used be a brief transfer letter	Repetition of *I've felt stronger*	Growth in her voice in CAMHS	Stronger SW voice in transfer from CAMHS to adult MH
1203	R	Oh right.				
1204	P	But eh, there'd be no voice as to what she did here really.	No voice of work done in CAMHS		Gaps in transfer letter to adult MH	
1205	R	Oh yeah, yeah.				Loss of MDT work in CAMHS in adult MH
1206 1207	P	Eh or you know if you worked with the child, you wouldn't really kind of=				
1208	R	=Go into detail.				
1209 1210 1211 1212 1213	P	You might, you might send something but who do you send and eh you know, you don't. Whereas now, I send a like a social work report to the social worker but not just, not, knowing that the social worker is there and would be delighted to have it, but it's to the team kind of, you know.	Now, send SW report to SW in adult MH	*Delighted* – really happy		Communication with SW colleagues in adult MH
1214	R	Yeah yeah.				
1215 1216 1217	P	So like a transfer, a joint transfer letter you know, where the psychiatrist is transferring with me, with my stuff in it, do you know?	Joint transfer with psychiatrist			
1218	R	And you're your stuff I assume would be then=	Include all work done			
1219	P	=Everybody's stuff.				
1220 1221	R	Everybody else's stuff; would be sort of a bit more personable is it? Or just a just a case review?				
1222 1223	P	Well I I would see myself, in that I see myself as taking everybody's, I mean I take everybody's=				
1224	R	=Sure.				
1225 1226 1227 1228	P	Eh so I would be like 'What SLT was done? What OT was done?' So I'd kind of take that kind of case management, kind of position on it. And whereas the Consultant, and everyone's got different style, but the Consultant would be more about the medical piece.	Include other disciplines Take position of case management	*The medical piece* – what	SW transfer letter addresses these gaps	Representation of MDT in CAMHS in adult MH via SW

1229	R	Yes, yes.		does this mean?		
1230	P	'She's got depression, review her, eh she's she tried to kill herself	Consultant more about medical pieve		Consultant letter omits MDT?	
1231		seven times'. Now I don't say that they're saying it that way...				
1232	R	Yeah, no, I get what you mean.				
1233	P	But you know it would be that kind of...				
1234	R	But do you put all the other=				
1235	P	bits=				
1236	R	=Bits together?				
1237	P	Just to get a holistic, and, and that other, all that good work doesn't	SW giving holistic account	Other work can get *lost* – disappears, *Drop it* – forget it		
1238		get lost. And and that some people, the the that go into adult			Adult MH not able to make sense of some of the MDT work in CAMHS?	Potential loss of MDT voice from CAMHS to adult MH
1239		services can't language that, eh. Or they might forget it and drop it	Other work not getting lost			
1240		or whatever, and sometimes it's like good for the clinician to be able	SW needs a sense of what work was done			
1241		to get a sense of what work has been done.				
1242	R	Yeah.				
1243	P	So there's not duplication and misuse of time again.	Less duplication and misuse of time			
1244	R	Yeah and like you said there, you said about you know, before they				
1245		land in adult mental health. Cause it's very, I mean it's very				
1246		different to eh to CAMHS I think?				
1247	P	It's completely, completely different.	Adult MH completely different to CAMHS			
1248	R	You come here when you're seventeen and ten months then you go,				
1249		you're eighteen,yeah.				
1250	P	Yeah it's completely different. Eh and again, that's only coming	Learning from being on regional SW group		Limited understanding and communication between CAMHS and adult MH services?	Differences between CAMHS and adult MH
1251		from my understanding from really being on the, on the regional				
1252		social work, eh Britvale/Dolla regional social work group. But I've				
1253		heard more about that so I would've had a very limited				
1254		understanding otherwise. Again, more so just through the Laurel				
1255		View services and that, I think that's a very different type of a	Adult MH as a very different service			
1256		service because it's more private and it's, it's just different I think				
1257		than the HSE eh. But yeah, very different, very diff and eh like it's				
1258		really quick review and 'What's your problem today?' you know.	Quick reviews	*What's your problem today?* – (hypothetical) talk in adult MH		
1259		And it's just, and I guess they've such a volume of people coming in	Large volume of people attending			Comparison between CAMHS and adult MH practice
1260		and also the legal piece is gone out of it then, you know. You're no			Contrast between CAMHS and adult	
1261		longer a child, you're responsible to do whatever you want to do. So	No longer a			

