

**EXPLORING LOOKED-AFTER CHILDREN'S EXPERIENCES OF
CHILD AND ADOLESCENT MENTAL HEALTH SERVICES**

By

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Volume 1 of a thesis submitted to
The University of Birmingham
towards the degree of
Applied Educational and Child Psychology Doctorate

The School of Education
The University of Birmingham
September 2012

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ABSTRACT

Looked-after children (LAC) are particularly vulnerable to poor mental health. Yet there appears to be limited research on their experiences of Child and Adolescent Mental Health Services (CAMHS) despite the concept of participation and being listened to strongly exemplified throughout government policy and guidance. A multiple case study design explores the lived experiences of four looked-after young people who have accessed CAMHS and attended a therapeutic intervention. Semi-structured interviews were conducted with four looked-after young people, using activities that are congruent with personal construct psychology (Kelly, 1995). Thematic analysis highlights that 'CAMHS as a secure base' is a facilitator to attending CAMHS. Barriers for the looked-after young people in attending CAMHS related to limited accessibility due to in-care factors and CAMHS factors. LAC's experiences of attending a therapeutic intervention through CAMHS were positive. The overarching theme of 'exploring trauma, loss and rejection' highlights that attending a therapeutic intervention at CAMHS supported the looked-after young people to process and resolve difficult past experiences and reconstruct working models of self and attachment figures. Participants also highlighted ways in which CAMHS could be improved for LAC through a need for transparency. Implications for all professionals working with LAC are discussed.

To my wonderful niece Humaira

for your prayers, smiles and snacks throughout my research journey

ACKNOWLEDGEMENTS

Thank you to Dr. Anita Soni for her invaluable support and advice, and thought provoking questions throughout my research journey.

Thank you to Bushra for her warmth during my research journey.

Finally a special thank you to the four looked-after young people who participated in this research study. Without their honesty, openness and strength, this research would not have been possible.

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List of abbreviations

ADHD	Attention Deficit Hyperactivity Disorder
CAMHS	Child and Adolescent Mental Health Services
CORC	CAMHS Outcomes Research Consortium
CAPA	Choice And Partnership Approach
EP	Educational Psychologist
MST	Multi-Systemic Therapy
LA	Local Authority
LAC	Looked After Children
NHS	National Health Service
NICE	National Institute of Clinical Excellence
PCP	Personal Construct Psychology
SCIE	Social Care Institute for Excellence
SDQ	Strengths and Difficulties Questionnaire

CHAPTER 1: LITERATURE REVIEW

1. Introduction to the literature review

Looked-after children (LAC) are some of the most vulnerable and socially excluded in society (Golding, 2008). Throughout this paper, the abbreviation LAC will be used for looked-after children, otherwise commonly known as children in care. The term LAC will be used to refer to children and young people in care up to the age of 18. Children and young people frequently enter the looked-after system as a consequence of abuse and neglect and bring with them a high level of need including poor mental and physical health (Mooney et al., 2009). LAC are much more likely than other children to have experienced risk factors that predispose them to the development of mental disorders (Richardson & Lelliot, 2003). There is considerable evidence of poor long-term outcomes for LAC with Mooney et al. (2009, p.7) calling for this area 'to be treated as a public health priority'. The increased risk of a range of health and education difficulties has focused attention on the importance of mental health, education and social care services working closely together at all levels (e.g. Arcelus et al., 1999; Callaghan et al., 2004; McAuley & Young, 2006; McAuley & Davis, 2009;).

1.1 Aims and objectives of the literature review

The purpose of the literature review is to critically review existing research on the mental health needs of LAC. Additionally, there has been limited research into the experiences and outcomes for LAC who have accessed interventions through CAMHS. This literature review will address the broad questions presented in Box 1.

Box 1. Questions for the current literature review

- 1) What does research say about the mental health needs of LAC?
- 2) What is the role of CAMHS for improving mental health outcomes for LAC?
- 3) What is the evidence base for the success of therapeutic interventions delivered by CAMHS for LAC?
- 4) To what extent is the voice of the looked-after child or young person represented in CAMHS research and practice?

1.2 Literature search method

Sources were identified from a range of academic databases using the University of Birmingham electronic library service. The databases included *ASSIA*, *Education* (SAGE), *ERIC* and *Psychology* (SAGE), *Swetwise*, and *PsycOVID* (1996 to date). 'LAC/ children in care and mental health' were initially entered as keywords but produced an unwieldy number of articles. Using Boolean logic, these search terms were subsequently combined with a range of other keywords, namely, 'CAMHS', 'user-views', and 'therapeutic interventions'. The abstracts and references of resulting articles were explored for their pertinence to the review. As the focus of the literature review became more refined, a snowball technique was used to identify further relevant articles. This involved following up references from the articles found through initial database searches. These references were obtained and further relevant references were identified from the text. Government legislation and guidance were searched for using the Department for Education website. In total more than 92 articles from a range of journals were identified and examined to determine their relevance to the questions being considered. The initial searches were carried out in early 2011, with additional database searches conducted up until the time of submission of this thesis (February 2012).

2. Background: Who are LAC?

The 1948 Children Act was the first legislation to set up the care of children by Local Authorities (LA) and resulted in the creation of specialist Children's Departments, which were later absorbed into social services departments. The current care system is based on the Children Act 1989 which puts a duty on LAs to 'safeguard and promote the welfare' of all children within their authority who are in need, and to encourage these children being brought up by their birth families, as long as this does not compromise their physical and emotional wellbeing. The 1989 Children Act considers any child who is in the care of the LA or who is provided with accommodation for more than 24 hours to be 'looked-after' (Department for Education and Skills, 2006a). The four routes through which a child can become looked-after are summarised in Table 1.

Table 1: Routes by which a child can become looked-after (Department for Education and Skills, 2006a)

Section of the 1989 Children Act	Route by which the child has been taken into care
20	Accommodation under a voluntary agreement with parents (parental responsibility remains with the parent)
31 or 38	Child is the subject of a care order or interim care order (parental responsibility shared between the LA and parents)
44 or 46	Child is the subject of an emergency order for their protection (taken into police protection to prevent significant harm occurring to them)
21	Child is compulsorily accommodated, including children remanded to the LA or subject to a criminal justice supervision order with a residence requirement

Once in care, a child or young person is allocated to a placement, of which the most frequent are foster care and residential children's homes, although the Care Matters Placement Working Group Report (Department for Education and Skills, 2006b) recognises that the

range of available placements and access to these will vary. Over the past ten years there has been an increase in the number of children placed in foster care, with seventy-four per cent of the looked-after population in a foster care placement, while only thirteen per cent were in residential settings as of March 2011 (Department for Education, 2011a).

In 2009, sixty-three per cent of LAC were the subject of compulsory care orders. The majority (61%) had entered care as a result of abuse or neglect (Department for Children, Schools and Families, 2009). However, the compulsory care order statistics may not be an accurate representation of child abuse and neglect. Under section 20 of the 1989 Act, children can come into the care of a LAC by a voluntary agreement. It may be that parents have abused or neglected their children, but this remains latent and other factors such as family dysfunction are perceived as the reason to voluntarily accommodate children.

Additionally, it is important to highlight that there are a range of reasons why children enter the care system aside from abuse and neglect. Parents may be unable to cope due to illness or disability, or their parents may be absent for a variety of reasons. For example, they might have left, have died, be in prison or the child might be an unaccompanied asylum seeker. In some cases children are taken into care for short periods to give their parents the chance to recover from illness or other traumatic event (Vostanis, 2007; Golding, 2010). Some children enter the care system with the voluntary agreement of their parents. Others enter care through the youth justice system after becoming involved in criminal activity. This reflects that not all children who enter the care system bring histories of abuse and neglect.

Sempik et al. (2008) looked at the emotional and behavioural difficulties of children at entry into care. They found that seventy-two per cent of LAC displayed indications of behavioural and emotional problems at the outset of their care journey. This research is consistent with the view that children in care have risk factors which make them susceptible to developing

mental health problems prior to becoming looked-after (Mental Health Foundation, 2002). However, one can argue that it is imperative to not make generalisations regarding the mental health of LAC, as this can compound the stigma already attached to LAC.

2.1 National policy context for improving mental health outcomes for LAC

The change in government has led to revised legal framework for LAC which came into force in April 2011. Revised regulations and statutory guidance on care planning, transition to adulthood, the voice of the child and independent reviewing officer (IRO) functions are among the recently revised elements (Department for Education, 2011b). Earlier guidance from the previous government on the promotion of the health and educational attainment of LAC remains in force.

The previous government's commitment to improving the mental health of LAC is reflected in the policy frameworks and guidance over the last decade. The Government's White Paper *Care Matters: Time for Change* (Department for Children, Schools and Families, 2007) highlights the significance of improving the health of LAC through targeted and dedicated CAMHS services that prioritise children in care. This is consistent with *Standard 9: The Mental Health and Psychological Well-being of Children and Young People* from the National Service Framework for Children, Young People and Maternity Services (Department of Health, 2004).

Additionally, the independent CAMHS Review (Department of Children, Schools and Families and Department of Health, 2008) states that long-standing problems persist for LAC in accessing a full range of appropriate support. Progress on the implementation of recommendations listed in the CAMHS Review has been set up by the government's National Advisory Council for Children's Mental Health and Well-being. A report (National Advisory Council, 2009) by this body looks at examples of progress and the challenges to

date if the CAMHS Review recommendations are to be achieved. The report highlights that one year on from the recommendations, the needs of LAC who are vulnerable to poor mental health outcomes are still not being addressed. Similarly, the government's statutory guidance on promoting the health and well-being of LAC (Department for Children, Schools and Families and Department of Health, 2009) highlights the responsibility of health authorities to provide specialist support to meet the health needs of LAC. This includes providing dedicated CAMHS for LAC where there is an identified local need or seconding a CAMHS professional into a LAC multi-agency team. Guidance also highlights that a LAC is never refused a mental health service on the grounds of their placement being short-term or unplanned. However, there is a lack of research evidence as to whether this is implemented.

2.2 The mental health needs of LAC

The World Health Organisation (2004) defines mental health as:

It is defined as a state of well-being in which every 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 her or his community.

(World Health Organisation, 2004; p3)

Mental health can also be defined as an expression of emotions, and as signifying a successful adaptation to a range of demands (Department of Health, 2004). The ability to cope with a range of demands and adapt in the face of stress and adversity as highlighted in the World Health Organisation definition relates to the concept of resilience. The concept of resilience has been neatly defined by Newman and Blackburn (2002; p.1) as 'the capacity to resist or bounce back from adversities'. Resilience is most commonly understood as a process rather than a trait of an individual (Rutter, 2008). Most research now shows that resilience is the result of individuals being able to interact with their environments and the processes that either promote well-being or protect them against the overwhelming influence of risk factors (Zautra et al., 2010). These processes can be individual coping strategies, or

factors within the home or community setting that make resilience more likely to occur. In this sense "resilience" occurs when there are cumulative 'protective factors. These factors are likely to play a significant role when the greater the individual's exposure to cumulative 'risk factors'.

The more risk factors to which a child is exposed the greater their vulnerability to mental health problems. Risk does not cause mental health problems but it is cumulative and does predispose children and young people to poorer outcomes. Research has given us a clear picture of a range of factors that are statistically associated with poor mental health outcomes, namely risk factors, as well as protective factors that are associated with good outcomes (Mental Health Foundation, 2002). Risk factors increase the likelihood of poor mental health outcomes. They do not necessarily cause them. The relationship between factors and outcomes is complex, and the two may influence each other. As the number of risk factors increases, so the likelihood of a child experiencing mental health problems increases dramatically. However, not all children facing the same risk factors will develop problems; some will be more resilient than others because of other protective factors in their life (Department for Children, Schools and Families/Department of Health, 2008a).Table 2. displays the risk and protective factors related to children and young people's mental health (Mental Health Foundation, 2002).

Table 2: Risk and protective factors in children and young people (source: Mental Health Foundation, 2002)

Risk Factors	Protective Factors
<p>Individual level</p> <ul style="list-style-type: none"> • Learning difficulty • Low self-esteem • Genetic influences • Substance misuse • Communication problems 	<p>Individual level</p> <ul style="list-style-type: none"> • Female • Humour • Religious faith • Good communication skills • Higher intelligence
<p>Family level</p> <ul style="list-style-type: none"> • Family breakdown • Hostile and rejecting relationships • Physical, sexual and emotional abuse • Severe parental mental health problems 	<p>Family level</p> <ul style="list-style-type: none"> • One good parent-child relationship • Authoritative discipline • Support for education • Affection
<p>Community/environmental level</p> <ul style="list-style-type: none"> • Socio-economic disadvantage • Disaster • Homelessness • Discrimination 	<p>Community/environmental level</p> <ul style="list-style-type: none"> • Wider support networks • High standard of living • Good housing • Schools with strong academic and non-academic opportunities

Rates of mental health problems amongst LAC are high in comparison to the general population. Ten per cent of children and young people within the general population in the UK will be diagnosed with a mental disorder (Meltzer et al., 2003). Figures for children and young people living in care in England are much higher, approaching fifty per cent for those living in foster care and rising to nearly seventy per cent for those in residential care (Meltzer et al., 2003). This is unsurprising considering the histories of abuse, neglect and instability which most children have experienced before and after entering the care system (Kenrick, 2000). This high level of mental health need is recognised in the revised Department for Children, Schools and Families and Department of Health (2009) guidance on promoting the health and well-being of children in the care system, which highlights the need for flexible

and responsive mental health services that are able to address the complex needs of this group. However, it is important to acknowledge that not all LAC require access to specialist mental health services. Rather, as highlighted by the CAMHS review (Department for Children, Schools and Families, Department of Health, 2008a), mental health is everybody's business. As a result, schools are more proactive at promoting and supporting mental health and psychological well-being through the environment they create and the relationships they have with children and young people. Recent initiatives such as the National Healthy Schools Programme, the Social Emotional Aspects Learning programme and the Targeted Mental Health in Schools programme share a common aim of developing the capacity of schools to promote well-being and to play a pivotal role in prevention and early intervention (Department of Children, Schools and Families/Department of Health, 2008b).

The types of mental health disorders that children in care undergo covers a wide spectrum of both internalised and externalised problems. Meltzer et al.'s (2003) comprehensive survey identified clinically significant conduct disorders such as Attention Deficit Hyperactivity Disorder (ADHD) as the most common among LAC (thirty-seven per cent), while twelve per cent had emotional disorders such as anxiety and depression and seven per cent were classified as hyperactive. Such data appears to have face validity as it was subjected to a very large sample. However, a methodological limitation of Meltzer et al.'s (2003) survey is that it used clinical diagnostic criteria to identify mental disorders from interview and questionnaire data obtained from carers, teachers and many of the young people (aged eleven to seventeen) themselves. This medical approach of diagnosis may not reflect a true account of the emotional and behavioural difficulties that children in care undergo. Meeting the needs of LAC within CAMHS teams can be problematic when their needs do not fit with either dominant medical diagnostic and treatment models. Attempting to quickly move children and families through the system, focusing on biomedical models of mental health interventions, and utilising checklists like HONOSCA as measures of 'effectiveness', does

not work. These are measures & timescales entirely inappropriate to these children and their families. Instead adopting a bio psychosocial model of assessment and intervention in the form of stable committed support from CAMHS over a 'developmental' timescale, even when there are not specific 'symptoms' to be addressed has been found to be more helpful (British Association for Adoption and Fostering, 2008). For LAC, a biopsychosocial model of mental health takes into account the social systems they exist within and the interaction of this alongside biological and psychological factors on their mental health. LAC and their carers need access to a range of interventions that provide support, training and advice for both carers and the professional network around the child, as well as direct interventions with the LAC. A priority for these interventions is to ensure that children are situated within environments where they feel safe and can develop secure relationships. Tailored interventions with children and their carers are aimed at helping the children build trust in their carers, and so learn to elicit care in straightforward ways. Children who have been traumatised by their previous experience are more likely to benefit from interventions which provide physiological regulation, and support to develop capacity for emotional regulation. Interventions need to enable children to experience increased positive interactions and to increase their capacity for reflective functioning. Therefore a biopsychosocial model of mental health is of clear relevance when considering the importance of the social systems and the relationships that exist within these for LAC.

A more accurate reflection of the prevalence of emotional and behavioural difficulties among LAC would be to gather information from social workers as they are the professionals most involved in the ongoing monitoring of a child's needs and progress throughout their time in care (Leeson, 2010). Additionally, one could study the social services' case files to gain a better understanding of what agencies have been involved that relate to mental health needs. This method was applied by Stanley et al. (2005) who justified that mental health

concerns should be categorised according to emotional, interpersonal and social behaviour rather than clinical diagnosis.

2.3 Placement stability and mental health needs

One way to improve life outcomes is to build children's resilience (Rutter, 1999). The concept of resilience has been neatly defined by Newman and Blackburn (2002; p.1) as 'the capacity to resist or bounce back from adversities'. However, building the resilience of children who have experienced complex adversity requires careful thought and understanding of their needs rather than simplistic solutions. An important property of resilience is that it enables individuals to shape their future rather than allow the effects of unpredictable events to determine the shape of their lives (Cameron & Maginn, 2009). Characteristics such as self-esteem, the capacity to reflect and plan for the future, the capacity to be both autonomous and to seek help can support children and young people to develop the ability to cope with challenges across different environments. To compensate for many children's pre-care exposure to abuse and neglect and to reduce the psychological impact of these experiences, the care system must seek to build LAC's resilience by maximising the number of protective factors in children's lives, such as a stable base, a secure attachment to a carer, positive school experiences and peer relationships (Cameron & Maginn, 2009).

Changes in care placements can predispose children in care to a higher risk of mental health problems and poor life outcomes. The Utting report drew attention to the extent of placement instability and the effect of this on the lives and safety of individual children in the care system (Utting et al., 1997). Often, it is the very troubled children who move most often, thereby exacerbating their mental health needs. There is some evidence from Stanley et al.'s (2005) study that more disruptive behaviour in children contributed to placement changes and this finding receives support from Newton et al.'s (2000) study. This claim has been further supported by consultations with children in care which informed the Care Matters

White Paper (Department for Children, Schools and Families, 2007) to highlight placement instability and changes of social workers as key factors which impacted on LAC's well-being. As one 14-year-old girl who had been through 30 placements remarked, 'you feel like a bit of rubbish yourself who no one wants.' (Sergeant, 2006, p. 212).

This is further supported by the knowledge that many CAMHS professionals prefer only to see children once they are established in a stable placement, with the result that some of the most needy children are excluded (Arcelus et al., 1999; Richardson & Joughin., 2000). However, the Department of Children, Schools and Families and Department of Health (2009) guidance highlights that a LAC should never be refused a mental health service on the grounds of their placement being short-term or unplanned. Stanley et al. (2005) identified an association between high levels of mental health need and placement disruption. Yet, the relationship between placement disruption and high levels of mental health need is complex because it is not clear from their study whether high levels of mental health need contribute to placement disruption, or are a consequence of multiple placements or both.

2.4 Attachments and mental health of LAC

A key basis for why children experiencing placement disruption are more vulnerable to mental health problems is due to a lack of stable relationships and attachments. Due to reasons such as abuse, neglect and placement instability, children can experience attachment difficulties prior to and during placement in the care system. However, children who are not in care may also experience attachment difficulties, for example, through experiencing loss as a result of parents separating or a family bereavement. This is a predominant message in psychoanalytically orientated theories, not least in attachment theory (Fonagy, 2001), which is a key theory for understanding a child's reactions to separation and placement in residential or foster care (Bowlby, 1980). Attachment theory (e.g. Bowlby, 1969) proposes that all children seek to form emotional links with a parent or

caregiver who is able to meet their physical and emotional needs. Ainsworth et al. (1971) highlights that caregiving consists of four dimensions that support secure attachments. They are:

- Availability – helping children to trust
- Sensitivity – helping children to manage their feelings
- Acceptance - building children's self-esteem
- Co-operation – helping children to feel effective

Schofield and Beek (2009) suggest that caregivers who offer these dimensions can support children to develop a positive view of themselves and positive expectations for their relationships with others. Bowlby (1969) proposes that these attachment relationships play a crucial role in the child's social and emotional development. Within close relationships children acquire representations, or internal models, of themselves and their worthiness based on the availability, ability and willingness of the caregiver to provide care and protection. The child of an attuned, emotionally available and supportive caregiver is more likely to feel secure and have a model of self as valued and competent. Whereas, the child of a neglectful or maltreating caregiver may be more likely to be insecure and have a model of self as worthless and incompetent.

The view that early experience in infancy has a powerful effect on later life has led to disapproval of attachment theory as deterministic, since it suggests that an adverse start in life results in poor life outcomes and has a profound effect on adult personality and behaviour (Slater, 2007). However, recent studies of children brought up with adverse early years experience suggest that they can form attachments, even though a number of them are insecure and atypical (Goldberg, 2000). Furthermore, rather than perceive early experiences

as deterministic of later behaviour, such findings also provide a useful framework for identifying risk and resiliency factors, in children who may have experienced difficult early years, and are therefore vulnerable to later behaviour and development problems. Bowlby (1988) himself rejected such a “deterministic” model in his later work, replacing it with one that emphasises risk and resilience (Rutter & O’Connor, 1999). This view is supported by evidence that is consistent with a sensitive period for early attachment, rather than a critical period (Thomas & Johnson, 2008).

3. CAMHS for LAC

The term Child and Adolescent Mental Health Services (CAMHS) commenced after 1975 with the first government recognition that mental health services for children and young people should be based in the community rather than in institutions. Prior to that child guidance clinics had been based largely in local authorities and children with more serious problems were placed in health service hospital units. CAMHS is now the name for the National Health Service (NHS) provided services for children in the mental health arena in the UK. In the UK they are often organised around a structured tier system.

The four-tiered system (Department for Children, Schools and Families and Department of Health, 2008a) has been used for over a decade to conceptualise the planning and delivery of mental health services, and is well embedded within the culture and the systems of health services. Yet, across Children’s Services more widely, there has been a more recent move to the concept of universal, targeted and specialist services as a result of the Every Child Matters agenda (Department for Education and Skills, 2003). Both models are subject to local interpretation and differences in understanding, although they share the basic aim of helping people understand which services are available to everyone and which are available to some (see Appendix 1 for CAMHS and Children’s Services tiered structure). However, the

levels of service described in Every Child Matters (Department for Education and Skills, 2003) of universal, targeted and specialist do not map readily on to the four tiered structure. A targeted service, such as a mental health service that works solely on the emotional well being of LAC may span two or more tiers. Furthermore, a specialist mental health service could be offered by a team of primary mental health workers (Tier 2), or a multidisciplinary community service (Tier 3) providing specialist assessment and therapeutic interventions.

CAMHS have developed alternative and more accessible models for LAC through designated time offered by existing specialist mental health staff, development of jointly commissioned posts, and designated teams. Designated posts integrated within specialist CAMHS may be appropriate for smaller districts and rural/semi-urban areas, whereas designated teams may be more effective in inner-city areas. Such a team has been set up in Leicestershire, for example, offering direct access and treatment to LAC, and consultation and training to carers and staff (foster carers, social workers, residential care staff) (Callaghan et al., 2003). The service applies the same principles to other vulnerable populations, such as young offenders, the homeless and refugees/asylum-seekers (Vostanis, 2007; Callaghan et al., 2004).

Innovative services have been developed in some areas to improve the mental health and emotional well-being of LAC. Young Minds in partnership with the National CAMHS Support Service (YoungMinds, 2007) have published descriptions of designated mental health services for LAC. Box 2. summarises the key characteristics of a successful mental health service for LAC based on the examples.

*Box 2. Ten characteristics of a successful mental health service for LAC
(YoungMinds, 2007; p.11)*

- 1) Flexibility
Many LAC have complex needs and do not readily access traditional CAMHS services.
- 2) Joint commissioning
Mental health services for LAC are at the interface of health, education and social care. Each party needs to understand the systems, time scales and expectations of the others, and have a commitment to working in new ways.
- 3) Strong leadership
Individuals with vision and a passion for providing relevant, accessible services to help turn around children's lives.
- 4) Engagement
Taking time to engage with children and young people whose past experiences have often caused them to mistrust all adults and to battle through life alone.
- 5) Long-term work
The ability to offer long-term support, where appropriate, sometimes at an intensive level and at other times in a low-key way, is important.
- 6) Holistic
Support for the whole child, not just mental health needs.
- 7) Systemic thinking
Using systemic thinking to engage all those in contact with the child and family.
- 8) Participative
It is important to listen to the young people about what they want from a service, develop formal and informal mechanisms for consulting with young people.
- 9) Evidence-based
The importance of evidence-based practice. Evaluation, to ensure that service developments produce effective outcomes, is fundamental.
- 10) Reflective and responsive
Building in processes of reflection and review and responding to feedback from all stakeholders is implicit in their successful development.

A survey of CAMHS in London completed by twenty-eight of a possible thirty-two CAMHS showed that all but one had developed designated or targeted CAMHS provision for LAC

(Cocker et al., 2004). This provision varied as to which age range was served, and also whether the service was available to children living in the borough but placed by another local authority. Some services worked with care leavers up to age 25, others had a cut-off age of 16. Just under half had conducted a recent health needs analysis for children in care, but only three had developed an action plan to take this forward (Haywood & James, 2008). This highlights the variation in designated CAMHS teams for LAC at a national level. This has relevance to the present study as the research aim is to explore LAC's experiences of CAMHS within an urban local authority given the variation in how the mental health needs of LAC are met nationally at Tier 2 and Tier 3.

3.1 Limitations of the research on mental health services for LAC

National policy and guidance clearly recognises the importance of mental health services for LAC. However, very little research has been conducted on the effectiveness of these services through an evidence based approach of evaluation. The CAMHS Outcome Research Consortium (CORC), which is responsible for coordinating measurement of outcomes in CAMHS nationally, do not currently make specific recommendations for measuring outcomes in this client group. The review of outcome measures for CAMHS (Department of Children, Schools and Families and Department of Health, 2008b) recommended the Strengths and Difficulties Questionnaire (SDQ) (Goodman, 1997), which is a general measure of child psychopathology, for use in all CAMHS services, combined with other measures to be identified locally by individual services.

