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**“The discourse of professional identity in
Child and Adolescent Mental Health Services.”**

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MA (Oxon), BSc (Hons), RN

**Thesis submitted to the University of Nottingham
for the Degree of Doctor of Philosophy**

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Abstract

Background: Child and adolescent mental health teams have traditionally been constructed using multidisciplinary teams of different professions. Current workforce policy in mental health, however, stresses team function and the skills and competences required to fulfil that function which leads to a questioning of professional identity within those teams.

Aims: This study aims therefore to define how professional identity is constructed in the policy discourse and amongst a sample of current practitioners in mental health teams.

Methodology: This study uses a linguistic method, Critical Discourse Analysis, to question whether functional approaches based on role theory are appropriate when identity work discourse has overtaken role theory as a way of thinking about professional working. It uses elements of role theory and identity work thinking, informed by postmodernist theorists such as Pierre Bourdieu, to look at the need for the underlying conceptual frameworks that professional training and socialisation bring.

Findings: By analysing the current policy discourse, and a sample of practitioner discourse on the subject, the study shows that there is a need for the professional identity of individuals to be better addressed and understood. It examines the importance of the

underlying conceptual frameworks that inform the skills and competences and what these frameworks bring to team functioning. The study also questions the way in which policy uses linguistic capital as a change agent to bring about workforce modernisation in child and adolescent mental health teams.

Conclusions: The study highlights the need for professional groups to maintain their professional identity by being better able to articulate the contribution they make to team functioning by virtue of their conceptual frameworks. These are shown to inform the way in which individuals use their skills and competences to care for service users and their carers.

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"There is no right or wrong in our profession. The present changes the past from moment to moment. Only pray that the future vindicates our actions."

Helem Camaru, Master of Assassins.

Warhammer 40,000 Sourcebook

(Games Workshop 1989)

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GLOSSARY and abbreviations

| | |
|---------|--|
| AfC | Agenda for Change |
| AFT | Association for Family Therapy and Systemic Practice |
| AHP | Allied Health Professional |
| AMHP | Approved Mental Health Practitioner |
| ANCAMH | Association of Nurses in Child and Adolescent Mental Health |
| ASW | Approved Social Worker |
| CAMH | Child and Adolescent Mental Health |
| CAMHS | Child and Adolescent Mental Health Services |
| CHI | Council for Health Improvement |
| CMHT | Community Mental Health Team (usually adults and elderly services) |
| CNS | Clinical Nurse Specialist |
| CPA | Care Programme Approach |
| CPN | Community Psychiatric Nurse |
| CSIP | Care Service Improvement Partnership |
| ENB | English National Board |
| ENB 603 | ENB approved nursing course in CAMH |
| GMC | General Medical Council |
| GSCC | General Social Care Council |
| HAS | Health Advisory Service |
| HPC | Health Professionals Council |
| Int: | Interviewer |
| KSF | Knowledge and Skills Framework |
| LA | Local Authority |
| MDT | Multidisciplinary Team |
| MHN | Mental Health Nurse |
| MSW | Medical Social Worker |
| NHS | National Health Service |
| NICE | National Institute for Clinical Excellence |
| NIMHE | National Institute for Mental Health - England |
| NMC | Nursing and Midwifery Council |
| NOS | National Occupational Standards |
| NSF | National Service Framework |
| NWW | New Ways of Working |
| OT | Occupational Therapist |
| PCT | Primary Care Trust |
| PIG | Policy Implementation Guidance |
| PMHW | Primary Mental Health Worker |
| PSW | Psychiatric Social Worker |
| RCN | Royal College of Nursing |
| RDW | Regional Development Worker (of National CAMHS Support Service) |
| Res: | Respondent |
| SLA | Service Level Agreement |
| SoN | School of Nursing |
| SSD | Social Services Department |
| UKCC | United Kingdom Central Council (for Nursing and Midwifery) |
| UKCP | United Kingdom Council for Psychotherapy |

Notes on transcription conventions:

- All direct quotations in analysis chapters are given in boxes.
- Quotations from documents are given in normal type.
- *All direct quotations of respondent speech are in italics.*
- Interpretations and editorial clarifications are given in [square brackets].
- Brief pauses (up to three seconds) in speech are recorded as ...
- Longer pauses are given a timed period in normal brackets i.e. (four seconds).
- Laughter and sighs are recorded as (laughs) or (sighs).
- Other speech sounds recorded phonetically (i.e. um, tch, tut)
- *Strong accenting or emphasis within spoken text is underlined.*
- For clarity all quotations are given in single spacing as opposed to the more normal double-spacing required for thesis submission (and used for all other text).

Chapter One – Introduction

1. Professional identity in workforce policy

The existence of outpatient Child and Adolescent Mental Health Services (CAMHS) is still a relatively new phenomenon, and there exists little documentation and no widely understood rationale for the original professional composition of these teams. As such it is a good example of how mental health teams have historically been created from a local perspective, with little central policy guidance until recently. It can be used, however, to illustrate wider issues of team working for mental health teams. Whilst this study, therefore, takes a wider perspective on the construction of mental health teams and how people within those teams think about their professional identity, it will refer to CAMHS constantly as the main focus of the study.

The importance of this study is that professional identity may be perceived as having been sidelined in recent years by workforce policies that stress roles rather than professions and put emphasis on the skills and competences needed to fulfil those roles. This study will look at the development both of services and of policy in reaction to those developments, in order to trace the significant changes in workforce policy with regard to mental health teams and CAMHS. It will show the move in emphasis from 'multidisciplinary teams' to 'capable teams'. Multidisciplinary teamwork, as the name implies, holds central the contribution of different disciplines (such

as psychology, psychiatry, nursing, social work and allied health professionals) to a team that functions together to provide mental health care. Within this multidisciplinary team (MDT) each discipline has a specific function and contribution to the work of the team. Over the years, as will be demonstrated, these roles have become blurred to the extent that current policy questions the needs for specific disciplines to provide distinct roles, and concentrates instead on what skills and competences are required to fulfil the overall team function. Whilst the justification for this move is strongly portrayed as being in the interests of service users (patients) and their carers, this study will question that premise as being the primary motivator for change, and look at the wider social and political context.

Part of the motivation for examining this subject arises from the researcher's own position within CAMHS. As a Nurse Consultant I hold a post which is research based, and has a clear set of guidelines as to dimensions and function of the role, and which is clearly based in the conceptual framework of the parent discipline of nursing. This is in contrast to the very blurred role and function of many of the other CAMHS staff I meet in clinical practice. Given the current emphasis on creating capable teams, therefore, the issue of how professional identity is constructed and enacted in daily practice is one of direct relevance to service delivery.

1.2 Aims and objectives of the study

This study **aims** to define how professional identity is constructed in the policy discourse and amongst a sample of current practitioners in mental health teams. The construction of professional identity and the importance attached to it is contrasted with the dominant policy discourse, which concentrates on skills and competences rather than professional contributions to teamwork.¹

The specific **objectives** of the study are:

- 1) To examine in detail some of the most important policy documents which are currently shaping the development of workforce policy in mental health teams and examine how this policy discourse relates to professional identity;

- 2) To look at how a selected sample of policy makers, implementers of policy and practitioners are reacting to this policy. A close examination of their discourse on professional identity will give rise to ideas of how people are currently thinking about their identity at work;

¹ NOTE: The terms 'competences' and 'competencies' are commonly used interchangeably within the literature examined in this study. Where quoted, the term used in the document or by the respondent will be used. Elsewhere in this study I have largely used 'competences' as that is marginally more commonly used. Technically 'competences' implies the minimum standard acceptable, whilst 'competencies' suggests higher levels of abilities within a given range, and was used in this sense in some of the earlier literature.

- 3) To discuss how identity work is important to individuals working in mental health teams and CAMHS, and to discuss what implications this has for the development of services for children, young people and adults who have need of mental health care;
- 4) To make recommendations for taking forward the debate on workforce policy within mental health services in England.

1.3 Structure of the study

In order to achieve this, the study looks first at the current literature on policy development within mental health services and CAMHS in England (Chapter 2), and then at specific literature relating to roles and professional identity in mental health teams, using nursing and CAMHS as exemplars of current changes (Chapter 3). It will then look at the theoretical debate around role theory and 'identity-work' as a way of understanding how people talk about their work, their roles, and their individual and professional identity (Chapter 4). This is followed by an examination of methodology for conducting the study, and a rationale for the choice of Critical Discourse Analysis (CDA) as a tool for analysing the discourse generated (Chapter 5). The three main policy documents are subjected to a close analysis, using CDA (in Chapter 6), and the practitioner discourse is looked at (in Chapter 7), using a thematic analysis informed by CDA. The results of these analyses are discussed (in Chapter 8), with a thesis offered for understanding professional identity construction in current mental health teams

and CAMHS. Finally some recommendations are made for policy makers and practitioners as a result of this thesis (Chapter 9).

Chapter Two – Mental Health and CAMHS policy development in England

2.1 Introduction

The purpose of this chapter is to set the context for the study in terms of contemporary policy and practice in mental health teams in England, and specifically Child and Adolescent Mental Health Services (CAMHS) within that context. It is important to understand how individuals function and construct their professional identity, in a time of rapid change within National Health Service provision.

The chapter begins by looking at mental health policy and the rapidly expanding workforce component of that policy. It will then explore in more detail the much scarcer but developing literature that pertains to children's and young people's mental health.

2.2 Current mental health policy in England

In order to try to make sense of how the current context for workforce policy has developed, it is important to understand the overall political and policy situation regarding mental health within the National Health Service (NHS) of England. This study will confine itself to England because over the past few years the political agenda has been one of the devolution of certain functions of government including healthcare provision. Thus, whilst the NHS was originally set up to cover the whole of the United Kingdom, there are now separate departments within the Welsh Assembly, the

Northern Ireland Assembly and the Scottish Parliament dealing with healthcare provision. The Department of Health, which issues guidance and policy, now covers only the English part of the NHS. In practice, of course, there are still important links between the different parts of the UK, so influential reports such as the Carlile Report for the Welsh Assembly (Carlile 2002) will affect thinking in England, without having direct statutory authority.

The National Service Framework (NSF) for Mental Health shapes current mental health provision for working age adults within England (DoH 1999a). This is a product of the Government's move to modernise the Health Service and include mental health as a key priority. The Health Service Circular, 'Modernising Mental Health Services: safe, sound and supportive' (DoH 1998), put this within the context of the structure of the Government's vision, laid out in 'Our Healthier Nation' (DoH 1999b). The NSF provides guidelines for care for 'working age adults', usually aged sixteen to sixty-five, with the mental health care of older adults being dealt with in a separate NSF for Older People, a wider document looking at all aspects of older people's healthcare, but including mental health (DoH 2001a). Younger people are only considered within the Mental Health NSF where they are carers for parents and other relatives with mental health problems. The system of National Service Frameworks and other guidance is now established as the Department of Health's way of influencing service provision across a wide range of health related issues, with other NSFs covering, for example, coronary care

and diabetes (DoH 2001b; DoH 2002a). The mental health of children and young people is now covered in Standard Nine of the NSF for Children, Young People and Midwifery Services (DoH 2004a), which will be examined in more detail later.

As a ten-year plan, the NSF for Mental Health set several targets for provision. The seven underlying principles of the mental health NSF were supported by the Government's much broader vision of the NHS Plan (DoH 2000a), and given substance by the detailed Policy Implementation Guide, the 'PIG' (DoH 2001c). This guide makes specific reference to CAMHS services, noting that effective transitions from CAMHS to adult services are particularly critical times. As well as dealing with the strict chronological age group of the NSF (16 – 65), it highlights the need for Early Intervention for Psychosis services. This new brand of service covers the age group of 14-35. The overlap of services thus brings CAMHS closer to adult services than before and makes CAMHS include an age group where services for major mental illness problems become more prominent (DoH 2001c Sec. 5.2).

2.3 Policy relating to Child and Adolescent Mental Health

Policy developments in CAMHS can be seen in two or three major phases, the first being the move from Child Guidance to health-based provision. The second phase was characterised by the changes of the 1990s, based on the Health Advisory Service 'Together We Stand' model (HAS 1995). Most current are the

expansion of services and change of service models detailed in the National Service Framework for Children (DoH 2004a).

2.3.1 Development of Child and Adolescent Mental Health Services from the Child Guidance movement

CAMHS developed from the earlier Child Guidance movement. This started as early as 1927 in East London, and had developed from an American model. Child Guidance services were originally staffed by specially trained social workers rather than medical, nursing or other staff groups (Sampson 1980). Bowlby (1987) records the first introduction of psychiatrists and educational psychologists into a London (Canonbury) Child Guidance clinic in 1936. By the 1970s an organization called the Child Guidance Trust had developed to promote the interests of the clinics and of their client group. As late as 1986 an article by Peter Wilson (1986) still talks of the main staffing of child guidance clinics as 'psychiatrists, psychologists, social workers, psychotherapists and others', which implies that, even if nurses and allied health professionals were included amongst the 'others', they were not a normal part of child guidance clinics even at this relatively recent date. Whilst talking of the need for multidisciplinary co-operation, he also warns of ongoing professional polarisation within clinics and a lack of managerial coherence. The theme of multidisciplinary working was obviously taxing the child guidance movement considerably at this time, for in the following year there was a passionate plea for increased multidisciplinary working between Child Guidance and departments of

child psychiatry (Orford 1987). There seems, therefore, to have been a period of overlap, when differently focused services were providing broadly similar services, with inevitable professional jealousies. Departments of child psychiatry would have worked within a medical model in contrast to the social work based Child Guidance clinics. At the time there seemed to have been some debate about this disparity and some discussion of the benefits of children getting more than one point of view on their difficulties (Orford 1987). As the Child Guidance Trust struggled with its future in the context of developing services, it reports (Orford 1988) on a meeting at which, for the first time, Community Psychiatric Nurses (CPNs) are recorded as being present. From this meeting the Child Guidance Trust dissolved and became Young Minds, a non-statutory charitable organisation that still lobbies for the mental health interests of children and young people. The structure of Young Minds was somewhat different from the Child Guidance Trust, including, as it does, organisational representatives from a variety of bodies, and, from the beginning, the Royal College of Nursing and other professional bodies were part of that structure (Bennathan 1989). Whilst the exact composition of teams was changing at that time it remains clear that CAMHS saw themselves as examples of multidisciplinary team working. As new disciplines came into those teams, some way was needed to define the contribution of those new disciplines. In this respect the introduction of nurses into CAMHS is a useful example of role blurring and lack of clarity in their introduction.

No literature was identified directly referring to the use of nurses in outpatient clinics before McMorrow's article (McMorrow 1990). He looked at the confusion created by the use of different titles by nurses working in CAMHS. This proliferation of titles may also reflect the uncertainty as to exactly what part nurses were meant to play when those posts had been set up. There remains no documented evidence as to the thought processes behind the planning of those posts, and what their precise role and contribution to the team would be. Its timing, however, coincides with the period in the 1980s when adult mental health provision moved very rapidly from an institutionally-based model to the 'Care in the Community' philosophy (Nolan 1993), with its accompanying expansion of community mental health teams, and much larger numbers of CPNs dealing with adult mental health problems. In one of the very early articles on the role of the CPN, Cheadle (1970) spoke at length about the overlap of 'social work' and nursing roles in the community setting.

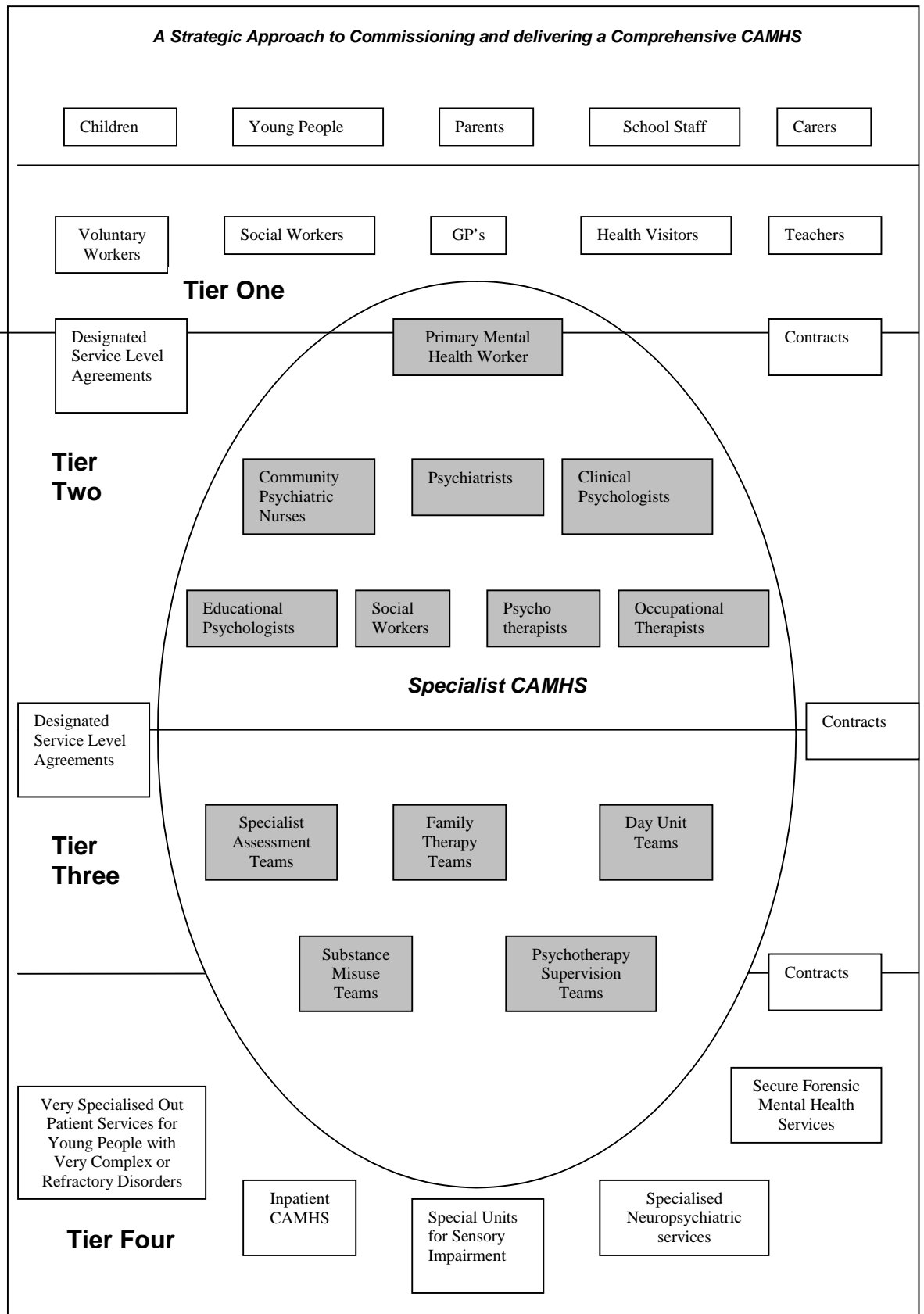
2.3.2 Policy initiatives prior to 2004

Whilst there was a blueprint issued in 1995 (HAS 1995), it was not prescriptive, with a four-tier model open to very different interpretation across the country. Most services did not, at that time, have clear or detailed Service Level Agreements (SLAs) with the commissioning Health Authorities as to exactly what services they were to provide. Although more attention is being given to this now, the commissioning Primary Care Trusts (PCTs) often remain

very unclear about exactly what services they require from CAMHS (e.g. Chesterfield PCT 2003). For example, where the Chesterfield PCT SLA attempts to pick up the guidelines in the HAS model (op cit), they stick to a very broad definition of what children and young people's mental health needs are, and are not prescriptive about how they want the provider services to address these needs.

The HAS document (op cit) set out to be the commonly accepted blueprint for the commissioning and organisation of CAMHS services in England. Its main drawback was a lack of authority to compel coherence of service provision, resulting in multiple interpretations being made across the country as to how its four tier model is applied (See Figure 1 below). Since its inclusion in the NSF for Children (op cit), the model has come to have more authority, but it has been interpreted and implemented differently across the country.

Figure 1 Health Advisory Service model (HAS 1995)
(after p63)



This model does list the core skills necessary for all professionals working in CAMHS, based on the research work of Kurtz et al (1994). Importantly though, the HAS review model of service provision makes an assumption that mental health nurses and allied health professionals (such as Occupational Therapists) will be part of CAMHS, though again without a clear reason why. To be fair to the document, it does not seek to justify the membership of other disciplines either.

Briefly Tier One consists of primary care staff without specialist mental health training providing basic identification and treatment of mental health problems. As such school nurses, paediatric nurses and health visitors are an important part of the primary care workforce, alongside paediatricians, GPs, school staff and social work staff. Tiers Two and Three are the domain in which specialist outpatient CAMH staff work. Tier Two is defined as staff with specialist mental health training, assessing and treating children and young people working in a unidisciplinary manner, though usually in the context of a multi-disciplinary team. Tier Two would include all direct work done by Primary Mental Health Workers (PMHWs), a new type of worker suggested by the HAS model, which includes much liaison with, and consultation to, Tier One but can include a substantial amount of direct face to face work with service users. PMHWs can come from a variety of professional backgrounds, but in practice most commonly have either a nursing or a social work training. Tier Three includes all professionals working in specialist

CAMHS, from whatever professional background, but working in a multi-disciplinary fashion, i.e. more than one professional discipline is involved in providing care for each service user or their family. Tier Four is the provision of inpatient care to children and young people, or highly specialist regional facilities.

The HAS document was largely based on an original survey by Kurtz et al. (1994). It is worth noting the findings of that survey, since so much of the consequent work in CAMHS development has relied upon its findings. For example, the wide ranging survey noted '*with surprise*' that two thirds of community CAMHS were employing nurses. The authors described the introduction of community psychiatric nurses as a "new phenomenon" (p13), despite the fact that Community Psychiatric Nurses in adult mental health services had been employed since the 1960s, and pointed out that traditionally CAMH nurses had been employed on in-patient units. Kurtz et al (op cit) saw the increase in community nursing posts as a sign of an increased commitment to community CAMHS. It is not clear whether this is actually so, or merely their interpretation of a widespread phenomenon towards the provision of community based care. It is possible, however, that this was just a move in location of the same sort of services. What had been provided on an inpatient basis was now provided in people's own homes; location had changed but the underlying philosophy and model of care had not altered significantly. The survey also pointed out, however, that the training of nurses was very variable, few having the ENB 603 (Child,

Adolescent and Family Psychiatric Nursing) qualification, and many relying on supplementing their original training with '*random short courses*' (Kurtz et al 1994 p59). These would be often therapy-specific courses, and not necessarily designed for nurses, so not building on their original conceptual framework. The survey's conclusions and recommendations included encouraging the employment of nurses, but also developing the training of nurses, and the funding of such courses. Whilst the survey had taken an interest in the distribution and training of nurses they did not attempt to define why nurses and allied health professionals (AHPs) were being employed, and what function they were providing. It does imply that some better form of training would be preferable to the variable quality of training that had been uncovered in the case of the newly employed nurses. This lack of specificity seems to reflect the fact that the survey was originally set up without expecting to find so many nursing staff in post, so it had not originally considered this aspect of service provision.

The HAS document (HAS 1995) identified as one of its main themes the need to identify and strengthen the 'components, roles, functioning, leadership, management, and communications' of specialist CAMHS. It did not seek to do that very accurately itself. For example, when making recommendations with regard to nursing and AHPs it simply states that: *"It is important to recognise that disciplines other than psychiatry, psychology, social work and child psychotherapists offer specific training in child and adolescent*

mental health work. This is particularly relevant for nurses and occupational therapists." (p 95 para 292). The document also highlights that skills learnt in adult mental health or paediatric trainings are not always "*transferable or sufficient*" for working with younger age groups (p.35). It takes up the recommendation of Kurtz et al (1994) that training for nurses be increased, but still does not define what role nurses (or OTs) are expected to fulfil, though it does list core skills expected of all professionals working in CAMHS. Importantly though, the HAS review model of service provision makes an assumption that mental health nurses and AHPs will continue to be part of CAMHS, though again without indicating a clear reason for this. It is noteworthy that the document also does not seek to justify the membership of any other disciplines either; rather it continues an assumption that this will be so.

Kurtz et al's surprise at the number of nurses in post is in contrast to the Health of the Nation Handbook on Child and Adolescent Mental Health (DoE 1995), which was published only a year later. This document explicitly put nursing in the core group of four professions which might be expected to be found within a CAMHS multidisciplinary team (Sec. 4.10), alongside psychiatrists, psychologists, and social workers. It goes on to list other professions (Sec. 4.11), which may be included, from the various psychotherapies, including child psychotherapy and AHPs like Occupational Therapists. This difference in emphasis from the Kurtz et al report and the HAS review actually reflected current (and

contemporary) national practice more accurately. Again, within the Handbook, an implicit assumption was made about the existence and place of nurses within the team, but without any clear reason given for what their differentiated role might be.

Also, in 1995, the Trent Regional Health Gain Investment Programme Lead Document for Child and Adolescent Mental Health (Pearce and Holmes 1995), whilst making few specific recommendations regarding CAMHS staffing, does take up the comments about nursing. It suggests that purchasing authorities may wish to encourage the employment of specially trained nurses. Although again no rationale for this is developed within the document. Pearce and Holmes (op cit) again note the existence of the ENB 603 course, and comment that while it remained the most appropriate nursing course for CAMH nurses, there were relatively few nurses in CAMHS who actually held this qualification. Across England there were, however, only six or seven such courses being run at any one time, each course being a year long, and graduating between six to ten students each year. Therefore the potential pool of specialist nurses at any time actually holding the ENB 603 qualification had always been small. With the change of regulating authority from United Kingdom Central Council for nursing and midwifery (UKCC) to Nursing and Midwifery Council (NMC), the functions of the English National Board were lost and not replaced by an equivalent body. There are now, therefore, no equivalent standardised and regulated courses such as the ENB603, rather a

series of diplomas and degrees (and even a few Masters level courses) that are offered under University regulations. Often these are now multidisciplinary courses, even if offered through a School of Nursing, which further erodes the attachment to the underlying conceptual framework of nursing.

The Audit Commission conducted a major survey of CAMHS services across England in 1999, titled 'Children in Mind' (Audit Commission 1999), to which brief reference has already been made. This covered 60% of English CAMHS and noted a wide variation of staffing patterns. Amongst their findings, they noted that nurses at that time constituted 26% of the CAMHS workforce, and made up the largest single professional group. They were present in approximately 64% of services, the third most commonly present professional group after child psychiatrists and clinical psychologists. This represents a change from the assumptions of the survey by Kurtz et al (op cit). Kurtz et al used a different sample (based in London and the South East), as opposed to the Audit Commission's national (English) sample and they found social workers were the most prevalent profession, perhaps reflecting the Child Guidance origins of CAMHS. The 'Children in Mind' report does not address why nurses, AHPs, or other disciplines are in such teams, but it does make some interesting points about the ways in which different professions work, for example, in frequency of contact. They noted that nurses appear to have a similar contact pattern to CAMHS social workers. Both professional groups see

children and families more frequently than psychologists and psychiatrists, but less frequently than child psychotherapists. This seems to reflect different approaches to therapeutic work. Most child psychotherapists see children on a weekly basis (or more often) for the type of in-depth analytic psychotherapy that they provide, whilst child psychiatrists and psychologists might be expected to adopt an 'expert' advisory approach to their work, make recommendations and review on an extended timescale. Nurses and social workers are often expected to pick up the middle ground of work within CAMHS that includes behavioural interventions and emotional support work, and commonly offer fortnightly appointments. The Audit Commission report noted that Kurtz et al. had pointed out the way CAMHS seemed to have been provided on the basis of historical service patterns rather than assessed need. That observation had been true also within their findings, and so had not changed in the intervening five years. The effect of the HAS report, then, in setting out a clear four tier model, had been only very limited in the intervening four years. They also comment that only one third of the Trusts surveyed had written operational policies which included the roles, professional relationships and responsibilities of the different professionals within their CAMHS.

The Audit Commission 'Children in Mind' report (op cit) also makes recommendations that Trusts should better assess which staff they need to employ and be able to justify their choice of skill mix. They note that some professions are more able to justify and explain

what they can bring to the multi-disciplinary team and cite the Child Psychotherapy Trust as an example of a professional organisation which produces material supporting the methods of working of their own staff group (Child Psychotherapy Trust 2001). The report also notes that one Trust in Liverpool had moved to a completely generic workforce of Mental Health Practitioners in recognition of the 'inevitable overlap of skills offered by CAMHS professionals' (p.36). This is an extreme example, but is reflected in practice elsewhere in CAMHS across the country. As such this marks the beginning of the move in workforce policy in CAMHS towards a better understanding of the skill mix of teams and what different individuals and professions contribute.

The erosion of professional demarcation, and the recognition of the generic nature of much of CAMHS work led to many 'Mental Health Practitioners', or similarly titled generic workers being employed. In part this is about professional groups such as nurses not being able to justify their place (as a discipline) rather than as individuals, but it also reflects the withdrawal of social work staff from CAMHS during the 1990s as Social Services Departments retrenched into their own 'core business', and ceased paying for social work input into CAMHS. The teams still felt the need for social care trained staff and, because they were not able to directly employ social workers (for legislative reasons prior to the establishment of the General Social Care Council), they offered these sort of generic posts (Limerick and Baldwin 2000). The skills required to fill the gaps in

teams left by the loss of social workers were ideally suited to staff with a wide range of skills in mental health and eclectic therapeutic interventions, and were hence filled by either nurses or former social workers who had additional training and interest in children's mental health issues. In many cases nursing posts were also withdrawn, as definable nursing posts, and replaced by the new Mental Health Practitioner posts. The community mental health nursing survey of 1998 (White and Brooker 2001) actually notes a drop in the number of nurses working in CAMHS during this period.

This tendency was noted in the House of Commons Health Committee report in 1997 on its sittings regarding CAMHS (Health Select Committee, 1997). The report considered service provision and notes the withdrawal of educational psychology services and social workers within local authority provision and the lack of a corresponding increase in health service provision. It makes little reference to the specific role of nurses or AHPs within CAMHS, but notes at one point (p.xxxvii) that there is a role for specialist mental health nurses to advise, support and train health visitors and other primary care professionals to intervene with child and adolescent mental health problems. From a nursing point of view the Royal College of Nursing (RCN) was invited to contribute to the Committee's hearing. The RCN's specialist Children and Young Peoples Mental Health Forum gave evidence to the Committee and noted the existence of nurses within the four-tier model. The evidence given was largely descriptive, and did not seek to

differentiate the contribution of nurses from that of other health professionals (Symington 1997).

Interest in CAMHS was not confined to Government, however, and mainstream mental health charities started to look at the difficulties experienced by children and young people. 'Bright Futures', a report by the Mental Health Foundation (1999) made reference to service provision within CAMHS, but did not include specific comments about individual professional contributions to those services. It did refer, however, to the need to assess and develop better training for primary care staff and for CAMHS professionals. It recommended that the Royal College of Nursing should be involved in a comprehensive audit of needs and an analysis of present and future staffing arrangements in all services (along with the Royal College of Psychiatrists and the British Psychological Society) which implied that it saw nurses as part of the ongoing provision. 'Bright Futures' has become an important influence on policy, with its central theme that children's mental health is not a specialist function, but 'everybody's business' being taken up in other publications (National Assembly of Wales 2001, RCN 2004). Despite coming from a voluntary organisation, which therefore has no authority to implement its findings in statutory services, it recognises the role of nurses and other professional groups within those services, even if it does not explicitly define the various roles that those different professionals might play.

Young Minds is another very important charitable resource in the field of children and young people's mental health issues. Its report, 'Whose Crisis?' (Street 2000), had as one of the concluding recommendations: *"CAMHS human resource issues must be clearly identified and addressed within the NHS Workforce Planning strategy."* This recommendation was in the context of noting the difficulty of recruiting staff to some CAMHS teams, and in particular the problems with Consultant Psychiatrist recruitment within this speciality. The report is interesting in that it does not mention nurses at all, except where it reproduces the HAS four tier model. This includes a lack of reference to inpatient staffing, as well as out patient nurses. In contrast to previous comments about an assumption of the presence of nurses in services, it is a worrying indication of the possible marginalisation of nurses that this study was conducted by interviewing Consultant Child Psychiatrists and representatives of other (non-CAMHS) agencies. The absence of consultation with nurses from the sample consulted may be indicative of low value placed on the nursing role in these teams. In itself this is odd, given the nature of Young Minds, which includes on its board representatives from sponsoring organizations, including the RCN.

Other documents, however, continue to make an assumption that nurses and other professional groups will continue to be part of outpatient CAMHS. The Health Care Needs Assessment in CAMH, which was conducted by the Wessex Institute (Wallace et al. 1997),

makes brief reference to training, stating that nurses are an integral part of inpatient units, but that additional training is required for working in this area (p42). Again it makes this comment in passing, with little explanation. The same document, in discussing the needs of a CAMHS for an 'average' health district makes reference to the importance of multidisciplinary working in both in and out-patient services, and includes 'child psychiatric nurses' in its list of disciplines expected to be present within such a service. It also (p59) refers back to Kurtz et al's (1994) survey of staffing as its source for numbers and variation of staffing. As with other documents there is no real attempt to justify why nurses or others might be part of this sort of team. They are assumed to be present in many teams, but there is no attempt to discuss in detail the contribution of any specific disciplines, so the nursing contribution as such is not discussed. The Wessex report is similar to HAS in going so far as to define a broad view of what the service needs to provide, both in terms of services and the skills required. The assumption is that different disciplines will be able to provide all the listed skills between them. This implies that no one discipline can provide all of the skills on the list, and that the different disciplines are able to complement each other. Again there is no definition of the different contributions, and the literature does not examine this area.

As another sign of the increase of interest in the work of CAMHS, in 1998 the Royal College of Psychiatrists set up a multidisciplinary

project group (FOCUS) to support the evidence base of CAMHS, which was recognised as limited. Amongst their several important pieces of work, they published an information booklet called 'Who's Who in CAMHS' (Joughin et al. 1999). The booklet specifically notes that it: *"..acknowledges the uncertainties around roles, levels of service and individual professional preferences in CAMHS, but in no way attempts to address them."* Its description of the different disciplines within CAMHS is variable in length and detail, and seems to reflect the amount of information submitted by the different associations and individuals consulted. In the case of nursing, for example, the report's authors consulted with the Royal College of Nursing, and at least one nurse educationalist is acknowledged in the preface. It describes the training available to nurses and their statutory responsibility to keep themselves up to date in their field of practice. In describing the nursing role, it includes three main areas: direct work; consultation and liaison; and teaching. However it does note that nurses may vary considerably in how they tackle their work, and appears to include only one area that may be specifically a nursing intervention, and this is the creation of a 'therapeutic milieu' on in-patient units. Within the outpatient context its only nursing-specific suggestion or contribution is that consultation from CAMHS nurses to their primary care nursing colleagues may be important.

2.3.3 The National Service Framework for Children, Young People and Midwifery Services

In recent years then increasing policy attention had been given to the mental health needs of children and young people, and the services provided for them, following the policy vacuum that preceded it. The Audit Commission (1999) noted that CAMHS provision had developed in an ad hoc fashion, with limited centralised planning. The implications of this were only just becoming apparent, though it was clear that services across England were organised in very different ways (Glover et al. 2003). The then Health Secretary, Frank Dobson, realising that there was no coherent policy for children and young people, commissioned a Children's Taskforce, with the aim of working towards a National Service Framework for Children (Ainsley-Green 2001). This led, after a lot of effort by external working groups (EWGs), to the publication of the 'Emerging Findings' document (DoH 2003a) which laid out the likely NSF for Children as a discussion document. Whilst offering many challenges to service provision, it held back from being prescriptive about how services are organised and commissioned, and made few direct recommendations beyond a pointed comment that CAMHS should have 'more robust management'.

The outcome of this consultation was the publication, in 2004, of a National Service Framework for Children, Young People and Midwifery Services (DoH 2004a). The NSF covers all children's and

young people's services, plus midwifery services. It is split into Standards, of which Standard Nine covers the emotional wellbeing and mental health of children and young people. One major change is that CAMHS becomes the lead agency for mental health provision up to the age of eighteen (specifically to a young person's eighteenth birthday). The previous norm was up to sixteen, with then a dearth of services for the sixteen to eighteen age group (Audit Commission 1999). The sixteen to eighteen age group naturally includes more early episodes of psychosis (DoH 2001c), but also is covered by the NSF for Mental Health and the need to implement the Care Programme Approach (CPA), which is not applicable to young people under the age of sixteen (DoH 1999c). All of these service changes bring CAMHS closer to mainstream adult services and inevitably force changes to bring them more in line with adult service provision.

The NSF for Children is examined in more detail as one of the policy documents used for detailed analysis. At this point it is worth noting that it followed in broad terms the direction of the HAS (1995) document, specifically reproducing the four-tier model, for example. This seems to reflect the way in which the NSF was constructed, to be less directive and more reflective of best practice. The system of external working groups for each standard of the NSF consisted of an expert within each field of practice, and as such it tended to reflect best practice rather than radically change it. This is in contrast to the NSF for Mental Health (1999a), which had issued

very specific policy guidance (DoH 2001c) which reshaped provision of services by encouraging provider Trusts to establish new and separate services for areas such as assertive outreach, crisis resolution and early interventions in psychosis. What the NSF for Children did was to add authority to the four-tier system and the new roles it envisaged, such as Primary Mental Health Workers (PMHWs). It did not add much to the skill mix debate, reflecting what was common practice in CAMHS at the time, and repeating the core skills that it felt ought to be present in a CAMHS team. The differentiation of different professional groups' contribution to those core skills was not addressed, but the document does make reference to a generic term 'CAMHS professional' as a hybrid term for the different professional groups. This reflects an assumption that professions will continue to be present in the teams rather than a purely generic worker, but recognises the generic nature of some of the work. This is examined in more detail in Chapter Six. There are training and inter-agency implications for service delivery throughout the NSF, but in the section on Tier Three multidisciplinary CAMHS team the NSF expands the range of people who have the 'necessary skills and competencies' from the previously cited lists to include: *'child psychiatrists, clinical child psychologists, CAMHS trained nurses, occupational therapists, and other allied health professionals, social workers, child and adolescent mental health workers, child psychotherapists, family therapists, specialist teachers and a range of creative therapists.'* This reflected the practice of diversification to achieve a broader

skill mix. Whilst the NSF goes on to mention a variety of therapeutic skills, it does not specify discipline specific strengths. There is an assumption, however, within the Training and Development section of Standard 9 (p41) that the nursing role, for example, within CAMHS is well established. In specifically mentioning the need to identify new or extended roles that might be needed, it takes for granted the fact that the nursing role exists and assumes that it does not need to be clarified in the same way as the new ones do. In contrast the section on Primary Mental Health Workers, reference is made to a definition of PMHW role, again assuming that there may be a lack of clarity, and pointing to a way of providing an explanation of the new role. Whilst no mention is made of the original core groups of professions, psychiatrists, psychologists, nurses and social workers or psychotherapists, it must be that there is an assumption by the authors of the NSF that these roles do not require clarification and explanation in the same way as new and developing roles. What it does go on to complete, in Appendix 2, is a statement that: *'The professional mix within specialist services and teams should be balanced to ensure the availability of an appropriate representation of skills, in particular, professional and team isolation should be avoided...'* Once more it stops short of defining which professions might provide which elements of the service, and inherently assumes that there are a range of skills that would be provided to a greater or lesser degree by the core professional groups.

As part of the preparation towards the NSF for Children the Department of Health also realised that it had very poor information on CAMHS service provision. Until recently they did not have, for example, a list of service providers for CAMHS (Twitchett 2001). The Department of Health moved to rectify this by commissioning a series of CAMHS mapping exercises, starting in 2002 (Glover et al. 2003) and this has been repeated and refined annually since then to try to capture more complete information than the 2002 study was able to obtain. The previous attempt by the Audit Commission (Audit Commission 1999) to survey CAMHS managed to find information on only sixty percent of the estimated services. The initial 2002 mapping exercise managed to capture better results on the English CAMHS provision, getting information from 296 out of 304 PCT areas, a much better percentage, and therefore more reliable and current information. It said that nurses are the highest percentage of the CAMHS workforce (at 38% a significant increase from the 1999 Audit Commission figure of 26%²), though not present in every service, but the exercise was still finding a lack of integration in services, with clinical psychology often being provided separately (and therefore not likely to have a nursing component to their workforce).

² Significantly the mapping exercise requested information on original training rather than job title, so nurses employed as Mental Health Practitioners, for example, would have been recorded as nurses, unlike the Audit Commission methodology. This difference in approach would explain the difference in figures and reflect better the numbers of nurses working in CAMHS.

2.4 The rise of workforce policy in mental health and its impact on CAMHS

Workforce policy in mental health has been touched on in the previous section on general mental health policy, but as a separate body of work it is relatively recent, at least in the quantity and specificity of documents produced. There are two main strands to the work, those which have been provided as guidance, which reflect the pressures of the service user movement and the independent sector (largely in the shape of the Sainsbury Centre), and the more concrete statutory effect of Agenda for Change (AfC).

2.4.1 The impact of Agenda for Change

Agenda for Change is the name of the pay system in the NHS that covers almost all staff (but not doctors, dentists and chief executive grades of Trusts). It was first announced in 1999 as part of the New Labour government's strategy for modernising government and public services (Cabinet Office 1999). It had the aim of setting out a 'reward strategy' for staff that would:

'Enable staff to give their best for patients, working in new ways and breaking down traditional barriers;

Pay fairly and equitably for work done, with career progression based on responsibility, competence and satisfactory performance;

Simplify and modernise conditions of service, with national core conditions and considerable local flexibility.'

(DoH Health Service Circular HSC1999/035). After considerable negotiation with the employees' representative bodies and a period of piloting, the Final Agreement for AfC was issued at the end of 2004 (DoH 2004b) and implemented across England in the following years. The importance of this process is twofold. Firstly it had an impact on all staff, in a way which policy guidance sometimes does not through the process of local implementation of policy guidance being at times patchy and inconsistent. Secondly it was based on a Knowledge and Skills Framework (DoH 2004c) which included levels of formal training and qualification, but also set out skills and competences as a critical transferable measure of worth, which translated directly into the 'reward strategy' of how much people got paid. The implementation process affected all staff in the NHS (with the exceptions mentioned) and was tremendously disruptive as all job descriptions had to be reviewed and matched against agreed job profiles for job descriptions and matched to the Knowledge and Skills Framework (KSF). The King's Fund review of the process (Buchan and Evans 2007) found that implementation had been '*rushed and costly*' and questioned the '*endurance*' of the KSF as a useful tool in the longer term, reporting (p22) that not all staff had KSF profiles for their jobs three years into the process.

Nonetheless AfC remains the basis of pay and conditions within the NHS, including most mental health staff, and it is examined in more detail in Chapter Six.

2.4.2 Workforce policy and new ways of working for everyone

Within the CAMHS policy, as exemplified by the HAS (1995) 'Together We Stand' guidance, there is a dual recognition of the ongoing involvement of professional groups, but also a description of a generic set of core skills which were needed within a team or service, without specifying how these were to be provided, or by whom. This has been replicated within mental health workforce policy generally. Led by the Sainsbury Centre, which concentrated on generic skills and competences, and the development of 'The Capable Practitioner' (Sainsbury Centre 2001), the work has been taken up by the National Institute of Mental Health in England (NIMHE), which is now part of the broader Care Service Improvement Partnership (CSIP). The publication of the Ten Essential Shared Capabilities by NIMHE, in conjunction with the Sainsbury Centre and the NHS University in August of 2004 (Hope 2004) is significant because it moves the ideas of genericism away from the aspirations of an independent body like the Sainsbury Centre and makes them into government policy guidance (NIMHE is funded by the Department of Health, and the report was issued as 'Best Practice Guidance'). The Ten Essential Capabilities document makes it clear in its foreword that the work is heavily dependent on the 'Capable Practitioner' report (Sainsbury Centre 2001), which itself had been commissioned to address issues arising from the NSF for Mental Health (DoH 1999a). It also attempts to tie up the shared capabilities with the KSF and the National Occupational Standards

for Mental Health (Skills for Health 2005). Skills for Health had been commissioned to produce these competences as part of its wider role as the Sector Skills Council for England. Ironically for an organisation that has been so closely involved with the development of mental health workforce, the Sainsbury Centre continues to criticise the progress made in workforce development, noting (Sainsbury Centre 2003 p2-3) that: *'There is a history of poor workforce planning in both the public and private sectors in the UK. Neither the NHS nor social services have shown great expertise or success in workforce planning.'* This perhaps reflects some frustration with a process that they had independently initiated with the 'Pulling Together' review (Sainsbury Centre 1997). That review had first highlighted the need to identify future roles of mental health staff based on team function and the needs of service users and carers rather than by looking at the traditional professional roles. In fact the measure of their success has been that what they were suggesting in that early report has now become mainstream policy guidance in the form of the new ways of working project.

New Ways of Working within mental health originated from the need of psychiatrists to look at the pressures with which their profession perceived itself to be struggling. Although psychiatrists were exempted from Agenda for Change, they had been included in the renegotiation of the medical consultant's contract, and this had brought up questions of what was their proper function, and whether they were performing at optimum efficiency. From the

beginning, however it was recognised that changing the way that psychiatrists work would impact on other professionals within mental health. The first report on New Ways of Working for Psychiatrists (DoH 2004d frontispiece) has a foreword that comes before even the title page stating that: *'This guidance has been produced to ensure that all staff active in mental health and social care are working most effectively...'* Although the National Steering Group was initially set up with aims that related initially to the role of psychiatrists (op cit Sec. 1.4 p2), it soon widens out the guidance to include much more than this, and the subsequent actions were to include other professional groups much more closely. The actions points of 2004 therefore were reported on in 2005 with a degree of success in their "Final report 'but not the end of the story'." (sic) (DoH 2005a). The effect of bringing other professional groups into the New Ways of Working (NWW) project was a proliferation of working groups looking at their contribution and how NWW might affect them, with the expanded and new roles that it was proposing. Groups were established for Allied Health Professionals and Occupational Therapists (who are AHPs but wanted a separate group to look at their needs), Non-professionally Qualified Staff, Nursing, Pharmacy, Psychology, Social Work, Psychological Therapies, Primary Care and Service Users and Carers. Each of these reported back into the Progress Report of April 2007 (DoH 2007a) which was titled 'Mental Health: New ways of Working for Everyone: Developing and sustaining a capable and flexible workforce.' This progress report summarises the project in

its most complete form and is used as the basis for analysis of NWW in Chapter Six. During the course of the NWW project there have also been nine pilot sites for NWW in CAMHS, which reported varying degrees of involvement. The feeling of most of the project sites was that CAMHS already involved many of the principles of NWW but that further work could be done on implementing the changes in response to further developments (DoH 2007b).

The final creation of the NWW project has been a toolkit for redesigning services, the Creating Capable Teams Approach (CCTA) (DoH 2007c). This provides a tool for looking at the function of a mental health team and from that determining what skills and competences are required to fulfil that function. This toolkit: *'..helps a team reflect on their function, the needs of service users and carers, the current workforce structure and the current and required capabilities...'* with the aim of creating a 'needs-led workforce'.

New Ways of Working, then, represents the bringing together of all the elements of workforce policy in mental health since the creation of the NSF for mental health, and adapts that to the subsequent NSFs (for older people as well as for children and young people).

2.5 Chapter Summary

The current context of mental health workforce, and the developments heralded by the National Service Frameworks for Mental Health, Children, and Older People, mean this is an important time for the whole mental health workforce. The position of the professional groups in the services has always assumed, rather than well understood, and this lack of definition has meant that in the recent past there has been a movement towards the use of mental health practitioners and primary mental health workers who may come from either nursing, social work, or other backgrounds. This genericisation of staff in mental health, and NWW's development of 'New Roles' (a concept which introduces more non-professionally qualified staff) brings with it a threat to the concept of professional identity. This is true both for those within the existing professional groups, where the distance from their professional group of origin may be an issue, and for the development of a professional identity for those in the New Roles, especially those without a professional qualification.

In the next chapter a closer examination will be made of the importance of these concepts for the identity of those who deliver services, and the impact that this might have on service delivery.

Chapter Three – Roles, Conceptual Frameworks and Identities in Mental Health teams and CAMHS – Nursing as an example

3.1 Chapter purpose

In order to look at the part different professional groups play in mental health teams and CAMHS we need to go beyond the current political context, and several areas need to be explored. There is, of course, a huge body of literature relating to the theory and conceptual frameworks that different professions bring to the task of providing care or therapy. This often relates to the broader context of the parent profession for those groups who have wider professional allegiances; so, for example, the history and development of physical health nursing is very different to that of mental health nursing. So, whilst, for example, mental health nursing usually benefits from the positive press that nursing enjoys (Parish 2004) its evolution has differed in recent years. Nolan's (1993) history shows how adult mental health nursing moved from asylum-based care to its present format, and CAMHS nursing has followed on the back of those changes.

It is important to look at what constitutes a particular intervention, particularly within mental health teams, to see if there is anything distinctive about those interventions that can be seen to add value beyond the application of a set of skills and competences. There are several different professional groups working within mental health

teams and CAMHS as we have seen. For some the conceptual framework in which they work pertains purely to mental health work. Psychology and the psychotherapies fall within this group, even where they are applied to physical healthcare, whilst other professional groups come from a wider umbrella, forming only a subgroup of the wider profession. These groups follow often quite divergent paths from their parent professional body. The specialisation into mental health, and for this study into child mental health, gives a degree of distance from those parent bodies. Psychiatrists (and specialist Child Psychiatrists) work in a way that is connected to, but distant from, the work of many other doctors. Allied Health Professionals in mental health, such as Occupational Therapists, are also seen only as a subgroup of their main profession. A dietician in a mental health trust will work with a very different client group to a dietician in a physical healthcare setting. This distinction can also be drawn for social workers and nurses. Yet all of these professional groups retain links to the parent group and need to conform to the professional regulation and governance of those groups.

In order to look at the issue of professional identity and how it is created in groups which are at something of a distance from their parent organisation and discipline, it is proposed within the constraints of this study to take one discipline as an example and look in detail at how these issues apply to that one professional group in order to understand those issues as an exemplar for all

groups. The identity of 'nurse' compared to 'mental health nurse' is one of conflict, for arguably a mental health nurse has more in common with other staff in mental health services in terms of skills and competences than they do with most physical healthcare nurses, yet they retain a nursing identity. Nursing, and nursing within CAMHS will therefore be used as an example of how professional identity is created and to look at what underpins that identity as well as how it is changed in different settings.

3.2 The development of adult mental health nursing

Nolan (1993) traces current mental health nursing practice primarily back to the asylums and the initial role of attendants who were largely subservient to the medical profession in the treatment of the insane. In fact there is a longer history of the mentally disturbed being humanely treated through the more enlightened monastic and religious houses, to which Nolan alludes in his references to Bethlem Hospital and its predecessors. This function, along with the mainstream healing and hospital facilities provided within religious organisations, failed, he contends, to cope with the expansion of population that the Industrial Revolution brought to this country. The expanded unmet need led to the establishment of asylums. Indeed there remains a link between the religious vocation and secular caring through mental health nursing and other caring professions (Crawford et al. 1998).

In the modern era, however, Hildegard Peplau is largely credited with focussing psychiatric nursing on the therapeutic relationship between the nurse and the person they are nursing. In the early 1960s (article reproduced in Peplau 1982) she was looking at this in relation to nursing people with schizophrenia, and much psychiatric and mental health nursing theory has developed from this approach. In the UK, Annie Altschul (Tilley 1999) brought many of Peplau's ideas across the Atlantic and translated them into a British context, adding her own distinctive element by emphasizing the 'common sense' approach as being a particularly nursing contribution.

In the same tradition, Professor Phil Barker and others in Newcastle have explored ideas about what is the 'proper focus' of psychiatric nursing (explicitly drawing on Peplau's work), and what people might need psychiatric nurses for (Barker et al. 1995 and 1999). Barker's main thesis is that, while 'caring' is often seen within wider nursing as a core element, there does not exist an adequate definition of 'caring'. He feels that, whilst there is no harm in nurses identifying what caring means to them, this could not, however, become the 'raison d'être' of nursing. Barker points out that if caring is the essence of nursing, not only must all nursing involve caring, but that caring must only occur in nursing, or occur in some unique way. This is clearly not the case. He concludes that if nursing is to be defined, globally, by any one thing, it is the social construction of the nurse's role. The nurse's role changes more as a function of societal shifts than as a result of any actualisation of the 'essential' nature of the profession. Barker has been scathing about

the 'nursing theology' of nursing as caring, and religious overtones of nursing apologists like Watson (1985). Professor Barker (1999) notes that many of Watson's defining features of nursing can also be found in psychotherapy literature, when the nature and role of psychotherapy are described. Barker concludes with the important point that: *'As long as nursing is defined in terms of what nurses do, rather than what nursing is meant to achieve, an evaluation of its worth will be impossible, however its "core" is defined.'*

This is an important point, as much of the literature relating to 'role' within nursing does restrict itself to a description of function. Duffy and Lee (1998), for example, make good points about role ambiguity, but essentially describe the way that nurses work, rather than analysing that work in the context of a theoretical or conceptual framework. This phenomenon also occurs in one of the few pieces of work on CAMHS nursing (Leighton et al. 2001).