1262		it’s I think, and also I think the person is seen as more of an	child, no legal responsibility, seen as individual		MH	
1263		individual, as opposed to here, I think we see more of the child, the				
1264		individual and the systems. And I do think that people has, have an				
1265		appreciation for systems, you know everyone on the team. I don’t	In CAMHS, child as part of a system			
1266		think, in any way think that I’m the only one that has an		*In any way* – at all, clarifying her opinion		
1267		appreciation for systems eh. But I think in adult, maybe you know a			Adult is not really seen as being part of a system?	Child as part of a system in CAMHS
1268		little bit less because for loads of different reasons, you know. As a				
1269		different service, the age is different, the legal piece around it is	Range of differences between CAMHS and adult MH			
1270		different, as eh the individual is seen as somebody who can make				
1271		their own choices. Or family, you know in all the different policies,				
1272		like family are seen as (sighs) the carers, I think more so and eh				Role of family in CAMHS
1273		(pause). And I don’t know much decision-making the family is you	↓Collaboration with families	Pauses twice here		
1274		know, eh (pause). I don’t know how much collaboration the families	Voluntary/ involuntary stuff		Lesser role for family in adult MH > CAMHS	
1275		would have in adult services. And I appreciate that as well in terms				
1276		of the involuntary stuff and voluntary stuff, and all that eh historical		Use of word *stuff*		
1277		stuff that went before. But yeah, I feel it’s very different.				
1278	R	Yeah yeah it seems sometimes, and other people brought this up eh.				
1279		Eighteen in some ways seems so young to be, even when it used to				
1280		be sixteen, but to change into that system of being autonomous,				
1281		being able to that you know?				
1282	P	And and yet there’s a lot of people who haven’t been here, seen here	Some attending adult MH aged 16			
1283		before sixteen, go straight to adult services.				
1284	R	Okay.				
1285	P	So sixteen to eighteen year olds aren’t served here unless they have	16-18 not served in this CAMHS unless attended before	*Served* – verb to describe work in CAMHS with young people	CAMHS as working for children & adolescents?	
1286		been served here before. I say served like as if it’s, sorry for the use				Age-restricted referrals to CAMHS
1287		of words. Eh yeah, they haven’t been seen here.				
1288	R	Oh right, okay. So the team here don’t accept new referrals for				
1289		seventeen year olds?				
1300	P	After sixteen, no.				
1301	R	Okay.				
1302	P	No. But eh hopefully, nationally that’s going to change very	Hopefully will change soon			
1303		quickly.				
1304	R	Yeah, I. Yeah I, I think it has changed.				

1305	P	It’s happening across the country.	Happening nationally			
1306	R	Yeah.			Change in age of referrals needs to happen	
1307	P	Yeah. Bring it on, quickly.		*Bring it on* – make it happen		
1308	R	Yeah				
1309	P	Cause it’s just horrendous that a little one would go and sit with	Horrendous that a child has to attend adult MH	Use of adjective *horrendous* – awful		
1310		very unwell people who ((are in depots)) and who are really like.				
1311		Cause it’s quite acute, the adult like here. I think it’s just a			Inappropriateness of child attending adult MH services	
1312		completely. Like our idea of recovery here is like, the word doesn’t	Adult can be acute			Children & adolescents having to attend adult MH
1313		even fit in lots of ways, cause we see it as a blip: ‘This is a normal,	Recovery in CAMHS doesn’t fit	*Blip* – to describe an incident of MH distress		
1314		this is kind of, like this is a blip and we’re going to get you back on				
1315		track with with in conjunction with yourself’. Whereas in adult, I			Contrast between a blip and recovery – and the meaning of this?	
1316		think that piece of, that idea of recovery is so different. Like you	More of a blip			
1317		were in need to recover and you’ve got very acute kind of cases in	Need for recovery in adult			Recovery vs blip in adult MH and CAMHS
1318		adult. Like there’s, there’s none of some of the stuff maybe that we				
1319		would see here, you know. Eh ADHD isn’t seen in adult like,	ADHD not attending adult MH, but over half of caseload in CAMHS			
1320		whereas half the clinic here is ADHD you know? Eh so mental		*Half the clinic* - ?an exaggeration, emphasizing a large number	Why do children with ADHD not progress to adult services?	
1321		health is viewed in a very different way and eh yeah (pause). Yeah.				
1322	R	Eh (pause). And if you if you could create your ideal CAMHS				ADHD in CAMHS, not in adult MH
1323		Deirdre, what what, would is there anything that you would do				
1324		specifically or?				
1325	P	Yeah, I think we really need to see sixteen to eighteen year olds as a				
1326		matter of urgency. I think it’s really inappropriate that a child who is	Urgent need to see 16-18y.o.	Referring to legislation here to back up her point		
1327		a child under the Childcare Act until eighteen, should be seen in an	In appropriate that a child has to attend adult services			Urgent change needed in age of referrals to CAMHS
1328		adult service. I think even for, for people who are attending you			Inappropriateness of children attending adult MH services, and its legal context?	
1329		know, and there there are different criterias for adult services eh and				
1330		very vulnerable kids here. I think it eh at sixteen, very vulnerable		Repetition of *very vulnerable*		
1331		child eh for all different reasons, why they would be presenting and	Child of 16 very vulnerable			
1332		the mix I just think it’s really. I struggle with it eh. I think eh I think	Struggles with this			
1333		there needs to be a process, eh a a multidisciplinary team process eh				
1334		that really I don’t think. I think documents happened and things like	Need for MDT process			
1335		that, when maybe the Vision for Change and all those in the last				
1336		eight years. I think documents and different initiatives, the	Documents happened			Making sense of nature of changes in CAMHS
1337		teamwork eh team, what’s that the the initiative to, to enhance the?	Team-work			