However, given the unique needs of LAC, it is unlikely that this approach can be transferred without careful consideration of the potential issues with this. In particular, the attachment and trauma issues which are characteristic of this client group. The impact of this on the nature of interventions undertaken would need to be considered in order to identify appropriate outcome measures for designated CAMHS services for LAC. Also, one could

question how effective the SDQ is in evaluating outcomes in LAC, and capturing the nature of difficulties typically experienced by LAC.

3.2 Barriers to accessing CAMHS

Children and young people in care are less likely to engage with mental health services (Vostanis, 2007). In a study exploring the views of young people in foster care and their carers, the young people reported that they refused mental health services because of a lack of information, transport difficulties and inconvenient appointment times. They also experienced therapists as not understanding their language and culture. Carers in this same study reported difficulties with waiting times, off-putting venues and the lack of home visits and support for themselves (Beck, 2006). Thus CAMHS can lack the flexibility, sensitivity and accessibility required to meet the needs of LAC (White, 2006). Furthermore, barriers common to all children such as long waiting times, and the stigma attached to attending mental health services as well as being in care (Golding, 2010) can also be experienced. The latter can be compounded for children who have experienced parental mental illness, further adding to their worries about accessing services perceived as being for 'mad people' (Beck, 2006).

A key barrier to accessing mental health service for LAC is placement stability (Golding, 2007). However, the rationale for requiring placement stability, often advocated by CAMHS, does not need to be a requirement for mental health interventions. Whilst it is difficult to provide successful intervention in the face of instability, it is equally difficult to achieve stability whilst mental health difficulties are unresolved and can become more entrenched (Callaghan et al., 2004; Golding, 2010).

4. Therapeutic interventions within CAMHS

With its roots in attachment theory, a key focus for improving outcomes for children in care is through individual or group therapeutic interventions. Therapeutic work may involve the direct intervention of a professional (psychologist, family therapist, primary mental health worker) with an individual child or a group of children (MacKay & Greig, 2007). Therapeutic interventions offered to LAC through CAMHS services vary across the country. Cocker et al. (2004) carried out an examination of 46 current specialist mental health projects for LAC in UK through the Department of Health funding projects via the Mental Illness Specific Grant in 1998 for three years. The different types of therapeutic interventions offered by the targeted CAMHS teams for LAC included:

- Non specific therapeutic treatments and direct work (18)
- Art psychotherapy (3)
- Attachment intervention (1)
- Cognitive behaviour therapy (1)
- Counselling (5)
- Life story work (1)
- Multi-systemic therapy (5)
- Post-abuse therapy (1)
- Person-centred therapeutic work (1)
- Psychodynamic therapy (1)
- Therapeutic play (5)

Interestingly, the non specific therapeutic treatments and direct work was the most frequently offered therapy in eighteen of the targeted CAMHS for LAC. However, given the ambiguity of the category, it is unclear what underpins such therapeutic work in terms of an evidence base. It may be that non-specific therapy is informed to meet the needs of individual children

and young people through adopting a combination of therapeutic modalities (e.g. cognitive behaviour therapy with attachment intervention). However, there is a lack of research on what psychological models and theories inform practitioners' and clinicians' practice when carrying out direct therapeutic interventions with LAC.

Yet research suggests that the therapy type (e.g. cognitive-behavioural therapy, family systemic therapy) is less important, rather the experience of being heard and understood could be the foundation for a good match between a child's need for action and therapeutic responsiveness (Davies & Wright, 2008). This implies that despite National Institute of Clinical Excellence (NICE) and Social Care Institute for Excellence (SCIE) guidance (2010) focusing on intervention type, other aspects of staff interactions may be more important to children as found by Davies and Wright (2008) and Davies et al. (2009). These aspects may cut across therapeutic orientation and may be important for staff training. This is consistent with literature suggesting therapeutic orientation might be secondary to other factors in distinguishing effective therapies (Stiles et al., 1986). The importance of attending to the way that staff relate to children is likely to be particularly significant for LAC, given that children's responses to staff may well be influenced by previously damaging interactions with adults (Golding et al., 2006; Hughes, 2004).

Davies and Wright (2008) reviewed thirteen studies and the key themes expressed by the young people about mental health services as relevant to therapeutic interventions. These included:

- the personal qualities of staff;
- the skills and attitudes of staff;
- therapy process where non-verbal interactions were consistently perceived to be particularly helpful;

- the importance of practical arrangements and physical surroundings for meaningful involvement in treatment decisions; and
- the social context.

The primary importance of individual contacts was a recurring theme in the studies including personal attributes (e.g. kind, approachable), the sense of something being done, and respect for confidentiality. However, only two of these studies specifically elicited the views of children with a trauma history or disrupted attachment. Furthermore, no studies were found that exclusively investigated LAC's experiences of mental health services. This is particularly concerning given the potential ambivalence for these children and young people concerning involvement of mental health services in their lives. A further limitation of the studies reviewed was the focus on quantitative methods such as questionnaires to elicit the views of young people. This has implications for the present study as the research aim is to explore looked-after young people's experiences of accessing CAMHS through obtaining rich in-depth information which is not possible using solely quantitative methods (Robson, 2002).

The government (Department of Education, 2011c) recently announced an extra £6 million a year to provide additional support for foster carers and vulnerable families. Thirty-seven LAs will share this extra funding to implement a range of intensive, cost effective and evidence-based interventions for LAC that have been advocated by the government (Department for Education, 2011c). All local authorities who were already delivering intensive evidence based programmes were invited to apply for funding of up to £200,000 per annum in order to test new ways of delivering the programmes. Local authorities who had not previously developed these intensive programmes were invited to apply for funding to develop one of the four programmes. The Department for Education undertook a rigorous assessment process which included carrying out interviews when selecting the local authorities. Table 3. displays the three evidence based interventions which have been supported by the government, and

as recommendations from the National Institute of Clinical Excellence (NICE) and Social Care Institute for Excellence (SCIE) guidance (National Institute of Clinical Excellence and Social Care Institute for Excellence, 2010).

Table 3: Evidence-based interventions for LAC (Dickson et al., 2010)

Intervention	Description
Multidimensional Treatment Foster Care (MTFC)	There are three programmes for different age groups operating across England. Each foster carer is trained in behaviour management for the age group with which they will work and they are supported by a clinically led team. The foster carer works with one child at a time for between six and twelve months. Their aim is to reduce behavioural problems, increase social, emotional and relationship skills and improve foster placement stability whether the long term plan is to return home, long term foster care or adoption.
Keeping Foster and Kinship Carers Trained and Supported (KEEP)	The standard programme has been designed for carers of children aged 5 to 12 years. It is a preventative programme to increase the parenting skills and confidence of foster carers and kinship carers which helps to reduce the possibility of placement breakdowns.
Multi-systemic Therapy (MST)	Therapists use evidence based approaches, such as cognitive behavioural therapy and structural family therapy to work with young people aged 11-17 and their families. They aim to increase young people's engagement with education and training, reduce young people's offending or anti-social behaviour, increase family cohesion and tackle underlying health or mental health problems in the young person or parent, including substance misuse.

From these three interventions, multi-systemic therapy (MST) is most common within CAMHS for LAC (National CAMHS Support Service, 2011; Dickson et al., 2010). Seven reviews on the impact of MST have been identified. The majority of reviews (n=4) concluded that, to date, evidence of the effectiveness of MST for improving emotional and behavioural health outcomes was inconclusive. Although some evidence of effectiveness was found for

particular emotional and behavioural health outcomes, such as offending behaviour, the majority of MST studies were conducted by the authors of MST and this may have influenced the positive findings (Dickson et al., 2010). In addition, none of the reviews in this area specifically focused on LAC, making it difficult to draw overall conclusions for this population. This limited research suggests that more evidence on the impact of therapeutic interventions for LAC is required. Especially in relation to using qualitative methods to obtain rich data from LAC receiving therapy to identify what aspects of a therapeutic intervention they valued (Davies & Wright, 2008). Therefore the following research question was devised:

- What are LAC's experiences of attending a therapeutic intervention from CAMHS?

5. The voice of the LAC

In 1989 the United Nations adopted a human rights treaty for children, known as the UN Convention on the Rights of the Child (UNCRC). UNCRC covers all children aged 17 (up to 18th birthday) and under and gives children a set of economic, social, cultural, and civil and political rights. The UK ratified UNCRC in December 1991. Article 12 highlights that participation grants all children the right to express their views, and to have these views given due weight in all matters that affect them. This led to the Children Act 1989 as the first legislation to require children's views to be elicited, and this continues to feature in the Children's Act 2004. Additionally, eliciting views from children and young people about CAMHS is central to the thinking of Every Child Matters (Department for Education and Skills, 2004), the National Service Framework (Department of Health, 2004), and to the modernisation of CAMHS (Aynsley-Green, 2005).

There are a number of benefits to listening to the voices of vulnerable children and young people. It is commonly argued that taking vulnerable children's views on board will lead to more successful interventions (Triseliotis et al., 1995) and to better outcomes. Children may

be able to construct a more positive sense of identity (Eide & Winger, 2005), become more confident and assertive (Kinney, 2005) and less vulnerable to ill-treatment (Cairns & Brannen, 2005) if they have a voice and feel they have been heard. However, true listening to disaffected young people requires time, so that a trusting relationship can be developed (McLeod, 2007). This is pertinent to the present study, as research indicates that LAC are often reluctant to share their experiences of being in care as they may not trust adults due to the number of adults involved in their lives whilst in care (Cameron & Maginn, 2009).

Social workers are the professionals most involved in working with children in care, yet LAC rarely have the sort of relationship with their social worker that they want (Leeson, 2010). Simmonds (2008) highlights that the social work workforce is increasingly uncomfortable engaging with children. The competence-based approach to social work training, the increasingly task-focused nature of supervision and the pressure on social workers to generate information both for inspections and for court processes may all have contributed to creating a style of working that is no longer centred on the use of relationship (Baynes, 2008). This is concerning given the fact that although not therapy, the most common form of therapeutic support LAC receive is through life story work and the overall responsibility for obtaining information and ensuring that life story work is carried out rests with the child's social worker.

Cook-Cottone and Beck (2007, p.1) describe life story work as a model for 'facilitating the construction of personal narrative for foster children'. Life story work is intended to help LAC make sense of their situation. It attempts to answer the following questions for the child:

- Who am I?
- How did I get here?
- Where am I going?

It often results in the production of a book but, with technological advances, could take a digital format. This might include photos, drawings, a family tree, an ecomap and birth certificate, usually accompanied by narrative explaining the child's story (Willis & Holland, 2009). Ryan and Walker (2007) whose guides to life story work are widely used in UK social work practice, stress that it is about the 'process rather than just the product' (2007, p.4). It is the discussion and understanding resulting from the activity that should be defined as 'life story work'. However, whether social workers are able to carry out the process effectively is questionable given the high staff turnover, heavy workloads and an administrative burden which all militate against relationships flourishing (Leeson, 2010; Baynes, 2008). Furthermore, one could question how much information children in care should be given in relation to their birth families when life story work or therapeutic interventions are carried out. Especially for young children who have come into care due to extremely traumatic situations such as the murder of birth parents or severe neglect. Professionals working with these children to ensure there is a balance between how much information is given to LAC about their pre-care experiences so as to protect them yet offering them an understanding which they are entitled to. Willis and Holland (2009) highlight that how much detail should be given about birth families from professionals is dependent upon the relationship between the child and the professional and if there is trust and understanding between them.

5.1 The voice of LAC regarding mental health services

Research incorporating LAC's views on mental health services is extremely limited. There are a few small scale studies focussing on such views but very little 'effectiveness' research in this area incorporates a user perspective. In one UK sample of care leavers thirty-one per cent had been referred to mental health services and most of them had been dissatisfied with the services they had received, describing them as 'crap', 'stupid', 'a waste of time', and complaining that they had been 'treated like a child' by mental health professionals (Saunders & Broad, 1997). Similarly, looked-after young people in another study referred to

mental health services as 'mad' and 'mental' (YoungMinds, 2012a) One study with 12–19-year-olds reported that looked-after young people particularly appreciated the informal approach of mental health services offered by the voluntary sector as well as being given a choice in whether or not they participated in counselling or therapy, or another service (Stanley & Manthorpe, 2002). Choice is an inherent part of user-led services and LAC may have different priorities to their carers. This is consistent with the NHS White Paper *Equity and Excellence: Liberating the NHS* (Department of Health, 2010, p.3) which emphasises the need to put people who use services at the heart of commissioning and delivery: the concept of 'no decision about me without me'.

The views of LAC's access to and experiences of mental health services were obtained by Beck (2006) using a postal questionnaire. The results highlighted that relatively few LAC were able to suggest what sort of services might help them with their problems and a number of those who responded to this question simply said that they wanted something different. A key limitation of this study was the use of a postal questionnaire to explore the experiences of LAC. Rather, using a qualitative method may have supported one to further delve into the themes, for example, exploring what 'wanting something different' would look like through a dialogue. This gap within the existing literature gives grounds for employing a qualitative approach to the present study in providing detailed accounts of LAC's experiences of accessing CAMHS, and paying particular attention to the therapeutic intervention they have attended.

5.2 Methods used to explore the voice of the LAC

Worrall-Davies and Marino-Francis (2008) conducted a systematic review of children and young people's views of CAMHS to identify the methods used to gain the views of children and young people and the methods most effective in leading to service change. Using a standard framework, thirteen studies were identified that were both relevant and of sufficient

quality to be included in the review. Interviews, focus groups, brainstorming exercises, and questionnaires were the methods used. Whilst the authors of the thirteen studies should be applauded for employing different methods of understanding and representing young people's experiences of CAMHS, they could perhaps have gone further in using more creative and participatory methods. Additionally, one could argue that these tools and techniques are not appropriate for LAC, given their reluctance to trust adults and share openly their feelings and experiences (Dahl & Aubrey, 2006). Utilising communication methods other than interviews is an important consideration when gaining the views of children and young people. Children are more familiar with communicating via drawings, games and exercises (Hill et al., 1996) and interviews can be enhanced by incorporating activity-based techniques (Aubrey & Dahl, 2006). Furthermore, Binney and Wright (1997) developed the 'bag of feelings' technique whereby the child represents feelings by writing or drawing. This method was adapted and applied in Davies et al.'s (2009) study. It could be argued that incorporating such non directive communication methods may enhance the ability of mental health services to meaningfully engage with LAC.

This systematic review highlights that for children and young people to have a meaningful role in research it is important to develop appropriate methodology to support their voice being heard and also support capturing life as lived by the young people. In line with this, Christensen and James (2000) advocate encouraging young people to represent their feelings and beliefs through the use of non-directive techniques and qualitative methods. These creative methods "can serve as constructivist tools to assist research participants to describe and analyse their experiences and give meaning to them" (Veale, 2005, p.254). This has relevance to the present study as non-directive techniques using inanimate objects will be used to encourage the participants to share their experiences at ease.

Davies et al. (2009) identified that children with disrupted attachments including LAC and adopted children can be engaged in reflective discussions about mental health services when a methodology is developed specifically for them. Similarities between the views of participants in Davies et al.'s (2009) study and those reviewed by Davies and Wright (2008) are apparent: children commented on the therapeutic process, identified a preference for non-verbal communication, appreciated the therapist's personal qualities over techniques, wanted to contribute to therapy, made suggestions and recognised the significance of social context. However, this study has two key limitations. Firstly, it focused on children who were currently receiving therapy, rather than those who had experienced therapy. One could argue that the timing of participation for service users was inappropriate. During treatment for a mental health difficulty children and young people are by definition unwell and it may not be the best time for them to give meaningful thought and reflections to their experiences of therapy until it has ceased (Day, 2008). Secondly, given the diversity of therapeutic models experienced by the participants' in the study, one cannot make any firm conclusions about whether a particular model used in therapeutic interventions is more effective in achieving positive experiences of CAMHS.

5.3 Seeking the views of LAC

Seeking the views of LAC in CAMHS presents challenges and this may be a reason why user involvement has on the one hand been high on the agenda of CAMHS whilst making quite slow progress across services in England (Rees, 2007). Potential conflicts of interest arise out of the holistic nature of most approaches in CAMHS, in which users of services can include parents, carers and other family members, those with corporate or statutory responsibility for the child's welfare, as well as the referred child or young person. Each of these individuals and units may have different perspectives and diverse interests (Wolpert et al., 2001). For example, the outcome of a therapeutic intervention that a LAC has undergone may vary in its success dependent on whether it is from the perspective of clinicians', social

workers, foster parents or LAC themselves. There is a need to elicit the subjective accounts of CAMHS experiences for LAC, as opposed to depending on professional and/or adult based judgements. This reflects movement towards a particular epistemological position. Namely, an interpretive paradigm that emphasises subjectivity which leads to greater understanding and knowledge.

Developing child-focused services in a rational and evidence-based way demands understanding clearly what children and young people would like from CAMHS. Previous research has noted that children find it difficult to talk about negative aspects of their experiences (Bond, 1995). Asking children how they would improve services proved less threatening to elicit areas of dissatisfaction (Rosen-Webb and Morrissey, 2005). To this end, the following research question was devised:

- In what ways can CAMHS be improved for LAC?

6. Limitations of the research

It has been highlighted throughout this literature review that the studies referred to are subject to critique in relation to the sample used and how representative it is of LAC, and the types of method used to identify outcomes of attending CAMHS for LAC. Much of the information cited about LAC uses a positivist approach which produces figures and percentages in order to generate and meet government-led targets. The data that these positivist studies create is subject to interpretation by the authors who, in many cases, were writing reports to inform government policy and guidance. Furthermore, research on children and young people's experiences of CAMHS has been conducted with the view that all children and young people attending CAMHS are a homogenous group and the views are representative of LAC.

However, as highlighted in this literature review, LAC are a group particularly vulnerable to poor mental health and this has led to innovative projects and development of teams within CAMHS to meet the mental health needs of this vulnerable group. Yet there appears to be limited research on their experiences of CAMHS despite the concept of participation and being listened to strongly exemplified throughout government policy and guidance. The limited research that has been conducted within the domain has accessed the views of LAC who were currently undergoing therapeutic interventions thus their experiences of CAMHS were still ongoing so it is unclear what difference CAMHS has made to their life (Davies et al., 2009). As a result, there is a gap in the literature which explores the experiences of LAC who have accessed CAMHS in the past, seeks their views and gives them a voice. To this end, the present study will focus on LAC who are no longer accessing CAMHS, leading to the following research question:

- What do LAC identify as facilitators and barriers to attending CAMHS?

Furthermore there is a bias towards the use of directive communication methods to obtain children and young people's views about CAMHS. Questionnaires, structured interviews and brainstorming exercises were most commonly used. However, children and young people attending CAMHS are often not comfortable verbally to reflect on their experiences. Therefore, there is a need to adopt non directive methods using drawings and objects to describe feelings and thoughts. In this way LAC can feel at ease and empowered by sharing their experiences and being listened to. This is in line with NICE/SCIE guidance which promotes the voices of looked-after children, young people and their families as being at the heart of service design and delivery (NICE/SCIE, 2010).

There has been a lack of qualitative methods which allow for rich in-depth data about the experiences of LAC attending CAMHS and whether there are similarities and differences in

what is valued as important in CAMHS. In particular there is a lack of information about what factors encourage LAC to attend CAMHS and undergo a therapeutic intervention. This information has a key significance as many LAC refuse access to mental health services (Vostanis, 2007), therefore such insightful information would help mental health services for LAC to better support young people who would benefit from CAMHS as this has not been understood or acknowledged fully from the looked-after child or young person's perspective.

Additionally, much of the research regarding experiences of CAMHS for children and young people has been carried out by professionals who work within CAMHS. This may explain why Davies and Wright (2008) found interventions were universally rated positively in their systematic review of the research. It could be the case that these studies consisted of a biased sample of children and young people who had positive outcomes from attending CAMHS, or social desirability bias was present with the looked-after child or young person wanting to please the researcher, especially if they were a professional from CAMHS. One could argue that a mental health professional from CAMHS carrying out a dual role as a researcher may result in a lack of trust and honesty from the looked-after participant. A prerequisite for adults working with disaffected youth is sensitivity towards issues of power, and an understanding of how powerlessness can shape the responses of those who are marginalised (McLeod, 2007). Consequently, practitioners who do not work within CAMHS may be more appropriate to carry out research regarding CAMHS. Yet, a researcher's previous experience with the group on which the research focuses can help establish relationships of trust and is an important dimension to success (Claveirole, 2004). This bears an importance for the present study as my role as a Trainee Educational Psychologist (EP) has involved experience of working with LAC.

Norwich et al. (2010) found that EPs work with children in care through their school-based work, thus they have experience of supporting this vulnerable group. Furthermore, EPs aim

to promote evidence based practice and use a variety of approaches when listening to the voice of the child or young person (Harding & Atkinson, 2009) and therefore are well suited to carry out research with LAC regarding their experiences of CAMHS. Additionally, this can support multi-agency working between educational, health and social care professionals to meet the holistic needs of LAC.

7. Context for the present study

By studying intensively and qualitatively how LAC understand and experience CAMHS, researchers can gain insight into what factors are important for them. The present study aims to adopt an idiographic approach which deals with individuals accounts in detail and in context, and has the potential to generate a rich and contextualised analysis about the experience of CAMHS from the perspective of LAC. This would address an area that remains largely unexplored by research to date, and could inform interventions and practices aimed at improving outcomes for LAC, with particular reference to their mental health.

This research is based on a Tier 3 CAMHS within an urban local authority. It consists of a multi-agency team made up of social workers, mental health nurses, child and family therapists and clinical psychologists. These professionals become involved with LAC who have been referred to CAMHS through the looked-after child or young person's social worker. This research aims to explore LAC's subjective experiences of accessing CAMHS in an urban local authority through the following research questions:

- What do LAC identify as facilitators and barriers to attending CAMHS?
- In what ways can CAMHS be improved for LAC?
- What are LAC's experiences of attending a therapeutic intervention from CAMHS?

CHAPTER 2: METHODOLOGY

2. Introduction to methodology

The aim of the present study is to explore LAC's views and subjective experiences of accessing CAMHS in an urban local authority. The key research questions were developed after an examination of the available literature on meeting the mental health needs of LAC at policy level; the role of CAMHS in improving mental health outcomes for LAC; the evidence base for the success of therapeutic interventions for LAC delivered by CAMHS and the extent to which the voice of the LAC is represented in CAMHS research. The research questions allow detailed and in-depth exploration of the experiences of CAMHS from the perspective of LAC. The research questions are:

- What do LAC identify as the facilitators and barriers to attending CAMHS?
- In what ways can CAMHS be improved for LAC?
- What are LAC's experiences of attending a therapeutic intervention from CAMHS?

2.1 Epistemology

The present study adopts an interpretive epistemological stance (Robson, 2002), which is sometimes referred to as a hermeneutic approach (Cohen et al., 2003). This approach rejects the view that knowledge is concerned with prediction and control. Instead, this study aims to explore the experiences of LAC that are unique and rich in subjective interpretation and meaning (Usher, 1996). This approach is consistent with taking the view that LAC are not a homogenous group, the only thing they have in common is they are in care. Therefore, it is important not to over-generalise as this can lead to stigma for LAC (Golding, 2006).

Hermeneutic or interpretive epistemology assumes human action is understood and interpreted within the context of social practices. In adopting this position, research is viewed as a subjective undertaking, concerned with interpreting the experiences of people in specific contexts (Cohen et al., 2003). Furthermore, I have adopted a 'double hermeneutic', which

focuses on the assumption that researchers who are engaged in social practices of research, make sense of what they are researching through their own research perspective (Usher, 1996).

In subscribing to an interpretivist epistemology, this study is concerned with understanding the subjective reality that is represented and constructed through the eyes of the LAC, by eliciting rich, contextually-grounded descriptions about their experiences of CAMHS. The present study aims to adopt qualitative methodology in order to explore LAC's subjective views and the way they construct their experiences of CAMHS.

2.2 Research design

The research questions suggest appropriate options for approaching the research design to be action research or case study. A key principle of action research is gathering information to inform new practice. This is compatible with the stated research questions for the current study, i.e. to gain an insight into how CAMHS can be improved for LAC within an urban local authority, and what are the facilitators and barriers to attending CAMHS for LAC. This methodology would involve the hermeneutic activities of reflecting, understanding and interpreting the practices of CAMHS for LAC with the ultimate if unstated aim of improving practice, but there are reasons why action research design is not appropriate in this instance. Cohen et al. (2003) describe action research as a form of 'systematic self-reflective inquiry' conducted by practitioners in order to improve and understand situations in which they work.

However, as a Trainee EP I do not directly support the LA Looked-after Children's Virtual School or CAMHS, so it is questionable as to whether I could legitimately undertake action research in this area as my role is not that of practitioner within either of these services. Another option might be to act as an external consultant and work collaboratively with professionals from CAMHS to conduct action research into their practices regarding LAC.

However, the research was not developed and agreed on this premise and CAMHS professionals did not commit to active involvement of this nature despite it being suggested by myself. Feedback from the CAMHS Manager regarding this idea was that the CAMHS professionals are managing a high level of work as a result of staff reductions; therefore it would be difficult for them to invest their time in research actively.

