

**EXPLORING THE PERCEPTIONS OF PROFESSIONALS REGARDING CHILDREN'S
MENTAL HEALTH: AN EXPLORATORY STUDY USING FOCUS GROUPS**

by

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**A thesis submitted to
The University of Birmingham
in part fulfilment for the degree of
Applied Educational and Child Psychology Doctorate**

**School of Education
The University of Birmingham
January 2013**

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ABSTRACT

The global concern of mental health difficulties amongst children and young people has been widely reported over recent decades. Consequences of unmet need highlight financial, societal, and quality of life considerations. Research indicates that some staff responsible for supporting children's mental health do not feel sufficiently skilled to address difficulties. Furthermore, there is wide variety in organisational structures of mental health services, with little known about the effects of such contexts upon the support children receive. This research consequently explored how professionals view the concept of mental health, perceptions regarding their role in identification and support, perceived competency in addressing difficulties, barriers and facilitative factors, and effects of the working environment upon support for children's mental health difficulties. Five focus groups were conducted, each with a different professional group working in children's services, including practitioners from health and educational contexts. Findings were analysed using thematic networks, a framework for qualitative data analysis. Participants made a number of recommendations to improve service delivery, including enhanced training opportunities, increased mental health resources to assist practitioners in intervening using an evidence-based approach, and the development of stronger links across tiers of working.

ACKNOWLEDGEMENTS

I would like to thank all participants who took part in this research, as well as their managers, who kindly granted the time to enable them to do so.

I would also like to thank Gemma Butler, Assistant Educational Psychologist, for giving her valued support and time as a research assistant.

Many thanks also go to my academic supervisor, Dr Jane Leadbetter, for her sustained, invaluable support throughout.

Finally, I wish to thank my parents, Vivienne and David King, who instilled in me a passion for lifelong learning, without which this research would not have been possible.

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INTRODUCTION

Introduction to Thesis

This thesis explores the perceptions held of children's mental health by professionals working in educational and health contexts. It considers how staff working across a range of tiers of intervention perceive their role with regard to supporting children's needs, and what skills and qualities they consider important. As the study was located within the context of a local authority with a particular emphasis on multi-agency working, it also explores any organisational factors which staff may consider to impact upon the delivery of children's mental health services. As a result, the following research questions, which are considered in more depth in Chapter Three, 'Research Design and Methodology', were considered pertinent:

- What are the ways in which professionals view children's mental health?
- How do staff see their role with regard to children's mental health promotion, identification and support?
- What are the skills and qualities considered necessary for staff to effectively support children's mental health difficulties?
- What are the perceived barriers in supporting children's mental health?
- What are professionals' views on working culture in relation to supporting children's mental health?

Although a number of studies have explored perceptions of individual groups of professionals, such as teaching staff and mental health practitioners, no literature including the views of a range of professionals, across tiers of intervention, was evident. This research therefore sought to explore the complexities and challenges in supporting children's mental health across the tiers.

Chapter Overview

This chapter begins with an outline of one of the principal challenges with regard to mental health: that of definition. Within this area of research, it is a key area of concern, due to the interest in practitioner perceptions of mental health. As how one defines mental health was considered a fundamental aspect of overall perceptions of the concept, it was crucial to acknowledge the challenges in arriving at a common understanding. Later, the chapter focuses specifically upon the rationale for exploring children's mental health needs; namely due to enduring concerns of unmet need, despite legislative changes over recent decades.

Defining Mental Health

Perhaps one of the key challenges when examining mental health is arriving at a shared understanding of what is meant by the concept, for, as yet, no universal definition exists. Many decades ago, the difficulties resulting from the absence of a ubiquitous definition were highlighted: 'A serious obstacle to research in the area of mental illness lies in the lack of a clear definition of the phenomenon to be studied' (Scott, 1958, p.29). However, currently, this difficulty persists, as contrasting conceptualisations remain ever present

within mental health literature. As noted by Morant (2006): 'A defining feature of mental health expertise is its heterogeneity and lack of consensus. The world of mental health science is characterized by competing paradigms and models of mental illness. Mental health experts rarely agree about even what mental ill-health is, let alone about causation or treatment' (p.819).

However, the overall usefulness of a universal definition has been challenged, and MacDonald and O'Hara (1998) argued that a consideration of factors which promote or demote mental health may not only be more straightforward to achieve, but also of more practical benefit. They further noted that any definition of mental health is bound by culture, and therefore of limited value.

Despite this, The World Health Organisation (WHO, 2005) developed a definition which has been widely referred to in recent years, which describes mental health as: 'a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community' (p.XIX). Although this focus upon strengths and abilities is becoming more prevalent amidst mental health literature, with Jormfeldt et al. (2007) noting: 'A new understanding of the concept of health is needed...which besides reducing disease is to strengthen the patient's health' (p.50), it is not a conceptualisation consistently adopted, and conflicting perspectives concerning how it is perceived and defined remain.

The overarching debate within mental health could be conceptualised as whether it is perceived from an 'illness' or 'wellness' framework. Jormfeldt et al. (2007) go on to define

these polar conceptualisations: 'Illness prevention can be described as the avoidance of disease, and health promotion comprises a number of activities seeking to expand positive potentials for health' (p.50). Scheid and Brown (eds., 2010) consider that these poles can be viewed as two distinct areas: 'Mental health and mental disorder represent two different areas of theory, research, and policy implications, reflecting our tendency to dichotomize healthy and sick, normal and abnormal, and sane and insane' (p.1). As a consequence, it is perhaps helpful to examine the two perspectives independently.

Meeting Children's Mental Health Needs

Despite the considerable concerns regarding children's mental health, Burns et al. (1995) identified that only 40 per cent of those demonstrating severe mental health difficulties received support. As a result of the identified deficits in mental health provision for children, a restructuring of services was undertaken. In 1997, the creation of a new role in children's mental health, the Primary Mental Health Worker (PMHW) was developed, to assist in addressing unmet needs, and bridge the gap between primary care and specialist mental health services (Hickey et al., 2010). Additionally, a comprehensive Child and Adolescent Mental Health Service (CAMHS) was alluded to in a Department of Health (DH) document (2002), to be established by 2006, incorporating mental health promotion and early intervention in addition to specialist support for those with complex and/or persistent difficulties, and perhaps deemed to reflect the growing emphasis upon holistic, salutogenic perspectives in mental health. The Department of Health document (2004) notes that: 'While these standards are confined to the provision of NHS health care, they recognise the need to develop services in a co-ordinated way, taking full account of the responsibilities of

other agencies in providing comprehensive care' (DH, 2004, p.26). This comprehensive framework, incorporating a range of services providing support to children, was outlined in more detail in a Department for Education and Skills (DfES) and DH (2004b) document, and is shown in the table below:

Table 1: CAMHS Four Tier Strategic Framework

Tier and Description	Professionals Providing the Service	Function/Service
<p>Tier 1 A primary level of care.</p>	<ul style="list-style-type: none"> • GPs • Health visitors • School nurses • Social workers • Teachers • Juvenile justice workers • Voluntary agencies • Social services 	<p>CAMHS at this level are provided by professionals working in universal services who are in a position to:</p> <ul style="list-style-type: none"> • Identify mental health problems early in their development • Offer general advice • Pursue opportunities for mental health promotion and prevention
<p>Tier 2 A service provided by professionals relating to workers in primary care.</p>	<ul style="list-style-type: none"> • Child and Adolescent Mental Health workers • Clinical child psychologists • Paediatricians (especially community) • Educational psychologists • Child & adolescent psychiatrists • Child and adolescent psychotherapists • Community nurses/nurse specialists • Family therapists 	<p>CAMHS professionals should be able to offer:</p> <ul style="list-style-type: none"> • Training and consultation to other professionals (who might be within T1) • Consultation to professionals and families • Outreach • Assessment
<p>Tier 3 A specialised service for more severe, complex or persistent disorders.</p>	<ul style="list-style-type: none"> • Child & adolescent psychiatrists • Clinical child psychologists • Nurses (community or in-patient) • Child psychotherapists • Occupational therapists • Speech and language therapists • Art, music and drama therapists • Family therapists 	<p>Services offer:</p> <ul style="list-style-type: none"> • Assessment and treatment • Assessment for referrals to T4 • Contributions to the services, consultation and training at T1 and 2.
<p>Tier 4 Essential tertiary level services such as day units, highly specialised out-patient teams and in-patient units.</p>	<ul style="list-style-type: none"> • Child and adolescent in-patient units • Secure forensic units • Eating disorders units • Specialist teams (eg. for sexual abuse) • Specialist teams for neuro-psychiatric problems 	

Table from: DfES & DH (2004) *National Service Framework for Children, Young People and Maternity Services: The Mental Health and Psychological Well-Being of Children and Young People*.

The DfES and DH (2004) draw attention to the importance of support across all tiers of intervention, as opposed to solely specialist services, noting that 'the provision of education to increase awareness of mental health issues and to improve the recognition of children's emerging needs, and the provision of support for those children with particular needs, have a vital role to play in improving the chances for children and young people' (p.10). However, despite this emphasis upon prevention and early intervention, children's mental health provision remains a source of contention. In a review of CAMHS (DCSF and DH, 2008), it was noted: 'improvements in mental health and psychological wellbeing are still not as comprehensive, as consistent or as good as they could be' (p.8). As a result, meeting children's mental health needs remains an area of much debate. Furthermore, it is important to note that children's mental health is not necessarily a static phenomenon, and can be subject to change, dependent in part upon environmental circumstances, such as family difficulties, like divorce or loss (Meltzer et al., 2000). This is important, as it could have implications for the demand for children's mental health services which, as previously noted, is a cause for concern (DCSF and DH, 2008).

The creation of the comprehensive CAMHS framework could, however, be said to alleviate the burden, and arguably assist with children's changing needs more effectively. Furthermore, if met with effective support at early stages of intervention, there is the potential for children's mental health needs to lessen in severity, thus reducing the burden. The DfES and DH (2004) note the significance of such a comprehensive framework, stating: 'It is important to recognise that supporting children and young people with mental health problems is not just the responsibility of specialist CAMHS. In many cases, the intervention

that makes a difference will come from another service' (DfES and DH, 2004, p.7). However, a potential criticism of this approach is that a greater range of non-specialist services, many of whom may have little or no relevant training, are therefore considered responsible for the tasks of identifying and supporting children's mental health. Even within occupations with a specific mental health focus, there remain issues with regard to appropriate training, with Hickey et al. (2010) noting that 51% of PMHWs reported unmet training and development needs.

Knowledge of mental health across services could indeed be considered extremely variable, with Roeser and Midgley (1997) identifying that 8% of teachers reported uncertainty regarding whether a given pupil required input from specialist mental health services. This finding is in contrast to the standards laid out by the DfES and DH (2004) that universally, staff across children's services should possess a good knowledge of mental health difficulties, stating: 'All staff who work with children and young people, in any service, are able to recognise the contribution they can make to children's emotional well-being and social development and use their own professional skills in supporting children when there is concern about their well-being' (p.11).