1338 1339 1340 1341 1342 1343		Enhancing Team initiative, that came and I think that just, I think it should have been made mandatory that every team. Because every team I think is. I I go to the social work SIG group in IASW and I I hear that every team is struggling in similar ways and I think Enhancing Teamwork needs to be done with every CAMHS team around the country.	initiative Needs to be mandatory SW SIG: every team is struggling	Teams are *struggling*	Need for work on MDT development in CAMHS Her team as similar to other teams in CAMHS	MDT struggles in all of CAMHS
1344	R	Yeah.				
1345 1346 1347 1348 1349 1350 1351 1352 1353 1354 1355 1356 1357 1358 1359 1360 1361 1362 1363 1364 1365 1366 1367 1368 1369	P	Eh I think there needs to be, eh eh a real, a real, eh not just a tokenistic, but a real eh sense of what multidisciplinary team working is. And there, I feel that there is tokenistic at the minute eh. Eh I feel that there needs to be eh a dumbing down of the medical model eh and a more flattening of, eh you know, the hierarchies around around around that. Eh I do appreciate that eh consultant psychiatrists are the, are the eh you know. They hold clinical responsibility for cases coming in here and I think that that is very appropriate, particularly for CAMHS teams eh (pause). And and and at this level, eh. But I I I I still think there needs to be a kind of a a a (sighs). The model needs to be different around that, in terms of the hierarchy. I think there needs to be a clinical co-ordinator here. We get the referrals or I, you know the the referral meetings are (pause) not 'one person one vote.' And I think even some of the referrals that come in, that people don't know who we are. So social, school sends in this urgent message to the parent 'Go to the GP.' GP responds to that. We get a message in and then when the letter is read, it's like 'Okay, wants to kill self, hasn't seen the child, he wants to kill self, of course we see them, of course appropriately.' (pause) And yet that system doesn't support, for me it doesn't support you know, it doesn't support the KPI. It's it's all, I I would think a clinical co-ordinator needs to be created. I think that somebody who can triage before ever that, so those, so that letter should go to the clinical co-ordinator who, or the triage person, maybe that's not the right word but you get what I'm getting at.	Need for real > tokenistic MDT working Tokenistic at present Need to dumb down medical model, flatten hierarchy Consultant has clinical responsibility: appropriate Model and hierarchy needs to change Need for clinical co-ordinator Referrals meetings are not 'one person, one vote' Current referrals system doesn't support KPIs Need for clinical co-ordinator Triage referrals	*Not just a tokenistic* - a pretence *A dumbing down* - simplify it? *Flattening Hierarchy* - repetition from earlier *One person, one vote* – repetition from earlier, a sense of equality *Triage* – borrowed from medical language	MDT work in CAMHS it not real at the moment? Need for hierarchy on MDT to change Need for role of clinical co-ordinator Referrals in CAMHS to be triaged	Need for authentic MDT work in CAMHS Psychiatry as holding clinical responsibility, but not all the power Clinical co-ordinator as a means of responding to hierarchy on team Need for increased clarity and understanding of CAMHS amongst referrers
1370	R	Yeah yeah, yeah yeah.				