A case study design is suited to the current research study for a number of reasons, which will be presented below. Robson (2002) defines case study as:

‘..a strategy for doing research which involves an empirical investigation of a particular contemporary phenomenon within its real life context using multiple sources’ (p. 52)

This suggests that case study is an approach rather than a specific method. Case study methodology is embedded in a commitment to a particular worldview, which assumes that individuals are ‘conscious, purposive actors who have ideas about their world and attach meaning to what is going on around them’ (Robson, 2002; p.24). This interpretative epistemological stance rejects the idea that ‘knowledge’ can be derived through scientific means (Pring, 2000), and instead argues that knowledge and reality are represented through the perceptions of the people who experience it (Scott, 1996). The current research questions relate to LAC’s experiences of CAMHS. It seeks to identify facilitators and barriers to attending CAMHS, and to understand LAC’s experience of attending a therapeutic intervention from CAMHS. A case study approach is appropriate as it aims to address the questions within a real life context, namely the perspective and the experiences of LAC.

Table 3. outlines the different components of the research design as they apply to the current study. Yin (2009, p.26) indicates that ‘in the most elementary sense, the design is the logical sequence that connects the empirical data to a study’s initial research questions and,

ultimately, to its conclusions'. The information contained within Table 4. was therefore used as a template throughout the research to ensure that the study's research questions were addressed.

Table 4: Components of the research design (adapted from Yin, 2009)

Components	Current Study
1) The study's questions	<ul style="list-style-type: none"> • What do LAC identify as the facilitators and barriers to attending CAMHS? • What are LAC's experiences of attending a therapeutic intervention from CAMHS? • In what ways can CAMHS be improved for LAC?
2) Its propositions	As the current study is exploratory, it does not have any additional propositions to be tested. The overall purpose of the study is to explore LAC's experiences of CAMHS and determine what they value from attending a therapeutic intervention and what could be improved.
3) Its unit (s) of analysis	This relates to the fundamental problem of defining what the 'case' is. For the current study, the individual (the looked-after child or young person) is the primary unit of analysis.
4) The logic linking the data to the propositions	There is no logic linking the data to propositions as the current study is exploratory in nature.
5) The criteria for interpreting the findings	The case studies will be analysed using an analytic technique called 'cross-case synthesis'.

The current study adopted a 'multiple-case' design. Multiple-case designs are said to have distinct advantages in comparison to single-case designs in that the evidence is often considered to be more compelling, making the overall study appear more robust (Herriott & Firestone, 1983). Although generalisation is not a primary aim of the current study, it was felt that a multiple-case study design was relevant to the research questions. In order to obtain an insight into LAC's experiences of CAMHS and what were the facilitators and barriers in

attending CAMHS, it was considered more robust to carry out more than one case study. It was also felt that from an analytic perspective, the benefits of using more than one case study would be more powerful than if they had been drawn from one case alone (Yin, 2009). Any use of multiple case designs needs to follow a replication logic which relates to each case selected carefully on the basis that they will provide either similar or contrasting results. Yin (2009) describes how multiple case studies can be used to either predict similar results (a literal replication) or predicts contrasting results but for predictable reasons (a theoretical replication). The current study opted for the selection of four cases that were believed to be literal replications on the basis of findings arising from the literature. In the current study, the sampling method was purposive as it related specifically to LAC who had attended a therapeutic intervention within CAMHS which reflects literal replication logic. Furthermore, the case studies were analysed using cross case synthesis (Yin, 2009) as this type of analysis looks at the data from the case studies as a whole rather than separate case studies.

A significant body of research suggests that much of the research on LAC's experiences of CAMHS has been conducted with the view that all children and young people accessing CAMHS are a homogenous group and the views are representative of LAC (Davies et al., 2008; Worrall-Davies et al., 2008; Davies et al., 2009). However, as highlighted in this literature review, LAC are a group particularly vulnerable to poor mental health and this has led to innovative projects and teams within CAMHS to meet the mental health needs of this vulnerable group. Yet there appears to be limited research on LAC's experiences of CAMHS despite the concept of participation and being listened to being strongly exemplified throughout government policy and guidance. From a Local Authority perspective, LAC have been identified as refusing to access CAMHS, with only 15 out of the 45 LAC referred to CAMHS giving consent to accessing CAMHS (LAC Steering Group, 2010), thus the Local

Authority and CAMHS want to explore how they could improve CAMHS for this specific population.

2.3 Rationale for method

In accordance with an interpretive epistemological stance, the study adopts a qualitative methodology to explore LAC's subjective views and the way they construct their experiences. In accordance with the research's assumptions that reality is subjective and individually constructed, personal construct psychology (PCP) techniques were used. PCP (Kelly, 1955) aims to understand each individual's unique view of the world through exploring their thoughts, feelings and beliefs or 'constructs'; it is this subjective view of events which is of importance to the researcher (Beaver, 1996). It views the experience of everyday life as valid for study. A fundamental concept of Kelly's theory is the formulation of the 'construct'. Kelly (1955) proposed that each individual has access to a number of personal constructs, which drive their unique prediction, interpretation and understanding of events. Kelly's fundamental postulate of PCP states that "a person's processes are psychologically channelized by the ways in which he anticipates events" (Kelly, 1955, p.32). This suggests that an individual's experiences are determined by the way s/he predicts events in their world, based on the learning derived from previous similar experiences. PCP is a psychology of individual differences, which argues the only truth we have access to is constructed by each individual person (Fransella & Dalton, 1990).

PCP is appropriate when considering how to interview children and young people who are likely to have very different constructs from adults (Burnham, 2008). It is vital to remember that the meaning of language used by people differs; this is especially true within an adult-child situation. PCP accepts the role of the individual as an active agent and is able to show how beliefs and actions are interdependent. It is also able to explain how the accounts people use to describe events reflect the wider culture of which they are part. Kelly (1955)

also discussed the role of 'bipolarity', which argues that all constructs are bipolar and have a specific contrast. This relates to the dichotomy corollary, namely, "A person's construction system is composed of a finite number of dichotomous constructs" (Kelly, 1991, p.5) in which our perception of experiences falls into simple dichotomies, and constructs have two ends or poles, e.g., worried/confident, popular/unfriendly (Burnham, 2008).

Beaver (1996) argues that PCP provides a useful structure for exploring individuals' models and interpretations of the world: their subjective versions of reality. Taking into account, the vulnerable emotional states likely to characterise the LAC whose CAMHS attendance had led to their nomination as prospective participants of this study, I considered that LAC may perceived direct questioning as invasive and potentially overwhelming. When interviewing children and young people, Arksey and Knight (1999) stress the importance of making interviews enjoyable and non-threatening, through combining a variety of activities and methods (e.g. drawing pictures, writing and/or speaking). Therefore, I believed that the application of PCP activities to obtain LAC's views would be relatively unthreatening and accessible as an appropriate methodology.

2.4 Procedure

Individual semi-structured interviews were conducted with the LAC, using activities that are congruent with PCP (Beaver, 1996). Semi-structured interviews were selected as they aimed to answer the research questions through an interview guide, yet allowing for flexibility depending on each looked-after child's specific experiences of CAMHS varying. There are a variety of methods that can be used with children and young people to explore their constructions of the world, which allow for visual modalities as well as oral communication (Beaver, 1996). The purpose of the activities was to elicit constructs from each looked-after child/young person and endeavour to support the elaboration of constructs through the techniques of 'laddering' (Hinkle, 1965) and 'pyramiding' (Landfield, 1971) (section 2.4.3.

describes this process further). I used a variety of construct elicitation and elaboration techniques throughout the semi-structured interviews with the LAC to facilitate the interview through the following activities:

- Sentence completion task
- 'Talking stones'

These techniques will be described in more detail below.

The semi-structured interview consisted of placing the talking stones on a table at the outset of the interview. I presented the sentence completion task to the LAC verbally and received their responses verbally. During this task, I was able to use laddering and pyramiding techniques to facilitate discussion within the interview. After this task had taken place, the talking stones script (see Appendix 3 for script) was presented verbally. Semi-structured interviews lasted approximately an hour in duration. All four LAC were given the opportunity to choose from three options where the semi-structured interviews took place. The three options were:

- Home environment
- School or college
- My office

Two of the LAC chose to have the interviews at college, and the other two LAC chose the home environment. The follow up meetings took place in the same setting as the semi-structured interviews a month later. At this meeting I provided a brief summary of the themes based on the thematic analysis.

2.4.1 Sentence completion task

A sentence completion task was created to elicit constructs from the looked-after child/young person. Grice et al. (2004) propose the advantages of the sentence completion method for eliciting personal constructs, as individuals are likely to consider it more meaningful to respond to methods that emulate the narrative aspect of the self. Additionally, this activity generates idiographic information in a highly efficient manner, which is akin to Kelly's (1955) self-characterisation technique in psychotherapy.

The more prominent method of this kind is the Rotter Incomplete Sentences Blank test (Rotter & Rafferty, 1950). This technique generates idiographic information by inviting the participant to complete unfinished sentences, which aim to 'cull the "essential" verbal statements from his or her larger narrative response' (Grice et al., 2004, p. 61). The LAC in the current study were provided with a range of incomplete sentences to elicit some of their thoughts, feelings and experiences associated with CAMHS, e.g. 'When I first heard I was referred to CAMHS, I thought...', 'I liked/did not like coming to CAMHS because...' (see Appendix 2 for the sentence completion task). The design of these sentences were based on Grice et al.'s (2004) methods in their empirical research that explored the use of sentence completion tasks for eliciting personal constructs. My research question relating to what are the facilitators and barriers to attending CAMHS was explored through this activity. These sentences were purposely left general and open ended, to allow for the looked-after child or young person's subjective views. However, I also noted recurring themes throughout the activity which focused discussion further (e.g. recurring positive or negative factors in accessing CAMHS). This was through writing short notes during the interview. In this respect, it is important to acknowledge that researchers can never fully separate themselves from their own constructs and identity as a researcher; 'researcher bias' cannot therefore be fully eliminated and is likely to influence the content of discussion. The constructs elicited from this task were explored further through laddering and pyramiding of bipolar constructs.

2.4.2 Talking stones

As a result of reviewing the literature around eliciting the views of children and young people in research (Beaver, 1996; Fraser et al., 2004; Hogan, 2005; Geldard & Geldard, 2007; Kellett, 2005; Lewis & Lindsay, 2002; Punch, 2002; Tangen, 2008) I decided to explore the use of a technique detailed by Wearmouth (2004) as 'talking stones'. Wearmouth (2004) describes the use of 'talking stones' as a method of interviewing to promote "self-advocacy...for disaffected students" (2004: p.7). It involves presenting a child/young person with a selection of stones and shells which are different colours, textures and sizes and asking them to choose stones and shells to represent their emotions and experiences. This technique was used in two one-to-one interviews and allowed Wearmouth (2004) to establish young people's core constructs and understand how they felt towards school and the future. The stones 'enable students to articulate their feelings in relation to school in ways not previously open to them' (2004: p.11). It also allowed 'a way of glimpsing more of what the student's experience is from the student's own perspective' (2004: p.11). This tool was used as it offers a non directive way of facilitating LAC to tell their story about their CAMHS experience (see Appendix 3 for script for using the stones and a photo of the selection of stones and shells used). The aim of the script was to prompt the use of the stones to facilitate reflection and discussion for the participant. It was felt that this technique may be useful for LAC in relation to reflecting on their experiences as the process of reflection may be something they may find difficult if they have had to repress traumatic experiences from their past (Davies et al., 2008). Ethical considerations are presented further on in this chapter.

2.4.3 Laddering and pyramiding of constructs

Laddering and pyramiding techniques (Hinkle, 1965; Landfield, 1971) were used with the LAC throughout the interview (during both the sentence completion task and the talking stones) in order to explore their emergent constructs in greater depth. Once bipolar

constructs were established (the identification of two contrasting poles, see Appendix 4), the LAC were asked to indicate their preferred pole. Following this, a variety of laddering and pyramiding questions were asked, in order to explore their values and beliefs about CAMHS further (see examples of laddering and pyramiding process in Appendix 4). My aim was to develop a shared understanding of LAC's views of CAMHS in their own words which would answer the research questions:

- What do LAC identify as the facilitators and barriers to attending CAMHS?
- In what ways can CAMHS be improved for LAC?
- What are LAC's experiences of attending a therapeutic intervention from CAMHS?

2.5 Pilot semi-structured interview

I piloted a semi-structured interview with a young person who was 14 years old who had accessed CAMHS for two years. EL attended a therapeutic intervention with a mental health nurse fortnightly. Informed consent was obtained and it was highlighted to the young person that the aim of the interview was to pilot the methods. This pilot allowed me to consider the use of the sentence completion task and the 'talking stones' method. The young person who formed the basis of the pilot was not included in the current study as she was not a looked-after child; she was under a kinship adoption as she lived with her grandmother. Nonetheless, this pilot was valuable as it allowed me to consider the use of the sentence completion task and the 'talking stones' method to facilitate the interview.

The sentence completion task was a useful way of encouraging EL to elaborate on her experiences of the therapeutic intervention attended through CAMHS. It sufficiently cued in her reflections about the intervention, while containing risks inherent in more structured and potentially leading questions.

EL demonstrated evidence of using the ‘talking stones’ when expressing her feelings and reflecting on her experiences. Using phrases such as “can you tell me a little bit about why you’ve chosen that stone” elicited an in depth response. As a result of the pilot, I decided that the methods selected for the semi-structured interview were appropriate. There were no changes to the methods selected as a result of the pilot.

2.6 Participants

Flyvberg (2004) highlights that where the aim of research is to obtain the greatest amount of information about an issue or phenomenon, representative or random sampling is unlikely to be the most appropriate strategy. Participants were selected on the basis that they were LAC who had accessed CAMHS and had undergone a therapeutic intervention through CAMHS. In selecting participants on the basis of their possession of certain characteristics, the sample can be classified as purposive (Cohen et al., 2003). As the generalisation of findings was not the aim of the study, the benefits of adopting this type of sample significantly outweighed any concerns relating to generalisability.

Participants were therefore selected by asking professionals from CAMHS within the urban LA to identify LAC they had worked with in the past 12 months, who met the following criteria:

- The LAC is between 11 and 18 years of age (thus including recent care leavers too)
- They have undergone a therapeutic intervention within CAMHS
- They are no longer receiving any CAMHS involvement

A comprehensive account of how professionals within CAMHS were informed about the study and the ethical considerations relating to accessing a sample is provided in Table 5. Professionals who consisted of clinical psychologists, clinical therapists and mental health

nurses from the urban Local Authority CAMHS were asked to identify LAC who met the criteria. This led to a sample of 10 LAC identified. The CAMHS Manager highlighted that throughout the filtering process, it was clear that over 45 LAC had been referred to CAMHS by their social workers over the last 18 months, however; only fifteen LAC had consented to accessing CAMHS and five of these LAC did not meet the research inclusion criteria as they only underwent assessment from CAMHS, rather than attended a therapeutic intervention. The duration of the therapeutic intervention was not considered in the inclusion criteria as the sample of LAC who had accessed a therapeutic intervention via CAMHS was limited (n=10). Similarly, the length of time since the looked after child or young person had been discharged from CAMHS in relation to participating in the research was not part of the inclusion criteria due to the limited sample of LAC who met the inclusion criteria.

Given the limited pool of LAC who met the criteria and the challenges of LAC participating in research, I decided to initiate contact with the entire sample. In line with the Local Authority being fully or partly responsible (dependent on the care order section of the 1989 Children Act for the young person) informed consent was obtained from the Local Authority's Corporate Parenting Team, more specifically, the social worker for each LAC identified. At this stage, the only information provided was the type of care order they were placed on. Further consent from birth parents or foster parents alongside consent from the looked-after child/young person was dependent on the section of the 1989 Children Act which identifies the route by which the LAC was taken into care. Table 5. displays the implications for consent based on the care order of the LAC.

Table 5: Type of consent required

Type of care	Who has parental responsibility	Implications for seeking consent
Section 20 - accommodation under a voluntary agreement with parent	Parents	Consent from parents as well as Local Authority and LAC
Section 31 or 38 - child is subject of a care order	Shared between Local Authority and Parents	Consent from parents as well as Local Authority and LAC
Section 21 – child is compulsorily accommodated	Foster parents and Local Authority	Consent from foster carers as well as Local Authority and LAC

All ten LAC were under section 21 of the 1989 Children Act, which indicated that foster carers and the Local Authority had parental responsibility. A comprehensive account of how participants were selected and the ethical considerations relating to this is provided in Table 6.

Table 6: Selection of Participants

Stage	Process	Ethical Considerations
Sharing research with CAMHS professionals	CAMHS professionals were informed of the research study during a service away day. The research proposal was shared, and professionals were provided with criteria for participant selection.	At this stage, CAMHS professionals were asked not to identify LAC by name, but make the researcher aware if they could identify anyone who met the criteria.

<p>Initial consent from local authority and each LAC's social worker</p>	<p>Consent was obtained from the Manager of the Corporate Parenting Team within the named Local Authority, who informed me of the social worker for each LAC identified by the CAMHS in the LA.</p> <p>Each social worker was contacted through an email sent to obtain their consent (see Appendix 5 for email) and a phone call.</p>	<p>Social worker maintained confidentiality of the case history and placement stability of the LAC as consent had not been obtained from the looked-after child/young person at this stage.</p>
<p>Potential participants and their foster carers contacted by their named social worker</p> <p>Consent from foster carer</p>	<p>Foster carers and the LAC were introduced to the research by the looked-after child/young person's named social worker. The information sheet and consent form was presented to them (see Appendix 6 for foster carer information sheet and consent form).</p> <p>Once consent was obtained from the foster carer, the research study was introduced by the social worker to the looked after young person using the information sheet and consent form (see Appendix 7 for pupil information sheet and consent form)</p>	<p>Foster carers were told that if they chose not to give consent then the looked-after young person would not be approached. Social worker informed researcher if foster carers refused to give consent so that a follow up call by the researcher to the social worker did not take place.</p> <p>The looked after young person was informed that they did not have to make a decision immediately. They could inform their social worker when they had made a decision at a later date.</p>
<p>Consent for participation from the young person</p>	<p>Out of a potential sample of 10 LAC who met the criteria, 4 looked-after young people gave consent to taking part in the research.</p>	<p>It was emphasised that participation was voluntary, and there would be no consequences if the looked after young person declined to take part in the research.</p>
<p>Informed consent</p>	<p>Participants were provided with an in-depth account of the research (see Appendix 7 for pupil information sheet and consent form)</p>	<p>Informed consent was obtained in line with the protocol outlined in the University of Birmingham Ethical Review Form (see appendix 8).</p> <p>Participants were asked to sign a consent form stating that they understand issues such as confidentiality, data storage and</p>

		<p>protection, how the results will be presented to them, and their right to withdraw at any stage. Participants were asked to sign statements relating to these areas.</p> <p>It was emphasised by the social worker that participation was voluntary, and there would be no consequences if the young person declined to take part in the research or withdrew at any stage.</p>
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Four LAC consented to take part in the research. Three of the LAC who met the criteria (from the identified sample of 10) chose not to participate. The feedback from the social workers about reasons given by the looked-after young people choosing not to participate in the research consisted of:

- Not wanting another adult in their lives;
- The CAMHS experience was very short-lived; and
- The CAMHS experience is a part of their lives they have moved on from.

I was unable to contact the remaining three LAC from the potential sample due to a lack of communication and co-operation from their social workers. Emails were sent to the named social workers for all ten young people in July 2011, followed by letters and phone calls where messages were left or brief conversations took place and the research was explained. The Corporate Parenting team manager was also notified to remind social workers to contact me regarding consent at team meetings. The main barriers to contacting the social workers are set out in Box 3.

Box 3: Barriers to making contact with social workers

- Rarely in the office to receive phone calls
- Social workers themselves found it hard to contact LAC
- Social workers were only required to have limited contact with the LAC
- Many demands on social workers' time

Four LAC were still considered an appropriate sample size to use in the study, as each interview provided an opportunity for an in-depth examination of meanings by the use of PCP techniques, which would allow for analytical generalisations to be made (Yin, 2009).

The LAC were all 16 years of age and above, and had accessed CAMHS and undergone a therapeutic intervention within CAMHS. A therapeutic intervention consisted of direct intervention of a professional (psychologist, family therapist, primary mental health worker) with an individual looked after child or young person (MacKay & Greig, 2007). The table on the next page provides further details about the young people. Pseudonyms are used to refer to them: Ali, David, Tina and Sarah.

Table 7: Details of the four participants in the study

	Ali	David	Tina	Sarah
Sex	Male	Male	Female	Female
Ethnicity	South Asian	South Asian and Afro Caribbean	White	White
Age	17 years old	16 years old	16 years old	17 years old
Time in care	12 years	13 years	11 years	5 years
Current care placement	Foster care	Foster care	Foster care	Foster care
Placement stability	5 foster placements	7 foster placements	10 foster placements and 2 residential placements	3 foster care placements
Length of CAMHS involvement	1 year 10 months	1 year 4 months	9 months	1 year 6 months
Length of therapeutic intervention	1 year 8 months	1 year 2 months	6 months	1 year 1 month
CAMHS professional delivering therapeutic intervention	Clinical Psychologist	Family Therapist	Primary Mental Health Worker	Clinical Psychologist

2.7 Documentary evidence

Prior to conducting the interviews, the evidence and facts of the case studies were explored through a trawl of each looked-after young person's CAMHS file. Consent for access to CAMHS files for the 4 looked after young people participating was obtained through the foster carer's and the looked after child's consent form (see appendix 6 and 7). Permission to access these files was also obtained from the Information Governance section of the Mental Health Partnership Trust in which the CAMHS is situated within. Based on the literature review, files were explored for:

- notes from therapeutic intervention
- length of therapeutic intervention
- type of therapeutic intervention

- number of therapists
- attendance patterns
- placement stability
- Any barriers to involvement (re-referral?)

In all four files, it was evident that the LAC were discharged from CAMHS once it was agreed by the young person, the foster carer and the CAMHS professional that the therapeutic intervention had been successful. Furthermore, in all four files it was unclear whether a specific therapeutic modality was selected. This was further supported by the CAMHS Manager highlighting that CAMHS professionals often draw on a number of therapeutic modalities. Although such files do not contain information regarding the experiences or the voice of the looked-after young person for each session attended at CAMHS, they do provide insight into the nature and extent of CAMHS involvement. Holstein and Gubrium (1995) emphasise the importance of having some background knowledge relating to the cultural context within which the interview is taking place; allowing the interviewer to support the respondent in fully exploring their circumstances, actions or feelings.

2.8 Ethical considerations

Although issues pertaining to ethics have been alluded to throughout this discussion, it is important to consider some of the ethical challenges arising when working with LAC. LAC might be described as being vulnerable not only because of their experiences prior to and during care but also because of the emotional and mental health needs which may be associated with their experiences. Lewis (2002) identifies issues such as access, consent, confidentiality and recognition which may be relevant with any research participant but around which there is increased sensitivity when working with vulnerable, young participants. An overview of the study's general ethical considerations is provided in Appendix 8 which

outlines information submitted to the University of Birmingham ethics committee as part of the ethical clearance process.

I made efforts to ensure that the looked-after young people were not harmed as a result of participating in the research by alerting the looked-after young person's social worker and foster carer about possible reactions and the need for support. Also I met with the looked-after young people a month after the interviews regarding their feelings and responses following the interview process and to summarise the main themes from the interview to them. In addressing these ethical issues I observed the British Psychological Society's (BPS) Code of Conduct, Ethical Principles and Guidelines (2004) and the British Educational Research Association (BERA) (2004) revised ethical guidelines for educational research.

2.9 Reliability and validity

Issues relating to reliability and validity as they apply to the current study are different to those that are relevant to quantitative research, but still warrant careful consideration (Parker, 2004). Discussions should therefore be located within the research paradigm that is being used and should enable the quality of the research design to be explored. Yin (2009) alerts the reader to four tests that have been used to establish the quality of any qualitative empirical social research, and the ways in which the current study controlled for these is reported in Table 8.

Table 8: Case Studies: Validity and Reliability (Adapted from Yin, 2009)

Test	Case Study Relevance
Construct Validity	<p>This test of validity can be problematic for case study research; as such research is by its very nature subjective. Within the current study, this was controlled for by:</p> <ul style="list-style-type: none"> • The use of more than one source of evidence (data was corroborated through a trawl of the looked-after young person’s CAMHS file).
Internal Validity	<p>Internal validity aims to reflect that an explanation of a specific event can be justified by the data (Cohen et al., 2007). As the current study is exploratory, issues relating to internal validity present less of a threat than if the research was seeking to explain a particular phenomenon.</p> <p>Based on the semi-structured interview, it was important to check that any inferences made were correct. This was achieved by sharing the data analysis process back to participants for them to check that their experiences had been understood and reported accurately.</p> <p>The thematic analysis coding process also helped to ensure internal validity. I followed a systematic approach in order to minimise research bias (Lincoln & Guba, 1985), conforming to the phases set out by Braun and Clarke (2006) The thematic analysis process was also verified by a second Trainee EP to ensure the process was adhered to as objectively as possible. Thus, I believe that I have endeavoured to represent the full richness and scope of the data.</p>
External Validity	<p>External validity relates to the extent to which the results can be generalised to the wider population (Cohen et al., 2003). Case studies differ from survey and experimental methods in that they rely on analytic generalisation. In analytical generalisation, the researcher strives to generalise a particular set of results to some broader theory (Yin, 2009). This was accounted for through the use of multiple case studies. However, the generalisation of results is not a primary aim of the current research.</p>
Reliability	<p>Reliability is concerned with the extent to which a subsequent researcher could replicate the study and arrive at the same findings and conclusions, if they followed the procedures outlined in the research. The goal of reliability is therefore to minimise the errors and biases in the study.</p> <p>In the current study this was controlled for by ensuring that case study research procedures were documented.</p>

2.10 Data analysis

Yin (2009, p.69) suggests that ‘as you collect case study evidence, you must quickly review the evidence and continually ask yourself why events or facts appear as they do’. Case study methodology is therefore reliant on the researcher’s ability to interpret the information as it is

being collected, as it allows changes to be made or alternative lines of enquiry to be pursued in light of the data provided. A timeline of the research activities can be seen in Appendix 9.