Repper (2000) sees the difficulty in defining mental health nursing as springing from the variety of roles inherent in this field of nursing. She notes the essential difficulty of measuring the nature of nursing, compared to the move towards quantifiable evidence-based approaches to service delivery as espoused by Gournay (1995). Her solution is to recognise the multiplicity and diversity of nursing roles, whilst reinforcing that service users value nurses for their 'ordinariness'. In particular, she recognises that each nurse will bring individual skills that will be used in different ways with different situations and relating differently to a variety of service

user needs. A study of the general public by Walker et al. (1998) emphasised that those members of the public who had any knowledge or opinion on the role of mental health nurses valued them primarily for caring, talking and listening.

Pilgrim and Rogers (1994) had also found that service users valued 'ordinariness' and the basic listening skills demonstrated by nurses. They also found that having enough time to employ these skills was directly related to the grade of the staff, so non-qualified staff and student nurses were the most valued, at least in a ward setting. There is also an implication that this 'ordinariness' relates to either a lack of expertise, or consciously adopting a non-expert stance, in contrast to other professionals. The extreme conclusion of this would be that rather than training people, the solution is simply to recruit the right sort of intuitive staff in the first place. Others have attempted to quantify which human qualities can be recognised and enhanced in order to understand the process that allows good nursing. Graham (2001), for example cited holism, partnership and empowerment alongside relationship-building, as essential elements of the meaning of nursing. The conscious employment of skills, and an active use of self-awareness, rather than relying on intuitive or innate qualities, seems, therefore, to contribute towards an understanding of the essence of mental health nursing.

In 'Working in Partnership' (DoH 1994) it was suggested that psychiatric nursing '*..should play a central role in the provision of high quality mental health care.*' Yet defining what nursing has to

offer, and what nurses actually do, or ought to be doing, remains a contentious and difficult area, even in adult mental health settings. The recent Chief Nursing Officer's review of mental health nursing specifically asked for views on the core values and roles of mental health nursing (DoH 2005b), yet when that review was published (DoH 2006a), it held back from defining which values underpinned mental health nursing specifically. It referred instead to more generic principles such as the Recovery Approach and the need to (p 13): *'...move away from a traditional model of care to a biopsychosocial and values-based approach.'* The review was called 'From Values to Actions' yet the values are not specifically nursing values; they are based on the wider principles of service user need. This is in itself laudable, but does not help in defining the perspective of nursing in any way that might differentiate it from other mental health professions who also aspire to utilise these general principles. In defining a conceptual framework, or even an underlying set of specifically nursing values, the review is therefore unhelpful. It concentrates instead on the actions, with only recommendation 5 (of 17) being suggestive of a specifically nursing approach to the task. Recommendation 5 (p 29) is that: *"All MHNs will be able to develop strong therapeutic relationships with service users and carers."* Again the influence of Peplau and her followers is evident here. Other recommendations, such as the importance of holistic assessments (Recommendation 6) might be indicative of a values based approach, but are harder to define as specifically nursing approaches as many other professional groups espouse

holism as important (whilst none have the same emphasis on therapeutic relationship building as central to their approach).

Duffy and Lee (1998) suggested there remains a dilemma for many nurses in practice between the 'clinical support role', of running the ward, administering medication and completing necessary paperwork, and the development of 'specialist clinician' roles. They suggest that nurses are often tolerant of role ambiguity, and would be happy to develop either or both directions for the future role of nursing. However they also warn that many of the 'clinical support' roles could be fulfilled by people who are not trained nurses. The previous Department of Health (1994) review of mental health nursing 'Working in Partnership' struggled with precisely defining the unique role of mental health nurses. The movement towards looking at what you actually need nurses for, and which of their functions could be fulfilled by others, is also prevalent in some influential areas of policy making. The Sainsbury Centre (1997) published ideas about the increased use of 'generic workers' with relevant experience, and was based on skill mix concepts. Their report focused primarily on the needs of those with more severe and enduring mental health problems (and does not mention CAMHS). They note, however, that the role of nurses is often differentiated from other disciplines as 'caring, rehabilitation and medication supervision skills'. However the report, whilst addressing the training needs of the various professionals within the multi-disciplinary teams who currently provide adult mental health care, suggest a focus on establishing core competences and standards for

all workers. The report affirms the genericism of mental health work, with each specialist discipline having a specific contribution to make on top of the generic element of the work. What it fails to suggest is what those specialist contributions might be, beyond nursing being a 'caring' profession. Other professions would claim 'caring' as a useful addition (though sometimes with a warning about professional boundaries), but not put it at the centre of their philosophy. The Sainsbury Centre has led in this with the Capable Practitioner document (Sainsbury Centre 2001). The recent publication of National Occupational Standards (NOS) in Mental Health (Skills for Health 2003) has increased this drive towards competency based measurement of practitioners worth. It is, of course, possible to separate out from within the generic competences which might be more likely to be found amongst a particular staff group, by virtue of their training and likely experience. From within the NOS it would be possible to identify areas of nursing strength, areas of medical strength and areas in which clinical psychologists or Occupational Therapists, for example, might have more to offer. No-one has attempted to do this in a detailed manner though.

The Sainsbury Centre also published a report on the working of Community Mental Health Teams (Onyett 1995), which looked at the roles, relationships and job satisfaction of team members in terms of core profession. It also specifically excluded from its study teams for older people, alcohol and drugs misuse and learning difficulties. It does not seem to recognise the existence of CAMHS

(neither excluding or including them, simply omitting reference to them). Many of the issues they report (p.21), however, are very familiar to professionals in CAMHS, particularly the 'special dilemma' of being members of, and having loyalty to, both discipline and team. These difficulties are defined as being torn between the egalitarianism inherent in the aims of the community mental health movement, with its associated role blurring, and the desire to maintain traditional, socially valued role definitions and practices. They felt that ideal conditions would be for each discipline to have a clear and valued role within the team, and that the team as a whole has a clear role. With regard to nurses, the report makes some curiously conflicting conclusions. Nurses are seen as an essential element of Community Mental Health Teams, being present in 93% of them, but are amongst the most exhausted, with the least satisfaction about their work relationships. However they are also reported to be the members of the team with the highest team identification and professional identification. They are described as having a high degree of clarity about the role of the team and their own role within the team, which was previously noted as 'ideal conditions' for working in such a team. The report does not expand on what these nurses saw as being their role, or how it differed from that of the other disciplines.

What this demonstrates, then, is the difficulty of nurses in mental health in articulating what they bring by virtue of their professional background and training, to the task. This in turn opens up the

question of whether that is important, or if, as the Sainsbury Centre reports suggest, this is no longer relevant, as long as the task is completed.

3.3 The evolution of CAMH nursing

This lack of definition is more acute in those specialities of mental health nursing, such as CAMHS, which have acquired even more distance from their parent organisation, and from mainstream mental health nursing. Within CAMHS there is very poor documentation and very little published about the development of services. Whilst there are many academic papers on child development and specific syndromes, and a large body of literature on the individual therapies used, the development of services and the contribution of different disciplines to service delivery has not been extensively recorded. CAMH nursing has always seen itself as a 'Cinderella service', being a speciality within a speciality, and falling between two camps, i.e. neither truly belonging to mental health nor to paediatrics.

Nurses have been involved in caring for children and young people with mental health problems since the 1960s, but have only in the last twenty-five years been involved in their outpatient care. The use of nurses on inpatient units is easier to understand in terms of traditional nursing skills. Direct care on wards was a natural place for nurses to have input as child psychiatry units developed in the early 1960s. Whilst not strictly within the remit of this study, as a

context for the development of outpatient nurses it is important to at least be aware of the development of in-patient CAMH services, because that is where out-patient CAMH nurses originally began. Nolan's (1993) history of mental health nursing overlooks any role for nurses at all in child mental health, perhaps because his book is primarily about asylum-based nursing.

Child and adolescent psychiatric inpatient units were developed in the 1960s and 1970s following a Ministry of Health Memorandum of 1964 (cited in Horrocks 1986). Haldane (1963) first looked at the 'functions' of a nurse on such a unit, from a medical point of view. This article concentrated on what would now be called 'milieu therapy', the establishing of an environment conducive to change, and the development of therapeutic relationships between children and the nurses (i.e. Geanellos 1999a). Much of what Haldane (op cit) describes could be seen as a parenting function for children whose parents were not present on the wards. Even at this stage, however, a need for flexibility amongst the nursing staff is stressed, and he made a point of saying that the nurses required on these units needed slightly different qualities to those employed on adult wards. It is worth noting that this is a medical point of view and there is no credit for any nursing input into the preparation of the article. When Haldane (1971) later revisited this subject he laid more stress on the part played by nurses in the psychotherapeutic work of the unit. The way nurses were involved in running therapeutic group work was becoming much more established,

whilst the intensity and depth of the relationships developed between nursing staff and the young people was also felt to be very important. Although not specifically mentioned, this seems to reflect the influence of Peplau and Altschul on psychiatric nursing in this period, as noted before. Haldane at this point attempted to define the levels of nursing skills. He defined 'basic nursing skills' in this context as a parental caring function. 'Special nursing skills' are seen as more sophisticated self-awareness, with greater technical skills, and an understanding of psychodynamic processes. This would equate with mental health skills in other areas. He then goes on to define 'advanced nursing skills' as more in-depth analytical understanding, and 'consultant nursing skills' which include training (of others) and independent practice development. Haldane justifies the use of nurses instead of a proposed 'generic care worker' on the grounds of nurses' knowledge of organic and psychosomatic illness, psychopharmacology, and 'technical nursing procedures'. This is an early attempt to differentiate nursing skills from those of other workers, and it is important to note that as these are not twenty-four hour care skills, they are transferable to out-patient settings. It is also the first instance of the medical model of nurse training being highlighted as a valuable (at least to medical staff) asset not available from other staff groups. At that point in time, however, Haldane did not see a role for nurses working outside of an institutional setting. His analysis of nursing skills in CAMH seems to rely for a conceptual framework on physical caring, mental health

skills and the therapeutic use of self in the development of therapeutic relationships.

Subsequently what was written in the 1980s and 1990s about the overall theory and practice of child and adolescent mental health nursing (e.g. Delaney 1992, Puskar et al. 1990, and Hogarth 1991), continued to see the work of CAMH nurses as primarily institutionally based. Wilkinson (1983) noted that it was 'rare' to find nursing totally in the community, whilst Bhojrub and Morton (1983) state that nurses are not integral to the out-patient child psychiatry clinic, and described the nursing task in outpatient settings which seemed to consist of greeting the patients and preparing them to meet their 'therapist'.

Whilst no literature relating to service developments in the 1970s has been found, by the mid 1980s the report 'Bridges Over Troubled Waters' (Horrocks 1986) was published, looking at the specific needs of adolescents. This had an effect mostly on the provision of adolescent inpatient services, but it does make some comments about nursing roles. Its recommendations (p68) include the idea that: *'...each profession should define its own role in the management of disturbance in adolescence, and state what it can contribute to the work of others.'* Earlier the report had looked at the differing roles within the treatment of adolescents. It emphasized the broader recommendation by stating (p61): *'The nursing profession needs to define the specialist contribution which*

nurses can make to the care and treatment of adolescents with specific psychiatric disorder.' It also noted that nurses must work increasingly in community settings, either as specialist Community Psychiatric Nurses (CPNs), or in an outreach function from inpatient units. The definition of what specialist contribution nurses made which was different from other professions was not made explicit in the report. Role definition was, however, touched on in a section discussing levels of staffing and training needs (p12-14). Here mention is made of nurses' increasing work with families rather than individual patients on units, and of nurses' developing ability to offer specific interventions for specific problems. It also notes the increasing number of nurses working in child guidance clinics. In this section it identifies the specific ability of nurses to offer: *'...close and continuing support and therapy, enhanced by knowledge of the patient.'* In the community, nurses are seen as offering support, advice and consultation to a variety of agencies, but again this would also reflect what other team members in CAMHS would be able to provide. Given that the historical evidence for nurses moving out of in-patient units is very poorly documented (Baldwin 2002), this is one of the few clues evident about the reason for nursing staff joining out-patient teams, which were often initially attached to in-patient units to provide continuity of care. Usually the Consultant Child Psychiatrist running the unit would also have responsibility for outpatient care, and could see some benefit of using experienced nursing staff in that area of work too. The most experienced nurses, who had developed family work skills

from within their in-patient work, were seconded to the out-patient teams, where their jobs later became permanent, and the nursing workforce later expanded (Goodman and Matthews 1989).

In the same year as 'Bridges Over Troubled Waters' (op cit) was published Professor Rutter, the leading UK child psychiatrist at the time, made a series of predictions for the next thirty years in child psychiatry (Rutter 1986). He suggested that there was likely to be an increase in the development of a course to produce nurses who could act as independent clinicians. This move for nurses towards independent practice within the community he saw as based on the social work model, with a need to change the salary and status hierarchy to reward clinical nurses. He also stressed the need for clinical research and teaching to be integrated within the care functions of nursing, as is now explicitly the case for Consultant Nurses, and increasingly for Clinical Nurse Specialists. This illustrates some concurrence at the time in the thinking of how nursing roles might be developed. He did not, however, cover the issue of what the profession actually brought by way of underlying conceptual framework.

3.4 Roles in Child and Adolescent Mental Health nursing

Within the British literature, the earliest reference to nursing roles in community CAMHS is McMorro (1990). He noted the proliferation of job titles in CAMHS and suggested that this reflects the uncertainty as to exactly what role nurses were meant to perform

when those posts had been set up. A clearer role, he felt, might have brought with it more uniformity of job title across different services. Limerick and Baldwin (2000) later discussed some of these issues in terms of generic workers and core skills for CAMHS staff. They made the point that professional accountability is important in an era when the move towards generic workers tends to emphasize capabilities over training.

Other writers have made efforts to define the nursing contribution but these are often incidental to the central thesis of their argument. Lacey (1999), for example, refers to child mental health nurses as making good Primary Mental Health Workers (PMHWs) because of their holistic approach, good interpersonal skills and communication skills. She noted that in her survey, a high proportion of PMHWs at that time had a nursing background, and the holism of nurse training led to an integrative approach to their work. Similarly Leighton et al (2001), whilst aiming to provide a *'...detailed profile of the nursing contribution within ...outpatient CAMHS'* do not address areas of difference from their non-nursing colleagues. A good description of function and skills likely to be employed are offered, with emphasis on therapeutic relationships, assessment and treatment modalities, and a discussion of the limitations imposed on CAMH nurses. They conclude that nurses' lack of specialism, whilst in many ways a strength, also prevented CAMH nurses from promoting the work they did. This links to the concept that nurses make good generic workers within CAMHS, in

this case described as eclecticism, rather than having areas of distinctive expertise or strength.

In more general articles about children's mental health needs, the applicability of nursing skills are also mentioned. Townley (2002), for example, comments on a wide range of areas where nurses have an opportunity to promote good mental health, but does not specify how nursing skills would be used. He implies, for example, that nurses' communication skills would enable them to engage with children and young people but he does not spell this out. Likewise Davies et al (2002) commenting on the CAMH service in South Wales make passing reference to nurses employed as therapists, rather than with a nursing job title, but do not enlarge or comment on this. The implication is that nurses may be under-represented in the workforce calculations because they are not all employed in a specific nursing capacity, but rather for their generic skills, with a generic job title.

One of the few pieces of work that made a concerted effort to define the nursing role in the developing CAMHS agenda remains unpublished. Sue Croom's secondment to the Department of Health led to a draft report which was never widely circulated (Croom 2001). Her key point was that: *"Skilled nursing involves working closely with children and families to anticipate needs, to support, to nurture and to provide key therapeutic interventions. Yet because it is sustained as a continuous and seamless process its complexity*

can be invisible to some observers who assume that it is a less sophisticated activity than it actually is. Skilled nursing is crucial to a modern CAMH service and needs to be strengthened and developed." (para 6.) Much of the rest of her report was taken up in the preparatory work ahead of the publication of the NSF for Children (2004a). This included suggestions for strengthening nurse education and the need to recognise the contribution of primary care nurses in the continuum of CAMH nursing (Baldwin 2005).

As nursing has established itself within CAMHS there have also been two further attempts to provide up to date textbooks on CAMHS care in the community. The first of these (Dhogra et al 2001) concentrated on primary care and the range of interventions available. In addressing primary care there was an overview of treatment approaches available and no real attempt to relate these to underlying conceptual frameworks of different professional groups. The second book (MacDougall 2006) did address specifically nursing approaches, at least in the title, though this is not evident in all the chapters of the book itself. There is again an attempt to describe the range of different approaches and treatments in which CAMHS nurses are currently involved. These chapters are largely descriptive, however, and there is little attempt to look at what conceptual frameworks underpin the nursing application of these approaches.

Two international studies have made efforts to look at aspects of in-patient CAMH nursing. These are important in that they relate to the nursing role in community CAMHS. Scharer (1999) took a grounded theory approach to uncover ideas about relationship building by nurses, and did relate these skills to core nursing skills. She noted that nurses were in the best position to develop relationships with parents of young people accommodated on the in-patient unit. She focussed on this because nurses often saw the parents at times of stress, i.e. when collecting or returning their children to the unit. Scharer felt the intensity of this experience led to much quicker and more accurate relationships between nurses and the parents than they might have with other staff members who saw them at different, more settled, times. Geanellos, in an Australian context, put emphasis on the nurses ability to create a therapeutic milieu within the CAMH in patient unit (Geanellos 1999a). Her study concentrates on the nursing skills used during time spent with young people on the unit, and the human qualities used by nurses over the lengthy periods of time they spend on shift. She does, however, point out that despite the fact that nurses are most likely to be the ones using milieu theory, nurses are rarely generating nurse based theory to support their work.

In the arena of out-patient or community CAMHS in England there remains little published that is specific. Only one previous study attempts to address this issue in any depth (Baldwin 2002). This study covered six different English CAHMS, and did make attempts

to look at perceptions of nursing roles within these teams. When respondents were asked what they knew of the history of the introduction of nurses into these teams there was an overall recognition that the nursing posts were never clearly planned. Within this study there was, however, a perception (proposed by disciplines other than nurses and doctors) that nurses were in the teams because they are more compliant to doctors orders than other disciplinary groups, being more used to working within a medical hierarchical model. The study developed a detailed series of themes within the interviews that were carried out:

The first theme was of team composition and history. Although each team visited had a generally similar task their composition varied quite considerably;

The strength of clinical autonomy within CAMHS. All the nurses interviewed fulfilled the criteria for autonomous practice suggested by Leddy and Pepper (1993);

Clarity of specific roles of non-nursing staff in CAMHS. Most of the interviewees were able to identify clear differentiated roles and methods of working for the non-nursing disciplines within the teams. It was also recognised that all members of CAHMS (including the nurses) had a generic core function which overlapped and in which differences of practice were much less marked;

Difficulty in defining the nursing role. Interviewees found it much more difficult to define what was the core, defining role of the nursing staff. Although several nursing skills were mentioned by different interviewees, there was no consensus at all as to what nurses brought to the team by virtue of their nurse training and experience. Perhaps the most worrying aspect was that nurses were taken 'for granted'. Their role was assumed, although not well defined;

Personality versus professional training. In teams where there was more than one nurse, it was acknowledged that the different nurses did their jobs in often very different ways, largely dependent on their character;

The generic function and role overlaps. It was clear that the generic function, which all team members fulfilled in addition to any specialist function that they have, was a function performed well by nurses.

Whilst this study remains the only detailed published examination of roles in CAMH nursing, it has a number of methodological limitations. It was limited to a small convenient sample, and lacked a sound academic theory or philosophical underpinning on which to base its analysis.

3.5 Summary

This chapter has looked at the way CAMH nursing has developed out of a broader tradition of mental health nursing, as a way of understanding underlying conceptual frameworks and their contribution to professional identity. Whilst there is a literature regarding mental health nursing in multi-professional teams, and some discussion of the role of nurses in CAMHS, there is no consistency in the methodology used by writers to discuss this phenomenon. Despite this lack of methodological consistency, a variety of themes emerge which might give leads in examining what it is that nurses bring, or what are the strengths of nursing practice that lead to them being members of multidisciplinary teams (MDTs) in mental health settings, and in CAMHS.

The principle themes are those of relationship-building, 'caring', 'ordinariness', an holistic approach and knowledge of the medical model of psychiatry. There is recognition of the overlap of skills and approaches that occurs in mental health MDTs much more than in physical healthcare teams. This is particularly important in the 'generic' element of CAMHS work, which constitutes a higher proportion of the overall task. There is also some understanding that the individual personalities and other personal qualities of the people who take on nursing and other roles in some ways shape their approach to the work.

These themes, however, remain inadequate in providing us with a comprehensive understanding of the conceptual framework underlying the contribution of nursing to mental health teams and to CAMHS, and how this affects individual professional identity. Although there are hints of commonality with other mental health professions and with the wider professional groupings, there is a clear lack of definition. This illustrates the difficulties in defining, for each professional group, what is the exact contribution of different professions to a mental health or CAMHS team (and indeed whether this is actually important). This is in contrast to other organisational models that seek to define how to achieve a desired skill mix within a team (i.e. in business models and in physical healthcare models). Nursing and other professional groups continue to struggle with these issues, though increasingly there is a recognition that this is about 'identity' and the way in which this affects service delivery. As Lynch and Trethowen (2008 p6) note: *"Mental health nursing needs to develop its definite identity as a profession, and with this illustrate to service users what contribution it can make to delivering the sort of quality-assured and compassionate care they want."*

In the next chapter methodologies and theoretical models that might help to examine these themes in more detail will be examined.

Chapter Four – A Theoretical Framework – From Role Theory to 'Identity-Work'

4.1 Overview

In order to make sense of the general lack of information about the particular subject of this study, it is important to pursue a theoretical framework in which to place the study. Without a framework, it is difficult to make sense of the subject matter or to understand the issues in their broader context.

Throughout the previous chapters there has been an attempt, not entirely successful, to avoid using the word 'role'. Although this study is essentially about roles and identities in mental health teams and CAMHS, the term 'role' is generally used in healthcare literature in such loose terms as to be meaningless. Shewan and Read (1999) point out in their review of nursing developments that few writers on the subject of nursing roles define what they mean by the term, and often use the word 'role' in its most general meaning of 'tasks' or 'function'. Role clearly has a much wider meaning than just this. How are we to best approach the way in which individuals and professional groups work and create their professional identity within the multidisciplinary arrangements that until now have been taken for granted? How much will this change and how will it adapt to the changes currently proposed in workforce policy? Much has been written about multidisciplinary team working, though very

little, as we have seen, about CAMHS teams specifically. Some have chosen to look at effectiveness from a managerial angle (Onyett 2003), and whilst considering role in passing do not use it as a central basis for their analysis of the working of the team. Others (McCallin 2001) have looked at teams and concluded that there really is not a need to worry about what individuals within teams do, so long as the team functions effectively. This way of thinking has been relatively prevalent over the last decade, being the basis of the Sainsbury Centre reviews of community mental health teams (Onyett 1995), and the move towards genericism that was discussed earlier. The concept of genericism sounds very attractive in theory but has some important practical downfalls. It ignores pay differentials, for example, which are based on the importance attributed by management to the contribution offered by different professional groups to the team. The move towards genericism can also be seen in political terms as a move towards the lowest common denominator in terms of pay. The NHS Plan (DoH 2000a), for example, proposed graduate counsellors for primary care (including CAMHS), as a way of filling the skills gap, but did not define what training they needed beyond graduate level psychology skills, which does not usually include any therapeutic training. This goes against the experience of those working in the field, which suggests that this level of work requires a great deal of experience (i.e. Lacey 1999). This level of experience and training does not come cheaply, however. The generic model can also lead to some complacency. Hayes (2005), for example, suggested a new skill mix

for acute mental health wards, stating that a new generic worker could "...respond to patient need rather than be confined by job descriptions." This statement suggests in itself that little thought has been given to incorporating a skill mix which is enshrined in the job descriptions of existing team members.

The concept of teamwork as a generic model, regardless of the individual contribution of team members, is also not reflected in other areas of work, where team composition and clarity of individual contribution is often valued highly. Management gurus like Handy (1993), and Adair (1998) stress the importance of balanced teams within a model of organisational theory, but also stress the importance of individual contribution and balance within those teams. The composition of business teams is more often based not on professional groups, but on personality types and their likely contribution to the team's effectiveness. It may be, therefore, that this type of management thinking is influencing healthcare workforce planning. Other management techniques, such as the use of force field analysis (Lewin 1951) have also had an impact on current thinking about workforce planning in the NHS (Iles and Sutherland 2000). The use of personality typing to determine team composition within business is now quite common, the main models in use being Belbin (1995), which concentrates more on the likely contribution of individuals (i.e. as 'completer-finisher' or 'creator'), and the Jungian-based Myers-Brigg Type Indicator (i.e. Bayne 1997). Even Aldous Huxley's novel 'Brave New World' (1976) noted

that, within the social stratification proposed in his vision, a mixture of types (and abilities in Huxley's case), were needed in any team, using teams with all "Alphas" did not work.

The study of organisational and role behaviour within the caring and healthcare professions has a distinct place, however, and Strauss's early work (Strauss et al. 1963), from which the grounded theory approach developed, took place within a psychiatric hospital setting. The study of roles, in particular the interplay between the medical and nursing staff in institutional settings also has a long history (Stein 1967 & Snelgrove 1999). These studies, however, took very different views of things and do not state the theoretical background they are using to contextualise their observations.

4.2 Theoretical background to the discussion on roles in mental health teams

Within the literature there is relatively little written about roles in CAMHS, as we have seen. For example, in the USA, which has a very different system to England, there exists an Association for nurses in the speciality (the Journal of Child and Adolescent Psychiatric Nursing), unlike in England where the speciality is too small to sustain journals for separate professional groups. Even within that journal though, the actual role definition and differentiation issue has only been addressed in passing. Bishop (1989) noted that there are several difficulties inherent in the speciality. She pointed out that nursing students have little or no

mention of CAMH in their basic training, or even reference made to the speciality as a possible career path. This would also be true in the English setting (Croom 2001). Those specialists who do experience working in child and adolescent services in the course of their basic training often cite this experience as a reason for selecting the speciality for a career (Goodman and Matthews 1989). There was also a perception in Bishop's paper that other fields of practice are more attractive, and she pointed out that at the time there were only a thousand child psychiatric nurses in the US with Masters and Doctoral preparation, and only twelve institutions offering advanced CAMH nursing courses. This would equate to the situation in England, where, until recently very few specialists were trained to degree level in a nursing subject, though there are a number of CAMHS specialists holding Masters level qualifications in therapeutic subjects. Bishop also pointed out that CAMH nurses often work in isolation from other nurses and therefore do not build strong collaborative networks, and that there is a lack of consensus regarding the boundaries and focus for child psychiatric nursing research. Bishop concluded by quoting the US Institute of Medicine (IoM 1989) report saying nurses had a 'unique perspective' on CAMH, particularly due to a 'holistic preparation'. That report includes nurses (from a US perspective) having a central role alongside other professions. The special area that the report identifies as a possible area for nurses to contribute research is delivery of clinical services as well as early detection systems for various disorders. Whilst this is clearly a research report, it infers

that these particular areas might be of interest to nurses because of their closeness to the client group.

At around the same time as this concern was being raised about nursing, there were also worries being expressed about the dangers of role diffusion in child mental health work. Koldjeski (1990) saw this as rooted in deliberate (American) long-term policy. She felt it vital to reconceptualise psychiatric and mental health nursing to show unique and different aspects. Koldjeski argued that the uniqueness of mental health nursing lay in its holistic nature and systemic interconnectedness, although she failed to define these in any detail. She also thought that those elements of therapeutic interventions that nurses use ought to be adapted to develop a unique nursing paradigm, although again she offers no direct thoughts as to how this ought to be developed. Killeen (1990) makes a similar plea, but notes that nurses are not seen as 'experts' in child mental health care, and are not good at publicising their research and practice successes in order to raise the profile of the profession. Whilst these writers concentrated on nursing, the same could be said of other disciplines who fail to define clearly their own conceptual frameworks or the unique contribution they are able to make to the broader task of mental health work and CAMHS.

If a theoretical or conceptual framework exists amongst these American writers on nursing it is probably that of systemic thinking. Systemic inter-relatedness and interaction between systems

permeates the thinking and descriptions of these articles. The influence of systems thinking on American nurse writers in CAMHS is highlighted by Shirley Smoyak (1969, 1975) an early advocate of the use of family systems thinking in nursing practice. The attractiveness of family therapy, which is based on systemic principles, has also been demonstrated by Wright and Leahey's (2000) Calgary model of 'family systems nursing', which has been adopted in both child mental health and paediatric settings.

On a wider scale, when Onyett (2003) returned to his descriptions of adult multidisciplinary mental health teams, he made important observations about the complex nature of these teams in the context of changing policy imperatives. His primary interest is in measuring (and enhancing) the effectiveness of these teams from a management perspective. He chooses to see the effectiveness of teams also in systemic terms, examining the interplay of ideas and professional needs from that standpoint. Using systemic concepts (Senge et al. 1999) and his work on learning organisations as a basis for his analysis of team working Onyett inevitably draws on Senge's (1990) earlier work. This early organisational theory again used a systemic basis for the interpretation of business teams.

In contrast Geanellos (1999a & 1999b) in conducting a study of therapeutic relationship building within an adolescent mental health unit in Western Australia, used a phenomenological framework for her study, rather than the systemic frameworks described above.

Whilst this study effectively looked at the nursing role, it concentrated on the individual contribution of nurses on an in-patient unit, and did not seek to actively differentiate the nursing contribution from that of other staff members. The use of phenomenology gives useful insights into one central aspect of that role, and covers some of the skills which nurses would be expected to display. As a method, however, it lends itself to a close understanding of the individual relationship building experience rather than the context of differing roles within teams.

There are other writers whose theory base is also implicit but not stated. Crawford et al (2001), for example, use terms from role theory like 'role-blurring' without making explicit how they are using those terms. The language of role theory, of which this is an example, has become so embedded in sociological thinking that its terminology is widely used without reference to the original body of thought. Koldjeski's (1990) use of 'role diffusion', for example, also explicitly uses a role theory term without explaining the background to its use, presupposing some knowledge of the theory base in the reader.

Other writers have explored the broad concept of roles without referring to an explicit theory base at all, preferring to use role as a description of tasks or ways of working without defining their presuppositions. Amongst these writers are a number who have looked at mental health care, using a variety of qualitative methods

such as grounded theory (Strauss et al. 1963; Forrest et al 1996; Barker et al 1999; Bamford and Gibson 2000), phenomenology (Bousfield 1997), and practitioner-centred research (Spilsbury and Meyer 2001). Shewan and Read's (1999) review of methodologies in nursing role research, however, is highly critical of the poorly designed studies they had reviewed.

4.3 Role Theory as a model

In the previous chapters, I have established that the role of different healthcare professionals in mental health teams and in CAMHS teams can be indistinct. It is currently difficult to establish a clear rationale for distinctive contributions to mental health teams and CAMHS, in particular for what each group do that distinguishes them from other workers. Studying their contribution within an established framework would allow a more rigorous demonstration of their usefulness (or otherwise) within the teams, and would help clarify what other team members contribute by way of their professional background. In order to do this a theoretical framework is needed which is clearly identified and explicitly used to understand the roles that each professional group perform, and how this impacts on their professional identity.

As I have noted the word 'role' continues to appear in any description of team functioning. Within sociological, psychological and anthropological writing, a broad theory of role has developed which allows a much tighter definition of the area of this study.

Whilst there are variations in emphasis put by the differing elements of role theory, the concept allows a more refined definition of role to act as the background for this study, and gives a measure against which it will be possible to examine the data which this study generates. It is important, however, to define which elements of role theory are appropriate to this study and to be clear about the definitions which can be used for helping to understand the contribution of different members to mental health teams and CAMHS and the impact of their contribution for service users.

Clifford (1996) notes three main schools of role theory, based on the work of Mead, Moreno and Linton. Biddle and Thomas (1966) identify these as originating in the sociological, psychological and anthropological traditions respectively. The concept of role, and the roles played by individuals according to their circumstance is not new. William Shakespeare famously noted, in 'As You Like It' that: *'All the world's a stage, and all the men and women in it merely players'* (Shakespeare 1599), implying that everyone has a role or roles in life that they adopt. The scientific study of this phenomenon is relatively recent, however.

The sociological perspective developed from Mead's early work (Mead, 1934) that centred on the need to understand socialisation and how people understand their place in society. Mead developed the concept of taking a 'role' by which he described how the

individual within that role was influenced by the expectations of others around them.

This was taken forward, in a psychiatric and psychological setting, by Moreno (1962) who developed psychodrama techniques based on the concept of a two stage genesis of roles, i.e. role-perception followed by role enactment. His subsequent development of and use of role-play has been widely used in educational settings, including in mental health training. The theoretical understanding of role taking, according to Moreno, would be preceded by the role-playing, which makes it such a useful teaching instrument in mental health.

The final influence on the basis of role theory was Linton, who came from an anthropological background. His primary contribution was to make a distinction between the status and role, status being the collections of rights and duties, and role being the dynamic enactment of those rights and duties. By doing so he made the distinction between the structure and the individual, an aspect which is important for this study which has a thread of distinguishing between the expectations of team members in mental health teams and in CAMHS, and the individual enactment of the job by different individuals across the country. Linton's work was refined by Biddle and Thomas (1966), who suggested that each individual interpretation of a role could be seen as 'role performance'.

Role theory, however, is not without its critics. Coulson (1972) suggested that there was insufficient clarity within the theoretical model for it to be useful. Her reaction to the building up of role theory as a major plank of sociological theory in the 1960s was to suggest that the differing definitions given by theorists seeking to refine the model actually led to a fragmentation of the underlying model. Undoubtedly some of the earlier writing did give the impression that the individual was subjugated by the role they took on, but this had also been addressed within the literature by way of looking at agency and control. Biddle and Thomas (1966) in particular make an effort to look at this and explicitly state that their aim is to: *'...encompass the numerous and subtle ways in which persons may be associated with behaviours. To handle systematically these relationships, we shall define and discuss a person – behaviour matrix that deals with the interface between persons and behaviour.'* (p29)

Coulson's argument is that Biddle and Thomas then go into an overly elaborate characterisation of different forms of 'person-behaviour matrix', which eventually becomes so complicated as to be unhelpful. Whilst Coulson has a valid point about the relative unhelpfulness of overly complicated characterisations of behaviour, it does not logically follow on (as she suggests) that because of this we should throw out the rest of role theory. There are many concepts within the overarching theory of role that can be useful within this study. It is possible to use these elements of role theory

to address the issues that have began to emerge in this study, and to provide a framework for testing further developments as the data emerges. What cannot be claimed is that there is a 'grand theory' of role, any more than there is a 'grand theory' of nursing, or some of the other disciplines (social work or occupational therapy, for example). There is, however, a body of knowledge that is known as role theory, and usually referred to in that way (Hardy 1978). In this respect it may be more technically correct to follow Clifford's (1996) view that rather than having a fully formed theory, what we are actually dealing with is a series of constructs relating to role.

Clifford (op cit) defines theory as an abstract notion which may be speculation, a guess or an idea to explain reality. She quotes Field and Morse (1985) as suggesting that this mental construct will always remain just that until such time as it can be tested and demonstrated to be the 'truth'. Leaving aside post-modern interpretations of what 'truth' might consist of, we can say that this may be achieved in one of two ways. Firstly it could be achieved by a scientific paradigm within the physical sciences. Alternatively a theory becomes accepted with social sciences in a slightly different way, when there is no empirical truth that can be established. In this context a theory, after much debate and academic testing, seems to be the most plausible explanation for a phenomenon. Given that role theory has yet to complete that process to a point where it is generally accepted as a homogenous body of thinking we are left with the level below fully formed theory, that of constructs.

Theory would consist of a variety of constructs that can be tested and then eventually come together to form a theory. Concepts are the building blocks for constructs, and we need, therefore to define both in order to understand what lies in the way of role theory achieving its final state (if indeed it ever does).

Concepts may be concrete or abstract, Clifford suggests, and consist of a term to which meaning has been ascribed by definition or common usage. A concrete concept would be observable (such as teaching, a process which can be witnessed), whilst an abstract concept may not be directly observed, but has a commonly held meaning (such as learning). Concepts may be combined to form a construct, so that the combination or juxtaposition of the two concepts forms a new meaning. In this context 'role' and 'blurring' as separate concepts combine to form a new construct which may require some explanation, but carries a new meaning if the proposition of the new term makes sense and has validity for those who encounter it. It is also important to understand that constructs can, and usually are, joined by a prepositional statement that implies a relationship between the two constructs. Role blurring, for example, suggests that the role is inadequately well defined to actually be a viable role, which may be a good or bad thing. The juxtaposition of the two constructs, however, allows a theoretical proposition to be tested for validity, and debated until the construct becomes accepted into common usage, or is discarded as an inadequate descriptor of the phenomenon it seeks to define, and

falls out of favour, whilst another construct to explain the same phenomenon is explored instead. Eventually the construct would complete the testing process and become a fully formed theory, and accepted as a body of knowledge which might continue to be explored, but would be rarely challenged at a fundamental level because of its previous period of establishing itself.

Whilst Clifford (op cit) has already applied these ideas to nursing education in some detail, it would be useful for this study to examine which role constructs have some usefulness in relation to mental health workforce.

4.4 Constructs within role theory

Briefly some of the possible constructs are outlined below as an aid to understanding how these are enacted and tackled in the policy discourse and practitioner discourse that is examined later.

4.4.1 Role strain and role stress

Whilst it is possible to see this as a negative starting point, it is nonetheless a useful point because of the appropriateness of this construct for the study. Due to the inter-relatedness of the two constructs, they will also be handled together. Hardy (1978) identifies role stress as being located in the social structure, and primarily external to the individual. The related construct of role strain describes the subjective feelings of frustration, tension or anxiety experienced by an individual or group who are expected to

perform a role characterised by its role stress. Hardy identifies possible ways for individuals to avoid role strain, primarily by closing down lines of communication with any person or agency who might question the role, or by deliberately bargaining in order to clarify the role. She sees healthcare (and the same is true of social care settings) as being particularly prone to situations where these circumstances might occur.

4.4.2 Role Ambiguity

Role ambiguity is characterised by disagreement on what is the accepted norm for any position, by virtue of their being vague, ill defined or unclear. In such circumstances, individuals have a tendency to interpret the role in an idiosyncratic manner. Given what we know of how CAMHS in particular have been set up (with less direct guidance than other areas of mental health practice), this seems to be an important construct. The HAS model (HAS 1995) described overall team functions but not what individual contribution might be to that function, leaving services across the country to decide in different ways what role different staff members might perform. If services have defined what they expect from individual professional groups, then this ought to be discussed in either the services' operational policy documents, or clearly stated within individual job descriptions.

4.4.3 Role Conflict

Role conflict is a condition in which role expectations are either contradictory or mutually exclusive. In this condition there might be different parts of either written or unwritten job descriptions or policy implementation that make it difficult to complete all the expectations satisfactorily. Reactions to these conditions vary according to individual or group processes. Currently within CAMHS, as elsewhere, there is high importance put on reducing waiting list times in order to achieve government targets. Whilst staff may agree in principle that service users need to be seen quickly in order to prevent their difficulties becoming worse, they may object to managerially imposed methods of achieving these targets if they feel that these methods reduce the quality of service they are able to offer (i.e. by reducing the number of appointments offered per case).

4.4.4 Role Incongruity

Role incongruity is usually more personal than role conflict, which is largely an institutionally based difficulty. Role incongruity occurs when the expectations of the role occupied by an individual are at odds with their personal beliefs about how best to achieve that role. This may occur when roles are changed, even subtly, in the context of a changing healthcare environment. For example, a social worker who has been in post for some time may find that their original job description allowed time for the altruistic and therapeutic elements of their job to be at the front of their practice. In time the pressures

of work, either short or long term, may lead to their necessarily having to spend most of their time in statutory (i.e. child protection) duties. This construct will also have resonance with how individuals construct their own professional identity within the changing expectations, over time, of their employers.

4.4.5 Role Overload

Familiar to most health and social care professionals is the excessive demands on their time made by the system for which they work. Whilst the individual may be able to carry out each part of their role adequately, being able to do all that is asked, or expected, of them in the limited amount of time available proves impossible. This may be manifested in the volume of work, or the different variety of tasks expected of one individual. Hardy (op cit) identified this as being particularly prevalent in high level posts where a wide variety of expectations and responsibilities are put on one individual. For the purposes of this study, therefore, it would be useful to look for a correlation between role overload and professional grading. In doing this, allowance would need to be made for the fact that almost all CAMHS staff are employed at a relatively high grade in recognition of their degree of professional autonomy.

4.4.6 Role Incompetence and Role Overqualification

As the name suggests role incompetence exists whenever a role occupant's resources are inadequate for the demands of the job

asked of them. Sound management processes, and a clear understanding of what skills are required for the performance of the job, ought to make this a rare occurrence in CAMHS. For the purposes of this study the out-patient posts normally attract, by virtue of their banding, the best qualified of the available CAMH workforce in the country, but it is possible that services would accept lower levels of qualification in order to fill posts as the workforce expands. By contrast, role overqualification is created by tasks being simplified, or expectations changed and downgraded from what was previously expected. In mental health teams and CAMHS, the tasks are neither routine nor simple, but CAMHS largely has staff who tend to continue to ensure that their own professional development needs are met, particularly in the area of therapeutic interventions. Without a rigorous programme to monitor personal development, it is possible for staff to develop themselves into something that they were not recruited to be, and for which the service does not have a robust plan. Nurses and social workers, for example, often train in particular therapies, family therapy, cognitive behavioural therapy or child psychotherapy, and become fully qualified in those therapies. They may seek to change their job description or post designation because of this, and become frustrated if this is not accommodated by the service. A previous study (Baldwin 2002) identified nurses who no longer saw themselves as nurses, but identified instead with their new professional orientation as a qualified psychotherapist. Likewise

Crawford et al (2008) uncovered the concept of 'growing out of role' amongst community mental health nurses in adult teams.

Additionally for mental health staff and CAMHS staff the opportunities for career progression beyond outpatient or community based CAMHS are very limited. For most CAMHS nurses, on high pay bands (i.e. AfC Bands 6 and 7) there are few opportunities for financial advancement beyond this level. Currently, within nursing for example, there are less than thirty Nurse Consultant posts in CAMHS across England (on AfC Band 8), and a handful of nurse teaching posts devoted exclusively to CAMHS. Other options would include management or mixed teaching posts that would take staff away from direct contact with service users, which is what staff have trained to do.

4.4.7 Role diffusion, Role confusion and Role blurring

The blurring of roles within mental health multidisciplinary teams is commonplace, in contrast to physical health inter-disciplinary teams that more commonly have clearer definitions for healthcare professions. Physiotherapists, radiologists, nursing and medical staff may know in principle what each other's role is but they would rarely have the degree of overlap in role that is common in mental health teams, and particularly present in CAMHS teams. Where there are exceptions to this clarity, then problems of hierarchy become apparent, if often disguised (i.e. Long et al 2008). The move to community based teams in mental health, where the

immediate availability of other team members is severely hampered by geography, has led to even more pronounced blurring of roles, which may not be a bad thing according to some of the staff who work in those teams (Crawford et al. 2001). But whilst some resistance to this role blurring may be seen as 'professional defensiveness', there is also an element of preservation of professional identity which may be seen as in the service user's best interests, particularly where clear lines of responsibility are being lost. Brown et al (2000) pointed out that the generic route was leading to an increase in boundaries between disciplines rather than a diminution of them in the community mental health teams they studied. Within CAMHS this experience is replicated, and it is not surprising that one of the recommendations of the 'Emerging Findings' (DoH 2003a) was that all CAMHS should have more robust management structures.

The issue of working across the boundaries and role blurring seems a common one in the English-speaking world, with community mental health practitioners working in broadly similar ways despite essentially disparate healthcare systems (Ashforth et al. 2000; Grigg 2001; Cowman et al. 2001) all coming to similar conclusions from differing backgrounds.

4.4.8 Professional Socialisation

Although it fails to include the concept of role in the construct, it is important to also bear in mind that professional socialization is a construct of role theory, with the emphasis more squarely in the sociological aspects of how individuals adapt to a societally imposed role. Hurley (1978) noted that the nature of socialization, from the role theorist's perspective, has largely been defined in terms of the learning of social roles. Such role prescriptions might come explicitly or implicitly from a variety of sources. In this area there is a difference between the schools of role theory, in that followers of Mead would define the socialization effect as prescriptive, but are learnt in an interactive manner in a two way process by which the learner of the role and the teacher of the role learn from each other and are modified by the experience (though to what degree in each case is not clear). Linton sees the process more as a one-way street, by which the learner either conforms to the expected social role or is excluded from the group. Within nursing, for example, it can be seen that conformity to the norm is expected to a large degree and rules are laid out at a national level by the Nursing and Midwifery Council (NMC), professional expectations of learning and understanding are imparted by the local Schools of Nursing within a University framework, and local cultural expectations are passed on by experienced staff in clinical placements. Conformity to the laid down regulations are tested formally and clinical competences or proficiencies measured by clinical staff. Public expectations and early socialization as to what might constitute the behaviour and

expectations of a good nurse will also play a part. The individual must learn to become part of this way of thinking, or they will not complete their training and become part of the workforce. During the process they imbue their own definition of the role with part of themselves as they adapt their personal identity to incorporate the conceptual framework they are learning. Within mental health the use of self is generally encouraged rather than a strict conformity to a stereotypical nursing ideal, based on Peplau's (op cit) model of therapeutic use of self.

Each professional training, however, has its own distinctive emphasis and the socialization to this professional norm leads to some of the differences within service delivery in mental health teams and in CAMHS. Defining this professional element, which is a very powerful influence, often at a subconscious level, on individuals is very difficult to achieve without resorting to stereotypes. The level to which it affects people can also be almost impossible to measure. CAMHS team members in particular will often have been exposed to more than one socialization process, their original professional one, and a supplementary one which derives from a qualifying training in a particular therapeutic orientation. It may also be that the personality and inclinations of individuals are likely to make them inherently more attracted to one profession or therapeutic orientation anyway, so separating out personality and socialization elements will be an extremely complex process.

4.5 Use of role theory in this study

The constructs outlined above give one basis for examining the qualitative material gathered from this study. Whilst accepting that role theory is not fully developed as 'grand theory' it does allow a series of constructs that are sufficiently developed and understood in sociological writing to be useful for us.

The literature review has highlighted the difficulty of differentiating between profession specific and generic or other-discipline specific areas of work in mental health teams and in CAMHS. Given the aim of the study is to examine the professional identity of team members, it is also important that we have some device for attempting to make sense of this differentiation. Biddle and Thomas (1966) developed a construct that is applicable to this as it focuses on the degree of specialization within any given role. They devised a categorization of the amount and type of specialization that can be applied to the work of mental health team and CAMHS practitioners. Their categorization is illustrated below (adapted from p34 *ibid*)

Figure 2 – Biddle & Thomas – Differentiated Behaviours

| Amount of Behaviour Engaged in. | Differentiation in a Given Domain of Behaviour | | |
|---------------------------------|--|-----------------------------------|-----------------------------------|
| | Many Differentiated Behaviours | A Few Differentiated Behaviours | Mainly Undifferentiated Behaviour |
| ALL | I Exclusivist Generalist | II Exclusive Multispecialist | III Exclusive Specialist |
| SOME | IV Nonexclusive Generalist | V Nonexclusive Multispecialist | VI Nonexclusive Specialist |
| NONE | VII Nonparticipant | | |

The 'Undifferentiated Behaviours' are those that only that a professional group (or in some cases an individual by virtue of their specialized training or experience) might perform. As an example, the domain of some psychometric testing is licensed only to clinical psychologists, so psychometric testing would be an 'Undifferentiated Behaviour'. In the unlikely event of a clinical psychologist within CAMHS claiming only to ever do such tests, and take no other part in the service, their contribution would be as a Type III Exclusive Specialist. More likely is that they would claim to do some psychometric testing and a larger amount of work which would be shared with other team members (i.e. family assessments and treatment), putting them into a Type VI Nonexclusive Specialist.

What we are looking to define for each professional group is whether there is anything common that would justify their being included in Type V Nonexclusive Multispecialist, rather than having no defining features, which would place them in Type IV Nonexclusive Generalist. This is against the political background discussed earlier, which suggested that staffing CAMHS primarily with Type IV Nonexclusive Generalists might be a good idea.

For each professional group we are also expecting to find where they fit within this spectrum of definition, if indeed professional groups fit neatly into such categorization. If there is a spread of individuals from each discipline fitting into different categories this will, in itself, inform us about the range of individuality being expressed in mental health teams and in CAMHS compared to a model where central planning and an effective understanding of skill mix is being implemented.

Unfortunately Biddle and Thomas' model is remarkably lax in their construct defining what 'All' , 'Some' and 'None' constitute. In absolute terms it is unlikely that many CAMHS staff will claim to be doing 100% or 0% of any activity.

Role theory, although not fully developed, and often used loosely, does have constructs which are useful for looking at how different professional groups perform within mental health and CAMHS teams, as in our case example. The particular constructs outlined

above can be used to develop ideas about the level of differentiated and undifferentiated work that is specialist and generic elements within mental health teams and in CAMHS. However there is a need for a more rigorous academic understanding if we are to fully understand professional identity creation and maintenance.

4.6 From Role Theory to 'Identity-Work'

Whilst role theory has many uses it also has flaws and shortcomings. Principal amongst these, as we noted, is the way in which role appears subjugated to the individual. The concept of identity as a useful way of examining how individuals perform a role, or understand their place within a team, has become much more important in recent literature on work. Within the remit of this study this can be refined to look at 'professional identity' and how individuals understand their contribution to the overall work of mental health teams and CAMHS.

4.6.1 General concepts of identity

At its most basic, 'Who am I?' is a central philosophical and theological concept with which humans have struggled since early times in an attempt to make meaning of life. The construction of personal identity, however, has become separated into facets of that struggle, and each element has been studied in isolation or in context to a greater or lesser degree. The most commonly researched areas in sociology, are:

- 1) Gender based (either as a basis for feminist research or in terms of trans-gendered persons);

- 2) 'racially' based, describing the experiences of different ethnic groups;

3) social class based (including research on constructed identities dependent on educational attainment) and;

4) age group based.

But identity is also a social preoccupation itself now, especially in recent times with the advent of internet blogs (weblogs), social networking sites like Facebook, Bebo and MySpace, and the massive popularity of reality television, whose essential focus is to lay bare the constructed identity of the participants (Richards 2006). Craib (1998 p.2) writes: *"The central feature of the self in modern society is its reflexivity, a constant questioning and reconstruction of the self in a lifetime project. We are constantly constructing and revising our personal stories and so reconstructing ourselves."*

In looking at professional identity, however, we need to recognise that a person's professional identity is no longer likely to be their only, or even their main identity. In the past it was possible to find people who would primarily construct themselves in this way: 'I am a miner'; or 'I am a teacher'. Society, however has moved a long way from this and it is no longer likely that any person will stay with the same employer for the whole of their working life, even if they stay within a certain type of work. Whilst Taylor (1989) could argue that the empiricists had developed a romantic concept of self which was linked to a responsibility to fulfil one's own destiny he is also clear that the development of psychoanalytic and postmodern ways

of thinking in the twentieth century have helped popular thought to move beyond this concept. No longer does everyone have a place within the natural order of things, but Freud, Jung and Lacan have studied the development of the unconscious and the attempt to make sense of individual identity. Lacan located this within social context as well as individual consciousness and entered the arena of discursive interaction. Most recently Nikolas Rose has attempted to critique this as an internal reproduction of meaning rather than any production of inner truths of themselves (Rose 1990).

4.6.2 Othering – ‘what I am not’

Davies (2003) sees the development of the power relationships within identity in terms of ‘othering’, in what she terms classic professional identity theory. Davies sees much of the identity theory (especially that used in healthcare writing) as related to comparison between one’s own identity and those around one. This is most classically seen in the early writings on the ‘Doctor-Nurse Game’ (Stein 1967, 1990), where the interaction between key clinical partners is compared and contrasted and the way that power is used within the relationship defines the roles that the different professional groups take. Even very recently the Mental Health Nursing Advisor at the Department of Health used the relationship between psychiatrists and nurses as a way of describing nursing practice (Brimblecombe 2005). Davies (2002a) also describes the way in which this tendency to compare and contrast with other professional groups can be divisive and unhelpful. By concentrating

on difference and attempting to find uniqueness, Davies claims, there must be an element of devaluing the 'other', which demeans the contribution of the 'other' in order to value the contribution of the self. This classical approach to self definition, therefore, although usually not conscious, is unhelpful by overly stressing positive attributes and negative ones too. Masculinity, for example, has been defined as rational and detached, compared to stereotypical feminine traits of empathy and intuition. The extreme characterisation of each, whilst maintaining insights into elements of their characteristics, disallows the interaction that each may bring by using parts of the 'other'. This has some resonance with the role theory construct of Biddle and Thomas (op cit), that some behaviours can be differentiated and held as the exclusive domain of one professional group or another.