1371 1372 1373 1374 1375 1376 1377 1378 1379	P	So that a triage person can eh triage eh the the that referral, so it goes to them first and they can do that, it could be their core job that they they do that kind of initial triage stuff, you know and see. They could be the kind, the, I suppose if you like the gate-keepers. That would, would just get rid of all that, you know inappropriate referrals stuff. Eh you know that and there would be more of a kind of 'Okay like I hear that bit but I need this information, that information and the other information' and then if it goes to the team, that all that information is gathered.	Triage as gate-keepers Stop inappropriate referrals Seek more information with referrals	Emphasis on *they* *Get rid of* – really needs to go	A need to manage referrals better	Clinical co-ordinator as a triage for CAMHS Potential benefits of ↑information-gathering in referrals
1380	R	Okay.				
1381 1382 1383 1384 1385 1386	P	And it's just that time-wasting and that that inappropriate. See for me, it's all about the the families. I just feel that you know it's so… And they've waited, some kids wait here for a year on a waiting-list and then when we see them, 'You're inappropriate'. And I just, that for me is just you know, I just. That kills me because a parent is waiting 'Oh please God, it will come up soon.'	Inappropriate referrals waste time Impact also on families That kills her Families really waiting	Emphasis on *kills* and verb choice, significant impact on her	Guilt about waiting-list? Waiting-list and expectations in parents	Impact of waiting-list on families Impact of waiting-list on self
1387	R	What kind of referrals would they be then?				
1388	P	It could usually be ADHD cause they're not seen as urgent.	ADHD not seen as urgent			
1389	R	Yeah.				
1390 1391 1392 1393 1394 1395 1396 1397 1398 1399 1400 1401 1402 1403	P	And yet somebody who's struggling with, eh with eh a little boy or a little girl in school, who's like impulsive and risk-taking behaviour and all that sort of stuff, you know. That can be very urgent for them but again you know like, if if if there was a proper triage done on that. Now we would sometimes say, you know 'Oh get to the GP' but the GP then is the one who has to do all that and sometimes it doesn't happen. We would sometimes say Triple P programme in the community, parenting or this or this, we recommend this, but it often doesn't happen. So I think if we had that link person to kind of say, 'Okay our waiting-list you know, what what sort of what needs to happen for these?' So link them into those primary care services, so maybe when it gets to that point, you know. A lot of the reason, cause they're coming to us without having any interventions from anywhere.	ADHD could be having significant impact, could be urgent GP cannot triage Parenting programme may be recommended Person to consider needs of W/L Referrals often have no	Emphasis on *them* – the child and family Emphasis on *any*	Impact of MH difficulties on functioning Primary care services as an initial response to some MH difficulties	Context of each child/adolescent and their difficulties Local community services as a precursor to CAMHS

1404	R	Oh I understand what you’re saying now, yeah yeah, yeah yeah. So	previous interventions			
1405		they’re inappropriate in that they, they (pause)?				
1406	P	They’re waiting forever on a waiting-list without any, and then	Families can wait for a long time, then be inappropriate	*Waiting forever* – a long time		
1407		when they come, it could be that they’re inappropriate, that they				Ways to manage waiting-list better
1408		don’t fit any criteria, they’re just what somebody might classify as				
1409		behaviourally…				
1410	R	Yeah.				
1411	P	Just a bit, there’s no boundaries at school or at home or like that, or	Other difficulties, or for other services		CAMHS could be doing more to manage and respond to referrals?	
1412		they’ve an intellectual disability and they should be in a different		Direct (hypothetical) speech to back up her point		
1413		service↑. ‘Sorry, wrong service’ and we would have known that if				
1414		we did some of that, you know?	Could have found this out			
1415	R	Initial, yeah.				
1416	P	And I I think that’s just, you know that’s not how we operate. I	Not how teams currently operate, but make suggestions on one letter			
1417		don’t think clinical teams around the country operate in that way,			Query decision-making on referral letter only	Need for ↑information gathering for referrals
1418		but yet we make some suggestions based on one little letter.				
1419	R	Okay.				
1420	P	You know and then they wait for a year and? So I just yeah more of				
1421		that and and and even just, yeah team co-ordinator. Like that there	Then wait for a year			
1422		would be you know eh you know like (sighs) real eh (pause) real		*Team spirit* – what does this mean for her?	How would a team co-ordinator lead to team spirit?	
1423		sort of team spirit. I think that would be important you know.	Team co-ordinator would bring team spirit			
1424	R	Yeah.				
1425	P	Eh (cough) and I don’t know what else I would do. I’d probably do				
1426		loads of other things but they’d be the things I think are…				
1427	R	Yeah. And then were you saying then, just to make sure I got you				
1428		right, that when these referrals come in with someone saying (pause)				
1429		eh you know ‘They they said they’re going to kill,’ they get seen				
1430		straightaway and then if. Does that delay other, the other wait-list is				
1431		that?				
1432	P	Oh yeah.				
1433	R	Part of it.				
1434	P	Absolutely. There’s a hierarchy, there’s a there’s a criteria.	Hierarchy in response to referrals	*Hierarchy* to describe referrals also	Hierarchy on MDT & a hierarchy in referrals	
1435	R	Yeah, yeah.				
1436	P	So if there’s something, see first of all the risk, the suicide risk is the	Risk of suicide			Hierarchy in referrals to CAMHS