A formal analysis of data was carried out at the end of the data collection process. Thematic analysis was selected as a method to analyse the qualitative data. Thematic analysis does not subscribe to any particular pre-existing theoretical framework, yet it is important that the manner in which it is applied is made explicit and transparent (Braun & Clarke, 2006). Thematic analysis is a method for identifying, analysing and reporting patterns (themes) across an entire data set, rather than within a data item, such as an individual interview or interviews from one person, as in the case of biographical or case-study forms of analysis, such as narrative analysis (eg, Murray, 2003).

Taking this into consideration, a process of cross case synthesis was decided upon (Yin, 2009). Thematic analysis (Braun & Clarke, 2006) was used as a tool to carry out this cross case synthesis, as it allowed for the identification and analysis of key themes within the data corpus. This process enabled themes to be identified across the case studies and cross case conclusions to be drawn relating to the research questions. However, despite thematic analysis being widely used, there is no clear agreement about what thematic analysis is and how to carry it out (Tuckett, 2005). As this research aligns itself with an epistemological stance that argues that each person's experiences are subjective, thematic analysis was used within a social constructionist framework which identifies patterns (themes, stories) within data, and theorises language as constitutive of meaning and meaning as social.

In relation to the current study, thematic analysis is a method of analysis that aims to reflect the reality of the participants and for this reason is considered to be 'essentialist' or 'realist' (Braun & Clarke, 2006). An inductive or 'bottom up' approach was predominantly applied where the identification of themes was driven by the data (Patton, 1990) and themes were

identified due to their frequency with which they occurred within and between the strands of data. However, it is important to note that on occasion a deductive or 'top down' approach may inadvertently have been applied as data is not coded without researcher bias (Braun & Clarke., 2006). This was counteracted by the use of a co-researcher (a Trainee EP) viewing the thematic analysis process. The Trainee EP transcribed one interview and carried out the phases of the thematic analysis process (see Table 9) independently. Furthermore, she then observed the initial codes as phase 2, and generated themes. This was then compared to my thematic analysis of the data which was carried out independently. It is possible that certain elements of the thematic analysis were driven by my theoretical interest in the area rather than emerging from the data itself. Braun and Clarke (2006) would therefore maintain that researchers do not just give voice to the participants and that it is important for researchers to recognise the possible influence of bias in data analysis (Fine, 2002). I therefore describe the process of analysis that I undertook. Also I presented a summary of each participant's interview to the participant after the thematic analysis process had taken place to minimise my subjective interpretation of the data.

Coding was generally conducted at a semantic or explicit level rather than a latent or interpretative level (Boyatzis, 1998). In this sense, the coding represented a description of the content of looked-after young people's responses. I believe that this allowed for the face validity of the data to be preserved whilst minimising my subjective interpretation of looked-after young people's comments. I contained the 'double hermeneutic' (Giddens, 1982) in that I did not attempt to interpret looked-after young people's comments which were already their interpretation of their world. Thus, I adopted a realist approach (Cohen et al., 2003) in data analysis through not donating any further interpretation of the social/contextual influences that may have shaped looked-after young people's views.

An outline of the phases of thematic analysis (Braun & Clarke, 2006) and how they were applied in the current study is provided in Table 9. This highlights how the data gathered from the semi-structured interviews was integrated and analysed. The data was not analysed separately in relation to each of the PCP techniques (sentence completion task, talking stones, and laddering and pyramiding). This was because the primary aim of the PCP techniques was to facilitate the discussion within the interview rather than to ask direct questions. As a result the data was analysed as a whole using a semantic approach to coding.

Table 9: Phases of Thematic Analysis (adapted from Braun & Clarke, 2006)

Phase	Description of the process
1. Familiarising yourself with the data	All interviews were transcribed one-by-one (an example transcript can be seen in Appendix 11). They were read and re-read and initial ideas were noted. Transcribing data has been acknowledged as a good way for researchers to familiarise themselves with the data (Riessman, 1993) and as providing a thorough understanding of the data (Braun & Clarke, 2006).
2. Generating initial codes	Extracts noted in Phase 1 were examined to see if it might be represented by a code (based on my impression of patterns). I generated a list of provisional codes (as many potential codes as possible) and linked these to excerpts in the transcripts. I then re-read the entire data corpus to see how the codes fitted and to look for further potential codes.
3. Searching for themes	This phase involved considering how codes may be combined to form candidate themes.
4. Reviewing themes	The process of analytic abstraction (Miles & Huberman, 1994) was used where themes with similar content were combined and therefore reduced using diagrammatic representation of relationships between themes and subthemes to form an 'explanatory framework' (Avis et al., 2007). When this phase was completed, a thematic map was created that was examined to check whether it accurately reflected the data corpus as a whole. This was also reviewed by a second Trainee EP to reduce the extent of researcher bias.

Phase	Description of the process
5. Defining and naming themes	I refined the names of my themes so that they captured the essence of the data and fitted with the overall analysis and research question.
6. Producing the report	Selection of vivid, compelling extract examples, relating back of the analysis to the research question and literature. Produce a scholarly report of the analysis.

In order to demonstrate the thematic analysis process in the context of my research, a systematic illustration of the thematic process between Phase 2 and 6 is presented in Appendix 10. Additionally, an example of one transcript is presented in Appendix 11.

CHAPTER THREE: RESULTS

3. Introduction to results

In this chapter I describe the research findings derived from the thematic analysis. Braun and Clarke (2006) suggest that:

'Ideally, the analytic process [relating to a semantic approach to thematic analysis] involves a progression from description, where the data have simply been organised to show patterns in semantic content, and summarised, to interpretation, where there is an attempt to theorise the significance of the patterns and their broader meanings and implications (Patton, 1990), often in relation to previous literature....' (Braun & Clarke, 2006; p. 84)

Themes were identified at a 'semantic' level (Braun & Clarke, 2006), whereby the analytic process involves a progression from 'description' to 'interpretation'. The themes selected were prevalent across the data and can be said to capture significant aspects of looked-after young people's experiences of CAMHS as they relate to the study's research questions. From this perspective, although the emphasis of the current study is on allowing LAC to share their experiences in their own words, it is important to remember that even a 'giving voice' approach involves some element of selecting and editing the data (Fine, 2002).

Five overarching themes emerged from the data set, all of which serve to highlight a significant aspect of looked-after young people's experiences of CAMHS. Within each theme, two sub-themes were identified which gave further structure to the analysis. The themes are discussed below and are illustrated with verbatim quotes from the interviews. In some cases, a theme was only present in three of the four LAC's narrative; where applicable this will be highlighted in the chapter. This allows the voices of the LAC to be heard and helps the reader to trace the analytic process. Although themes are presented separately, a full understanding of each theme can only be achieved through an appreciation of the connections between them (see Diagram 1). The results of the current study will be presented in terms of their relevance to the study's research questions:

- What do LAC identify as facilitators and barriers to attending CAMHS?

- In what ways can CAMHS be improved for LAC?
- What are LAC's experiences of attending a therapeutic intervention from CAMHS?

As noted previously, the names of participants, and any references to identifiable information, have been changed in order to maintain anonymity.

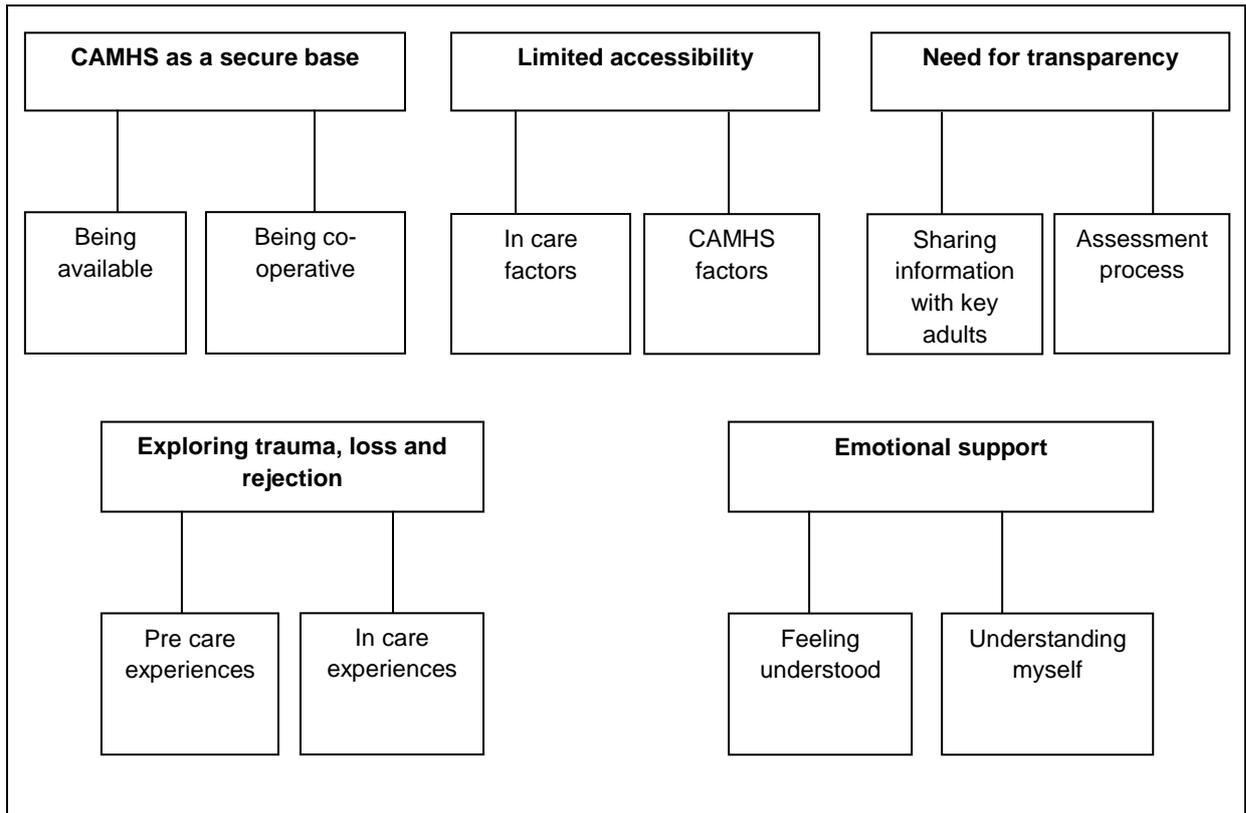
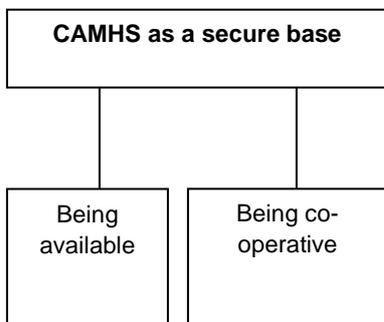


Diagram 1: Overarching and subordinate themes

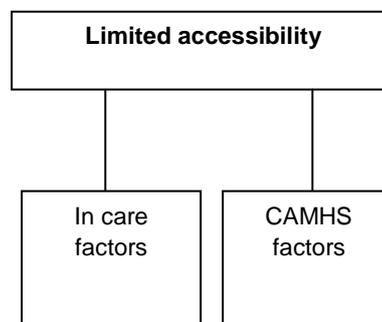
3.1 What do LAC identify as facilitators and barriers to attending CAMHS?

This research question was designed to explore what do LAC feel supported them to attend CAMHS and what were the barriers to them attending CAMHS. The overarching themes related to this research question are presented on the next page:

Facilitators to attending CAMHS



Barriers to attending CAMHS



3.1.1 Facilitators to attending CAMHS – CAMHS as a secure base

This theme was prevalent in all four interviews, with each looked-after young person reporting that CAMHS was a secure base. From this secure base, the looked-after young people felt that they were safe in the knowledge that care and support was available to meet their mental health needs. Within this theme, the sub-themes: 'being available' and 'being co-operative' were identified to explain how CAMHS was a secure base.

3.1.1 (i) Being available

Looked-after young people positioned CAMHS as being available. They felt that the continuity of seeing the same professional at CAMHS allowed them to feel safe and to trust in order to explore difficult feelings:

I felt like I could trust XXXX and that I didn't need to hide my feelings anymore, I felt protected because I knew that whatever I said wouldn't be shared with anyone else. (David)

Seeing XXXX every week helped me to feel safe, because before that I was always seeing new people and my social worker had changed 6 times in one year. So it was nice that I was seeing XXXX for over a year. (Sarah)

I felt safe because no-one apart from XXXX knew me at CAMHS so I would just wait in waiting area and she would come get me. She would always ask me first where I wanted to sit. (Tina)

I knew I could leave at any point because she would say that it is up to me and I am glad it was in the clinic not the school because I felt safe that no-one would know that I was going there. (Sarah)

I knew that CAMHS was a safe place for me to talk about my past and how I felt about my birth parents with XXXX. I couldn't do that with anyone else because that wasn't their job and I didn't feel like I could really trust them. (Ali)

Looked-after young people also highlighted that the CAMHS professional was the professional they trusted the most and felt comfortable and secure with. CAMHS professionals included clinical psychologists, mental health nurses and family therapists. Alongside CAMHS professionals, looked-after young people were in contact with their social workers, teachers and contact supervisors regularly. However, despite having known some of the latter professionals longer, they felt that the CAMHS professional was the adult they trusted the most:

I really liked XXXX at CAMHS, before her I didn't trust anyone working to help me. I thought they just wanted to get their job done, as they saw me as another child, another day. Like my social worker...I have known for years but she doesn't really understand me and I never know whether I can tell her the truth about how I feel as it seems like she doesn't really want to listen. (Tina)

Sometimes, I thought to myself I have only known XXXXX for a few months but I had already started to trust her and didn't mind talking about my dad with her. I didn't have that with anyone else. I thought I did with this one teacher, but then he just wouldn't make time for me, and when I told him I didn't feel happy he just ignored me, after that I realised that XXXXX was the only person that I could trust. (Ali)

I started seeing a learning mentor at school first for my problems, and I was meant to see him every week but he would just let me down. Then when I started seeing XXXX every fortnight it made such a big difference to me. I felt like I was safe, and I mattered to him. It was when I started seeing him that I realised that I trusted him and I could start trusting other people too. (Sarah)

I used to feel really frightened talking to anyone and would start crying, everything was a yes or a no with my teachers and my social worker. It wasn't like that with XXXXX, I felt like she cared for me and would be thinking of me even when I wasn't at the clinic. (David)

3.1.1 (ii) Being co-operative

Following on from the previous sub-theme, looked-after young people felt that they were given autonomy and choice at CAMHS. In turn, they spoke of how they felt effective and competent in making decisions about themselves, something they didn't expect when attending a mental health service:

I understood why it would be good for me to go and CAMHS even asked me if I wanted to have family sessions on the first day I went and I said yeah because I felt like that way I am not on my own with it and it didn't feel as uncomfortable and I really felt that the family sessions made a big difference to why I didn't move home again. We didn't used to have that many arguments after the family sessions, like Mrs XXXX would say things to me differently now that I think about it and it made me less angry. Like instead of saying "come down right now and have your dinner", she would say "would you like to have dinner after you have washed you hands" and it made such a difference. (David)

She asked me first what I wanted to talk about or if there was anything on my mind. No one else did that with me since I have been in care, it was like they were just ticking boxes and trying to just quickly see me and go leaving me to deal with all my problems on my own. XXXX wasn't like that though, she always gave me choices about the sessions and that's why I wanted to come to them. (Tina)

Since I have been in the care system, I feel like everyone has been telling me I am not good enough, and then when I knew I had been referred to CAMHS, I just thought I going to find it hard to speak out and that what I say isn't worth listening to as I had problems. But XXXX always asked for my opinion, like once she asked if I wanted to do some role play, and she always gave me a choice of the character I played. (Sarah)

It is interesting to note that Sarah and Tina mentioned that the care system led to a lack of power and choice and equate this with not being given autonomy. It is also interesting to note that David felt that the CAMHS professional offering the choice of family sessions was a significant factor in his placement stability. From David's perspective, the family sessions allowed for co-operative behaviour to be modelled with the foster carers:

David: I was in 6 different foster placements and with them I think it was always breaking down because I just used to get angry and we never used to talk. And then at the family sessions, we used to do role play, and have reflecting, repeating and fair fighting. I think the sessions helped strengthen the bond between my sister me and Mrs Brown.

Interviewer: Ok, could you explain what you mean by reflecting, repeating and fair fighting?

David: Erm, like reflecting was when my foster carer talked about her feelings, and then I would repeat what she said. It helped us to understand each other and understand where we were coming from. And then with fair fighting we would listen carefully and express difficult feelings.

Therefore the family sessions allowed for better communication between David and his foster carers and his sister. The family sessions promoted family membership and supported David to experience a sense of belonging which led to placement stability and permanence.

3.1.2 Barriers to attending CAMHS – Limited accessibility

This theme highlights the difficulties experienced by LAC in attending CAMHS. All four looked-after young people accessed CAMHS for a substantial period of time. The shortest length of CAMHS involvement was nine months and the longest was one year ten months. Throughout CAMHS involvement from referral to attendance to being discharged, accessibility was a key barrier experienced by the looked-after young people. Poor accessibility was experienced by all the looked-after young people in two fundamental ways, namely in care factors and CAMHS factors.

3.1.2 (i) In care factors

This sub-theme relates to the significance of being in care for all four looked-after young people, and how this was a barrier to accessing CAMHS within the process of referral to attendance. Three out of the four looked-after young people stated that there was a double stigma for them attending CAMHS in that they are already a child in care and then have a mental illness. One looked-after young person highlighted that this could have been improved by being seen earlier and more effectively through targeted/preventative services rather than by a specialist service. Describing how she felt about her mental health she said the following:

When my social worker told me that she had referred me to CAMHS, I thought I would see them quite soon. I didn't hear anything for ages, and I had just changed foster placement again. By that time it was 4 times in 2 months, and I was at risk of being excluded from school as I kept getting into fights and didn't have any friends. But now I think, why wasn't something done far earlier to help me. Like they knew I was looked-after when I went into care at 5 years old and I moved schools lots too, so I'm not sure why I had to wait till I was 14 to have proper help about my anger problem. The school and other people could have helped me before I went to CAMHS to have therapy. (Tina)

Feelings relating to frustration were also prevalent when all four looked-after young people spoke of frequently changing placements as a barrier to accessing and attending CAMHS regularly. The mobility of the young people within the care system was a well recognised barrier to receiving timely access to CAMHS:

I was having a bad time with my foster carers during my CAMHS sessions, so I changed and then again...about 3 times in 5 months and in that time I couldn't go to CAMHS. It didn't help as that's when I needed it the most. (Sarah)

I was on the waiting list for CAMHS, then I moved foster placements, and then I joined another CAMHS team and I was on the bottom of that list. It's a lot of hassle waiting. (Tina)

I found it difficult starting again with another therapist when I moved to XXXXX, because everything was new already..new school...new foster carers...and then it would be new CAMHS too. (David)

3.1.2 (ii) CAMHS factors

This theme highlights the extent to which practical arrangements and the physical setting related to attending a therapeutic intervention was a barrier to accessing CAMHS effectively. It captures looked-after young people's experiences of disappointment and a lack of predictability in relation to the therapeutic setting and cancellation of appointments.

Participants described occasions where they experienced unpredictability about the room where the therapeutic intervention would take place. The looked-after young people's use of

language referred to feeling 'worried', 'scared' and 'confused' in response to not knowing which room the therapeutic intervention was taking place in:

I used to get really worried, I never knew which room we were going to be in for the therapy sessions, sometimes it was a really massive room and other times, it was a much smaller room. (Tina)

We kept having to change the room I went to. It wasn't the same room every week, so I found it a bit confusing. (Ali)

But one thing about CAMHS that made me think they didn't really care about me was that the room was always different, and when I used to go to counselling before it was always the same room. (Sarah)

This highlights the importance of practical arrangements and a predictable setting for the therapeutic intervention as being especially pertinent to looked-after young people. Additionally, one looked-after young person spoke of the significance of the surroundings within the room where the therapeutic intervention took place, and the impact of this on expressing their feelings:

One room I used to meet XXXX had loads of things on the wall, and it was a bit distracting so I found it difficult talking about my dad there. (Sarah)

Alongside the unpredictability of the therapeutic setting at CAMHS, all four looked-after young people spoke of occasions when appointments were cancelled and rescheduled by the professional they were seeing at CAMHS. Although rare throughout the therapeutic intervention, this led to feelings of frustration and disappointment for the looked-after young people:

I would always meet XXXXX every 2 weeks, but sometimes she would ring me and change the appointment time at the last minute...and that was really annoying because I used to look forward to having the same thing the same time. (Tina)

Sometimes the appointment time changed and then I didn't have an appointment for ages...during that time I was having loads of problems and I did really need to see XXXXX. (David)

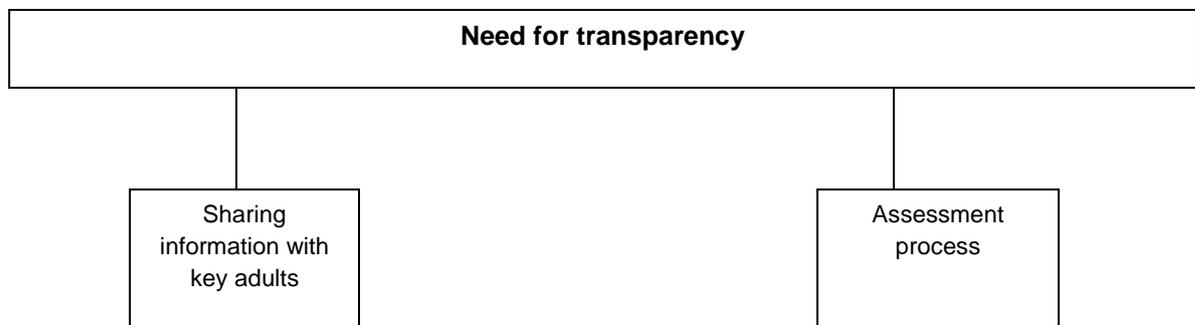
In my whole time at CAMHS, I saw XXXX every two weeks, she only cancelled on me

three times, but I was really upset when she cancelled the sessions because I used to enjoy going to them so much. It was a chance for me to talk and get everything that had happened in the week off my chest. That was probably the worst feelings I had about CAMHS. (Sarah)

Despite the young people accessing CAMHS for over a period of time and finding it a secure base as highlighted in the previous theme, they felt that the infrequent occasions where appointment times changed led to disappointment as they were looking forward to their regular session.

3.2 In what ways can CAMHS be improved for LAC?

This research question was designed to explore what LAC would like from CAMHS as previous research has noted that children and young people find it difficult to talk about negative aspects of their experiences (Bond, 1995). The overarching theme and sub themes related to this research question are presented:



3.2.1 Need for transparency

This theme was prevalent across the data set with each looked-after young person making reference to the need for transparency so that the CAMHS process is underpinned by openness and collaborative working. The need for transparency was seen to be a key way to improving CAMHS for the looked-after young people and to help empower them to take control of their mental health problems. All the looked-after young people spoke of how it was

important for CAMHS to share information with other key adults for good planning and care. Furthermore the participants spoke of how increased transparency was required during the assessment process. Within the overarching theme of 'need for transparency', the sub-themes: 'sharing information with key adults' and 'assessment process' are identified which help to bring further structure to the analysis.

3.2.1 (i) Sharing information with key adults

All four looked-after young people spoke of how they would have liked CAMHS to share more information about the nature of the therapeutic intervention they attended to key adults in their lives. Looked-after young people stated that foster carers and teachers were the key adults in their lives whom they wished to have an increased understanding of the role of CAMHS in dealing with mental health problems they were experiencing.

All four looked-after young people highlighted that that they would have liked some information from CAMHS shared with teachers to explain the role of CAMHS as they were unsure of how to explain the therapeutic intervention or felt uncomfortable doing so when they were asked about their poor attendance at specific lessons which conflicted with the CAMHS appointment times. Furthermore, the looked-after young people felt that some of the strategies they had learned and were adopting at school to manage their anger and anxiety could have been shared with their class teachers by the CAMHS professional:

There was one teacher who always asked me why I missed his lesson every fortnight and I told him I was at CAMHS and he said what for, and I didn't know what to say. I just think that it would be good if CAMHS explained to the school why I am going there so I don't have to. (Sarah)

My form teacher didn't know I was going to CAMHS and he used to think I had a anger problem for no reason and sometimes I used to try and practice the strategies at school, but he didn't know what I was doing and I thought he would know that. (Tina)

It would be really good if everyone knew why I was going to CAMHS every fortnight and

they understood what they could do to help me rather than think I am just messed up. (Ali)

Looked-after young people did however suggest that too much information to other adults was intrusive and that a balance was required to ensure their autonomy was respected.

Like I wanted them to know all about why I was going to CAMHS and how they could ask me how things were going, but as I am getting older I don't want them to know everything about my life and what's happened in the past. (Ali)

She (*form teacher*) should ask me how things are going but not ask me in loads of detail because that makes me feel uncomfortable and there does need to be some confidentiality. (Sarah)

Furthermore, three of the four looked-after young people expressed that they would have preferred their therapeutic intervention to have involved their foster carers more. David, the only looked-after young person who attended sessions with his foster carers and his sister highlighted that the family sessions during the therapeutic intervention supported him to attain placement stability for the first time in care. The three looked-after young people who did not experience family sessions emphasised that they would have preferred their foster carers to be more involved in the therapeutic intervention:

I didn't really talk much about how the sessions went with XXXX my foster carer though. Thinking about it now, it would have been good if CAMHS told her how I was getting on and what was working well for me and what were my problems. Especially because I think she saw me as bad and like I was born like that and in the end I only stayed there 3 months. (Sarah)

It would have been useful if I attended some sessions with XXXX because we were having problems at home. I never used to sit with them and straight after school would go up and not come out till the next morning. In the end, CAMHS did help but they could have helped me with my foster carer. Maybe I would still be with her now if she came to some sessions because CAMHS told her to. (Tina)

I think it would have been good if they spoke to my foster carers abit more at the end, and have a session with them at the end...that would have felt like a good ending. Because they could see from what XXX says about how well I've been doing coming up with understanding who I am and how I want to have a career now and do things. It would have

been nice for them to see because normally my parents would see that. But they don't know me, so my foster carers were like my only real family then. (Ali)

These extracts from the looked-after young people suggest that they felt CAMHS professionals could have offered their foster carers advice alongside the individual therapeutic sessions. The looked-after young people highlighted that this would have supported collaborative multi-agency working to meet their mental health needs and to avoid placement breakdown.