In order to define the 'other' it is, of course, necessary, to have some concept of the qualities which are to be valued. The elements which professional groups have traditionally valued have also been those for which they are most likely to be criticised, in a much less deferential society. The classic possession of expertise and knowledge (often held in an exclusive manner), leads to a sense of trustworthiness, and ultimately to the possession of professional autonomy. The three go together because the exclusive possession of a body of knowledge means that others have to have a sense of trust in that knowledge, and consequently, if that knowledge cannot be questioned by those who do not possess it, then autonomy is

generated. There has also, in the past, been a sense that this knowledge is held in an altruistic way (at least within the UK health sector). This independence and personal responsibility has been rewarded by the public by the status accorded to healthcare professionals and the trust put in them. Recently, however, this has been more vigorously questioned, in the same way that other professional groups (such as lawyers, social workers and teachers) have come to be questioned as not always holding the public interest as their highest ideal (Foster and Wilding 2004, Aldridge 1994).

Davies (2002b) later went on to outline different elements of the tendency to contrast and compare between professional groups as a way of defining uniqueness, in looking at three specific 'others':

- the Incompetent other;
- the Invisible other;
- and the Unnecessary other.

In order to maintain an expert position, for example, it is important that others are 'incompetent' and do not have the expert knowledge that one professional group is said to hold by virtue of training, socialisation or research development, and key elements of professional identification. This devalues the other by underplaying what they may be able to bring to the healthcare interaction. A doctor, for example, may be an expert in pain relief, but the patient, who is not trained in medicine, will have insights into their own

unique experience of the pain suffered, which are vital in defining the outcome of a consultation. The creation of an expert position can also be seen in the development of psychotherapeutic practice, where individual psychotherapies seek to define their expertise in a particular mode of therapy to the exclusion of others who have not had 'sufficient' training. Early writing on family therapy, for example, stresses its utility for all types of worker (i.e. Smoyak 1975), but as the profession has developed it has become more exclusive and now defines itself as 'systemic and family psychotherapy' with only those trained to Masters degree level entitled to call themselves 'systemic psychotherapists' and register with the United Kingdom Council for Psychotherapists (c.f. editorial comment in Baldwin and Jones 2000). The use of language is important here, as 'family therapy' as it was originally called, becomes referred to as 'systemic psychotherapy' in order to emphasize the special knowledge and qualifications needed in order to practice in that field.

The concept of 'invisible other' is also devaluing in terms of simply ignoring the contribution of colleagues and workers whose own work is valued by the service user or client. Most often this is used in terms of 'support staff', who bring skills and contributions which are not valued because they are not the result of professional training, or an evidence, or research base. NICE guidelines, for example, use a definition of the value of different types of research which is scientifically based and values anecdotal or practice based evidence

very lowly compared to rigorous scientific methods like randomised control trials (c.f. NICE 2005 p.22). Those support staff who do not subscribe to the methods of the professional group, therefore are devalued as incompetent because they do not use the correct methods, and the contribution they do bring, often empathic, grounded, relationship skills, are not recognised as being as important. Clearly there are also links through to the difference in gendered values and the importance attached to those qualities here (see Boschma et al 2005). Clough (1998), for example looked at the role of home carers in relation to personal care, observation of day to day symptoms and change, mobility, washing and feeding. These activities and behaviours include strong elements of nursing care, yet they are at the bottom of the social care hierarchy, and the opinions of such workers are often ignored by better trained staff and their low levels of remuneration reflects their poor status and the value attributed to them.

In terms of the 'unnecessary other', Davies (2003) characterises the relationship between professional groups and healthcare management in this way. The change in political climate has seen the introduction of commercial values into healthcare provision. This change detracts from the powerful positions of clinical autonomy and self-regulation which most professional groups had managed to establish in the mid twentieth century. Foster and Wilding (2000) characterised this as a 'golden age' for professional groups, at a time when they had a professional mandate to exercise their

discretion in defining and meeting need. This 'golden age', they suggest, started to decline with the election of a Conservative Government in the UK which installed a new kind of manager, drawing on the commercial skills which had been used to good effect in the wider economy (Du Gay 1996), and this has continued with the New Labour Government's emphasis on performance management, measurement of outcomes (which implies a lack of trust in 'professional judgement'), and the overall project of 'modernisation' (i.e. DoH 2000b). This project also uses elements of 'othering' in contrasting professionalism which it sees as:

'paternalistic, mystique ridden, standard oriented and self-regulating', with a management task which is instead: 'customer centred, transparent, results-oriented and market tested'.

Elsewhere similar political movements have seen a diminution of professional autonomy, for example in the United States, where 'Managed Care' has had repercussions for practitioners, albeit in a very different healthcare system (Sullivan 1999). A political analysis of this move from respect for professional groupings towards a more flexible method has been characterised by Clark and Newman (1997) as the 'vilification of the old and idealisation of the new', in a new form of 'othering' that sees the two approaches as mutually exclusive.

4.6.3 Role blurring in identity work

Davies (2002b) sees the way forward from these antagonistic positions (whether taken consciously or unconsciously) as *'bothering about othering'*, and points to a more complex way of looking at professional identity than the traditional antagonism of 'othering'. Hall (1996 p4), has argued that identities are never unified, but are increasingly fragmented and fractured, multiply constructed across different and often intersecting, even antagonistic, discourses, practices and positions.

As noted in the literature review, policy direction within mental health has been towards the use of more generic working in multidisciplinary mental health teams and in CAMHS (i.e. Onyett et al 1995). This has been resisted by some, using classic role theory as an example of how role strain and role confusion can be detrimental to the individual's self identity and self worth. Others have seen 'role blurring' as a positive thing. Brown et al (2000) refer to the 'creeping genericism' of such teams and looked in some detail at the issues of professional identity and role boundaries. In the context of effective team working it was considered that an overly restrictive sense of professional identity could prevent the development of new ways of working. The study found that opinions were divided as to the value of the blurring of roles, with some respondents ascribing more value to their professional identity than others, who were more likely to embrace the concept of increasingly generic work patterns. The final conclusion of the study was that

increased role blurring actually made people think more about their professional role, and to act in a manner that was likely to accentuate the demarcation.

4.6.4 Organisational Control and Identity Regulation

Whilst role blurring may be the way forward in terms of understanding how professionals construct their own identity, there is also a body of work that seeks to look at how control is exercised by organisations, including governments, over this construction. Whilst we have touched on this before it is important to be explicit about the way power is used to influence the ways in which different individuals and professional groups seek to define their own identity. Fairclough (1992) contended that changes in organisational cultures, and the implications for this on construction of identity, were primarily changes in discourse practice. This follows on from the work of Foucault (1977) in defining the difference between what an individual might define as true knowledge, and what the predominant discourse allows that individual to articulate; predominant discourse is shaped by the organisation that has the power to define it. Parker (1989), therefore, argues that to use this in breaking free of the organisational control we need to embrace uncertainty and relinquish the expertise that allows the organisation to channel our thinking. Alvesson and Willmott (2002) pick up Du Gay's (1997) point that the merger of economic and cultural elements of work actually allow more control rather than liberate employees from the constraints of work identity. They argue that

the: '*...Language of liberation and self-actualisation may be promulgated as a seductive means of engineering consent and commitment to corporate goals.*' (Alvesson and Willmott 2002 p624). The process of increasing flexibility and 'multiskilling' of staff allows the questioning of traditional hierarchies and practices. However it is not that workers are merely passive recipients of the dominant discourse, and by their own discourse on the dominant culture they may create their own 'resistance discourse' with an alternative outlook on what is occurring around them. Avis (2006), and Bathmaker (2006) give examples of the way teaching staff have resisted 'corporate professionalism' where they see the values that they prize being undermined by the policy changes around them. Alvesson and Willmott (op cit) note the twin discourses of 'self-identity', which individuals create for themselves in the midst of the surrounding pressures, and the 'identity-work' of interpretive work which occurs through discourse to reproduce and transform that self-identity. Each of these are affected by the more dominant organisational pressure of 'identity regulation'. They claim that in order for the dominant discourse to effect change it must be linked to the discourse of the workers themselves, and their own processes of identity work and self-identity. They define several ways in which the organisation controls the discourse and shapes, therefore, the individual process of self-identity and identity-work (whilst recognising that individuals and groups may resist these pressures). Although Alvesson and Willmott (op cit) do not explicitly mention it,

this use of power also has links to the concept of 'linguistic capital' which will be examined in more detail in the next chapter.

4.6.5 Defining the person directly

This is the most explicit form of control, in specifically naming the role or job. The job description or title may explicitly set out the expectations and status of the job holder, and the clearer the definition, the clearer the degree of control. The way in which this is shaped may also be a form of control in enhancing or defining status. A 'middle manager' is still a manager, but is in the middle, and therefore subject to considerable control from 'above' in the hierarchical structure, for example. The use of generic job titles with no relation to a professional background and training will also reflect the intention to control a role more directly and concentrate on role performance rather than allowing the creation of a professional identity. The definition, by the organisation, of the role as different from another group (either within or outside the organisation) is a powerful way of establishing a *modus operandi* for the job. Jobs defined as being specifically masculine, for example, may imply a 'tough' approach that prevents incumbents from objecting to things they might otherwise have done, for fear of being seen as 'weak'.

4.6.6 Providing a specific vocabulary of motives (and explicating morals and values)

Alvesson and Willmott (op cit) also note that this is used to achieve an aim, by the organisation setting out a series of cultural issues to

which the organisation is said to subscribe, and then encouraging adherence to this philosophical underpinning of corporate values. By establishing a series of values and motives for the work being done, a culture is established where adherence to those values is put above 'selfish' motives of self-need, whether in terms of pay or personal advancement. Healthcare workers could see a particular resonance to this construction, in the policy imperative of always putting the patient at the centre of everything they do, for example. Promoting particular values and narratives is a way of orienting identity in a certain direction. This may involve a hierarchy of values, and specifically militates against any resistance discourse by putting active resisters in a category of immoralists. By resisting the dominant discourse, particularly where it is framed in this moral context and backed up by a strong team adherence to a central (moral) framework, the individual who seeks to create an alternative self-identity is made to feel somehow inferior set against the dominant discourse.

4.6.7 Knowledge and Skills

This is particularly important in a field where, as we have seen, one of the claims to professional identity is the possession of exclusive knowledge. By framing knowledge and skills in a more generic setting, as interchangeable building blocks, rather than as separate blocks of knowledge exclusive to particular professionals, it is possible to deconstruct some of the power base from which professional groups may work. The Knowledge and Skills Framework

for the NHS (DoH 2004c) and the National Occupational Skills for Mental Health (Skills for Health 2005) could be seen as examples of this kind of explicit attempt to reframe professional knowledge in a manner which extracts the power from the professional groups, whilst at the same time having used those professional groups to develop the standards.

4.6.8 Group categorisation and affiliation

This method is described as generating alternative social categories to which the individual is ascribed. By engendering a sense of belonging and community within a group of workers, and by implication setting a difference between 'us' and 'them', a group coherence can be created which may cause tension with previous affiliations. This new grouping may not have a particular values base, and therefore may not be in direct conflict with previous elements of affiliation and identity, but can be directly managed through management of shared feelings.

4.6.9 Hierarchical location

In most organisations there is an explicit or implicit hierarchy that is supported by symbolism and remuneration. Individual identity within the organisation is defined therefore by relative positions of superiority or subservience to other members of the organisation. Even in organisations where there is a nominally 'flat' organisational structure there will be informal hierarchies of experience, influence or personal charisma. Some progressive companies may downplay

the hierarchical structures that inevitably exist, or may shape the whole company as being 'elite' and therefore hierarchically superior to competitors. The way in which this hierarchical structure plays out within multidisciplinary teams can be multifaceted and related to implicit rather than explicit power factors. Long et al (2008) pointed out the underlying tensions within a nominally democratic team where actually professional identity continues to have a powerful influence on team functioning and hierarchy. Even where these professional identities can change to adapt to a team function they struggle within a wider setting that continues to reinforce hierarchies based on status.

4.6.10 Establishing and clarifying a clear set of rules of the game

Within organisational culture (as described by Alvesson and Willmott, op cit) this is the expectation of 'how things are done'. The naturalisation of rules and standards calls for individuals to adapt to a particular way of doing things. Often this will be a form of professional socialisation, but there may also be organisational differences that establish different ways of doing things and therefore contribute to identity formation. As an example it used to be that different hospitals would have their own view about how beds were made up and this group identity of how things were done 'here' served to mark nurses as 'belonging' to their particular institution, as opposed to the one across town. The learning of, adaptation to, and natural adoption of particular sets of rules and

mores marks the way in which identity may be forged, smoothing the daily operations of a particular organisation.

4.6.11 Defining the context

By describing a particular context for operating, individual identity can be defined. This wider contextualisation of an individual's or an organisation's situation invites employees, for example, to define their own identity in the context as described by the organisation, but using the context as the organisation chooses to describe it. An organisational 'Mission statement', for example, sets a context within which all staff are expected to locate their own purpose. These different forms of identity regulation may occur simultaneously and may contradict each other as well as complementing their own internal messages. In those cases it is for the individuals to make what sense they can of the dominant discourse. The potency of these messages is, of course, always conditional upon the individuals' receptiveness to those messages, but then again the staff members may have been recruited, in part, according to whether they fit in with the messages being disseminated by the organisation.

4.7 Identity Work and the creation of professional identity

Having looked at the way in which organisations can shape the identity of their employees, it is also necessary to look at the response of those individuals. Clearly, as Alvesson and Wilmott (op cit) have pointed out, the concepts are closely related, and interactive. Sveningsson and Alvesson (2003) point out that identity work occurs in social and discursive contexts. It is assumed that these contexts are constantly shifting and uncertain, so that the identity work is also an ongoing project in response to the changing situation in which the individual or group find themselves. In some ways the groups we are particularly concerned with, in multidisciplinary mental health teams, are more coherent than others. Alvesson (2001), for example, looks at developing work groups where the commonality of the group has far more ambiguity, and contrasts this with professional organisations that, he claims, are characterised by the relative homogeneity of the professional group. Identity work in relatively stable professional groups may lead to uncertainty, but that would derive more from there being competing discourses as to how to construct a current identity that fits with personal self identity. By use of a case example Alvesson (op cit) seeks to place identity work as a constant struggle, but a productive one. He argues that individuals seek stable identities, which assume that individuals strive for comfort, meaning and integration as well as some coherence between self-definition and the work situation. These insights, from an organisational perspective can be seen to have resonance in healthcare settings.

Butler (1990 and 1993) felt that identities were largely performative, and that those identity performances are broadly shaped by social sanction and taboo. Within healthcare the social context of what makes a 'good patient' or a 'caring nurse' is particularly powerfully loaded (Brown et al 2006). For healthcare professionals then this social context and the value attributed to professional identity by individuals, and by those for whom they care, should not be underestimated.

Lemke (2008) notes that there are different elements to this complex performance of identity. He suggests that there is a difference between longer term identity, which constitutes a pattern across time and situation, and those shorter term identities which play out in relation to particular events. In this he links identity creation to the ideas of Pierre Bourdieu (which will be examined in the next chapter) about the creation of a 'habitus' that shapes long term identity formation.

Crucially this concept of 'identity-work' needs to be related to the healthcare professions and specifically to mental health care teams (including CAMHS). In the literature review it was noted that this is now starting to happen (particularly Brown et al 2000 and 2003), but that it is particularly difficult for staff in community settings where role blurring is more prevalent than in hospital settings. Whilst there are many examples of role descriptions within healthcare teams, the number of attempts to describe what Tracy

and Naughton (2000) describe as 'identity-work' are still very limited, probably because of the difficulty in defining that work. Tracy and Naughton (op cit) suggest that much of what can be learnt from practitioners comes from their 'small talk', the ways in which they describe their work in conversation. This emphasis on 'small talk' and the use of language will be examined more closely in the next chapter as the choice of methodology is explained.

Chapter Five - Methodology

5.1 General Qualitative background

The arguments for purely quantitative research and the benefits of qualitative research have been well rehearsed over the years (i.e. Polit and Hungler 1993, Morse and Field 1996, Robson 1993, and Brown et al 2003). Primarily research looks now to what is the most appropriate method for the research aim, and to establish a good fit between the intended outcome of enquiry and the method best suited to achieve that aim (Robson 1993). This study is looking at establishing new knowledge about the nature of how people construct their professional identity. The following pages therefore make an argument for the use of one particular form of qualitative enquiry, Critical Discourse Analysis as the best fit of method to the aims and objectives of the enquiry.

5.1.2 Qualitative methods

The nature of the knowledge to be uncovered within this study is not seen in a positivist manner. The philosophical position from which I start is an interpretivist one, based on the idea that the world is separately and uniquely constructed by each individual on the basis of their experience. There will naturally be areas of commonality that will be highlighted, but essentially the argument will not be one of establishing a single answer, or series of answers that will be generalisable. The validity of the arguments developed will be in the resonance, or otherwise, that they generate within the

people affected by these issues, and the thesis is designed to be a contribution to the debates on professional identity within mental health workforce and CAMHS. This development of ideas and the inherent validity of those ideas can only come from a qualitative approach that seeks to gather the views of the people affected and set it in the context of the constructed world in which they operate. This social construction, within the health service, is guided by the policy context which establishes and regulates the operation of the health service, and which provides the commonality of context within which practitioners operate. The arguments for the use of qualitative research within health settings, despite their lack of generalisability, have been well made over the years (i.e. Silverman 2000, Denzil and Lincoln 1994, and Miles and Huberman 1984). The rest of the chapter will focus on the philosophical underpinnings of this approach, and the choice of a specific method for this particular enquiry.

5.2 Philosophical underpinnings

Having alluded to the need for a social constructionist view of the world order to make sense of how people construct their own personal and professional identity it is important to put these ideas in context. Social constructionism is a broad term used to describe the twentieth century philosophical move towards relating all human experience to what individuals can make sense of for themselves. In this respect it assumes that these realities will not all be the

same for each individual because each person is different and shaped by a variety of experiences and social contexts.

Philosophy worked its way from a purely empiricist and positivist position which derives from the Renaissance, through the history of western philosophy, to current 'postmodern' positions. The beginning of the twentieth century was marked by social upheaval caused by a number of structuralist movements, most notably Marxism and the accompanying communist political systems. Marxism, alongside other structuralist philosophies criticised the use of science and positivist thinking, through its claim that science was the most authoritative, even the only, source of knowledge. The relationship between exclusive claims of knowledge and its use as a form of power over the people was given a personal and individualistic twist, though expressed in political terms (Benton and Craib 2001). At the same time Freud's thinking about how the current experience affects and changes the past within a psychoanalytic framework was of great influence in the structuralist movement (Lechte 1994). The relation between personal experience and how we perceive the world and react to it was further developed by Lacan, who stressed the importance of language within Freud's work. Lacan stressed that language has the capacity to say something other than what it says, that language speaks through human beings as much as they speak through it (Lechte 1994). Whilst Lacan sits within the structuralist tradition his

contribution to the development of this thought is to emphasise the effect of language on human behaviour (Brockelman 2001).

Within postmodernist thought the influence of Michel Foucault has been critical in the interpretation of history, power, and the individual's place within society. Foucault tied together the themes mentioned already in 'The Order of Things' (1966), in which he posited that, if the present is in a state of re-evaluation in the light of our experience, then the past must also be continually revisited, and that to write a history of the past is to see it anew in the light of contemporary experience. This thinking developed into Foucault's link between the exercise of knowledge as power. Foucault's central preoccupation with the ways in which power is exercised within society have been of great influence since he first wrote them. In 'Power/Knowledge' (Foucault 1977) he created a difference between structuralist interpretations of power, where a single block of power interests create a situation with a single intent (i.e. the Marxist theory that capitalists control the means of production) and a position where power emerges as the result of a number of individual or group interests and intentions, which may be either convergent or divergent. Thus, in order to understand what is going on in any given situation it is necessary to understand the motivations and interests of a number of different parties and how these lead to the current situation. Thus the emphasis changes from monolithic social control to a situation in which social order in the modern world relies more upon the internal disciplining of the

individual. We are not made to behave in a certain way, Foucault argues, but we make ourselves behave in that way. The very ideas of choice and freedom that we hold so dear thus ensure that we actually act in a way that is subordinate to the created norm or identity. The use of purely Foucauldian thought processes in studies of identity and organisational theory, whilst hugely influential, has been criticised for not adequately addressing issues of individual agency. Implicit in Foucault's arguments is the notion that resistance to power is still part of the same system, that resistance is never in a position of exteriority to the power that is present. Since Foucault's death the increased interest in 'identity-work' has led to more thinking about the possibilities for autonomy, resistance discourse, and individual struggles against systems of power (Brown et al 2006). As we will see below in more detail Fairclough (2005) looked at the need, particularly when Critical Discourse Analysis is used in organisational studies, to adopt a more 'realist' stand towards the world that is being investigated, recognising the existence of power structures within their social context.

Pierre Bourdieu's contribution to health care communication and to the understanding of identity creation within professions is also important. His work creates an understanding of the symbolic structures around us and how they affect an individual or collective understanding of the social world. As a sociologist rather than a pure philosopher Bourdieu also adopts a realist stance towards the the investigation of social phenomena. He proposed, for example,

that research methodology is a process through which one constructs 'objects of research' (Bourdieu and Wacquant 1992). In this respect the emphasis is on yielding coherent objects of research, and the process of constructing those objects involves selecting theoretical frameworks, perspectives and categories to bring to bear on the research topic, and which can make sense of it.

Specifically Bourdieu focussed on language, categorization and labels, with their systems of reproduction and transformation. Bourdieu posited that an individual's mental schema is an embodiment of social divisions, distinctions and categorizations, thus linking the social and cognitive. He also saw this as serving an important political function, that symbolic systems were not only instruments of knowledge, but of (political) domination. The medical emphasis on diagnosis, for example, gives the power (as well as the knowledge) to the medical profession by driving a wedge between the professionals and those whom they ostensibly seek to 'serve', and thus reinforces the social order. From this Bourdieu also posited that essentially these systems of classification are sites of a social struggle for power between groups and individuals, so that the promotion of very fixed groupings such as professions, ethnic groups and treatment groups (those affected by particular medical conditions) leads to divisiveness and difference in power relationships. The essence of how language is used to enforce these power imbalances was central to Bourdieu's understanding of the way in which social power is used (Bourdieu 1992). The

understanding of how 'symbolic power' and 'symbolic capital' (often called linguistic capital) are used depends on the social value attributed to certain things, such as knowledge, practice, economic resources or political power. Each of these might be given different weighting by decision makers, for example, in determining how health care is provided (depending on the prevailing political climate) and thus affects things like team compositions and workforce planning.

Bourdieu further elaborated on this by developing three concepts which directly affect this study. He looked at 'fields', defined as *"..the networks of social relations, structured systems of social positions within which struggles or manoeuvres take place over resources, stakes and access."* For the purposes of this study this relates to the different fields that different professionals might occupy depending on how much capital they have acquired through the amount of prestigious language and social practice they are able to perform. The tensions between different professionals (as individuals or groups) may therefore be directly related to their use of language to defend or reinforce their status (social capital) and position within the healthcare system. Bourdieu, however, recognised that these fields are constantly changing dynamic social microcosms that adapt to their circumstances and their relationships with other field groupings. Drummond (1998) suggested that this can be applied specifically within healthcare to different organisations (and professional groups) as 'subfields', within a

larger field. Thus each group creates a space in which the social game takes place as each group (or individual) jostles for position.

This is further refined by Bourdieu to relate to individuals by virtue of their own 'habitus' as embodied by individual social actors within the larger field. This concept relates to individual reactions to the wider social game according to their (individual) feel for the rules of the game. Habitus can exist as mental schemata, as a matrix of perception, appreciation and action, and crucially is usually so deeply imbued within an individual that their ways of reacting to the social game are deeply subconscious rather than overt: it is simply what they see as a 'common sense' reaction to a situation. This habitus, as with other areas, is not a static creation, but is a dynamic reaction to a whole array of different influences, and will change according to experiences that may reinforce or modify an individual response. Clearly there are strong links between field and habitus, the one having a strong influence on the other, but there can also be a reflexive changing of the field based on the individual's influence on it. The individuals may act as social agents to change the field either consciously or due to their actions that may be unconscious.

Finally Bourdieu developed a complementary concept, that of 'doxa', which relates to how committed an individual is to the 'rules of the game', and thus how easily they will go along with those socially constructed rules. This can also relate to political use of the rules to

exercise power and influence the outcome of collective decision making and will be important for this study when looking at the explicit use of particular phrases and ways of thinking, in order to further the aims of a particular direction of policy. By utilising the 'doxa' of public thinking or vocational professions, for example, it is possible to undermine opposition to a direction of travel.

5.3 Linguistic methods of analysis

Having focussed on language as a way of analysing the meaning inherent in what people say, think about and write on their identity, it is necessary to be clear about which methods are most useful for this particular study. Qualitative methodology, as applied within health research, has traditionally focussed on the lived experience, rather than the language used to express that experience. Studies using phenomenology, for example, use the philosophical and hermeneutic methods to find meaning in the experience (i.e. Crotty 1996, Walsh 1999, & Geanellos 1998), and ethnomethodology has also been used to try to comprehend the human understanding of situations (i.e. Strauss 1963, Taylor 2003). These methods have their place within health research, and grounded theory, in particular, is a popular method (Strauss and Corbin 1998). These methods, however, have little scope for including external reference points, such as the relation of policy to practice, which is central to this study.

The field of linguistic studies offers more variety in techniques in the study of discourse, and is closely related to philosophically based techniques of investigation. Whilst philosophical investigation, such as Ricouer's examination of the hermeneutics of narrative (Ricouer 1984,1985,1988), has much to offer, it is essentially an abstract method, which does not focus on individual narratives and research techniques in a manner which makes it usable in health research terms. Linguistic analysis of specific discourse, both written and spoken, offers tools for health research that can be more readily applied to this question.

Within linguistics, and specifically applied linguistics, there are a variety of tools that have been developed with research in mind. They include quantitative tools, such as corpus linguistics (see Reppen and Simpson 2002, Baker 2006), as well as more qualitatively focussed methods. Some methods, such as conversation analysis (e.g. Woofitt 2005) focus very closely on spoken language, and as such would be useful for analysing the spoken, though not the written policy element of this study. In addition conversation analysis has been criticised for focussing too closely on the content of individual spoken discourse, and failing to give enough attention to the social and political context of that spoken discourse (Titscher et al. 2000).

Recently there has been an increase in interest in using linguistic methods for analysing health communication, and an understanding

is being developed that there is a place for this use of linguistic methodology within the health domain. Crawford et al (1998) set out the practical basis for the use of linguistic methods, and have defended that thesis (Crawford & Brown 1999) against those who contest its place in the pragmatic world of nursing, for example (Clark 1999), and emphasizing the need for 'evidence-based communication' (Brown et al 2006).

5.4 Critical Discourse Analysis

5.4.1 The influence of Norman Fairclough

Having looked at the background to the use of linguistic methods in health settings it is important to move onto the method that seems most appropriate for this study. Jaworski & Coupland (1999) note that all forms of discourse analysis adopt a '*critical perspective in language*', but that not all such writing would call itself critical discourse analysis.

It is, of course, true that many methods of qualitative research are ultimately dependent on a form of textual analysis for their final conclusions. This may, for example, be a thematic analysis of notes collected for an ethnomethodological or grounded theory study, or of transcripts of structured interviews. Titscher et al (2000), for example, identify these approaches amongst a wider group for which they see applied linguistic approaches as appropriate. They also identify other specific approaches to linguistic analysis as

sociolinguistic analysis and functional pragmatics. The application of such linguistic approaches, and particularly the use of conversation analysis, has been criticised within social sciences as putting too much emphasis on the language elements of the discourse. Whilst we have argued that language is an instrument of change and a method of exerting power and influence the social context in which this is done is also vital to fully understand the way in which language is used. Conversation analysis, for example, puts emphasis purely on the words presented in conversation and avoids looking for contextual markers which might inform that analysis. Whilst some authors (e.g. Woofitt 2005) have argued that conversation analysis might be used to look at how power is exercised, for example, within verbal exchanges, they fall short of applying the tools that a critical approach to discourse analysis allows for the wider sociological interpretation of discourse.

Whilst Fowler (1981) may be seen as the likely originator of this style of work, it is undoubtedly the work of Norman Fairclough that has led to a distinct body of methodological work known as Critical Discourse Analysis (CDA). Fairclough (1995) theorised that 'ideological discursive formations' (IDFs) were formed in a social context, usually by the dominant social group, and that these IDFs then became subsumed into what society takes for granted as 'common sense'. In this way social structures determine properties of discourse, and discourse in turn determines social structures. The goal of critical discourse analysis is therefore a politically based one

because to see through the predominant IDF is to 'denaturalise' it from its social and political context. The processes of naturalisation and the critical denaturalisation of discourse, however, are dynamic, implying a struggle between social arrangements and acts of imposition and resistance to that imposition. Fairclough's use of language analysis is deeply rooted in postmodernism, and is closely related to the Foucauldian interest in institutional power. As his methods developed, however, he was keen to distance himself from purely Foucauldian methods. In his later work (i.e. Fairclough 2005) he argued for a more 'critical realist' stance, and suggested that methods of discourse analysis which fail to embed themselves in the very real world of social and political structures cannot hope to do full justice to a critical analysis of discourse. Whilst retaining an interest in close textual analysis the realism inherent in Fairclough's approach is demonstrated through this attention to immediate social context and broader political concerns.

In 'Language and Power' (Second Edition 2001) he is explicit in his political analysis, and his illustrations of CDA in practice are often rooted in explicit critiques of political reporting (i.e. *ibid* Chapter 7 Creativity and struggle in discourse: the discourse of Thatcherism.) However it is not necessary to share Fairclough's political views in order to use the method that he proposes, because inherent in the system is the thorough explanation of how conclusions are drawn, which leaves the reader to then construct their own reality around what is written. Whilst Fairclough is keen to avoid reducing CDA to

a tickbox system for analysis, he is strongly in favour of its use as an interdisciplinary method rather than restricting it to a purely linguistic endeavour. Thus he has been clear in looking at its application to all forms of social research, for example in 'Analysing Discourse' (2003) he produces a 'manifesto' for the use of CDA in social research, which consists of what he considers to be the most significant areas of analysis that should be applied to texts. Phillips and Jorgensen (2002) identify three key concepts in Fairclough's work: the text; the discursive practice; and the social practice. Analysis therefore should concentrate on the linguistic features of the text (text), the processes relating to the practice and consumption of the text (discursive practice), and the wider social practice to which the communicative event belongs (the social practice).

5.4.2 Other CDA authors and uses

Fairclough is not the only person to have applied CDA to social analysis or to healthcare settings. Its application has been seen as a way of developing an awareness of the facility for linguistic analysis to be used across a wide variety of disciplinary settings. Teun van Dijk (2001) has argued passionately for CDA to remain a flexible tool which can be applied by non linguists and integrate the influences of different authors and approaches. Both Wodak (2001) and Meyer (2001) separate out the possible ways of applying CDA to an analysis of socially relevant material which takes into account the context from micro to macro levels, and even Fairclough himself

allows different interpretations of his style of using CDA at different stages of his published work on the subject, giving different levels of detail as being useful in different forms of analytical work.

5.4.3 The Practical Use of CDA

Whilst Fairclough and others have wanted to avoid a tickbox approach to CDA he did, as we have seen, produce a summary 'Manifesto' which highlights the key areas for analysis of text and spoken discourse (Fairclough 2003). This is within the context of his desire to see CDA as an interdisciplinary exercise, not just one for applied linguists, and he continues to stress the social aspects of the analysis as well as the more technical linguistic approaches.

5.4.3.1 Social Events

Within a postmodern context all discourse within CDA is seen as part of a social event. Whilst there may be a greater or lesser degree of social interaction involved, the key element is that discourse cannot be separated from the social event by which it gains meaning. A book that is never read loses much of its connection to its social context, but it has still been produced and deposited in a social context. The production of discourse therefore takes place socially, produced by agents who are socially constrained (but not totally socially determined), and received or consumed by others who are also socially contextualised. The social structures in which discourse is produced also strongly influence how discourse is shaped, and how it influences those for whom it is

produced (or those it reaches, even if not originally produced for them). Fairclough also refers to this concept as 'orders of discourse' and sees this as a way of exerting control, through discourse, in a linguistic way through the production of text and spoken discourse.

5.4.3.2 Genre

The concept of genre describes the format in which a particular text is created, although it is recognised that there are not always strict rules or conventions by which to judge the genre. Texts often have a strict, almost ritualised style and genre, against which they are judged, as in the case of formal academic scientific writing.

Departure from the recognised style would only be contemplated in order to make a point, whilst normally editorial style would ensure consistency of style and presentation. Most other genres are less formalised, although there would also be a recognisable genre feature of newspaper reporting, for example, with slight differences of style between newspapers designed to reflect their perceived readership. There are two main parts of the analysis of genre within CDA. The first concentrates on genre structure (of 'genre chains' and 'genre mixtures'), whilst the second part draws on more detailed textual analysis to look at the relationship between textual elements and the way they incorporate intertextuality.

In terms of genre activity the concentration is on the intention of the textual creator within the genre. What is the intention of the writer (or speaker) when they choose a particular genre of

discourse? The intention therefore is to look at what is the purpose of the discursive activity. There is also the possibility of hierarchy of purposes within the textual activity; that there exists a primary purpose to the creation of the discourse and a secondary (or tertiary) purpose also.

It is worth noting at this point that for the purposes of this thesis there will be two main genres to examine, the policy document and the research interview, so the concentration will be on aspects of discourse creation within these two genres and how they relate specifically to professional identity discourse.

5.4.3.3 Difference

Primarily this category of analysis is in respect of the discourse's apparent openness to recognition of, and acceptance of, difference. Hence the need to examine the discursive reference to alternative ways of approaching the subject matter, an understanding of alternative ways of approaching the subject and dialogue with this alternate paradigm. The absence of reference to alternate ways of understanding a subject, for example, might betray a lack of analytical rigour on behalf of the creator of the discourse.

Alternatively it may be that the discourse creator is deliberately attempting to portray their own version of events as the only possible interpretation. Failing to countenance different ways of relating to the subject matter serves the purpose of dismissing those ways of thinking, and is again an exercise of power. By

making overt the assumptions inherent in the text in relation to difference, the analyst can draw conclusions as to the intention of the discourse creator.

5.4.3.4 Intertextuality

Closely allied to the examination of difference, but specific to the use of text within the discourse is the issue of intertextuality. The examination of the discourse's use of other textual, cultural or social references shows an orientation towards the original text. The ways in which other texts are used can be examined and critiqued. The use of direct or indirect quotations and referencing of source material may be a feature of genre (as noted above, and inevitably there is overlap in each of these categorisations of analysis), so the way in which source material is used in academic papers is very different from the practice of journalists, for example. In particular it is important to distinguish between direct reporting which would be very explicit, including direct attributed and referenced quotations, and indirect reporting which might summarise the content of a previous document or speech act rather than giving an exact report of the words and phrases used. Clearly it is often easier and quicker to do the latter, though it does rely on a level of trust that the summariser accurately reflects the intention of the original discourse, as there will inevitably be a level of interpretation in the indirect report which does not allow the recipient to draw their own conclusions from the more direct reporting style. Sometimes this

indirect reporting may add to the discourse, for example by reporting ironic or sarcastic intonation in a speech act which may not be easily determined from a direct report (i.e. *'That's nice, isn't it...'*). Indirect and unattributed reporting, however, may also be interpretive without allowing the recipient to decide for themselves what the actual intent of the original author was. Journalists reporting on medical breakthroughs, for example, have an intention of creating an interesting story for the readers of their newspaper, website or other medium, and would look for an attention grabbing element of a medical report without necessarily reporting the more cautious conclusions and intent of the academic authors. It is even possible to use intertextuality as a way of misleading people, for example the habit of theatres to quote very selectively (using a word or phrase out of context) from critics' reviews when advertising their productions.

5.4.3.5 Assumptions

Assumptions within discourse can take one of three main forms. There is, within such assumptions both the inherent need of social cohesiveness and the capacity to exercise social power by the dissemination and propagation of what is assumed to be good and desirable, for example. Fairclough identifies the three main assumptions to be:

- Existential assumptions – assumptions about what exists;
- Propositional assumptions – about what is or can be, or will be the case;
- Value assumptions – about what is good or desirable.

To a certain degree there is a need to make assumptions within text and discourse, for explaining each of the underlying assumptions of every discourse may be an unnecessarily lengthy process. It is a reasonable expectation that readers of certain types of texts, or consumers of different forms of media might have some understanding of the stance of the producers. The producers of journalistic text on Fox News or CNN will make different assumptions about the political and philosophical worldview of their consumers than those reporting for Al-Jazeera, for example. Likewise readers of scientific papers will be expected to have a positivist view of western science and some understanding of the principles and assumptions of that discourse.

5.4.3.6 Semantic and grammatical relationships

The concentration on semantic and grammatical relationships may appear esoteric for social research, but it has its basis in the issue of social exercise of power. This is particularly important for this thesis in terms of policy discourse, as the central discussion is of the use of language in legitimising the text, or establishing its authority. Particularly as this thesis looks at how change processes are introduced, and how the subjects of the proposed change react to it, then the way in which the changes are 'sold' to them through use of

language becomes central to the analysis particularly of the policy discourse, but also in examining whether the subjects respond on a conscious level to the language used to 'sell' the changes.

Within this part of the analysis the emphasis is on how semantic relationships are established, through causal, conditional, temporal and other semantic relationships (i.e. additive, elaborative and contrastive or concessional statements). The way in which the text is constructed is therefore used to examine how the authors of policy documents might generate, for example, a plausible argument for the changes they propose, or use the language to forestall anticipated obstacles or challenges to the proposed change process.

5.4.3.7 Exchanges, speech functions and grammatical mood

The use of this category of analysis is less obvious within this thesis given the nature of the two main forms of discourse being examined, but it does relate to the research interview section in that the participants of research interviews are aware of the function of the exchange (for the researcher to ascertain the interviewee's views on a certain subject). In this respect the functionality is clear, but given that amongst the interviewees in the study were a number of the authors of policy documents, it could be expected that what Fairclough calls 'promotional culture' might occur, that the authors would seek to promote the ideas inherent in the documents which they had helped to create, and seek to play

down criticisms of those documents, again to legitimise the ideas they promote.

5.4.3.8 Discourses

Although the whole exercise is about discourse in its broadest sense, there remains a central need to identify and characterise the discourses used within the subject matter. The particular use of metaphor as well as vocabulary is important, in the ways that metaphor can produce an emotive response, for example, or build up an atmosphere of measured reasonableness as a way of persuading the reader or consumer of discourse of the validity of the argument presented. Fairclough again emphasises this as an important element within the political analysis of discourse, for example in the way in which political persuasion is dressed in emotive metaphor as a way of trying to generate an argument that is hard to dispute. Given that much of the policy discourse examined in this thesis is set within the context of a change process within government funded public services, then, this element of analysis again becomes important.

5.4.3.9 Representation of social events

This element of analysis concentrates on the representation of how social activity is created or actioned. The focus is primarily on agency and process, again very important for the change processes and reactions of the 'social actors' that forms the basis of this study. The emphasis is on how language is used to create an impression of

structures, and reactions to policy change. For the purposes of this study, for example, there needs to be an examination of the way in which policy documents explain the need to change and possible reactions to it. If, for example, a monolithic structure is created whereby there is only one possible reaction offered, then the reaction of the social actors affected by this change might be one of resentment that they do not have an option (given that in a postmodern world most people like to have a sense that they have sufficient agency to enact elements of choice within their lives). The way in which social structures relating to government provision of mental health care, and the staffing of those teams, in our case, can be examined within the context of the way in which policy documents set out proposals for the use of such teams, and the structures that are set up to enact and 'deliver' services.

5.4.3.10 Styles

Fairclough defines styles as "the discursive aspects of ways of being, identities." (Fairclough, 2003, p159). This is central to the thesis, but can be seen through textual methods, in particular the words used to describe self-identity. As we have seen, construction of identity is a complex area combining personal and socially constructed elements. It is important to look, however, at particular grammatical structures and the vocabulary used to describe identity as levels of abstraction.

5.4.4 Reason for choice - summary

To summarise then, there are a wide variety of qualitative methods that could have been used to examine the documents and responses that form the central research question of this thesis. Critical Discourse Analysis has been chosen as it provides the best fit of method to the material that is being examined. It takes into account a wide variety of tools for the examination of the texts produced by government and the words used by policy makers, implementers of policy and those affected by the policy. It allows an examination not just of the words used, but also of the social and political context in which the policy change has been created and consumed, and gives tools for examining in detail the identity issues which arise for those social actors who are ultimately affected by the change.

5.5 Method and process

Having settled on a methodology that suits the aim of the study, it was necessary to select texts that best represented the policy discourse on workforce policy within mental health and CAMHS, and to seek the reaction of practitioners and others involved in the creation and implementation of that policy.

5.5.1 Sampling

The initial aim of the sampling was to get an idea of the areas that would be important to the groups involved in creating and implementing workforce policy as well as those who are affected by it. The initial phase was to create an email questionnaire which would inform a later interview phase, and which would allow an indication of which documents would be most important to analyse using a Critical Discourse Analysis method. The interview phase was designed to allow a free discussion of the issues with a national sample, in order to gather a wide range of views.

5.5.1.1 Email contact

Given that the policy shift is current, a Delphi method was used to establish contact with policy makers, implementers, and practitioners in this field within England. The initial sample of people who were emailed (the policy makers) was taken by reviewing literature, as above, and using the names mentioned as authors of documents, or named in public sources as authors. For example, whilst in preparation and consultation, the National Service Framework for Children had a series of External Working Groups, so

the membership of the group working on children and young people's emotional well-being (which eventually produced Standard Nine of the NSF) was publicly known. During the consultation period email addresses of the External Working Group members had been published as a way of views being gathered. Where document authors were known and the institutions for whom they worked were available, the websites for their institutions were consulted and the publicly available email addresses used. Other institutions and public bodies, such as the National Institute for Mental Health in England, the Centre for Clinical and Academic Workforce Innovation and the National CAMHS Support Service also had publicly available websites which contained the email addresses of staff. The National CAMHS Support Service had been set up to oversee and help with the implementation of the NSF for Children, Young People and Maternity Services, so this provided the source for the 'implementers', primarily Regional Development Workers for CAMHS.

These initial contacts were sent an email asking them three things (see Appendix 1 for exact text):

- 1) what they thought were the key texts on mental health workforce development within the NHS currently and recently;
- 2) who else did they think I should be asking this of;

- 3) and whether they would be interested in partaking in an interview in more depth in the issues of professional identity in multidisciplinary mental health teams.

In total 125 emails were sent, of which twenty-three received automated 'Unable to deliver' messages, despite best efforts being made to ensure these email addresses were as up to date as possible. Of the remaining 102 there were ten full replies, fifteen short replies saying people were unable to help, and seventy seven went unanswered completely.

The responses from this initial email were then used to determine the texts for analysis and to gather the expert sample for interview. As the response from the email survey was so limited a note was kept from the interview responses in order to further refine the policy texts to be used, based on frequency of mention of specific documents.

5.5.1.2 Interview sampling

From the above it was possible to identify a group of expert policy makers and current implementers of policy for more in depth interview. However it was also important to gather current practitioners in order to get a view of how policy was being implemented on a day-to-day basis. Some of the policy making and implementing group were also practitioners, having day-to-day clinical practice as part of their job. For the rest of the sample a

group of practitioners was used as a purposive sample, as they had previously expressed an interest in this area for a similar piece of research. They were contacted by email and letter and asked if they would be interested in taking part in this project, and arrangements made to visit them in order to interview them at a time and place convenient to themselves.

5.5.2 Sample size and interview structure

The purpose of the interview cohort was to generate a variety of discourses on the current operation of the policy and how it was affecting the professional identity of staff working in multidisciplinary mental health care (particularly relating to child and adolescent mental health care). The balance between policy makers and implementers and current practitioners was important, as was the avoidance of 'group thinking' that might distort the richness of the discourse generated. It was also important to allow as much free expression as possible. In order to gather a wide range of views a sample size of thirty was the initial aim, with a geographical spread across England.

With this in mind an open interview format was used, but with some constraints. A framework was generated which followed interview principles of easing the respondents into the interview by asking more factually based questions initially and then inviting them to move the discussion forward within the area set out. The interview schedule did, therefore, follow a very loose format which still keeps

it within the description of an open interview rather than a semi-structured one (see Appendix 2 for schedule used). Each interview therefore began by establishing the respondents' professional background and their current job title, as demographic background. They were then asked what they knew of current workforce development within mental health in England and what they thought were the most important documents currently and recently shaping those changes. These responses were used, alongside the email responses, to validate the choice of documents for analysis. The responses to this section were quite varied, which allowed a much more free flowing open interview for the bulk of the interview time.

The interviewer made a deliberate policy of minimal intervention during the interviews, allowing each respondent as much time as they liked to discuss the current situation. The interviewer did pick up on things that the respondents said, however, and invited them to expand on certain points, or clarify issues, but again did so in a minimalist way, in order to get the maximum richness and diversity from the discourse of the respondents. As a result the interviews lasted very different amounts of time, depending on the focus of the respondents, varying from thirty-five minutes to sixty-five minutes. As a way of rounding off the interviews, and ensuring that the respondents had the opportunity to express themselves freely the last two questions tended to be similar for all cases. The penultimate question was normally to invite the respondent to speculate where mental health workforce issues would be in 'five to

ten years'. The last question was always to see if there were any questions the respondent had expected to be asked, but which had not come up so far in the interview. This was designed to ensure that areas of interest to them were available for discussion and to avoid the interviewer having subconsciously shaped the content of the interview to the exclusion of potentially useful areas of discourse. The interview was piloted on one person (an employee of the Centre for Clinical and Academic Workforce Innovation), and minor refinements made as a result of this interview, primarily the addition of the last question allowing respondents to cover areas they thought might have been covered, but which had not been.

5.5.3 Recording and transcription

All interviews were recorded both on audio tape and on video tape, with an explanation given to respondents of the need to ensure backup recordings of each interview. It was also explained that under the methodology being used it was the words recorded that were of importance and that no formal analysis would be made of the video tapes for body language or visual cues. After interview the audio tapes were transcribed and the video tape used as a backup source for clarification of any indistinct words. A simple transcription method was used which recorded emphasis and timed pauses for reflection and thought (see 'Note on transcription conventions' p.12). The transcriptions were analysed using N'Vivo 1.3 software as a medium for sorting and coding the texts. The document texts

selected for analysis were also used in electronic format to allow sorting and coding with the same programme.

5.6 Limitations of the methodology chosen

Whilst this study has sought out leaders in the field and a representative sample of practitioners from a particular practice area, the findings of this research can never hope to be fully representative of opinion within a complex and rapidly developing field. Within the postmodern philosophy in which this research is conducted there is recognition that the conclusions drawn are inherently interpretivistic, and alternative interpretations are possible. The methodology, whilst seeking to address this, can never fully overcome the argument that a different sample would have given different results, and can only seek to be as explicit as possible about the interpretations given throughout the analysis and the reasoning that leads to the conclusions drawn.

A further limitation on the use of CDA was the size of the corpus generated for this study. The methodology generated a consensus around three large policy documents as the primary policy discourse, and led to thirty-two interviews. Following transcription the interview corpus came to over 180,000 words. Applying the full rigour of CDA to the whole of this corpus would have extended the scope of this project several times over. The insights of CDA have therefore been applied to the policy discourse, whilst being used to

inform and deepen the thematic analysis of the practitioner discourse.

There is also the limitation that this research has not sought to directly address the views and opinions of service users and carers, other than in ways that can be uncovered in the policy discourse.

5.7 Ethical issues

Given that this research sought only to address the concerns of practitioners and policy makers within the public sector there were limited ethical constraints. The intrusion into the time of publicly paid staff needed to be negotiated with managers to ensure that this was seen as a valuable use of their time. The potential that respondents might be upset or need to reflect upon their practice as a result of the interviews was addressed in the information sheet which was given to all respondents (see Appendix 2). In principle most mental health practitioners are expected to seek professional supervision and to be reflective about their practice. The interview process would enable them to focus on one area of their practice and was unlikely to provoke an emotional response. Any professional issues upon which they reflected could be taken up in the course of their normal professional supervision. Nevertheless contact details of the academic supervisor were provided as a backup to this.

Ethical clearance, however, was still required because of the involvement of NHS staff. This was obtained from the Trent NHS Multi-site Research Ethics Committee under the normal procedures relating to NHS-based research. This was administered at the time by the Central Office for Research Ethics Committees³ which provided a peer review service and ensured the quality of research applications as well as their ethical integrity. The approval for this study specified that arrangements had to be made with local employing Trusts for NHS staff to satisfy local research governance requirements. In practice these varied from Trust to Trust, but care was taken to ensure full consent from respondents and authorisation from local employing Trusts where appropriate, including an honorary contract in one case (See Appendix 3 for Consent Form).

³ This has now been replaced by the Integrated Research Application System of the National Research Ethics Service.

Chapter Six – Analysis of Policy Documents

6.1.1 Introduction

This chapter looks at three published documents that currently impact on mental health teams and CAMHS in particular. It justifies the selection of the group of three documents given closest scrutiny from the much larger group of other documents which respondents feel have been influential. The aim is to establish the actual guidance given to workforce planning and how this might impact on the professional identity of workers in these teams before going on, in the next chapter, to look at the response to that guidance and influence by the interview respondents.

6.1.2 Selection of Documents

Initially it was anticipated that the email responses would provide a sufficient number of responses to determine which were the key documents for analysis. As there were only ten full responses to the questions it was decided that to ensure rigour in the selection of the documents that additionally the frequency with which documents were mentioned in the interviews would also be used to select key policy texts for analysis. The aim of this is to avoid bias in selecting those texts that seemed most pertinent without reference to external verification.

Each document is counted if mentioned by the email or interview respondent, as an indication that they are thinking about the

document. This does not allow for a weighting by the number of mentions each document gets. Whilst this might have allowed an indication of the importance attached to it, there would then have been a distinct bias towards those mentioned in interviews (which inevitably get mentioned several times in the course of conversation) rather than the simple listing requested in the email questionnaire. The figure below shows the number of mentions each document received in the email responses, and during the interviews. If a document was mentioned more than once in an interview it was counted as a single mention; the relative weight applied to individual documents is explored more in the analysis of the interview responses.