1437		first you know. And and eh if they're, if they're killing themselves	is priority Intent to hurt themselves			
1438		with intent or if they're killing themselves, if they're hurting				
1439		themselves with intent.				
1440	R	Yeah.				
1441	P	To kill themselves or if they're homicidal or something like that.				
1442		Like they're prioritized and then it would go down, now that's	Referrals are prioritized Moveable decisions			
1443		decided. So there's like there's obviously moveable sort of decisions				
1444		made there it's not like 'Oh if you, if you're not without intent, we				
1445		don't see you.' But there's, yeah that would be first and then there			Risk of suicide> Risk of self-harm> ADHD	
1446		would be eh (pause). There would be eh you know, the next thing	Self-harm also a priority			Rating of referrals according to risk to self/others
1447		then would be, you know self-harm. Maybe wait a little bit longer if				
1448		they've seen somebody in such a place, and then ADHD unless it's		Diagnoses to refer and name to groups of children and adolescents		
1449		like at risk at come coming out of school and is threatening to kill,	ADHD or other behavioural difficulties on W/L			
1450		because of you know whatever eh. But usually ADHD would go on				
1451		a waiting-list or other behaviour, other kind of pieces.				
1452	R	Yeah anxiety or just=				
1453	P	=Eh anxiety is actually kind of probably up there, like yeah. And	Anxiety may be referred to community psychology			
1454		and actually probably wouldn't be seen, we'd refer to community or		*Up there* – referring to hierarchy again?		
1455		primary psychology.				
1456	R	Okay, okay.				
1457	P	Well no, we do see anxiety but it depends on the flavour of eh. But		*Depends on the flavour* – how it appears?		
1458		that wouldn't, that would probably prioritized as well, it depends on	Depends on level of anxiety and impact on functioning		Response to referrals about anxiety depends on impact on functioning	
1459		the the functioning, whether their social functioning is being you				Acceptance of anxiety referrals in context of functioning
1460		know eh (pause). Anxiety, if they're, if they're out of school and				
1461		they're withdrawn and they're not with their friends. Like if if it's				
1462		imp impacting on their social functioning, you know, so it's around				
1463		that kind of...				
1464	R	So when you see them you decide whether or not they're for=	Decisions based on referral letter			
1465	P	=Well no, even the referral letter.				
1466	R	The referral letter yeah, depending on what was on it?				
1467	P	But that's what I'm saying if there was a co-ordinator or somebody	Team co-ordinator could triage			
1468		that would kind of just you know that do a triage or...				
1469	R	Yeah, ring up and sort, suss it out more, is it?				