3.2.1 (ii) Assessment process

The looked-after young people highlighted that the assessment process within CAMHS could be improved. They highlighted that they experienced long waiting times to be assessed after the initial referral to CAMHS by their social worker. This was highlighted as 'frustrating' and 'annoying' by the looked-after young people and made them question if CAMHS were just another agency involved with them:

My social worker referred me and then I was waiting forever, I didn't hear back from them after my social worker filled the form in, when I finally got the letter that they wanted to assess me, I felt annoyed that they took so long because in that time I was getting even more messed up. (Ali)

They should give us a time scale in which they see us because I was waiting for ages and then when I did get seen by someone, they called me back and said a psychologist had to see me and not a therapist. By that point I was really frustrated and just thought what's the point going. (Sarah)

I went once before but it took ages being seen, like months and months and then in the end I didn't like what the therapist got me to do, and I didn't want to be seen as having mental problems. (David)

Furthermore, looked-after young people suggested that the assessment process could be improved by the CAMHS professional sharing feedback about the formal assessments carried out as part of the problem formulation:

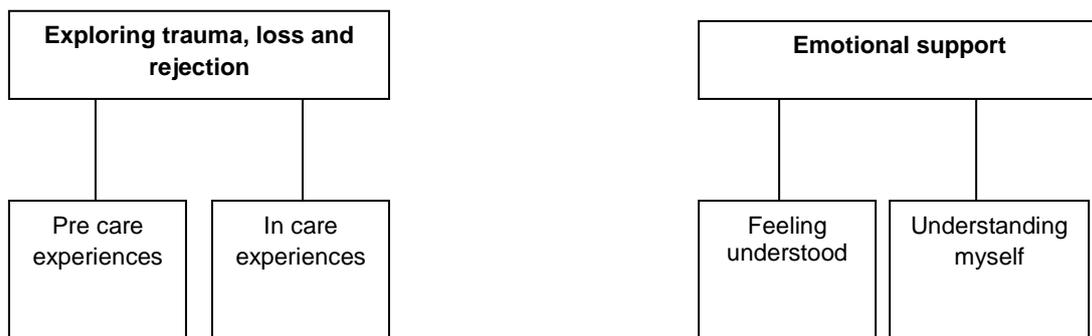
It was a bit weird...I went with my foster carer. I talked about my problems and my foster carer and me completed some questionnaires. I don't really know what they were for though. So that confused me a bit, it would be good if they gave me a bit more information about what the questionnaires were for and what they found from them. Because I never saw them again. (Tina)

'...and also that the CAMHS person should tell you what the forms are for and what they found from them because that confuses people. We always have to fill in so many different forms and half the time we don't know what comes out of them. (David)

This highlights the extent to which CAMHS professionals were not transparent in sharing information about the formal assessment measures conducted.

3.3 What are LAC's experiences of attending a therapeutic intervention from CAMHS?

This research question was designed to explore LAC's experiences of attending a therapeutic intervention from CAMHS. The length of each looked-after young person's therapeutic intervention varied, with the shortest intervention lasting six months and the longest intervention lasting one year and eight months. The overarching themes related to this question are presented below:



3.3.1 Exploring trauma, loss and rejection

This was one of the most prevalent themes throughout the data set with each looked-after young person highlighting the impact of the therapeutic intervention in exploring the trauma, loss and rejection they have experienced. Looked-after young people felt the therapeutic intervention successfully explored trauma, loss and rejection they had experienced before entering care, and during their care experiences. This led to improved relationships with foster carers, friends and other adults in their present life. For all the looked-after young people interviewed, exploring negative emotions related to their pre and in care experiences supported them to manage their mental health problems. Techniques used during the therapeutic intervention to express feelings towards birth parents and acceptance of pre care experiences were significant to the looked-after young people. Similarly, all the looked-after young people experienced trauma, loss and rejection whilst in the care system. Within this theme, the following subthemes were identified:

3.3.1 (i) Pre care experiences

All the looked-after young people explained that they had not discussed their feelings towards their birth parents with professionals or foster carers because it caused them emotional distress. More specifically looked-after young people made reference to life story work and said it did not help them to explore the trauma, loss and rejection they had faced throughout their life prior to and during care (to be explored further in the next chapter). However, they highlighted that the therapeutic intervention supported them to begin to talk openly about their pre care experiences due to the techniques used by the CAMHS professional:

Yeah like I brought stuff I had from my mum and dad and we talked about them and the attachment I had with them. At first I didn't understand why we did it. But then I could see that it helped me. Like I used to be really negative and not saying anything good at all about my mum and dad. But XXXX helped me to think about the positive things with my dad and mum. Especially my dad because I didn't like talking about him at all and then I remembered some good things which made me less angry. Like I used to talk about some

of my memories that were quite positive about my dad. And XXXX was helpful because I used to get angry and she used to explain how it's in the past and it's the present that matters and I can change how I feel about my dad. I went from this jagged stone to this nice smooth one (points at stones). (David)

Yeah it reminds me of this stone because I used to think my parents were bad people and I had to forget about them but this stone is all dark but it has some shiny bits in it, and I realised that so did my parents. In the sessions, XXXX helped me to think about how I felt, thought and behaved when I was younger and from then I started to actually talk about how I felt towards my parents and what made me angry about them, especially my mum because she was the one who hurt me so much, but I realised that she wasn't bad, she just had mental problems. (Ali)

At first I didn't want to talk about my parents at all at the sessions because I couldn't remember any of the bad feelings, it's like my mind was like this stone all white on top pretending everything is good and I'm happy but underneath it's black and that's the bit about what I thought about my mum and dad but I tried to keep it hidden. The CAMHS sessions helped me to talk about losing my mum and dad and how they had abused me, and helped me understand that I was treating all my foster parents really bad because I used to think bad of my mum and dad. Only when I thought more positive and understood this, I started to have a better relationship with my foster carer. (Tina)

During the semi-structured interviews, the 'talking stones' were useful in facilitating discussion about birth parents and pre care experiences and supported the looked-after young people to describe their experiences with minimal prompting from myself as the interviewer.

Furthermore, when talking about traumatic experiences prior to care, all the looked-after young people highlighted that the therapeutic intervention supported them to not only talk about difficult experiences before entering care but also supported them to accept these experiences and manage their anxiety and aggression more effectively:

It was somewhere for me to talk...because before that I used to just bottle everything up and just deny that my mum left me and that my dad was hurting me. I used to make excuses for them. But now I understand and accept things...it's like...I am less angry now inside. (Tina)

I never really understood why my parents left me, the life story work didn't help. And I just used to deny that they were having problems looking after me. I used to think everything would be ok. But XXXX helped me to understand my feelings more and why I was so hurt

and angry about my birth parents leaving me and never seeing them. (Sarah)

The sessions helped me to think of why I was being hurtful to people at school and getting angry at them. I used to blame them and accuse them of being aggressive and showing anger towards me, but really it was me, and after talking about my mum and dad in about 5 sessions I was able to see that and start to make friends. (Ali)

Like I used to be really negative and not saying anything good at all about my mum and dad. But XXX helped me to think about the positive things with my dad and mum. Especially my dad because I didn't like talking about him at all and then I remembered some good things which made me less angry. Like I used to talk about some of my memories that were quite positive about my dad. And XXX was helpful because I used to get angry and she used to explain how it's in the past and it's the present that matters and I can change how I feel about my dad. It was good because like with the life story work that didn't really help me talk about my past and also with CAMHS I then started to have a better relationship with my foster mum because I realised I used to get angry at her because of my dad, I was putting all those bad feelings onto her. (David)

These extracts demonstrate that looked-after young people's behaviour changed as a result of accepting their early experiences with their birth parents. Understanding previous relationships supported them to manage their present relationships more effectively.

3.3.1 (ii) In care experiences

This theme illustrates how the therapeutic intervention focused on an exploration of trauma, loss and rejection experienced by the looked-after young people within the care system. Looked-after young people felt that their care experiences caused them to feel 'rejected', 'unloved' and 'angry' and that these feelings changed as a result of the therapeutic intervention. Upon reflecting on the therapeutic intervention experienced at CAMHS, looked-after young people said that they began to understand the relationships they had with foster carers:

When I was in care, I moved like 10 times with different foster carers and even stayed in children's homes because no one wanted me. I felt like I was never wanted and I was damaged goods. Then at CAMHS...I started to talk about the relationships I had with different foster carers and what was good about each one even though I didn't stay there long. (Tina)

I was with really abusive foster parents who used to torture me and not understand that I

was Muslim, they used to give me pork and drink in front of me. And it was XXXX at CAMHS who helped me get over that experience because it did give me nightmares and panic attacks. (Ali)

Furthermore, all the looked-after young people spoke of how their care experiences caused them to feel negative and that these feelings changed once the therapeutic intervention had taken place. These were made explicit through elaboration of constructs during the interview. Sarah stated that prior to the therapeutic intervention she had felt 'angry' and that this changed to 'relaxed' after her involvement with CAMHS:

Before CAMHS I used to hate being in care, I was angry all the time because of the amount of times I had to keep changing school and foster placements and I just used to get all angry and start hurting everyone, but after CAMHS and even now I am much more relaxed and getting on with my life. I don't get angry much anymore. (Sarah)

Similarly, David highlighted that he was always 'angry' before CAMHS and stated that his preferred pole was to be 'calm', and that this was possible after he had CAMHS involvement:

I would say calm because before I was very angry and just used to go out doing crime and stuff and throw things around. But now I talk about things and think is it worth getting angry for.

Erm this smooth one (picks up cream curved shell) because I felt much happier. Like if someone said no to me, I would just become really angry. It was not good at all. But after the sessions I became much more calm.

Furthermore, two looked-after young people highlighted that the therapeutic intervention made them reflect on their bipolar construct of unloved/loved. Ali and Sarah stated that they felt 'unloved' throughout their experiences of being in care. However, after attending the therapeutic intervention through CAMHS they felt 'loved' and were able to reflect on aspects of care experiences which made them feel 'loved':

Because you get moved around so much, I just ended up getting all depressed and feeling like no one loved me. But after going to CAMHS I realised that I did have people in my life who loved me and cared about me but I just couldn't see it before because I was so depressed and down in the dumps. (Ali)

One of foster carers who I did like would tell me she loved me but it seemed like she didn't mean it, but then when I went to CAMHS, I felt like she did understand me and I understood her, and I knew she loved me, but I just couldn't live with her because she was having problems of her own. (Sarah)

3.3.2 Emotional support

This theme illustrates the extent to which all the looked-after young people felt that the therapeutic intervention supported them emotionally. Feelings of 'being understood' and 'understanding myself' were key aspects highlighted by the looked-after young people when sharing their experiences of the therapeutic intervention. Looked-after young people stated that emotional support allowed them to take control of their lives and led to improved mental health. Within this overarching theme of emotional support, two subthemes were identified:

3.3.2 (i) Feeling understood

Looked-after young people highlighted the importance of rapport with the CAMHS professional delivering the therapeutic intervention. They experienced professionals who were approachable and able to enter into a genuine helping trusting relationship with them. They felt that the personal qualities of the CAMHS professional were attuned to their emotional needs at the time of the therapeutic intervention. This was particularly significant for the looked-after young people given that looked-after young people's responses to staff were influenced by previous damaging interactions with adults:

With XXXX, you say what you feel and no-one is there to tell you are wrong. He helped me understand how my behaviour and the bad thoughts I was having...it was good. Without him, I would still be mad and depressed. (Ali)

She asked me in a really nice way. She wasn't like my social worker or my foster carer or the teachers at the school who judged me. It was like she really cared about me, she

always looked like she was listening and she respected me and that I could trust her. I think she didn't judge me about my past because she never used to talk about me in a bad way or say things that made me think "how dare you ask me that? (Tina)

Like with the life story work didn't really help me talk about my past. In CAMHS, I found that XXX was nicer and I could talk and that I knew someone was definitely listening to me and I could say what I want and what I feel like. (David)

She helped me feel understood and listened to by saying back my feelings to me..I didn't realise it at the time but when I think about it now, I could tell that I had a connection with her and she was not judging me. (Sarah)

3.3.2 (ii) Understanding myself

This final subtheme relates to the therapeutic intervention supporting the looked-after young people to understand themselves in relation to their identity and their life experiences. Looked-after young people spoke of how the therapeutic intervention supported them to develop a stronger sense of personal identity and personal history which they associated with increased self worth and positive emotional wellbeing:

I was calm in those sessions and this stone shows that. Like before CAMHS I didn't want to be mixed race at all, and after CAMHS I didn't mind being mixed race because there are lots of mixed race people in the world...because when we talked about my dad it helped me. And now I see myself as mixed race. Like I was with lots of different foster carers, white, black, asian but never mixed race. (David)

Yeah..it was like I went from this small white stone (picks up white and black stone) which underneath is all black, abit like my past. And then I went to this (picks up white smooth shell) which is all round and white. I was clear who I had become and I knew after the CAMHS that I could be loved. (Sarah)

Erm...this one (picks up a cream large shiny stone). I felt like all the bad things that I went through were slowly going away. I was beginning to understand who I was. I felt really angry with my mum leaving and my dad abusing me and then my boyfriend doing the same. I didn't like my past and couldn't deal with, but then when I started going to CAMHS, I was accepting things and knew that my mum and dad will always be a part of me even if I didn't really have good times with them and that I am still a Muslim and Asian even though I have always lived with non-Asians and Christians. (Ali)

These extracts also highlight the use of the 'talking stones' to facilitate the looked-after young people to reflect on their experiences of CAMHS. The use of the 'talking stones' method will be discussed in Chapter 5.

CHAPTER 4: DISCUSSION

4. Introduction to discussion

Within this discussion the results of the research study will be reported in terms of their relevance to the study's research questions, and how they make an original contribution to knowledge. This will be explored with reference to the extant literature and consideration of the ways in which the current research study adds to existing knowledge and contributes to the understanding of LAC's experiences and views of attending CAMHS.

4.1 Key findings

The key findings of this research study will be discussed in relation to the study's research questions and will therefore be split into three sections:

- What do LAC identify as facilitators and barriers to attending CAMHS?
- In what ways can CAMHS be improved for LAC?
- What are LAC's experiences of attending a therapeutic intervention from CAMHS?

4.1.1 (i) What do LAC identify as facilitators to attending CAMHS?

This research question was designed to explore what LAC feel supported them to attend CAMHS. Within the literature, a number of studies report on facilitators to attending CAMHS for all children and young people, but fail to use looked-after young people as participants, an issue which the current research has sought to address. Thematic analysis highlighted that LAC felt that the overarching facilitator was that CAMHS was a secure base. LAC were safe in the knowledge that care and support was available to meet their mental health needs. One of the key facilitators for the looked-after young people in attending CAMHS was that the clinic setting felt emotionally and physically safe as it was separate from the educational setting they attended and their foster care placement. Hinshaw (2007) highlights that traditional clinic settings can be stigmatising for children and young people attending

CAMHS, and that other locations such as the home environment and school may be less stigmatising. Providing a variety of locations is recommended by the National Service Framework for Children, Young People and Maternity Services (Department of Health, 2004) to removing the stigma of accessing CAMHS. However, this study identified that looked-after young people felt that the clinic setting was preferred over the home or school setting for CAMHS intervention. LAC already experience the stigma of being in care, and therefore by accessing CAMHS at a location where adults and professionals are already involved with them (e.g. school setting, foster home) may reflect a lack of privacy and confidentiality.

A further key facilitator in supporting LAC in attending CAMHS was that the CAMHS professional was the adult that was most available and whom they could trust. Alongside CAMHS professionals, looked-after young people were in contact with their social workers, foster carers, teachers and contact supervisors regularly. Looked-after young people spoke of how other professionals were not always 'available' for them, therefore they didn't feel safe. Being available is a dimension of caregiving identified by Ainsworth et al. (1971) that relates to being able to trust in order to experience emotional well-being and social functioning (Schofield & Beek, 2009). The looked-after young people comments highlight that they felt they could trust the CAMHS professional which facilitated their attendance at CAMHS over a period of time. The message that LAC particularly value relationships with professionals that last is highlighted in the Munro Review of Child Protection (Department for Education, 2011d). For LAC to talk openly about personal and often painful problems requires trust in a professional, and a change in professional or a short working relationship can mean the child always having to put their trust in someone new (Department for Education, 2011d). The implications of this for all professionals working with LAC will be discussed in Chapter 5.

Looked-after young people reported that CAMHS professionals were co-operative which facilitated them to attend a therapeutic intervention. Being co-operative is a dimension of caregiving highlighted by Ainsworth et al. (1971) which supports children to feel effective. Attuned caregivers will be trying to form an alliance with the child and working together to solve problems. In the process, they will be promoting the kind of competence and confidence that will be at the heart of resilience and the capacity to adapt to new challenges. (Schofield & Beek, 2009). In the current study, looked-after young people stated that they were given autonomy and choice at CAMHS, something they didn't expect when accessing a mental health service. Looked-after young people's comments suggest that they felt effective and empowered by experiencing a co-operative CAMHS professional. These findings contrast with previous findings of looked-after young people dissatisfied with CAMHS and complaining that they had been 'treated like a child' by mental health professionals (Saunders & Broad, 1997). In the current study, looked-after young people spoke of how previously they rarely experienced co-operative adults and they found that professionals and adults in their life were often either too controlling and intrusive or too passive and ineffective. Consequently, experiencing co-operative adults facilitated their attendance at CAMHS. Other studies have also emphasised the importance of choice and respect for LAC (Stanley, 2002; Davies & Wright, 2008). Furthermore, choice and autonomy can lead to feelings of empowerment for LAC (Munro, 2001). Rutter's (1990) research emphasises the benefits of empowerment: children with positive feelings of self-esteem, mastery and control can more easily manage stressful experiences. This is especially pertinent given the nature of the complex mental health needs of LAC. Implications for all professionals involved with LAC will be discussed further in Chapter 5.

The data obtained from the current study offers a new perspective in understanding what supports LAC to attend mental health services. CAMHS can act as a secure base for LAC through being available and co-operative which supports long term attendance at CAMHS to

meet their mental health needs. The secure base lies at the heart of attachment theory (Bowlby 1969) as it defines close relationships as a means to an important end; trust in the availability of help and support reduces anxiety, which was demonstrated to the looked-after young people by CAMHS professionals. These findings have implications for all professionals supporting LAC through highlighting a need to provide a secure base through being available and co-operative. This is supported by NICE/SCIE guidance which recommends a core training module for all professionals in contact with LAC to develop an understanding and awareness of the emotional needs of this vulnerable group (NICE/SCIE, 2010).

4.1.1 (ii) What do LAC identify as barriers to attending CAMHS?

Looked-after young people also reported significant barriers in attending CAMHS for a substantial period of time. The shortest length of CAMHS involvement was nine months and the longest was one year ten months. Throughout CAMHS involvement from referral to attendance to being discharged, accessibility was a key barrier experienced by the looked-after young people. Limited accessibility was experienced in two fundamental ways, namely in-care barriers and CAMHS barriers.

In-care barriers relates to the significance of being in care for all four looked-after young people, and how this was a barrier to accessing CAMHS within the process of referral to attendance. Looked-after young people experienced frustration regarding long waiting times to begin the assessment and intervention process. The CAMHS review highlighted that waiting times remain one of the biggest barriers for access to specialist services for children, young people and families, in situations where the child's needs cannot be met by universal services (Department for Children, Schools and Families/Department of Health, 2008). One way in which services have addressed waiting times, within existing resources and while bringing about wider services improvement, is through redesigning services such as

implementing the Choice and Partnership Approach (CAPA) which is highlighted in the guide *Improving Access to Child and Adolescent Mental Health Services* (Department of Health & Department for Children, Schools and Families, 2009). In relation to the CAMHS within the urban local authority where the current study took place, the CAPA is being introduced to improve waiting times for all children accessing CAMHS. Robotham et al. (2010) carried out an evaluation of CAPA within a mental health service and found that if well managed and implemented, demand and capacity models such as CAPA appear to provide teams with structured, formal planning mechanisms.

These feelings relating to frustration were also prevalent when all four looked-after young people spoke of frequently changing placements was a barrier to accessing and attending CAMHS regularly. This is consistent with previous research (Beck, 2006; Callaghan et al., 2004; Vostanis, 2007) which recognises that those children who move placement frequently are less likely to access mental health services in a timely manner. Golding (2010) acknowledges that a lack of placement stability and parental advocacy combined with more complex needs means that children in care do less well with traditional models of mental health services. These findings highlight the need for multi-agency targeted and specialist mental health services to meet the mental health needs of children in care (Callaghan et al., 2004; McAuley & Young, 2006; Richards et al., 2006; Vostanis, 2007; Ward et al., 2002). These include the use of: designated mental health workers (e.g. psychologists, psychiatric nurses, primary mental health workers); existing CAMHS staff with protected designated time; and teams for high-risk groups among children and young people in care.

Barriers specific to CAMHS were also identified in the current study. Looked-after young people reported the extent to which the physical setting and space related to attending a therapeutic intervention was a barrier to accessing CAMHS effectively. A lack of predictability

and consistency about the room within which the therapeutic intervention took place for each session was frustrating and confusing for the looked-after young people. Indeed, Davies et al. (2009) found that children identified the importance of the physical space within which they received therapy and how it could have been improved. Similar findings are also supported by Carroll (2002) and Day et al. (2006) whom acknowledged that LAC pay attention to high quality physical surroundings and the significance of physical space is especially pertinent, echoing Bettelheim (1950).

The data obtained from the current study regarding the barriers to attending CAMHS for LAC highlights the importance of specialist and targeted mental health services for children in care. Furthermore, issues related to the physical setting and space being consistent to provide continuity and predictability for LAC needs to be accounted for. CAMHS for LAC need to be flexible, sensitive and accessible to meet the needs of this group of children and young people.

4.1.2 In what ways can CAMHS be improved for LAC?

This research question was designed to explore what LAC would like from CAMHS as previous research has noted that children and young people find it difficult to talk about negative aspects of their experiences (Bond, 1995). The need for transparency was seen to be a key way to improving CAMHS for the looked-after young people. They spoke of how it was important for CAMHS to share information with other key adults for good planning and care. Furthermore the participants spoke of how increased transparency was required during the assessment process. These findings offer original and rich insight into what LAC would like from mental health services. Previously, Beck's (2006) findings from a postal questionnaire highlighted that relatively few LAC were able to suggest what sort of services might help them with their problems and a number of those who responded to this question

simply said that they wanted something different. Through engaging with LAC via a qualitative research design led to rich insight into what they would like from CAMHS.

All four looked-after young people spoke of how they would have liked CAMHS to share more information about the nature of the therapeutic intervention they attended to key adults in their lives. Looked-after young people felt that some of the strategies they had learned and were adopting at school to manage their anger and anxiety could have been shared with their teachers by the CAMHS professional. However, this raises ethical issues as sharing information with other agencies is not part of general practice. Yet, increased communication and information sharing are vital in meeting the holistic needs of children with mental health needs. This is supported by research by YoungMinds (2012a) which found that looked-after young people stated that they did not feel that they could talk about their emotional needs at school. Additionally, children's mental health is viewed as only one component of inter-related difficulties that also involve relationships, development and learning (Anderson et al., 2004; Vostanis, 2007). CAMHS may need to consider ways of collaborating more effectively with schools in supporting the complex mental health needs of LAC they are involved with (Ward et al., 2002). Looked-after young people did however suggest that too much information to other adults was intrusive and that a balance was required to ensure their autonomy was respected. This is consistent with findings from Butler and Williamson (1994) whereby LAC stated they wanted confidentiality respected. This is particularly pertinent for CAMHS to consider given the sensitive nature and stigma related to mental health difficulties (White, 2006).

Also in line with the theme of transparency, three of the four looked-after young people expressed that they would have preferred their therapeutic intervention to have involved their foster carers more. Although the therapeutic intervention may not actively involve the foster carer, transparency and good communication were highlighted as being essential. The

importance of effective communication between carers and therapists is documented in the research (Delaney, 1998; Golding, 2007). Otherwise, the therapist and carer can easily be working at cross-purposes, often leaving the carer feeling blamed while continuing to deal with problems that could be deteriorating (Delaney, 1998). In relation to the current study's findings, this suggests that CAMHS need to communicate more effectively with foster carers which can support LAC to experience improved relationships in addition to developing secure attachments (Golding, 2007).

One looked-after young person in the current study (David) highlighted he was given the choice and autonomy to involve his foster carer actively throughout the therapeutic intervention at his initial assessment. This reinforces the sub-theme 'being co-operative'; the CAMHS professional ensured that the looked-after young person had the opportunity to choose whether they wanted the therapeutic intervention to involve foster carers or not.

These findings have implications for CAMHS ensuring that they work collaboratively and systemically to involve foster carers as part of therapeutic interventions with LAC. Golding (2007) highlights that the role of the foster carer is critical in ensuring that therapeutic work with the child is beneficial. The carer will continue to support the child at home, therefore it is important that foster carers are involved and informed about the CAMHS therapeutic intervention that the child is undergoing. Bowlby (1969) proposes that these attachment relationships play a crucial role in the child's social and emotional development. Within close relationships children acquire representations, or internal models, of themselves and their worthiness based on the availability, ability and willingness of the caregiver to provide care and protection. The child of an attuned, emotionally available and supportive caregiver will be secure and have a model of self as valued and competent. This is clear in David's case, whereby he explained that during the sessions his foster carer was able to support him which led to improved relationships between one another. This suggests that foster carers can be

powerful allies for the CAMHS professional delivering the therapeutic intervention. They can support the therapeutic process, as it is ongoing, and continue to provide safety and containment for the child between CAMHS sessions. To this end, it can lead to improved relationships between foster carers and LAC and ultimately offer greater placement stability as exemplified in David's narrative in the current study (Golding, 2004).