Figure 3 – Document mentions

| Document name | Email mentions | Interview Mentions | Total |
|--|-----------------------|---------------------------|--------------|
| National Service Framework for Children, Young People and Midwifery Services (DoH 2004a) | 5 | 18 | 23 |
| New Ways of Working (for Psychiatrists DoH 2004d) / (for Everyone NIMHE 2007a)* | 1 | 17 | 18 |
| Agenda for Change (DoH 2004b) | 2 | 14 | 16 |
| National Service Framework for Mental Health (DoH 1999a) | 4 | 6 | 10 |
| Every Child Matters (DfES 2004) | 3 | 7 | 10 |
| From Values to Action: The Chief Nursing Officer's Review of Mental Health Nursing (DoH 2006b) | 1 | 8 | 9 |
| The NHS Plan: a plan for investment, a plan for reform (DoH 2000a) | 2 | 6 | 8 |
| Together We Stand: Child & Adolescent Mental Health Services. (Health Advisory Service 1995) | 1 | 7 | 8 |
| The Ten Essential Shared Capabilities (NIMHE 2004e) | 2 | 5 | 7 |
| NHS Knowledge and Skills Framework (DoH 2004b) | 2 | 4 | 6 |
| National Occupational Standards for Mental Health (Skills for Health 2003) | 2 | 3 | 5 |
| 'Children in Mind' (Audit Commission 1999) | 1 | 3 | 4 |
| Creating Capable Teams Approach (DoH 2007c) | 1 | 3 | 4 |
| NICE guidelines (mentioned generically) | 1 | 3 | 4 |
| 'Bright Futures' (Mental Health Foundation 1999) | 3 | 1 | 4 |

| | | | |
|--|---|---|---|
| Building and Sustaining Specialist CAMHS: A consultation paper on workforce, capacity and functions of Tiers 2,3&4 CAMHS. York, A & Lamb, C (Royal College of Psychiatrists 2005) | 2 | 1 | 3 |
| Making a Difference: Strengthening the Nursing, Midwifery and Health Visiting Contribution to Health and Healthcare. (DoH 1999d) | 1 | 2 | 3 |
| CAMHS Grant Guidance (NHS Circular 2003) | 0 | 3 | 3 |
| NSF Standard Nine Implementation Review (DoH2006b) | 0 | 2 | 2 |
| Mental Health NSF (and the NHS Plan) Workforce Planning, Education and Training Underpinning Programme: Adult Mental Health Services: Final Report by the Workforce Action Team Main Report August 2001 (DoH 2001d) | 1 | 0 | 1 |
| National Service Framework for Mental Health: Policy Implementation Guide (2001c) | 0 | 1 | 1 |
| Our health, our care, our say: a new direction for community services. (DoH 2006c) | 1 | 0 | 1 |
| Valuing People: A new strategy for learning disability for the 21 st century. A really useful guide to the Government's ideas on how to get services right for all people with learning difficulties. (DoH 2001e) | 1 | 0 | 1 |
| Role Design Directory of Tools – Changing Workforce Plan (DoH 2004f) | 1 | 0 | 1 |
| The Future of Mental Health: A Vision for 2015 (Sainsbury Centre 2006) | 1 | 0 | 1 |
| The Choice and Partnership Approach (CAPA). (www.camhsnetwork.co.uk Accessed September 2007) | 1 | 0 | 1 |
| National Child and Adolescent Mental Health Service Mapping Exercise 2004. (www.camhsmapping.org Accessed September 2007) | 1 | 0 | 1 |

| | | | |
|---|---|---|---|
| The Competency and Capability Framework for Primary Mental Health Workers in CAMHS. (www.camhs.org.uk accessed September 2007) | 1 | 0 | 1 |
| Child and Adolescent Mental Health Services: Everybody's Business. (National Assembly for Wales 2001) | 1 | 0 | 1 |
| The Post-Registration Education and Training Needs of Nurses Working With Children and Young People with Mental Health Problems in the UK. Jones, J. (RCN 2004) | 1 | 0 | 1 |
| Guidance for the Commissioners and CAMHS Providers on the Development of the Role of the Primary Child Mental Health Worker in CAMHS: Commissioning, Service Provision and Training the workforce. National Committee of Primary Mental Health Workers (CAMHS), for Scotland, Wales, Northern Ireland and England (Gale, F, Sebuliba, D & Dover, S. 2004) | 1 | 0 | 1 |
| The NHS Improvement Plan: Putting people at the heart of public services. (DoH 2004g) | 1 | 0 | 1 |
| Choosing Health: Making healthy choices easier. (DoH 2004h) | 1 | 0 | 1 |
| Saving Lives: Our Healthier Nation. (DoH 1999b) | 1 | 0 | 1 |
| Common Core of Skills and Knowledge for the Children's Workforce. (DfES 2005) | 1 | 0 | 1 |
| Delivering race equality in mental health care: An action plan for reform inside and outside services and the Government's response to the Independent inquiry into the death of David Bennett. (DoH 2005c) | 1 | 0 | 1 |
| Breaking the Circles of Fear (Sainsbury Centre, 2004) | 1 | 0 | 1 |
| Reaching Out: An Action Plan on Social Exclusion (Cabinet Office 2006) | 1 | 0 | 1 |
| The Capable Practitioner (Sainsbury Centre 2000) | 1 | 0 | 1 |

| | | | |
|---|---|---|---|
| Mental Health Workforce Strategy (DoH 2004i) | 1 | 0 | 1 |
| Primary Care and Graduate Workers (DoH 2003b) | 1 | 0 | 1 |
| Developing the Workforce (Northern Centre for Mental Health March 2003) | 1 | 0 | 1 |
| Workforce development and design a care group approach (DoH 2004j) | 1 | 0 | 1 |
| Mental Health Workforce Design and Development Outcomes study (DoH 2006c) | 1 | 0 | 1 |
| A health service of all the talents (DoH 2000) | 1 | 0 | 1 |
| Emerging Findings of the Children's National Service Framework (DoH 2003a) | 1 | 0 | 1 |
| The Mental Health of Children and Adolescents in Great Britain (Meltzer et al 2001) | 1 | 0 | 1 |
| 'Turning CAMHS into learning organisations' (Birleson 1999) | 1 | 0 | 1 |
| Total Number of different documents cited: 48 | | | |

* New Ways of Working is usually mentioned generically by respondents rather than specifying one of the documents. 'New Ways of Working for Everyone' was published in April 2007, just after the interviews were completed, though many of the respondents who mentioned it were aware that it was due. As the later document summarises the 'project' of NWW, it will be used as the document for analysis.

6.1.3 Document Selection – rationale

The figure above illustrates the wide range of documents mentioned by different respondents as being pertinent or important to current changes in workforce in mental health and CAMHS. There is a wider range mentioned by the email correspondents, despite there being only ten email correspondents compared to thirty-two interviewees. This reflects the difference in time allowed for a response to the question, in that the interview respondents were able to quote only those that they could remember in an interview setting, whilst the email format allows time to reflect and look for references (and some of the respondents gave quite extensive lists). This is particularly highlighted in the fact that the interview respondents averaged 3.75 documents mentioned in the interview, and ranged from mentioning no documents at all (even when gently prompted) to a maximum of nine documents mentioned in interview (from a respondent who had been directly involved in policy writing, and might be expected to know about the breadth of available documents).

The documents mentioned can be divided into four broad groups:

1. A group of three that are mentioned most and by a clear margin (the NSF for Children, New Ways of Working and Agenda for Change);

2. A group of eight documents that are mentioned between five and eleven times but which have an even spread of mentions across email and interview respondents (Every Child Matters, the NSF for Mental Health, the latest CNO review of mental health nursing, Together We Stand, the NHS Plan, Ten Essential Shared Capabilities, Knowledge and Skills Framework, and the National Occupational Skills for Mental Health);
3. A group of documents that are mentioned more than once, but with an uneven spread across the respondents, making it harder to judge their relevance. This group, however, are all mentioned by at least one interview respondent, giving the impression that they are on the mind of people involved in this area of work, and sufficiently important that they can discuss them 'off the top of their head' in an interview setting. This group includes: Children In Mind, Bright Futures, NICE guidelines, Building and Sustaining Specialist CAMHS, the previous CNO review of nursing and midwifery, CAMHS grant guidance, the NSF implementation review and the Emerging Findings (a precursor to the Children's NSF).
4. Finally there is a large group of documents mentioned only once, and almost exclusively only by email correspondents as being relevant to the current study.

There is, therefore, a fairly broad spectrum of documents which this sample of respondents regard as relevant to this study. The sheer number of possibly relevant documents illustrates the range of different influences on those who are planning, implementing and living the experience of being a mental health worker (or CAMHS specialist) at the moment. Of significance, however, is that whilst there are potentially forty-eight different documents that might (according to these respondents) affect the professional identity of a mental health worker or CAMHS specialist, most respondents can mention only three or four in an interview situation. These appear to be the ones which impact most on their working lives, and of the respondents who could mention fewer than that, not surprisingly it is the actual practitioners who are less able to name even the most influential documents.

In selecting documents for a closer analysis, therefore, it is important to look at the different categories of document mentioned. The three most popular documents represent children's policy, mental health workforce and overall workforce policy (though arguably Agenda for Change was not workforce policy at all). Further categorisation of the documents mentioned would include mental health policy (including mental health nursing) and specialist CAMHS policy, both of which are strongly represented in the second group. The thread of specialist CAMHS policy becomes more strongly represented within the third group, although within this

group the numbers of mentions are quite low, and are affected by the preponderance of CAMHS specialists who were interviewed.

Selection of documents for a closer analysis than already performed in the literature review needs therefore to capture the three main categories of policy relating to:

- Workforce;
- Mental health policy and
- Children's health policy.

However it is also important to recognise the relative importance attached to the different strands of policy as defined by the number of mentions. This in turn needs to be balanced against representing a fair coverage of the different policy initiatives. A simple use of the three most mentioned documents might fail to reach this, despite the fact that they are clearly the most important in the minds of respondents as defined by number of mentions.

The three most mentioned documents, however, in some ways do represent these three main areas:

- The NSF for Children (and respondents use this phrase primarily as shorthand to represent Standard 9 within the NSF, which deals with CAMHS work) clearly is seen as the primary influence on the development of CAMH services in England, and was written in a well-informed way with

reference to an External Working Group which included leaders within all the professional and interest groups;

- New Ways of Working incorporates the most influential elements of changing professional practice within mental health and has spread from its original intention to deal with particular issues within the practice of psychiatrists to encompass a workforce modernisation programme for the whole of the mental health workforce;
- Agenda for Change has been of enormous influence in simplifying the terms and conditions of a multiplicity of disparate professional groups across the whole of the health service, and did so by focussing on what skills and competencies different jobs were being asked to perform and assessing those against a points scheme to provide a much simplified pay and conditions structure.

For the policy section of this thesis, therefore, these three documents will be analysed primarily, but with reference to the other documents mentioned by respondents.

6.1.4 Document selection initial discussion

Whilst a rationale has been outlined for the selection of key documents for a Critical Discourse Analysis, there are some initial reflections that need to be made in the context of this selection.

The first important point is the sheer number of policy documents that were mentioned by respondents as being influential on how mental health teams and CAMHS in particular are operating currently. In the literature review it was pointed out that for CAMHS there had historically been very little literature until the HAS 'Together We Stand' document in 1995. Yet in the last few years there has been an explosion of policy guidance that potentially relates to CAMHS teams and how they are made up. Of the forty-eight documents mentioned by respondents 'Together We Stand' is the oldest, written in 1995, followed by the NSF for Mental Health (which specifically excluded CAMHS) in 1999, and the earlier CNO review of nursing and midwifery in the same year. That year also saw the publication of two documents important for CAMHS 'Bright Futures' and 'Children in Mind'. The majority of the rest of the documents have been written in the last four years, dating from around the time of the NSF for Children. Whilst it is true that a number of these documents were mentioned only once (and often in the email responses, where respondents had time to consider the policy which had influenced how they think about the work of creating and constructing CAMHS) it remains true that this is a great deal of material for those working in the field to absorb and

consider. The fact that in interview the mean average number of documents mentioned is only 3.75 reflects an inability to effectively absorb all this policy input. Those three or four documents that interview respondents could mention 'off the top of their heads' therefore would seem to be the ones that they consider the most influential.

Yet there is no consistency in the documents that are mentioned by respondents. Even New Ways of Working, which is the most current initiative, was not mentioned by all respondents by a long way (only eighteen out of thirty-two). In this case those who failed to mention it were primarily active practitioners with no specific remit for the implementation of policy, so it is possible that they had not yet been influenced by the development of this policy initiative. The lack of consistency, however, extended across the other documents, in that not everyone mentioned the well established NSF for Children.

Again not everyone who was interviewed was directly involved in CAMHS work, but most had some knowledge of it as an adjunct to the main discussion of mental health workforce, and were aware of the subject of the research through the process of setting up the interview and the need to sign a release form at the beginning of the interview which bore the name of the study.

The influence of Agenda for Change (AfC) on the respondents' views of what was changing workforce practice within the broader health service setting was a surprise. AfC is a different type of document to

many of the others mentioned, as will be examined in more detail below, but is not a policy directive in the way that many of the other documents mentioned by respondents are. However its introduction affected practitioners, and their identity, in a much more direct way than many of the other documents or policy initiatives could, by directly affecting the pay and conditions of those practitioners. It also systematically rated the relative value attributed to different skills and competences in a way which had never been done before across such a broad group of health workers.

If the inclusion of AfC so highly amongst the influential documents was a surprise then so also was the relative absence of *The Capable Practitioner*. At its publication in 2000 the document was seen as hugely influential, because it reflected Sainsbury Centre research into what users of mental health services wanted from those who provided services. In the document analysis below it will be noted that the importance attached to service user needs and wants in terms of workforce is given a high priority as a driver for changing the workforce composition, yet this document, which in many ways summarises the research into what service users need from professionals, is hardly mentioned anymore. The only respondent to do so was an email respondent, so *The Capable Practitioner* was not mentioned at all during the course of thirty-two face to face interviews. There was mention, as will be documented in the next chapter, of the needs and desires of service users, but this was not couched in terms of this particular document.

What this initially suggests for the professional identity of mental health workers in both mainstream mental health and in CAMHS is that the documentary influences on both how teams are formed and how individuals create their identity is multifaceted and complex.

6.2 Critical Discourse Analysis of the National Service Framework for Children, Young People's and Maternity Services (Standard Nine)

6.2.1 Standard Nine of the Children's NSF

Respondents throughout the email correspondence and during the interviews referred to 'the Children's NSF' in fairly generic terms. The NSF is itself a lengthy document, covering, as it does, all children's, young people's and maternity services. It contains ten standards or chapters in all, of which the one dealing with "The Mental Health and Psychological Well-being of Children and Young People" is Standard Nine. This standard will be used as the basis for the analysis, though the general principles of care outlined elsewhere in the NSF also apply to the provision of care in mental health. This analysis will obviously be concentrating on what the document has to say about professional identity rather than attempting a full analysis of the discourse.

6.2.2 Textual content of the NSF

6.2.2.1 'CAMHS professionals'

This document is the only one that uses the phrase 'CAMHS professionals' as a generic reference to all workers in CAMHS. The phrase occurs five times in this format, with a further two references to professionals defined as '(CAMHS) professionals'. This is in the context of a total of twenty seven references to

'professionals' in general. The generic reference to 'professionals' occurs with sufficient frequency that it becomes characteristic of the document.

Examples:

When children and young people are unavoidably placed on paediatric or adult psychiatric wards, there is collaboration and joint working between the child health, adult mental health and CAMHS professionals. There is a shared aim to ensure a timely and appropriate placement, if required, in a child or adolescent inpatient unit.

NSF for Children Standard 9 Section 9.11

Psychological/behavioural interventions have received relatively little research attention and yet they constitute the main work of CAMHS professionals.

NSF for Children Standard 9 Section 9.16

6.2.2.2 Identity in the NSF for Children

Given that this study concentrates on how people construct their professional identity, it is important to note that the word 'identity' does not occur in the NSF for Children. As we have seen above, the document concentrates on 'professionals' and 'CAMHS professionals', and mentions individual professional groups like nurses, psychiatrists and psychologists, with an assumption that identity is constructed through membership of one of these professional groups. In this way it continues its intertextuality of using the HAS 'Together We Stand' document's way of looking at

the groups of professions likely to be employed in a multidisciplinary CAMHS team or in support services.

Staff who work directly with children are able to access support and advice from specialist CAMHS. In addition to specialist CAMHS, there are a range of staff from children's services who can work in collaboration with front line staff to aid early identification and support of children with mental health difficulties. These include social workers, behaviour specialists, educational psychologists and specialist support staff.

NSF for Children Standard 9 Section 4.1

6.2.2.3 Skills and Competencies in the NSF for Children

The NSF mentions 'skills' twenty three times, and 'competencies' ten times. Whenever competencies are mentioned it is often in the context of 'skills and competencies' (four occurrences) and the importance attached to this is illustrated by it's positioning in the vision statement at the beginning of the Standard:

Vision

We want to see:

An improvement in the mental health of all children and young people.

That multi-agency services, working in partnership, promote the mental health of all children and young people, provide early intervention and also meet the needs of children and young people with established or complex problems.

That all children, young people and their families have access to mental health care based upon the best available evidence and provided by staff with an appropriate range of skills and competencies.

NSF for Children Standard 9 Section 1.3

However there are a variety of phrases which the NSF uses in talking about the skills and competencies needed to deliver services,

and it does not confine itself to just this one way of talking about the subject. Later in the same section it sets out markers of good practice which refer to the same issues in rather different terms:

Markers of Good Practice

1. All staff working directly with children and young people have sufficient knowledge, training and support to promote the psychological well-being of children, young people and their families and to identify early indicators of difficulty.

...

8. Arrangements are in place to ensure that specialist multi-disciplinary teams are of sufficient size and have an appropriate skill-mix, training and support to function effectively.

NSF for Children Standard 9 Section 1.3

Here the NSF uses different phrases 'knowledge, training and support' and 'skill-mix, training and support' as the phrases indicating what is needed for effective working. Whilst these are slightly different to the concept of 'skills and competencies', it is another illustration of the authors' intent not to be drawn into homogeneity of language use with other government policy. Significantly they also resist the combination of 'Knowledge and Skills' which is an important phrase within Agenda for Change, as will be seen below.

6.2.2.4 Roles and extended roles in the NSF for Children

The NSF for Children talks primarily about the different roles of professionals (and agencies) rather than extending current roles and developing new roles, as is characteristic of New Ways of Working (as we will demonstrate below).

Partnership working across agencies working with children and young people with mental health problems can be a challenging task. The lack of understanding of the respective roles, duties, responsibilities and organisation of the different agencies and professionals and of their different language, may lead to poor communication, misunderstandings and frustration.

NSF for Children Standard 9 Section 8.2

In talking about 'role' generally the document has eight specific mentions of the word, several of them generically used, rather than referring to job roles. The only new role that they discuss in any detail is that of the CAMHS Primary Mental Health Worker, a concept developed in the HAS 'Together We Stand' document, and as such familiar territory for CAMHS professionals as this had been published several years previously.

The National Committee for Primary Mental Health Workers in CAMHS has prepared a description of the role of the CAMHS Primary Mental Health Worker. Whilst there are core components of the skills and knowledge base and role that are universal, each area will also need to develop the detail of these posts with their own local needs in mind.

NSF for Children Standard 9 Section 4.3

Late on in Standard 9, however, there is reference in the training and development section to new and extended roles in language that is curiously similar to New Ways of Working. Given the piecemeal way in which the NSF seems to have been constructed it is interesting to note this as a possible addendum to the general way of thinking demonstrated elsewhere in Standard 9:

As part of the development of the workforce, it is important to identify any new or extended roles that might be appropriate to help deliver the expanded services, for example:

- CAMHS Workers in Primary Care to act as a key link between primary care and specialist CAMHS services;
- New types of child and adolescent mental health workers;
- Extended roles for professionals acting as first on call in emergency and out-of-hours services;
- New support roles, and
- Paediatricians and general practitioners with a special interest in child mental health.

NSF for Children Standard 9 Section 11.2

The phrase 'extended roles', for example, occurs only twice in Standard 9, and both are included in the above section. The section seems rather vague as to the exact nature of these new roles. Of the five sections mentioned one is an established 'new role', that of PMHW developed from 'Together We Stand'. The third suggested one is directly related to New Ways of Working for Psychiatrists (DoH 2004) looking at ways of relieving the pressure on psychiatrists who had hitherto been almost exclusively responsible for providing emergency and out of hours cover for young people's mental health. The final point '*... [doctors] with a special interest in...*' seems to be lifted from the NICE Technical Appraisal on use of Methylphenidate (for the treatment of ADHD) (NICE 2000), where it is strongly suggested that prescription of methylphenidate be limited to Child Psychiatrists and Paediatricians '*...with a special interest in child mental health*'.

The other two points, for 'new support roles' and 'new types of child and adolescent mental health worker' are relatively vague, given that the authors of the document would have had knowledge of graduate mental health workers (as described in the NHS Plan, specifically including work with young people), and the movement towards non-medical prescribing and other roles like nurse consultants in CAMHS. The rationale for mentioning some of the known new developments and not others suggests some hesitation in endorsing those new roles, all of which were, at the time, relatively untested, in contrast to the PMHW role, which had been given time to establish itself and begin some evaluation studies (i.e. Gale and Vostanis 2003).

6.2.2.5 Service User needs in the NSF for Children

The NSF for Children stresses the need for service user involvement in the same way that all government policy for health does in recent times. Standard 9 does not headline it in the way that some parts of policy do, but recognises the difficulties inherent in effectively representing the rapidly changing needs of developing children. Whilst it is clear that children's policy has in some way led on putting the needs of the child as paramount (i.e. in the 1999 Children's Act and in Safeguarding Children policies since the Climbe report of 2003), there has been some difficulty in engaging service users involvement in CAMHS.

It has been challenging for CAMHS to ensure the participation of children and young people and their families at all levels of service provision. It is clear that a variety of creative approaches are needed to improve participation and user involvement. Ways in which children and young people can participate can be found in Building a Culture of Participation 4. See Standards 3 and 4.

NSF for Children Standard 9 Section 5.1

Needs of service users, then, are mentioned as a central driver for the development of policy. The overall policy is one of inclusion, as evidenced by the use of the phrase 'Every Child Matters', in the same way that the MHF report 'Bright Futures' (1999) had coined the phrase that children's mental health is 'everybody's business'. There seems to be no impact of this particularly on the professional identity of the workforce, other than to emphasize the need to have this remembered at the centre of service delivery.

One feature of the service user voice does come out in this document, however, that is characteristic of government policy. In the section on access the service user voice is directly quoted:

6. Access and Location of Services

"We want a choice where we get help, for instance in school and outside school in a place that isn't medical."

(A user of child and adolescent mental health services)

6.1 Children and young people and their carers want to be able to access services easily.

NSF for Children Standard 9 Section 6

This tendency to use a direct quote from a service user to justify a generalised statement goes against all research principles, but is a commonly used convention within policy documents. Silverman (2004) for example, warns of generalising from limited statements that can only be said to apply to the one person who made the statement at that particular time. However the service user voice often has the 'ring of truth' about it, and makes it hard to question the statement that follows it. The location and origin of the statement is not given, and whilst confidentiality and anonymity of research subjects is an important factor, the study from which this statement is drawn is not referenced in a way that would allow the reader to draw their own conclusions as to the level of importance to attach to the statement.

This tendency to use the service user voice to justify broad ranging statements does also come across within the interviews, most clearly in the Pilot interview (with a policy maker at NIMHE), again broadly quoting the needs of service users, without specifying exactly whence this statement might be derived:

You know, that's the message we have received in developing some of our care activities is in significant service user consultation and carer consultation, the clear message, yeah, that, they are not, you know... and yet, professionals have their worth and it's not about the agenda, it's about saying it's about saying we don't need them ...

Pilot Interview, Nurse, Policymaker

6.2.2.6 Need for Flexibility in the NSF for Children

The theme of flexibility is central to workforce policy, but appears only fleetingly in the NSF for Children. The word 'flexible' appears five times, and 'flexibility' only four times in the Standard. Of the latter only one refers to workforce, the others applying to service delivery:

Flexibility of recruitment so that people move between posts across organisations;

NSF for Children Standard 9 Section 8.2

This is the section on what factors make for effective working between CAMHS and schools, so is hardly afforded a high priority as an issue, and is not mentioned in the workforce section later on in the document.

Likewise the word 'flexible' is primarily related to access and service delivery, although it does also occur in relation to engagement of young people. This obviously has an indirect relationship to the workforce, in that flexibility in being able to apply their skills and competences is necessary, but the phrase is never directly applied to workforce in a way that will be demonstrated to be important elsewhere in the policy discourse.

A flexible approach to the engagement of young people in their own mental health care is often necessary and the relationship with their mental health worker is crucial.

NSF for Children Standard 9 Section 6.5

This is also the only place where the phrase 'mental health worker' is used in preference to 'CAMHS professional', other than as part of the title 'Primary Mental Health Worker'.

6.2.3.1. Social Events providing the context for the NSF for Children

CDA defines the context of a document's development in terms of 'social events' and the NSF for Children Standard 9 sits in a context that needs to be understood in order to understand how it discourses about professional identity. The NSF for Children is one of a range of National Service Frameworks dealing with a wide range of topic areas, some very well defined (i.e. the NSF for Coronary Heart Disease (DoH 2001b)), and others with a much broader remit, like this one. When the Government developed the NSF for Mental Health (DoH 1999a) it had specifically excluded children and young people's mental health, as well as that of older people, concentrating instead on 'working age adults'. This age range was taken to be age 16 to 65 as a general guide, but there was little attention given to the specific needs of 16 and 17 year olds, whose needs are explicitly recognised as different and addressed in Standard 9. Likewise the NSF for Children was developed to address a lack of coherent strategy for children and young people's health services. In developing series of NSFs the Government thinking seems to have changed in the way in which it sought to implement these frameworks. Whilst it was at pains to avoid looking prescriptive with the NSF for mental health, for

example, the DoH issued a Policy Implementation Guide (PIG) following its publication. The PIG (DoH 2001c) was quickly seen as a handbook for reorganising services, and for accounting to commissioners on service delivery within mental health. It has separate chapters on Assertive Outreach, Crisis Resolution and Early Intervention in Psychosis teams, for example, which led to many mental health services across the country reorganising their services with new teams to address these different aspects of service, where previously all aspects of community care, for example, would have been dealt with by generic Community Mental Health Teams. In the intervening years between this and the introduction of the NSF for Children there seems to have been a recognition that the way to do implementation should be less prescriptive and more consultative. When the NSF for Children was proposed a series of External Working Groups were set up for the different Standards of the proposed NSF. These were intended to be representative of expert opinion in the various specialist areas of practice, so were constituted to include different disciplines and bodies. The External Working Groups published their proposals for consultation prior to the finalisation of the NSF, and there is some evidence of their responding to that consultation process. For example:

Estimating the numbers of staff required to populate viable multidisciplinary teams and services at Tier 3, that can meet all the demands and provide a sustainable service, is not straightforward. Much depends upon the local demography and the range and types of service needed and offered. Nonetheless guidance has frequently been requested. An analysis of a number of attempts to estimate staffing need has suggested the following:...

NSF for Children Standard 9 Section 9.1

However, instead of making relatively firm proposals about how Standard Nine should be implemented, and publishing a Policy Implementation Guidance document, the External Working Group proposed a National CAMHS Support Service consisting of Regional Development Workers who could assist local implementation and interpretation of the NSF. Ironically this service was established in 2003, prior to the publication of the NSF, though after the publication of the EWG's report 'Emerging Findings' (DoH 2003a). This change in emphasis from a prescriptive to a collaborative method of developing services has contributed to a lack of standardisation within service delivery across the country within CAMHS, compared to adult mental health services. Part of that lack of standardisation is in how different services have developed workforce plans and looked at workforce modernisation, which inevitably impacts on how professionals see themselves and construct their own identity. It does comply with the Government's often stated policy, however, of implementing local solutions to service delivery, rather than having a 'one size fits all' approach, which is how the NSF for Mental Health PIG was interpreted, despite the already noted protestations in that document.

6.2.4 Genre in the NSF for Children

Fairclough (2003) notes that texts rarely conform to a single genre, despite the clear place of the NSF for Children as Government policy, published formally as a document that is intended to heavily influence service delivery across England. We have already seen the way in which the NSF for Children was developed, through a series of External Working Groups, effectively expert reference groups. This has influenced the way in which each Standard reads and reflects that influence, despite an overall editorial hand from the Department of Health. The EWG for Mental Health and Psychological Well-Being of Children and Young People was primarily responsible for the development of Standard 9, and we will see below the direct intertextuality evidence that shows the influence of CAMHS policy. The editorial influence and framework element of the document can be illustrated by the introductory wording, which seeks to put the rest of the Standard in context:

| |
|--|
| <p>Introduction</p> <p>1.1 The National Service Framework for Children, Young People and Maternity Services establishes clear standards for promoting the health and well-being of children and young people and for providing high quality services which meet their needs.</p> <p>1.2 There are eleven standards of which this is the ninth. They cover the following areas: ...[goes on to list the eleven standards]</p> <p style="text-align: right;">NSF for Children Standard 9 Section 1</p> |
|--|

This is also apparent when, in Appendix 2, the document reproduces the text of the Health Service Circular that set out the need to introduce 'comprehensive CAMHS' across country. The Circular (DoH

2002) sets out an 'expectation' that this will occur, a more directive term than stating aims and guidance:

A Comprehensive CAMHS

Improvement, Expansion and Reform has set the expectation that a comprehensive child and adolescent mental health service (CAMHS) will be available in all areas by 2006.

NSF for Children Standard 9 Appendix 2

Elsewhere there is less formal language, and the vision of the NSF sets out what 'we' want. It is not entirely clear who 'we' are, when the document itself purports to be Government guidance. 'We' is presumably the government, but actually the Standard does include a list of those whose voices are heard in the document.

Vision

We want to see:

An improvement in the mental health of all children and young people.

..[Continues]

NSF for Children Standard 9 Section 1.3

The list includes a list of those involved in the EWG, giving their professional titles and their employer or affiliation (if academic or of a professional organisation). It also includes a list of DfES/DoH officials who were involved, but then goes on to thank the EWG in the following terms:

We would like to thank the members of this External Working Group for their invaluable contribution to the development of this standard of the Children's National Service Framework.

NSF for Children Standard 9 endpiece

This both explicitly acknowledges the contribution of the EWG in constructing the shape of the Standard, but also takes ownership of the 'we' back to the DfES/DoH who published the document.

6.2.5 Difference in the NSF for Children

Difference in textual analysis is seen as an important marker of any text's openness to understanding the social world in which it operates (Fairclough 2003). On a superficial level the NSF does explicitly recognise elements of difference and the need to supply a wide variety of services for a variety of needs, for example:

Concepts of mental illness and the understanding of the origins of children's emotional and behavioural difficulties vary across cultures. Services need to be sensitive to these differences and ensure that staff are equipped with the knowledge to work effectively with the different groups represented within the community they serve.

NSF for Children Standard 9 Section 5.3

What the document fails to do, however, is recognise any of the difficulties in providing for different needs that might be inherent in power relationships between individuals, professionals or agencies. This is alluded to in the interviews as will be demonstrated in the

next chapter, but there is no explicit reference to this in the guidance given here.

6.2.6 Intertextuality in the NSF for Children

We noted above the use of the phrase 'CAMHS professionals' which does not occur elsewhere in the main three documents or in the interviews as a common generic reference for the range of different people working within CAMHS. The phrase, however, is not unique, and is taken from the HAS 'Together We Stand' document, as is made clear later in the NSF when it reproduces the Four Tier model of service provision. The Four Tier Model of CAMHS provision itself originates within the 'Together We Stand' document (HAS 1995), and whilst it had been used as a way of explaining service delivery it was not a well-known model outside of CAMHS until it was 'mainstreamed' by its inclusion in the NSF for Children.

Tier 4

Essential tertiary level services such as day units, highly specialised out-patient teams and in-patient units

CAMHS at this level are provided by professionals working in universal services who are in a position to:

- Identify mental health problems early in their development
- Offer general advice
- Pursue opportunities for mental health promotion and prevention

CAMHS professionals should be able to offer:

- Training and consultation to other professionals (who might be within T1)
- Consultation to professionals and families
- Outreach
- Assessment

NSF for Children Standard 9 Appendix 1 Box 4

By alluding back to a specifically CAMHS related document, one which will not be very familiar to those in wider children's services or in mental health services, the authors of this section seem to be aiming at establishing their credentials as 'CAMHS professionals' themselves. They almost exclude other groups and seek to establish a specific identity, that of 'CAMHS professional' which is actually not echoed elsewhere in the discourse on this. Even more curious in this respect is the fact that three of the authors of this section of the NSF were included in the interview cohort, and they did not use the phrase in their interviews either.

6.3 Critical Discourse Analysis of New Ways of Working for Everyone

6.3.1 The New Ways of Working Project

As outlined in the rationale for selection of documents, New Ways of Working (NWW) is a phrase used generally to refer to a body of work or project of mental health workforce modernisation that started by looking at the role of Consultant Psychiatrists, but now encompasses the roles of all staff working in mental health. The document that will be used as the basis for this analysis is New Ways of Working for Everyone: Progress Report published in April 2007 with a national launch event held in Leeds. This document summarises the work done for psychiatrists as well as looking at the work of the separate groups for different disciplines. There is also a separate implementation report that will be referred to, but NWW for Everyone (NIMHE 2007a) is the key source in this discourse.

6.3.2 Textual themes in New Ways of Working

The following sections look at the key textual themes in NWW, as well as the key elements of critical discourse elements as they apply to this project.

6.3.2.1 Characteristic features in New Ways of Working – Motivations for Change

NWW strives to look at the reasons for the need for change in the workforce, and makes it clear from the beginning that it puts service user needs at the centre of its motivations for looking at 'new ways of working'. This awareness of the need to forestall arguments against the project is much more overt in NWW than it is in Agenda for Change, as we will see below, but is noteworthy because of the effort put into the change management process. In each of these documents you would expect to see some explanation of the need for change, as part of managing the process, but there are differences in the way in which this is put across.

In the section below it is clear that 'service user needs' are one justification for change, but it is also clear that there are other motivations that are less overt, though alluded to within the document. Other motivations are usually preceded by allusion to service user need, almost as though they (any other motivations) are an afterthought:

It is clear from the way the Ten Essential Shared Capabilities evolved that service users and carers felt that mental health services were not delivering a holistic model of care in the way they wanted; so we all need to seize this opportunity to make the best use of all our staff, particularly given that we anticipate a slower growth in numbers, combined with an ageing workforce.

NWW for Everyone 2007, Foreword by Louis Appleby

This mixing of motivations continues throughout the body of the report, as the document tries to forestall objections and emphasize the theme that what is being done here is primarily about getting a better service for service users:

NWW is about making the best use of the current workforce, providing job satisfaction and career development for staff, and providing services that meet the needs of service users and their carers and make efficient use of resources.

NWW for Everyone, Section 3.1.2

The above section seeks to address the needs of staff, but also includes a section on service user needs, and again adds a management imperative 'efficient use of resources' almost as an afterthought. Each of these alternative imperatives are valid reasons for looking at the need for change within workforce of whatever kind. However there develops a pattern of defensive language which aims to justify these other motivations as part of the wider movement to develop the kind of mental health service that service users need and want:

NWW is not about undermining the role of professionals, nor about 'dumbing down' the workforce. It does recognise, though, that with an ageing workforce and population, we need to concentrate on how we develop all our staff, in order to ensure we provide the mix of capabilities required to meet the needs of service users and carers.

NWW for Everyone, Section 3.1.4

The danger of this tendency to always relate motivations to service user need rather than being completely honest about the alternative

motivations for workforce redesign is that it leads to scepticism, and within the interview analysis it will become apparent that there is some suspicion about the motivations behind the development of new roles and new ways of working. The above section is actually honest about the need to put these considerations in context, but the sentence structure is fairly abrupt, giving a statement of what the project 'is not about'. The recognition of external demographic factors that follows is then couched in terms of a more positive statement about developing staff, which is again justified in terms of what service users and carers need from that workforce.

6.3.2.2 Identity in New Ways of Working

Whilst NWW does talk about identity it does so in an inconsistent manner. The only time the phrase 'professional identity' occurs is in the section on leadership, a part of the section on 'cross-cutting themes':

Professional leadership: No agreed definition. Includes the development of professional identity and standards in a professional group dispersed throughout many different types of team, representing the profession and developing its contribution to the overall objectives of the organisation. Further work needs to be done on this.

NWW for Everyone Section 4.4.2

Whilst we are told that a leadership sub-group had been formed and done some work on this, the section quoted above indicates that this is an area which that group seeks to recognise, but which has not actually done a great deal of work on. The form of the prose is

in notes form, with incomplete sentence structure, in contrast to other parts of the document that flow much better. This section of the document continues in a fragmented way, almost as though the thoughts of the group were still at an early stage and evidenced in bullet points rather than fully formed elements of the strategy:

2. While recognising that there will always be some need for uni-professional leadership development, the overall emphasis of the sub-group's work will be multi-professional, because multidisciplinary teams deliver services to service users and carers, and groups of teams deliver organisational and system goals.

NWW for Everyone Section 4.4.2

This contrasts with the extensive work put in by different professional groups and explained at length elsewhere in the document. These separate sections reflect differing emphases according to the various current needs of different groups, and the writing style as well as content differs from one section to another. Most of the other references to 'identity' come in the social work section. Of the nine occurrences of the word in this document, it occurs as 'professional identity' once, but as 'social work identity' four times.

Social Workers involved in this project, therefore, saw the issue of identity as an important one, in a way that is not reflected elsewhere in the document, naming it first in their list of priorities:

Following both the discussion paper and the national conference, four key areas for development emerged around social work identity; social work research; career pathway/progression; and leadership to include education and training.

NWW for Everyone Section 7.10.3

The feelings of threat to social work identity were felt to be important for social workers seconded or directly employed by NHS Trusts (and therefore away from the normal direct managerial structures of local government in which social workers have traditionally practiced):

Although they may be part of a particular mental health team, they often feel that they are professionally isolated, that their contribution is not valued, that they are not receiving effective, professional supervision, and that they are under enormous pressure, etc.

NWW for Everyone Section 7.10.5

The issue then is of their distinctive contribution as social care staff being valued by others and receiving profession specific supervision (which would reinforce their professional identity, by implication).

The other main threat to professional identity that this group reflects within the document is the legal change that was proposed to develop alternatives to the role of Approved Social Worker:

In terms of social work identity, one of the future challenges is around the proposed introduction of the Approved Mental Health Professional (AMHP) under the Mental Health Bill. Although the formal designation of the ASW will be replaced, social workers will have a critical influence in ensuring that the practice competence of AMHPs embraces and actively promotes the independent nature of the role.

NWW for Everyone Section 7.10.9

This fear reflects the key element that social workers had valued in themselves, that they are not part of the medical system in a way which other disciplines are perceived to be. The independence of ASWs to prevent the medical system from incarcerating service users in psychiatric facilities has long been held to be an important check and balance on the power of the psychiatric system, and the threat that this might be opened up to other disciplines is clearly keenly felt by this group. The fear that nurses, for example, remain the doctor's handmaiden and would not be able to exercise the element of independence associated with traditional ASWs (who are themselves quite different from many other social work practitioners), appears also in the interviews section in the next chapter.

The social work section of NWW for Everyone concludes with a summary that again puts social work identity as first on the list of priorities:

This report from the NWW4SW sub-group, taken together with the Portfolio of Evidence, clearly sets out the need:

- to maintain and nurture the social work identity to help with recruitment;
- to promote the leadership expectations of social workers;
- to encourage the expectation among both staff and employers that research will form an integral part of future employment arrangements for social workers;
- For employers to put in place a career pathway or progression not only to help raise the profile of the social worker profession, but also to help with retention; and
- to actively embrace new opportunities.

NWW for Everyone Section 7.10.20

Elsewhere in the document the concept of identity occurs only one other time in the professional sections, amongst the contribution of Occupational Therapists (who, incidentally, had decided to report separately from their 'parent group' of Allied Health Professionals).

As the profession embraces both programmes, occupational therapists will be enabled to work towards achieving the vision for occupational therapy: 'By 2017, mental health service provision in the United Kingdom will be better for the active role and inspirational leadership provided by the cultural heritage and identity of occupational therapy, which at its core is social in nature and belief and, therefore, will deliver the kind of care that service users want, need and demand' (COT, 2006).

NWW for Everyone Section 7.3.4

Again the tone of this statement, although defiant, is that the identity of this group needs to be reasserted as though they feel that identity is under threat. In stating the need for an assertion of OT identity the statement, itself a quote from a vision statement, takes care to state exactly what it feels that identity is, rather than leaving it in doubt (COT 2006).

The only other place where identity is mentioned is in the section that seeks to reinforce the vision of how the new ways of working will look in the future, "Diary of a 'New Ways of Working' Consultant Psychiatrist" Appendix D. In this rather whimsical section, which is set in the future (it is written as a diary entry dated November 4th 2007, whilst the document was published in April 2007), identity is seen in terms of team identity rather than professional identity, as the workforce starts to relate to its purpose and team function rather than older notions of professional identity:

I am aware that I am not anxious about going to work tomorrow. I don't expect to walk in and find a service anxiously waiting for me to turn up. I do expect to find a team with a sense of identity and common purpose, increasingly proud of its effectiveness, that sees me as a valued specialist member.

NWW for Everyone Appendix D

Whilst the fabricated diary does continue to refer to individual team members by their profession (CPNs and Social Workers) the purpose of the 'diary' section is to present an idealised view of how teams will function if the NWW project is put in place. This is again related to team identity and to reinforcing the positive benefits of the project:

..and I believe that can be directly related to the sense of ownership and to a coherent identity developing within the services.

NWW for Everyone Appendix D

6.3.2.3 Skills and Competences in New Ways of Working

The lack of central attention to personal or professional identity in NWW is in sharp contrast to the emphasis put on skills and competences (and ultimately how these link to role definition).

As we saw earlier the definition of what NWW means includes the need to:

..to share knowledge, skills and competences across professional and practitioner boundaries;

NWW for Everyone Section 1.3.2

And as this definition is stated very early, the emphasis put on it is a heavy one.

The phrase 'skills and competences' actually only occurs four times in the document (and once as 'competences and skills') but the use of the word 'skills' and 'competences' is frequent within the document. 'Skills' occurs eighty-five times, and 'competences' occurs thirty-one times. This is not entirely unexpected in a document which is talking essentially about changing workforce, but does emphasize the importance put on the concept compared to reference to individual professional groups. The word 'nurse', for example, occurs, twenty-nine times.

In addition the document uses the word 'capabilities' in the context of skills and competences almost interchangeably. This phrase picks up from the NIMHE sponsored document 'Ten Essential Shared

Capabilities' and the previously discussed 'Capable Practitioner' published by the Sainsbury Centre. The phrase is also used in conjunction with skills, sometimes with a very explicit intention of contrasting it with a professional background or identity, that there is an intention to emphasize these elements over the traditional recruiting of someone with a professional background. Appendix C describes indicators of 'success' that would show NWW is working, including:

- Job adverts described in terms of competence/capabilities, not profession.
- NWW for Everyone Appendix C

The emphasis on skills and competences is apparent in the section on developing new teams, the Creating Capable Teams Approach. This is highlighted as the approved way of designing mental health teams for the future, and a separate document or 'toolkit' was launched at the April 2007 conference that accompanied the publication of NWW for Everyone.

- Teams describe skill mix in terms of competences and capabilities ...
- The process helps a team reflect on their function, the needs of service users and carers, the current workforce structure and the current and required capabilities.

NWW for Everyone Section 4.3.4

These sections also betray some mixed thinking about the use of skills, competences and capabilities against a traditional model of

constructing a team with a variety of professions (who are assumed to have these skills, competences and capabilities). Whilst the section above seems to indicate that the important thing is that each team has the correct range of abilities rather than a specific group of professions the whole exercise has necessarily had to engage the existing professional groups in developing the new way forward. As such the document at one point is pointing towards the development of 'capable practitioners' who do not actually need the apparatus of a professional training and all that comes with it. Yet at the same time there is a recognition that this may be a step too far, and that engaging the professional groups in looking at what are the ways forward for each professional group, the 'new ways of working' for each group, is an essential step in the change management process.

6.3.2.4 Roles and extended roles in New Ways of Working

The emphasis on skills, competences and capabilities naturally leads on to discussion of new roles and extended roles. As we have seen, the whole project hinges around three main changes: working differently with the existing workforce; extending existing roles and developing new roles. The changes to existing workforce start from the needs of the consultant psychiatrists, but have developed into looking at the whole mental health workforce. Role, as we have seen within the literature review, applies mostly to function rather than the wider concept of identity, which takes it away from professional identities into a functional process of meeting needs.

This way of meeting needs, which NWW sees as being achieved through the new process of creating capable teams assumes that existing teams are not currently able to do this in their current configuration. It seeks to change the existing workforce, which includes developing some changes in how they work. This fits with the discussion within the literature, particularly around the 'expanded role' of nurses to fill in as medics seek to offload some parts of their role and function which they are no longer able to, or willing to do (i.e. Castledine 1995). As the literature shows, this expanded role is something which some parts of the non-medical professions are keen to do, whilst others have their reservations about whether this is a productive direction of travel. The final element is similar, in developing new roles, but assumes there are gaps in the workforce which existing practitioners cannot or will not be able to expand into. These are described in various ways, Support Time Recovery (STR) Workers, graduate mental health workers, child primary mental health workers and many more.

6.3.2.5 Service User needs in New Ways of Working

Service user needs are rated very highly in NWW. In structural terms the document begins with a commendation of service user satisfaction on the way in which NWW is working:

Service user satisfaction with New Ways of Working

Service users in Wiltshire were asked to complete a user satisfaction questionnaire after attending a new style of multidisciplinary assessment clinic. Some 97% were satisfied or very satisfied at being seen by two people; with the length of the interview (45 minutes) and with the questions asked. Some 83% were satisfied with the outcome of the assessment, and 82% planned to make use of advice they had been given.

NWW for Everyone, Page 3

This recommendation of the project comes immediately after the title page, and before the executive summary or the forewords to the main document. In putting such a recommendation so prominently at the beginning of the document the authors set out their intention to put the needs of service users and carers at the heart of the change agenda. Everything within the document, as we will see, is justified as being in the interests of service users and their carers. The quotation above, however, is not referred to elsewhere in the document, and does not actually relate to the planned operation of NWW - it is not, for example, a key element of NWW that service users would automatically be seen by two people.

This emphasis is immediately followed up by the fact that NWW has no less than three forewords, the first two written by, and for,

service users and carers, followed by a third foreword by the National Director for Mental Health Louis Appleby. The importance attached to this is clear, that all professionals presumably came into the health service and the mental health arena because they had a belief in doing what they could to alleviate distress amongst what we now call service users. This underlies what professionals do, and the need for that is stated clearly by the service user foreword author:

Will you see what I see in this report? Namely the utter and total belief and commitment to the cause on the part of everybody, including all the professions involved, the cause being to improve the lives of service users, carers and the workforce by increasing the skill mix, the flexibility, and the competences of the workforce, alongside the clear intent to be collaborative in delivering the kind of services that service users want in their lives.

NWW for Everyone, Foreword for Service Users

This makes it hard to argue against what follows, because a statement is made which all mental health professionals would agree with, that service user need is central to what we do, they are the reason that we deliver services, and as individual workers our intention is to improve their mental health. The difficulty is in the way that this is used throughout the document to justify things that are not directly related to the preceding statements. Once a statement is made that 'this is in service user's interests, this is what they want' then it is hard to question what follows. But what NWW is not good at doing is justifying in what way the changes it proposes are in service users interests. It does propose a system of organising change which puts service user need at its centre, and

incorporates their feedback (the Creating Capable Teams Approach), but at other times the linkage between an evidence based approach to understanding service user need and the subsequent developments is noticeably weak.

After making such an impassioned plea for putting service user need at the centre of change, for example, the service user foreword goes on immediately afterwards to suggest that this means:

- Giving a strong, solid platform, with mass exposure to the three professions (Dietetics, Social Work and Occupational Therapy) that will, I hope, in the lifetime of this document, become widely accepted as the most significant in aiding and maintaining service users' recovery.

NWW for Everyone, Foreword for Service Users

There is no linkage to the work done by the social work group or the allied health professionals or separate occupational therapists group as to why these might be the 'most significant' in helping recovery. Dietetics, for example, only occurs in two other places, in a reference to the British Dietetics Association, and to a small project used as an example of good practice. Dieticians are mentioned twice in the Allied Health Professionals section of the document. There is no denying that dieticians have an important part to play in the delivery of mental health care, and improving the physical health of service users with mental health needs, but they are not, from the evidence base as presented in the accompanying document, one of three professions which are central to the provision of this care. The importance attached to this group and to the OTs and social workers

may be valid, and may reflect the experience of the individual service user who wrote the foreword, but it is not related to any evidence based or generalisable piece of research. The work accompanying the development of the Ten Essential Shared Capabilities, for example, may contain some evidence that would back up this claim, but again it is not referenced. This leads to a suspicion that the use of service user endorsement is a way of forestalling criticism or a critical reading of what follows. By saying that "service users want..." something, a critical reading of what follows is made uncomfortable for health care professionals who are trained to put service users needs at the top of their own priority list. By questioning the words of the service user who wrote that foreword, for example, I am myself made uncomfortable in that I question his experience. It is clear from the words that this individual does believe in the importance of the three groups he mentions and has received a good service from individuals in those professional groups, and maybe by implication less so from other disciplines. It is also interesting to note that he also highlights professional groupings rather than specifying a set of skills and competences that were valuable to him. The issue, however, is not in questioning the individual experience, which would make most mental healthcare professionals uncomfortable, but is about questioning whether this necessarily means that individual experience can be generalisable to mean that all service delivery ought to take account of that more personal experience. In research methodology much is made of the need to be careful about what is

generalised from qualitative statements, yet that principle is widely ignored within NWW.

6.3.2.6 Need for Flexibility in the New Ways of Working

A constant textual theme within NWW is the need for staff to be flexible, a theme that implies that in the past they have been rigid in their practice. The word 'flexible' occurs twenty one times and 'flexibility' a further seven times. It is a prominent theme, occurring first in the subtitle to the document, whose full title is:

Mental Health: New Ways of Working for Everyone
Developing and sustaining a capable and flexible workforce
Progress Report April 2007

NWW for Everyone, title page.

The use of the term is not restricted just to staff but to service delivery and teams, all of whom apparently need to be flexible in how they meet service user need. Given that it is staff who deliver services and that teams are composed of staff then the implication is that it is essentially people who have to change, either their role or their thinking about service delivery:

NWW challenges existing senior clinical roles to review their practice and work in new and more flexible ways to respond to the needs of service users and carers.

NWW for Everyone, Section 4.7.2

And:

Some of the general guidance from complexity theorists is useful, for example, the emphasis on a whole-systems approach, keeping rules minimal, simple and flexible, and good communication through the easy flow of information and the opportunity for continuous feedback.

NWW for Everyone, Section 4.12.12

This emphasis on the need for flexibility, and the implication that staff do not currently operate flexibly enough, is made clearer when the approach of NHS staff is specifically contrasted with that of staff working in the voluntary and independent sectors:

Work in 2006/07 has concentrated on the implications of NWW for professionals working across mental health, but usually in the NHS. This workforce is also employed, however, in the voluntary and independent sectors: in the former often in different roles, and in the latter usually in their traditional roles, but on different terms and conditions. The voluntary sector has a time-honoured reputation for providing person-centred, flexible services.

NWW for Everyone, Section 4.15.1

Whilst there may be some justification for the lack of flexibility being portrayed in NWW there is also some contrast with the perceptions of those staff when interviewed, as we will see in the next chapter. Exactly what this source of contention is (the lack of flexibility) is not spelt out in the document; it is assumed that the readers will understand this is a problem and take it for granted. Some clues are given in the issues which NWW seeks to address, many of them coming from the original NWW for Psychiatrists. This is particularly so when discussing the issue of responsibility in which the traditional notions of medical responsibility are loosened to allow

more flexibility. In particular the idea that psychiatrists are 'medically responsible' for all their team's clients is replaced by the concept of 'distributed responsibility' which gives much more responsibility to other clinicians:

This section provides a summary of the guidance available to support those professionals who are being asked to carry out new roles at the interface, and enable them to complete these roles in a high-quality, safe and defensible way. The sub-group responsible for this piece of work included representation from different professions, unions, defence bodies, the Department of Health and Royal Colleges. As traditional boundaries between professionals, and between primary and specialist care, are broken down, the notion of medical responsibility is transformed into sharing responsibilities between practitioners and patients or service users.

NWW for Everyone, Section 7.8.7

The concept of distributed responsibility is seen as a challenging one, but essential for the implementation of the project:

This 'distributed responsibility' model, across and between teams, represents a challenge - not just about how members of the workforce operate as a team, but also to those individual members of staff who are currently not working to their full potential or capabilities. It may mean some of them having to 'up their game' if they are to take their proper place in a more fully functioning team.

NWW for Everyone Section 3.1.3

Again the concept is presented as one which suggests some people are not functioning at the newly required standard, and is confrontational in suggesting that those who are failing to do this need to "up their game". The use of management theory based terms in this section is characteristic of the need to implement the

required change, and the implication of the section is that those who are unable to change will have no place in the new teams. Again the origins of this need for flexibility are shown, for although all the professional groups have been consulted about the document, this issue of responsibility has specifically been accepted by the psychiatrists' representatives as an essential precursor for acceptance more widely across the professional groups:

- the model of 'distributed responsibility', consulted upon by the Royal College of Psychiatrists, had been accepted by the General Medical Council and was reflected in its updated guidance;

NWW for Everyone, Section 3.6.1

The fact that this is more important for the practice of psychiatrists, but which impacts on the need for others to act more flexibly is that the phrase occurs only elsewhere in the document on a section regarding the training of psychiatrists:

- A paper was produced identifying where the requirements for data collection were at odds with NWW and distributed responsibility, and anomalies are being rectified.

NWW for Everyone, Section 7.9.10

The implication that flexibility gives extra responsibilities to other team members may be a liberating one for some practitioners, but there is also an implication elsewhere in the document that they haven't been pulling their weight and need to 'up their game' in a way which they haven't been so far, reflected in the diary of the ideal team working:

My working week has become much more flexible and the community team is now so competent that they are quite happy when I disappear off to other parts of the country.

NWW for Everyone, Appendix D

6.3.3.1. Social Events providing the context for the New

Ways of Working

The social context of NWW is complex, but has been alluded to in the literature review. As the preceding section shows, the main driver initially was a need to address issues arising from the role of psychiatrists.

5. Why is NWW necessary?

Back in 2003, NWW was necessary to help tackle the difficulties being faced by the psychiatrists. Together with other levers for change, including the new consultant contract, NWW has contributed to a significant improvement in vacancy rates and the development of fulfilling, sustainable jobs providing effective care. However, reform and regulation, the drive towards Foundation Trust status, and the rising expectations of service users, carers and the general public have all focused larger lenses on mental health services now than ever before, and have demonstrated that, in order to be sustainable, services need to be more flexible and person centred, at the same time as providing demonstrable value for money.

NWW for Everyone, Appendix B Frequently Asked Questions

This section includes reference to the needs of service users, but is clearer about the need to address a variety of demographic, social and political changes. The importance attached to the new consultant contract is matched by the way in which the respondents

give precedence to Agenda for Change, which addressed the pay, terms and conditions in the same way as the new consultant contract did for psychiatrists. Whilst Agenda for Change, however, is based on a system of assessing roles and job descriptions on the basis of the Knowledge and Skills Framework, there is no similar framework to apply to doctors (or dentists). Agenda for Change, as will be seen below, was intended to apply to the whole of the NHS, with the exception of doctors, dentists and some very senior management posts (effectively Chief Executives of Trusts).