LITERATURE REVIEW

Chapter Overview

The focus of this research is upon practitioner perceptions of children's mental health across different tiers of intervention, including an understanding of their roles within the comprehensive CAMHS framework. The tiers most relevant to the role of the educational psychologist (EP) were considered those pertinent to the study, as this is the professional orientation of the researcher. As EPs are located within Tier 2 services, and as a result, responsible for providing support and training on mental health issues to Tier 1 staff, and seeking support from and liaison with Tier 3 professionals, tiers 1-3 were incorporated. A consideration of the expectations of support provided, rationale for particular support, manner of support given, and key challenges faced, was therefore deemed helpful. As staff within the target local authority largely operated within multi-agency teams, coupled with literature indicating the importance of this manner of working in order to effectively meet children's needs, a consideration of multi-agency factors pertinent to supporting children's mental health was also deemed appropriate.

Recent literature has drawn attention to the fact that a wider number of professionals than ever before are responsible for identifying and supporting children's mental health needs, raising issues of skills, knowledge and competency, resulting in this area being considered worthy of much attention. The contexts in which professionals worked was also deemed important to explore, as environmental and cultural factors within the workplace have been identified as impacting upon one's capacities to support service users.

Overall, the focus of the research was upon exploring practitioner perceptions with regard to children's mental health, and as such, it was considered necessary to explore a range of conceptualisations. These included pathogenic, salutogenic, social, psychological and biological perspectives, as well as factors associated with stigma and discrimination.

Mental Health Support in Tier 1 Services

In recent decades, the necessity for early intervention with regard to children's mental health has been outlined in service standards documents. The DH (2004a) state: 'An important component of promoting the health of children and young people is the early identification of illnesses, environmental factors or individuals' activities that may contribute to disease, ill health or injury' (p.23). The identification of children's mental health difficulties could be considered an essential role of Tier 1 staff. As noted by Simpson et al. (2009): 'children are dependent upon adults to recognise symptoms and seek services for them' (p.472), emphasising not only the vulnerability of children per se, but the particular responsibilities practitioners have for safeguarding those with mental health difficulties.

The rationale for mental health promotion and early intervention in particular has been justified by delineation of the potential severity of consequences for children who do not receive adequate support in the early stages of mental illness. For instance, Her Majesty's Government (HMG) and DH (2011) state: 'Suicide among the young is often preceded by psychosocial difficulties of one kind or another' (p.113). Additionally, the acknowledgement

of the potential for unaddressed emerging difficulties in childhood leading to more substantial problems in adult life provides a further justification. As noted by Sayal et al. (2010): 'difficulties often persist over time and present risks for later development and impaired functioning in adulthood' (p.476).

As previously noted by Weare (2005), an additional benefit of Tier 1 activity, such as offering universal services to all children, is the possibility of reducing stigmatization, thus perhaps securing more active engagement in mental health services for those children who need it most. The harmful effects of stigma with regard to mental health have been noted by Schachter et al. (2008), who described it as manifesting in 'discriminatory attitudes, stereotypes, labels and behaviour... [which could result in] 'exacerbation of MHDs [mental health difficulties]; unwillingness to seek help; withdrawal; feeling shame; self-blame or self-harm' (p.2).

Within an educational context, mental health promotion can occur across differing levels of intervention, and is not confined to direct identification and support. For instance, Nelson and Mann (2011) note that mental health support and early identification can be supported at the systemic level, with appropriate policy development facilitating the process. They state: 'It has been well documented that early experiences matter', and adding: 'Public policies that promote social-emotional wellness in the early years can help to establish the foundation needed for successful relationships...[and] success in school and in life' (p.129).

The role Tier 1 services can play in the early identification of mental health difficulties was highlighted in a study by Meri et al. (2011), who noted that teachers' perceptions of

behavioural and emotional difficulties as reported in questionnaires completed for children aged 7 and 8 were good predictors of life satisfaction in adolescence. This finding provides an insight into the subsequent importance of Tier 1 services' role in identification, as the timely recognition of mental health difficulties in young children could assist in their receiving appropriate support at an earlier stage, thus reducing the likelihood of entrenched difficulties at a later stage. Additionally, many children with mental health difficulties are not supported by specialist mental health services, with only 20% of those with emotional and behavioural disorders having contact with CAMHS (Sharp et al., 2005), suggesting a key role for staff working at earlier levels of intervention.

The current government have also emphasised the particular importance of intervening in the earliest stages of a child's life, in order to minimise the potential for entrenched difficulties, and assist positive change, stating: 'What happens in pregnancy and the first few years of life gives children a lasting legacy because they are growing rapidly and particularly susceptible to physical, environmental and psychological harm. After the age of three it becomes much more difficult to make changes in both a child's development and in parental behaviour' (DfE, 2011, p.50). This emphasis upon intervention at the earliest levels, before children even reach statutory school age, has implications for work conducted by professionals prior to this point, particularly with regard to identification and risk factors, and appropriate liaison with others at the time of transition to educational settings.

However, a fundamental issue within Tier 1 services concerns professionals' understanding of the role they play with regard to mental health support. The DH (2001) notes that: 'Many agencies working in areas that have a direct impact on mental health, for example social

exclusion or regeneration, would not describe themselves as involved in mental health promotion' (p.17). Without this acknowledgement of the valuable role played by Tier 1 services, opportunities may therefore be lost to identify and appropriately support children's mental health needs.

Mental Health Support in Tier 2 Services

Tier 2 delivery plays a vital role at the interface between universal and specialist services, with the responsibility frequently involving supporting staff working within universal services. The role of EPs is particularly significant within this tier, with Perfect and Morris (2011) noting an expectation that they become the leading experts in schools with regard to children's mental health. Indeed, Tier 2 services could be considered to possess a specific remit with regard to mental health and well-being promotion and support. Within the realm of educational psychology, for example, supporting children's mental health is considered crucial, and referred to within the domain of emotional development. As noted by the DfEE (2000), the role of the EP is to 'apply psychology to promote the attainment and healthy emotional development of children and young people' (p.5).

The development of specific Tier 2 mental health roles has occurred over recent decades, to address what was described by Hickey et al. (2010) as a 'service gap' in children's mental health services between Tiers 1 and 3. They noted the difficulties Tier 3 services faced with regard to meeting children's mental health needs, stating: 'Since [Tier 3] services are generally characterised as unable to cope with the volume of children presenting with mental health problems increasing the numbers of referrals to tertiary care does not

present a solution' (p.23). As a result, an alternative solution to children's burgeoning mental health difficulties was required. Such a solution has taken the form of the employment of PMHWs in some local authorities, who work at the Tier 2 level, providing training and consultation to Tier 1 services, and treatment, involving direct work with children and families around emotional and behavioural difficulties (Macdonald et al., 2004).

A range of services not explicitly referenced within the CAMHS Four Tier framework could be considered to be positioned within Tier 2 delivery, due to the focus upon assessment and support of emerging mental health difficulties, with varying dispersal across local authorities. For instance, the role of parent support advisors (PSAs) was first alluded to in a report produced by HM Treasury and DfES (2005), which noted the importance of supporting parents in order to meet children's mental health needs, stating: 'Parents' own behaviour and parenting impact on a number of children's outcomes, from physical and mental health to academic attainment and lifestyle choices' (p.21). The role was piloted in twenty local authorities, and began in 2006, with an important function being the formation of positive relationships with parents, in part to facilitate engagement in courses, such as parenting programmes, as described by Lindsay et al. (2007), who went on to note that: 'PSAs have the potential to provide important support to parents, which other research has indicated will have a positive impact on children' (p.4).

Within educational contexts, the emergence of roles and initiatives supporting behavioural difficulties have become prevalent, with the association between behaviour and mental health difficulties identified by Alexander (2005), who noted: 'Long-standing behavioural

difficulties [may] represent a more entrenched mental health problem' (p.20). He furthermore highlighted the vulnerability of children with behavioural difficulties, stating: 'Students with emotional and behavioural difficulties are over-represented in exclusion and nonattendance rates, and children out of school are over-represented in youth offending figures' (p.12). As a result, behaviour support worker roles have emerged within some local authorities. This role was described in a case study by the Children's Workforce Development Council (CWDC) as involving: 'working with groups of children..., supporting and encouraging pupils who, for various reasons, lack confidence or self-esteem as well as suffering from poor social and/or behaviour skills' (CWDC, 2008, [online]). The rationale for this work has been made evident, with Weare and Gray (2003) noting: 'There is sound evidence from the literature...that work on emotional and social competence and wellbeing has a wide range of...benefits, including...improved behaviour,...learning, and...mental health' (p.6).

One of the challenges associated with Tier 2 work is that sometimes, children whose difficulties are more entrenched in nature, and perhaps require a higher level of support, are not necessarily receiving this, due to the degree of support available across other tiers. For instance, Lindsay et al. (2007) raised concerns about PSAs 'becoming 'overloaded' with problems... [due] to lack of referral routes for mental health issues...' (p.45). They went on to note that: 'There was a need to involve other agencies and a danger that PSAs were "picking up the needs of the whole family by default because other agencies are not involved"' (p.45).

Additionally, there have been concerns raised with regard to the degree and consistency of practitioners' training, and consequent ability to appropriately support children's mental health needs. For instance, with regard to the PMHW role, there is no universal training, with Bradley et al. (2009) noting: 'there has been little exploration of the attributes required to successfully deliver this demanding and complex interface role' (p.15). Operating within levels of competency is particularly important. With regard to the EP role, the Health Professions Council (HPC) alludes to 'scope of practise', which it defines as 'the area or areas of your profession in which you have the knowledge, skills and experience to practise lawfully, safely and effectively' (HPC, 2009, p.3).

Mental Health Support in Tier 3 Services

Within Tier 3 services, specialist CAMHS could be considered the main provider of support for children's mental health difficulties. Edwards et al. (2008) outline its role, stating: 'The broad objective of specialist CAMHS is to provide assessment and skilled interventions for children, young people and their families, and to target the younger people who have more severe problems that often amount to disorders and multiple or complex mental health needs' (p.23).

CAMHS teams are considered largely heterogeneous in nature, with staffing composition typically incorporating a wide range of professionals, such as clinical psychologists, social workers, community psychiatric nurses, psychiatrists, family therapists, and art or play therapists (Pettitt, 2003). Perhaps one of the key challenges associated with this heterogeneity could be establishing consistency of approach, and ensuring service users

receive treatment from the particular professional considered most appropriate to meet their needs. With the range of professionals and resultant therapeutic approaches at the disposal of CAMHS, matching client need appropriately could be considered crucial, as specific techniques are deemed appropriate for a given presenting issue. For instance, one therapeutic approach utilised by CAMHS, and considered an evidence-based psychological treatment (EBPT) (McHugh and Barlow, 2010) is that of cognitive behaviour therapy (CBT). James et al. (2009) explain its rationale, stating: 'The aim of CBT is to help the child to identify possible cognitive deficits and distortions' (p.2). However, it is widely considered most appropriate for the treatment of anxiety disorders (Rapee et al., 2009, Hirshfield-Becker et al., 2010, Ishikawa et al., 2007), suggesting the need for a careful mapping of practitioner skills and approaches, according to client need.