Furthermore, looked-after young people commented on a need for improved transparency during the assessment process. Evidence from the interviews highlights that looked-after young people felt that CAMHS professionals were not transparent in sharing information about the formal assessment measures conducted during their attendance at CAMHS. The NICE/SCIE (2010) guidance highlights that professionals should allow sufficient time and preparation for the child/young person to be given a clear understanding of the process and what is involved, so that they have the confidence to fully participate in the assessment. However, evidence from the interviews suggests that looked-after young people felt confused about the initial CAMHS assessment and did not receive feedback about what the assessment highlighted. In David's case, this led to him refusing to attend CAMHS and only participating in CAMHS a year later when his difficulties had become increasingly complex. This highlights how a negative experience of assessment can adversely influence the use of health services (Department of Health & Department of Children, Schools and Families, 2009).

4.1.3 What are LAC's experiences of attending a therapeutic intervention from CAMHS?

This final question was designed to explore LAC's experiences of attending a therapeutic intervention from CAMHS. The length of each looked-after young person's therapeutic intervention varied, with the shortest intervention lasting six months and the longest intervention lasting one year and eight months. The type of therapeutic intervention

experienced by three of the four looked-after young people interviewed was unknown. David's therapeutic intervention was multi-systemic therapy. This was evident through a trawl of his CAMHS file notes and through the interview in which he explained the involvement of his foster carers and sister throughout the therapeutic intervention. However, the remaining three participants' file notes did not state the type of therapeutic treatment delivered. This finding is supported by Cocker et al.'s (2004) review of specialist mental health projects for LAC which found non specific therapeutic treatments and direct work was the most frequently offered therapy in eighteen of the targeted CAMHS for LAC. However, given the ambiguity of the category, it is unclear what underpins such therapy in terms of an evidence base. It may be that non-specific therapy is informed to meet the needs of individual children and young people through adopting a combination of therapeutic modalities (e.g. cognitive behaviour therapy with attachment intervention) or focusing on a specific modality (play therapy).

In the current study, the overarching theme of 'exploring trauma, loss and rejection' highlights that attending a therapeutic intervention at CAMHS supported the looked-after young people to process and resolve difficult past experiences and reconstruct working models of self and attachment figures. This theme interlinks with another theme namely, 'CAMHS as a secure base' which suggests that CAMHS was an emotionally and physically safe setting for the looked-after young people to explore and express their thoughts and feelings. Bowlby (1988) suggests that the aim of therapy is to support the 'patient' to consider ideas and feelings about others that have been unimaginable and unthinkable. The CAMHS professional being 'available' and 'co-operative' allowed the looked-after young people to reflect on their experiences of trauma, loss and rejection prior to entering care and during their in care experiences. Looked-after young people spoke of how they had not discussed their feelings towards their birth parents with professionals or foster carers because it caused them emotional distress. Whereas, the current study's findings suggest that CAMHS professionals

supported them to feel safe and secure enough to explore difficult feelings. Bowlby (1988) likens the therapist to a parent 'who provides her child with a secure base from which to explore' (p. 140). It appears that the therapeutic interventions led to the looked-after young people using the CAMHS professional as a secure base from which they explored unhappy and painful aspects of their past and present.

Interestingly, looked-after young people made reference to life story work and said it did not help them to explore the trauma, loss and rejection they had faced throughout their life prior to and during care. Cook-Cottone and Beck (2007) describe life story work as a model for 'facilitating the construction of personal narrative for foster children' (p.1). Life story work is intended to help LAC make sense of their past and their present. However, for the looked-after young people in the current study, the CAMHS therapeutic intervention enabled them to reflect and understand the trauma, loss and rejection rather than the life story work. These findings are consistent with the sample of looked-after young people in Willis and Holland's (2009) study stating that they found the life story work process tedious at times. Life story work is a process that is dependent on the therapeutic alliance the looked-after child has with the adult delivering it (Baynes, 2008). Generally foster carers and social workers carry out life story work (Willis & Holland, 2009). One could argue that the life story work and the process associated with it was not effective for the participants in the current study because the looked-after child may not have built up a relationship with the adult carrying out the life story work. Whereas with the CAMHS professional, they were able to build up a relationship and trust due to the longevity and continuity of seeing the same adult and the professional displaying dimensions of caregiving.

James (1994) draws on attachment theory in recognising the importance of a therapeutic relationship between a looked-after child/young person and an adult. Looked-after young people highlighted the importance of rapport with the CAMHS professional delivering the

therapeutic intervention in the subtheme 'feeling understood'. They experienced professionals who were approachable and able to enter into a genuine helping trusting relationship with them. They felt that the personal qualities of the CAMHS professional were attuned to their emotional needs at the time of the therapeutic intervention. This is consistent with literature suggesting therapeutic orientation can be secondary to other factors in distinguishing effective therapies (Stiles et al., 1986; Davies & Wright, 2008; Davies et al., 2009). In relation to the current study, the importance of attending to the way that CAMHS professionals related to the young people was particularly significant, given that LAC's responses to professionals can be influenced by previously damaging interactions with adults (Golding et al., 2006; Hughes, 2004).

The overarching theme of 'exploring trauma, loss and rejection' can be explained in terms of psychoanalytic orientated theories, in particular attachment theory (Bowlby, 1969). Bowlby (1969) proposes that attachment relationships play a crucial role in children's social and emotional development. LAC who have experienced trauma, rejection and loss display fear and anxiety developed through past experiences. This leads to self-defences which are obstacles to trust and communication. For example, Tina stated:

'It was somewhere for me to talk...because before that I used to just bottle everything up and just deny that my mum left me and that my dad was hurting me. I used to make excuses for them. But now I understand and accept things...it's like...I am less angry now inside.'

In Tina's case, denial was a defence mechanism used to protect herself. The therapeutic intervention attended to defence mechanisms for the looked-after young people to feel understood and understand themselves. This was through techniques used by the CAMHS professional to provide the means of communication. For example:

'Yeah like I brought stuff I had from my mum and dad and we talked about them and the attachment I had with them. At first I didn't understand why we did it. But then I could see that it helped me. Like I used to be really negative and not saying anything good at all about my mum and dad. But XXXX helped me to think about the positive things with my dad and mum. Especially my dad because I didn't like talking about him at all and then I remembered some good things which made me less angry.' (David)

'...like we did this flipchart exercise where I wrote down the things I did, and the things I was feeling and thinking. I had one paper with how I felt about going into care. One paper with how my parents and sisters and brothers would have felt. And then how I felt now. That exercise was amazing. That's when I began to understand myself.' (Ali)

Golding et al. (2006) highlights that attachment based therapy aims to create a secure base and apply therapeutic tools to help children to develop different views of themselves and their experiences. The above extracts indicate that using possessions and writing down feelings supported the looked-after young people to understand their past and develop new ways of behaving.

Furthermore the overarching theme of 'emotional support' also reflects aspects of attachment theory which were fundamental to the looked-after young people 'feeling understood' and 'understanding themselves'. The therapeutic intervention within CAMHS provided a safe, dependable, empathetic, and attuned presence that enabled the looked-after young people in the study to do some of the "growing up" they could not do in the unsafe early environment. This relates to the CAMHS professional's capacity for emotional attunement - the ability to hear, see, sense, interpret, and respond to the looked-after young person's verbal and nonverbal cues in a way that the young person felt and understood (Fonagy, 2001). This attunement is important to a child/young person's ability to learn to regulate their nervous system and deal with distressing events. Fonagy (2001) argues that attunement is the building block to how one learns to be connected to others, build relationships, and feel safe in the world. For the looked-after young people in the current study, they were able to feel understood and understand themselves through the emotional attunement offered via the therapeutic relationship with the CAMHS professional. This is congruent with findings

from Davies et al.'s (2009) study in which children with disrupted attachments commented on appreciating the relationship they had with the therapists. This offers insight into how attachment theory informs the relationship between the looked-after child/young person and the CAMHS professional delivering the therapeutic intervention.

In summary, looked-after young people's experiences of attending a therapeutic intervention through CAMHS were positive. Looked-after young people highlighted improvements in managing behaviour problems and improved current relationships to be significant outcomes of the therapeutic interventions they undertook. Furthermore, looked-after young people recognised how their internal emotional states changed once they had attended the therapeutic intervention. These were made explicit through elaboration of constructs during the interview. Sarah stated that prior to the therapeutic intervention she had felt 'angry' and that this feeling changed to 'relaxed' after her involvement with CAMHS. Looked-after young people highlighted that the therapeutic intervention made them reflect on their bipolar construct of unloved/loved. Ali and Sarah stated that they felt 'unloved' throughout their experiences of being in care. However, after attending the therapeutic intervention through CAMHS they felt 'loved' and were able to reflect on aspects of care experiences which made them feel 'loved'. These findings offer rich and detailed insight into the impact of therapeutic interventions from LAC's perspectives, an area which previously was under represented in relation to measuring CAMHS outcomes for LAC.

CHAPTER 5: CONCLUSION AND IMPLICATIONS FOR PROFESSIONAL PRACTICE AND FUTURE RESEARCH

5. Introduction to discussion

Implications for practice will be explored in terms of how CAMHS and other services involved in supporting LAC can be improved based on the key findings emerging from the current study. Limitations of the study's methodology will be considered before making recommendations for future research in the area of exploring LAC's experiences of CAMHS.

5.1 Conclusion

The current study has sought the views of looked-after young people themselves, and highlighted aspects of their CAMHS experiences which were positive as well as the barriers and ways to improve CAMHS based on their subjective experiences. LAC's experiences of attending a therapeutic intervention through CAMHS were positive. The overarching theme of 'exploring trauma, loss and rejection' highlights that attending a therapeutic intervention at CAMHS supported the looked-after young people to process and resolve difficult past experiences and reconstruct working models of self and attachment figures. They felt that the personal qualities of the CAMHS professional were attuned to their emotional needs at the time of the therapeutic intervention. The importance of attending to the way that CAMHS professionals related to the children was particularly significant for the LAC, given that their responses to professionals can be influenced by previously damaging interactions with adults (Golding et al., 2006; Hughes, 2004). Looked-after young people highlighted improvements in managing their behaviour and improved current relationships to be significant outcomes of the therapeutic interventions they undertook.

5.2 Implications for practice

The overarching theme 'CAMHS as a secure base' highlights that looked-after young people value the relationship they had with the CAMHS professional. A relationship that was based on the CAMHS professional 'being available' and 'being co-operative' over time. This has implications for other professionals working with LAC in ensuring they are 'available' and 'co-operative' as caregiving dimensions highlighted by Ainsworth et al. (1971). Social workers are the professionals most involved in working with children in care, yet LAC rarely have the sort of relationship with their social worker that they want (Leeson, 2010). This is supported by the Munro Review of Child Protection (Department for Education, 2011d) which highlights that the social work profession is faced with high staff turnover, heavy workloads and administrative burdens which all militate against relationships flourishing (Leeson, 2010; Baynes, 2008). As a result, Social Work Practices (SWPs), which are social worker led organisations that are independent of the local authority, are currently being piloted to address many of the long-standing problems in the relationships between LAC and their social workers. Munro in her final report on the child protection system (Department for Education, 2011d) highlights the Three Houses model which presents workers with a series of techniques using a combination of play, conversation and drawings to bring out what a child is feeling and thinking. However, it could be argued that when working with children in the care system, a deeper understanding of attachment principles is required to build a trusting relationship with a looked-after child.

One could argue that a key professional whom could provide a secure base for LAC and offer emotional support is EPs through therapeutic work. MacKay (2007) suggests that EPs are a key therapeutic resource for children and young people, especially in educational contexts such as schools. MacKay (2007) makes reference to the increase in prevalence of mental health issues in children and young people, the value placed on therapeutic work by stakeholders as highlighted by Farrell et al. (2006) and the fact that EPs have identified

therapy as an area which should be expanded within their practice (Atkinson et al., 2011). In the current study, it was highlighted that the LAC felt that they should have been referred earlier or wished they had accessed a therapeutic intervention before reaching crisis point. It could be argued that therapeutic interventions are not solely unique to CAMHS, EPs are well equipped to deliver therapeutic interventions in schools and mental health is everybody's business (Department for Children, Schools and Families/Department Of Health, 2008a).

Atkinson and Bragg (2012) explored the role of EPs in relation to the delivery of therapeutic interventions and supporting emotional well-being through the use of an online survey completed by more than 450 EPs working in England, Northern Ireland, Scotland and Wales. Questionnaire responses revealed that 90% of EPs use therapeutic interventions as part of their current practice, in a variety of educational settings, with children and adults. A wide range of therapeutic interventions were reported, with the most popular being Solution Focused Brief Therapy (SFBT), Cognitive Behavioural Therapy (CBT) and Personal Construct Therapy (PCP). As well as in direct work with children and young people, therapeutic interventions were used in groupwork, consultation and assessment and also at a systemic level through training or developing the skills of others. This highlights that EPs have the skills to deliver therapeutic interventions, children do not need to be referred to specialist mental health services.

Fallon, Woods and Rooney (2010) consider possible opportunities which might emerge from different levels of commissioning of EP services. These include '*...the opportunity to expand the influence of the EP role beyond previous limitations of ring-fenced EPS budgets*' (p.15). It is possible that as the role of the EP emerges, one contribution could be the increased opportunity to support or deliver therapeutic interventions in school. The nature of this work could focus on an early intervention and preventative approach as well as targeting children

'at risk' of developing mental health problems. In this way, referrals to CAMHS can be reduced.

Within the local authority I am employed, the Educational Psychology Service has become partly traded which has allowed schools to buy additional EP sessions alongside their core time allocation. I have been involved in delivering training to a 3 primary schools regarding supporting resilience. The focus of the training has been to raise awareness of resilience and how school staff can develop children's resilience at the individual level but also how the school can develop the school environment to become more nurturing. This training originally arose through a high level of casework related to LAC within the three schools. This reflects that EPs have a fundamental role in supporting schools to adopt an early intervention approach to improving children's psychological well-being.

The emphasis on CAMHS professional's being 'co-operative' through supporting LAC to have the choice and autonomy highlights the significance of listening to and working with LAC rather than working for them by making decisions on their behalf. Professionals working with LAC as 'corporate parents' must ensure that the voice of the looked-after child is at the heart of all decision making (The Education Committee, 2011). In the current study, looked-after young people spoke of how previously they rarely experienced co-operative adults, they found that professionals and adults in their life were often either too controlling and intrusive or too passive and ineffective. Consequently, experiencing co-operative adults facilitated their attendance at CAMHS. Professionals working with LAC should aim to empower them through providing them with autonomy and choice.

The data obtained from the current study offers a new perspective in understanding what supports LAC to attend mental health services. CAMHS can act as a secure base for LAC through being available and co-operative which supports long term attendance at CAMHS to

meet their mental health needs. These findings have implications for all professionals supporting LAC by highlighting a need to provide a secure base through being available and co-operative.

A key professional that could offer consultation and training regarding attachment theory and knowledge of trauma and loss are Educational Psychologists (EPs). Norwich et al. (2010) found that EPs work with children in care and adults supporting children in care. It could be argued that EPs can provide an early intervention and preventative approach to the mental health of looked-after children through supporting adults working with LAC. Norwich et al.'s (2010) research emphasises that EPs offer a distinct contribution regarding children in care. They reported that EPs have a rich insight into how children in care respond to school settings and attachment theory. This can lead to understanding the impact of their emotional well-being on their educational attainment difficulties. As one EP from Norwich et al.'s (2010) study highlighted:

'CAMHS have got as much understanding as we have about attachment, but one thing you've probably got more of in relation to CAMHS workers is your experience of education. Those two areas, attachment theory and education systems and impact on education are distinctive for EPs with children in care'. (Norwich et al. 2010; p. 167)

This suggests that although CAMHS work is often intensive with the looked-after child or young person, CAMHS professionals often do not work with school staff, or understand the impact on education. LAC achieve poorer educational outcomes than all children. The Department of Education's official statistics found that in 2011 only 31 per cent of LAC who have been looked-after for at least a year achieved five good GCSEs compared to 70 per cent for all children (Department for Education, 2011a). This reflects the importance of EPs working with designated teachers in schools who are responsible for promoting the educational achievement of LAC in their schools. In this way, attachment theory and principles can be shared so that adults working with children in different contexts are aware

of how to promote positive outcomes for LAC through forming effective relationships. Additionally, EP services commissioning EP work within schools, could consider prioritising a core allocation model dependent on the number of LAC in each school.

Looked-after young people also reported significant barriers in attending CAMHS for a substantial period of time. Throughout CAMHS involvement from referral to attendance to being discharged, accessibility was a key barrier experienced by the looked-after young people. Limited accessibility was experienced in two fundamental ways, namely in care factors and CAMHS factors. These findings highlight the need for multi-agency targeted and specialist mental health services to meet the mental health needs of children in care (Callaghan et al., 2004; McAuley & Young, 2006; Richards et al., 2006; Vostanis, 2007; Ward et al., 2002).

A key aspect of the CAMHS process highlighted by the looked-after young people was the limited accessibility from referral to assessment. One way this could be addressed is through the implementation of the Choice And Partnership Approach (CAPA), whereby the first clinical contact for the looked-after young person is in a 'choice appointment' which aims to improve access through combining assessment with motivational enhancement and goal setting. The data obtained from the current study reinforces the importance of the CAPA being implemented within the urban local authority in which the research was carried out, as well as highlighting the need for a targeted approach within CAMHS for LAC.

The need for enhanced communication was seen to be a key way to improving CAMHS for the looked-after young people. They spoke of how it was important for CAMHS to share information with other key adults for good planning and care. These findings highlight that therapeutic interventions should not be delivered in isolation; due attention must be given to addressing the contextual factors that are impacting on LAC's lives. For CAMHS, this is likely

to mean increased collaboration with other agencies that are part of, or could potentially be part of the systemic context in which LAC interact within. This includes schools and foster carers.

The level of children's and young people's participation in the new NHS landscape is a major concern of YoungMinds (YoungMinds, 2012b). Almost 80% of respondents had not been informed how children and young people can get involved in shaping local health services through Health & Wellbeing Boards and HealthWatch. This reflects the limited participation of children and young people at the heart of improving mental health services. With the Government investing £32 million in psychological therapies to help children and young people suffering from mental health problems (Department of Health, 2011), mental health services must reflect on how they will involve children, young people and families to consider if the service change is necessary. Methodologies from the current study could be adapted for routine service-user feedback within CAMHS. For example, the sentence completion task (see Appendix 2) could be used within a questionnaire to encourage children to speak about what they might otherwise find challenging and enable children to talk more freely about areas of dissatisfaction.

Looked-after young people highlighted the importance of rapport with the CAMHS professional delivering the therapeutic intervention in the subtheme 'feeling understood'. They experienced professionals who were approachable and able to enter into a genuine helping trusting relationship with them. They felt that the personal qualities of the CAMHS professional were attuned to their emotional needs at the time of the therapeutic intervention. This is consistent with literature suggesting therapeutic orientation can be secondary to other factors in distinguishing effective therapies (Stiles et al., 1986; Davies & Wright, 2008; Davies et al., 2009). In relation to the current study, the importance of attending to the way that

CAMHS professionals related to the children was particularly significant for LAC, given that their responses to professionals can be influenced by previously damaging interactions with adults (Golding et al., 2006; Hughes, 2004). This reinforces how professionals within education, health and social care should be aware of meeting the emotional needs of LAC. This is further supported by YoungMinds (2012a) report which highlights the importance of professionals working with LAC in meeting the emotional needs of LAC. One way this could be done is through sharing information about attachment principles such as emotional attunement. Emotional attunement consists of an adult responding to a looked-after child's verbal and nonverbal cues in a way that the child feels understood (Fonagy, 2001). This attunement is important to a child's ability to learn to regulate their nervous system and deal with distressing events. Fonagy (2001) argues that attunement is the building block to how one learns to be connected to others, build relationships, and feel safe in the world. One could argue that as corporate parents, all professionals working with LAC should aim to display emotional attunement through having an understanding of attachment theory.

5.3 Critique of the methodology

The rich and detailed information gathered about the looked-after young people's experiences was supported by the use of the 'talking stones' technique (Wearmouth, 2004). This tool was used as it offered a non directive way of facilitating LAC to tell their story of their CAMHS experience. The process of reflection can be something LAC may find difficult if they have had to repress traumatic experiences from their past (Davies et al., 2008). During the semi-structured interviews, the 'talking stones' were useful in facilitating discussion about birth parents and pre care experiences and supported the looked-after young people to describe their experiences with minimal prompting from myself. In many cases the young people used the stones directly to explain what life was like for them as highlighted in the theme 'exploring trauma, loss and rejection'.

The current study demonstrates how ‘talking stones’ can be used by young people to represent different feelings and create a shared understanding between an adult and young person about their experiences. By asking the young person to choose a stone that represents what it was like for them at different points in their lives was beneficial, as it allowed the young people to be creative, or choose more than one stone to represent how they were feeling. This tool therefore is useful in direct work with young people and may be further applicable in gathering the voice of marginalised vulnerable groups

The sentence completion task was a useful way of encouraging the LAC to elaborate on their experiences of the therapeutic intervention attended through CAMHS. It sufficiently cued in their reflections about the intervention, whilst containing risks inherent in more structured and potentially leading questions. The sentence completion task could be used within a questionnaire or an interview to encourage children to speak about what they might otherwise find challenging and enable children to talk more freely about areas of dissatisfaction. This tool can be adapted for professionals to use when gaining children’s views.

The PCP laddering and pyramiding questions provided useful prompts to help the LAC to elaborate their construing. However, at times, the LAC experienced difficulty in answering laddering and pyramiding questioning (e.g. the why/what questions). This may reflect the level of language development. This acted as a constraint to data collection, particularly considering that PCP relies on language as an important medium for communication (Burnham, 2008).

The small sample in the study clearly limits the legitimate generalisation of its findings to the heterogeneous population of LAC. Although the aim of the study was not to draw general conclusions about LAC’s experiences of CAMHS, the present study does provide a source of

rich descriptions. Additionally, the research findings are permissive of analytical generalisation (Yin, 2009), and so of contributing to the wider body of research on LAC attending CAMHS.

A limitation of the current study is a lack of triangulating the experiences from the looked after young person's perspective with the CAMHS professional's or foster carer's perceptions regarding the impact of the therapeutic intervention. The documentary file trawl highlighted that the young person was discharged due to the therapeutic intervention being successful as agreed by the foster carer, the young person and the CAMHS professional, however, no detail was displayed. Interviewing the relevant CAMHS professionals would have offered further insight into the effectiveness of the therapeutic interventions for the young people.

Despite the benefits associated with engaging LAC as 'active research participants', it is important to consider the potential limitations associated with adopting a 'giving a voice' approach. It is acknowledged that the results presented are bound within the limits of participants' ability to articulate their experiences, as well as their willingness to share information with the researcher in an honest and open way (Miles & Huberman, 1994). Interpretative approaches to research and the methods they employ can be subject to confirmatory bias through the ways in which they are interpreted, which is seen to be a limitation of this type of methodology (Elliott et al., 2009) Although this was controlled in a number of ways (see Box 4), it is important to acknowledge that a researcher cannot fully abstract themselves from their own interpretative framework and this is therefore likely to have affected the interpretation and analysis of results.

Box 4: Reducing interpreter bias

- Once 'themes' had been identified, they were fed back to research participants to check that they had relevance.
- Before the research was written, the 'interpretation of findings' was shared with participants to check that their experiences had been properly understood and not misinterpreted.
- Also, a second Trainee EP reviewed the thematic analysis process.

5.4 Suggestions for future research

In order to be able to make more general claims about LAC's experiences of CAMHS, the results of this exploratory study could be extended to other looked-after populations. This approach is consistent with taking the view that LAC are not a homogenous group, the only thing they have in common is that they are in care. In the present study, there were no children in residential care whilst undergoing CAMHS involvement. The current methodology employed (literal replication logic, Yin, 2009) did not allow for an exploration of whether type of placement during CAMHS involvement directly affected the looked-after young person's experiences of CAMHS. This could be explored through the use of case studies employing a 'theoretical replication logic' (Yin, 2009) which would enable the experiences of LAC in residential and foster care during CAMHS involvement to be compared. Furthermore, all four LAC who participated in this study accessed CAMHS within an urban local authority. The experiences of LAC accessing CAMHS within a rural local authority would highlight any differences.

In the current study, it is impossible to draw firm conclusions about the impact of specific therapeutic interventions as there was no attempt to measure CAMHS therapeutic intervention outcomes. As highlighted by Berger (1996) no measured outcome can be causally linked to an intervention; rather, outcome measures assess various aspects of a child's life at a particular point in time and are influenced by a variety of factors, of which

CAMHS interventions are but one. Nonetheless, future research that replicates the current study but purposively samples groups of LAC who have achieved a good or a poor outcome from therapeutic interventions is likely to be fruitful. Future research might also be directed towards exploring the experiences of a specific therapeutic modality. This could be achieved through CAMHS professionals identifying the type of therapeutic intervention delivered.

Furthermore, a key limitation of the current study is that only LAC who attended CAMHS were interviewed. It would have been insightful to interview the LAC who stopped attending CAMHS to understand their experiences. During the initial stages of the research, this was highlighted to the Corporate Parenting Team Manager and the CAMHS Manager. However, they stated that the LAC who stopped attending CAMHS were difficult to engage with as they were not attending educational provision. Furthermore, the Corporate Parenting Team Manager highlighted that their social workers would not give permission to consent as this cohort of LAC refuse to engage with social workers. These constraints led to focusing the current study on those LAC whom attended CAMHS and were discharged upon agreement that the therapeutic intervention had been a success.