6.3.3.2 Genre in New Ways of Working

Genre is important in NWW because it explains some of the inconsistencies within the document. There exists within the document a variety of contributors, and a variety of genres as a result. Each section has been constructed by different groups, and this is demonstrated in different styles of writing and intentions. The whole of the document is intended as 'Best Practice Guidance', as specified on the Information Reader Box which all Department of Health publications now carry setting out such information along with intended readership and details of any documents which are to be superseded by the current one:

Description: This Best Practice guidance sets out what New Ways of Working (NWW) means for everyone, how to make it happen, and what it looks like. It also updates progress on NWW for all the individual staff groups in mental health.

NWW for Everyone, Information Reader Box

The intention of Best Practice guidance is always to set out what the 'received wisdom' of best evidence is. The most commonly issued best practice guidance is the series of NICE guidelines and technical appraisals. These cover a huge range of subjects, and employ a series of evidence-based appraisals to come to conclusions about how best to treat service users. NICE guidelines always employ a clear definition of the type of evidence they use, based on research principles (i.e NICE 2004). NICE guidelines are also clear about the financial implications of the advice they offer and follow a clear structure which is consistent, but will, as with this document, represent the thinking of the authors in a way which is recognised to be subjective in some ways.

Within the document, however, there are passages that seem less certain than others, and while contributing to the whole are not always consistently 'on message'. We have already seen that the service user foreword, for example, is given high importance, but refers to ways of working which are not directly based on evidence, and refers to particular professional groups as important over others. Individual professional groups have different sections within NWW for Everyone, and they represent the views of those groups with no real attempt to provide a consistent framework for the different chapters. The social workers group, as we have noted, takes a particular interest in identity formation and social workers' identity within the healthcare settings they find themselves in, whilst other sections do not mention identity at all. The section for

Applied Psychologists concentrates on developing new roles and career structures for psychologists, whilst the nursing section (NWW for Everyone, Chapter 6) has received less dedicated time from the group, and largely references the work of the Chief Nursing Officer's report on Mental Health Nursing as the direction of travel for mental health nursing.

6.3.3.3 Difference in New Ways of Working

In the next section we will look at the assumption that NWW is a project that will be completed, and in this respect the document is quite clearly not open to different ways of doing things. However elsewhere in NWW the authors work hard to demonstrate an openness to alternative ways of thinking. This openness to alternative paradigms is one of the elements that Fairclough (2003) stresses as important for judging the value of a text. This is undermined within the document, however, because there is a tendency when discussing different and innovative approaches to steer these back to the 'approved' method (in the case below to CCTA), as prescribed by the project, which leads the reader to question just how open to alternative discourses the authors really want to be:

..to identify and explore different and innovative approaches to staffing levels, skill mix and ward team composition, capability and capacity within acute in-patient care, which can be translated into practical guidance. It was agreed to utilise the CCTA as much as possible;

NWW for Everyone, Section 4.16.1

Likewise where NWW has set up pilot projects to look at different ways of implementing specific elements there is open-ness to this difference, but an insistence that this still falls within the overall project of NWW:

Further replication sites and small medicines management innovations. Although the primary aim of Phase 3 was to improve medicines management in mental health, providers were encouraged to develop alternative ways of working and to introduce small innovations that improved care and demonstrated NWW.

NWW for Everyone, Section 7.7.4

6.3.3.4 Assumptions in New Ways of Working

The clearest assumption within the text of NWW is the assumption that this project is going to happen. Naturally there should always be an assumption of success within a change management project such as this, but this demonstration of the 'iron fist within the velvet glove' can at times be quite overt within a document which seeks primarily to use persuasion of the validity of its arguments in order to effect change. There is even an element of exasperation that people haven't quite 'got it':

Despite earlier guidance and the conferences, workshops, correspondence and meetings some confusion still remains about NWW and the new and extended roles. This report aims to clarify beyond doubt what is meant by these terms (see Section 1) and in Section 3 we look at what's in it for you, how we make it happen, and what it looks like when we have got there.

NWW for Everyone, Executive Summary

This assumption is further clarified by the explicit obviating of other ways of interpreting alternative possibilities for change. In the section on intertextuality below I will look at the use of the phrase 'New Ways of Working', but again the document is very explicit that it sees the project going in a very specific direction:

NWW is now a term in common usage in mental health circles. It has come to mean different things to different people, so right at the outset we should make it clear what we mean: ...

NWW for Everyone, Section 1.3.1

The section then continues to set out the aims of the project in a bullet pointed format to highlight the direction of travel.

The use of language in these sections is quite emphatic, '*..so right at the outset...*' and '*..clarify beyond doubt..*' are both phrases which almost defy the reader to challenge this way of thinking. Policy writers will often state facts and make an assumption that the policy set out will be followed, but these phrases seem to go beyond a simple statement of fact to an almost confrontational stance. If these statements were made in a verbal form, it would be possible to interpret them as bullying depending on the tone in which they were delivered.

6.3.3.5 Intertextuality in New Ways of Working

A confrontational stance is taken on by the use of the phrase 'New Ways of Working' itself. As we noted above it is possible to interpret the phrase in more than one way, but the authors of NWW for Everyone do not want the readership to think in that way, they want us to understand the phrase in the way that they understand it:

NWW is now a term in common usage in mental health circles. It has come to mean different things to different people, so right at the outset we should make it clear what we mean: ...

NWW for Everyone, Section 1.3.1

The authors then go on to clearly enunciate the 'correct' way to understand new ways of working. This is reproduced in full as it is key to the interview discussions later:

1.3.2 Working with the current workforce:

- to match the knowledge and skills of practitioners to the needs of the individual service user (the more complex the needs, the more experienced and skilled the worker);
- to think in terms of competence, not profession;
- to think in terms of dispersed leadership;
- to share knowledge, skills and competences across professional and practitioner boundaries; and
- to adopt a team approach to NWW, rather than an individual practice or practitioner focus, thus making better, more effective use of existing resources.

1.3.3 Extending roles and scope of practice of existing professions, including:

- non-medical, independent and supplementary prescribing;
- the proposed Responsible Clinician and Approved Mental Health Professional, as set out in the Mental Health Bill;
- advanced and consultant practitioner roles; and
- delivery of psychological therapies.

1.3.4 Brand new assistant and practitioner roles to bring new people into the workforce, including:

- Support, Time and Recovery workers;
- graduate Primary Care Mental Health Workers;
- case managers
- Associate Mental Health Practitioners
- community development workers in black and minority ethnic communities (non-clinical role);
- psychology associates; and
- Peer Supporters.

New Ways of Working for Everyone Sections 1.3.2-1.3.4

New Ways of Working, then, must mean these three things: working with the current workforce, extended roles, and new roles. So by definition it cannot mean anything else. This section also sets out the difference between roles and professions, and the need to '*..think in terms of competence, not profession.*' It also, as noted before, justifies the policy in terms of service user need, in order to reinforce the previous thinking, although again without justifying it explicitly (having previously made the case).

The use of the phrase 'new ways of working' to mean this project becomes cemented by the capitalisation of the phrase into 'New Ways of Working' or NWW. The use of capitalisation for key phrases is taken further within the document when the phrase 'new roles' becomes 'New Roles' or NR. Whilst it is common to use acronyms as shorthand within the healthcare professions, and within documents where it prevents lengthy use of cumbersome phrases, this usage seems to go beyond simple acronymic use. By capitalising these two phrases the difficulty in using alternatives becomes greater. It is actually not necessary to have NR as an acronym because it is a short phrase and easy to reproduce as a concept. By capitalising it, and then using the acronym, the phrase is no longer a free floating concept: it must refer to the definition of New Roles already set out in the document. Likewise New Ways of Working (NWW) cements the usage of the phrase as defined by the document authors rather than allowing alternative thinking about 'different ways of organising service delivery' or even of developing 'capable practitioners'.

Whilst earlier I expressed surprise at the emphasis put on Agenda for Change as a document having influence in this workforce, it should be noted that in terms of intertextuality the phrase 'new ways of working' (uncapitalised) actually occurs within that document, published slightly before NWW was begun:

The signatories to this agreement will accordingly work together to meet the reasonable aspirations of all the parties to:

- Ensure that the new pay system leads to more patients being treated, more quickly and being given higher quality care;
- Assist new ways of working which best deliver the range and quality of services required, in as efficient and effective a way as possible, and organised to best meet the needs of patients;

Agenda for Change, Introduction.

This is particularly apposite in that Agenda for Change does not apply to the Consultant Psychiatrists for whom New Ways of Working was originally envisaged, before its expansion to include everyone. The link between the two documents is clear in terms of this particular phrase, when previously the work on developing mental health practitioners who had the appropriate skills and competences to meet the needs of service users had been couched in terms of 'capable practitioners'. The Sainsbury Centre's 'Capable Practitioner' document had, as we have seen, been the primary driver for developing service-user led workforce, based on an extensive survey of service user opinion which is well documented in that report. This is further compounded by the fact that there is actually no reference to 'The Capable Practitioner' in NWW for Everyone or in the Implementation Guide (NIMHE 2007b), despite there being representatives of the Sainsbury Centre on the group which wrote it.

This may be entirely innocent, as the reference back to service user involvement usually quotes the 'Ten Essential Shared Capabilities' that NIMHE developed in conjunction with the Sainsbury Centre,

again based on service user need. The Ten Essential Shared Capabilities document (2004) does reference the Capable Practitioner document, but the influence of the earlier document seems to have been subsumed entirely into the NIMHE sponsored Ten Essential Shared Capabilities. The keystone development (of Capable Practitioner Framework) can, therefore, be traced in NWW, but only indirectly, and what had been a useful phrase, (and arguably one which was equally directive) is completely lost in favour of the new phrase of NWW.

This new phrase then, must have a utility that the old one did not. The phrase 'capable practitioner' could itself be the key, in that by using a generic term so prominently, as the title and key phrase, an emphasis is put on a loss of professional identity, that individual professions will be subsumed into one generic 'practitioner'. This is not what the Capable Practitioner Framework suggests, of course:

Previous competency projects emphasised the notion of 'core' or 'common' competencies or skills that were shared by all practitioners. This thinking is continued in this framework but also included, is the recognition that profession specific skills and expertise are needed to implement the NSF in modern service configurations.

The Capable Practitioner, Executive Briefing, Section 7

The phrase used without explanation, however, does reinforce a perception of loss of identity, despite the fact that the document does not actually say this. The fact that several of the practitioners interviewed, as we will see, were not able to name a single

document which had impact on workforce planning and professional identity (see next chapter) suggests that the impact of documents can be limited. The naming of the document may actually be the only part of the thought process that extends to, and pervades the level of clinician. For example the quotation below is of a clinician referring to a presentation on New Ways of Working:

I have got to say that when that presentation was introduced to the service by the um.. the psychiatrist, the penny didn't drop for me, in terms of how that was going to impact or not on what everyone else was trying to do, or is doing.

Respondent 28 - Social Worker – Practitioner

In this respect then 'New Ways of Working' is less threatening to professional identity than a perception, however incorrect, that the new ways involve everyone becoming 'capable practitioners' rather than being nurses, doctors, psychologists, social workers or therapists.

As we have traced the pulling back from the use of the phrase 'capable practitioner', through the use of the 'Ten Essential Shared Capabilities' document, to 'New Ways of Working' presented as the only possible way forward, there begins to be an element of careful planning about how this movement is 'sold' to its intended audience as a non-threatening change. The use of language is crucial in this respect because it anticipates the objections of professional bodies and individuals who might fear a loss of personal or professional identity into a generic worker role. Although the question was never

asked in interview I did email the principal authors of NWW during the analysis phase of this project and asked if there was a direct correlation, or where the phrase had come from. Their answer was simply that it had come from the Modernisation Agency. As we have noted before, the Modernisation Agency does use the phrase in other contexts within health.

In contrast to this is the way in which the toolkit for changing teams is named. Much emphasis is put on the use of this toolkit, which starts from service user need and then looks at what skills and competences are needed to meet that need, and then looks at how to gather together those skills and competences. The toolkit is called 'Creating Capable Teams Approach', which does again echo the 'capable practitioner' phraseology. Within the NWW for Everyone document the word 'capable' occurs thirty-nine times, and is co-located with 'teams' on thirty-six of these occasions. Elsewhere it occurs twice, in the subtitles of the document itself and in passing, in a section describing a voluntary sector project:

Operating in Northamptonshire, the project has two main objectives:

to develop a third sector workforce capable of delivering services that promote recovery and social inclusion;

NWW for Everyone 4.15.3

This suggests that the word was carefully chosen to echo the 'capable practitioner' language, rather than being randomly chosen. They could, after all, be 'effective teams', 'purposeful teams' or

'proficient teams'. In using this language then, the move towards teams that are not dependent on the professional identities of their constituent team members, but rather are a functional unit, is further sealed.

6.4 Critical Discourse Analysis of Agenda for Change

6.4.1 The Agenda for Change Project

As noted above, Agenda for Change (AfC) was not one of the documents originally anticipated as being mentioned as frequently as it was in the course of this research. It is different from the other two documents in that it is the result of some very lengthy negotiations between the management of the NHS and the trade unions and professional bodies that represent the 'staff side' of the workforce. In many ways when people refer to Agenda for Change they seem to refer not to the document, but to the intention and effect of Agenda for Change. In analysing the document, then, I will maintain a tight focus on the implications within the document for professional identity (rather than a full exegesis of the effects of the exercise). For the purpose of analysis the text used is the AfC Final Agreement published in December 2004 (DoH 2004b).

6.4.2 Textual themes in Agenda for Change

6.4.2.1 Characteristic features in Agenda for Change

The most characteristic feature in AfC is the fact that it does not shy away from discussing pay and remuneration in the way that the previous two documents do, because this is the main focus of the document. Whilst the other two documents talk of skills and competences as ways of looking at skill mix and effective service delivery, the opposite is true of AfC, which necessarily has to tackle

the issue of how the skills and knowledge bases of a wide variety of professional groups can be put into a framework which can then be used as a basis for working out a grading scheme on which staff can be re-graded and paid.

The characteristic features of AfC would relate to the technical matters of how changes are made to the pay grading of individuals, how these changes are implemented and what provisions are made for exceptions negotiated to terms and conditions, i.e. inner city payments.

6.4.2.2 Identity in Agenda for Change

The word 'identity' does not occur in AfC. This seems to be because it is one of the assumptions of AfC that the professional identity of each staff group is tied up in their professional grouping. The word 'professional' occurs fifteen times, of which five times it collocates with role, to refer to 'professional role(s)'. This high usage of 'professional', as well as the reliance throughout the process on professional bodies, means that in this particular document, despite its relevance in the minds of those questioned for the research, there is actually no need to discuss identity because it is taken for granted.

6.4.2.3 Skills and Competences in Agenda for Change

By contrast skills and competences are mentioned in AfC, and very frequently, for they provide the basis of the eventual settlement.

However the phraseology used in AfC is very different, for the word 'competences' again does not occur in the document, although 'skills' are mentioned twenty-three times. The word 'competencies' occurs only once, in the context of the Knowledge and Skills Framework:

The KSF will continue to be developed so that it:

- is simple, easy to explain and understand;
- is operationally feasible to implement;
- can use current and emerging UK or national externally quality assured standards or competencies;

AfC, Section 7.3

This emphasis instead is on the Knowledge and Skills Framework (KSF) and is important because it is the basis for career development within AfC, but it is a different emphasis from that in NWW, for example, where teamwork is the more important feature. The AfC necessarily has to focus on the individual staff member, because this is where it relates directly to the pay and conditions of that staff member.

Both frameworks value the skills which staff bring, but AfC largely substitutes 'knowledge' for competence. The word 'knowledge' occurs twenty one times in AfC. In NWW it occurs more frequently (twenty eight times) but in the context of a much larger document, so the significance is lower. The reasons for this are based in the purpose of the documents, in that AfC uses formal (academically acquired) knowledge, as defined by level of education, as one of its

key points for determining grading. The assumption is that the levels of formal education equate to similar levels of knowledge, so:

The NHS Job Evaluation Scheme recognises that all health care professionals who have, as a base level, graduate qualification evaluate at a similar level. Whilst there may be differences these are unlikely to be sufficient to justify a different pay band. This means that it is very likely that they will be placed on pay band 5.

AfC, Annex K1

6.4.2.4 Service User needs in Agenda for Change

It is perhaps not surprising that 'service users' are not mentioned at all in AfC. The phrase 'service users' is characteristic of mental health services rather than the broader NHS, which still generally uses 'patients' to refer to those who use services. The word 'patient' occurs five times, and 'patients' fifteen times, but these are almost incidental to the description of what staff are doing, rather than being used as the justification for all that follows, in the way we have seen in the NSF and NWW. Again this seems to be a function of the nature of the document. 'Psychiatric patient' does occur once in the document, in relation to the absorption of psychiatric lead (a special payment under the old terms and conditions) into the mainstream of grading. The system, however, is said to have the needs of patients at its heart.

6.4.2.5 Need for Flexibility in the Agenda for Change

Given the emphasis put on the need for more flexibility in NWW it is perhaps more surprising to find that when flexibility is mentioned in AfC it is usually in a very different context, that of offering more flexible working arrangements for staff, i.e.:

Improve all aspects of equal opportunity and diversity, especially in the areas of career and training opportunities and working patterns that are flexible and responsive to family commitments;

AfC, Introduction

The emphasis in this document, then, is very much on staff needs, with only a passing thought to service user needs. The feeling appears to be that in order to provide a better service the needs of staff are to be taken into account:

A series of Improving Working Lives toolkits have been produced to provide guidance to both managers and staff covering the whole range of issues within Improving Working Lives, including flexible working.

AfC, Annex 4C

This may, of course, reflect the origins of the document and particularly the negotiations with trade unions who see their service users as their members, the staff members, and thus stress their needs.

6.4.3.1. Social Events providing the context for the Agenda for Change

Whilst the NSF for Children and NWW for Everyone both have a political element, they have less impact because each affects only a part of the workforce, either the children's workforce, or the mental health workforce, though for CAMHS there have been elements of impact from each one. AfC has been political in a much wider scale because it affected almost the whole NHS workforce, and the NHS is one of the largest employers in Europe. The process of negotiation to change the terms and conditions of a wide range of staff whose pay, terms and conditions had evolved over a very long period of time, took some considerable time and was politically very sensitive. The New Labour government was aware of the need for modernisation, indeed had been elected with modernisation as part of its agenda, but traditionally has a strong support amongst public servants such as healthcare workers. The process of modernisation, therefore, needed to be one that took these things into account.

The process, despite being a long one in terms of time spent on negotiation, was accused of being released at the time it was for political reasons because the government was facing industrial action by another group of well regarded public servants, the firefighters. The final agreement of AfC was launched in 2002 (though only implemented in 2004) at the height of the industrial dispute with the Fire Brigades Union and was presented as a reasoned example of a group of staff (within the NHS) who accepted

modernisation and were being rewarded for it, in contrast to the firefighters who were seen as being reluctant to modernise (BBC News 2002a, BBC News 2002b). It was also used as an example to the medical profession who were negotiating their own separate contract at the same time (BBC News 2002c), and which was finalised a couple of months later (BBC News 2003).

6.4.3.2 Genre in Agenda for Change

Genre is easier to define within AfC. The Department of Health Information box defines this document as 'Policy', which means it is agreed and should be implemented as written. The agreement is just that, an agreement that was made between the employers and representatives of the staff who would have agreed each area in some detail after prolonged negotiations, which leaves little or no room for divergence from that agreement. Divergence from the prescribed agreement could open up either side to potentially legally enforceable proceedings or industrial action, so the language used is dogmatic and precise, unlike the other two documents examined above which seek to be more persuasive (with the exceptions noted).

6.4.3.3 Assumptions in Agenda for Change

The assumptions inherent within the AfC agreement are likewise straightforward. As with the NWW document there is an assumption that this will go ahead, but this assumption is based on a much firmer basis because of the detailed negotiation process with

professional bodies and trade unions. Whilst NWW mentions that it has been consulted on with some of those bodies, principally the professional bodies, rather than actual trade unions, and is specific on some issues (i.e. distributed responsibility, as above), it cannot be as certain as AfC because NWW is only guidance, not policy. There is no compulsion to implement NWW in the way that there is for AfC.

What AfC does establish, however, is the principle that skills and knowledge can be broken down into a framework that can be used to determine the role of individuals employed by the NHS. This principle has been agreed by the trade unions and professional bodies as representatives of the individuals, in the form of the KSF and the Job Evaluation scheme. This is important as it forms the basis for moving on to the flexibility that NWW seeks and which the KSF assumes will happen. By accepting that a job evaluation is made up of a series of different skills, competences and knowledge, the scene is set for reviewing roles as they become available either individually or as part of a team review (as envisaged in the Creating Capable Teams Approach). The assumption that skills are transferable from one professional group to another is important in mental health teams where there is, as we have seen, an understanding that there is considerable overlap of skills. What this does is to move away from the concept that an assessment done by an OT, for example, is necessarily different from that done by a social worker. So long as the assessment format defines what is

being assessed (in a standardised way, like the Care Programme Approach) then the assumption is that either person could do it. The need for specialist assessments, therefore, needs to be better defined if professional groups are going to suggest that their skills are different from other groups. An OT, therefore, would have to define how they are going to assess the activities of daily living and employment or occupational potential of a service user in a way that is different from how a social worker or nurse would make that assessment. This links in with the findings of Crawford et al (2000) that role blurring actually tends to heighten the difference between professional groups in that they are forced by this process to better define what it is they bring that is different or unique to a team. The process of 'selling' the value of that difference or uniqueness to the service users who are now effectively buying those skills (through the CCTA and commissioning process) becomes more important. Actually defining what it is about how nurses, or social workers, or psychologists bring an element of difference of approach becomes more important for professional identity if indeed that identity is important to individual staff members.

The King's Fund assessment of the implementation of AfC, 'Realising the Benefits' (Buchan and Evans, 2007) summarised the aims of the project as:

The goals were nothing if not ambitious. Agenda for Change was designed to develop new roles and new ways of working. It was intended to improve recruitment and retention; pay fairly and equitably for work done; and create a system in which career progression was based on responsibility, competence and satisfactory performance. Agenda for Change was also created to simplify and modernise conditions of service and, if all that were not enough, its advocates also claimed that it would lead to better care for patients.

Realising the Benefits, Introduction

As noted above there is a realistic appraisal of the fact that patient benefit was a bonus, rather than the central intention of the process. 'Realising the Benefits' also described the previous arrangements as a 'mess', a system that needed sorting out, but concluded that the KSF process is 'cumbersome and costly to implement.'

The final assumption that comes across clearly in AfC is that professional identity is not inconsistent with the KSF skills and competences framework. It does not talk specifically about identity as we have seen, but does talk a lot about professional groups and professional skills in the context of the KSF. Although the King's Fund report (ibid) sees this as cumbersome, it does provide a framework to begin to provide a way of clarifying what each job profile (developed through the Job Evaluation scheme) brings to the team functioning. The assumption, therefore, is that each professional group can provide itself with a profile that will describe its own function in terms of skills and competences. Whether this is an adequate description of professional identity is not seen as

important, because it is not addressed in AfC, merely assumed that these identities will continue.

6.4.3.4 Intertextuality in Agenda for Change

It is also interesting to note the use of the phrases 'new roles' and 'new ways of working' in the quote above, as 'Realising the Benefits' is a review of the whole of the AfC process, but clearly picks up on the phraseology as used in AfC and increasingly across the NHS Modernisation Agency (DoH 2002). The NHS Modernisation Agency also has programmes of 'new ways of working' for other areas, principally surgery and critical care, though these are not directly mentioned as not being relevant in this context.

6.5 Policy discourse summary

There are a huge number of policy documents available to inform the development of CAMHS and mental health services, but only a few of these are making an impact as practitioners appear to be overwhelmed by the number and variety of documents.

There is no consistency amongst respondents about which documents are seen as most important. Even the most current one, New Ways of Working, was not mentioned by name by all the respondents.

There is evidence within the policy documents that the intended direction of travel is towards developing a generic workforce of 'capable practitioners' but this intention is not made clear, and the reliance on working with established professional groups may be seen as part of a change management process towards that eventual goal. The motives for this proposed change are always given as being what service users want, but other, more pragmatic, motives for change are also mentioned.

The way in which service user need is quoted as central to the process of change management is laudable, but is done in a way that allows doubt as to the intention of the authors. By failing to ensure that a rigorous method is attached to the use of service user and carer experience the authors allow doubt as to whether this is their true intention or whether this is being used as a justification for other motivations which are given but which are presented as very much secondary.

The identity of individual workers is not given much emphasis, in comparison to the role that is required. This emphasis on function, skills, competences and capabilities is within the framework of an existing professional structure that does take more account of the need for an individual identity that encompasses something bigger than mere function.

Chapter Seven – Analysis of Practitioner Discourse

7.1 Introduction

Having looked at the documentary guidance on how mental health teams, and particularly CAMHS, are envisaged by government policy, this section examines the response of a group of thirty-two people from across the country who have been involved with this process in a direct way. The discourse of their responses will be related to the documentary guidance where appropriate, with a focus on how they consider they and others around them are constructing their professional identity in the face of the documentary and policy discourse. This will lead onto a final chapter of analysis that pulls together the discussion of both areas of discourse (policy and interview respondents), and develops a thesis on the place of professional identity in mental health teams and CAMHS.

7.1.1 Demographics of the interview group

As set out in the methodology chapter, the intention was to capture a spread of people who have been affected by policy as well as those who have been influencing the development of that policy. As such it was an intentionally purposive sample and claims only to be representative of the thoughts of the respondents on the day that they were interviewed. Whilst no attempt is being made to claim that the thoughts of the respondents can be generalised across the whole workforce of CAMHS and mental health workers, it is still

important to demonstrate that this is not a homogenous group, but one which represents a variety of opinion and demographic spread.

7.1.2 Gender

Of the thirty-two interview respondents seventeen were female, and fifteen were male.

7.1.3 Ethnic Origin

This was not specifically asked; however all but one of the respondents appeared to be White British in origin.

7.1.4 Geographic Spread

The intention was to cover the whole of England. Of the thirty-two interviews conducted there were two clusters, geographically, and the rest were spread across the country. The two clusters were in London, home of the Department of Health, and the East Midlands, which is home to both the National CAMHS Support Service (in Leicester) and the University of Lincoln's Centre for Clinical and Academic Workforce Innovation (CCAWI) in Pleasley Vale, Nottinghamshire⁴. The clustering occurred, therefore, not from design, but because the snowballing method of gathering potential respondents meant that a proportion of these would be affiliated to one of those three institutions. The rest of the sample came from across the country, ranging from Southampton in the south of the

⁴ CCAWI has since relocated to the Brayford Pool campus in Lincoln.

country, to Somerset in the west, and as far north as Newcastle-upon-Tyne.

7.1.5 Original Profession

Given that this study is concentrating on professional identity, it seemed important to be clear on what was the original professional training of respondents in order to determine whether this had an effect on their views of current policy as well as how they continued to frame their own professional identity. Of the thirty-two respondents, their own description of original / core profession was:

Figure 4 Original profession of interview respondents

| | |
|------------------------|----|
| Psychiatrist | 5 |
| Clinical Psychologist | 4 |
| Nurse | 16 |
| Social Worker | 4 |
| Occupational Therapist | 2 |
| Civil Servant | 1 |

This spread of professions does largely represent the types of different original training that might be found in mental health teams and CAMHS. The civil servant had been involved in the development of policy and had been included for that reason. The obvious omission is of psychotherapists, but as has been noted in the literature review most psychotherapists have an original core professional training prior to postgraduate training in a particular psychotherapy, and whilst this additional training will undoubtedly

affect their professional identity this categorisation chose to concentrate on 'core professions' as defined by the HAS 'Together We Stand' (1995) document. Of those interviewed several were fully trained in psychotherapy, but were not using that in their job title.

The other clear thing to note is the high preponderance of those with a nursing background. This may reflect a bias towards the researcher as the invitations to participate clearly came from a researcher who was based in a School of Nursing (although the researcher's professional origins were not made explicit). This may, however, have made those of a nursing background more sympathetic and therefore more likely to respond. There are instances within the text where this is not an issue, as the respondent had clearly not been taking this into account until they felt the need to clarify it:

Res: But where do you come from, what's your profession?

Int: Nurse.

Res: ...nurse... so um.. um.. I .. so you find that the identity.. the professional identity varies, I think, even within the professionals.

Respondent 25 - Psychiatrist – Policymaker

It is also clear that nurses form the highest proportion of the CAMHS workforce at approximately forty per cent of that workforce (CAMHS Mapping 2004). The numbers above are clearly over a representative forty per cent. The other area of influence that appears to have pushed this percentage up is the current role of

those interviewed, as described below. Particularly there were several CAMHS Regional Development Workers (RDWs) included in the interview cohort, and these were all from a nursing background (though nationally not all RDWs are nurses). This reflects the overall composition of that workforce, which was advertised and recruited to at a salary level which was attractive to highly qualified nurses (or social workers and AHPs), but below that which would necessarily attract equally experienced clinical psychologists or psychiatrists.

7.1.6 Current role of interview respondents

In order to be clear about the current role of respondents it was also asked at the beginning of each interview what was their current job function. These were then broadly categorised as below:

Figure 5 Current role of interview respondents

| | |
|-------------------------------|----|
| Policy makers | 5 |
| Policy makers / Practitioners | 3 |
| Implementers | 9 |
| Implementers / Practitioners | 4 |
| Practitioners | 11 |

For the purposes of defining membership of each group the following definitions were used:

- **Policy makers** included those whose only current role was as a full time employee of an academic institution or

government department (including NIMHE/CSIP), and whose role did not include any element of practice. Though this group were also involved in implementation to a degree, this was not their primary role.

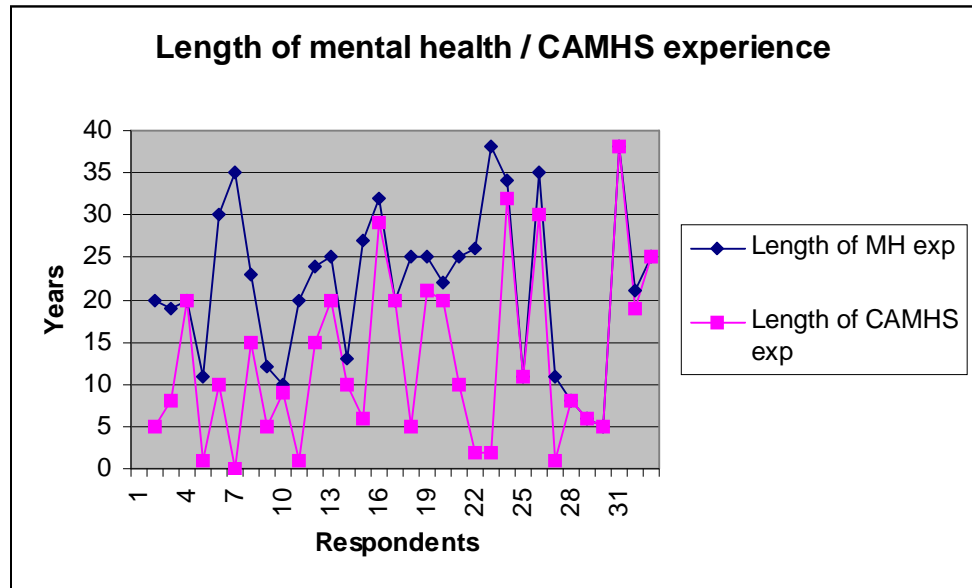
- **Policymakers / Practitioners** included those who had been heavily influential in the development of policy, but who had done so in a part-time role, and retained an active practice role in day-to-day clinical settings.
- **Implementers** were those whose primary role was to help clinicians and services to implement current policy. This group included some of the Regional Development Workers from the National CAMHS Support Service, for example. This group did not have active clinical roles, but all of them had an extensive clinical background in mental health teams or CAMHS.
- **Implementer / Practitioners** included some people who had a part-time role as an implementer but who retained an active clinical practice for the rest of the week.
- **Practitioners** included those who were in day-to-day clinical practice within a mental health team or a CAMHS.

Of the thirty-two interviewed, therefore, eighteen were currently in some form of current clinical practice. Only one respondent (as noted before) had no direct experience of working in a mental health team or CAMHS.

7.1.7 Direct experience in mental health teams or CAMHS

Respondents were also asked about their length of experience in mental health work, or directly in CAMHS.

Figure 6 Length of mental health / CAMHS experience



Whilst this represents a mixed picture for a mixed sample the range of responses for mental health experience was between 0 (n= 1) and 38 years (n=2) with a mean of 21.7 years, and a total mental health experience amongst the respondents of 705 years. The sample, therefore, represents a very experienced cohort in respect of mental health practice. Those with CAMHS experience tended to count CAMHS experience within their mental health total:

In mental health, I qualified in March [year]. I worked for 18 months in adult mental health... um... and then, in September [year], I went to work at in-patient CAMHS for two and a half years before coming to community CAMHS, here, um.. that'd be April [year], I think it was. So nearly, gosh, nearly six years.

Interview 09 - Nurse - Implementer/Practitioner

For CAMHS there was a similar mixed level of experience, with a range of responses between 0 (n= 2) and 38 years (n= 1) giving a mean of 12.4 years and a total of 409 years CAMHS experience. This figure is, however, skewed by the number of people interviewed for their overall experience of mental health policy who had only very limited CAMHS experience.

7.1.8 Time frame of interviews

The interviews were conducted between October 2006 and March 2007. This is important because the policy discourse was still developing rapidly at the time of the interviews, and this is alluded to by some of the respondents. New Ways of Working for Everyone, which included the summaries of different disciplinary working groups, was launched and published in April 2007, just after the interviews had been completed. Many of the practitioners were also involved in the third wave of NHS provider Trusts preparing to move towards Foundation status, and this is reflected in some of the management preoccupations in their clinical settings.

7.2 Textual themes in the Practitioner Discourse

As noted in the methodology section the interviews were conducted in an open format with only a small degree of framing of the discourse by the researcher (see Interview Schedule, Appendix 4). As such the interviews covered a wide range of areas relating to how policy is being enacted and shaping the professional identity of the workforce currently employed in mental health and CAMHS. The analysis which follows therefore will naturally concentrate on those issues which directly relate to professional identity rather than attempting a fuller analysis of many of the wider issues discussed. As noted in the methodology chapter, this section is a thematic analysis informed by CDA, rather than a strict application of CDA methods.

7.2.1 Characteristic features in the Practitioner Discourse

Within the discourse it is important to restate that almost all of the respondents were able to discuss the issues at length, with very little prompting. Without replicating long pieces of text here it is characteristic of most of the interviews that respondent replies often cover several pages of transcription without any intervention from the interviewer. This reflects the length of experience of the respondents, and their willingness to be interviewed on the subject matter in hand, but there are also specific references to professional identity as being important, even if not something they had specifically articulated before:

In terms of my own professional identity, I take great pride in being a nurse. And, haven't really kind of thought that through what that actually is.. actually about.

Respondent 23 – Nurse – Practitioner / Implementer

And:

Um... well .. that's .. I think that's an interesting.. I think that's a sort of .. a big part of it. But I think how people get that professional identity is also really interesting.

Respondent 10 – Occupational Therapist – Practitioner

7.2.2 Identity in the Practitioner Discourse

As the study and interviews focus on identity the initial exploration will focus on very specific reference to identity within the practitioner discourse, and then widen out to look at issues that relate to identity or which have been identified in the policy discourse (above) as being important.

7.2.2.1 Personal identity

As identified in the literature review it is clear that the concept of personal identity was on the minds of respondents, who did not describe professional identity in homogenous terms. Specifically, although different individuals are expected to perform a similar role and function within teams, there was reference to the individual differences which personal experience and personality bring which will affect how that function will be delivered:

Um, I think that's, that's really powerful. I mean, it's really frustrating because I've, obviously over twenty plus years worked with people that, I would say, were "ideal" for working in the profession. And I've worked with some that are not "ideal" at all and I think some of my frustration often um, when I worked with, looking at when I moved into a strategic role and looking at what it, why did some teams work better than others and it, you know, it is all about people's attitudes, values and visions really. And, and it would be really great wouldn't it, if you could bottle that and make the other team work in that way.

Respondent 01 – Nurse – Implementer

How important the personal aspects of the individual worker are in service delivery was an area where there was considerable uncertainty expressed by some:

Um... [4 seconds pause] there's obviously a strength in having professional... a profession or whatever it is. And there's obviously strengths in having personal skills. Where that balance comes into play ... I'm not sure... right at this moment, I'm not able to say where that balance lies.. um... there's strength in both I think. Not one is bad and not one is good either, I don't think.

Respondent 04 – Civil Servant – Policymaker

Others, perhaps coming from a more informed therapeutic model, were much more certain of the way in which individual and personal qualities are important in therapeutic relationships:

...some of the things that have been most noticed by the families are the things that we are commenting about the personal impact of what people are saying. Or you are making some links with ... er... how you see it as a person, as opposed to a doctor. Um.. um..[7 seconds pause] and er... it makes the work more difficult at times, because you are more emotionally identifying with your patient and you...you.. it's er.. it can stir things up far more, but it.. it also feels a far more powerful way of working than purely a very detached professional model. Um.. so I think you have to kind of rein yourself within limitations and with safety nets.

Respondent 08 – Psychiatrist – Practitioner

There was also a recognition that the underlying motivation to come into a certain profession was a personal one, and that underlying motivation contributed powerfully to the creation of a complete personal identity which involves both the personal and professional:

[Long Pause - 15 seconds]. I'd... don't knowI think, sometimes, there's that underlying thing... wanting to help people and wanting to kind of make people's lives happier and caring and those kind of basic, sort of nursing things I suppose. And I think about nursing, I think about myself, it's that wanting to make things OK.. and people better...um.. and sort of...but.. I mean.. the sort of curiosity about how people minds work and this fascination when it all goes wrong and... the psychology of it.. I don't know, some people are just really fascinated by that kind of thing, aren't they?

Respondent 09 – Nurse – Practitioner

In this respect there was also recognition that personal aptitude would be an important part of recognising people who would make good workers within different professions, or at least a common need for basic personal qualities:

So, I do think um.. and maybe people with particular views on life are attracted to particular professions or even.. not particularly professions but sort of the "helping profession" as a whole. Um.. but I think you do have.. particularly in mental health, I don't think you can work with people without it being you that's actually facing that person. It's not ...it's not a nurse.. you just happen to be a nurse.. it's you that's having the interaction with that person. So I think it's a big element of you as a person but I do think your training shapes that somehow.

Respondent 15 – Psychiatrist – Policymaker / Practitioner

Whilst this theme is common amongst nurses, who may well have in mind Peplau's concept of the 'therapeutic use of self' (i.e. Peplau op cit), there is a wide acknowledgement of this within the psychotherapeutic literature. This was best summarised:

Um.. tch.. the.. the personality qualities will obviously be the most important, I think, because it doesn't matter what professional training you get in the end.. The personal qualities to actually enact them, then, you know, will .. have a therapeutic benefit..

Respondent 32 – Nurse – Practitioner

7.2.2.2 Role blurring and genericism

As was discussed in the literature review there is a strong sense within mental health workers that the sort of multidisciplinary team working carried out in CMHTs and CAMHS is different from that which exists in physical healthcare MDTs. This is characterised by more blurred roles, and an overlap of skills that might not be expected elsewhere in healthcare provision.

Um, I've always worked in teams that have been ... I would say properly multi-disciplinary... so the consultant might have a ... kind of have a key role or other central role, but often... um.. it's not a clear.. in a sense of a hierarchy or leadership role..so it's quite different from the standard medical model that you'd find... or I have found when I have worked in other medical specialisms, such as paediatrics or medicine,...

Respondent 08 – Psychiatrist – Practitioner

With some reservations staff acknowledged the overlap of skills and ability for different people or professionals to offer a broadly similar service.

Yeah, and nine times out of ten, if somebody's accepted, it's like, we have a little section where it's like well "who would be the best person for this case?". And, nine times out of ten, it will be .. there's a tick box for "anyone". So.. it's ... "anyone can do that assessment" and it should be pretty much the same kind of assessment that they would get. I mean, in reality, I don't know if it is. I'm sure everyone puts their own certain slant on it, individually, let alone if you're from different disciplines.

Respondent 09 – Nurse – Practitioner

Within this acknowledgement of multi-disciplinary team working, however, there was some questioning of whether this was actually multi-disciplinary work, or simply a tendency for everyone to do the same thing. Roles therefore become blurred so much as to be indivisible, and a common generic role overtakes the individual professional contributions.

I think though, for me, things like CAMHS nursing has become more blurred as there's been a move to ... it's almost a move towards multi-disciplinary team but, actually, everybody does the same thing. Um.. and I've seen this happen in a number of different services I've worked in.. We've had a range of professionals there, with a range of skills and qualifications, but most of the people are doing the same work, including like consultant psychiatrists, which kind of makes a hash of it all.

Respondent 19 – Nurse – Implementer

This same respondent, however, pointed out one of the perils of making, not a multidisciplinary team, but one where everyone did the same thing. This relates to power and ultimately to how different team members are remunerated, which will be examined in detail later:

But do you analyse what everyone in the teams doing and work out how it can be most effective... whilst still feeding in some of the evidence around the profession. Or do you all just do the same thing, you know, (laughs) and pick out those who get paid loads (laughs)!

Respondent 19 – Nurse – Implementer

For others the theme of similarity of approach leads inevitably to a questioning of whether there needs to be sharp, or even soft professional differences between team members, when the function of the team, as a whole, is to provide a defined service:

I've worked in multi-disciplinary teams where.. it became quite difficult to remember or identify people's original profession. Because people were doing so many similar things. Everybody was in a position where they could offer some psychological intervention of some sort. It might be a bit more psychodynamic, or it might be a bit behavioural, but everyone was working with people and offering that kind of intervention.....

We may see; and I have.. it's rumbled around for a long time, but we may see a single professional entity which is no longer nurse/social worker er.. or er.. other specialist sub-sets of professions but somebody working in mental health, a person, and I can sense, in a way I think never sensed before, the sense.. this possibility of a mental health worker profession, which may be less about social work and nursing; and occupational therapy, than it is about service delivery. So that.. that's an interesting thing I think. To see the system change.

Respondent 22 – Nurse – Policymaker

In this sense the respondent is more at home with the concept of a single 'capable practitioner' than are most of the interviewees.

Within this respondent's comments there were recognitions that this 'capable practitioner' or 'mental health worker profession' would take a long time to develop and meet acceptance, perhaps as long as a generation.

Others might accept a move towards a more generic construction, but still had reservations about the move, including those that reflect imbalances of power and remuneration.

Um.. like.. like you know, I've thought long and hard about this subject and discussed it with colleagues. Um.. I have less anxiety about moving to a generic profession, um.. or a generic workforce. Um.. I am less um.. concerned about um.. preserving the professional identity within that. Because I think the professional identity is many things. Um.. I don't um.. think, however, that we should all have generic titles and do the same thing and be paid different amounts to do it.

Respondent 24 – Nurse – Implementer / Practitioner

7.2.2.3 The importance of professional identity

From this overall reluctance to accept a move towards a 'generic' style of working it was possible to detect some sense of what professional identity meant to those who were interviewed. In many cases they struggled to articulate this without appearing defensive about their own professional group, and seemed a little ashamed about this, but there was a strong sense that there was something worth preserving about the current professional set up.

In this sense the tendency was to look to articulate what it is about multi-disciplinary work that makes it valuable, principally that it is just that, multi-disciplinary, drawing on the strengths of different disciplines and perspectives, rather than a core of skills and competences:

I think there is an importance in actually having, I mean.. the.. the strength of having a multi disciplinary approach is bringing different frame works in the way of thinking. From research bases, different clinical skills, um.. different world views, if you like, have come out if professional discourse is to bear on one particular issue. You may be looking at.. um.. if people are not thinking the same way, we lose that potential rich.. rich mix of er.. er.. different views and possibilities I suppose. Um.. er.. almost thinking about a issue, with a family, um.. I do think it is important that...that disciplines do retain their other training, a sense of their own identity, basically.

Respondent 12 – Nurse – Policymaker / Practitioner

There was, within this, a realisation that the differences that different professional trainings bring might be quite overt, or they may be quite subtle:

Um...and.. but, that's the difference, tha...that's the danger, um.. people... it's, it's about... it's about having a lot of the knowledge that you acquire as a professional. You don't necessarily use, at.. the...the.. t.. at a particular time in a particular role. You use only a small bit in an overt way. But your approach to that role is governed by that sort of global knowledge that might respect in the culture you are in... That perfects...as...as I said... with the.. with the ...I realised this on the enquiries.. um...that.. that I come to things from a slightly different perspective. Because I am a social worker, not a doctor or a nurse. And it is subtle ...because basically we are all in the same business.

Respondent 06 – Social Worker – Practitioner

This difference of approach to essentially the same task was mentioned by different respondents at different times, and afforded a different amount of weight.

Some, for example, were happy to minimise the importance they gave to different trainings, or understate this:

The only difference between myself and a psychiatrist really... And most psychiatrists would probably shoot me for saying this... is that they, they, um,... they prescribe and I could easily do a nurse prescribing course.

Respondent 02 – Nurse – Implementer

Other respondents felt that the task of differentiating between disciplines and professions was so complex as to be almost impossible, again harking back to the overlap of skills and competences as well as role. This comment, however, does accept that professions have different things to offer, but find them, again, difficult to articulate in a manner which does not come across as overly defensive:

And I think.. in fact, we produced something called a matrix.. um.. where we tried to describe the individual professions... um What is it that only they can do.. um, what is it that give away.. um and what is it that they would like to do, if they had got the capacity to do it? And we found that, in fact, there is a lot of commonality. But, when people looked at it, they hated it, because they said it was so reductionist. You know. .. and it is a complex thing to try and capture.. And I think one of the things is not so much about who can do what kind of intervention or ..., but I think one of the things is about the conceptual framework that people come with.

Respondent 14 – Psychologist – Policymaker

The conclusion of this respondent, then, was that the conceptual framework that each professional group brings is the thing that differentiates them.

In the following sections, therefore, the conceptual frameworks of different professional groups are sought as well as looking for what individual respondents think is distinctive and unique about their own and other professional trainings.

7.2.2.4 Professional identity of psychiatrists

Although the interview cohort included five psychiatrists, it is obviously important to reflect the perceptions of the other professionals interviewed, as is done through all the following sections on individual professional groups. Not surprisingly in each case how the psychiatrists (and others) see themselves is often quite at odds with how others perceive them. Whilst some stereotypical views were recorded, it should be remembered that the respondents are a very experienced group, so some of the stereotypical behaviour must have been witnessed in their practice in order to reinforce those stereotypes.

7.2.2.4.1 Psychiatrists following a medical model

As noted above we need to concentrate on what conceptual models different disciplines follow, or are perceived to follow.

Whilst psychiatrists may have additional training in specific therapeutic modalities their core training is in what is usually referred to as the 'medical model'. There is an assumption within healthcare that if a medical model is referred to then everyone knows what is meant. One respondent did, however, elaborate slightly on this assumption:

And that what you will get, and the model that they work, is a.. is a very medical model, the same as their er.. their medical colleagues. So it's out-patient clinics, er medication and er.. ward rounds in in-patient units.

Respondent 21 – Nurse – Policymaker

This same respondent went on to clarify further that the medical model in psychiatry might well be rather more complex than a mechanical model of body function, and that the training of consultant psychiatrists (and specialist child psychiatrists) was a long and very thorough one:

I think psychiatry is very similar although within.. you know it's informed by a different model. It's very much led by a medical model. But you do get opportunities to learn.. to work with other models as well. And I think as models, they are excellent. And um.. up to .. up to consultant grade...um their posts are considered training posts, so there's a clear progression as well.

Respondent 21 – Nurse – Policymaker

Describing this model, and a more rounded approach to the psychiatrist role in mental health, has been problematic. As the following quote illustrates, psychiatrists clearly see their role as much larger than having a medical model available to a team, whilst others disagree.

..it was decided that there should be um.. um.. a short description of the distinctive contribution for psychiatrists. The first version was produced by [anonymised]

But what he produced, when we circulated all the professions, particularly psychologists, was howled down because they thought it claimed too much for the psychiatrists, because, basically, what it was saying was that they were the only profession that can take a health, social and psychological overview of the patient.

...

Um.. And so um.. the BPS and .. and.. the other groups were asked, "Well OK you produce it, let's see what you can come up with." So they produced something which was "that the doctor's role was to implement the medical model". And so we shared that with the psychiatrists, and they hated it.

Respondent 14 – Psychologist – Policymaker

This polarisation of thinking about the 'medical model' and what it stands for is particularly difficult in CAMHS, where there is a widespread belief that the medical model is not the best approach for dealing with the mental health of children and young people whose physical and emotional development are still progressing rapidly rather than being fully formed as is largely the case in adults. This is particularly the case where a CAMHS service sits within an NHS mental health Trust whose main services are for adults, and for whom that medical model may, appropriately, have dominance:

We're a very medical model service... um.. I wouldn't say it's a constant battle but I think there's a constant tension within CAMHS, between er the.. the needs of the severely mentally ill and then the majority of cases that get referred. Um.. the Trust listens to .. er.. the needs of the medics. It's very important that they are.. um.. catered for and looked after. So.. um.. there will always be some of those decisions that are very much driven by the medical model. And I don't think for CAMHS that's a particularly healthy place to be.

Respondent 11 – OT– Implementer / Practitioner

7.2.2.4.2 Psychiatrists as prescribers of medication

Until recently it was also clear that one of the distinctive elements of psychiatrist practice was their role in the prescription of medication (and certain functions outlined in the Mental Health Act).

Er... um.. so I guess in terms of medics, it seems that they can do what no-one else can do, which is pres.. prescribing and section 12 assessing and all that sort of thing.

Respondent 16 – Nurse – Implementer

Prescribing, however, is still relatively rare within CAMHS, compared to adult mental health, so there are elements of reluctance from psychiatrists and others, to see this as a core function, even though it has been a distinctive and unique function until recently. One respondent described this change in practice:

Yeah, I think so and I think that's because they've been pushed into prescribing. Whereas, if you look at 40 years ago, they hardly prescribed anything... the child psychiatrists. They didn't... so and what's happened is that you've had a treatment that's um... been available... there's been medicine, so therefore, they've been backed into it. Though some, I think, there've been mixed views. Some have just said, "We won't do it, we don't believe in it", and so on and so forth, so you get that sort of contrast and then you get others who say, "Well actually it does work, it does seem to help some of these kids, so we don't know what to do, so we will prescribe". But when they've said that, then they've been bombarded because they will prescribe. And I think they've lost some of their actual what I would call actual therapeutic skills actually... they've gone into medicine.

Respondent 13 – Nurse – Practitioner

This leads to a position where it is difficult now to see prescribing as a distinctive or unique position to take up, either because it

potentially restricts the practice of psychiatrists excessively, or because with the advent of non-medical and independent prescribing other professionals can become prescribers. Although this is currently restricted to nurses and pharmacists (as of 2008), the plan is to extend those privileges to other professional groups.

But what's quite clear is, in fact, um. . . as you begin to whittle it down, there are very few.. you know.. you get down to a very ... silly sort of distinctions; and which er.. with non-medical prescribing, for example, um.. it becomes um less clear.

Respondent 14 – Psychologist – Policymaker

A restrictive view of psychiatrists as prescribers also tends to underestimate their distinctive contribution, and one respondent at least was prepared to suggest that such a narrow definition almost made them redundant (as previously cited on p254):

The only difference between myself and a psychiatrist really... And most psychiatrists would probably shoot me for saying this... is that they, they, um,... they prescribe and I could easily do a nurse prescribing course.

Respondent 02 – Nurse – Implementer

7.2.2.4.3 Psychiatrists having the most complex cases

One of the essential elements of NWW is the axiom that service users should be seen by the person with the most appropriate competences and skill levels. This usually means that the most complex cases should be seen by the staff member with the most training and experience, which many take to be the consultant psychiatrist, whose training is the most exhaustive and lengthy of

any of the mental health professionals. This was summarised by one respondent, though with the caveat that other professionals at consultant level would also qualify to deal with such complex cases:

Um.. so it means that.. er. I'm talking particularly about people of consultant level, and this is true, not just of psychiatrists but of all professions. If you are working to consultant level, you should be seeing, clinically, those people with the most complex needs. Um.. because you have the most experience and the most skills etc., and then you should be seeing.. you.. and therefore, in parenthesis, you should not be seeing people who don't need that.

Respondent 14 – Psychologist - Policymaker

This emphasis within NWW, which started with NWW for Psychiatrists, is seen as core to a more effective workforce, but also as a way of reducing the burden on psychiatrists who traditionally held large caseloads of complex (and not so complex) cases.

What we are trying to do, for example, take consultant psychiatrists, is that there's a great feeling amongst a number of them that they're totally overburdened, overwhelmed with demands, service re-organisation, and so on. And the job is not becoming doable and it is their words not ours.