Specialist services have been reported to have undergone substantial change over recent decades, as increasing awareness regarding risk factors and client need has facilitated the ability to plan service delivery more effectively, and an enhanced knowledge of evidence-based appropriate interventions, in accordance with research findings, has resulted in more targeted approaches (Vostanis, 2007). The launch of the 'New Ways of Working' initiative was reported in a DH (2007) document, which aimed to modernise and strengthen the mental health workforce, including CAMHS. It noted that despite recent staffing increases within CAMHS, there remained difficulties meeting need, stating: 'The absolute number of workers still does not meet the need or demand for services. A range of workforce strategies is, therefore, needed to meet the needs of young people, while making best use of limited resources' (p.119). The rationale, therefore, in seeking the assistance of other

services for early intervention activities, and support for less complex needs, subsequently becomes apparent.

Indeed, the acknowledgement of burgeoning waiting lists, and subsequent unmet need within Tier 3 services, has been widely reported. As noted by Patel et al. (2007) 'most mental-health-service needs are unmet...and there is a dearth of interventions to prevent mental disorders and promote mental health' (p.1303). Furthermore, the CAMHS Review, which took place in 2008, noted certain vulnerable groups were particularly at risk of not receiving appropriate treatment, stating: 'evidence shows high levels of unmet mental health need for children in care, despite notable improvements' (DCSF and DH, 2008, p.81). This is in spite of substantial increases in the workforce within CAMHS Tier 3 provision, with staffing raised by 39% in generic teams between 2003-2005, and 56% in targeted teams (Barnes et al., 2006).

It is therefore evident that meeting the mental health needs of children referred to Tier 3 services remains a continuing challenge. This may in part be as a result of reported increases in the numbers of children deemed to possess mental health difficulties. For instance, Sawka et al. (2002) note that: 'The number of students presenting with serious emotional and behaviour problems is increasing' (p.223). The importance, then, of practitioners working effectively together across tiers, incorporating preventative and early intervention activities, is therefore evident.

Critique of Mental Health Support Across Tiers

Despite the establishment of a comprehensive CAMHS framework, some remain sceptical as to what extent work across all levels is consistently and appropriately undertaken. For instance, Stiffman et al. (2010) state: 'The issue of a comprehensive approach to mental health is tied to...barriers related to policy perspectives and disjointed systems. A comprehensive approach needs more than mere linkage. Such an approach should move from the public health arena to specialty services, beginning with health promotion, moving to screening and then to increasingly specialized mental health services' (p.4). This criticism suggests a perceived lack of coordination within the current comprehensive CAMHS framework, resulting in an overall lack of smooth transition across tiers. This suggestion is also consistent with concerns regarding professionals' knowledge and understanding of how they contribute to a comprehensive mental health framework for children (DH, 2001).

Multi-Agency Mental Health Support

The term 'multi-agency working' is not unequivocally defined, and could therefore be considered somewhat difficult to delineate. Additionally, a confounding factor is noted by Atkinson et al. (2007): 'Activity that could be characterised as 'multi-agency' is referred to by a large number of different terms' (p.13). Percy-Smith (2006) similarly noted this difficulty, and provides numerous terminologies commonly employed to refer to activities which involve working in collaboration with others. She states: 'it is difficult to find a clear definition of the concept... [There are an] abundance of related terms in use across public policy. These include: holistic governance; joined up working; multi-and cross-agency

working; multi-professional/disciplinary working; cross-boundary working; integration; networks; collaboration and coordination' (p.316).

Regardless of the terminology used, multi-agency working has been considered a government priority of recent decades, and Abbot et al. (2005) note: 'Current legislation requires professionals to find ways to move across the boundaries between health, education and social care' (p.229). The legal framework for the implementation of coordinated, multi-agency collaboration arose with the arrival of the Green Paper 'Every Child Matters' (DfES, 2003) and the Children Act 2004. The former document noted that the latter would provide the legal framework, placing 'a duty on Local Authorities to make arrangements to promote co-operation between agencies and other appropriate bodies...in order to improve children's well-being' (p.5). As a result, the prevalence of multi-agency working within children's services in recent decades has indeed been widely reported, and is considered a key priority following high-profile cases of significant child abuse, which underpinned the call for systemic improvements, with a particular emphasis upon enhancing appropriate information-sharing protocols and collaborative practice (Laming, 2009).

Despite several decades of legislative reform, Laming (2009) identified continuing difficulties with regard to multi-agency working, particularly pertaining to practical implementation, stating: 'there remain significant problems in the day-to-day reality of working across organisational boundaries and cultures, sharing information to protect children' (p.10). Worrall-Davies and Cottrell (2009) similarly identified challenges in operationalizing multi-agency approaches, suggesting that in practice, effective partnership working is still not

thoroughly and consistently embedded across children's services, stating: 'Many countries have seen an increased emphasis on integrated work with children and young people, sometimes referred to as 'joined-up' working. Indeed, this is now embedded within the culture of working practices and legislation, although its practical exposition is perhaps more patchy' (p.336). This indicates that although there is a widespread professional commitment to multi-agency working, the reality of its application can be problematic.

A number of barriers have been highlighted which impact upon practitioners' ability to work effectively with other agencies. Darlington and Feeney (2008) considered some of the main challenges to be: 'A lack of information on services available, a lack of knowledge about the role of workers in the other agency, a lack of a culture of liaison, and the absence of effective liaison structures and guidelines' (p.188). Although cultural factors within an organisation are hereby considered important, some of the identified barriers pertain to a lack of appropriate knowledge of other agencies, which could therefore be considered a training issue.

Another key barrier concerns communication, with breakdown in effective contact and interactions with others perceived as a serious threat to effective multi-agency working. For instance, an interviewee in a study by Atkinson et al. (2002) noted that 'this can be where it falls apart'. Three key elements of successful communication within multi-agency working were subsequently noted, namely: 'providing opportunities for dialogue, communication skills, [and] information dissemination' (Atkinson et al., 2002, p.148). These factors indicate the importance of communication abilities across levels, incorporating the need for

appropriate practitioner skills, as well as systemic factors, such as appropriate information-sharing at an organisational level.

When considering multi-agency working in relation to children's mental health services, it is important to note that mental health tiers of intervention should not necessarily be deemed a linear model, and professional boundaries frequently overlap. Across children's services, a range of roles commonly exist which cross tiers, such as CAMHS workers within youth justice teams, or social workers within CAMHS, which can sometimes prove problematic. As noted by the DfES and DH (2004): 'The complexity and variety of children's service provision in any one locality...creates a logistical challenge for services attempting to achieve good partnerships' (p.25).

Furthermore, the DfES and DH (2004) highlight particular difficulties with regard to collaborative working in relation to mental health, stating: 'Partnership working across agencies working with children and young people with mental health problems can be a challenging task' (p.25). They further elaborate underlying reasons for its problematic nature, stating: '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' (p.25). Many of these difficulties have been identified more generally in literature examining multi-agency teams per se (Atkinson et al., 2002), but are particularly pertinent when considering effective partnership working within the mental health arena in particular, due to the fact that some services, such as CAMHS, are deemed a largely heterogeneous group, as previously noted by Pettitt (2003), which could result in differing professional experiences, training, perspectives

and approaches to mental health support within a given team, resulting in both inter- and intra-group issues.

Additional challenges faced by multi-agency working within CAMHS teams have been highlighted by Worrall-Davies and Cottrall (2009), who state: 'The psychotherapeutic nature of much of CAMHS work and its inherent multi-agency nature make an evidence-based approach to practice especially difficult' (p.339). It could thus be argued that inter-disciplinary differences, perhaps with regard to desired outcomes, and means of measuring impact, could result in difficulties reliably evaluating the effectiveness of work within a team, and potentially result in service users experiencing inconsistency of approach.

However, there are advantages of multi-agency working too, and such diversity within a team can indubitably have the potential for combining skills and experience, and providing rich opportunities for appropriate information-sharing and pooling of expertise and knowledge (Atkinson et al., 2002). Indeed, the challenges in addressing children's complex, multifarious needs is arguably best met with the support of colleagues who may have more specialist skills in other areas, outside of our domain of knowledge or experience. As noted by Salmon (2004): 'Children with complex problems do not fall neatly into the health, education or social service categories into which we divide our services. Even if they did, no one professional discipline can now be expected to have the knowledge and the skills required to deal with them' (p.157).

In order to facilitate multi-agency working, Atkinson et al. (2002) interviewed a number of professionals from education, health, and social care, working in multi-agency teams, and

subsequently identified a number of factors considered of key importance. These included: commitment or willingness; understanding roles/responsibilities; communication/information sharing; funding/resources; good working relationships; and having adequate time (p.138). Although not specific to children's mental health contexts, they could be considered generic across multi-agency teams, and have relevance in that they incorporate the views of those working in education.

Skills, Knowledge and Training in Mental Health within Children's Services

As previously noted, the range of professionals involved in supporting children's mental health has grown over recent decades, with policy stipulating it be everyone's concern, placing responsibility on all involved in the lives of children to become active participants in identifying and supporting difficulties. As noted by HMG and DH (2011): 'Mental health is everyone's business- individuals, families, employers, educators and communities all need to play their part' (p.5).

The resulting diversity of staff now involved in supporting children's mental health is a complicating factor in ensuring sufficient skills and training, and it may be those with the least skills, training or experience who are responsible for providing the more intensive forms of support, particularly within an educational context. For instance, Groom and Rose (2005) note: 'A growing number of TAs [teaching assistants] are deployed to work specifically with pupils with social, emotional and behavioural problems' (p.20). However, they consider that: 'teachers, who have received specific professional development in classroom management, are better placed to manage pupils with challenging behaviours

than TAs who have often received little training' (p.21). Having said this, they note that schools frequently considered the contribution TAs make to supporting pupils' emotional development to be significant, and facilitating 'groups aimed specifically at raising self-esteem [and] emotional development' (p.25) was considered a key area of successful deployment of TAs. A complicating factor, however, is that school staff showed a preference for personal qualities above professional qualifications when employing TAs. The fact that training and expertise is not necessarily a fundamental priority to employers, though, does not necessarily reduce its importance, and it could be argued that such a perspective ultimately results in staff being less likely to receive the professional development required to most effectively support children's mental health.

A key issue of concern with regard to training is that the identification of a universal core set of skills required to assist professionals in the endeavour of supporting children's mental health remains undefined. For instance, a National Institute for Health and Clinical Excellence (NICE) recommendation is for school staff to receive 'training and support in how to develop children's social, emotional and psychological wellbeing' (2008, p.6-7). However, guidance does not specifically identify what such training may incorporate, and the somewhat vague stipulation regarding the trainer's skills and credentials is that they be 'appropriately qualified' (p.7). This lack of clarity appears problematic, as literature indicates staff involved in identifying and supporting children's mental health needs report some degree of uncertainty in this area, evident to some extent across all tiers, including the more specialist. For instance, Edwards et al. (2008) note: 'The lack of any CAMHS-specific training or experience was highlighted as a common issue, particularly for new staff' (p.26).