Carrying out qualitative research with LAC can be challenging given their reluctance to trust adults and share openly their feelings and experiences (Dahl & Aubrey, 2006). Furthermore, it is important to acknowledge the difficulties that are encountered in gaining consent to engage LAC in research. For research purposes the concept of the 'corporate parent' poses significant problems for locating responsibility within bureaucratic organisations, such as social services. Consequently the requirement for researchers to identify and engage multiple party consenters (foster-carers, birth parents, social services and the child) can be a lengthy process. In the current study, all children were in care under section 21 of the 1989 Children Act, which indicated that foster carers and the Local Authority had corporate parental responsibility. Consequently, birth parents did not have to be contacted. A key

method of communicating with social workers, foster carers and LAC was through mobile phones. I found that social workers were able to respond quicker to mobile phone calls than emails or ringing the office base. Additionally, texting the LAC who consented to participating in the research led to arranging dates and times for the interview to be carried out and rearranging visits. Mobile phone texting also allowed for confidentiality as the young person could then choose if they wanted to inform the foster carer when the interview was taking place. Such informal methods of social media communication may be useful if LAC's views are going to gain significant representation within research contexts in the future.

5.5 Concluding Comments

The current study affirms the importance of listening to LAC's experiences and engaging with them as active participants in research, as this provides a powerful source of evidence which can inform interventions. It highlights the significance of employing research methodologies that support a 'giving voice' approach, and enable researchers to explore participants' lived experiences in a way that takes their account beyond the anecdotal. This is in accordance with NICE/SCIE guidance which promotes the voices of LAC as being at the heart of service design and delivery (NICE/SCIE, 2010).

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Appendix 1

Four-tiered CAMHS framework and universal, targeted and specialist services **Source: National CAMHS Review (Department for Children, Schools and Families and Department for Health, 2008a)**

Box 1: The four-tiered CAMHS framework

Tier 1: Services provided by practitioners working in universal services (such as GPs, Health Visitors, Teachers and Youth Workers), who are not necessarily mental health specialists. They offer general advice and treatment for less severe problems, promote mental health, aid early identification of problems and refer to more specialist services.

Tier 2: Services provided by specialists working in community and primary care settings in a uni-disciplinary way (such as Primary Mental Health Workers, Psychologists and Paediatric clinics). They offer consultation to families and other practitioners, outreach to identify severe/complex needs, and assessments and training to practitioners at Tier 1 to support service delivery.

Tier 3: Services usually provided by a multi-disciplinary team or service working in a community mental health clinic, child psychiatry outpatient service or community settings. They offer a specialised service for those with more severe, complex and persistent disorders.

Tier 4: Services for children and young people with the most serious problems. These include day units, highly specialised outpatient teams and inpatient units, which usually serve more than one area.

Box 2: Universal, targeted and specialist

Universal services work with all children and young people. They promote and support mental health and psychological well-being through the environment they create and the relationships they have with children and young people. They include early years providers and settings such as childminders and nurseries, schools, colleges, youth service and primary health care services such as GPs, Midwives and Health Visitors.

Targeted services are engaged to work with children and young people who have specific needs – for example, learning difficulties or disabilities, school attendance problems, family difficulties, physical illness or behaviour difficulties. Within this group of services we also include CAMHS delivered to targeted groups of children, such as those in case.

Specialist services work with children and young people with complex severe and/or persistent needs, reflecting the needs rather than necessarily the 'specialist' skills required to meet those needs. This includes CAMHS at Tiers 3 and 4 of the conceptual framework (though there is overlap here as some Tier 3 services could also be included in the 'targeted' category). It also includes services across education, social care and youth offending that work with children and young people with the highest levels of need – for example, in pupil referral units (PRUs), special schools, children's homes, intensive foster care and other residential or secure settings.

Appendix 2

Sentence completion task (Grice et al., 2004)

The looked-after young people were given the following incomplete sentences to elicit their constructs in the domain of facilitators and barriers in attending CAMHS. The looked-after young people's answers were explored further through laddering and pyramiding of bipolar constructs.

When I first heard of CAMHS I thought.....

At my first session I felt.....

I liked going to CAMHS because.....

I did not like going to CAMHS because.....

When I entered my regular CAMHS session I felt.....

When I left my regular CAMHS sessions I felt.....

One positive thing about CAMHS is.....

One negative thing about CAMHS is.....

When I was discharged from CAMHS I felt.....

One top tip I would give to CAMHS is.....

Appendix 3

Script for 'talking stones'

I'm here to find out about your experience of CAMHS and how you feel about it.

1. Tell me how you felt when you began to access CAMHS; which stone would you choose to show how you felt on your first day (prompt as appropriate e.g. what did you think? Did you know what would happen?)
2. Can you choose a stone which reminds you of when you started seeing someone at CAMHS regularly? Tell me a bit more about this stone, how come it reminds you?
3. Tell me about what changed once you started going to CAMHS (what stone represents how this?)
4. Is there anything you would improve about your experiences of CAMHS? (what stone would show this?)

Diagram 2: Photo of stones and shells used



Appendix 4

Laddering and Pyramiding

The discussions that took place between me and the looked-after young people in the interviews were structured by PCP techniques; the sentence completion task (Appendix 2) and the talking stones (Appendix 3) . These activities generated several themes related to the looked-after young people's constructs which were explored in greater depth through laddering and pyramiding. The following provides an illustrative example of the laddering and pyramiding process, which was characteristic of the interview techniques I used with the looked-after young people.

An example of construct elaboration: using bipolar constructs and laddering/pyramiding:

- 1) A construct of 'mad' was elicited by a looked-after young person when she was discussing her initial thoughts about CAMHS.
- 2) The contrast pole is explored, in order to obtain a greater understanding of what the looked-after young person felt. This is called the bipolarity of construing (Kelly, 1955). E.g. what would you call someone who isn't 'mad'? (e.g. the looked-after young person construed this to be 'normal, see below)

mad-----normal

- 3) Once the bipolar construct is established (e.g. 'normal'), the looked-after young person is asked 'Which pole do you think describes you best' or 'Which is your preferred pole'
- 4) Starting with the pole that the looked-after young person would most like to be, a number of laddering and pyramiding questions are presented (see table below)

Example of 'Laddering and Pyramiding' questions, developed from Beaver (1996), Burnham (2008), Ravenette (1999),and Shilvock (2011).

Laddering	Laddering involves a series of 'Why' questions.
Exploring the young people's core beliefs and basic values	'Why is that important?' 'Why do you feel it is a good thing to be...?' 'Why would that be important to you' 'Why does that matter' 'You mentioned that you would rather be.....than.....Why is that?' 'What is so bad about being.....' 'What is so good about being.....'

<p>Pyramiding</p> <p>The surface behaviours associated with a bipolar construct</p>	<p>Pyramiding involves a series of 'What' questions.</p> <p>'What doCAMHS do?'</p> <p>'How would aperson behave?'</p> <p>'What difference did your sessions make?'</p> <p>'What would you see them doing?'</p> <p>'Anything else?'</p>
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Appendix 5

Social worker consent

Dear XXXXXXXXXXXX

My name is Sidra Aslam and I work as a Trainee Educational Psychologist for Walsall Educational Psychology Team. I am currently carrying out some research in conjunction with the Virtual School for looked-after children and the Walsall Child and Adolescent Mental Health Service (CAMHS) as part of my Doctoral training at the University of Birmingham.

I am interested in exploring looked-after young people's experiences of CAMHS. CAMHS have provided me with information about LAC who have accessed CAMHS and undergone a therapeutic intervention.

From this cohort, I am hoping to interview pupils in order to find out about their experiences of CAMHS. I understand that you are the named social worker for the following looked-after young person:

XXXXXXXXXX

I would be grateful if you could spare the time to ring me to let me know the following information:

- The young person's current educational and care placement, and if either of these would be appropriate places to carry out an interview with them and when you are visiting them next to introduce my research.

I hope to contact you by phone in the next few days, or you can contact me at the number below or by e-mail at XXXXXXXXXXXXXXXXXXXX to discuss whether you think it is appropriate to give consent for this research to take place.

Thank you for your time and co-operation with this piece of research, which should provide valuable information for all agencies supporting looked-after children and young people. Please contact me if you have any queries.

Best Wishes

Sidra Aslam
Trainee Educational Psychologist

Appendix 6

Foster carer information sheet and consent form

Dear Sharon

I am writing to ask for your support in a research project being carried out. The project aims to explore looked-after young people's experiences of CAMHS. I would like to invite Xxxxx to take part in this research.

During the project, I will carry out an interview with Xxxxx to talk about her experiences. I will not report the information to anyone else. The interviews will be audio taped and written down.

The information that I collect during the research will be written up in a report. None of the pupils will be named in the report, so no one will be able to tell who has said which things. Xxxxx can change her mind about taking part in the project at any time, without having to give a reason.

If you are happy for her to take part in this project then please complete the *Foster Carer Consent Form*. Xxxxx will need to complete the *Pupil Consent Form*. A Pupil Information Sheet is also provided, which explains what Xxxxx can expect from taking part in the project.

If you have any c

Many thanks for your help.
Yours sincerely,

Sidra Aslam
Trainee Educational Psychologist

Foster Carer Consent Form

Dear Sharon

Please read the Foster Carer Information Sheet before filling in this form. Please read the statements below and tick the boxes if you agree with them. Signing your name at the bottom of the page means that you agree to your child to take part in this project.



I have read the information sheet about this project.



I have had time to think about the information.



I understand that I am choosing for Xxxxx to be involved and I can leave the project at any time without giving a reason.



I understand that the things Xxxxx talks about in this project will be written in a report. Their name will not be used so no one will know who said what.



I understand that the session will be audio taped so that

there is a good record of what was said and Xxxxx's CAMHS file will be read.



I agree to Xxxxx to take part in this project about
looked-after young people's experiences of CAMHS.

(Please print your full name)

(Please sign your name)

(Date)

(child's name)

Pupil Information Sheet and Consent Form

Dear XXXX

I would like to invite you to take part in a project about experiences of CAMHS. That's because I'm interested in finding out about looked-after young people's experiences of attending CAMHS.

- The Child and Adolescent Mental Health Team and the Virtual School team have given permission for me to contact you. I need to ask your foster carers for their permission, and I also want to make sure that you are happy to take part in the project.
- If you agree to be in this project, you will meet with me one-to-one to talk about your experiences of attending CAMHS. This session will last for about 1 hour and will take place somewhere you are familiar and comfortable with. We will carry out some activities to get the conversation started but there are no wrong or right answers! The session will be audio taped so that I have a good record of what was said. No one else will listen to the recording.
- All the information that I get from carrying out the interviews will be written up in a report that other people will read. Your name will not be put in the report so what you have said will not be linked to you in any way. I will not talk to other people about what you tell me about your experiences. The only thing that I'm not able to keep confidential would be if you let me know that you or someone else had been harmed, or are in danger of being harmed, or have broken the law- then I will have to share this information with another adult and I'll let you know.
- Being in this research is your choice. It's okay if you don't want to take part or if you change your mind later and want to stop half way through. Just let me know or if you had a think after the interview, you can ring or email me.
- Please keep this information sheet in a safe place in case you want to read it again in the future.

- You can ask any questions you have about the research now or at any time.
 - Here are my contact details and my research supervisor's if you would like to know more about the research project.

Sidra Aslam, Trainee Educational Psychologist - 01922 686 375

Dr Anita Soni, Educational Psychologist - 0121 414 4843

Pupil Consent Form

Dear XXXX

Please read the Pupil Information Sheet before filling in this form. Please read the statements below and tick the boxes if you agree with them. Signing your name at the bottom of the page means that you agree to take part in this project.



I have read the information sheet about this project and give consent for Sidra to view my CAMHS file.



I have had time to think about the information.



I understand that I am choosing to be involved and I can leave the project at any time without giving a reason. I can do this by contacting Sidra on 01922 686 375 or by email sidra_aslam@hotmail.co.uk



I understand that the things I talk about in this project will be written in a report. My name will not be used so no one will know who said what. The only thing that I'm not able to keep confidential would be if you let me know that you or

someone else had been harmed, or are in danger of being harmed, or have broken the law- then I will have to share this information with another adult and I'll let you know.



I understand that the session will be audio taped so that there is a good record of what was said.



I agree to take part in this project about looked-after young people's experiences of CAMHS.

(Please print your full name)

(Please sign your name)

(Date)

Appendix 8

Overview of ethical considerations

Participant Feedback

Participants will be presented with a summary of the main themes from their interview after the data analysis has taken place. This will take place through a follow up face to face session.

Participant Withdrawal

I will outline the LAC's right to withdraw at any time during the process and will request that they verbally give an indication (on audiotape) of consent at the beginning of the interview as evidence that they understand the points outlined above and are still willing to participate. When meeting these participants in order to carry out interviews I will repeat the information in the letter and give them the opportunity to ask any questions.

I will also be sensitive to any non-verbal communication which may suggest the looked after child/young person is ill at ease during the interview and take appropriate steps to pause or terminate the interview, in line with standard counselling practices which are integral to my day-to-day professional practice as a Trainee Educational Psychologist.

There will be no attempt to coerce or persuade individuals to continue to participate, and offers to withdraw will be accepted without question (BERA ethical guidelines, 2004).

There will be no consequences for participants withdrawing prior to the interview, during the interview or immediately after the interview. If participants' withdraw, their individual contribution will be identified on the transcript and will not be included in the research. The recording of the interview will also be deleted.

After the research has been completed written notes relating to the data will be shredded and Dictaphone recordings will be deleted.

Confidentiality

I will ensure anonymity of participants by allocating code numbers to all related data, rather than names and by erasing any information that may allow them to be identified from the interview scripts and when analysing the records. Such identifying details include: names of schools, addresses, names of residential homes or young offenders units; names of friends / peers / teachers / social workers. If a young person had been through an experience which was relevant to the research question but would be unique enough, in addition to other information reported about them, to compromise their anonymity I would not report it specifically in the research without their consent about this specific circumstance (BPS ethical guidelines, 2009). Information provided to the Virtual School for Looked-After Children on the completion of the research will relate to general trends amongst the sample group, rather than specific information relating to each participant's experiences.

The interviews will be conducted in a room that is not accessible to any other persons (Nesbitt, 2000). This will help maintain confidentiality of the interview.

It will be explained to participants that anything they say will remain confidential. However, if an individual discloses something which is illegal or places them or others at risk, safeguarding procedures will be followed. I have received Child Protection Training regarding what constitutes confidentiality and what constitutes safeguarding. The Virtual School's policy for LAC on confidentiality and safeguarding will also be consulted and followed. At the end of the interviews, I will discuss any concerns with the Virtual School Manager and decisions will be made about any concerns and if further action needs to be taken. Also, the knowledge that I obtain from the interviews with the participants will leave me with certain degree of vicarious responsibility (Scaife, 2001). Although I will adhere to the principles of confidentiality, I recognise that I hold a degree of professional and personal responsibility through having acquired knowledge that may be particularly sensitive in nature. At the end of interviews, I will inform participants that if the interview has raised any feelings which they would like to speak to someone about in more depth, at the first instance, I will make contact with their social worker or if they have left care provide them with a list of organisations they may want to contact, such as Connexions, Samaritans, and Open Door (free counselling service for young people 16-25).

Significance/Benefits

Gaining an insight into a sample of LAC's experiences of CAMHS will help gain rich and contextualised information about what looked-after young people value most in relation to their experiences of CAMHS.

This research aims to explore what difference attending CAMHS makes to LAC and whether there are similarities and differences in what is valued as important. I aim to find what factors encouraged looked-after young people to attend CAMHS. This information has a key significance as many LAC refuse access to mental health services (Vostanis, 2007), therefore this insightful information will help designated mental health services for LAC and social services to understand how to better support LAC as this has not been understood fully from the young person's perspective.

The benefits for participants should include empowerment from having their views listened to.

Risks

Raising emotive and sensitive issues with looked-after young people who have undergone therapy

One possible detrimental effect could be that I am asking LAC to discuss issues which may be particularly emotive and sensitive. I am asking the LAC to reflect on their experiences of therapy. I will minimise risk to the looked after child/young person feeling distressed during the interview through:

Using an appropriate method: by using appropriate methodology, young people who have undergone therapy can participate in research (Farrell *et al*, 2002; Potter *et al*, 2002; Owen *et al.*, 2004; Dance and Rushton, 2005; Irwin and Johnson, 2005; Aubrey and Dahl, 2006; Mudlay and Goddard, 2006). Using non-directive techniques in the interview, such as the stones (Wearmouth, 2004) as a medium to reflect on the therapy will help to engage with the young person. Furthermore, I aim to draw upon my humanistic values of empathic listening and summarising back to the young person so they feel understood as part of the process.

Sign-posting to other relevant sources of support with the young person's consent.

Increasing my awareness of the risk and protective factors that looked-after young people have by working closely with the Virtual School and the designated CAMHS team for looked-after young people to gain knowledge of this group. A researcher's previous experience with the group on which the research focuses can help establish relationships of trust and is an important dimension to success (Claveirole, 2004).

There is a risk that abusive practices and/or participant's ill-health becomes apparent through their responses. In this case, the local authority safeguarding procedures will be followed, and necessary intervention would be provided by informing the Virtual School for LAC team.

Undermining the professional work of therapists from the designated CAMHS team

The nature of the study is qualitative, so that rich information can be obtained. LAC will be asked to comment on their experiences of a therapeutic intervention, which includes the relationship with the CAMHS professional. I will emphasise to the LAC that I have no contact with the therapists, so they feel comfortable to discuss this if they would like to do so. As the research concerns LAC who have undertaken a therapeutic intervention, there will be no contact with the CAMHS professional. I will feedback my results to the designated CAMHS team through similarities and differences and the CAMHS will not be aware of which LAC were interviewed so as to undermine their professional practice or competence.

Research activity timeline

<p>September – October 2010 Initial meetings with University Tutors, Principal Educational Psychologist and key personnel in Local Authority to identify areas of interest and potential research.</p>
<p>October 2010 - January 2011 Review of relevant literature and consolidation of research aims in collaboration with Principal Educational Psychologist and University Tutors. Attended a looked-after children's governing committee meeting and spoke to professionals about my potential research.</p>
<p>February 2011 Development of research proposal and specification of research methods (including development of information sheets, consent protocols and data collection) and submission of research proposal to the University of Birmingham Ethics Committee.</p>
<p>March 2011 Presenting research proposal to professionals from the CAMHS within the Local Authority at their service day. Gathered background information about the type of work carried out by CAMHS for LAC. Identified that the CAMHS within the Local Authority want to improve their services for looked- after children.</p>
<p>April 2011 Ethical committee approval of the research. The CAMHS team manager was provided with criteria for identifying the names of all LAC who met the inclusion criterion (10 looked-after young people met the criterion).</p>
<p>May - June 2011 Contact with Corporate Parenting Team in order to identify the social worker for each looked-after young person so to introduce the research and obtain consent.</p>
<p>July – August 2011 Introducing research to foster carers and looked-after young people. Also waiting for social workers to make contact to inform them of research.</p>
<p>September - October 2011 Data gathering (interviews with looked-after young people)</p>
<p>November 2011 Data analysis began (Phase 2 and 3) Fed back to research participants.</p>
<p>December 2011 - March 2011 Continued refinement of data analysis and write up of research. Present findings to the CAMHS within the Local Authority and the Educational Psychology Team.</p>

Appendix 10

Thematic Analysis Process

Generating the initial codes (Phase 2 of thematic analysis)

1. Feeling listened to	2. Trusting my therapist	3. Feeling valued and cared for
4. Changing foster placement	5. Feeling supported	6. Didn't feel judged
7. Understanding relationships with different foster carers	8. Room for therapeutic intervention was unclear	9. Techniques to talk about past experiences
10. Consistency of seeing the same person at CAMHS	11. Reflecting on emotional experiences related to being in care – hurt, lost, worried, scared.	12. Appointment times changed with short notice
13. Stigma of being in care and attending CAMHS	14. Making choices about the therapeutic intervention	15. Bipolar constructs of angry/relaxed
16. Feedback about assessment process	17. Clinic setting felt emotionally and physically safe	18. Understanding reason for referral to CAMHS
19. Accepting past experiences	20. Understanding life story work	21. Therapeutic intervention was at the right time
22. Understanding thoughts and feelings and behaviours	23. Recognising my racial and ethnic identity	24. Waiting times
25. Had a choice to leave at any point	26. Involving foster carers in CAMHS sessions	27. Bipolar constructs of unloved/loved
28. Explain the role of CAMHS to school staff		

Searching for themes (Phase 3 of thematic analysis)

Potential Theme A – Facilitators to attending CAMHS

- 2. Trusting my therapist
- 10. Consistency of seeing same person at CAMHS
- 14. Make choices about the therapeutic intervention
- 17. Setting felt physically and emotionally safe
- 18. Understanding reason for referral to CAMHS
- 21. Therapeutic intervention was at the right time
- 25. Had a choice to leave at any point

Potential Theme B – Difficulties associated with CAMHS

- 8. Room for therapeutic intervention was unclear
- 12. Appointment times changed with short notice
- 13. Stigma of being in care and attending CAMHS
- 4. Changing foster care placement

Potential Theme C - Improving CAMHS

- 16. Feedback about assessment process
- 24. Waiting times
- 26. Involving foster carers more in CAMHS sessions
- 28. Explain the role of CAMHS to school staff

Potential Theme D – Exploring trauma, mourn and losses experiences

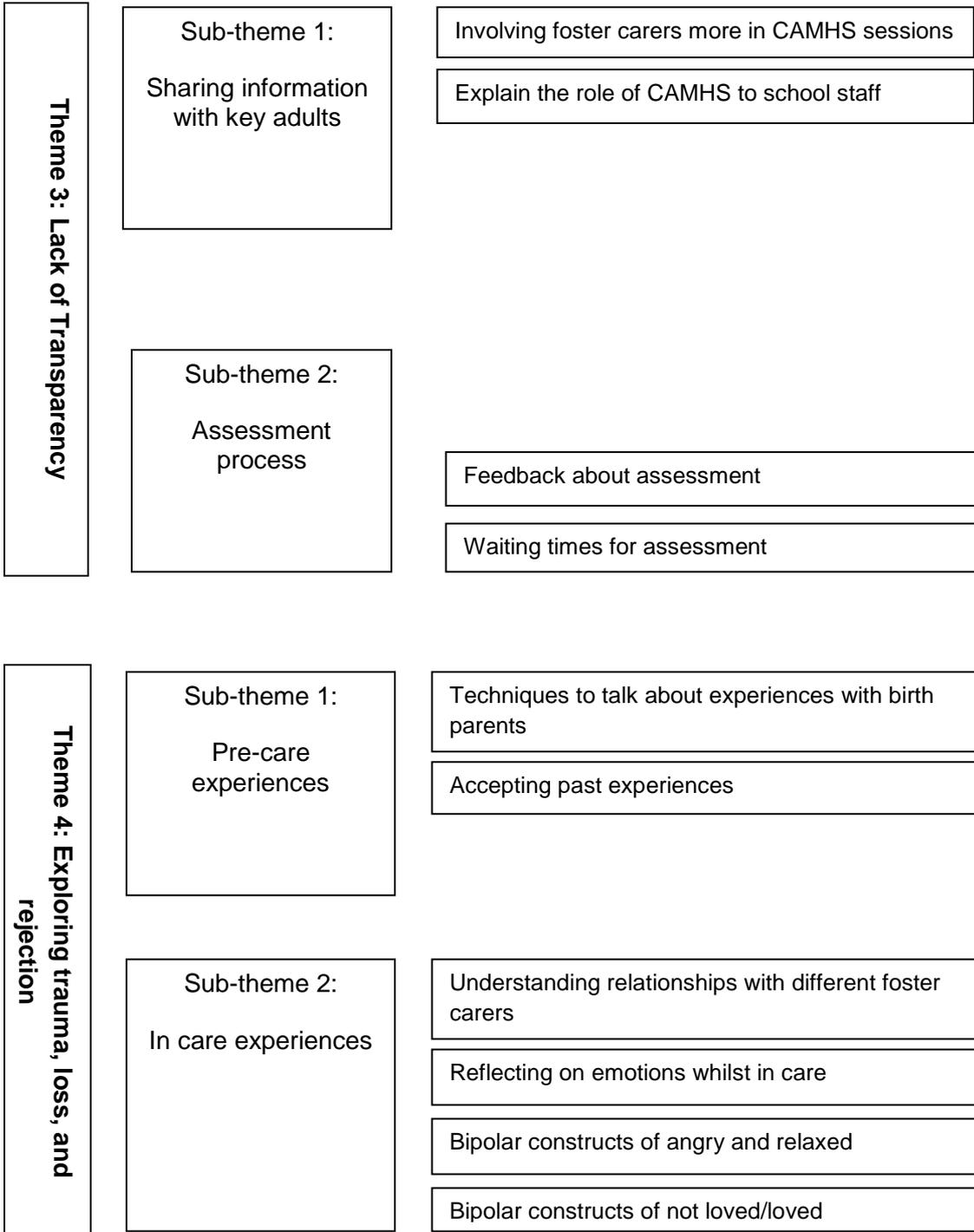
- 7. Understanding relationships with different foster carers
- 9. Techniques to talk about past experiences
- 11. Reflecting on emotions whilst in care
- 15. Bipolar constructs of angry (before CAMHS) and relaxed (after CAMHS)
- 19. Accepting past experiences
- 27. Bipolar constructs of unloved/loved