Respondent 04 - Civil Servant – Policymaker

Certainly there is a feeling of being the person of last resort when it comes to the most complex cases, which may hark back to the concept of medical responsibility that NWW is trying to replace with the 'distributed responsibility' model:

...psychiatry has a role to play and I certainly know that when there is anything serious, then... there are footsteps running down the corridor and "Can you please see this case?"...

Respondent 15 – Psychiatrist – Policymaker / Practitioner

7.2.2.4.4 Being a 'doctor'

So far the discussion has been primarily about being a psychiatrist (or child psychiatrist). Whilst the medical model was discussed it was in the context of psychiatric practice. However psychiatrists train as medical doctors first, and there is an element of continued connectedness with that original training and wider profession (as is the case with some of the other mental health professions, of course), even if they have some distance from that group. In terms of professional identity it is clear that for some, if not all, of the respondents that this 'core training' and socialisation is deeply ingrained:

Well everyone tells me that I'm a doctor to my fingertips. Um.. so.. I suppose I was put on that conveyor belt and processed and.. um.. that won't ever go away.

Respondent 15 – Psychiatrist – Policymaker / Practitioner

Whilst the sort of doctor who is likely to move into psychiatry, and even more to child psychiatry, is unlikely to be the most hung up on the status of doctors compared to other professions, it is nonetheless still an element recognised by some:

I've always like working with local authorities, working with education and so on. And I seem a bit peculiar, because I am comfortable with that. Whereas others would see themselves, doctor first, and come with a position of, you know by prescription pad, and by authority and so on is the key.

Respondent 25 – Psychiatrist – Policymaker

As with other professional groups there is also an element where this commonality of original training is felt to be of use in networking or working with other doctors. The common understanding that develops from a core training, and the respect that goes with it seem to be at the core of this:

But I think working with complex whole systems, I expect doctor to doctor understanding, particularly when primary health care, ... and across the community / in-patient breach... it can be quite an important role.

Respondent 17 – Psychologist – Implementer

7.2.2.4.5 Psychiatrists as the most powerful professional group

The final area of comment has been alluded to in the previous quotes, that of the inherent authority and power of the medical profession. Whilst NWW sees the traditional concept of medical responsibility being replaced with the 'distributed responsibility' model, there is an element of that remaining as the basis for medical authority. As this changes, so the basis of psychiatrists'

power also seems to be changing, although there are elements of it remaining.

And also, to be fair you know, I think shifts in the role of the medical profession as well, from a situation where, although you still encounter it, it's more rare now for the senior member of the team to think that they're more responsible for the work of other members of the team in the manner of a .. officer in the army, you know, they've been responsible for the.. the welfare of their troops, you know, and their behaviour.

Respondent 17 – Psychologist - Implementer

For most respondents the differences in power and the hierarchies inherent within the NHS are accepted as a de facto of the system and one that would be very difficult to challenge.

Um.. I guess there's a fairly well recognised hierarchy of power around the medical profession. Psychology being the sort of pretenders to the throne really. Um.. you know um.. in waiting (laughs) you know. Maybe seeking out the same types of um.. tch.. sorry.. er.. power I guess. Um.. The influence and prestige that the medical professions always had. Um.. that's the way out. And I guess because we're all in a medical hier.. hierarchy in the NHS, I guess we're all positioned by that .. in various ways.

Respondent 27 – Social Worker – Practitioner

The need to have the psychiatrists 'on board' with changes that might be seen as threatening to their power and authority was clearly seen within the NWW project. The project started (in mental health) in response to the needs of psychiatrists, and only later opened out to be 'NWW for Everyone' when the impact of changes on other groups was obvious.

Well the reports that we've published .. er.. particularly the interim report on new ways of working, which focuses very heavily on psychiatry... Um.. because what we want to do is to recognise that they are ...um...not the biggest numbers, but perhaps a very important player in delivering services, leading of teams, and so on. So, our focus initially was on them.

Respondent 04 - Civil Servant - Policymaker

The final element of the power wielded by psychiatrists and doctors is evidenced by the way in which they are remunerated. Agenda for Change, as we saw in the previous chapter, has been seen to have a huge impact on professional identity and how individuals see themselves. Yet the medical profession alone out of all health service employees (with the exception of Trust Chief Executives, who also wield considerable power) is the only group that was not included in Agenda for Change.

Tch..so.. there's that agenda and I think there's also the impact of um.. the financial impact of Agenda for Change and the high cost of consultant psychologists and psychiatrists and, "Do we need them?" and the Commissioners saying, "Well, what are we getting for our money now?"

Respondent 07 – Nurse – Implementer / Practitioner

7.2.2.5 Professional identity of psychologists

For lay people the difference between a psychiatrist and a psychologist can often be a confusing one, but psychology has managed, in a way which many other mental health professions have not, to develop an identity of its own which it defends quite robustly.

And I think in many ways clinical psychologists, um.. this may be um.. unfair, but in some sense, you got a sense that they had ... a quite considerable clarity about their professional role and identity. Um. . which is sometimes irritating to others (laughs).

Respondent 25 – Psychiatrist - Policymaker

7.2.2.5.1 Psychologist, Clinical Psychologist or Applied Psychologist?

One of the risks of naming a profession after an approach is that its essence can be diffused by others claiming to be able to use that approach. Nurses and others, after all, are taught psychology and use psychological approaches in the way they treat their patients and service users. As one respondent put it:

So, in my own background, as a psychologist, ... there's a thing in California, where if you ask someone if they are... they are in show business, they'll say "sort of"... And, er, there will be all sorts of people, who, if you ask them whether they're a psychologist, they'll say "sort of".

Respondent 05 – Psychologist – Practitioner

In order to refine and define what it is that makes psychologists different (from others who use psychology) therefore a strict restriction is applied in England to who can properly use the title.

The applied psychologies include clinical, counselling, health, forensic, educational and child, occupational, sport and exercise psychology and neuropsychology. In order to become a chartered member of the British Psychological Society (BPS), ..psychologists must first have completed an undergraduate degree in psychology (or equivalent), which entitles them to register as a graduate. Following this first degree, most psychology graduates gain some additional work experience before going on to register for a three-year programme of work and academic experience that leads to chartered membership.

NWW for Applied Psychologists (2007)

The path to practising as a clinical psychologist within a mental health team or CAMHS is not an easy one, therefore, and it is one of the issues raised by respondents that actually whilst psychology is very popular in British universities as a first degree, it is very difficult to then progress into clinical psychology.

Er.. um.. I have recently been made aware that something like 13,000 psychology graduates graduated last year, compared with 600 clinical psychology placements. So 12,000, or somewhere around that number, are not going into CAMHS.

Respondent 18 – Nurse – Implementer

In addition to this refining of who can be a clinical psychologist there is, within this area, a further definition of those who specialise in working with children and young people, again similar to other professions where the sub speciality is important as a distinguishing

mark (CAMHS nurses, as opposed to psychiatric / mental health nurses, for example).

..most of my colleagues who are psychologists I think see themselves as child psychologists. They would not say they're psychologists....

Respondent 30 – Psychiatrist – Policymaker / Practitioner

7.2.2.5.2 Psychologists as well-trained academics

Maureen Lipman famously said in a 1970s British Telecom advert '*If you've got an 'ology' you're a scientist*', and psychology more than any other professional group, apart from medicine, claims a scientific foundation or evidence base. This element came out in some of the discourse, as a distinguishing factor of psychologist identity:

And a psychology degree requires you.. [to have] a, you know, a pretty philosophical take on things .. you have to be able to argue stuff at that sort of theoretical level of.. of discussing that way. You've got to have that scientific ... a.. ability, you know. You've got to be able to argue the stuff in the same way as any of the other sciences. But you've also got to have ... this ability to be able to write essays, to be able to analyse text and everything else. And so it's.. I think, if you take that academic background, ... that that produce... there's a certain group of people who go into that .. and it used to be very small.

Respondent 23 – Psychologist – Implementer / Practitioner

Or, more succinctly put:

You've got to be very clever to get into psychology.

Respondent 30 – Psychiatrist – Policymaker / Practitioner

The quality, quantity and type of training, therefore comes through as being essential to what gives psychologists their professional identity. Contrasting the basic conceptual model with the medical model of looking for illness, one psychologist characterised it as starting from a normal developmental model:

Whereas I think for psychology, our fundamental training isn't about that at all, it's about how people are and how children develop and how... families and groups and everything else function. So that then, when we come to work with groups of people, for whom we have identified problems, it's always on the back of that... that knowledge base and that way of thinking... and I think that is probably one of the differences.

Respondent 23 – Psychologist – Implementer / Practitioner

With clinical psychologists now being trained to doctorate level (a taught DClinPsych, previously qualifying at Masters level) the idea that psychologists are very well trained seems ingrained in what respondents said about them:

The training is excellent, the training is very good. It's um.. it's on the job training. It's very much an apprenticeship model. Um .. and people who come into CAMHS as psychologists are very bright and have a sound psychology background.. a good psychology degree. They are all very bright people and they er.. they will learn how to use at least two .. often different therapeutic interventions during their training. So um.. technically, they are very good.

Respondent 21 – Nurse – Policymaker

7.2.2.5.3 Psychologists as an expensive resource

One result of this high level of training and function is that under Agenda for Change, psychologists have often done very well. The level of academic qualifications required for the job (as opposed to

those held, but not specified in a job profile) attracts a high score under AfC banding criteria and therefore leads to higher salaries. Given the awareness and sensitivity of most respondents to the relatively recent AfC process, it did not pass unmentioned that psychologists were therefore now seen as 'expensive'.

And with Agenda for Change, psychologists have managed to do really well and they've gone up a couple of bands, whereas nurses and social workers seem to be quite equally paid and the jobs that are advertised are banded around that level.

Respondent 09 – Nurse – Practitioner

This, however, seems to have its downside in a climate where NWW is looking at having the right level of skills for the individual need (as discussed previously). The risk, as pointed out here, is that psychologists will be pricing themselves out of a job:

Er.. clinical psychology seems to be expanding. On the other hand, they are quite expensive and I know colleagues are now saying .. there's a question about whether they should be recruited.

Respondent 15 – Psychiatrist – Policymaker / Practitioner

This in turn fits with the concept developed within the NWW for Applied Psychologists (in NWW for Everyone, DoH 2007a) that new roles be developed for less well-qualified psychology staff.

You just look and think this is a much better job, I want to do that and the rates of pay are better and.. we've been able to attract a lot of experienced staff.. BUT.. I think we are reaching the end of .. of being able to do that in large numbers. So providing we are able to increase our staffing level.. we're going to have to be in.. er.. attracting staff with far less experience, possibly staff who are coming out of er.. college with psychology degrees, or say.. applied psychology in some form or another;

Respondent 20 – Social Worker – Implementer

7.2.2.5.4 Psychometric testing as a unique skill

At the beginning of this chapter it was noted that some stereotypes do persist within views of certain professions, and whilst there is an understanding by respondents that the discipline of psychology is much more than an ability to do psychometric testing it does come up in the discourse when respondents are struggling to ascribe elements of uniqueness to certain professional groups:

And they do have a framework, they have ...and I hate to use the word but they have a unique contribution to.. to.. make to the team and that is around psychometric testing... to some extent.

Respondent 18 – Nurse - Implementer

However, there was generally more talk about psychologists being skilled providers of therapeutic input, and one respondent was able to illustrate how the view of psychologists as psychometric testers was outdated (but which provides the basis for the stereotype):

So clinical psychology at that time, you know, and there was back in those days...just, you know, moving into, into the NHS.. not to do therapy, it was .. I mean therapy really only really started to develop in the sort of mid 1970s as a role that psychologists undertook. I mean, we were primarily, at one time, sort of psychometric testers. You know, providing information to psychiatrists.

Respondent 23 – Psychologist – Implementer / Practitioner

The fact that certain psychometric tests are licensed for use only by qualified psychologists, however, could be given as one way that the psychology profession has managed to maintain a strong identity separate to other mental health professions.

7.2.2.5.5 Strength of psychologists' professional identity

This theme, of psychologists having and maintaining a clear professional identity, came though quite robustly, as is hinted in the quotes already cited.

*And clinical psychology, very interestingly, I think has...has .. has actually a very strong identity in some um..
...where you find that 50% of them saw themselves as clinical psychologists allied to multi-disciplinary teams; and 50% saw themselves as sort of clinical psychologists, wanting to be managed separately with clinical psychology teams. So, in a sense, you had two different sorts of identity...in clinical psychology.*

Respondent 25 – Psychiatrist - Policymaker

This sense of professional identity, as psychologists rather than mental health team members, seems to have been deliberately reinforced in the past, as one respondent explained:

There was then a report in 1975 called the Trethowan Report.. a Government Report on what should happen, you know how clinical psychology (which was a pretty new profession, you know even at that point in the NHS) should be organised.

...

So the Trethowan report said that psychology should be organised as a... on a uni-disciplinary bases, it should have specialisms in it for the different clinical groupings. And that.. was actually drove the developments of the psychology departments... probably for the next 20 years.. that was the basic model.

Respondent 23 – Psychologist – Implementer / Practitioner

7.2.2.6 Professional identity of nurses

From a professional group with a strong identity the contrast with nursing is a sharp one, for it is almost a theme in itself that nursing identity in mental health, but particularly in CAMHS, is weak:

I don't think that nurses should ... give up their own future, but maybe there er... professional base is less clearly defined, um than maybe more so that in others working in this field, which basically makes it more difficult to argue for what they want at times.

Respondent 12 – Nurse – Policymaker / Practitioner

And:

Um.. tch.. I just think we can become faceless. um... nonentities of people if we don't help others understand what nursing is and what we offer. It's very hard to say what a nurse is (laughs)... I've just realised!

Respondent 09 – Nurse – Practitioner

7.2.2.6.1 Difficulty in articulating nursing identity

If there was one thing that the respondents were agreed about with regard to nursing identity within mental health teams, and CAMHS in particular, it was that it was difficult to articulate exactly what they did. Unlike psychiatrists and psychologists it was harder for people to clearly say what was different about nursing skills.

..nursing, not just in CAMHS, but nursing generally, has always struggled I think to articulate its .. its particular identity, and I think .. I think .. you know, the research definitely shows, research tends to indicate that a lot of nursing, um.. a lot of nursing knowledge is tacit.. that it's experiential. And, within our research culture.. um.. and our professional culture, that's often devalued.

Respondent 32 – Nurse – Practitioner

Whilst it is true that nursing as a whole struggles with its identity at times, as described in the literature review, mental health nursing identity is even harder to pin down, and very little has been written about CAMHS nursing identity. This lack of evidence base to refer back to is mentioned by some of the respondents:

I think that psychology has much more of a traditional view about their training and their competencies and their skills. Um, and I don't think, you know, nursing is... is way behind in terms of looking at, um, research and evidence based practice, compared to psychology and psychiatry, as well. I think that makes a difference.

Respondent 02 – Nurse – Implementer

And

And I think it's.. it's.. I think there's a lack of academics (laughs).. that look at that.. um.. that look at those skills in nursing and actually looks at decision making and how you make those. How you come to make a decision and I think as nurses we take for granted.. we don't recognise our skills and we don't publish enough our skills and outcomes and certainly there's been a lack of research. I think that actually shows up...

Respondent 13 – Nurse - Practitioner

7.2.2.6.2 Flexibility as a key attribute in nursing

Whilst flexibility of role is a theme within the policy documents, and one to which separate reference will be made later, it also came across in a particular way within the discourse on nursing identity. This, however, could be characterised as either a positive or a negative attribute. Generally it was seen as positive, and something to be proud of, a distinctive element of nursing practice, over and

above the potential flexibility of other disciplines, or in direct contrast to the perceived inflexibility of others:

And er.. there's something... nurses find it incredibly.. I think extremely difficult to er say what they do, that nobody else does. And.. they're flexible in er.. a way that almost no other professional group is. And they provide ... support for people 24 hours a day.

Respondent 21 – Nurse - Policymaker

This flexibility, however, can detract from professional identity because taking a very broad view of what one does as a professional means that it is harder to pin down the specific things that are unique to a discipline.

...because nursing um.. in the traditional sense, has involved some degree of "mucking in", and sometimes in the muck, in order to help people, other workers, it wasn't as tightly contained in um.. er.. a rigid sort of task, actually perhaps...I don't like the word.. because I think it gets over used, but in some sense, in the care of a patient in a hospital ward for instance, nurses would have to take quite a broad view about what they need to do to help somebody.

Respondent 25 – Psychiatrist - Policymaker

This breadth of approach, and flexibility about what methods are used to get the job done can, however, also contain negative connotations concerning practice. One nurse referred to it within nursing:

..you know, nurses being 'jack of all trades and master of none'. I actually think it is a master of many ways of thinking and working, and actually it's er.. one of it's about sort of key capabilities in a way.. um..

Respondent 09 – Nurse - Practitioner

Elsewhere it is clear that this can be damaging to professional identity, as in this section (actually referring to the process of junior doctors training):

...well certainly watching when the junior doctors come through ... um.. they um.. have to do some individual psychotherapy. They have to do some family therapy and they end up feeling totally de-skilled.. 'jacks of all trade and masters of none'.

Respondent 15 – Psychiatrist – Policymaker / Practitioner

7.2.2.6.3 Relationship building and caring within nursing identity

In the literature review the importance of Hildegard Peplau in providing a focus for mental health nurses was discussed, as was the concept, more common in adult nursing than in mental health, of 'caring' as a central quality of nursing. This does come across in some of the responses, though no-one mentioned Peplau by name.

I think it is that .. that the.. capacity to be, what's the word? "up close and personal" with people in a professional way, and in quite creative ways at times perhaps. And in places, across boundaries, and um.. working.. working sort of.. working both with people's minds in terms of mental health, in psychology and their emotional well-being, but equally their bodies as well. It is a sort of, um.. I always thought ...I'd like to be able to sort of articulate this a bit more theoretically, um.. in a way. But it is a mingling of minds and bodies, that is what the focus of nursing is and seems to be for me, that aspect of nurturing, you know, the relationship between the two, whether it is in a family or the individual and.. and I think um.. nursing is a .. is a .. um way of doing that in quite creative ways that you don't necessarily find in other disciplines.

Respondent 12 – Nurse – Policymaker / Practitioner

Another respondent (ironically not a nurse by profession) did mention by name a nursing academic who has acknowledged the strong influence of Peplau on his understanding of nursing practice:

Um.. nurses um.. I tend to agree with people like Phil Barker on this one.. you know, I think that the um.. soft stuff of kind of compassion and building relationships and good listening skills are incredibly important and tend to become over-devalued in the.. in the effort to professionalise nursing even more.

Respondent 17 – Psychologist - Implementer

Whilst we have acknowledged the difficulty of claiming 'caring' as a central feature of nursing practice, it does remain an influence on how people think about nursing, even if they acknowledge the inherent difficulties of claiming for oneself an attribute which one would hope all clinicians would possess in some degree:

But it's a mixture of the essence of .. of.. and.. and the .. the humanity of caring for children and young people, which is a kind of nursing construct, but it's also .. um.. about doing things such as monitoring medication and.. um.. and I use that as an example because it's a task that has previously been um.. associated with nursing, as in giving ...depots [injections] as a sort of task orientated function. Um.. but to try to describe our role in those task terms would be problematic for a number of reasons. One.. is you end up with a load of, of.. a list of things that many people could do.

Respondent 24 – Nurse – Implementer / Practitioner

There is, also, within this discourse, some attempt to differentiate the nature of nursing relationships from those that other healthcare professionals make with their service users or patients. One clear element of this is the way in which nurses work with people, on a

longer and more intensive basis. These relationships may have a basis in caring, but are also steeped in the 'being there' nature of nursing, that nurses may come and go in order to perform specific interventions, but on a ward are also the only ones who are always there, around the clock:

Um... I think that nursing is very much associated with caring, traditionally, and.. um.. in .. society terms then that isn't valued... Um.. and yet I think that, you know, what tends to differentiate nursing from the other professionals is their ability to care, in a 24 hour or.. or across a 24 hour live space.

...

I think it's always been the nursing role to actually synthesise and integrate those different.. components to.. help children or families or patients to actually be able to function in a 24 hour setting, to help children or families or patients to actually function in a 24 hour work setting. Which I think is a different remit to a therapist who works in a... on a sessional basis.

Respondent 32 – Nurse - Practitioner

And

And er.. there's something... nurses find it incredibly.. I think extremely difficult to er say what they do, that nobody else does. And.. they're flexible in er.. a way that almost no other professional group is. And they provide ... support for people 24 hours a day. They're responsive, very responsive usually to people, er.. to people's needs, and I think that there are lots that nursing could celebrate.

Respondent 21 – Nurse - Policymaker

This longer and more intense style of relationship building was also mentioned by nurses as a part of what they do, at least in residential or in-patient settings, by creating the atmosphere and conditions for people to get better, a concept Nightingale herself

would have recognised but which is generally called 'milieu therapy' in the mental health literature:

In an in-patient environment like that; in acute care, which is .. it is in decline in some places; as one has to say, sadly. But I always felt that that was part of our responsibility to create that therapeutic environment. And by that I don't mean therapeutic environment, I just mean creating a .. a .. an environment where care and interventions could be taking place. And it was safe and people were cared for in that er kind of broad way, at times of acute need, I think.

Respondent 22 – Nurse – Policymaker

Having focussed on an element of nursing care which is easier to define within in-patient settings there was also a recognition that it wasn't entirely clear how this affected the practice of nurses working in community mental health teams of CAMHS, and that although it seemed to be important it was still a bit vague:

So, I think er.. the er.. argument for nursing in NHS in-patients units is made.. but just not dealt with. Um.. but the um... argument for nursing in the community is one which has to be... still has to be ...um.. made.. but it has to be made preferably from within the nursing community. And then, you're clear what nurses need to be trained on.

Respondent 20 – Social Worker - Implementer

7.2.2.6.4 Nurses as therapists

Increasingly within mental health teams and CAMHS there seems to be a feeling that being a nurse is not enough, and that training in a therapeutic model is essential in order to define better what is the nurse's contribution but this also leads to some confusion of role:

I mean, I am aware of their training, that they have to do basic nursing first and then they go on to specialise but, in terms of nursing therapy, I imagine that there are some similar conflicts, "Am I a nurse, or am I a therapist?" "Can I be both?"
Respondent 28 – Social Worker – Practitioner

One respondent was able to reflect on this from a historical perspective, that as the psychotherapies have developed their own identities they have also sought to defend those areas with increased regulation and a sense of boundary around who may or may not use a particular intervention:

And, I think the other thing is that therapeutic qualifications are the currency in the health service. If you don't,... if you're not qualified to do something, you're not allowed to do it. [laughs] 25, 30 years ago, we did the things we weren't qualified to do but then nobody else was... You, you know.. you did them! You did group work, you did psychotherapy, you did, you know, every new therapy that.. you what, what.. because there are fashions in these things.

Respondent 06 – Social Worker – Practitioner

Long gone, then, are the days when Shirley Smoyak (1975) could write a book entitled 'The psychiatric nurse as a family therapist.' There is also, however, the feeling that taking on the new conceptual framework which a psychotherapy gives its trainees, might mean an individual moves on from being a nurse (or social worker, or other professional), and become a 'therapist' instead.

Um.. so there is.. there is kind of a lot... and social workers take family therapy, and some people change being individual therapists and give up their core identity and take on family therapy or individual therapy identity.. So, it's not easy.

Respondent 15 – Psychiatrist – Policymaker / Practitioner

This move from one key identity to another is seen by some as being in relation to power or status, that the psychotherapist is seen as a better paid, or more respected, profession:

Um.. a function of the system is that um.. once you become something that's clearly identified, like a therapist, you tend to be rewarded better... To have more prestige, to have more money and.. therefore, nurses can strive towards.. those roles um.. I think that nurses, as individuals are usually quite proud of their role as a nurse. But also perceive that it's not as well rewarded, or as well respected as some other profession.

Respondent 32 – Nurse – Practitioner

Whilst it might be convenient to draw a direct correlation between the perceived prestige and status of psychotherapy and use this as the answer for why some nurses (and social workers and others) choose to 'escape' from nursing into a new professional identity, this is not a simple correlation, as some nurses engage in these forms of training yet continue to see themselves as nurses:

Some times people will train as psychotherapist, if they have been nurses and they have gone off and become a child psychotherapist, and that then becomes their sort of leading professional, um .. identification, if you like. Um.. because they have moved out they.. they, you know, they have developed and they want to do something a bit different and, similarly, even some, family therapists at times. Because there are also, of course, rewards to changing and moving with the times as well, in terms of kudos, um.. political power I suppose at times.. in a .. with a small "p" as well as money. But.. um.. I also know from the field of nursing, nurses have actually stayed, er.. on in their role as a nurse with a family therapy training or, indeed with a child psychotherapy training. Um. um.. so it is not impossible for them to do that and to apply that to their field of interest.

Respondent 12 – Nurse – Policymaker / Practitioner

For some this desire to hang on to the original professional identity seems strange, for the new conceptual framework has a powerful draw. This came across most strongly from a social worker who had just completed systemic family therapy training:

I know that some of the nurses, I mean, I've noticed that some of the nurses are much keener to maintain their um.. identity as nurses. And said consistently throughout the training that, you know, um.. when they've finished they will still be.. they will still choose to be called nurse. ... "I am a nurse". And that .. was surprising to me.

Respondent 27 – Social Worker - Practitioner

7.2.2.6.5 Impact of the ENB603 on CAMHS nursing identity

Before moving on to look at other professional identities it is important to note that one final theme did come up in relation to the identity of CAMHS nurses in particular, which was the affection in which the old specialist course in CAMH nursing was generally held. The ENB603 was for several years the identifying badge of a CAMHS nurse, the standard against which a CAMHS nurse was measured; you either had it, or you didn't. Having it meant you were a proper CAMHS nurse, and not having it meant you weren't really in the speciality. It was simple and clear, but under a reorganisation of regulatory authorities (from UKCC to NMC) the English National Board that standardised such courses for nursing was lost and not replaced.

And .. and you know, one.. one of the things I heard a lot about was the.. the old 603 and how that was the be all and end all and... I.. I.. I.. it was clear to me that people were proud of that qualification; that was something that they had done and it meant that they were.. were.. you know wor.. that's.. working with children with psychological problems was their core business, it was what they were..

...

What I think what I was experiencing wasn't so much the issue of what 603 contained, but what it didn't do in terms of preparation. But it was about this issue of holding onto professional identity. Because, if that went, then would the professional identity go with it?

Respondent 24 – Nurse – Implementer / Practitioner

This lack of standardisation is also an issue for other specialist areas of nursing, of course, for the ENB covered more than mental health nursing courses, but the diffusion of courses on child and adolescent mental health into multidisciplinary style courses seems to have had a particular impact on the identity of CAMHS nurses:

And that.. that.. er both... the.. I wonder if the death of that was what seemed the most sensible thing at the time. Which was to make it a multi-disciplinary ...to allow people other than nurses to take the certificate and to widen the scope. I can.. I absolutely accede and at the time some would almost certainly have agreed that that was a sensible way forward. In hindsight, that may have caused its demise, and um.. that.. but in the .. in .. if you look at the 603 and what it's trying to achieve, as it expanded, then you can also see that might be better than by a modular approach, in which case there's a .. there's something specifically for nurses... in that context.

Respondent 20 – Social Worker - Implementer

7.2.2.7 Professional identity of social workers

If the professional identity of nurses could be considered as relatively weak, compared to psychiatrists and psychologists, then other groups have similar, or worse, problems in defining their unique professional contribution, and therefore maintaining a distinct professional identity:

Social Workers, I think are a bit more like nurses, perhaps in terms of describing.. I think they could describe their role but I think their role is very similar in some ways. There's a lot more overlap.. um.. and also.. I think.. I think there are issues around career progression for Social Workers and nurses that are very similar.. that.. that aren't around for.. certainly for medics and psychologists.

Respondent 16 – Nurse - Implementer

7.2.2.7.1 What's in a name? Not wanting to be a social worker

One of the elements of CAMHS, which distinguishes it from adult mental health teams is that although there are a lot of people in CAMHS who were trained as a social worker, there are relatively few that have a job title that describes them in that way. There are historical reasons for this, as we saw in the literature review, but also a lack of clear definition for the task. For some people with social work training there is also a reluctance to be identified with the perceived negative elements of social work:

Do I see myself as a social worker .. I try hard not to I guess! Er.. and um.. and I guess there's all sorts of cultural and er political reasons why .. um.. I would have had enough of social work er.. and um... it's a very hard environment to work in. And the.. they expect a huge amount from their staff. They don't pay them particularly well, they certainly don't support them very well, and there you are, you're asked the earth from them.

*...
So it's hard, I think, to be.. to identify as a social worker and be.. or to want to identify as a social worker, and to sort of be proud of your profession and that sort of thing.*

Respondent 27 – Social Worker - Practitioner

And:

..but thinking about it, it might have been easier for me because, even though I worked as a field social worker, I was very clear that I was not coming to CAMHS to be a social worker.

Respondent 28 – Social Worker - Practitioner

From a more therapeutic orientation there was also a perception that the term 'social worker' was no longer seen by the public to portray a sympathetic and helpful image (unlike nursing, for example). As such the title might actually get in the way of establishing an initial rapport and developing a helping relationship as the basis for the more therapeutic element of CAMHS work:

Yeah.. definitely, yeah...power and control. So I don't feel.. and that's one of the reasons why I wanted to leave social work... because I don't feel that families generally perceive.. I think social work has changed dramatically. It has had a massive cultural shift and I think that the families perceive the social work agency as a policing agency .. and not as a supportive, helping agency. And that's one of the reasons why I left.

Respondent 28 – Social Worker - Practitioner

7.2.2.7.2 Social Worker or Psychiatric Social Worker?

This concept of social workers as social police leads onto the issue of where social workers get their identity. Staff coming into CAMHS seem to be able to identify with one of two models of social work training, as Psychiatric Social Workers or as 'field' social workers, effectively officers of the local authority Social Services department. The two were seen as very different training and experience routes.

And, um.. it always struck me there that there was a period of time in the old PSW... psychiatric social worker.. if you like, had some sort of professional identity.

...

Now of course things have changed and they've took on much more in the way of child protection focus... which is fine... Um.. but I never, I never felt that social workers, as a breed, had that .. had actually been able to rely on some sense of what their job was actually about... what their profession was about.

Respondent 25 – Psychiatrist - Policymaker

Psychiatric Social Worker training, as we have seen, was a much more therapeutically and independently minded training than that offered for social work staff now, and because of that had more of a professional identity than is perceived to be the case for local authority social workers:

If that means that social work becomes more like... [laughs] the NHS professions, it means, it means that social workers have to go back to the way of thinking like the PSWs and the MSWs... because they had all that... in their own way they had all that. You couldn't mess around with a PSW. They.. they defined their own conditions ... Um, basically, we have got to go back to all that... er.. in some... not necessarily a sort of elitist, or a military elitist, very conservative way of those values. But, nevertheless, they have got to have those kind of... they've got to have certain parameters which define, define their role, which distinguish... er a clear view as to what their primary values ... their contribution... and that has got to be developed.

Respondent 06 – Social Worker - Practitioner

In contrast to this the local authority social workers were seen to necessarily focus on statutory responsibilities, and to get their authority from the status bestowed on them as officers of the local authority. This is also important for our understanding of role as the direct relationship between the direct employment of social workers by an employer with a very specific and changing task at hand, and a relatively weak professional structure allows for a much more role-focussed approach:

Um.. from the back end of the 80s through the 90s, children and social work said local authorities social workers weren't focused exclusively on child protection. As we said it increasingly focuses on . . the determined criteria.. determining the criteria of children in need, which increasingly becomes children specifically in need of protection, children in need of being looked after, children with some severe complex difficulties. And the.. a broader 'in need' term gets far.. far less response and the .. you also see the ... task focused social work short term run out. So you.. social work retreats from a broader community social work perspective in the early 70s and 80s.

Respondent 20 – Social Worker - Implementer

The dangers of this were seen by at least one respondent; that training is very focussed to the task in hand, a task which may change, and leaves practitioners without a broader framework from which to practice:

There's no, no bars involved in local government in the way that there are in the Health Service. Um and people are basically... you, you.. basically you train people for the job you want them to do. Er.., there's no interest in, in, in people having professional qualifications .. because that means you having to spend money training them to do things that the authority doesn't need doing. Um, so, social work has been constrained by that, um,... In mental health what needs doing is the ASW roles and that's where the training money goes. Um, er, doing psychotherapy ..it's not.. not, you know, the local authority has no corporate interest in that... Um, so you are not going to get seconded to do CBT or whatever, because that isn't part of the local authority's role. What you will be seconded to do is to learn about care management, commissioning and purchasing ... And the... the whole, er, that, that's... because that.. that's the statutory role, that's the local authority's prime concern is to, has been in the last few years to develop care management... and that's the danger that.. that.. you don't get a rounded professional animal. You get the person that has the skills that you need at that particular moment.

Respondent 06 – Social Worker - Practitioner

There was, however, a role within local authority social work which directly impacted on mental health, and had been developed as an independent check against perceived medical power, that of Approved Social Worker (ASW). Developed from the medical social work model, the role was in sectioning patients under the Mental Health Act (i.e. detaining them against their wishes because of their mental state). The role of the ASW was to try and ensure that the patients' wishes were taken into account, and the ASW was seen as independent even of the normal local authority power structures in this respect, using very personal judgement in a difficult situation:

The ASW is unique ... there is no other role in local government, where an offic... where an officer holds personal power... there's.. there are two very, very specialised exceptions. But, as a general rule, that's the case. Traditionally, in local government, the only officers that did hold personal power were the Medical Officers of Health. And of course they still hold that power, although technically they now work for the PCT, they are still officers of the Local Authority. Otherwise, everybody is an impersonal individual in acting on behalf of the Director of Social Services.

Respondent 06 – Social Worker - Practitioner

Ironically, of course, the exclusivity of this role is being taken away from social workers under the current revision of mental health legislation. As we noted in the examination of New Ways of Working, the social work section was the only one to have a major section on identity, and the concerns about losing the exclusive 'Approved' status, and it moving to an 'Approved Mental Health Practitioner' were foremost in the thoughts of the group who wrote that section:

In terms of social work identity, one of the future challenges is around the proposed introduction of the Approved Mental Health Professional (AMHP) under the Mental Health Bill. Although the formal designation of the ASW will be replaced, social workers will have a critical influence in ensuring that the practice competence of AMHPs embraces and actively promotes the independent nature of the role.

NWW for Everyone 7.10.9

7.2.2.7.3 A new professional structure

One of the results of social work being so closely tied to the local authority is that it traditionally hasn't needed those professional structures that other professional groups have developed over a

very long period of time. This will be covered in more detail later, but it is particularly highlighted in the social work discourse because it is so new, with the General Social Care Council only being finally established in 2001. The role of such a regulatory authority in establishing a distinctive professional identity is also recognised as important in this respect:

Um.. we have to think about building professional structure and professional defences. Er...which the old professions have got, er and which social work doesn't have, they never needed them. And, equally we have got to be much more clear about what it is that, social work.. makes social work unique what it is that social work contributes and make sure that those things are actually built on. Um.. er.. that is again, not been necessary up till now. But it's becoming very urgently necessary.

Respondent 06 – Social Worker - Practitioner

7.2.2.7.4 Community focus as a conceptual framework

What is clearer in the social work discourse, is the basis of difference in the conceptual framework in which social workers are trained. In part this comes from their role within local authorities, but it is also sufficiently different from the medical and psychological models discussed previously that it remains fairly easy for practitioners and others to identify.

... social work retreats from a broader community social work perspective in the early 70s and 80s.

Respondent 20 – Social Worker - Implementer

And:

...you are a local government officer ...you are, er responsible to the community. Er.. you cannot focus on your individual exclusively ... your individual client.. because that's not what you're paid to do. You're paid to do... to deliver a service, but you are also paid to look after the community's interests as well as the individual client's needs.. especially in Child Care, very often..so there are some major conflicts which health professionals approach differently ... because they are much more focused on their individual patient. So, that's one way, I think which.. that sort of tends to permeate within the way you see things.

Respondent 06 – Social Worker - Practitioner

This community focus is sometimes characterised instead as a sociological model:

Um.. I think personally, when I compare myself to others, I think maybe, the training... the kind of model, the way of thinking .. it is very sociological, rather than purely medical. Well it is not medical at all, as you know, it isn't at all.. so it is very sociological, but you are talking to someone who has gone on to do the medical training, so I have changed, I have changed as well. But, originally, it is a very sociological perspective to looking at, um, children's problems.

Respondent 28 – Social Worker - Practitioner

7.2.2.7.5 Social Workers as therapists

Social workers shared with nurses the feeling that their core training was somehow not enough, and that to validate their position within teams they needed to have a specific therapeutic training to enhance what they are able to offer:

How do I think of myself? I think of myself as somebody .. um.. I use the word therapist in my head, but I.. I don't.. I don't like to add that I am a little uncomfortable with saying that, because I am not trained as a therapist, so to be respectful to people who are trained as therapists, but at the same time and this is where the confusion comes from, I am employed to do therapy, so I do feel that there some confusion sometimes...

Respondent 28 – Social Worker – Practitioner

This move towards doing a therapy task has its own perils in terms of professional identity, as we noted in the nursing section, and the dominance of a new conceptual framework may lead to a change of identity to that of therapist more completely:

Um.. so there is.. there is kind of a lot... and social workers take family therapy, and some people change being individual therapists and give up their core identity and take on family therapy or individual therapy identity.. So, it's not easy.

Respondent 15 – Psychiatrist – Policymaker / Practitioner

There was a hint though that a relatively weak core professional identity, such as social work, might be more likely to be attracted to a new professional identity which was tied up in the better defined conceptual framework of a psychotherapy such as family (systemic) psychotherapy:

...there is this whole issue of family therapy is a discipline or not.. that's a silly discussion, but it illustrates your point. So ... there are a lot of people like psychologists and psychiatrists, who have good status at [Institution], were quite happy to continue to be in the psychology or psychiatry discipline, as well as being a family therapist. But the group of people who wanted to form a family therapy discipline, were the social workers. You could have guessed that.. couldn't you?

Respondent 32 – Nurse - Practitioner

It may be worth pointing out by way of conclusion, that the influence of social work on the development of the policy interest in children's mental health has been vital, if arguably indirect. As we noted in the literature review, and was noted by some of the practitioners interviewed, the emphasis on attending to what had previously been seen as a neglected area initially came from the Conservative Minister Virginia Bottomley:

*... the changes go back to 1992, Virginia Bottomley, Secretary of State...
... And in there [Care in the Community] there's that line about um.. er Children's Mental Health and she was a Psychiatric Social Worker um.. and so she first kicked off the... um.. it was off the Hampton Policy. So you put a line in.. it's a little wedge and it widens and it widens and, by 1995, what you then have is the Health Act.. the Health Advisory Services thematic review, "Together we Stand"*

Respondent 20 – Social Worker - Implementer

7.2.2.8 Professional identity of occupational therapists

Ideally a wider range of Allied Health Professionals would have been included, but the sample actually only included two occupational therapists. Whilst OTs do form part of the wider Allied Health Professional grouping they do tend to see themselves as different from many of the others included in that overarching term, as is witnessed by their insistence that they have a separate section within New Ways of Working, in addition to the AHP section. In reality whilst the other AHP disciplines, such as dieticians and speech and language therapists do make a contribution to mental health and CAMHS teams it is OTs who are most likely to be involved within them. As with the other sections it is not only the voice of those who belong to the profession that is important, but the perceptions of the other respondents, who have experience of working with OTs and other AHPs.

7.2.2.8.1 OTs as undervalued or embattled

There was a perception within the respondents that OTs in mental health and CAMHS had been overlooked in the past, either by design or because they had not advocated for their role assertively enough. There was also a perception that this was finally changing:

...they were just desperate to actually get some help in thinking about how they were going to define themselves in the future. Where their place is? They didn't really feel at that point, as a national group of professionals, that they'd got a sense of .. where they were positioned well within the system, and how they could... um.. be a stronger group and act as advocates of themselves.

Respondent 25 – Psychiatrist - Policymaker

In part this may be a function of the separateness of OTs within mental health. As with other disciplines the role of OTs in physical health multidisciplinary teams is easier to define, but mental health OT has adopted a more flexible approach which has marked them out from their original discipline:

And the professional identity of OTs is quite weak.um.... that's the evidence.. And um.. and I think that's why the OT profession has been struggling a bit...in the role of mental health because OTs really... You know, they'd rather be doing something else. You know, because also the OT professional body hasn't necessarily been aware of what has been going on.. up until now.

Respondent 10 – OT – Practitioner

Part of this difficulty in establishing themselves as a distinctive professional group may be in the lack of a strong academic tradition which can provide an evidence base for professional development. In this respect OTs have the same problem as nurses and social workers, where the depth of academic backing to the profession (at least within CAMHS work) is very limited:

Er.. I think everybody should have a good mixture of ...generic skills, shared skills and some specific things that they offer as well. Tch.. um.. the culture of the profession, well I mean.. I it's a very long.. long held belief, I think, that we, not Occupational Therapists, would never um.. would have that enquiring and sort of scientific background. I think it is seeing itself very much as an art rather than a science. So, it doesn't .. people don't come into the profession because they are interested in research, they come in because they're interested in engaging in activity with other people.

Respondent 11 – OT – Implementer / Practitioner

7.2.2.8.2 Purposeful activity and relationships

As noted in the quote above the concept of activity is core to OT identity as the one thing that they use in order to engage people.

This activity focus also extends to the underlying concept of activity being an essential part of the human experience and thus helping people back into purposeful activity is part of a normalising and healing process. This manifests itself more in work related activity within the adult field:

Um.. will er.. work with people's daily living skills, social skills, personal relationships... um.. er with...and employment, I think is one of the big things that .. and vocation, which I think is something that OTs are really getting back into. I think they've missed out on it a bit and they've been trying to do.

...

Very much more kind of involved in that sort of work now; which is what I think the bread of butter of what an OT always did in the beginning.

Respondent 10 – OT - Practitioner

And:

Um.. we always hold that the core belief of the profession ... the doing something.. 99.9% of the time is always better than doing nothing. Inactivity will not get.. will not move you from where you are to where you want to be.

Respondent 11 – OT – Implementer / Practitioner

The purposefulness of activity in establishing therapeutic relationships is also given a high importance in a way that is distinctively different from other relationship building techniques (such as in nursing or creative therapies):

Why am I spending time with you? You're spending time with me because there is a relationship with me, you and an activity. There's a third element in it. And it's not using that third element in the way that a psycho-therapist or an art-therapist might use it, it's using that third element in a very different way... almost as an external reference point that you can both have a relationship with, and at times you can turn that relationship onto the person or with the person you are with. And then that's a very powerful way to make a relationship .. It's a sort of.. it's.. it goes right back to parallel play and things from very early childhood.

Respondent 11 – OT – Implementer / Practitioner

Although there was some difficulty in articulating the concept there was also a feeling that the social skills required to enable activity made OTs good at systemic approaches to mental health working, and necessarily had to engage in community work:

...daily living obviously but also things like supporting community links and working with the third sector for example... I think occupational therapists... I am not sure why occupational therapists are good at that; whether it's the people that the profession attracts or it's something inherent in the models that they use in their training. That's just my.. it's just my ignorance being reflected there. But.. every OT I've every worked with has been a fantastic networker um..

Respondent 17 – Psychologist - Implementer

7.2.2.9. Professional identity of psychotherapists

In earlier sections we identified the process of individuals 'becoming' psychotherapists and modifying or changing their professional identity as a result of their new training. In some ways the identification of the professional identity of the various psychotherapies is easier than for the traditional professional groups we have already examined. Training in, and adherence to, the conceptual framework inherent in the different psychotherapies are what mark you out as a psychotherapist. Essentially the training gives you a conceptual framework (as well as a distinctive set of skills) which mark you out as a particular type of therapist:

If you're a family therapist... then you're a family therapist and everyone knows. And if you're a psychotherapist then everybody knows it. But if you're a nurse ...look at the range of nursing, so you could be anything.. and I think that's what.. that's what happens.

Respondent 13 – Nurse - Practitioner

.. if you're an art therapist or a play therapist or whatever.. you, I think you could describe more easily what it is you do. Because it's specific isn't it? You might work with lots of different children or young people, and lots of different.. you might use a different theoretical framework.. .but.. er.. but it's still within a particular, larger framework in some way.

Respondent 16 – Nurse - Implementer

The difficulty is the degree to which people make this leap of conceptual framework, either moving wholly from one way of thinking to another, or being able to incorporate one into another.

Certainly some people see that the psychotherapies try very hard to form professional identity based on their conceptual framework:

It's the mentality of the Jesuits, if you go into child and adolescent psychotherapy training and give up everything you have done before.

Respondent 12 – Nurse – Policymaker / Practitioner

This certainly reflects the strength of certainty with which some psychotherapies seem to 'preach' their underlying philosophies, as taken up in the theological reference below (cp John 14.6):

And the individual therapists have the way, the truth and the light, the family therapists have this.. very often think they also have the way, the truth and the light...and.. and.. that.. um.. nurses and social workers and doctors are the kind of jobbing people that pick up the rest, really.

Respondent 15 – Psychiatrist – Policymaker / Practitioner

Others saw the tendency to adopt new identities as a function of perceived power and status rather than as a reaction to a better defined conceptual framework (as cited before):

So ... there are a lot of people like psychologists and psychiatrists, who have good status at [Institution], were quite happy to continue to be in the psychology or psychiatry discipline, as well as being a family therapist. But the group of people who wanted to form a family therapy discipline, were the social workers. You could have guessed that.. couldn't you?

Respondent 32 – Nurse - Practitioner

7.2.2.10 The function of governance and accountability

Having looked at distinctive elements relating to specific professional groups there remains a couple of cross cutting themes within the practitioner discourse, in how all professional groups talked about professional identity, to pick up before relating this discourse to the themes present in the policy discourse.

Across the professional groups represented in the sample there was a consensus that one of the things professional structures offered were governance arrangements that held practitioners accountable for their actions. The importance of this was primarily seen as one of public protection, or as one respondent put it, a 'safety net':

If you are, like, diagnosing, um... offering treatment plans, thinking about discharge plans and there needs to be some kind of governance and some kind of ... um... professional safety net around that really.

Respondent 02 – Nurse - Implementer

In this thinking the role of the different regulatory authorities as primarily providing the public with protection from poor practice by healthcare professionals is in the forefront of people's thinking:

So, I do think there's some... some good in being a member of some particular profession and within some regulation... I think it's around protecting patients as well and not being ...just going off and doing anything that.. that you feel like doing but actually there are some parameters to that practice put down and, if you want to extend that practice, then you've either got to be trained for it or there's you know.. there's got to be reasons for it; and it's got to be looked at closely. And permission sought, rather than an individual thinking.. oh.. I fancy doing a bit of CBT.. or something, when they're not trained for it..

Respondent 16 – Nurse - Implementer

The way in which this public protection is enacted by the various regulatory authorities is seen as being in standard setting, and in holding professionally registered clinicians to account by ensuring that these standards of practice are upheld (and those who do not maintain these standards are subject to disciplinary action, including the option to prevent them working):

..in this country, we run on professional, you know, on our professional bodies. And... and I don't know another way around that in terms of, um... governance arrangements and kind of, um, keeping people up to date and ensuring that they're working at a correct standard, without having it formalised... in some kind of professional capacity

Respondent 02 – Nurse - Implementer

Whilst this system is familiar within the NHS, and most Trusts now insist on all their clinicians being registered with a core professional body for the reasons of accountability, there was also a recognition that this was different from the local authority model under which most social workers had previously been employed. The move towards direct employment of social workers by NHS Trusts under

partnership arrangements has thrown this difference of governance into sharp relief, and had only really been resolved by the establishment of the General Social Care Council as an equivalent body for social workers:

There was no point in having a registered body, where, you know people could be subject to disciplinary action in a local authority that was perfectly adequate.. Um, er it's different now, um.. I.. I'm, perfectly happy with the way things have gone since. Because things have changed...because there are lots of people like me.. who are now working outside the local government system. Er...It's still.. it's still social, social work is still predominately a.. local authority activity, but it is much less so. And, of course, what's now happening is that people, the people are beginning to work ... to work for ...um.. people, er.. are now beginning to be employed again in large numbers by um, people are now beginning to be employed by in large numbers by Trusts. And that raises a whole new series of issues.

Respondent 06 – Social Worker - Practitioner

This highlights some of the issues that respondents could see with the development of new roles within services. Whilst the concept of developing new roles was not dismissed out of hand, the difficulty was raised of employing people who did not hold a state registered qualification, and therefore were not perceived as being accountable for their practice in the same way. Clearly there were instances where this was already happening, and specific instances were cited as having raised the issue in practice:

.. it's good for people to say they're part of a profession, rather than somebody who's decided to do a bit of counselling or something. That really worries me, when you're going to schools and they've got counsellors that just.. nobody's necessarily checked their qualifications...or done anything like that.

Respondent 16 – Nurse - Implementer

Whilst this worry (about accountability and governance) seems real, it also seems to be a potential hindrance to the development of new roles and how professional identity might be constructed. In some ways the registration seals the professional identity of an individual. Very few people are registered with more than one body (although it is not unknown for people to hold dual registration, i.e. with the NMC and GSCC). This is enshrined in the variations of Code of Conduct (which most registering authorities have) and the conceptual frameworks of different professional groups are often clear through a close reading of those codes of conduct:

There are OT registration rules, you know, so who is going to look after those.. if they don't know what they are. And OTs code of conduct and practice... there has to be someone to make sure they're working to those and not.. on the nurse ones, 'cos actually their not nurses they're OTs... (laughs).

Respondent 10 – OT - Practitioner

In developing new roles this worry then has been seen as an issue, if not an obstacle. For some the new roles could potentially be seen as becoming new professional groups with their own governance and regulatory systems; indeed that in order to be effective they would eventually need these structures:

And then there's other jobs, like primary mental health work, like mental health practitioners, which I've seen a lot of in the paper recently advertised... that I think there needs to be a lot of work done around them really.. in terms of where they fit, how they go about the regulations... that sort of thing...

Respondent 19 – Nurse – Implementer

For one respondent the way around the issue, and that of the differences in the way various professional bodies actually enact their professional and state regulation, would be to eventually have a single governing body:

We've had Councils and Regulations for each profession in great number and in great special-ness. And it's becoming much more generic... It think the requirement for competence and safety is .. quite .. er fairly singular. It doesn't need twenty ways of reinterpreting it. So.. er.. re-licensing is a single issue for me. Um.. so you're seeing, I think, society changes. This need for.. er.. very individual approaches for each profession is becoming a bit more into that

Respondent 22 – Nurse - Policymaker

Having said that, the same respondent went on to describe the implications for this in terms of a single mental health worker identity which obviated the professional differences, but saw identity in terms of being a 'mental health worker' rather than a member of one of the existing professional groups. This was the closest any of the respondents came to describing a full move towards a single generic mental health worker or 'capable practitioner' in mental health:

What professional identity brings is all the infrastructure that supports it. So.. regulation, safety, um...um.. adequate performance, evidence based, research understanding, those kind of things that perhaps is normally provided by all those professions I guess...

...

Well there might be.. um.. You could see a Royal College of Mental Health Workers springing up, or .. now people do need those points of reference, and professional support to make it work well. You know, in order to advance your practice.. you need that kind of infrastructure support. Um.. . the advantage is it wouldn't be quite so burdened by history perhaps, that you could actually say, "Well, here's a place to start, now." And it could be quite creative and interesting. I think. It's quite heretical.. I think.

Respondent 22 – Nurse – Policymaker

7.2.2.11 Practitioner defensiveness and reservations about change

From this 'heretical' view of a move towards genericism, it is salutary, at least for policymakers who might want to move in that direction as a long-term aim, to note that there was naturally an element of defensiveness amongst respondents, and considerable resistance to some of the changes proposed. This defensiveness was understood, and in many ways anticipated by those involved in setting the agenda and implementing it:

Partly of course it's a defence mechanism as well. You know, people are very busy, highly pressurised, demand is increasing.. um, and so, by having these boundaries to your job role or title, there's a form of defence mechanism to a certain extent. Also, that's a way of course that many professionals are brought up and trained way back, sometimes many, many years ago..

Respondent 04 - Civil Servant - Policymaker

Indeed, despite the previous section on accountability there was some scepticism as to whether the regulatory bodies were actually able to ensure the level of standards that most respondents felt was a primary function of the different regulators:

...you know, part of the problem is having to tackle professional bodies and sometimes this sort of you know... arrogance about, that, that having a professional qualification somehow means your competent to do that job and challenge that and underpin it ... and look at what it means and how we do educate people, um,...

Respondent 01 – Nurse – Implementer

There was also a recognition that any sort of change is likely to be stressful, but particularly change that involves re-examining issues of professional identity which are essentially a very personal aspect of an individual's self perception. This was a widespread worry, but best summarised by this particular respondent:

Of course, it seems very difficult to get change in professionalism. Because professionals defend their own... and they have these constructs which are hard to change.... and this is the pattern of society generally.

...