Arguably in an attempt to address training issues, in 2006, a free e-learning resource, launched as part of the 'Everybody's Business' initiative, was commissioned by the National CAMHS Support Service (NCSS). The website states that the training programme was designed for people working with children, but who were not mental health professionals. However, it notes that the course is not formally accredited, and makes no reference to a statutory obligation to complete the materials if working with children (NCSS, 2009 [online]).

Within Tier 1 health contexts, professionals have been identified as lacking appropriate skills to support mental health. For instance, in a study by Browne et al. (2007), only 22% of GPs reported having an interest, and training, in mental health care. With regard to educational contexts, Finney (2009) noted that school staff may be ill-equipped to identify and support children's mental health difficulties, stating: 'The question of role adequacy (having the appropriate level of competence) is not a new one...[with] a deficit of skills and knowledge in the ability of mainstream teachers to fulfil this role' (p.22).

However, the complexity in accurately identifying mental health difficulties has been widely reported, and it is therefore unsurprising that non-specialist staff of Tier 1 contexts find this a challenge. The difficulties in separating mental health difficulties, for instance, from other problems is a particular challenge, as noted by Duff et al. (2006), who state: 'Aggression and violence are among the criteria for diagnosis of some mental health problems, including antisocial and impulsive personality disorders' (p.476). Rothí et al. (2005) noted that some teachers reported feeling unable to distinguish between behavioural and mental health problems. Consequently, extrapolating behavioural difficulties which are not deemed a

particular mental health concern from those considered to occur as a result of mental health problems is a particular challenge, arguably faced by all professionals working with children.

Concerns have also been raised for some years within Tier 2 services, with doubts regarding the skills and training EPs possess for effectively supporting children's mental health. For instance, Indoe (1998) noted that although: 'the roots of educational psychology can be traced back to mental health... the profession cannot claim competencies that it does not possess without further training and education if it wishes to be recognized as a provider of mental health services' (p.126). Indoe argues that educational psychology adopts a narrow view of mental health problems, which construes difficulties through an educational lens, concerned largely with 'emotional and behavioural difficulties' pertinent to the classroom, as opposed to a holistic, systemic consideration of mental health problems. However, it is important to note that since this time, considerable changes have been made within the profession, including the training of EPs at doctoral level, affording opportunities to incorporate greater depth of learning, particularly in the domain of mental health. As noted by Squires and Dunsmuir (2011): 'The training of educational psychologists (EPs) has been extended to three years and this provides an opportunity to increase the depth of knowledge of particular therapeutic models and their use in educational settings' (p.117).

The importance in professionals across all tiers possessing appropriate skills and knowledge is undeniable, as a number of issues can arise as a result of inadequate training in mental health. For instance, Percy et al. (1993) noted that teachers were more likely to refer pupils with externalising problems, suggesting there could be difficulties and confusion

regarding the identification of internalising mental health problems in children, resulting in a subsequent lack of support. However, it could also indicate that children's mental health needs are considered more worthy of attention if they pose a particular difficulty to a given professional, such as lesson disruption for teaching staff. For instance, Loades and Mastroyannopoulou (2010) discovered that when presented with vignettes of pupil difficulties, teachers 'were significantly more concerned about... a child with symptoms of a behavioural disorder than an emotional disorder' (p.150).

Associated with the skills and training available to professionals is the availability of appropriate tools to support this endeavour. Meri et al. (2010) conducted a study involving teacher-completed emotional well-being assessments for primary-aged children, and found these were good predictors of later life satisfaction. Arguing for the usefulness of such assessments, they therefore noted that: 'easily applied and valid tools should be provided for screening and monitoring mental health' (p.470). However, there is again a training component required for such an endeavour, with the necessity of staff receiving adequate guidance in order to undertake this task.

As well as appropriate tools, adequate opportunities and support to develop skills in supporting children's mental health are necessarily required. Cleary et al. (2011) conducted a study examining the perceived factors by newly qualified staff entering the mental health profession which facilitated skill development. Although not specific to a children's mental health context, the findings could be considered applicable across contexts, with many, if not all, elements pertinent to direct work with children. The newly-trained professionals identified 11 factors as crucial in their development, which were, in order of priority: '(i)

teamwork; (ii) experiential learning; (iii) self-development; (iv) confidence; (v) listening; (vi) rapport; (vii) keen observation; (viii) patience; (ix) empathy; (x) learning from colleagues; and (xi) maintaining a positive approach towards patients' (p.455).

Overall, the appropriate training in mental health issues by professionals working with children could be considered a key priority, particularly in light of recent government policies indicating the importance of early identification, and universal support. For instance, Finney (2009) notes: 'Training, which provides skills in low-level therapeutic approaches for pupils and students, in conjunction with a broad understanding of mental illness and mental health issues, could be a highly effective method of responding to the maxim 'mental health is everyone's business' (p.21). However, research findings and policy documents indicate this is an area in need of further development. As noted more broadly by Morris et al. (2009): 'Across all children's services workforce capacity and capability remains a significant issue' (p.13).

Learning Acquisition in the Workplace

When considering the issue of skills, knowledge and training within the workplace, it is pertinent to explore the process of learning, and how information may be acquired as a result of the context and environment in which one is located. Eraut (2007) distinguishes between formal knowledge acquired, say, within the course of academic training, and informal learning, occurring as a result of processes involving others. He states: 'The cultural perspective on knowledge focuses on knowledge creation as a social process, whose outcomes may take the form of *codified/reified knowledge* and/or *shared meanings and*

understandings...' (p.405). He clarifies the disparity between the two, stating: 'Universities are primarily concerned with *codified knowledge* published in books and journals' (p.405). However, he notes the importance of knowledge as shared understanding, stating: 'Other *cultural knowledge*, which has not been codified, also plays a key role in most work-based practices' (p.405). Lastly, the overall significance of such informal work-place learning is highlighted, with Eraut (2007) noting: 'What does appear to be generally acknowledged is that much uncodified cultural knowledge is acquired informally through participation in social activities; and much is often so 'taken for granted' that people are unaware of its influence on their behaviour' (p.405). The significance of this is particularly relevant, especially when embarking upon the task of exploring the work environment in relation to subsequent support provided via children's services, as it implies that professionals' working practices may not necessarily always operate at the conscious level. This is problematic, as when exploring factors which may impact upon professionals' practice, participants may not be directly aware of some influences, which may have become so automatic, or unconscious in nature, as to become indiscernible.

Furthermore, in a previous paper, Eraut (2004) notes that individuals commonly downplay the significance of workplace learning, compared to more formal means, stating:

'Most respondents still equate learning with formal education and training, and assume that working and learning are two quite separate activities that never overlap, whereas our findings have always demonstrated the opposite, i.e. that most workplace learning occurs on the job rather than off the job' (Eraut, 2004, p.249).

This may suggest that people's perceptions of skills and training received may be unduly negative, as they may only perceive more formal learning opportunities to be of benefit, thus disregarding or failing to acknowledge the learning which occurs as a result of more informal means.

Perceptions of Mental Health: Why Viewpoint Matters

Due to the array of professional groups now responsible for supporting children's mental health, it could be considered unsurprising that inconsistent perspectives and terminology exists. As noted by the DH (2001): 'There is a need to address the problem of language and conceptual frameworks in relation to mental health promotion, so that a meaningful debate can take place across professional and sector boundaries' (p.17). One's conceptualisation and terminology with regard to mental health could therefore be considered of paramount importance in terms of bridging professional boundaries and attempting to reach shared understandings.

Mezirow (1990) highlights: 'Perspectives provide *principles* for interpreting' (p.3). This suggests a person's perspective affects their understanding of a situation, which may consequently have repercussions for ensuing actions. As Merizow further notes: 'We [can]...use...interpretation to guide decision making or action' (p.1). Consequently, a professional's perspective on a child or young person's mental health difficulties may govern the manner in which they approach the problem, and inform the ensuing response.

This idea was developed by Hayden (2007), who similarly acknowledged the importance of problem conceptualisation across professional groups, stating: ‘perceptions are important because they tend to shape our responses... [and] interactions with that child. This in turn will shape their response to us’ (p.11). This suggests that the perceptions held by the professional may have a direct impact upon the quality of the relationship formed with the child, which may have significant implications with regard to overall outcomes. It indicates that the interactions children have with professionals can impact upon their mental health. As noted by Rudasill and Rimm-Kaufman (2009), when discussing children’s relationships in educational contexts, ‘positive teacher-child relationships appear to operate as protective factors for children’s social and academic development’ (p.108).

Hayden (2007) demonstrated how one’s professional group impacts upon conceptualisations using the example of behavioural difficulties, as shown in the table below. She surmised that: ‘terminology varies with perspective, as well as agency and profession, so behaviour that might be seen as ‘disruptive’ in a school may be seen as ‘anti-social’ in the community, or indeed as indicative of ‘mental health needs’, ‘neglect’ or even ‘abuse’, depending on the perspective of the observer and indicators used’ (p.12). Additionally, Hayden hereby introduced the association between behavioural and mental health difficulties, suggesting there may be inconsistency with regard to identifying, defining and categorising the two concepts across professional groups.

Table 2: Behavioural Attributions Across Services

Youth Justice	Social Services	Education	Mental Health
<p>Aggressive and impulsive behaviour.</p> <p style="text-align: center;">↓</p> <p>Manifest in public after a football match and recorded on CCTV. Police involved.</p> <p style="text-align: center;">↓</p> <p>Seen as offending behaviour.</p>	<p>Aggressive and impulsive behaviour.</p> <p style="text-align: center;">↓</p> <p>Child protection concerns from a neighbour. Social Services investigate.</p> <p style="text-align: center;">↓</p> <p>Behaviour seen as arising from abuse or neglect.</p>	<p>Aggressive and impulsive behaviour.</p> <p style="text-align: center;">↓</p> <p>School refer to educational psychologist; possible special educational needs.</p> <p style="text-align: center;">↓</p> <p>Seen as behaviour associated with SEN, specifically ADHD.</p>	<p>Aggressive and impulsive behaviour.</p> <p style="text-align: center;">↓</p> <p>Parent takes child to her GP. GP refers to child and adolescent mental health service.</p> <p style="text-align: center;">↓</p> <p>Seen as behaviour characterized by minor mental health problems, associated with poor parenting. Diagnosed as conduct disorder.</p>

From Hayden (2007), p.19.

The above example demonstrates how the professional ‘lens’ through which one views a concern can be most varied, particularly with regard to behavioural, social and emotional concerns. As Foster (2001) notes: ‘professional understanding of mental illness is highly differentiated’ (p.3.2). With regard to ensuing interventions, this is particularly significant, as it indicates the level or form of involvement which a professional may adopt. For instance, in the above example, a mental health professional may consider the delivery of an intervention at the parenting level appropriate, whereas education staff may be concerned with strategies targeted at the individual child, to reduce disruptive behaviours in school.