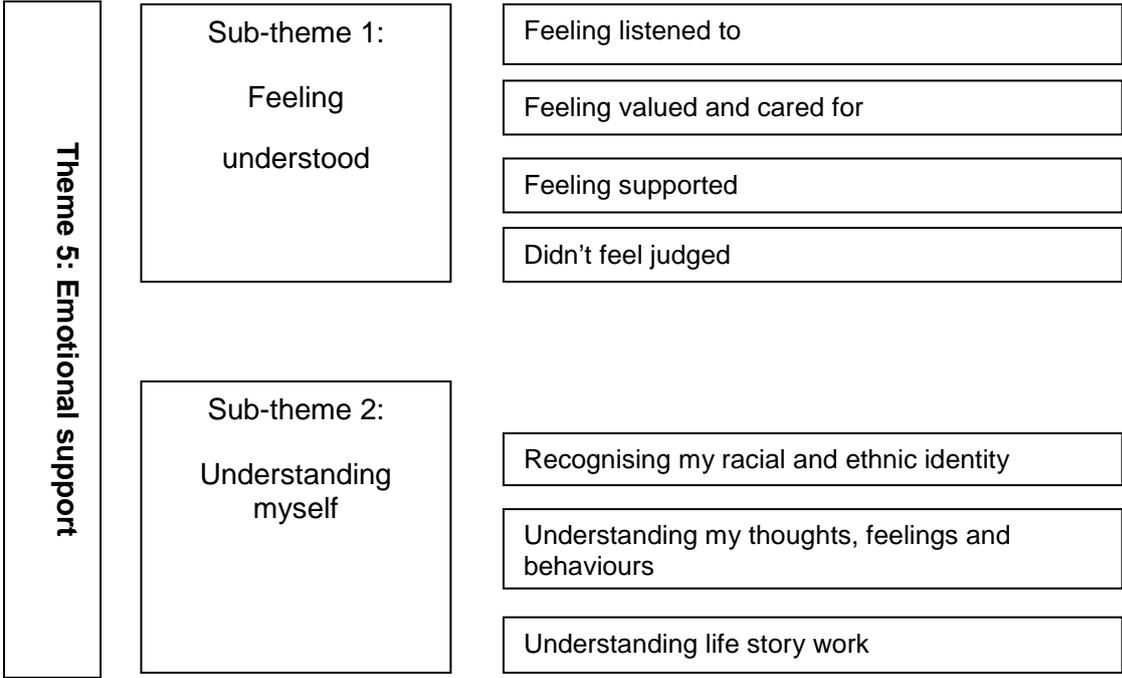
Potential Theme E - Feelings associated with attending a therapeutic intervention from CAMHS

- 1. Feeling listened to
- 3. Feeling valued and cared for
- 5. Feeling supported
- 6. Didn't feel judged
- 20. Understanding life story work
- 22. Understanding thoughts, feelings and behaviours
- 23. Recognising my racial and ethnic identity

Reviewing themes (Phase 4 of thematic analysis)

Theme 1: Facilitators to attending CAMHS	Sub-theme 1: Being available	Trusting therapist
		Consistency of seeing same person at CAMHS
		Therapeutic intervention was at the right time
		Clinic setting felt physically and emotionally safe
	Sub-theme 2: Being co-operative	Make choices about the therapeutic intervention
		Understanding reason for referral to CAMHS
Had a choice to leave at any point		
Theme 2: Barriers to attending CAMHS	Sub-theme 1: In care factors	Stigma of being in care and attending CAMHS
		Changing foster care placement
	Sub-theme 2: Accessibility	Room for therapeutic intervention changed often
		Appointment times changed with short notice





Name for each theme (Phase 5) and extracts (Phase 6)

Name of theme	Select quotations
<p>1. CAMHS as a secure base</p> <p>1.1 Being available</p>	<p><i>'I felt like I could trust XXXX and that I didn't need to hide my feelings anymore, I felt protected because I knew that whatever I said wouldn't be shared with anyone else.'</i> (David)</p> <p><i>'Seeing XXXX every week helped me to feel safe, because before that I was always seeing new people and my social worker had changed 6 times in one year. So it was nice that I was seeing XXXX for over a year'</i> (Sarah)</p> <p><i>'I felt safe because no-one apart from XXXX knew me at CAMHS so I would just wait in waiting area and she would come get me. She would always ask me first where I wanted to sit'</i> (Tina)</p> <p><i>'I knew I could leave at any point because she would say that it is up to me and I am glad it was in the clinic not the school because I felt safe that no-one would know that I was going there'</i> (Sarah)</p> <p><i>'I knew that CAMHS was a safe place for me to talk about my past and how I felt about my birth parents. I couldn't do that with anyone else because that wasn't their job'</i> (Ali)</p>
<p>1.2 Being co-operative</p>	<p><i>'I thought it was counselling, somewhere to get your troubles off your back. I knew it was to help me as I was going through a rough time, and I know why my social worker referred me. He knew that I was depressed and just going to end up in the gutter'</i> (Ali)</p> <p><i>The therapist told me that it was a place for me to talk about my anger and to try and explore why I used to hurt myself and others a lot. She told me that it wasn't a place where there was a magic wand and everything would be fixed, but that it would help if I kept coming'</i> (Sarah)</p> <p><i>'I was told when I was referred that it was because it would help me to deal with my night tremors and my panic attacks , and I knew that I wanted that to stop so I thought it would be good to go even though at first I thought it was just for mad people and she told me that that was ok and I didn't have to make out that it was for normal people'</i> (Sarah)</p> <p><i>'I didn't really like it, I went once before, and I didn't like what the therapist got me to do, and I didn't want to be seen as having mental problems, so I stopped going. But then when I was re-referred a few years later, I understood why it would be good for me to go and CAMHS even asked me if I wanted to have family sessions on the first day I went and I said yeah because I felt like that way I am not on my own with it and it didn't feel as uncomfortable'</i> (David)</p>

<p>3. Need for transparency</p> <p>3.1 Sharing information with key adults</p>	<p><i>Yeah definitely, it was like this (picks up the brown and white shell), I preferred the family sessions than the ones being on my own. I felt like the family sessions were somewhere where things were all open. I wasn't hiding my feelings. Like before I always used to hide my feelings and then go mad and angry' (David)</i></p> <p><i>'...at the family sessions, we used to do role play, and have reflecting, repeating and fair fighting. I think the sessions helped strengthen the bond between my sister me and Mrs Brown' (David)</i></p> <p><i>'I had just moved in with my new foster carers, and they didn't really understand me. In some ways I wish towards the end of CAMHS sessions they came and the therapist helped us to all get on because I used to get angry with them and they didn't know why' (Ali)</i></p> <p><i>'There was one teacher who always asked me why I missed his lesson every fortnight and I told him I was at CAMHS and he said what for, and I didn't know what to say. I just think that it would be good if CAMHS explained to the school why I am going there so I don't have to' (Sarah)</i></p> <p><i>'My form teacher didn't know I was going to CAMHS and he used to think I had a anger problem for no reason and sometimes I used to try and practice the strategies at school, but he didn't know what I was doing and I thought he would know that' (Tina)</i></p> <p><i>'It would be really good if everyone knew why I was going to CAMHS every fortnight and they understood what they could do to help me rather than think I am just messed up' (Ali)</i></p>
<p>3.2 Assessment process</p>	<p><i>'I didn't like waiting because..I didn't like waiting.. I was impatient and I didn't like seeing other people waiting and there was nothing to do whilst I was waiting, I just used to get more angry' (David)</i></p> <p><i>'Waiting for the assessment took ages. Like I saw XXXX and then she made me fill in loads of forms and my foster carer had to. But then I didn't hear anything for awhile. You just feel like everyone wastes time and that annoys you more' (Sarah)</i></p> <p><i>'She just got me to do stuff like fill out forms and say how I was feeling, and I didn't really think it was helping me and she didn't explain to me what the forms were for and what she was going to help me with' (David)</i></p> <p><i>'The first session was abit scary because we had to fill in lots of forms and I had to talk quite alot, and XXXX said that it was part of the assessment, but I didn't really understand what she found, she didn't explain what she thought my problems were' (Tina)</i></p> <p><i>'It would have been nice to have some feedback from XXXX about the assessment as she came to the house and my foster carer and me completed some questionnaires. I don't really know what they were for though. So that confused me abit' (Ali)</i></p>

<p>4. Exploring trauma, loss and rejection</p> <p>2.1 Pre care experiences</p>	<p><i>'I just didn't understand why they did the things they did to me and what made them do that, and now I know my mum's got mental health problems, it isn't her fault. And my dad didn't help her with them. It was at CAMHS that I actually understood that, and changed the way I thought about my mum and dad' (Ali)</i></p> <p><i>'Yeah like I brought stuff I had from my mum and dad and we talked about them and the attachment I had with them. At first I dint understand why we did it. But then I could see that it helped me. Like I used to be really negative and not saying anything good at all about my mum and dad. But XXXX helped me to think about the positive things with my dad and mum. Especially my dad because I didn't like talking about him at all and then I remembered some good things which made me less angry. Like I used to talk about some of my memories that were quite positive about my dad. And XXXX was helpful because I used to get angry and she used to explain how it's in the past and it's the present that matters and I can change how I feel about my dad' (David)</i></p> <p><i>'It was somewhere for me to talk...because before that I used to just bottle everything up and just deny that my mum left me and that my dad was hurting me. I used to make excuses for them. But now I understand and accept things...it's like...i'm less angry now inside' (Tina)</i></p> <p><i>'I never really understood why my parents left me, the life story work didn't help. And I just used to deny that they were having problems looking after me. I used to think everything would be ok. But XXXX helped me to understand my feelings more and why I was so hurt and angry about my birth parents leaving me and never seeing them' (Sarah)</i></p>
<p>2.2. In care experiences</p>	<p><i>'When I was in care, I moved like 10 times with different foster carers and even stayed in children's homes because no one wanted me. I felt like I was never wanted and I was damaged goods. Then at CAMHS...I started to talk about the relationships I had with different foster carers and what was good about each one even though I didn't stay there long' (Tina)</i></p> <p><i>'I got in a really violent relationship with this guy for years and he used to beat me up, but I really loved him and was pregnant with his baby..well I thought I did love him and then he just left me like everyone else, and he was my first ever boyfriend. XXXX at CAMHS made me do this flipchart exercise about the types of things he did to me and it helped me understand losing him in a different way, I knew it was the best thing that happened to me after' (Sarah)</i></p> <p><i>'I was with really abusive foster parents who used to torture me and not understand that I was Muslim, they used to give me pork and drink in front of me. And it was XXXX at CAMHS who helped me get over that experience because it did give me nightmares and panic attacks.'</i> (Ali)</p>

<p>5. Emotional Support</p> <p>5.1 Feeling understood</p>	<p><i>'With XXXX, you say what you feel and no-one is there to tell you your wrong. He helped me understand how my behaviour and the bad thoughts I was having...it was good. Without him, I would still be mad and depressed' (Ali)</i></p> <p><i>'She asked me in a really nice way. She wasn't like my social worker or my foster carer or the teachers at the school who judged me. It was like she really cared about me, she always looked like she was listening and she respected me and that I could trust her. I think she didn't judge me about my past because she never used to talk about me in a bad way or say things that made me think "how dare you ask me that?" (Tina)</i></p> <p><i>'Like with the life story work didn't really help me talk about my past. In CAMHS, I found that XXX was nicer and I could talk and that I knew someone was definitely listening to me and I could say what I want and what I feel like..' (David)</i></p> <p><i>'She helped me feel understood and listened to by saying back my feelings to me..I didn't realise it at the time but when I think about it now, I could tell that I had a connection with her and she was not judging me' (Sarah)</i></p> <p><i>'I didn't really get on with my social worker, he was never there for me and half the time used to call me my brother's name and thought I was 12. At CAMHS, XXX was a good laugh, we could joke about yet get all serious about my past' (Ali)</i></p>
<p>5.2 Understanding myself</p>	<p><i>'..I was calm in those sessions and this stone shows that. Like before CAMHS I didn't want to be mixed race at all, and after CAMHS I didn't mind being mixed race because there are lots of mixed race people in the world...because when we talked about my dad it helped me. And now I see myself as mixed race. Like I was with lots of different foster carers, white, black, asian but never mixed race' (David)</i></p> <p><i>Yeah..it was like I went from this small white stone (picks up white and black stone) which underneath is all black, abit like my past. N then I went to this (picks up white smooth shell) which is all round and white. I was clear who I had become and I knew after the CAMHS that I could be loved' (Sarah)</i></p> <p><i>Ermmmm..this one (picks up a cream large shiny stone). I felt like all the bad things that I went through were slowly going away. I was beginning to understand who I was. I felt really angry with my mum leaving and my dad abusing me and then my boyfriend doing the same. I didn't like my past and couldn't deal with, but then when I started going to CAMHS, I was accepting things and knew that my mum and dad will always be a part of me even if I didn't really have good times with them and that I am still a Muslim and Asian even though I have always lived with non-asians and Christians' (Ali)</i></p> <p><i>"I would say I'm more towards sociable after CAMHS. Before CAMHS I just to stay in bed, but now I am out and about doing things. Now I am way more happier' (Tina)</i></p>

'...like we did this flipchart exercise where I wrote down the things I did, and the things I was feeling and thinking. I had one paper with how I felt about going into care. One paper with how my parents and sisters and brothers would have felt. And then how I felt now. That exercise was amazing. That's when I began to understand myself. It was way better than the my life story work and the book I made. We looked at what I wanted to change about myself in small steps. After that, I felt like I could do alot more. I was going to school again and feeling more confident about myself and understood myself' (Ali)

Example of transcript

David Transcription (David's speech is in blue coloured font)

Interviewer: We will talk about your experiences of CAMHS in a few different ways. As you can see there is a sheet in front of you which has some sentences which are not complete. I will read out the sentence and you can finish it. It can be anything, absolutely anything you want...then we're going to talk a little bit about them...ok...so are you ready?

David: Ok, what are these stones for?

Those are for talking about different times and feelings throughout your experiences (picks them up). You do not have to use them, they are just there if you want to.

Yeah I love stones, can we start that first?

Yeah of course

Ok which one would you say you felt when you first began to access CAMHS?

(picks up grey and black shiny stone) its because its big and its jagged...because like when I first went I didn't really want to be there and I wasn't up for it. I didn't think it would help me. I thought it was for mad messed up people who got mental problems...it's bad enough being in care, and then you have mental problems too. No one said that people who are in care go to CAMHS too'

And why did you think it wouldn't help you?

Because I didn't really like it, I went once before but it took ages being seen, like months and months and then in the end I didn't like what the therapist got me to do, and I didn't want to be seen as having mental problems.

Could I ask what was it about this first session and what you had to do that put you off CAMHS?

She just got me to do stuff like fill out forms and say how I was feeling, and I didn't really think it was helping me and she didn't explain to me what the forms were for and what she was going to help me with. Also like...I found it difficult starting again with another therapist when I moved to XXXXX, because everything was new already..new school...new foster carers...and then it would be new CAMHS too'

And how was that experience compared to when you were re-referred and accessed CAMHS for a year?

I didn't really like it when I went once before, and I didn't like what the therapist got me to do, and I didn't want to be seen as having mental problems, so I stopped going. But then when I was re-referred a few years later, I understood why it would be good for me to go and

CAMHS even asked me if I wanted to have family sessions on the first day I went and I said yeah because I felt like that way I am not on my own with it and it didn't feel as uncomfortable and I really felt that the family sessions made a big difference to why I didn't move home again. We didn't used to have that many arguments after the family sessions, like Mrs XXXX would say things to me differently now that I think about it and it made me less angry. Like instead of saying "come down right now and have your dinner", she would say "would you like to have dinner after you have washed you hands" and it made such a difference.

Hmm ok, so what would be the opposite of uncomfortable?

Ermm like I would just feel relaxed because I knew that I wasn't on my own. Before when the first time I went, we just had to fill in lots of forms.

Ok so lets talk about the first session you had where you felt relaxed, what did that look like to you?

Ermm (picks up a few stones) like I was relaxed but I wasn't talking loads, I just said yes and no lots and that was fine because she didn't keep asking me loads of things anyway.

Hmm ok so when you started going regularly every 2 weeks, how was that? Did you feel more relaxed?

Yeah definitely, it was like this (picks up the brown and white shell), I preferred the family sessions than the ones being on my own. I felt like the family sessions were somewhere where things were all open. I wasn't hiding my feelings. Like before I always used to hide my feelings and then go mad and angry. And also...sometimes the appointment time changed and then I didn't have an appointment for ages...during that time I was having loads of problems and I did really need to see XXXXX.

Hmm and what did mad and angry look like?

I was always throwing things at the foster homes and swearing and just no-body liked me. I just didn't know what I was doing.

If you were mad and angry before, what were you after the sessions?

Ermm..calm. I just could talk about my problems with everyone and just stopped throwing things and hating everyone.

And why was that important to you to be calm?

Because no-one likes anyone going like mad or angry and I just didn't get on with anybody or spend much time with friends or my foster family.

Ok and did you see any difference in attitude and qualities of the therapist when you started going the second time?

Yeah..like I could trust XXXX and I wasn't able to do that with other therapist who I saw the once when I was referred first time round. She was alot nicer and she gave me lots of

choices. I used to feel really frightened talking to anyone else and would start crying, everything was a yes or a no with my teachers and my social workers. It wasn't like that with XXXX, I felt like she cared for me and would be thinking of me even when I wasn't at the clinic

Ok that's great to hear, what kind of choices were you able to have?

Like..I used to go every two weeks to CAMHS and that was too close I felt, so I asked for them to be more far apart and XXXX said that was fine. She really listened to me. Because most of the time I went I would miss the same lessons at school and I really liked those lessons, so it was good that Kim was ok about it.

Ok and what about if there was the option of Kim coming to school, how would you feel about that?

Ermm nah, I don't think that would be good because I wouldn't want people to know about my business or start asking me questions. So I was happy to go to the CAMHS clinic. I wouldn't tell my friends because it didn't concern them

Ok so lets go back to the structure of the sessions? Were all the family ones together and then the individual ones after?

Yeah me, Mrs Brown and my sister would go to them and then I had a few months by myself.

Ok..and what did the family sessions look like?

Ermm like all of these stones at different times. Because like at first we used to do role play and things to help us talk to each other more. I was in 6 different foster placements and with them I think it was always breaking down because I just used to get angry and we never used to talk. And then at the family sessions, we used to do role play, and have reflecting, repeating and fair fighting. I think the sessions helped strengthen the bond between my sister me and Mrs Brown.

Ok, so what was reflecting, repeating and fair fighting?

Erm, like reflecting was when my foster carer talked about her feelings, and then I would repeat what she said. It helped us to understand each other and understand where we were coming from. And then with fair fighting we would listen carefully and express difficult feelings.

Hmm ok, and what stone shows how you felt talking about your difficult feelings in the family sessions?

Ermm (picks up white stone with black underneath) like this one because all my problems were hidden away and I hated talking about my dad. I just didn't like it because he's black and I understood whether to call myself mixed race or white or black even though I look more black. And I never used to speak about my dad. At first at the sessions I told Kim I didn't want to and she said that was fine, but after the family sessions, when I was beginning to like going I didn't mind talking about my dad and then I started to think about myself. I realised

that I used to get really angry because I didn't understand who I was. And the sessions with Kim helped me realise that.

Hmm ok so it sounds like the sessions helped you to make sense of how you see yourself?

Yeah definitely and I was calm in those sessions and this stone shows that. Like before CAMHS I didn't want to be mixed race at all, and after CAMHS I didn't mind being mixed race because there are lots of mixed race people in the world.

Hmm and what was it about the sessions that helped you to see yourself as mixed race?

Because when we talked about my dad it helped me. And now I see myself as mixed race. Like I was with lots of different foster carers, white, black, asian but never mixed race. So I was just getting confused. And they didn't treat me like their own children. Mrs Brown treats me like her own children and the family sessions helped me and my sister to become part of a family.

And why is it important to you to be part of a family?

Because I have never had that, me and my sister were always moved around. And when people in school ask you about your family you want to be able to say you have one and invite them round and stuff. Like being part of family now makes me happy and makes me feel loved and cared for.

Hmm and what is it important to feel loved?

Because it makes you happy, otherwise you would just feel all hurt and get angry at people and be a bad person if you weren't loved.

Did you ever feel you could finish the session early if you wanted?

Yeah like when I was talking about my dad I didn't really like it at first, and Kim always gave me the option of not talking until I was ready. So I felt cared for and listened to. The sessions were timed well.

Ok you also mentioned that the family and individual sessions helped you to control your anger, how was that?

Ermm like I would focus on my breathing and I knew to think more before I got angry. So I would say to myself...is it really worth getting angry over something stupid and then wrecking things up and hurting people, and then I would just calm down. And like I talked about my past experiences and if I got angry where I could go to calm down.

Hmm so you were using strategies that you learnt from the sessions?

Yeah, and I was given homework, like what I wanted to do next time and to bring stuff in.

Hmm and was that useful for you?

Yeah like I brought stuff I had from my mum and dad and we talked about them and the attachment I had with them. At first I didn't understand why we did it. But then I could see that

it helped me. Like I used to be really negative and not saying anything good at all about my mum and dad. But Kim helped me to think about the positive things with my dad and mum. Especially my dad because I didn't like talking about him at all and then I remembered some good things which made me less angry. Like I used to talk about some of my memories that were quite positive about my dad. And Kim was helpful because I used to get angry and she used to explain how it's in the past and it's the present that matters and I can change how I feel about my dad. It was good because like with the life story work that didn't really help me talk about my past and also with CAMHS I then started to have a better relationship with my foster mum because I realised I used to get angry at her because of my dad, I was putting all those bad feelings onto her. In CAMHS, I found that XXX was nicer and I could talk and that I knew someone was definitely listening to me and I could say what I want and what I feel like and like other people go there.

Hmm so you were able to connect and feel comfortable talking about your past?

Yeah because Kim used to ask me about my past, present and the future so I didn't feel like it was always scary for me talking about my past. I could talk about other things too.

Yeah so what would be the opposite of angry for you?

Erm someone who is calm, like they would talk things through.

And why isn't it good to be angry?

Because not many people talk to you and it like just a waste of time. Instead of getting angry you could just talk about it. But if you get angry then it takes a while to calm down.

Hmm so what would being calm look like?

Just someone who is enjoying their time, and they would talk through their problems all calm and with the people they live and spend their time with rather than just keep it all bottled up.

Which would you say you are now after having had the sessions?

I would say calm because before I was very angry and just used to go out doing crime and stuff and throw things around. But now I talk about things and think is it worth getting angry for.

Ok and which stone would you choose to show how you felt after having the family sessions about controlling your anger?

Erm this smooth one (picks up cream curved shell) because I felt much happier. Like if someone said no to me, I would just become really angry. It was not good at all. But after the sessions I became much more calm.

Hmm so what about the relationship you had with Kim the therapist?

Erm it was better than the other people I spoke to like my social worker or people at school because she used good methods that helped me.

Hmm what did those methods look like?

Like she would ask me what I wanted to talk about which made me find it easier to talk.

Ok so let's talk about the setting at CAMHS, which stones represent how you felt about the room or rooms you were in for the sessions?

Erm this big one because the family rooms were massive and really comfortable and I sat next to Kim and my foster carer and sister sat on the side. But I had a different room when I used to go on my own, and that was small (small brown stone) but it was alright as well.

Ok so lets talk about which stone represents how you felt when you were discharged?

I was relieved that I could control my anger and I think it was good timing because I was able to cope on my own and Mrs Brown was helping me anyway by then at home.

Ok so lets try the sentence completion task, you may have answered some of the questions,so that's fine. I will read out the sentence and you can finish it. It can be anything, absolutely anything you want...then we're going to talk a little bit about them...ok...so are you ready?

Yeah

Ok so the first sentence is..When I first heard of CAMHS I thought...

I wasn't too keen. I didn't know what it stood for or anything.

Hmm did you know what it stood for?

Nah what is it?

Its an acronym for Child and Adolescent Mental Health Services, Do you think that would have made any difference to you?

Yeah I wouldn't have gone. I don't like the fact that its got mental health in it. It just makes me think I got problems inside me.

Hmm and why is that not a good thing?

Because like I don't like people even knowing i'm in care. I don't want them to think I got mental problems too. Then they'll think something wrong with me.

And do you still think that?

Nah because I understand my anger problems and managed them.

Hmm definitely. Ok so the next statement is..At my first session I felt...

Like i didn't want to be there.

So did you know you had the option of leaving?

Yeah but everyone was telling me to go to, like my foster carer and my social worker so I thought I would give it a try to help control my anger. It helped me understand why I got

angry. Like I didn't like the way things were so I just used to get angry and that's because of my past experiences. I wasn't happy.

Hmm ok, I did not like coming to CAMHS because...

I didn't like waiting because I didn't like waiting, I was impatient and I didn't like seeing other people waiting and there was nothing to do whilst I was waiting. I just used to get more angry.

Hmm so what would be the opposite of patient?

Like being patient and waiting and just sitting there with things to do.

Hmm what would you have liked to see there?

Erm some books for young people not just children.

Ok, and how about the next statement is...when I left my regular CAMHS session I felt.

I felt better.

Ok one positive thing about CAMHS is...

People will listen to you and try and help you

Ok...so one positive thing about CAMHS is....

I felt happy after the sessions

Hmm and what would be the opposite of happy?

Ermm annoyed

And what would annoyed look like?

Like the sessions wouldn't have made any difference and were a waste of time.

Ok and one negative thing about CAMHS is...

Ermmm talking about my dad. I didn't want to, but then I knew that if I didn't it wouldn't help me.

Hmm and if you didn't access CAMHS how do you think you would be?

Like annoyed and still angry and it isn't good.

And why is that not good?

Because people don't love you and respect you.

Hmm ok, and what about one top tip I would give to CAMHS is...

Ermmm to try and give young people more options if they want sessions and how they want them to be and also that the CAMHS person should tell you what the forms are for and what they found from them because that confuses people. We always have to fill in so many different forms and half the time we don't know what comes out of them. They should tell us more about the forms because we aren't children'.