1470	P	Yeah, even just like have a meeting with the triage person first. ‘Let				
1471		me...’ So do that basic, like they do over in A&E, where they have a	Families could meet for a ‘triage’ first			
1472		triage nurse first. All that is done and then they, you know they keep				Comparison between triage in A&E and potential triage in CAMHS
1473		people along the way, you know.			Triage as a better system of responding and managing referrals	
1474	R	Okay.				
1475	P	Can meet, be the person and or else they go and discharge back to				
1476		community, you know, if that makes sense?				
1477	R	Yeah.				
1478	P	Yeah.				
1479	R	And I want to just go back to something you said there eh, about				
1480		you you you’d like to flatten the hierarchy. Eh is that hierarchy eh,				
1481		one profession on top and everyone underneath, or is there some in				
1482		betweens?				
1483	P	Mmm.				
1484	R	Cause somebody else raised this raised this in an interview as well. I				
1485		just ((want to test)) it out.				
1486	P	Yeah eh flatten the hierarchy. I’m delighted with hierarchy in lots of				
1487		ways as in I think we need a structure and a line management	Hierarchy in has some benefits i.e. discipline line management			
1488		position. So for me, the hierarchy of me to go to my supervisor to				
1489		then go to my line manager to then go to ((a catchment)) manager; I			Comparing hierarchy in discipline structures and hierarchy in MDT	Role of structures within SW
1490		appreciate that.				
1491	R	Yeah.				
1492	P	And I think that’s a really positive model eh whereas before, I think				
1493		the hierarchy I’m talking about is the in-team hierarchy.	Hierarchy in MDT is not positive	Emphasis on *in-team* hierarchy		
1494	R	Yeah.				
1495	P	In that we can’t jump without psychiatry saying ‘Yes, how high?’	Follow direction of psychiatry	*Jump, how high?* - Ridicule	Other disciplines being answerable to psychiatry	Power of psychiatry in MDT
1496	R	Yeah.				
1497	P	And of course we can we all have our own, and I have a sense of				
1498		that because I’ve been empowered to have a sense of that.	Have a sense of that			
1499	R	Yeah.				
1500	P	But and I appreciate that, that you know, there is eh. I suppose it’s				
1501		all that stuff around clinical governance like, you know. I know that	Clinical governance being			
1502		that’s being implemented across the country, that idea of who holds			Lack of clarity around clinical	Uncertainty about

1503 1504 1505		clinical governance. Who's, you know? And and I suppose given eh line managers responsibility for what their clinical governance piece for what their...	implemented nationally Who hold clinical governance?		governance	clinical governance in CAMHS
1506	R	Yeah yeah.				
1507 1508 1509 1510 1511 1512 1513 1514 1515 1516 1517 1518 1519 1520 1521 1522	P	So for example, I'm responsible to my line manager and she has clinical governance over me and what, and I also have a responsibility, ethically to my own practice. As opposed to like that bit of I got at the beginning when I came, 'I'm the boss over you' and 'We don't want your other line manager and what they have to say.' I mean and on the team I suppose (sighs) you know, I I I always kind of had this picture of, you know, when you're in an emergency ward. If you were ever in hospital and you see somebody eh you know, who's who, you see, you hear a heart machine going off or something, and you've the Consultant and the Reg and then the the nurses and the whole team really coming behind, you know. Like 'Run! Wherever she goes, I go' you know? And and that's that's what I mean, I mean like you know, there is, there's there's there's, there is a. There has been a flattening of the hierarchy in that we have now got, you know, more clear structures around clinical governance and that's I think that's <u>powerful</u> stuff and brilliant stuff.	Responsible to line manager Responsible to own ethical practice Bossed at the start of CAMHS Akin to an emergency ward All follow the doctor Some flattening of hierarchy has happened Brilliant clinical governance structures	*The boss* – in charge of Comparison to clichéd medical practice *Flattening of the hierarchy* – repetition from earlier Emphasis on *powerful*	Shared responsibility between line manager and her to ensure good SW practice Description of an image that she does not want to be part of in her work	Being bossed by psychiatry initially Comparing power of psychiatry in hospital to that in CAMHS Recognition and value of hierarchy in CAMHS being flattened
1523	R	Yeah.				
1524 1525	P	And that's what I would continue if I was the boss of a CAMHS team.				
1526	R	Yeah, from a social work kind of=				
1527	P	=No, just in general.				
1528	R	Just in general.				
1529 1530 1531 1532	P	No. I think, like for SLT that they have a structure of their own to bring their worries. Again it flattens out you know, as in like 'We all have a piece here,' it's not just one and then you just, you know, that's what I mean.	SLT have structures All disciplines have a role in CAMHS, not just one	*Flattens out* – again		Comparison with structures within SLT
1533	R	Yeah.				
1534	P	I don't know if I'm making sense?				
1535	R	No, no I understand what you mean.				