Weare (2000) elaborates on the overall importance of perspective with regard to mental health issues. She notes: 'What we understand by mental health will depend on our values, preconceptions and assumptions, for example about the nature of health and illness, the nature of society, the place of the individual within society, what constitutes normality, desirable behaviour and attitudes, and so on' (p.13). These conceptualisations and assumptions could be considered to fall within several broad, overarching perspectives, which will now be considered in further detail.

Mental Illness: A Pathogenic Conceptualisation of Mental Health

Keyes and Michalec (2010) note that 'pathos' is a Greek word meaning 'suffering or an emotion evoking sympathy' (p.125). Therefore, a pathogenic perspective of mental health could be deemed a deficit model, insofar as mental health is viewed as the absence of suffering, or illness. A pathogenic perspective has been considered to be the model traditionally adopted in the arena of mental health, particularly amongst health care professionals, with Keyes (2005) noting: 'science, by default, portrays mental health as the absence of psychopathology' (p.539).

Weare (2005) highlighted the confusion often associated with the term 'mental health', noting that 'traditionally the words 'mental health' have been used as a synonym for mental illness' (p.119). This 'illness' model of mental health seeks to identify disorders, and employ treatments, in order to reduce the incidence of ill health. Wakefield (1992) offers a definition of 'disorder', stating: 'a disorder exists when the failure of a person's internal

mechanisms to perform their functions as designed by nature impinges harmfully on the person's well-being as defined by social values and meanings' (p.373).

Criticisms of this perspective postulate that mental health involves more than the absence of disorder. As Keyes (2005) states: 'Health has been alleged to be a complete state consisting of not merely the absence of illness but the presence of something positive' (p.539). As noted by Naidoo and Wills (1994), the word 'health' derives from the words 'whole', 'hale' and 'healing': 'signalling that health concerns the whole person and his or her...well-being' (p.3-4). Additionally, they go on to add that a focus on illness, as opposed to wellness, is considered negative, 'defined more by what it is not than by what it is' (p.6).

However, of recent years, the value in adopting a well-being perspective within mental health services has become more prevalent. As noted by Owens et al. (2010): 'There is increasing national and international recognition of the need to address mental health as an integral part of improving overall health and wellbeing' (p.2).

Mental Wellness: A Salutogenic Conceptualisation of Mental Health

Keyes and Michalec (2010) state that by contrast to pathogenesis, salutogenesis, which derives from the Latin word for health, 'salus', 'views health as the presence of positive states of human capacities and functioning in thinking, feeling, and behavior' (p.126). This perspective is therefore a strengths-based model, interested in exploring the factors which positively contribute to mental health.

Becker et al. (2009) note that: 'In 1979 Aaron Antonovsky introduced the concept of salutogenesis as the study of health development [which]... contrasted with the concept of pathogenesis or the study of disease development' (p.1). However, traces of this perspective were evident in the literature before this time, with the 1948 Constitution of the World Health Organization (WHO, 1948) stating: 'Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity' (p.2). Despite such efforts to redefine its conceptualisation, the pathogenic paradigm remained the prevalent and typical model of mental health for many decades following this, described as the 'most historically dominant vision' (Keyes, 2007, p.96).

The WHO definition of mental health incorporates a concept increasingly prevalent within mental health literature, particularly within the salutogenic field, and sometimes employed interchangeably, namely that of well-being. Attempts have been made over recent decades to define the term, and explore its composition. Ryff (1989) considered it to be comprised of: 'self-acceptance, positive relations with others, autonomy, environmental mastery, purpose in life, and personal growth' (p.1069). More recently, Seligman, considered the founder of positive psychology, a movement described as 'the scientific study of ordinary human strengths and virtues' (Sheldon and King, 2001, p.216) commented upon the concept. Seligman (2011) posited that well-being is a construct, with no single measure defining it, but 'several things contribute to it; these are the *elements* of well-being' (p.15). He identified these elements as 'positive emotion', 'engagement', '[positive] relationships', 'meaning', and 'achievement' (p.24). This shift in perspective from a deficit to a strengths model of mental health seeks to empower the individual, in accordance with the fundamental purpose of the positive psychology movement, which was to address concerns

that psychology had become a 'healing discipline based upon a disease model and illness ideology' (Linley et al., 2006, p.4), which results in individuals beholden to medical expertise.

A particular strength of the well-being conceptualisation of mental health lies in the fact it is not constricted to individuals considered to possess particular difficulties, and is therefore universal to all. As noted by Weare (2005), this perspective means that: 'The goal changes from a concern to address the pathology of individuals only, to the creation of an overall framework to promote the positive emotional well-being of all, including the learning of mental health skills and competences for everyone' (p.120-121).

Such a perspective could be considered less stigmatising, with services offered to all resulting in potentially higher engagement by those with particular mental health difficulties (Weare, 2005). However, a potential criticism of this approach concerns capacity issues, particularly with regard to ensuring that those children requiring specialist services receive it in a timely, appropriate manner. This is particularly relevant in an austere economic climate, termed the 'Great Recession' (Eaton et al., 2011).

Medical, Social and Biopsychosocial Perspectives of Mental Health

Within the domain of mental health, differing professionals have historically adopted varying frameworks to assist with their understanding of presenting issues. Morant (2006) considers the coexistence of multiple perspectives as due to the fact that 'expert knowledge is partial and provisional, with as yet, no definitive 'proof' to support one perspective over another' (p.820). She further draws attention to prominent paradigms within mental

health, noting that Strauss et al. (1964) 'detected the coexistence of three 'psychiatric ideologies' ('somatic', 'psychotherapeutic' and 'sociotherapeutic'), demonstrating that multiple and competing models of mental illness are nothing new' (Morant, 2006, p.821). Since this time, multiple paradigms have been generated, with Morant listing 'biological, psychodynamic, social, cognitive, behavioural, humanistic and systemic models' (p.820) amongst the theoretical perspectives a professional may adopt to understand and explain mental health difficulties.

Despite Morant's identification of extensive mental health paradigms, three fundamental dominant perspectives appear most evident, namely 'biological', 'psychological' and 'social', which could be considered synonymous with Strauss et al.'s (1964) 'somatic', 'psychotherapeutic' and 'sociotherapeutic' domains respectively. Mental health services have been criticised for an over-reliance on particular paradigmatic positions, with Jormfeldt (2010) stating: 'In mental health services, the concept of health is often perceived, from a biomedical perspective, as the absence of disease' (p.225). This biomedical perspective could be considered to pertain to biological or psychological perspectives, with the assumption that mental health difficulties are rooted within the person, possibly as a result of predisposing organic factors, and require medical treatment.

Substantial criticism has been levied against biomedical models of mental health conceptualisation. Tew (2002) comments particularly upon the perceived narrow focus on individual risk factors, deemed to negatively affect the capacity to consider factors external to the individual, stating: 'Research shows that it is social factors, such as substance misuse, unemployment, unstable family circumstances or poor education, rather than any

categories of medical diagnosis, that correlate more closely with risks such as violence... However, there has been a tendency to follow an individualised model of risk assessment... rather than engage in a more holistic dialogue' (p.144).

Perhaps the key factor therefore separating biological and psychological perspectives from the social domain is connected with the location of the problem, with the latter considering mental health difficulties to some extent as a result of factors located outside of the individual, within the social contexts and processes within which one operates. As noted by Beresford (2002), when commenting upon the perceived dominant medical model mental health ideology: 'it is a philosophy which essentially conceives of them [service users] as deviant and which sees the origin of the problem as primarily within them' (p.582). Beresford (2002) described the social model, by contrast, as one which: ...'highlight[s] social, rather than, or as well as, individual 'factors' to explain what makes people the way they are' (p.582).

Duggan et al. (2002) regard the social model as more complex than other paradigms, incorporating sociopolitical factors, such as the exertion of power with regard to mental health construction, and a consideration of broader factors within society which impact upon the individual's mental health. They note that the model 'emphasises the complexity of health and illness within individuals and communities and... opens the door for multiple strategies for intervention, drawing on the expertise of a range of different disciplines and agencies. The model is rooted in an understanding of the impact of power and powerlessness on health' (p.5). However, Duggan et al. (2002) raised concerns for the seemingly low standing of social approaches, stating that they may 'retain their Cinderella

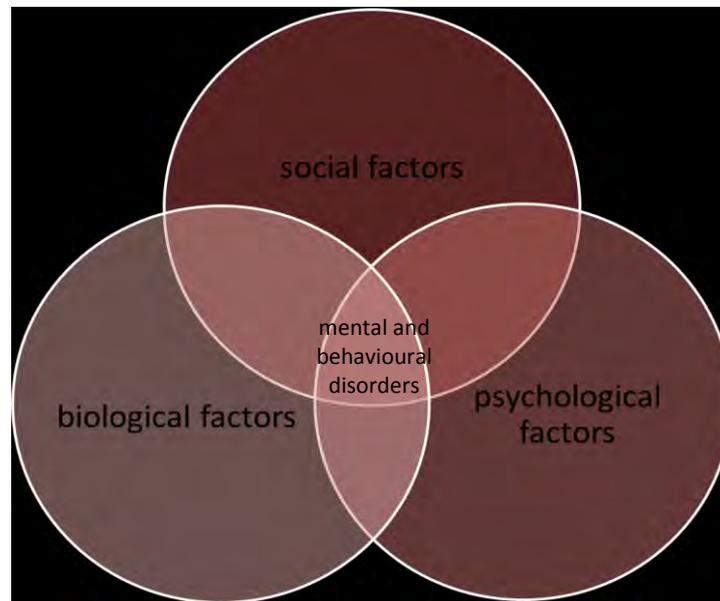
status in both the public imagination and in the focus and orientation of new structures for the commissioning and delivery of services (p.2).

The influences of power and control with regard to mental health conceptualisation were also highlighted by Beresford (2002), who considered it difficult for dominant models and ideology to be challenged, particularly by the individual deemed to possess mental health difficulties. When commenting upon the existence of mental health, as located within the individual, he stated: 'if we are seen to question the idea of 'mental illness', then that may just be taken as further evidence of our irrationality, leading to us being further discredited and excluded' (p.582).

Following controversy with regard to conceptualisations of mental health, some now argue for a united perspective, integrating biological, social and psychological elements, in order to gain a fuller, richer understanding of needs. Indeed, Keyes and Michalec (2010) referred to a 'complete state model', which they considered to incorporate both salutogenic and pathogenic elements, to provide a comprehensive, holistic framework for understanding and conceptualising mental health needs. An arguably similar perspective has been adopted by the WHO (2001), which sought to incorporate a unified conceptualisation of mental health, with a consideration for multiple elements which may impact upon the individual. This is demonstrated in diagrammatic form (see Diagram 1).