They're defending their identity. And what they've got used to. And, er I think, you know, people talk about change as exciting, but most people find it bloody stressful. I think, you know the idea of change being bloody great... and whenever you change... make any major change ... even make it, there are always casualties. There are people that were perfectly effective workers ... So even if you only go from A to B, where B is definitely better.. the process can be very ... stressful. It's like moving house. People are going into denial about all this. But, actually,.. most people are stressed by it. That's the top and bottom of it.

Respondent 05 – Psychologist – Practitioner

7.2.3 Skills and Competences in the Practitioner Discourse

Picking up on the principal themes of the policy discourse, the respondents talked about the concept of skills and competences in a variety of ways. Clearly there was an awareness that this was a central policy direction:

Well I think Mental Health Workforce Policy is.. um.. is, I suppose, a sub-set to the overall National Policy, in that there is a drive to move away from, professionally determined ...um.. skill mix, if you like and towards a "competence slash capability" approach. And, um.. you might call that um.. New Ways of Working.

Respondent 14 – Psychologist - Policymaker

From those who had been involved there was also recognition that this was a very direct political pressure, if at times a somewhat confused one:

And the other thing we were trying to do was that we were trying to get people away from saying, well we need forty-one nurses (what do we need forty nurses for?). Er.. why do you need this number of medics? You know, what is it that you get from.. what are the skills and competencies that you need? What are the needs er .. in your population, that's saying this is what we need? And that was with the full support of er.. government, and ministers were very keen on that. But, however, when you go through the workforce review process nationally, then they do that.. they cut that by discipline. So, on the one hand, Ministers will be saying, "Well, this is exactly the route we should be going down, you know, we should be looking at skills and competencies", and on the other hand, they were saying, "but how many more nurses do you need?" When actually you might not need any. You know, we might not need any more psychiatrists, we might not need any more psychologists, what we want is people who have got these competencies.

Respondent 21 – Nurse - Policymaker

In general the concept that there are a lot of things that are done by different professionals that are essentially similar was not dismissed:

In an ideal world, where would we be in ten years.. is.. is .. we'd have service that.. that were.. that planned on the basis of the needs of the whole community. That's where we'd be. We'd have services that understood the needs of the whole community. We'd have workers in there and, in that time, who had the skills and competencies which were able to mean those things. Um.. but.. we'd also have the resource to be able to help people to develop those skills and competencies as those moves changed. And we'd have ways, we'd have ways of um.. mapping the changing needs.

Respondent 21 – Nurse – Policymaker

And:

Again I think the policy, as it is with all the other policies, there's nothing wrong with that. You know.. I think it should be based on skills and competencies. However, what I do have some concern about is somebody's professional accountability for those skills and competencies

Respondent 07 – Nurse – Implementer / Practitioner

The issue came through, however, of the difficulty in defining what those skills and competences might be:

...there was a debate I was in yesterday about, isn't there a sort of core set of standards I think that is what everybody is agreeing, there is a core set of standards, that anybody working the field of Mental Health ought to have. Um, now one of the questions is does professional educational training, pre-registration give you that? I think some of it does and some of it doesn't but I think that it, at the moment it's a real assumption that if you've got a professional qualification, therefore somewhere in your Pre-Med, you have done that set of criteria. I think we just need to be very, we need to tighten what we understand in that box. Things like listening skills, um, assessment skills, um, we need to tighten what we mean, what sort of competencies so break it down into sort of bite size chunks, about well what.. how do you measure whether somebody is able to do that and is that more about direct observation of practising that skill?

Respondent 01 – Nurse - Implementer

The complexity of establishing what exactly these skills and competences might be was not underestimated by those who had started to look at what they might entail in detail:

...cos there's a lot of work going on which I just didn't mention with National Occupational Standards and Skills for Health and they're trying to put together a framework for CAMHS. So that's about competencies...and I think they struggle (laughs) a bit with it. Because, obviously, once you start to look at all the range of provision and professionals and different roles in CAMHS, it gets very complicated.

Respondent 19 – Nurse – Implementer

There was also an element of reservation about whether it is actually possible to capture the complexity of what practitioners see themselves as doing on a daily basis in terms of 'skills and competences':

No.. I think.. I think that skills and competencies are obviously important in terms.. in policy terms, that.. in terms of making sure that patients and clients are safe and are dealt with by practitioners, who have, you know, a certain.. um.. level of skill. But obviously they're too simplistic to be able to capture the complexity of experienced, advanced expert practice.. whatever you want to call it.

Respondent 32 – Nurse - Practitioner

There was also an element, alluded to above, of seeing a difference between core skills, which everyone should have, and those additional skills that only some people (or professional groups) might have:

I would see it is that there is a very large area of core knowledge and practice skills. And, er... um you know, it's about... it's about there being a core, it's about the individual professionals having a distinct contribution around the periphery of that core.

Respondent 06 – Social Worker - Practitioner

And:

Um... yes. I mean, there's always been this debate between, um... "do we all have the same skills?" versus "Do we have different skills?" Um... I think I fall more on the grounds of... we very clearly have different skills we bring, but we need to have sufficient core skills to be able to function together as a team.

Respondent 08 – Psychiatrist – Practitioner

For mental health it might be easier to see that these could be enumerated within the Skills for Health National Occupational Skills for Mental Health, but, as so often happens in CAMHS, there is more than one camp that children's mental health falls into. The concept

of core skills, for example, is also present in the children's workforce agenda, and the DfES has published a document setting out the Core Skills for the Children's Workforce (DfES 2005).

Importantly for this study was the fact that there was some questioning of the concept that skills and competences would be applied in the same way by different people. The respondent below, for example, used the concept of a lens to explain that what appears superficially to be a simple application of a task, or an explanation of a skill or competence, might be applied in different ways by different practitioners. Whilst this respondent uses 'lens' to explain this, it does seem that what is meant is that tasks might be done differently according to the underlying conceptual framework in which the practitioner has trained:

Yes, because I think there's um.. just focusing on skill, I think it's um.. a sort of reductionist, it suggests that you can break something down into such small bits that anyone can pick it up. But actually it's also about the lens that you look through.. at the bits..

Respondent 10 – OT - Practitioner

This was mentioned elsewhere, albeit indirectly, in terms of similar assessments being done by different clinicians. Whilst this may be seen as an efficiency, there is also an argument to be made for there being a different understanding elicited by different clinicians using different conceptual frameworks:

I was doing an awful lot of sort of cold assessments.. and, basically what I realised was that I was covering exactly the same ground as the ... of the SHO covers a few hours later. [laughs] Asking very much the same questions, eliciting very much the same kind of information, but in a totally different way..

Respondent 06 – Social Worker - Practitioner

This was explained more in terms of flexibility by another respondent, but the essential point is similar, of the need to have a wider understanding of the whole, a need for a conceptual framework in which to situate the skills and competences. This respondent shaped this in terms of understanding several different conceptual frameworks and being able to move between them according to the need of the individual or family presenting in front of the clinician, a high level skill by most standards. In this respect the respondent is perhaps restating the traditional concept of a multidisciplinary team which contains people who can at least understand the framework within which their colleagues work, even if they themselves do not have those skills (or share the conceptual framework) themselves:

... but it's about the flexibility so you don't get caught up with seeing what you expect to see, you're able to have a framework that you can record the fact that this doesn't fit with what you expected and to be able to shift frameworks in thinking well, maybe this, this particular way of thinking about this case doesn't apply best at this moment in time. Um, so when this child is presenting with difficult behaviour, um to be able to move away from, why his ADHD medicine needs adjusting, to wonder what else is going on. But not to go... solely down that route, to the exclusion of missing the fact that you probably could do a bit more methylphenidate. It's that kind of skill, it's that kind of flexibility. And you see people who've got the particular skills in one domain, but lack the flexibility... people who've got the flexibility but need to get their individual skills built up.

Respondent 08 – Psychiatrist – Practitioner

7.2.4 New roles and extended roles in the Practitioner Discourse

Naturally there was some discussion within the practitioner discourse about the creation of new and extended roles in mental health and CAMHS. Some of this centred around how those new roles which had been created or proposed were impacting on current services, but again for the purposes of this thesis the concentration will be on how this impacts on professional identity. Some of the new roles are clearly within existing professional groupings, and predate the New Ways of Working initiatives, whilst others are more clearly seen to be within the current project of modernisation. The role of Nurse Consultant, for example, was promoted as a research-based initiative from within the nursing discipline, whilst Primary Mental Health Workers in CAMHS stem

from the 1995 HAS 'Together We Stand' document. In current workforce policy, as we have seen, new roles such as graduate mental health workers stem from the NHS Plan, whilst Support Time Recovery Workers and Community Development Workers come from adult initiatives. There is a final category, the development of extended roles for non-medical or independent prescribers (in all areas of healthcare), which has been given a boost in mental health by their perceived utility for moving forward the NWW agenda.

7.2.4.1 Nurse Consultants

Nurse Consultant posts (and PMHW posts) are somewhat different from some of the newer roles in that there was initially much more of a structure around the establishment of such posts. The first cohort of Nurse Consultant posts had to be individually vetted by the Department of Health, for example, and even now establishing a new Nurse Consultant post requires clearance from the Executive Nurse at Strategic Health Authority level. Based on the original research by Kim Manley (RCN 2000), there was clear guidance on what these posts should entail, and they were intended to be attractive to senior and experienced nursing staff, keeping them in clinical practice. Nonetheless there has been considerable variation in the operationalisation of the posts, and there remain only limited posts in CAMHS (less than thirty posts in England):

I suppose, obviously, not everyone's the same, so you're going to get different motivations and drives within people. Um.. and I think that sometimes the identity around the role can have an impact on that. So, in the nursing role, we don't have a lot.. I don't think we have a lot of people who are driving forces. We do have a lot.. some strong people in nursing consultants sort of roles. But we've not got that many research posts... so that's the difficulty. .. because that doesn't really support that.. that... feeling strong within your role um..

Respondent 19 – Nurse – Implementer

The use of nurses in extended roles at a very senior level seems to have some effect in breaking deeply entrenched stereotypes about the dependency relationship that nursing has with the medical profession. This impacts on the establishing of a separate identity which is not dependent on that relationship but which then requires more certainty about difference that can be made by that profession in its own right:

Because of things like extended roles, New Ways of Working, Nurse Consultants...they're no longer that like.. I think.. when I first went into nursing, nurses were seen as like the help... the helpers for doctors and .. and they're no longer that anymore, they have their own.. they hold their own among a multi-disciplinary team now.

Respondent 19 – Nurse – Implementer

As a model it was seen as a useful one, possibly even one that could be used for other professions. Technically it is possible to have consultant level AHPs and psychotherapists, but these posts in actuality are rare:

I think the nurse consultant role... still.. still is an important role. It could be much more useful. Some Trusts are using them... most Trusts are using them in very different ways. But if there was that consultant grade there for most people to aim for... I'm not saying that everybody should do that. But um... then all other posts could be considered "training" posts, accepting obviously some people who use profession; some people don't want to go that far, some people don't have the ability to go that far. But the important thing is that even nurse consultants continue to see service users. In the past, nursing was particularly difficult, because if you wanted to progress in any way at all, you had to be working in patient contact, there was no other way of doing it. And I think the nurse consultant level, again, gets round that quite well. So that's the route you could go down. Not just for nursing, but for other professions as well.

Respondent 21 – Nurse - Policymaker

There was even a warning from one respondent that, from a Trust and service point of view, they were seen as too useful and their expertise was often wanted outside of the service area which was paying their salaries:

I think they are going to be a little like nurse consultants if we don't watch them. When we have supported them to be nurse consultants, we have bedded them in, we have supported them to be put in.. um.. in their organisations but suddenly they become very much wanted by everybody outside the organisation, including the Department of Health; and they disappear. You know, they are still in the Trust, but, you know, if you want them to come to a meeting, it is.. "Well, I have got a very important meeting sitting at the DoH"; and that's obviously where they should be, that's obviously fine; but I think we need to make sure that we are getting our moneys worth from them as well.

Respondent 29 – Nurse – Implementer

7.2.4.2 Primary Mental Health Workers in CAMHS

Nurse consultants seem to be fairly certain in their professional identity; they have to be a nurse by training, and the title reinforces their professional background, but this is less clear within Primary Mental Health Work. Although the role is fairly clear, it was established in response to a researched deficit in service provision (from Kurtz et al 1994), and set out in the 1995 HAS guidance (op cit), there was less clarity about who would fulfil the role. The posts were sporadically adopted across the country until their utility was reinforced by the NSF for Children, and specific ring-fenced funding given under the CAMHS grant initial rounds:

And um... it has been, it seems to me, to my experience, a lot of appointments of staff to tier 2 services, particularly Primary Mental Health Workers, following the ... 2000 and 2003 funding guidance, who aren't equipped to do the tasks they're asked to do. And it's... they certainly don't meet the... don't meet the requirements of the job descriptions that were originally set up by the Primary Mental Health Worker's Association for that post.

Respondent 12 – Nurse – Policymaker / Practitioner

Because there has been time since their initial proposal in 1995 the role of PMHW has begun to attract some evaluation (Gale and Vostanis 2003) but has also highlighted the difference between role and professional identity. There were criteria (and a salary band) which would shape who was likely to apply for these posts, but no definition of exactly which profession was being sought, so long as the set of skills and competences could be met:

But um... yeah.. um.. I mean, there's kind of some firm criteria around at the moment, that you have to have so many years experience within CAMHS ... and so many years qualified. But it does.. it generally seems to be either nurses or social workers that come into posts because they usually see them advertised at a specific grade.

Respondent 09 – Nurse - Practitioner

For some there appears to be, again, the idea that this may be an 'escape' from a discipline to which they are not particularly well attached, whilst for others there is not this desire, and a desire to see it more as a role which a variety of professions may be able to perform:

For those.. those who want to escape being a nurse, an occupational therapist, a social worker or whatever, then being a Primary Mental Health Worker and wanting a "disciplinary"... a discipline in their own right is extremely important. Um.. I'm not sure that that is going to happen... but um er... for those who are actually confident in their disciplinary role and see this as a role they have taken on in their.. in their nursing, social work, or occupational therapy role, they.. they're less concerned about it. It depends on where, I suppose, it depends on how .. on how passionate they are in wanting to escape... how passionate they are about primary mental health care work as it is, or wanting to escape the discipline they are in

Respondent 12 – Nurse – Policymaker / Practitioner

In some ways the PMHW is a perfect example of a new role that didn't specify a professional registration and training (though most employers insisted that employees had one, for governance reasons) but instead developed a role based in a set of skills and competences:

I... I... um was a Service Manager for a Primary Mental Health Worker Team. And again...it was more about people's skills and competencies. I mean, they had to be professionally qualified, but actually it didn't matter whether you were an occupational therapist or a family therapist, or...it was more about um what you could actually bring... in terms of, um... working in an... early intervention preventative way, and skills around consultation, liaison and training and that's much more what I was interested in.

Respondent 02 – Nurse - Implementer

In this respect then it illustrates the difference between role and professional identity, and echoes the previous suggestion that, eventually, there might be a move towards an identity that is about being a 'mental health worker' rather than being someone from a particular discipline doing a job that overlaps with other people, but which has an element of distinctiveness. For some it was clear that the aspiration towards PMHW becoming a separate profession, with a distinctive professional identity separate from the core professions, was going to be very difficult:

And now we've got the other complication of people who are in a role that doesn't have a professional identity but they have a professional background, like primary mental health work which is almost like, "where do I sit?". Um.. and a lot of them, when I ... when I talk to them, would say that their alliance would go with their professional background and not their primary mental health work.

...

...I think it's a role or a discipline of work, I don't think it's a profession. And then, of course, if it's going to be a profession, there will be a lot of things like how do you accredit a training, is there a regulatory body, um.. you know, looking at the different levels of autonomy and responsibility.

Respondent 19 – Nurse – Implementer

Again the issue of governance as a defining element of professional identity is raised. This does not stop the aspirations of some who would definitely want to see PMHWs developing a rounded identity and professional structure of its own:

I mean, what we are hoping to develop is a professional primary mental health worker group. So that actually that would become a profession in its own right.

Respondent 02 – Nurse - Implementer

7.2.4.3 Graduate mental health workers, STR workers and Community Development Workers

It is important, of course, to recognise that some of the new roles being developed are not intended to replace professional posts as they currently exist, but are building on perceived gaps in service and opening up opportunities for the sort of people who might not want to have a professional career path structure and the level of qualifications that go with that. NWW is very clear about this, as were the respondents closest to that policy development:

I think if you look at the total numbers at the moment. I mean, you know.. the.. the new workers and so on um... are miniscule in total. They really are um... OK., we've got, you know, two and a half thousand STR workers, we've got a few hundred CDWs but, you know, in terms of the numbers of nurses and so on that are in place, it is absolutely miniscule. So there... whilst I think there will be a shift in the... in the balance if you like... um.. it's not going to turn on it's head even in the longer term, I don't think. Um.. it's just trying to capture those who can come into the workforce, do a very good job at that level, but at the same time not to dumb down or dramatically reduce the number of nurses or psychiatrists and so on.

Respondent 04 - Civil Servant - Policymaker

There is also a clear recognition that the demographic problems that NWW acknowledges have an impact on policy design, that the current system would not be able, in the long term, to provide enough staff with full professional training to meet the need that is anticipated:

It has, well I've suggested there should be new kinds of workers (laughs). Um.. like the star [STR] workers, full time recovery workers, gateway workers.... and primary care workers.. er.. they're all kind of mooted as being very good. And partly because... um.. of, when the NSF was published, it was ... where I used to work in the [organisation], they identified that there were 10,000 people were... missing from the mental health workforce to achieve just the adult NSF. And suddenly, well it would be nice but where are we going to get the people from there.. you know, do we live in a society that's interested enough to recruit 10,000 people.

Respondent 10 – OT - Practitioner

There remains some confusion within the thinking about who will come into these posts, at some times it being referred to as a 'lower' level of post. For some posts, a relatively high level of qualification is required, i.e. graduate status, which is higher than the diploma level at which some professional groups train (i.e. nurses and some social workers). Again this is seen as a response to the demographic, in this case of the surplus of psychology graduates being produced:

So that is a great advantage because we can recruit from quite a wide pool. The slight disadvantage obviously, is trying to frame some sort of educational training programme for these people, because they all come from all sorts of backgrounds, ages, knowledge skills, etc. Um.. so again... it's like trying to tap into, not just an existing type of person will do this but look at the wider pool. Which indeed that's already happened... graduate primary care workers for example, a lot of them are psychology graduates but couldn't get clinical psychology posts. They can actually do that graduate primary care role and therefore increase the numbers in the workforce.

Respondent 04 - Civil Servant - Policymaker

Whilst it would be easy, therefore, to write off the new support roles as not relevant to this discussion, it did come through in some responses that there was a concern on behalf of these workers that they suffered from a lack of identity, and that this would ultimately make the role unsustainable. In particular the transferability of their skills and competences might be difficult if there was no way of verifying the level at which they were acting:

Because they wouldn't have that ...that.. you.. they wouldn't have that you know university training and those kinds of things actually to provide them with structure of support... that's who you are, and their identity ... would... can get quite messy. Because, er.. they haven't got anyone else to identify with... in the workplace.

...
And they wouldn't be recognised as a .. that role wouldn't be recognised anywhere else in the country, they're not recognised as a professional body, they wouldn't be registered.. you know. Who would reinforce who they are and what they could do. I don't know.. It's quite a concern of mine, that.. people will cont.. who have great identification do training but come from university when it's finished .. that there wasn't really anything else to validate who they were.

Respondent 10 – OT - Practitioner

This lack of identity was also explicitly seen as a difficulty in sustaining the workforce who might be tempted to move from this role into one with a better defined professional identity:

. well I think that's been half the problem, especially with graduate primary mental health workers.. Anecdotally, I've heard that they're tending to move on very quickly from their role ... because it doesn't really feel like they're in a career structure: they don't have that professional identity; they don't have that ability to share practice... evidence based practice.. which you would have, if you were involved in a professional body and you had that kind of identity..

Respondent 19 – Nurse – Implementer

7.2.4.4 Non-medical and Independent Prescribers

The final section touches briefly on another development of expanded role which has no direct aspiration to develop a separate professional identity, but which, as we have seen, erodes the distinctive domain of medically trained professionals as the only ones with prescribing rights. The role is seen as an enhancement by most, and smoothing the way in which other roles can be performed. Even though it could be said to be a threat to the medical profession, it is clear that the role enhancement has been designed to be as inclusive as possible, and has broadly met with a supportive response from doctors:

The medics, I have to say, um.. and this has been our mantra in all the conferences that we have presented, have been extremely supportive. We have had no problem at all in getting mentors for nurse prescribing. Independent nurse prescribing, I think they're a little bit worried. So we are having to constantly reassure them that, you know, these people that are being.. are trained, that they are being supported properly, and that they're going to be OK.

Respondent 29 – Nurse – Implementer

7.2.5 Service User needs in the Practitioner Discourse

Service user need is mentioned throughout the practitioner discourse, but not in the same way as in the policy discourse. In policy, as we have seen, there is a tendency to use service user need as the motivation for change, and the justification for it. In the practitioner discourse there is a 'taken for granted' aspect towards the needs of those who use the service:

Um, somebody asked, somebody in the room asked why we should have service user involvement. Now, ... I, I, at that point, I mean, I suppose part of me was really gobsmacked to think that we're in the year 2000+ and we are still having this debate. And actually the only reason why this debate is because now we've got to do it, rather than whether we would like to do it... it is now our statutory responsibility, you have to do it.

Respondent 01 – Nurse - Implementer

Given the reservations expressed about the way in which service user need is used to justify change it comes over that most respondents felt that it was the most important motivation for change, and did not question where the voice was coming from:

Well, I guess the advantage, if we can evidence that it is in the best interests of the patients, well then so be it. That speaks for itself.

Respondent 29 – Nurse - Implementer

Opinion, however, was somewhat divided on what service users actually wanted from professionals, which rather undermines the idea that there is a unified need which can be easily quantified. For example from the experience of one respondent:

Policy doesn't suggest it, but I think that there's enough evidence you know (laugh)... from my personal experience, and also from evidence that I have read, and.. and people that I've spoken to, that people want to know who they are and have a sense of belonging. Umm... especially when, er.. you know, service users just want to know who you are, where you come from, what your background is..er.. not.. not.. not in an in depth way, but so that they know what sort of thing that they might expect.. although that can be various as well. You know, they want to know if you're a nurse or an OT or a social worker perhaps.

Respondent 10 – OT - Practitioner

Whilst another, equally experienced practitioner came up with a rather different view:

And.. and...you.. and that I, I know how that sounds but I think often, um.. some of the comments back to me from the people who have used services , "all I wanted people to say, was, "hello, how are you?" not ask me three hundred and one assessment questions. Um... and do it in a manner that, you know reflects my values and my opinions. And I.. it's woeful, it is woeful and I, you know, I don't know how you do that. I think all you can do or I, or I would hope is lead by example.

Respondent 01 – Nurse - Implementer

A balanced view might be summarised as being so broad as to be not very helpful for workforce planning, or an examination of professional identity, which is that different service users have very different needs and ultimately just want the person who is going to be most helpful to them (which may be a particular professional, or just a good listener):

I think it.. it matters much less to them who they see. What.. what ... what they want to see is um.. somebody who is going to um... understand them, support them and to be helpful to them. I would say this is their prime aim.. um.. But they will still, I think because they're socialised into a particular society, they will still come along with pre.. you know, preconceived views of um... "it may or not be better to see a psychiatrist", they may be perceived as the expert or they may be perceived the person who controls things. Um.. it may or may not be better to see a nurse.. they may be perceived as more caring but not as experts. So.. um.. I.. I think it's quite complex to.. it's quite a complex issue and it will depend on what.. you know, what service users actually bring along with them, and what some of their ... aims and needs are. But, ultimately, I think, once they get over that initial who am I seeing, whoever I am seeing, whatever profession, I think ultimately what they want is someone who actually is going to meet their needs.

Respondent 32 – Nurse - Practitioner

7.2.6 Need for Flexibility in the Practitioner Discourse

In the policy discourse the theme of a need for increased flexibility amongst the mental health workforce came across strongly. Within the practitioner discourse there was some recognition of this, and some resistance to the notion that the workforce wasn't already flexible in how it delivered service:

I think we're already flexible. But it's just not acknowledged how flexible we are because I don't think anybody's actually asking specialist CAMHS staff what they do and don't do. I don't think they're asking other people what they can offer and then perhaps that's a cheaper version of .. or perhaps it's a more accessible version of what they want, or people are saying, "Yes, we can offer that".

Respondent 07 – Nurse – Implementer / Practitioner

Others saw flexibility as important, especially, as has already been noted, in being able to shift between different ways of seeing things, a flexibility of conceptual framework and understanding:

..but it's about the flexibility so you don't get caught up with seeing what you expect to see, you're able to have a framework that you can record the fact that this doesn't fit with what you expected and to be able to shift frameworks in thinking well, maybe this, this particular way of thinking about this case doesn't apply best at this moment in time.

Respondent 08 – Psychiatrist – Practitioner

Whilst highlighting the difference in perceived flexibility of different disciplines, the issue of having an underlying conceptual framework that allows a flexible approach to different roles and styles of working was highlighted.

Psychology for instance doesn't operate flexible service like that. Psychologists don't usually practice as case managers, because that's not how they're trained. It's not what they have the skills to do, as nurses do. Tch.. um.. psychology doesn't provide usually an off-site service, a domiciliary service, whereas nursing does. So nursing will take intervention to other people's homes, it will take them to other places. It will offer that sort of flexibility, so I think it has a very valuable role. The bit that worries me is the skills and competencies. That if you've got all that flexibility, then I think that, if you have a model, a therapeutic model that underpins your work, regardless of what that therapeutic model is, I think, makes it much easier to operate with that sort of flexibility.

Respondent 21 – Nurse - Policymaker

This very much foregrounds a dilemma within the workforce policy, at least in this respondent's understanding. Rather than seeking someone who has the skills and competences for a single role, in order to get the flexibility that is also being sought, a wider understanding, and crucially, a 'therapeutic model' or conceptual framework is necessary.

7.2.7 Issues of power and money in the Practitioner

Discourse

As we have seen in the literature review, and has already been mentioned in relation to specific professional groups, the issue of power is central to any understanding of how systems work. This applies, of course, to the way in which influence is exerted by policy makers, as seen in the New Ways of Working document, but also applies within teams and impacts on how team members see their own professional identity:

It's power dynamics, there's... we can't deny that there are power dynamics within multi agency, multi-disciplinary teams. There are .. so, sometimes your profession, or your professional background means that you're of a higher social status than someone else in the same team. So sometimes you can use that, you know, to get your point across and sometimes.. not.

Respondent 16 – Nurse - Implementer

There was recognition that this power differential can play itself out in multidisciplinary teams, either in personal or professional rivalries and the games that people play:

Um.. you have to have that degree of trust that you are exposing yourself by talking about things as they impact on you personally, rather than this rather detached professional relationship which might be misused. Um.. that people aren't out playing power games ... or they're out to make themselves feel better at the expense of others. Um.. , you know, which does happen in teams.

Respondent 08 – Psychiatrist – Practitioner

The same respondent felt that the traditional model of medical hierarchies was not enacted in the normal way within mental health multidisciplinary teams (and CAMHS), where a flatter hierarchy is more normal due to the type of work:

It's more influence than power. Um... and... and... er... so it's not... it's not a completely flat hierarchy... it's not um... it's not sort of ... so far down in that direction. It's a... I guess the wide extreme would be the kind of therapeutic community model. Um... it's... it's a kind of hybrid of some elements of, you know, hierarchy... and... um... um... power, but not... not a position of power, a bit more role or knowledge power.

Respondent 08 – Psychiatrist - Practitioner

The power ascribed to different professional groups was recognised by those who had been involved in policy development, but there was a feeling of resignation that some things were almost too difficult to change. The power of societal values, and the inherent power base of some professions, was therefore taken for granted, and unlikely to be changed by current workforce policy:

Yeah, I think there's a lot of how the role is.. yeah.. yeah, the power and the prestige that's socially ascribed is very different between nurses and.. .. tch.. psychologists and psychiatrists for example. But I.. I don't think that's immutable .. I think it's something that we have to acknowledge as a team.. um.. or, you know, as.. as a profession, and it has to be acknowledged in policy terms. Um.. and I think history shows that people don't give up.. um.. their power and their prestige unless there is something in it.. for themselves. I think we have a suggestion that's not immutable but is very easily stuck in the status quo..

Respondent 30 – Psychiatrist – Policymaker / Practitioner

In terms of professional identity there was also some recognition that the perceived power or status of different professional groups might be a factor in determining how people see themselves, or how they choose to identify more with one group than another.

Previously it was highlighted, for example, that some groups are more likely to maintain their original professional identity (as psychiatrist or psychologist) despite doing further therapeutic training, whilst others (social workers were mentioned) might choose to identify more with their new psychotherapy identity. This was explicitly mentioned by one respondent as a power issue (although hinted at in the previous quote):

I think.. I.. I know people who have managed to be both. Some times people will train as psychotherapist, if they have been nurses and they have gone off and become a child psychotherapist, and that then becomes their sort of leading professional, um .. identification, if you like. Um.. because they have moved out they.. they, you know, they have developed and they want to do something a bit different and, similarly, even some, family therapists at times. Because there are also, of course, rewards to changing and moving with the times as well, in terms of kudos, um.. political power I suppose at times.. in a .. with a small "p" as well as money. But.. um.. I also know from the field of nursing, nurses have actually stayed, er.. on in their role as a nurse with a family therapy training or, indeed with a child psychotherapy training. Um. um.. so it is not impossible for them to do that and to apply that to their field of interest.

Respondent 12 – Nurse – Policymaker / Practitioner

This quote also highlights an issue that is not mentioned in the workforce policy discourse of New Ways of Working, though it is clearly one of the central concerns of Agenda for Change, that of how individuals are remunerated for the skills and competences they bring. Issues of money and different grades of pay did come up a great deal within the practitioner discourse, with Agenda for Change having been a relatively recent process, forcing all practitioners into a very personal examination of how their skills were valued by their employers. The way in which money and pay is used as an example of how people feel valued can be illustrated with just a couple of respondent comments:

Um.. I think that.. that's a function of.. the system rather than the profession. Um.. a function of the system is that um.. once you become something that's clearly identified, like a therapist, you tend to be rewarded better... To have more prestige, to have more money and.. therefore, nurses can strive towards.. those roles um.. I think that nurses, as individuals are usually quite proud of their role as a nurse. But also perceive that it's not as well rewarded, or as well respected as some other profession.

Respondent 32 – Nurse - Practitioner

The awareness of this was not simply from those who were paid less, but was clearly also an issue for those on better pay scales who saw some unfairness in the system:

I mean, I've always felt that I'm not going to be apologetic for my salary, but I get pretty angry about other people's salaries. I mean that's the way I.. I take it. Um.. and in terms of actually where I came from with all the training and experience and all the jobs I did, you know, I personally don't feel guilty but, actually, I feel cross about those social work colleagues down the road.

Respondent 25 – Psychiatrist - Policymaker

7.3 Critical Discourse Analysis of the Practitioner

Discourse

Having looked at the principal textual themes within the practitioner discourse, it is important to revisit some of the analytical themes from the CDA perspective (although the textual analysis has been informed by this). There is no attempt to complete a fine grained analysis on account of the size of the corpus, which comes to 180,000 words for all the interviews; instead the common aspects of the texts will be reviewed.

7.3.1 Social Events providing the context for the Practitioner Discourse

The social context of the interviews has been set out, but in order to highlight this it is worth reviewing the critical points. The political background was characterised by a series of changes being introduced into the NHS in England over the period leading up to the interviews taking place. As some of the respondents noted, this was largely a political agenda of the New Labour Government that came into power in 1997 with a modernising agenda, setting up the NHS Modernisation Agency. The movement in children's services, however, has been traced back prior to the change of political party in power, and was initiated by the previous administration under Virginia Bottomley, a Conservative minister.

The changes had affected roles in the widest sense, and the Agenda for Change process had been central to this in putting a focus on the Knowledge and Skills Framework. This had been a traumatic process for many in the NHS as it put emphasis on methods of measuring competence in a way that was new and challenging. Despite the process being designed to be swift there was considerable time taken in completing it and some appeals dragged on into 2007, making it very fresh in people's minds as the interviews were being conducted. The New Ways of Working process was still ongoing at the time the interviews were being conducted

and the publication of New Ways of Working for Everyone actually took place just after the completion of the interviews.

7.3.2 Genre in the Practitioner Discourse

The issue of genre is also similar across the different interviews. All of the respondents had been recruited in a system with which they would have been familiar, a health model of research structured and regulated by the health service Central Office for Research Ethics Committees. With comprehensive information sheets and consent forms (see Appendices 2 and 3) the respondents were assured that the research interviews were being conducted in a way that ensured that the data would not be misused. The actual interviews were mostly conducted at people's places of work, although for a couple of cases these were held at their homes, as the most convenient place for them. In either case it is clear from the responses that people were relaxed and able to talk freely. The open format of the interview, with the interviewer making a conscious effort not to interrupt, allowed the respondents to say what they felt about the issues of professional identity without it being shaped by the interviewer's preconceptions. The respondents also seemed genuinely interested in what the research would find:

Well, I am intrigued, I am intrigued about your hypothesis. I am intrigued about... about what's motivated you to pursue this but I will not find that out for a while... Until I read the results

Respondent 28 – Social Worker - Practitioner

In this respect then, the informal and conversational quality of the language in the interviews as well as the promise that anonymity would be maintained encouraged a very frank discussion of the subject in a way that is different from the carefully crafted text of published documents. This occasionally came out in specific references:

Res: One was actually looking at clarifying what medical responsibility means for the multi-disciplinary teams, which is obviously core to it, because people of all professionals have been very exercised by that.. and it's caused a lot of ill feeling, I think, too. And, indeed, I was.. I'm not sure I want to be quoted on this or.. it might.. inadvertently..

Int: It will all be anonymised!

Res: Yeah, um.. I have .. I was in a meeting, I remember, within a few months of that,....

Respondent 14 – Psychologist - Policymaker

7.3.3 Difference in the Practitioner Discourse

Fairclough insisted that one element in checking the nature of text was to look at the openness to difference within texts, as we have already discussed. Within the practitioner discourse there are expressed a great variety of opinions on different subjects, but there is very little that is expressed in a dogmatic or unthinking way. This probably reflects the nature of the field of work in which the practitioners were used to working. Psychiatry and mental health has very little by way of certainty in it, and practitioners are used to making judgements based on an accumulation of probability. This is not an exclusive attitude, of course, we saw

mention earlier of some psychotherapists thinking they had 'the way, the truth and the life', a particularly evocative way of expressing the certainty that some conceptual frameworks seem to portray. For most of the practitioners in this sample, though, they were careful to give opinions as just that, their opinions, including some that would not be accepted as mainstream thinking:

I mean Mrs Thatcher even said that she was adopting this Maoist thing. But these people were intellectuals... who studied Mao and had a sort of right wing agenda. They said that he had some good ideas.

Respondent 05 – Psychologist – Practitioner

This theme of a variety of personal conceptual frameworks also came across in the ways in which some ideas were expressed, for example in the following ideas (about nurses) being from a working class background, which includes a socialist class perspective:

Um.. I personally see .. the people I am talking about are people who have erm.. maybe they've got more um.. maybe they have more powerful working class stories. Er... and er.. have struggled and, you know er.. making.. getting out of the working class position; whilst.. whilst also maintaining allegiance to this idea of them being working class.

Respondent 27 – Social Worker - Practitioner

The same respondent, shortly after, also expresses some uncertainty about this position, so was far from dogmatic in his approach, but clarified this as thoughts on the subject based purely in recent experience:

I don't think I'd be as bold as to .. to er make that claim. But er.. I'm just aware that that's my um.. that's something that I've noticed, but I wouldn't like to claim that that's the case across the board at all. It's just the group that I've been with that my experience has made me wonder about that. Um.. having said that, I prob.. I probably feel as though there is something in that. But to what extent, I don't know.

Respondent 27 – Social Worker - Practitioner

7.3.4 Assumptions in the Practitioner Discourse

Questioning the assumptions made by respondents is also important, though more difficult to ascertain in many ways. In this respect the practitioners share the background of the researcher in that all of the sample were (or had been until recently) ultimately employed by the government in one capacity or another, as academics, civil servants directly or indirectly employed by the Department of Health, or as healthcare practitioners who were employed by local provider Trusts. In general, then, they would share an ethos of public service rather than a purely commercial model of understanding the healthcare system. None of the respondents, for example, offered radical changes to the existing healthcare provider model, only looking at what might be considered minor changes to workforce policy in terms of how people were employed. Even the most radical suggestion (of moving to a generic mental health worker) was surrounded by caveats that it would be difficult to achieve and would take a 'generation' to pass through the existing system.

Another important assumption that is clear within the discourse is more implicit, centred around the use of the word 'worker'. Whilst this follows policy there are also echoes of the values around the use of the phrase 'worker' within the descriptions of role. Most commonly the word collocates with phrases (and most often in job titles) such as 'social worker', 'support time recovery worker', 'primary mental health worker' and 'community development worker'. Each of these are role descriptors, and each imply low status work, in a way which the job titles of professional groups do not. A nurse, psychologist, or doctor's job title speaks of a particular type of training, based on a conceptual framework, and gives the person who receives a service from that person an idea (albeit one which may be subject to a stereotyped vision) of the expertise they may expect from the particular person. When someone is referred to as a worker, there is more of an implication that they are part of a larger more impersonal workforce, with less individual expertise, but a role and function which fits in with the purpose of the larger organisational need. Examples of this would be factory workers or shipyard workers, who may have skills and expertise, but referring to them as workers (instead of welders, or electricians, or carpenters) lowers the value attributed to the contribution of those individuals to the whole.

The only professional group for whom the phrase is commonly used is the social worker group, and this, as we have seen, may reflect their relatively recent adoption of a professional status that is

separate from their function as part of a local authority apparatus. In that respect they again fit the concept that 'worker' describes a role and function rather than a professional status. Indeed the new regulatory body for social work is called the General Social Care Council, which reflects a move towards the use of the phrase 'social care' to describe the broader function of that group.

Within the sample there are other examples of the phrase 'worker' being used generically, as 'CAMHS worker', for example, but these are rare compared to the use of 'CAMHS professional' that is evident in the NSF for Children. There are examples across the country, as we have seen, of generic workers within CAMHS having a variety of job titles, but the title 'Clinic Worker' would be seen as lower status than 'Mental Health Practitioner' within the healthcare professions (Singhatey 2007). The only example of the word being used in a relatively high status role is for the group of CAMHS Regional Development Workers, who had a high profile function in implementing Standard Nine of the NSF for Children. Again this job title reflects a role and function in a way that is designed to be explanatory of that role and function, and, given that the role was undertaken by people from a variety of professional backgrounds, it was felt appropriate in that circumstance. For most professional groups the importance attached to maintaining the professional status is relatively high. This clearly has some importance in maintaining personally important areas such as how much pay is given for a certain job, but also reflects the need to maintain

identity. That identity can be enhanced by attaching other signifiers to the professional title to identify the level of experience or role. The increased use of 'Consultant' amongst nurses and psychologists, for example, maintains a high profile for certain professional groups, though use of this title is usually circumscribed by tight definitions of who can, and cannot use the title, reflecting (and protecting) a high level of expertise. This is in contrast to the 'worker' concept in which most of the new roles are described, where the emphasis is on the role and function that will be performed rather than the need for any conceptual framework as a basis for this role. Clearly this fits in with the underlying idea that skills and competences are what are needed to fulfil that role without necessarily having a conceptual framework in which to place those skills and competences.

7.3.5 Intertextuality in the Practitioner Discourse

In the section on intertextuality in *New Ways of Working* the importance of the use of 'capable' as a descriptor of teams was highlighted. Obviously as the NWW team chose to use the 'Creating Capable Teams Approach' as a description of the process for implementing team reviews and redesign, the phrase crops up in the practitioner discourse, most often as part of that phrase. One of the policymakers, however, used the phrase in more general terms to describe team functioning:

Um.. tch.. but the common direction of travel is for um.. every.. every profession to work together in a team to make sure that that team is a capable one. And so what we're producing in er.. a couple of months time is not only a report about what all the professions say about what New Ways of Working should be in order to reduce barriers for people on the ground or resistance to change, but also an.. what we've called a Capable Teams Approach;...

Respondent 14 – Psychologist - Policymaker

This again cements the move away from professional identity towards 'capable practitioners', although in this case both are used as a way of describing the 'direction of travel', which is presumably away from professional identification towards team identification. Elsewhere in the practitioner discourse the word 'capable' occurs only ten times, four of them in terms of 'capable teams' but more usually as a commonplace descriptor, for example:

So I do.. I do feel quite strongly about that.. that what makes a very capable, competent, skilled CAMHS professional has very little to do with their education and training.

Respondent 24 – Nurse – Implementer / Practitioner

Elsewhere the use of the phrase 'new ways of working' created some confusion, not least in the transcription of the interviews, where it was sometimes difficult to differentiate between times when respondents were referring to the project of New Ways of Working and capitalising it, or if they were using the phrase 'new ways of working' as a description of different ways of doing things. As an example of this, one respondent referred to a discussion

which had been held the day previously at a conference. In this case the reference is clearly to a capitalised NWW:

..I think um.. New Ways of Working is very current at the minute. There's a lot of work going on.

Respondent 11 – OT – Implementer / Practitioner

Later in the same interview the respondent expresses some misgivings about the pace of change. In this case the phrase, although echoing the name of the project, is clearly used as an original phrase. In this respect the repeated use of the same phrase to make it the natural way of talking about mental health workforce change, and obviate thinking about alternative ways forward that might not be part of NWW, appears to have been successful:

And we ... we keep blundering into the new ways of working, without necessarily thinking, "What are we losing, what's gone from our... what we used to do and is that.. do we want to lose that?"

Respondent 11 – OT – Implementer / Practitioner

7.4 Semantic and Grammatical elements in the Practitioner Discourse

Fairclough noted the importance of specific language use in discourse, as we have seen. Although it was also strongly present in the policy discourse there are, within the practitioner discourse, also elements of grammatical usage worth noting. Principal amongst these is the use of the phrase 'skills and competences' (or

competencies). This phrase occurs repeatedly throughout the practitioner discourse when referring to the abilities and knowledge that individuals bring to team working. Each word does appear separately elsewhere in the discourse, most commonly in context with other words, i.e. 'professional skills', but is most commonly linked together in the one phrase 'skills and competences'. Crawford et al (1999) noted this tendency, in a healthcare setting, to use binomial expressions as a way of emphasizing a point. This emphasis of a particular point becomes a 'fixed expression' when it achieves common usage as it clearly does in both the policy and practitioner discourse. The fixed expression 'skills and competences' in this context therefore detracts from any debate as to whether the phrase is an unnecessary doubling of two synonyms (as a way of emphasizing the functional elements), or whether there is any difference implied in the two parts of the phrase. As we have seen (in Footnote 1) the technical difference between 'competences' and 'competencies' is not recognised in common usage, the two being used interchangeably. The fixed use of this phrase also erodes the technical difference between 'skills' and 'competences/competencies' and makes this debate less likely by its repeated usage as synonyms.

7.5 Summary of the Practitioner Discourse

Across a quite diverse range of different responses to the policy initiatives some clear major themes appear which pertain to this thesis:

Professions bring not just a range of skills and competences, but a conceptual framework which binds together those abilities and practices. Those conceptual frameworks inform the way that function and role is performed, and the difference in the ways in which different professionals enact a generic role and function needs to be valued.

Different professions have a greater or lesser degree of difficulty in articulating the conceptual frameworks that bind them to their parent professional group, especially when the group is distanced from that original group by way of specialisation. The overlap of generic skills and competences between mental health professionals is quite large, but each professional group has ways of retaining its identity by reference back to the parent group, however difficult that becomes to articulate.

A multidisciplinary team is constructed to value the differences in conceptual frameworks and even to play off the creative differences which can arise from the tensions inherent in different ways of approaching issues. A reductionist tendency to bring this down to a

toolkit of different skills and competences may eventually lose this element of difference.

The next chapter will draw together the discourse from both the policy and practitioner sample, and propose a thesis around the importance of professional identity and the underlying conceptual frameworks which underpin that identity.

Chapter Eight – Discussion and Conclusions

This chapter will bring together the results of the policy and practitioner discourse to examine what are the current pressures on professional identity from policy, as a representative of the current needs of employers and service users. It will look at how professional identity is created, modified and protected in mental health teams and present a model for understanding this. Finally it will question the importance of professional identity for the individuals who provide services within mental health teams and CAMHS. In the following chapter this is summarised and recommendations for future action made.

8.1 Is current workforce policy a threat to professional identity?

8.1.1 Role and function versus professional identity

In the policy discourse it was demonstrated that that the primary aim of policy is to achieve the aim of meeting current service need. In this respect the policy concentrates on the role and function of teams and the component parts of teams, and puts them in the context of meeting the needs of service users. The assumption of this role and function driven approach is that what is needed to perform the currently needed function is a series of skills and competences which might be fulfilled by people who have these, without attempting to define who these people might be, or how they came to have this particular knowledge and skill set. This

approach is in contrast to the previous mantra of multidisciplinary team working, which had the separate assumption that the skills and competences needed to perform the role and function of a mental health team, or CAMHS, would be contained in the persons of particular disciplines. It was a 'taken for granted' element of the multidisciplinary model that different functions within the team would be performed by different professional persons. The model in mental health and CAMHS, however, overlooked the need to define what these different roles might be, and in contrast to physical healthcare teams, where the different roles of physiotherapist, medical physician and social worker, for example, were much easier to define. Mental health teams and CAMHS have a much greater area of overlap or generic working, where the different roles and function of team members can be harder to define. This role blurring may be of advantage, or may be unimportant to service users, so long as their needs are met, but has led to the current questioning of the role and function of different professional groups. Whilst individuals may see themselves as flexible in their approaches, there is also a view that multidisciplinary teams are inflexible and defensive about their practice (see below on professional 'apparatus').

8.1.2 Linguistic capital as an agent of change

Current mental health workforce policy, as summed up in the New Ways of Working project, is driven to achieve the aim of meeting the needs of service provision, using a model that focuses on the

role and function of teams. As we have seen, it uses service user need and preferred methods of accessing services as the justification for this concentration on role and function. It also, however, is aware that it does not wish to appear to be too directive in describing how services ought to be provided because the ethos of government is not about telling people what to do, but about providing 'local solutions to local problems'. Nonetheless it seeks to guide those local solutions along its preferred path. In performing this change management function it actually uses a lot of power, using linguistic capital, to ensure (or attempt to ensure) that the local solutions are along the lines that the policy makers prefer. In this respect Bourdieu's concept of symbolic or linguistic capital is a useful one to demonstrate the process. This is demonstrated by using CDA to illustrate Fairclough's (1992) point that organizational changes are primarily discourse changes. One of the reasons for this use of linguistic capital in the policy discourse is that the reasons for the need to change are not entirely honestly portrayed. As we have seen, service user need is frequently presented as the justification for the need to change, though often presented in a manner that would not meet the criteria of evidence-based practice, another central emphasis of government policy. In some places other motivations for change are discussed, although always as a secondary consideration to the primary motivator of service user need. These motivators for change are not necessarily issues which are either insurmountable or which could not be presented logically to professional groups as a reasonable basis for change. Presented

with a logical presentation of the change in demographics of the population, and the need to tailor workforce in the future to meet the changing needs and capacity of the general population, it is possible that the case could be made for that change, without resorting to the use of linguistic capital in this way. The expedience of fulfilling functions in an economic way by using lower paid and less qualified staff in new roles, for example, could be explained and presented within a current context of changing service provision. The possible objections of existing professional staff should be met with a coherent addressing of the worries about governance and accountability that often crop up in the practitioner discourse.

8.1.3 The buck stops here – accountability and governance

This issue of governance and accountability also highlights a contradiction in current policy discourse. The need for increased new roles and expanded roles, for more flexibility within workforce, goes counter to the pressures put on providers of service to ensure they provide a safe service in an increasingly decentralized health service in England. Foundation Trusts, as the main providers of mental health care in England, are acutely aware of the risk they carry in employing staff, and seek to mitigate this risk by having strict governance arrangements around the staff they employ. In health care this has always been through the professional bodies that hold individual nurse, doctors and allied healthcare professionals accountable for their practice. This is in contrast to the local authority model under which many social workers have

traditionally practiced where accountability has been held by the local authority itself. So whilst provider Trusts are seeking assurance that there is an external system for accounting for their staff's practice, the workforce policy is suggesting the employment of a range of staff in new roles who might not fit within this structure (though fit well into the local authority model).

8.1.4 Flexibility or built-in obsolescence?

Whilst policy is concentrated on responding to current need by concentrating on the role and function of mental health teams and CAMHS, there remains an inherent danger in this approach. As we have seen with the local authority model there is a danger that when the perceived need changes the system has to respond by having a different set of skills and competences available. Although the policy does stress the need for flexibility it actually does not encourage this in terms of service provision, but portrays this need for flexibility purely in contrast to the perceived inflexibility of the existing structures. Whilst there is economic sense in giving people only the skills and competences they need to perform their current role and function, the ability to react quickly and flexibly if the situation changes can be hampered if there isn't the wider understanding of context and range of abilities to do that. Policy in this respect may choose to follow an industrial model that suggests a flexible workforce may be able to multitask in contrast to the older model of clear demarcation between professional and trade groups that crippled heavy industry in the middle of the twentieth century.

In this respect the local authority model has its difficulties in that outmoded ways of working mean that workers who can only perform the function to which they have been trained would then need retraining to a new function. A person with the skills and competences for being a bus conductor, for example, would find difficulty in finding employment nowadays, and might require a training scheme to be able to actually drive the bus.

8.2 Professional identity in mental health teams and CAMHS

8.2.1 How professional identity is created

It seems from what we have seen in preceding sections that professional identity is initially created through the training and socialization process that occurs in initial training. It is at this point that students are introduced to the conceptual frameworks which provide the basis for their ongoing professional identity and at which point they are inducted into the culture and way of thinking which is characteristic of that profession. The way in which people get into this particular profession, and stay in it, is down to a number of factors. Their own personality and personal identity will clearly affect which profession they choose to apply to, although there are also constraining factors at this early point that will act upon the desire to enter some professions. Educational qualifications will provide a bar for some from entering the medical profession, for

example, and fierce competition for places will put some people off attempting this route. Within the psychology profession we have seen there are far more people attaining a first degree in psychology at university than there are opportunities for entry to clinical psychology training. Some psychology graduates may therefore enter other professional trainings, and this group has been particularly targeted in the policy discourse.

It is difficult to define the conceptual frameworks underlying each professional group, and a detailed attempt at defining the conceptual framework for each professional group is outside the remit of this study. Within the practitioner discourse we have seen attempts to define these varying conceptual frameworks, with only limited success. We can attempt broad definitions, using phrases like 'medical model' for the psychiatrists, a sociological perspective for social workers or the scientific basis to psychology, whilst other disciplines, like nursing, remain a little more elusive. It is also fair to say that, within disciplines, there would be considerable difference of opinion as to the conceptual framework underlying professional groups. In the respondent sample, for example, we had reference to a 'social psychiatry' model in addition to the medical one, and theorists of mental health / psychiatric nursing would not necessarily all agree with Peplau's concept of therapeutic relationships as the basis for nursing, let alone its wider position within the broader discipline of nursing.

Nonetheless it does seem to be a defining feature of professional groups that they have (however ill-defined at times) an underlying conceptual framework. These may have numerous variations, but retain a distinctiveness that differentiates them from other training models. The easiest way to relate to someone else is that they think in a similar way to you, and you don't have to explain your way of thinking to them, that you have a shared conceptual framework. This becomes very reductionist when examined in detail, and perhaps explains why respondents were reluctant to pursue it with too much detail. It results in very broad definitions, such as the Royal College of Nursing's definition of nursing (RCN 2003):

Nursing is the use of clinical judgement in the provision of care to enable people to improve, maintain, or recover health, to cope with health problems, and to achieve the best possible quality of life, whatever their disease or disability, until death.