1536	P	No I don’t mean it just for social work, I mean it for everybody	SW, and other disciplines			
1537		that=				
1538	R	=But eh, but am I getting you right, in that something that comes by				
1539		each, you’re saying some of that comes by each profession doing				
1540		their own (pause) background work and becoming a bit more…				
1541	P	Absolutely.				
1542	R	Yeah.				
1543	P	And that’s been really…				
1544	R	And that example you’d given about your how=	Doing own background work doesn’t get air-time			
1545	P	=Absolutely, big time. That’s that’s been major and it’s there but it		*Doesn’t get air time* – not valued	Importance of disciplines doing some work on their own development	
1546		doesn’t get air time because eh we we do. First of all, we mightn’t				The development of professional identity in CAMHS as a process
1547		know about it because we haven’t done the background work or				
1548		secondly, the other person who’s trying to be more in control can’t	Some people trying to be in control	*Control* x3		
1549		let go of that control or thirdly, they mightn’t know that they have to			Compromise in control on MDT	
1550		let go of that control. Two people you know, the the staff and the	People not recognizing that control needs to go	*Higher person* – again, a term referring to a hierarchy		Negotiation of control in MDT
1551		higher person you know.				
1552	R	Yeah, okay.				
1553	P	What else would I do though, before I finish, on the CAMHS team,				
1554		is the the school stuff. I’d really like to kind of develop that and to	Develop link with schools			
1555		have a kind of a link with schools, which we do have.				
1556	R	Yeah.				
1557	P	You know, we’ve worked hard but I’d like to, I think that’s very				
1558		important, and the the the link between primary care services and	Develop links between CAMHS and other services in community		Potential benefits of increased understanding between CAMHS and other services	
1559		CAMHS as well. So to include primary care psychology, GPs,				
1560		social work on the ground, eh maybe child protection and welfare		*On the ground* – as opposed to management?		Need to improve inter-agency communication and understanding
1561		eh. (pause) Like I’d like to kind of, you know, like I’d like to kind of				
1562		promote more of the the understanding of each other’s services	Promote understanding of CAMHS			
1563		within that, cause I think eh you know, that could cut out a lot of				
1564		the...				
1565	R	Yeah.				
1566	P	We could work much better as an inter-agency with that.	Better inter-agency working			
1567	R	Yeah.				
1568	P	Yeah we all have a role to play in mental health. That’s the bit that	All have a role			

1569 1570 1571 1572 1573 1574 1575 1576 1577 1578		loses it for me. Like when somebody hears mental health, a bit like child protection, we all have a role there as well and like everyone of us do. And and for me, when somebody hears mental health, that idea of pigeon-holing, you know. 'Oh throw them over there, wrap them up in a bow and throw them back then.' Whereas I feel 'No' you know, that's that's what gets lost for me, you know. Eh (pause) and I'd also involve service-users way more. I really don't think they have eh any say, eh. Because at the end of the day, I really just don't feel they do. I just feel like, eh that needs to be really addressed in CAMHS and eh (sighs) yeah.	in MH Similar to all have a role in child protection Involve service-users more in CAMHS	*Pigeon-holing* – overly restrictive *Wrap them up in a bow* – idiom expressing ridicule, idea of being precious?	MH not just for CAMHS Do service-users have any say in CAMHS?	MH is everybody's business
1579	R	It was in Vision for Change.				
1580 1581 1582 1583 1584 1585 1586 1587 1588	P	Yes it is so and there's been a lot of work done, I think in adult services around care-planning and things like that. And really the aspiration is there, but eh, but I, but eh for CAMHS, I just. Like what we do is: we come in and we tell them. Like I think it's down to the individual as well, 'What you would like?' and I think respectful staff do a lot of that, but on the agenda, how do we gen, how, what is it that we do to involve, as a team, to involve eh service-users? And I don't know that eh we could answer that very well. Eh yeah, so that will be another thing.	Work done in adult MH around care-planning, not in CAMHS Asking child and family what they want Need to review how service-user is involved	*We come in and we tell them* – general approach in CAMHS	Children and families being told by CAMHS Power?	Lesser role for service-user in CAMHS compared to adult MH
1589	R	Yeah yeah, yeah.				
1590	P	Yeah.				
1591 1592	R	That's great eh (pause). Yeah thanks that's really great. Eh (pause) is there anything else that you?				
1593 1594 1595	P	There's probably loads, there's probably loads and I don't. I I, one of the things is I I probably feel like I've. I I do feel like that I came across as very negative and there's...	Came across as negative?	Commenting again on the content of what she's saying	Why is she worried about coming across as negative? Politeness?	Concern about impression she has given me
1596	R	No no, no no.				
1597 1598	P	I hope there's. I I don't know whether that was what you were looking for or I'm sure you're looking for whatever?	Asking if I had a particular agenda			
1599	R	No no, I've no agenda. Yeah I've no agenda.				
1600	P	Yeah.				
1601	R	But a few people have commented that actually when they finish the				