Diagram 1: Interaction of Biological, Psychological and Social Factors in the Development of Mental Disorders

(Adapted from WHO, 2001)



Due to its emphasis on a holistic consideration of factors pertinent to mental health, including biological, social and psychological elements, this model is frequently termed 'biopsychosocial', and considered by some the dominant conceptualisation by mental health professionals in the present day (Ghaemi, 2009). Despite experiencing current popularity, the model was developed in the 1950s, and has received criticism, with Ghaemi (2009) considering its particular failing to be potential variability of emphasis placed upon each of the three components, stating: 'This eclectic freedom borders on anarchy: one can emphasise the 'bio' if one wishes, or the 'psycho' (which is usually psychoanalytical among many biopsychosocial advocates), or the 'social'. But there is no rationale why one heads in one direction or the other' (p.3). This suggests an almost tokenistic potential inherent within the model, with a seemingly holistic framework capable of catering to reductionist

principles, the very likes of which it was ostensibly developed to circumvent. However, it could be regarded a favourable alternative to paradigms which consider only one element of the self, such as biological or social, due to the fact that the incorporation of all such factors necessitates them worthy of at least some consideration.

Stigma and Discrimination in Mental Health Conceptualisation

It is important to consider that societal constructions of mental health can impact significantly upon individuals' perceptions. Common public perceptions of mental health frequently allude to stigma and negative conceptualisations. As stated by Sartorius (2007): 'The stigma attached to mental illness is the main obstacle to the provision of care for people' (p.810). Furthermore, it is worth noting that even professionals having received training in mental health are not infallible, and may be influenced by commonly held constructions. Indeed, Nordt et al. (2006) revealed that those with specific training in mental health were actually more likely to hold negative stereotypes than the general public, stating: 'the better knowledge of mental health professionals and their support of individual rights neither entail fewer stereotypes nor enhance the willingness to closely interact with mentally ill people' (p.709).

Learoyd-Smith (2010) notes the origins of negative conceptualisations of mental health with regard to stigma in particular, stating:

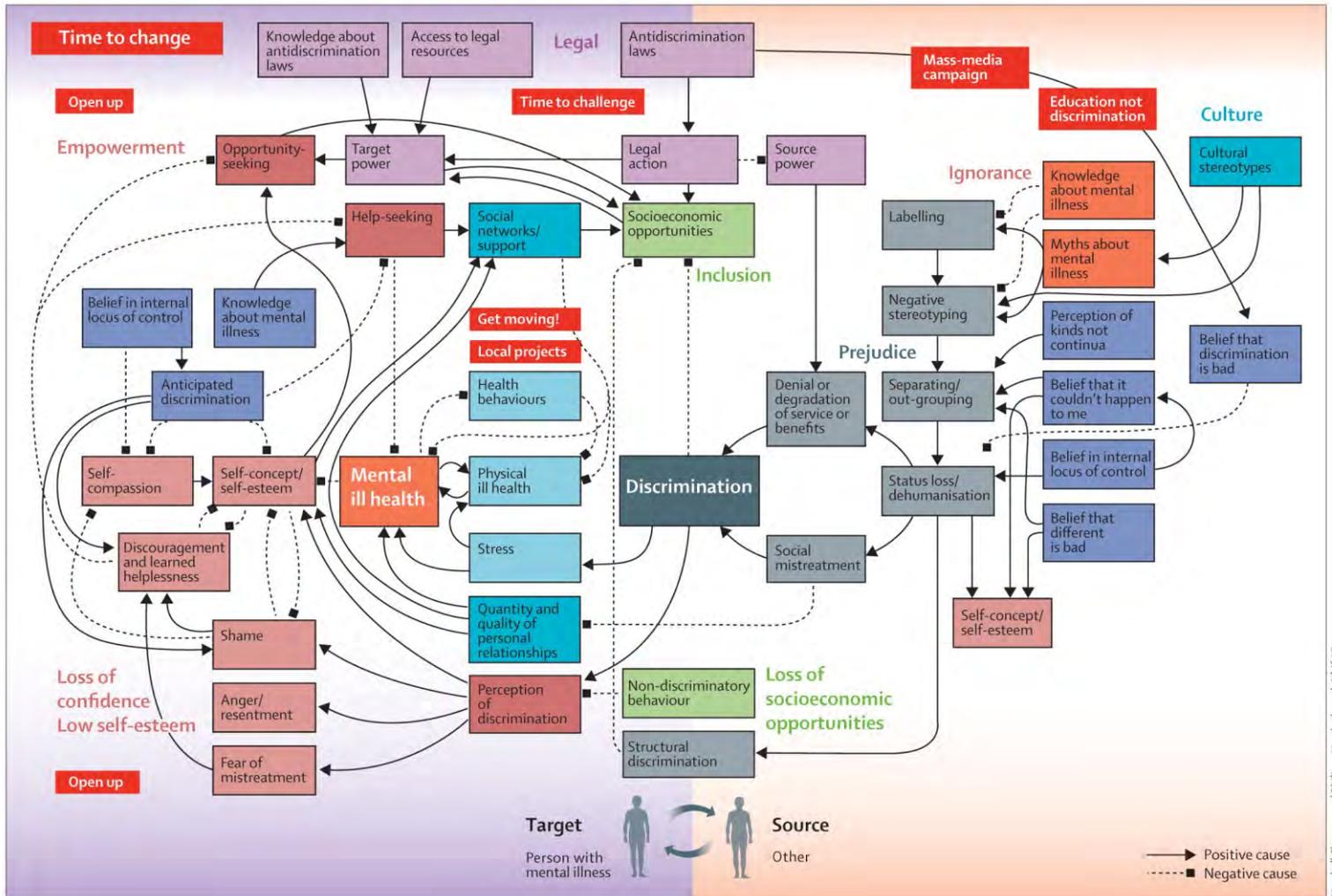
'In mediaeval times behavioural abnormalities were considered to be part of the divine plan for mankind; stigma in relation to mental illness was practically unknown. However, the

Reformation brought a splitting of the Christian world, a breakdown of values and a search for a scapegoat... Individuals displaying signs of behavioural abnormalities were now considered to be possessed by demonic spirits. The consequent 'witch mania' was the start of a relationship between stigma and mental illness,... a stigma which still exists today' (p.239).

The recognition of continuing discrimination and stigmatisation of individuals deemed to possess mental health difficulties was acknowledged by a 2-year initiative launched in 2009, entitled 'Time to Change', run by the charities Mental Health Media, MIND, and Rethink (Henderson and Thornicroft, 2009). The project sought to address negative perceptions of mental health by working at both national and local levels, incorporating mass-media advertising and public relations exercises, and maintains three key messages: 'mental illnesses are common and people with such disorders can lead meaningful lives; mental illness is our last taboo, such that the accompanying discrimination and exclusion can affect people in a way that many describe as worse than the illness itself; and we can all do something to help people with mental illness' (Henderson and Thornicroft, 2009, p.1928). The latter message, highlighting a shared responsibility to help and support the mental health of others, could be considered synonymous with current government documentation, stressing the expectations that it be everyone's concern (HMG and DH, 2011). The 'Time to Change' agenda highlighted a number of factors considered to contribute to stigma and discrimination with regard to mental health. These are shown in Diagram 2 below:

Diagram 2: Factors Associated with Stigma and Discrimination by the 'Time to Change'

Agenda



Reproduced from Henderson and Thornicroft (2009).

The above diagram highlights that factors contributing to stigma with regard to mental health include broader societal considerations, such as cultural factors, legal frameworks, socioeconomic issues, empowerment, and inclusion, as well as individual aspects, such as a lack of knowledge, belief systems, and prejudices. These elements interact with the individual aspects of a person with mental health difficulties, and factors such as self-

esteem, confidence, physical health, stress, and thought processes, resulting in subsequent ways of interacting with the world, such as learned helplessness, create a complex interplay.

Stigma associated with mental health difficulties is not confined to the individual in question; it can incorporate negative conceptualisations of people and aspects associated with the person with mental health difficulties. As noted by Sartorius (2007): 'Stigma does not stop at illness: it marks those who are ill, their families across generations, institutions that provide treatment, psychotropic drugs, and mental health workers' (p.810). This suggests that those responsible for supporting children's mental health difficulties, particularly those working at higher tiers, offering support within specialist settings, may need to be particularly mindful of the context in which they are delivering services, and potential barriers for engagement.

Language Use and Mental Health Conceptualisation

Another important factor with regard to the conceptualisation of mental health difficulties concerns language use, and its consequent impact upon how individuals construct explanations and meanings of children's needs. As noted by Rothí et al. (2005): 'Teachers tend to avoid using psychiatric language because of teaching tradition, and ethos and boundaries, and because it is perceived as stigmatising and harmful. Thus, teachers are generally more comfortable using language that is grounded in education, using terms such as 'emotional and behavioural difficulties' (p.18). By contrast, language use in health contexts may more commonly allude to mental health disorders (Belfer, 2008), and mental health treatment (Glisson, 2002 and Merikangas et al., 2010).

Organisational, Structural and Systemic Factors in Children's Support Services

As social, community and wider systemic factors have been highlighted as significant with regard to the conceptualisation of mental health difficulties, it could be considered appropriate to explore such issues with regard to the staff teams responsible for delivering mental health support to children. As noted by Dallender and Nolan (2002): 'How professionals perceive their work, and the environment in which it is undertaken, has received relatively little attention in the literature. Such perceptions may have more far-reaching effects than has hitherto been recognized' (p.131). Furthermore, the roles of individuals, and their relationships within a system, are recognised as important with regard to the overall functioning of an organisation (Munro and Hubbard, 2011). Consequently, individual attitudes and perceptions, group dynamics, working environment and culture, service structure, and organisational factors could all be considered pertinent when considering the delivery of children's mental health services.

However, certain concepts pertinent to this endeavour, such as 'working culture' have met with difficulties with regard to their precise meaning, as Solvason (2005) notes: 'The terms ethos, spirit, climate, ambience and culture are often used interchangeably, or without appropriate definition' (p.85). In an attempt to differentiate between such terms, he goes on to discriminate between culture and ethos, with a particular focus upon the school context, stating: 'Culture has solidity where ethos is more elusive. Culture is deeply embedded in the school's history: beliefs, values, choices made, traditions kept. The school ethos is the result of this; the ambience that is felt at a school as a result of its cultural history; past, present and ever changing' (p.86). Despite Solvason's attempts at accuracy of

terminology, the two terms continue to be utilised interchangeably in the literature, with some favouring 'ethos' (Weare, 2005, Brown et al., 2011), whilst others prefer 'culture' (Engels et al., 2008, Eilers and Camacho, 2007). Furthermore, Glover and Coleman (2005) suggest that the term implemented could indicate the nature of the study, with the suggestion that 'ethos', for example, indicates a more subjective quality to the research. Due to this lack of consensus, no particular term will be given precedence over the other when considering organisational or systemic factors in the workplace. Overall, within the context of this research, 'working culture', or the use of similar terms, pertains to the working environment within which a professional is located, and may include such factors as the physical building, protocols, colleagues, and the views, attitudes and ways of working in a given organisation.