Nursing is.. (RCN 2003)

This is followed by six defining characteristics of:

- Purpose
- Mode of intervention
- Domain
- Focus
- Value Base
- Commitment to partnership

Whilst this can be seen as a broad definition of what nurses do, in acute physical, learning disability, elderly care and mental health, it has elements that could be applied to other disciplines. This has been a difficulty in previous attempts to bring uniqueness to the professional contributions to mental health teams and CAMHS (see Baldwin 2002). Whilst you would expect a nurse, for example, to care, and develop a good therapeutic relationship with service users, other disciplines might also do this as part of their intervention. They might see it as part of their way of achieving a different goal, however, or in the context of a different way of thinking, rather than as being central to what they are trying to achieve. In the same way, many disciplines might attempt to ensure that service users engage in purposeful activity as part of an overall treatment package, but they might not see it as central to the recovery of the individual in the way that an Occupational Therapist might. Instead of unique approaches which are not shared with other disciplines, in an age where there is considerable overlap of skills and competences, the idea of a central conceptual framework which places emphasis on an aspect of treatment, and seeks to fit skills and competences within that central context or conceptual framework, is important. This conceptual framework may be explicitly stated at the beginning of training, but may also become such second nature to the members of that professional group that they apply it without thinking about it, it becomes 'taken for granted' because it is so deeply ingrained. There is a link here with what Bourdieu has said about the creation of 'habitus', a normal

way of thinking that is not questioned, because it is the normal way of thinking. In nursing, for example, the concept of caring is deeply ingrained in all that nurses do. It cannot be said that other disciplines do not care for the service users they see, but they do not see it as central to what they do. It helps, but the most important thing would be seeing the service user in the context of their family or community, as a biological being who might have a physical or organic component to their current difficulties, or who has moved away from a normal developmental path because of something that has occurred in their life. For a nurse, the caring path, the therapeutic relationship, may be a way of understanding what is going on for that person; it may also be the way in which that is changed and the conditions created for the person to get better, so the relationship and creation of certain conditions that promote healing become the central part of their role in working with the service user. It will be that, in the course of doing this, the nurse will use a number of skills and competences which contribute to that process. They may be skills and competences that other disciplines or professions also possess, but they are used in a certain way, with a certain aim in mind, and that is what is different from other contributions. Others might work in essentially similar ways, but with a different cluster of skills and competences, and with a different conceptual framework around what they are trying to achieve and how they will go about it. An Occupational Therapist, for example, will go about their work in a caring way, and engage in a therapeutic relationship with the same service user, but with the

intention of using purposeful activity to move the service user along the road to recovery. The approach may look similar, but the conceptual framework underlying the intent of the actions, and the way in which the skills and competences are used is very different, even if the end result may also look very similar. What appears to be happening in mental health teams is that whilst there are competing conceptual frameworks they are actually quite similar in many respects, maybe even sharing core values of compassion. Again Bourdieu's ideas are compelling here for this would be categorized in his way of thinking as a 'field' in which very similar 'habitus' exist. The overall 'field' of a caring approach to mental health, even the underlying concepts have been formalized in the recovery approach or the 'Ten Essential Shared Capabilities'. The differences that the varying habitus of professional conceptual frameworks hold as important become subsumed into the wider field of skills and competences, of shared capabilities. This is important because Bourdieu does not see the two as mutually incompatible in the way which current policy seems to suggest. Habitus exists within the field, and can be valued and differentiated from other habitus within that field, in the same way that different conceptual frameworks of professional groups can contribute to a wider and more diverse approach to service delivery. Current policy then, powerfully suggests the 'field' in which mental health teams and CAMHS should be operating. Individuals within those services are unlikely to have serious objections to the underlying principles which that field sets out via documents like the Ten Essential

Shared Capabilities, to which professional groups, after all, contributed. The method of delivering those shared capabilities seems to be at issue. The policy does not adequately value the current variation of habitus or conceptual framework available, as illustrated by the fact that whilst it allows for expanded roles (within existing conceptual frameworks) it also seeks to establish new roles which do not have a conceptual framework or habitus available to them. Clearly this is important as the more established of the new roles seem to be edging towards establishing professional identities of their own, as can be demonstrated by the case of PMHWs in CAMHS. Whether there is a valid habitus to be had in these roles, or whether they are actually roles that can best be performed by a range of professionals with existing conceptual frameworks is a matter of contention. Lemke (2008) has explicitly linked this creation of habitus to the changing performance of identity work in the course of an individual's career.

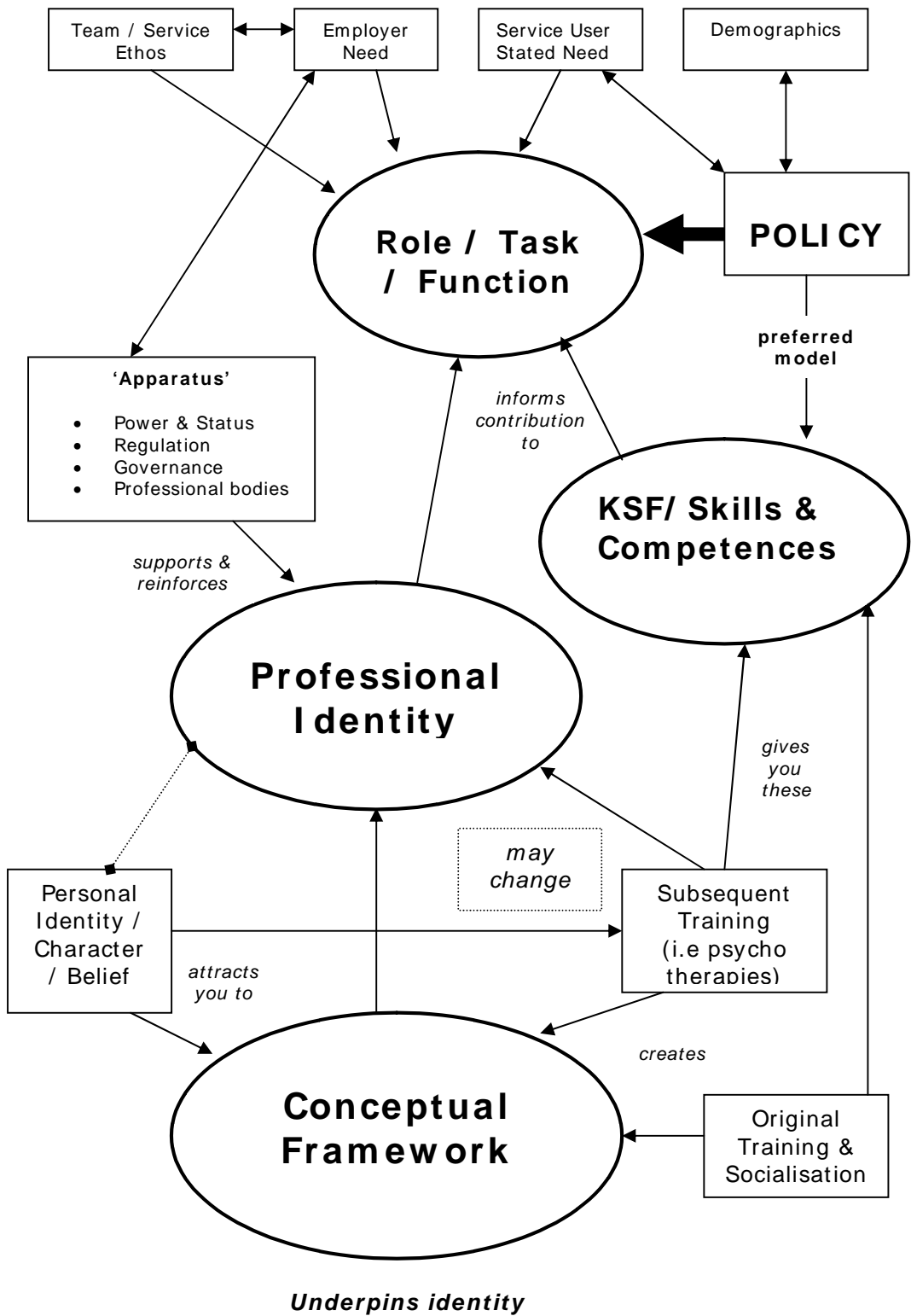
From the practitioner discourse we can identify elements of the conceptual frameworks that contribute to the creation of initial professional identity, as well as the wide range of other factors that are currently acting upon individuals as they struggle to construct a personal professional identity in the midst of competing pressures. Tracey and Naughton (2000) demonstrated how this could be detected in the small talk of practitioners and within the practitioner discourse this has also been seen clearly. These different pressures acting on each person will inevitably lead to individual

interpretations of professional identity, which helps to explain why that professional identity can be difficult to articulate, and may be different for two nurses in the same CAMHS team, for example. No two individuals will share exactly the same interpretation of their professional identity because they will have experienced and interpreted the pressures in different ways.

In this respect a visual representation of the range of pressures acting on individual creation of professional identity, at any given time, seems helpful. As the pressures continue to act in different ways this will inevitably change, perhaps even on an hourly basis as varying tasks or the individual needs of service users require a range of responses from clinicians. These staff require the flexibility to pull on different elements of their training or conceptual frameworks in order to respond to individual needs.

This can be illustrated in Figure 7, overleaf:

Figure 7 A model for understanding professional identity in mental health teams and CAMHS:



8.2.2 How professional identity changes or is modified

If professionals have an underlying conceptual framework that is important to their understanding of what they do, and how they apply their skills and competences to the work they do with service users, then how is it that the professional identity of some people will change over time? In the figure above the different pressures at work in identity formation are illustrated, but in the practitioner discourse there were examples of people wanting to develop new professional identities, as family / systemic psychotherapists, or as primary mental health workers, as well as of individuals performing those roles without losing their original professional identity as psychologist or nurse, for example. The new professional identity that is sought may be a function of perceived status or power for the individual, and there can be no denying that personal remuneration will always be a factor in this.

The apparent fact that some groups are more likely to lose their original identity may be tied up in the perceived financial advantage of being seen, and paid, as a psychotherapist rather than a social worker (as opposed to a psychologist who would probably gain no financial advantage from this change of job description). This would not, however, explain other areas where role definition does not automatically lead to financial gain. Primary Mental Health Workers in CAMHS, for example, are paid at the same banding level as nurses and social workers in CAMHS (and largely come from those disciplines) yet there is an aspiration amongst some to achieve a

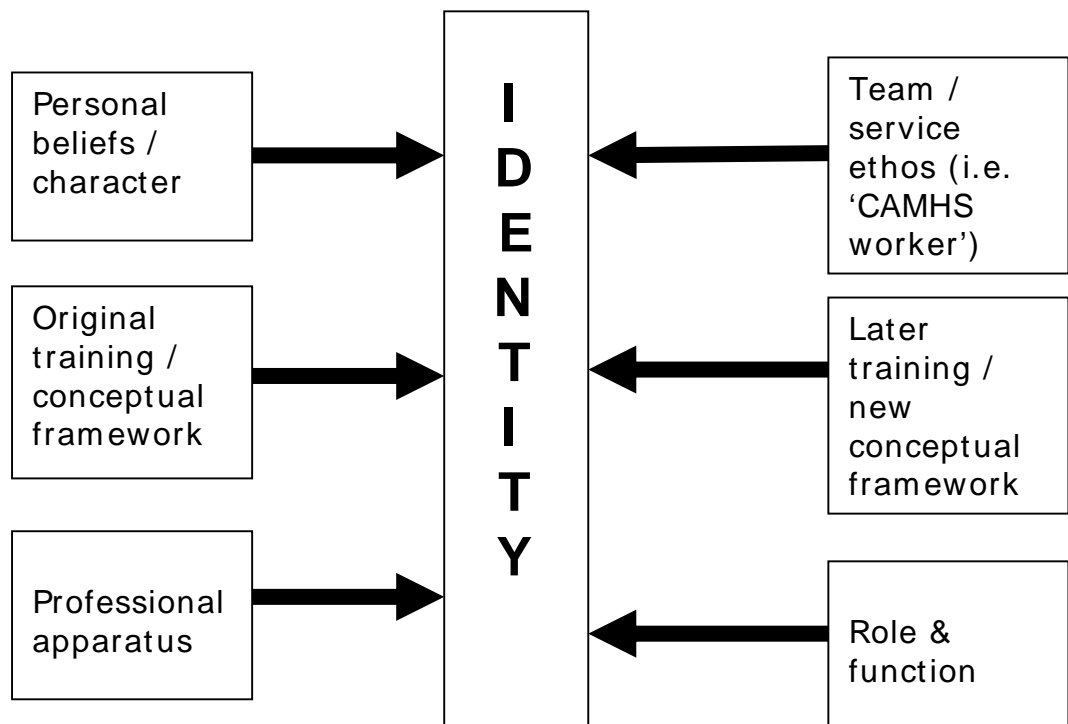
separate professional identity. For some who move their personal identity from a core professional identity to a psychotherapist identity there is also no actual financial gain, and possibly even a loss of career structure (i.e. for nurses) by seeking to narrow their identity to that of psychotherapist. For these individuals it seems that the new conceptual framework that their new training gives them overtakes their original conceptual framework, and they relate more strongly to the new identity, letting go of the original framework to a greater or lesser degree. Some psychotherapy trainings encourage this with the *'mentality of the Jesuits'* as one respondent put it, encouraging students to leave behind what they had formerly depended upon as their conceptual framework. For some, however, the original conceptual framework remains important to them, and they find a way of using the concepts of both (or multiple) trainings or conceptual frameworks to give a broader palette from which to apply different approaches to their work. In some places the policy discourse does recognize this, for example when talking about consultant level posts being able to use a range of approaches (i.e. Skills for Health 2007). In this case a nurse who completes family therapy / systemic psychotherapy training, for example, may retain their job description and professional registration as a nurse whilst incorporating family therapy and systemic ideas into their practice. It may be that they perceive some advantage in maintaining professional registration as a nurse and this effects their decision, but it is also likely that they have adapted the new conceptual framework which systemic

thinking offers them into their overall conceptual framework and still, therefore, 'think like a nurse'. There are areas where conceptual frameworks are relatively close, and which explain why it is more attractive for some professional groups to move towards a similar style of conceptual framework. Examples of this would be the holistic underpinning of nursing and the sociological perspectives of social work being quite close to the systemic and narrative thinking which underpins family therapy and systemic psychotherapy. Nurse and social workers are often attracted to this way of thinking, therefore, because it makes sense in the context of their underlying conceptual framework. That, for some, it overtakes the original conceptual framework seems to be related to the strength and certainty with which that framework is taught compared to the relative uncertainty about the underlying concepts of nursing and social work. On the other hand Cognitive Behavioural Therapy has a stronger evidence base behind it, and seeks to portray itself as more scientific in the way it alters cognitions and behaviour, and as such is often more attractive to psychologists, for whom some clinical psychology trainings are beginning to specialise in this form of therapeutic intervention.

It is natural that these changes in professional identity will occur over the course of an individual's career (Lemke 2008). In understanding how professional identity is developed and changed, then, it may be best to see identity as subject to a wide range of different pressures which will act differently on each individual (and

which will change over time) to create the professional identity that they ascribe to themselves as at any given point in their career. In the earlier discussion it was noted that Mats Alvesson, amongst others, characterized the struggle for professional identity as a constantly shifting one. It is subject to a wide range of pressures or forces which mean that professional identity for any given individual is constantly changing, according to a personal reaction to those external forces (and internal changes to conceptual frameworks). This could be illustrated visually using the framework of Lewin's force field analysis (Lewin 1951). Usually Lewin's model is used to understand change management processes, but in this case it illustrates a longer term process, over the life of an individual whose professional identity might change as a result of a number of factors, but most especially influenced by their conceptual frameworks:

Figure 8 The creation of individual professional identity



8.2.3 The apparatus maintaining professional identity

In the figure above reference has been made to the 'professional apparatus' impacting on professional identity. This includes a variety of aspects touched on by the respondents and by the policy discourse. It includes the concepts of governance and accountability which come through as strongly important for professionals, but it must also include the concepts of power and influence which we have seen are attached to some professional groups, and which are the subject of some professional defensiveness. It is also clear that for those who are trying to change the workforce that the apparatus is seen as an obstacle to progress, and one which has to be gotten around. This leads, in part, to the discourse around flexibility and the need for new roles to fulfill the new needs.

A difficulty arises, however, in the different needs of the state as represented in this discourse. The state registration of professional groups (though not all groups are subject to state regulation) is seen as an act of public protection, ensuring good standards of behaviour and training amongst healthcare professionals. This is particularly true of the 'older' professional groups, nursing and the medical profession, although the creation of the Health Professions Council and the General Social Care Council has strengthened the public safety requirement to regulate social care staff and allied health professionals. The changing face of healthcare provision in England, with the increased autonomy afforded to Foundation Trusts, has also meant that providers of mental health care have

looked to employ staff that are accountable through these state registering bodies. Psychologists and some other groups (including many psychotherapists) remain outside of this state registration process, as registration through the British Psychological Society and the United Kingdom Council of Psychotherapists has different status to that of the state regulatory authorities. This does have some impact on professional identity if an employing Trust, for example, insists on family therapists also maintaining a social care or nursing registration with the GSCC or NMC.

At the same time as this, however, policy in the form of New Ways of Working, backed up ultimately by Agenda for Change, with its emphasis on skills and competences, is looking to develop new roles which may lie outside of the traditional professional identities. It may not be essential for these roles to be outside of a professional identity, but we have identified within the policy a move towards the concept of 'capable practitioner' or 'mental health worker'. For some of those driving the policy there is recognition that this will not be an easy path to follow, that the resistance to it is likely to be strong, given the threat it poses to the power and status of some professional groups. It is therefore 'sold' in rather different terms, as a good thing for service users. In this respect it is easy to use Bourdieu's ideas of the use of linguistic capital as a way of ensuring that the overall end is met. The use of language to try and obviate objections to the policy direction is clearly an appeal to the better nature of professionals who have chosen to follow a healthcare

career. The emphasis on service user need as the motivator for change, whilst mentioning only in passing the other factors which impact on the need for workforce change, would fit well with Bourdieu's concepts of linguistic capital as a way of ensuring change is enacted. Likewise the move away from the direct policy initiatives (like the NSF for Mental Health's Policy Implementation Guide) to a more persuasive model enacted around the Children's NSF. NWW and the Creating Capable Teams Approach model make it clear that there really is no option in adopting this approach; they create, through the use of language, a climate in which the desired change is seen as inevitable, and which steers the change into only one possible direction. Bourdieu's concept of linguistic capital, and its use here as a method of effecting change in a certain direction whilst seeking to obviate objections, sits within the wider concepts of using knowledge as a way of wielding power. The use of this within policy and the way in which it has changed in a relatively short time (between the NSF for Mental Health in 1999, and the NSF for Children in 2004) may be reflective of a government policy which seeks to persuade rather than enforce, but which is still widely criticised as being centrally controlled. This central control is at odds with the stated intent of 'local solutions for local problems'.

Again students of organizational change (Alvesson and Willmott 2002, Fairclough 1992) have noted that policy makers and employers are likely to use linguistic capital as a way of effecting change. In order to be effective, however, the use of power in this

way needs to overcome some of the inherent contradictions in government policy. In order to effect a change towards a skills-based workforce, which seems to be a clear intent, some of the governance and public safety issues need to be integrated into the dominant discourse. Currently the need for state regulation as a public safety issue runs contrary to the workforce policy which emphasizes flexibility and new roles which may include non-professionally qualified (or regulated) staff.

8.2.4 Conceptual frameworks underpinning professional identity

If one measure of professional identity (perhaps the most important, or defining measure) is the possession of a conceptual framework, where does this leave a skills and competences model, or a Knowledge and Skills Framework? There are also mentioned, within the policy discourse, 'competency frameworks', so the importance of a framework within which to hold those skills and competences is recognized. The nature of the framework, however, is what is contested at this point. A conceptual framework, as defined by the sections above, is different from a 'competency framework', or a 'Knowledge and Skills Framework' in that it provides a coherent approach to understanding the skills and competences which may be shared by different professional groups, but understood differently by them. In multidisciplinary teams the creative tension between different approaches is sometimes highlighted as a positive factor that encourages different team

members to think outside of their normal frame of reference in order to achieve what is best for the individual service user. If a conceptual framework provides a point of reference for holding together the different skills and competences, what is missing in a policy context that does not value the need for such an overview? Policy seems focused entirely on delivery of a role or function. The reduction of the mental health team to performance of a series of tasks without a wider conceptual framework from which to work, or several competing conceptual frameworks, may hold some dangers. The use of competing conceptual frames of reference within a single team allows a wider view of the range of potential problems that a typical team might encounter in the course of its work with a wide range of service users. Individual service users might respond better to different approaches or viewpoints, have different needs that can be addressed by different conceptual frameworks (as embodied by team members). The reduction of teams to a task oriented approach will lead to a lack of flexibility in the longer run, as has been seen in the local authority model. The possession of a conceptual framework allows a greater flexibility for understanding the uses to which skills and competences might be put.

8.3 Is professional identity important in mental health teams and CAMHS?

In the literature review it was established that identity is a multifaceted aspect of an individual's life. In professional terms it may be that the policy direction is towards a skills and competences based workforce that takes into account the current professional structures, but which has aspirations towards reducing the power of those professional structures. The move within mental health workforce policy is towards a role and function driven model. Whilst some consideration is given to how people will see themselves within this new model it seems inadequate for the strength of feeling that remains within the practitioner discourse that there is importance to professional identity. Even the most enthusiastic advocate of generic mental health work saw that there was value in professional identity, which might even lead to a formalised new professional identity, even a 'Royal College of Mental Health Workers':

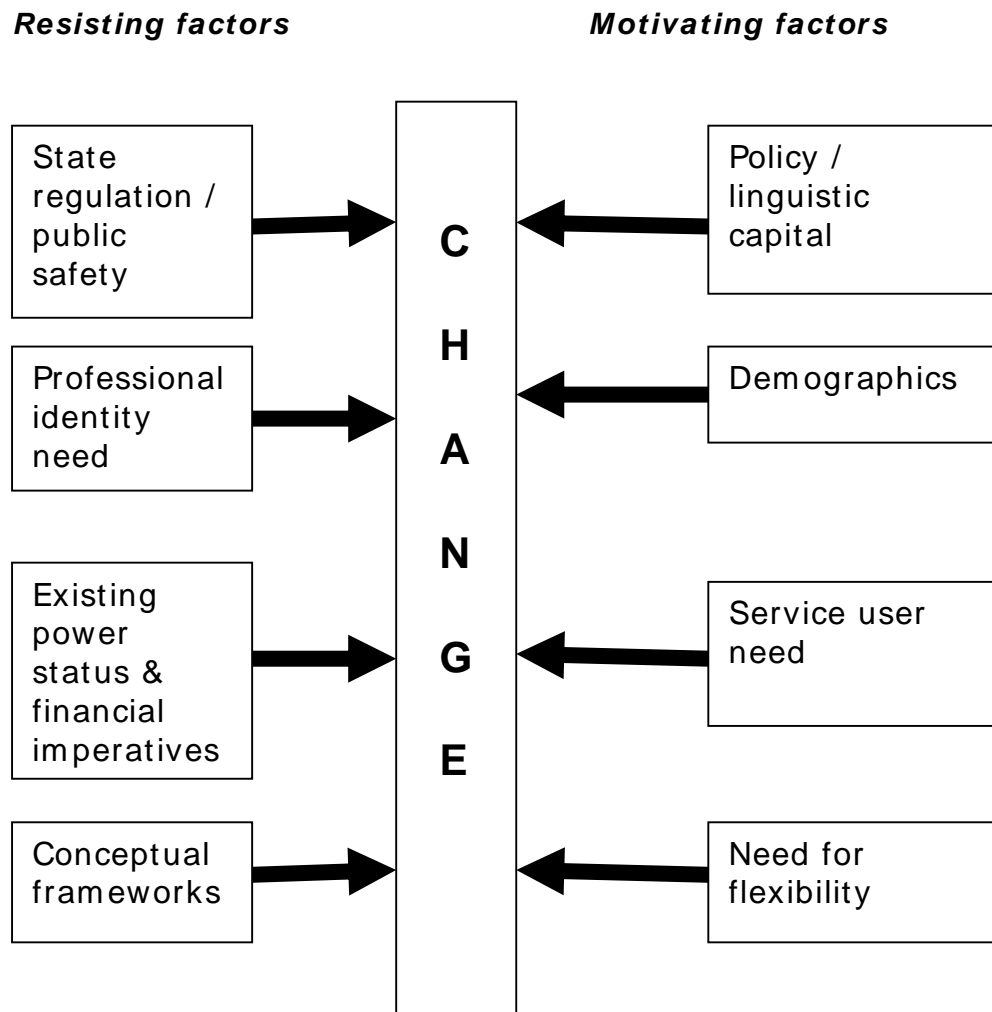
Well there might be.. um.. You could see a Royal College of Mental Health Workers springing up, or .. now people do need those points of reference, and professional support to make it work well. You know, in order to advance your practice.. you need that kind of infrastructure support. Um.. . the advantage is it wouldn't be quite so burdened by history perhaps, that you could actually say, "Well, here's a place to start, now." And it could be quite creative and interesting.

Respondent 22 – Nurse – Policymaker

Given that professional identity is important, and is likely to be created by new roles, even if the intention is to avoid some of the hindrances to flexibility which professional apparatus is perceived as

creating, it would be best not to ignore it as a factor within workforce planning. The guidance issued for developing organisational change within the NHS (Iles and Sutherland 2000) itself recognises that in order to effect change the most important factor is not to establish the reasons and motivating factors for change, but to find ways of overcoming the resisting factors. Lewin's (op cit) model of force field analysis is quoted in that document as a way of illustrating this. The risk that workforce policy development takes in minimising the importance of professional identity is that it will fail to achieve the goal of workforce change by underestimating that as a factor. Figure 9, overleaf, illustrates the place of professional identity within a force field analysis of the change process in workforce development. The basis of a force field analysis is to achieve change by sufficiently taking into account the strengths of the different forces, and balancing them in order to move forward. If the strength of one or more of the 'resisting factors' is not sufficiently addressed then the change, according to this model, will not take place.

Figure 9 **Force Field Analysis of workforce change
in mental health and CAMHS**



Varying strengths of different resisting and motivating factors need to be addressed in order to achieve change.

8.4 Summary of theoretical change in the viewing of professional identity

What has been proposed in this thesis uses elements of both role theory and identity-work to understand the current position of individuals in mental health teams and CAMHS. The difference from previous writing on the subject is the emphasis on conceptual frameworks as underlying a professional identity that will inevitably change over the course of an individual's life, dependent on a number of factors that are outlined above. By using Bourdieu's concepts of 'habitus', 'field' and 'doxa', I have sought to explain why it has previously been difficult for professions to articulate the importance of professional identity for the delivery of high quality mental health services to service-users and their carers. This difficulty has been exploited by a workforce policy that at times sees the apparatus around professional groups as a hindrance to the delivery of efficient service provision, and uses linguistic capital as a tool to drive down costs without taking into account sufficiently the other elements of government policy in the area of public safety and regulation of healthcare. The use of linguistic analysis in the form of Critical Discourse Analysis has served to highlight the assumptions underlying the policy discourse, and to question the way in which this is being conducted.

8.4.1 Role theory elements

There are elements within the discourse that relate very directly to role theory constructs. The policy discourse particularly relies on role theory because it is largely functional in content; it has the specific aim of improving service delivery, and concentrates on creating capable teams or practitioners, rather than on what individuals contribute by virtue of their wider training. The effect of the policy discourse can be illustrated by referring back to Biddle and Thomas' concept of differentiated behaviours (see Figure 2 p100). The amount of 'behaviours' which are seen to be exclusively the domain of one professional group are being reduced by policy, whilst the number of 'nonexclusive generalist' behaviours are being increased, through the use of a skills and competence based agenda. For example, independent prescribing will allow other staff to perform tasks that were previously only available from medically qualified staff. Likewise the role of the Approved Social Worker is replaced under new legislation by the 'Approved Mental Health Worker', removing the exclusive domain of social care trained staff. What Biddle and Thomas' model cannot do, however, is provide an explanation for the importance of retaining some of the conceptual frameworks inherent in those parts of the work that might benefit from being 'exclusivist'. By concentrating on behaviours rather than the conceptual frameworks that inform the performance of those behaviours, role theory shows some of its limitations and explains why theory has moved on from that position.

Other constructs within role theory have been seen within the discourse as increasing overlap of roles within mental health teams and CAMHS have become more generically focussed (or more 'nonexclusive generalist'). What can be seen as flexibility in some terms may also be seen as a developing role ambiguity. The constructs of role overlap and role blurring can be used to inform some of the discontent that individuals have expressed about the direction of team composition. This role confusion may be welcomed by some as a way of expanding roles that have previously been constrained. In this respect the long standing and mutually beneficial relationship between nursing and medical doctors serves as an illustration. New Ways of Working began as an exercise in reviewing doctors' roles, and opened up to encompass the roles of other staff, suggesting they take on new roles and accept 'distributed responsibility' for the care they offered in a much greater way than had been the case before. This is practically enacted in an increase in independent prescribing and in non-medical staff accepting Care Co-ordinator roles under the Care Programme Approach. Within nursing, however, there is a longstanding debate about expanded roles (i.e. Castledine 1995, Bryant-Lukosius 2004, Baid 2006) and whether this is actually enhancing nursing as a profession, or just making some nurses into 'mini-doctors'.

Given the emphasis within the policy on 'flexibility', it is also important to highlight the concept of 'role preparation' in the way

New Roles are envisaged. The model of developing new roles specific to immediate needs was criticised by at least one of the practitioners as being less flexible than the approach of training professionals who have a sufficiently robust underlying conceptual framework to adapt their training, skills and competences to a new set of circumstances when new roles are developed. Too narrow a role preparation leads to a difficulty in adapting to change when it inevitably comes. An illustration of this would be the development of Primary Mental Health Workers in CAMHS. When the role was proposed it was gradually adopted across the country, but largely staffed by individuals who had the right set of skills and competences by virtue of their previous training. They brought (largely nursing and social care) conceptual frameworks with them and adapted them to the new role. If there had been a need to train individuals specifically for this new role, the development of the new role would have been much slower, as the development of courses which have labelled themselves as specific to Primary Mental Health Work has only occurred in the last few years, and have so far trained only very small numbers of individuals.

8.4.2 Identity-work elements

Role theory helps to explain some elements of the current situation, then, but as we have seen theory has moved into a broader examination of how individuals create their professional identity (and other forms of identity). Some of these elements can also be directly applied to an understanding of the professional identity of

staff in mental health teams and CAMHS. Davies' (2003) concept of 'othering', for example, is illustrated in the practitioner discourse, when individuals directly contrast their own identity with that of other team members. Sometimes this is done in a 'devaluing' way, and other times it is done with more respect and understanding of the contribution of other professional groups and individuals. Within this construct the possession of sufficient skills, competences or knowledge to define one's own expertise (in contrast to others) is important, but is generally more important as a way of differentiating oneself from the 'others'. What this construct cannot sufficiently explain is the way in which an underlying conceptual framework is important in its own right as an identifying feature, as opposed to a way of creating 'otherness'. The difficulty we have seen in the articulation of different expert positions by way of having a coherent underlying conceptual framework is not fully explained by this construct. There are elements of it in the attempts that individuals make, but to explain a nursing framework, for example, as purely being 'not a medical or psychology' framework is an inadequate basis for professional practice. Those frameworks that are less well defined, however, do seem to rely more on 'othering' than on defining their own uniqueness.

The insights of 'organisational control' and 'identity regulation' have also been useful in looking at how policy allows an element of creation of identity. Fairclough (1992) and Alvesson and Willmott (2002) have shown how the dominant discourse of policy allows

some elements of discourse to continue, whilst other areas are shut down and not permitted. In this respect the discussion with the policy discourse analysis on the use of phrases like 'New Ways of Working' and 'New Roles' is important. The phrases channel thinking, as we saw, into seeing this as now the only way of doing things differently. They explicitly link this to Bourdieu's concept of linguistic capital, and as such provide a key into the ways in which language is used as a powerful tool to control the identity of individuals. What organisational control cannot do is explain the difficulties in articulating the value of professional contributions. It can look at the ways in which 'resistance discourse' occurs, but is inadequate to describe the particular difficulties of healthcare professionals in mental health teams and CAMHS.

8.4.3 Bourdieu's concepts applied

What this study has sought to do, therefore, is to develop these ideas using some of Bourdieu's concepts, specifically those of 'habitus', 'field' and 'doxa'. The difficulties that some professional groups have in articulating their particular contribution is primarily one of 'habitus', that they are so accustomed to thinking and behaving like a nurse, for example, that it is ingrained into their personal identity in a way which they take for granted. It becomes such a deeply ingrained way of thinking that it is hard to separate out the personal and professional identity, for some people, and therefore hard to articulate the professional from the personal. The strength of this will vary, as we have seen, and may change over

time, as people adapt to new ways of thinking, new conceptual frameworks, and depending on how firmly attached they are to their original conceptual framework. This 'habitus', however, includes elements of 'doxa' that make it hard to resist the linguistic capital that is used against professional groups. For example, one of the 'rules of the game' that is trained into healthcare staff is that the needs of the patient are paramount. When this is then used as a primary reason for change in workforce policy (however flawed that argument may be) it is very disarming, because to argue against the proposed change is seen as arguing against the needs of the patients and therefore being selfish (which is also against the rules of the game in vocational professions!). All of this, according to Bourdieu, takes place in the 'field' of healthcare generally which has its historically constructed social rules and power dynamics which are enacted in microcosm within teams, and at higher levels between services and professional groups. Likewise whilst the different conceptual frameworks of professional groups overlap in one 'field' (which is helpfully summarised in the Ten Essential Shared Capabilities), they each contribute separate and important 'habitus' perspectives on the work.

8.5 Summary of thesis

The primary argument of this thesis is that current workforce policy is functional in its approach to what is needed to create teams capable of adequately providing for the needs of mental health service users and their carers. It emphasizes role, and the skills and

competencies required to fulfil that role. As such it underestimates the need for individuals to establish and maintain a professional identity that informs the way in which they perform that role. Crucially this professional identity is underpinned by conceptual frameworks that professional training and socialisation provide, and which are essential to maintain the flexibility of approach which workforce policy is trying to ensure. The attempt to undermine professional identity is misguided as it underestimates the importance of the underlying conceptual frameworks for the performance of constantly changing roles. Whilst the apparatus of professional regulation which serves to reinforce identity may be seen as inflexible at times, it also performs a public safety function that remains important.

The difficulty in explaining some of the conceptual frameworks underlying professional identity can be best understood by using Bourdieu's concepts of 'habitus', 'doxa' and 'field' but this does not excuse us from the attempt to better articulate them. The failure of professional groups to articulate the value of their conceptual frameworks in providing high quality mental health care has allowed policy makers to infer that they are not important, and develop policy that marginalizes those important differences of approach.

Chapter Nine – Implications for Practice and Recommendations.

This study has looked at how the concept of professional identity is important to individual staff working in mental health teams and in CAMHS in particular. It has explored this both from a view of how identity is described in the current leading policy, and how individuals have responded to that policy discourse. The study also looks at which (of several areas which underpin professional identity) have most value to service users as well as to those who provide services. In this final chapter the implications for different groups are enunciated and suggestions made for practical changes which would enhance service delivery.

9.1 Overall

The critical discourse analysis of the three primary policy documents suggests that current policy is role driven, it attempts to create a workforce of people who can fulfil a role (through a framework of skills and competences for that role). It is the contention of this thesis that this underestimates the need for a fuller identity that is brought by a professional training which encompasses an underlying conceptual framework.

This research strongly suggests that for staff working in mental health services and CAMHS a role is not enough. At all levels, not just amongst professionally trained staff, this thesis suggests that

people need an identity which encompasses their role, but which is subtler than that, more complex, and which encompasses their whole experience. The work which has been done in recent years on development of identity in various settings suggests that the sociological concepts which are based on role theory are no longer useful without taking into account wider issues of 'identity-work' for the individuals who enact or perform those roles. Likewise roles can be enacted in different ways depending on the professional identity that an individual brings to that role. The underling conceptual frameworks which different professional groups by virtue of their original and subsequent training, as well as by the individual experience of staff, lead to a variety of ways of enacting roles in mental health. This variety of approach, and the insights which different professional trainings bring to similar roles brings a vibrancy and freshness to role performance which is not currently well recognised by those who have the task of developing policy. For those who are tasked with implementing policy it needs to be taken into account as they seek to foster the process of change management within the NHS in England.

Professional trainings bring the flexibility (in theory) that an underlying conceptual framework provides, and which a simple role preparation model cannot provide. The conceptual framework of different disciplines and their value in enhancing service delivery needs in the future to be articulated in a positive manner rather than appearing to be defensive or protectionist. For example, nurse

training prepares people with a conceptual framework and a range of skills and competences which means they can perform the role of PMHW, in-patient nurse, community clinical nurse specialist or advanced new roles such as Nurse Consultant, and they may move between roles during their career.

9.2 For policy makers

In order to progress change towards 'capable teams' more attention needs to be paid to the difference between defining role and function of the team, and identifying the way different professional groups bring valuable differences of conceptual framework to performing that role. Professional identity remains a powerful motivator for individual staff, who need to be sure in their identity in order to perform efficiently their current role. The use of self within mental health workforce, in therapeutic interactions between individual staff and service users, is at the heart of the work in a way that is not the same in more 'industrial' applications of role theory. A force field analysis of the resisting forces to change would include the powerful apparatus which maintains professional identity, but which is not immune to change. This apparatus is often seen as a hindrance rather than a positive force, but if the apparatus or the individual need for an identity which is broader than simple role definition is underestimated then the change process will not succeed.

The main function of the regulatory apparatus around professions is to ensure public safety, and this needs to be better understood as new roles are developed in the context of workforce development. The issue of governance and accountability came through the analysis very strongly as an area of public protection which in some ways helps to bolster professional identity, but which is viewed with some suspicion by policy makers. New roles need to be seen in the context of wider government in terms of public protection, and ways of ensuring public protection need to be addressed for non-professionally qualified staff who might fill the new roles. Currently it appears that the governance and accountability for new roles in health which are not state registered will fall to the employing Trust, along the local government model. This does not fit easily with the Foundation Trust ethos which prefers to manage risk through the employment of state registered accountable staff. Without this issue being addressed within the health service it is hard to see how consistent growth in these new roles will be managed.

The use of linguistic capital to try and channel change along one route is clearly detectable in the policy discourse. The analysis demonstrates ways in which it is clearly detectable that there are several motivators for change, for example, but service user need is trumpeted as the primary reason for change. The use of service user testimony to validate and justify the need for change does not meet the standards for evidence-based practice which are required in other areas of health service service delivery. A more

sophisticated understanding and presentation of the variety of potential service user need would lessen the amount of distrust felt amongst practitioners as to the real need for change. Likewise giving more weight to the demographics of the potential workforce would allow practitioners to understand that their own identity is not necessarily under threat, but that they will be required in the future to work as part of a more diverse workforce.

9.3 For mental health professionals

Whilst acknowledging that there are issues of power and self-interest at play in the apparatus that surrounds professional identity, healthcare professionals need to acknowledge the need for their identities to evolve and change in response to the changing needs of the world and the variety of needs of the people who use their services.

This need not be a threat to professional identity as long as the different groups can respond to those changes whilst still maintaining the elements of their identity that are still valuable. The professional apparatus which surrounds identity can be seen as defensive, and those professional bodies which can be seen as protectionist need to have the confidence in their own value to be able to respond to change in a constructive manner. Finding the

place for each professional group or discipline within a wider, more diverse workforce need not mean that the importance, status or even power of disciplines will be eroded. New roles, for example, do not necessarily mean a diminution of the 'old roles' which professional groups have practiced. An approach which values professional contributions (with the underlying conceptual frameworks that come with them) and seeks to more carefully evaluate how they can contribute to the creation of a more diverse workforce will be more productive. For example, the idea that nurses may have particular strengths within the overall skill set that is required for delivery of mental health services. These have been identified in the thesis as understanding of what Bourdieu calls 'habitus' within the broader 'field' of mental health skills. The most important thing in maintaining a professional identity is the conceptual framework on which that identity is built. This conceptual framework is a powerful contributor to the development of 'habitus', a way of thinking. The different groups have different levels of certainty as to the conceptual frameworks on which their identities are built, and some need to be more certain of those frameworks and be better able to articulate their value. In the thesis the strength of this in developing individual 'habitus' compared to other factors of personality, experience and subsequent training (in psychotherapies, for example) has been examined. What cannot be overlooked is that each individual worker does have a way of looking at things (their individual 'habitus') which affects the way in which they perform their role.

With certainty comes dogma and this can lead to inflexibility. The need for increased flexibility comes across strongly in the policy discourse, despite some interviewees thinking they already practiced in a flexible way. All groups need to recognise that within mental health there is more flexibility required in order to perform the roles and functions currently needed. In accepting that there are 'generic' functions which different groups can perform, they can still highlight the strengths of conceptual frameworks which different groups bring to the same task. Increased flexibility in service delivery does not necessarily imply a loss of identity, merely a response to changing circumstances and service user need as broader societal expectations change. Professional groups which are unable to respond to the changing needs and expectation of society will not survive, but each group needs to have confidence in defining and articulating the contribution of their different conceptual frameworks.

9.4 For researchers:

Whilst there exists for each professional group a body of literature on the conceptual frameworks that underpin each profession in a theoretical sense, there has been only a limited attempt to relate this to the concept of 'identity-work'. This thesis suggests that for healthcare professionals within mental health teams such as CAMHS this is a crucial element in defining the contribution of different professions to the overall team function. More work needs to be done on clarifying professional contributions to team function in a way which strengthens the progress towards teams which most effectively meet the needs of those who use the services. This needs to be articulated within the concept of the 'habitus' of individual workers. The contribution of each professional training to this individual development of identity and the value of the 'habitus' to service delivery has not been examined in detail. Whilst there is some understanding of the need to meet a wide range of service user need no work could be found which attempted to match individual service user need to the skill sets available within mental health teams. The development of a better understanding of ways in which to match the skills available to the expressed needs of service users would enhance service delivery in a wide variety of mental health teams.

This thesis expresses a concern that service user need is being misused in policy documents to justify changes that may well be in service users' interest, but those needs are not represented in a

manner that is credible to a research-aware audience. It highlights the way in which this is done in some policy documents, without justifying the way in which service user testimony or evidence is gathered. Further work needs to be carried out to present a more complex picture of the broad range of service user need in a way that better reflects different local patterns of service use. When used to justify service change it must be clearer on what basis service user need is being quoted. Service user need is not monolithic and individual service user needs will change over time or according to circumstances, yet in the policy discourse it is often represented as a simple entity around which services, or capable teams, can be constructed. Developing a research-based understanding of how service users react to their circumstances and what the different needs are over a period of time would allow better planning of future services which can respond to those changing needs sensitively.

In order to preserve the professional identity that is important to them, it is likely that professionals will resort to 'resistance discourse'. Further studies on the way in which professions resist changes with which they are not comfortable may help to smooth the ways in which future changes are introduced, reducing the amount of anxiety generated amongst the workforce. This would allow a better understanding of how professional identity can evolve to adapt to new circumstances and needs within a changing healthcare system.

Finally it would be of use to better understand the views of service users with regard to professional identity and how they regard healthcare professionals. It seems likely that there will not be a simple answer to this, given the variety of service user need, as outlined above. The degree to which it is important to have different aspects of professional skills and competences available will depend on each service user's need at any given time. It would be useful for healthcare professionals as well as policy makers to understand this better in being able to prepare the future workforce to best serve the needs of children, young people and adults who have need of mental health services.

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Appendix 1 Email Questionnaire

Dear....

I would be very grateful if you could spare a moment to participate in this study on workforce issues.

I am currently conducting a study on workforce issues within mental health multidisciplinary teams in the NHS in England. The study will concentrate on the discourse of professional identity and is part of a PhD study within the School of Nursing and Midwifery at the University of Nottingham.

The initial phase of this study is to gain the opinion of experts within the field as to which are the key documents on workforce development within mental health over the last few years. Within my methodology this allows me to demonstrate an expert consensus as to the most influential documents, from which I can then make a critical discourse analysis. Critical Discourse Analysis is principally a linguistic analytical method, but has been applied recently to written and spoken healthcare communication and policy studies. My study will be using Child and Adolescent Mental Health (CAMHS) as a case study, but this needs to be in the context of wider workforce documents in the NHS and mental health. I am attempting to identify the ten most important documents of recent years in relation to mental health workforce development. These may be from Government, or other influential, non-governmental sources (i.e. Sainsbury Centre, Mental Health Foundation, Young Minds etc).

The second phase of the study is to conduct a series of short interviews with experts like yourself, and with current practitioners across the country, to add detail to the background of the policy review. This will obviously be informed by the initial stage results, but it is anticipated that it will focus on the discourse of professional identity in the context of current workforce developments. The data generated from these interviews will also be subjected to analysis and compared with the policy review. The results of my study will be published and will hopefully contribute to the debate on current workforce developments. I will also feedback directly to participants in the form of a research report. If you would be available for interview I would be happy to travel to a location convenient to yourself, and will be clearly ensuring that all ethical committee needs are met. I would anticipate that this would involve a 45 minute interview, and for convenience I will try to cluster interviews if there are more than one potential interviewee in one area.

I would like to ask you, therefore:

- 1) What do you consider to be the ten most important or influential documents on the last few years for the development of mental health workforce in the NHS in England? (Please include on-Government sources and both documents which are specific to CAMHS, and those more general ones which provide context).
- 2) Who are the most important people currently working in workforce development within mental health at the moment? Apart from yourself I am attempting to contact current leaders within the field in order to get the most comprehensive response to this question. If you have thoughts as to who else could be included or ought to be included then I would be grateful for

leads and I will contact them to ask if they can be included in this study.

- 3) Would you be prepared to be involved in the short interview for the second phase of this research? The interviews are likely to take place in the autumn of 2006, and will be at a time and place convenient to yourself. If you are unable to participate I would still be interested in your answers to the first two questions.

Many thanks for taking the time to reply, I look forward to hearing from you. If you do not wish to be involved then feel free to ignore this email. I will also, however, be sending a reminder in three weeks time, but you can delete that too if you are unable to participate.

Best Wishes

Laurence Baldwin
Postgraduate Student.

Appendix 2 Information Sheet
(on University headed paper)

INFORMATION SHEET FOR PARTICIPANTS

"The discourse of professional identity in mental health multidisciplinary teams, in the context of a competency and skills-based mental health workforce. Child and Adolescent Mental Health Services as a case example."

You have been invited to take part in a research study. Before you take part it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information.

- Part 1 tells you the purpose of this study and what will happen if you take part.
- Part 2 gives more detailed information about the conduct of the study.

Please take time to decide and ask if there is anything that is not clear, or if you would like more information.

What is the purpose of the study?

This study aims to look at how people understand their professional identity as a member of a multi-disciplinary mental health team. Child and Adolescent Mental Health Services (CAMHS) are being used as a case study, but other people are also being interviewed to provide the context of the overall mental health workforce. This study will lead to submission of a PhD thesis.

Why have I been chosen?

You have been asked to be involved either because you have written or been involved in policy making, or because you are a clinician who has expressed an interest in these issues in the past. The interviews aim to cover the whole of England, with a variety of different professions and backgrounds. There will be approximately thirty interviews in total.

Do I have to take part?

No. It is up to you whether or not to take part. If you do you will be given this information sheet to keep and be asked to sign a consent form. You are still free to withdraw at any point without giving a reason.

What will happen to me if I take part?

The interview will last approximately 45 minutes. There is no further obligation beyond this, though you will be sent a copy of the research report when the study is completed. The interview is an open one, and it will be audiotaped, with your consent. This will enable a written transcription to be made and this transcription will be kept for seven years (to follow University guidelines). The audiotape will be destroyed when the written transcription has been completed and checked.

What do I have to do?

For this study you need to be available for an undisturbed 45 minute interview. If the researcher is coming to your place of work you may be asked to make arrangements for a room to be booked, and you will need to get permission from your manager to participate in the interview.

Are there any possible advantages or disadvantages to taking part?

Most people who work in mental health now expect to spend some time reflecting on their practice, and it is hoped that this research interview may be seen as part of your normal reflective practice. It is possible that the interview will cause you to reflect on issues that you have not considered before, and you may want to take those thoughts with you to your next supervision session.

What happens if there is a problem?

If you are unhappy with any part of the process you can contact the study's research supervisor, Dr Paul Crawford on: [Phone number deleted]

Will my taking part in the study be kept confidential?

Your manager will know you are participating, as you need to ensure their permission, but they will not have access to what you say. All data collected from the study will be anonymised, so that no-one reading the research reports, or any subsequent publications can tell who said what. Direct quotations may be used in these write-ups, but again they will only be reported anonymously.

Contact Details:

This study is being conducted by Laurence Baldwin. If you have any further queries you can contact him on: [Phone number deleted]. If you have any queries or concerns that you would prefer to discuss with the research supervisor you can contact Dr Paul Crawford on: [Phone number deleted]

This completes Part 1 of the Information Sheet.

"The discourse of professional identity in mental health multidisciplinary teams, in the context of a competency and skills-based mental health workforce. Child and Adolescent Mental Health Services as a case example."

INFORMATION SHEET FOR PARTICIPANTS

Part 2.

What happens if I don't want to carry on with the study?

This is a single interview, but if at any time you decide to withdraw you can do so, without the need to give an explanation. If you do so then the recording of the interview will be destroyed and not used. Likewise if you decide after the interview that you would rather not have your views used in the research study then you may contact me and I will destroy all data and not include it in the study. Obviously this will not be possible after the research has been fully written up, which will be by the end of 2007.

What if there is a problem?

If you are unhappy with any part of the process then you should contact Dr Crawford as outlined above.

Will my taking part in this study be kept confidential?

Your manager will need to give permission for you to spend the time involved for the interview, so they will know that you are involved, but they will not be given access to what you say. The interview will be audio and videotaped and then transcribed either by the researcher, or by a secretary. When it is being transcribed all personal information will be removed, and each transcription will then be given a number, and any quotation or reference to the data will be referred to by the number. For the purposes of this study it is also important to know the professional background of each participant, so data will be referred to in this format; 'Participant 26 – Clinical Psychologist' (for example). The University of Nottingham regulations for collection of qualitative data then require that all tapes are destroyed following transcription, but that the transcriptions themselves are stored in a secure University location for a seven year period following the completion of the study. In this case they would then be destroyed (in January 2015). For the purposes of supervision and examination the data would also be available to the University supervisors, Dr Paul Crawford, and Professor Sara Owen, (now at the University of Lincoln), although they would not have access to data that could identify you individually. Likewise when the PhD study is completed and written up it will be lodged in the University library, and will be available for academic use. This and any publications which arise from the study will not have any data in it which will enable you to be identified individually.

During the study your details will be held on university and NHS computers to allow us to send you a copy of the research report when it is completed, but this database will be destroyed on completion of the study, and will only be accessible to the researcher and his secretarial support, which are bound by normal NHS rules of confidentiality. As there is no clinical component to this study there will not be contact with anyone else or access to these details.

Who is organising and funding the research?

As this is a study which is being done for a PhD study it is funded by the researcher's host Trust (Derbyshire Mental Health Services NHS Trust). The Trust is paying for the academic fees and all postage and travel expenses. You will not be offered any remuneration for taking part in this study, but you will get a copy of the research report, which I hope you will find interesting.

Who has reviewed the study?

This study is supervised by Dr Crawford and Professor Owen as part of the University supervision of my PhD study.

If you choose to participate in this study you will be given a copy of this sheet to keep, and asked to sign a consent form, of which you will also keep a copy.

Many thanks for taking the time to read this and considering taking part in this study.

Laurence Baldwin
Version 1 - June 2006

Appendix 3 Consent form (on University headed paper)

CONSENT FORM

"The discourse of professional identity in mental health multidisciplinary teams, in the context of a competency and skills-based mental health workforce. Child and Adolescent Mental Health Services as a case example."

Please circle or delete as appropriate

Have you read and understood the information and had the opportunity to ask questions and discuss the study? Yes / No

Have all the questions been answered satisfactorily? Yes / No

Do you understand that you are free to withdraw from the study at any time, without having to give a reason? Yes / No

Do you agree to your interview being audio and videotaped? Yes / No

Do you understand that the recording will be destroyed after the interview has been transcribed? Yes / No

Do you understand that the transcription will be kept by the university for seven years, and will then be destroyed? Yes / No

Do you understand that direct quotations from what you say may be used in the research write-up and subsequent publications, but that it will be anonymised so that no-one can tell that it was you who said it? Yes / No

Do you agree to take part in the study? Yes / No

Signature: Date:

Name (in block capitals):

Researcher's signature: Date:

Name: LAURENCE BALDWIN

Appendix 4 – Interview Schedule
(as prepared for Ethics clearance)

"The discourse of professional identity in mental health multidisciplinary teams, in the context of a competency and skills-based mental health workforce. Child and Adolescent Mental Health Services as a case example."

Note: This interview is planned to be an open interview, rather than semi-structured, so the areas outlined below are generic areas which the researcher aims to cover within the course of a free-flowing interview. It is not intended that each area will be asked in turn, or in the format outlined below, rather that these are guidelines for areas of interest to be covered.

Demographics:

- Profession of the interviewee
- Current position / job title
- Length of time working in mental health / CAMHS
- Previous experience of working in mental health / CAMHS

Current thoughts on workforce developments:

- General overview of policy developments in mental health / CAMHS
- Specific thoughts on workforce changes over the last few years
- Any knowledge or mention of specific workforce policy documents

Professional identity:

- Ideas on own professional role within multi-disciplinary team
- Ideas of difference between disciplines and their contribution to mental health / CAMHS
- Personal identity constructs as defined by self as opposed to profession
- Levels of importance attached to professional and personal identity
- Thoughts on future developments within mental health / CAMHS

Closing

- Summarising and thanks
- Restatement of procedure for research report

"It's a very difficult job, and the only way to get through it is we all work together as a team. And that means you do everything I say."

Michael Caine as Charlie Croker
in 'The Italian Job' (1969)

Final Word Count: 99,949

(as submitted 13/05/08)