1602		interview like ‘Sorry!’ (laughs)				
1603	P	It does bring up that, it does bring up that?				
1604	R	Yeah.				
1605	P	It does it kind of brings up that? God, cause there’s been fabulous	Fabulous things in CAMHS Positive time to be working in MH Excited about her job and MH Glass is half full		Working in MH as a positive experience	
1606		things. Like I I think it’s such a positive time and I do want to say		Repetition of *such a positive time* *Excited* – looking forward to future *Glass is half full* - optimistic		
1607		that eh I think it’s such a positive time to be in mental health. Like				
1608		I’m so excited about my job at the minute and about, about mental				Optimism about the future in CAMHS
1609		health. It’s not just my my role in mental health but just about			Is she trying to balance out some of the ‘negative’ now?	
1610		mental health. I think, you know I really think, you know the glass is				
1611		half full and there’s loads of things not=				
1612	R	=Mmm=				
1613	P	=Not being done but there’s so many different initiatives and	Lots of initiatives and energy into MH			
1614		different energy going into into mental health at the minute, that				
1615		wasn’t there before.				
1616	R	Yeah.				
1617	P	I think it’s it’s a very positive time for reform. And when you hear				
1618		about the adult services, I know we’re talking about CAMHS but	Positive time for reform Changes in adult MH also gorgeous Need for more in-patient beds in CAMHS			
1619		CAMHS will be affected by this as well, like around all of that				
1620		involuntary the the shifts they won’t have as many people in them				Continuation of changes in MH services
1621		and there’s not as many children going into adult units, and that’s				
1622		gorgeous. And that’s another thing that I would do, I would open up		*Gorgeous* – choice of adjective		
1633		more in-patient beds. We’ve no access like we’re in XX so eh I				
1634		((would do that)).				
1635	R	Oh yeah, so go to X.		Commenting again on the content and tone of what she’s saying		
1636	P	X, XY and even just more access to to that. But eh I think it’s a				
1637		really positive time to be in mental health and I I. Like I know that	Positive time in MH			
1638		didn’t come across either, but like I do think...				
1639	R	Yeah.				
1640	P	And there are still challenges to be ironed out but I really think it’s a	Challenges remain and need to be sorted	*To be ironed out* – resolved		
1641		very positive eh time to be in mental health.				Working in MH as positive in the context of ongoing challenges
1642	R	Yeah, you you’ll be staying?				
1643	P	Oh↑ definitely. I’m hoping to leave actually here, but eh I can go to,	Definitely stay in MH, move		Personal and professional life	
1644		down on, eh hopefully going to XX. That’s where I live eh.				

1645	R	Oh I understand.	location closer to home			
1646	P	But yeah.				
1647	R	Okay.				
1648	P	But eh no, mental health I love it yeah, yeah.	Love MH	*I love it, yeah* – clear statement of feeling		Love of MH
1649	R	Okay so CAMHS in XX or?				
1650	P	Eh any mental health I don't think I can choose, whatever comes up.	Will work in any area of MH in future			
1651	R	Oh yeah, yeah.				
1652	P	But eh I'd like CAMHS the most.	Would prefer CAMHS			
1653	R	Yeah.				
1654	P	But yeah, no that's it Eimear. I eh, if I tell ya anymore you'd be				
1655		transcribing for=				
1656	R	=(laughs)				
1657	P	For three days (laughs).				
1658	R	No, no it's great, thank you. Thank you.				
1659	P	Thanks.				

Transcription Notation:

Researcher	(R)
Participant	(P)
Uncertain transcription	(( ))
Non-linguistic input	( )
Gesture	[ ]
Pause	(pause)
Latching of utterances	=
Emphasis	<u>underline</u>