The importance of working culture within the mental health domain has been highlighted with regard to service user satisfaction, and overall success of interventions (Rossberg et al., 2008). Despite its perceived importance, working culture is overall considered an under-researched area, as Branson (2008) notes: 'The quality of a person's work for the organisation is strongly influenced by the organisation's ideology, as experienced by its culture, yet insufficient research and organisational practice is devoted to this issue.' (p.377).

The importance of the working culture in which professionals find themselves could be considered paramount, due to the detrimental effect of such debilitating atmospheres. For instance, Rossberg et al. (2008) state: 'The stressful nature of a poor work environment has been associated with reduced job satisfaction, absenteeism, somatic complaints, burnout,

and depression among staff' (p.438). For professionals involved in supporting children's mental health, it could be considered of vital importance to feel emotionally able to meet another's needs, which may not be considered possible if environmental working factors have contributed to personal difficulties.

Furthermore, attention has been drawn to the benefits in examining systemic factors, with particular regard to children's behavioural presentation. It has been suggested, for instance, that settings are not culture-free, and the environment in which a child is located could be responsible for ensuing behaviours:

'Focusing on the setting rather than just on individuals...helps...identify ways in which the contexts in which the children and young people find themselves shape behaviour, for good or ill. It is important to realise that these contexts are not always benign, and that the adults who care for children may be, usually unwittingly, contributing to the very 'problems' they claim to be trying to address, for example through their own responses and behaviour'

(Weare, 2005, p121).

Despite the potential benefits for children's mental health afforded by an examination of systemic factors, there have been criticisms that limited consistent support has been provided at local and national levels in order to support services in organisational and strategic planning. For instance, Spratt et al. (2006) identified that: 'Local authorities had developed few specific policies for promoting good mental health, per se, but could point to policies on a range of related initiatives (e.g. anti-bullying, health promotion, inclusion and

behaviour support), the management of which was dispersed through various departments and between a variety of personnel' (p.16).

Organisational, Structural and Systemic Factors in Schools

The consideration of organisational factors in schools in the context of children's mental health is not a new concern, with research into classroom environment conducted many decades ago. For instance, Lippitt and Gold (1959) explored a child's social standing in the classroom, and subsequent correlates with mental health, discovering that social positions form quickly, with high stability over time. They noted that children with reduced coping strategies, particularly in the face of conflict, who demonstrated behavioural problems, or difficulties of a social or emotional nature, and generally considered to possess mental health difficulties, were the least liked, and afforded the least power or positive influence over peers. In conclusion, they surmised that classroom processes can perpetuate mental health problems, due to 'a continuing experience of social failure and rejection' (p.45).

Cultural factors within schools remain a matter of debate, particularly pertinent to children with mental health difficulties, and have associated connotations for behavioural presentation. As noted by Weare (2005), when considering the management of children's behaviour in schools: 'The ethos of an organisation is one of the most powerful determinants of the behaviour of those in it, and in particular the approach taken to dealing with difficult behaviour' (p121). Weare (2005) went on to note the benefits of examining organisational concerns in schools, stating: 'There is now a good deal of work on the kind of

positive, emotionally and socially healthy environments that help promote good behaviour and the growth of mental and emotional well-being' (p.122).

Perhaps one of the key challenges for schools in meeting the needs of children with mental health difficulties is the sometimes accompanying behavioural difficulties, which may impede a child's engagement in the learning process (Fergusson and Woodward, 2000, Brauner and Stephens, 2006). In an educational setting, behavioural difficulties are a particular concern, due to the impact this has on the learning environment, and subsequent achievement of both the individual and peers. As teachers have reported a lack of confidence with regard to distinguishing between mental health and behavioural difficulties (Rothí et al., 2005), there is the subsequent possibility that children with mental health problems could be managed in a manner detrimental to their needs. Indeed, Roeser and Midgley (1997) discovered that 68% of teachers felt burdened by children's mental health issues, despite 99% considering it part of their role to support such difficulties.

Furthermore, there remain various challenges with regard to addressing negative cultural issues in schools. Spratt et al. (2006) state: 'Existing school structures and cultures can be seen to create stress in a number of ways' (p.15), highlighting the pressures of exams, school work, and inflexible approaches. They also note that mental health initiatives in schools are frequently short-term, and delivered by outside agencies, resulting in the reduced potential for facilitating cultural change in schools with regard to how mental health is perceived and supported.

Organisational, Structural and Systemic Factors in Mental Health Services

Organisational factors within mental health teams are deemed of considerable importance with regard to ensuing consequences for service users. As noted by Glisson et al. (2008): 'The organizational social context in which mental health services are provided is believed to affect the adoption and implementation of evidence-based practices (EBPs) as well as the quality and outcomes of the services' (p.98). This suggests a direct causal link between organisational factors and outcomes for those receiving a mental health service.

Concerns have been raised with regard to working culture in mental health teams, with the common perception of a dominant 'expert' model of service delivery. As stated by Warne and Stark (2004): 'the prevailing mental health care culture remains steeped in a discourse of treatment and care, control and compliance and professional expertise' (p.654). However, this model may in actual fact be considered undesirable by individual practitioners, who might feel the pressure of obligation to provide conclusive answers to often complex problems. As Morant (2006) notes: '...much of practitioners' daily work... [may involve] attempts to implicitly manage ambiguity and uncertainty, and to reconcile this with public expectations of them as technical experts with definitive knowledge and problem-solving skills' (p.821). Indeed, Morant (2006) further added that uncertainty may form an integral feature of mental health services, due to 'the contested and multiple nature of mental health expertise' (p.821), which stands in stark contrast to a perceived 'expert' model of service delivery.

Research Design and Methodology

Chapter Overview

This chapter outlines the research design and methodology, beginning with a consideration of the epistemological and ontological positions within which the study is located. It then explains the rationale for the particular focus of the study, as well as chosen means of data collection, before exploring in detail practical elements of the research, such as the design, sample, and data gathering methods. Lastly, a consideration of ethical factors, and issues of reliability and validity are considered, culminating in an overall critique of the research design and implementation.

Epistemology and Ontology

The desire of humankind to attempt to make sense of the world in which we live has been acknowledged by Lincoln and Guba (1985) as a historical endeavour. The perspective adopted by a given individual in order to make such sense of the world is termed a 'paradigm', which is essentially 'systematic sets of beliefs, together with their accompanying methods' (Lincoln and Guba, 1985, p.15).

Epistemology is described as '...what is regarded as appropriate knowledge about the social world' (Bryman, 2008, p.4). A researcher's epistemological position of what constitutes knowledge has implications for the design of the study, as what is deemed knowledge will

determine what information is sought, and consequently influence the particular methods for obtaining it. Cohen et al. (2007) indicate that there are two antithetical paradigms which inform research within the domain of social sciences; one of these is positivism, which applies the laws of natural science to the study of the social world, considering it to exist as a directly observable, concrete entity, independent of human cognitions, and the other is interpretivism, which rejects the methods of natural sciences, as it posits that reality is represented according to an individual's construing. As noted by Cohen et al. (2007), positivist standpoints result in 'mathematical models and quantitative analysis' (p.10), as the social world is viewed as objectively measurable, whereas an interpretive paradigm may result in 'analysis of language and meaning' (p.10), as it is considered that the social world can only be understood from the perspective of the individual.

Positivist paradigms have been questioned with regard to applicability to the study of human behaviour, with Cohen et al. (2007) noting that 'the immense complexity of human nature and the elusive and intangible quality of social phenomena contrast strikingly with the order and regularity of the natural world' (p.11). As a result, this study is positioned with the interpretivist paradigm, which Cohen et al. (2007) note is subjectivist in nature, concerned with 'discovering how different people interpret the world in which they live' (p.10). As a result, methods congruent with the interpretivist perspective were adopted, with the focus upon exploring the discourse and meanings which professionals provide in relation to mental health, as opposed to attempting to identify universal truths or laws.

Ontology is concerned with the nature of social objects, particularly with regard to whether or not such entities have an external reality, or whether they are social constructs,

developed by the perceptions and actions of people (Bryman, 2008). These two antithetical ontological standpoints are defined as 'objectivism', which pertains to the former view that social entities exist with an external reality, compatible with a positivist epistemology, and 'subjectivism', which relates to the latter, and is deemed consistent with an interpretivist perspective (Cohen et al., 2007).

With regard to social research, the positivist paradigm has been criticised, as: '...it fails to take account of our unique ability to interpret our experiences and represent them to ourselves... In failing to recognize this, positivistic social science is said to ignore the profound differences between itself and the natural sciences' (Cohen et al., 2007, p.18). As a result, positivist approaches were considered largely undesirable, and a constructionist ontological perspective was deemed more helpful, viewing the concept of 'mental health' itself as a social construct. This ontological standpoint led me to consider professionals' individual meanings, as well as working cultures, as socially constructed, with the rules, characteristics, and manner of organisations socially created and negotiated, as a result of the values and perspectives held within a team (Branson, 2008). Interpretivist perspectives consider the researcher's accounts of the social world to also be constructions (Bryman, 2008), and as a result, I was aware that research findings were the product of interpretation. Giddens (1982) refers to this process of both researcher and participants engaged in the process of meaning-making as the 'double hermeneutic', which contrasts with the study of the natural world, which: 'has to do only with the theories and discourse of scientists, analysing an object world which does not answer back, and which does not construct and interpret the meanings of its activities' (Giddens, 1982, p.12).

Rationale of the Study

The literature review highlighted the importance and significant concerns with regard to supporting children's mental health. It made evident that a wide range of professionals are now considered responsible for identifying and supporting children's mental health difficulties. However, this widened responsibility does not seem to have been accompanied by appropriate training for all practitioners now involved within mental health, and some professional groups have expressed difficulties in correctly identifying and responding to difficulties. Various conceptualisations of mental health were evident within the literature, with differing terminology, seemingly as a result of one's professional group. The literature review highlighted how these differing conceptualisations may impact upon professional practice, dependent upon the perspective adopted. An exploration of different professional groups' perceptions of mental health was therefore deemed necessary, and an ensuing examination of how this may impact upon practice.

The current study aimed to build upon previous research, which frequently examined one professional group's perspectives in isolation. This research, by contrast, attempted to explore and contrast the perspectives of a range of professional groups. Additionally, there is a wealth of research exploring parents' and children's views of mental health, and some research into the perceptions of specific staff groups, such as teachers and Tier 3 specialist practitioners. However, the range of professionals now involved in identifying and supporting children's mental health are not comprehensively represented within the literature, particularly not those commonly responsible for providing direct support to often the most vulnerable pupils, such as teaching assistants and behaviour workers. As a result,

the inclusion of a range of staff responsible for delivering front-line services, across various tiers, was considered appropriate.

Research Aims

This research aimed to explore perceptions of a range of professional groups responsible to varying degrees for identifying and supporting children's mental health needs. The purpose of this was to explore how opinions differ across services, and how varying work cultures, conceptualisations, knowledge and understanding of mental health may impact upon the support provided to children. The overarching aim of this was to identify barriers and challenges in the delivery of a comprehensive CAMHS framework, and explore opportunities to improve the mental health services children receive across various tiers of intervention.

The researcher was particularly interested in exploring the views of professional groups relevant to the EP role. Tier 1 services, for example, were considered pertinent in that they are frequently a group with whom EPs may both liaise and help support, with regard to identifying and supporting children's mental health needs. Tier 2 services are the domain within which EPs are located within the comprehensive CAMHS framework, and were therefore particularly relevant to the study. Lastly, Tier 3 services are those with whom EPs may liaise, refer children to, or receive support and training from, with regard to a child's more complex mental health needs, and were therefore considered relevant to the study.

Research Questions

1. What are the ways in which professionals view children's mental health?
2. What are the perceived barriers in supporting children's mental health?
3. What are the skills and qualities considered necessary for staff to effectively support children's mental health difficulties?
4. How do staff see their role with regard to children's mental health promotion, identification and support?
5. What are professionals' views on working culture in relation to supporting children's mental health?

Rationale for Focus Groups

Barbour (2005) noted that there were various definitions of focus groups, which could lead to confusion, but overall surmised that any group discussion could be deemed a focus group, so long as the researcher is particularly mindful of, and attentive to, the interaction within the group. A focus group has been described by Powell and Single (1996) as: 'a group of individuals selected and assembled by researchers to...comment on, from personal experience, the topic that is the subject of the research... [using] guided, interactional discussion' (p.499). Freeman (2006) particularly focused on group processes within his

definition, describing them as: 'a particular form of group interview intended to exploit group dynamics' (p.491).

Although focus groups as a data collection strategy have been implemented since the 1920s (McLafferty, 2004), usage among psychologists and the social sciences did not become widespread until recent decades, with the suggestion that previously there were concerns regarding the use of such qualitative methods, not deemed compatible with the then dominant paradigm of positivism (Wilkinson, 1998). However, the challenge to this ideology has resulted in an increase in popularity, and their usage has been considered particularly appropriate for exploring issues regarding health and illness. As noted by Kitzinger (1995): 'Focus groups...are a popular method for assessing health education messages and examining public understandings of illness and of health behaviours. They are widely used to examine people's experiences of disease and of health services and are an effective technique for exploring the attitudes and needs of staff' (p.299). Additionally, Wilkinson (1998) notes: 'Focus groups are an ideal method for the study of people's own meanings of health and illness' (p.333). It was therefore considered appropriate to deploy focus groups for the purpose of exploring professionals' perceptions of mental health.

Employing focus groups allowed a larger range of participant views to be obtained than would have been afforded by alternative means, such as individual interviews. As Kidd and Parshall (2000) state: 'To some extent, the increased interest in and the use of focus groups are based on pragmatic issues of time and cost efficiency relative to individual interviews' (p.293). As the primary purpose of the research was to explore different staff groups' perceptions of issues related to children's mental health, interviewing only several people

from each group was not considered sufficiently representative, and to interview large numbers would have been time-consuming and impractical. As noted by Fossey et al. (2002): 'one team member's account would be insufficient if a study's aim were to understand and describe the practices of a...team' (p.726). Additionally, a focus group discussion has been suggested to elicit more candid data, with Powell et al. (1996) noting: 'opinions are more likely to be aired frankly and critically ...in a supportive group setting that is conducive to open discussion than they would otherwise in a one-to-one interview' (p.196).

Furthermore, the interactive nature of the focus group process allows for themes to emerge from participants, which may not have been thought of by the individual. As Kitzinger (1995) notes: 'The idea behind the focus group method is that group processes can help people to explore and clarify their views in ways that would be less easily accessible in a one to one interview' (p.299). Morgan (1996) also notes that focus group interaction: 'offers valuable data on the extent of consensus and diversity among the participants' (p.139). This highlights that a range of professionals' perceptions within a particular group can be explored, which may only otherwise be possible upon conducting numerous, time and labour-intensive individual interviews.

Focus Group Design

This study implemented a multiple-category design, with a series of focus groups conducted sequentially, each containing a different professional staff group. The purpose of this was to enable comparisons to be made across professional groups, as the fundamental purpose

of the research was to examine varying perceptions and viewpoints with regard to children's mental health. As Krueger and Casey (2009) note: 'If you want to be able to compare and contrast how certain types of people talk about an issue, you must separate these people into different groups' (p.21).

Ideally, focus groups need to be conducted exhaustively for each particular category of participant, to allow all relevant themes to emerge. As Fossey et al. (2002) state: 'sampling in qualitative research continues until themes emerging from the research are fully developed... In other words, patterns are recurring or no new information emerges; a situation sometimes referred to as 'saturation'' (p.726). However, in the case of this research, this was not possible, for several reasons. Due to the range of professional groups incorporated, it would not have been feasible within the time constraints of the research to conduct multiple groups for each category of participant. Additionally, the numbers of participants available for selection within a given professional group in the target local authority did not exceed numbers sufficient to allow multiple groups to be conducted. This meant such groups were, however, considered to be largely representative of a given professional team as a result.

Question Construction

In order to ensure all participants share their views and there is a balanced ratio in terms of contributions, it is advised that an introductory ice-breaker question is initially asked, which invites all to participate. As noted by Krueger and Casey (2009): 'The longer it is before someone says something in a group, the less likely he or she is to say something' (p.39). As

a result, an opening question, which asked participants to comment on the element of their work they enjoyed the most, was initially asked.

Krueger and Casey (2009) propose that focus group questions need to be short, clear, simple, open-ended, and free from jargon, or confusing terminology, which may inadvertently confuse participants, and inhibit them from engaging in conversation. As a result, all of the questions were short in length, and utilised clear, every-day language, to attempt to ensure it was accessible to all participants. Careful attention was paid to each question, to ensure that it was one-dimensional in nature, and could not be misinterpreted. Two-part questions were also avoided, to remove any ensuing confusion that could be afforded. Additionally, due to the suggestion that participants can feel confronted and defensive when presented with 'why' questions (Krueger and Casey, 2009), these were avoided, with all questions containing 'what' or 'how' instead.

Particular attention was paid to ensuring questions were free from negative wording; for instance asking participants to consider how instances could be improved, as opposed to examining undesirable elements per se. The purpose of this was to counter possible negative bias effects, which indicate that people have a tendency to focus upon undesirable, as opposed to positive, phenomena (Baumeister et al., 2001).

Krueger and Casey (2009) also note the importance of closing questions, which allow the participant the opportunity to reflect on whether there were any aspects of the topic which were not sufficiently explored. As a result, several closing questions were included (see Appendix 4 for the questioning schedule).

Sample

The particular sample of participants reflected the composition of local authority teams, to ensure research findings were relevant and appropriate, and that resulting recommendations were practicable within this context. As the local authority in question provided support to schools, children, and families via multi-agency clusters, comprised of a range of practitioners operating at the Tier 2 level of intervention, their inclusion within the study was considered of paramount importance.

As a result, the professional groups within the multi-agency teams considered to play the most active roles in identifying and supporting children's mental health were approached for participation. These groups included parenting support advisors (PSAs), behaviour workers, and assistant educational psychologists (AEPs). The rationale for selecting AEPs as opposed to qualified EPs was that the activities in which AEPs were commonly involved in the local authority commonly incorporated a particular focus upon mental health work, often resulting in more intensive casework opportunities than were permitted within the time demands of the EP role.

As Tier 1 services were also considered important for the purpose of the research, a target primary school was initially approached, which was considered representative of the geographical area. The school accepted the opportunity to participate. However, if it had not been willing to participate, other schools considered representative of the area would have individually been approached, until a willing school was located. Similarly to the AEP group, in order to include staff members involved in directly supporting children's mental

health, teaching assistants were considered appropriate. As previously noted by Groom and Rose (2005): 'A growing number of TAs [teaching assistants] are deployed to work specifically with pupils with social, emotional and behavioural problems' (p.20), which indicates that their inclusion is particularly appropriate. Also, TAs appear under-represented within the literature, with teaching staff more frequently prominent with regard to supporting children's mental health and emotional well-being.

A further Tier 1 service, that of a social work team, were also approached for inclusion within the study. The rationale for this was that practitioners were frequently involved in supporting some of the most vulnerable children and families, a number of whom potentially experienced mental health difficulties. However, due to work commitments and time pressures, the service dropped out of the study at a late stage, and it was therefore not possible to substitute the group with other professionals.

In order to include a Tier 3 team within the research, the local authority CAMHS team was approached for inclusion. Their acceptance was welcomed, for as noted by Morant (2006): 'mental health professionals... play a vital social role in translating policy directives into practical work with laypeople, yet their representations are relatively under-researched' (p.817).

It was initially hoped that each focus group would comprise a homogeneous professional team, in order to explore staff perceptions across practitioner roles. As noted by Kitinger (1995): 'Most researchers recommend aiming for homogeneity within each group in order to capitalise on people's shared experiences' (p.300). However, due to the characteristics of

certain professional groups, there were some complicating factors, and this was not always possible. As noted by Edwards et al. (2008), there is a 'varied composition of professional disciplines within specialist CAMHS' (p.26). As a result, the CAMHS focus group necessarily comprised staff from different professional groups, due to insufficient numbers of staff from each group, and willing participants spanning disciplines. Additionally, during an initial meeting offered to the team to outline the purpose and methods of the research, staff felt that a heterogeneous group may afford a more accurate range of views. Furthermore, as all staff worked to support children's mental health needs at the Tier 3 level of intervention, they could be considered to share similar occupational features.

The most pressing concern with regard to heterogeneity within focus groups pertains to hierarchy. As noted by Kitzinger (1995): 'it is important to be aware of how hierarchy within the group may affect the data (a nursing auxiliary, for example, is likely to be inhibited by the presence of a consultant from the same hospital)' (p.300). To compensate for this factor, all participants were asked to ensure that there were no managers or people with direct supervisory roles for others within the group.

Participants were recruited by an initial telephone call and email contact with their service manager. Upon confirmation that the manager was willing for staff to participate, participant information documents were emailed for distribution within teams, to explore potential interest of staff members. This was followed up with the offer of an informal discussion about the purpose and methods of the research at a time convenient to services, typically at the end of a team meeting. This occurred for two of the five services, including the CAMHS and school staff teams, with others opting instead for the opportunity for an

informal telephone conversation or email exchange. Details were then provided to interested participants via email, detailing times, dates, and procedures for the focus groups.

Rabiee (2004) states that participants in focus group research are: 'selected on the criteria that they would have something to say on the topic, are within the age-range, have similar socio-characteristics and would be comfortable talking to the interviewer and each other' (p.655). As a result, it was considered helpful for participants to know one another; so consequently, purposive sampling was used to identify participants. As focus groups aim to explore and understand people's perceptions, as opposed to ascertain generalisations, random sampling is not necessarily particularly appropriate. As noted by Krueger and Casey (2009): '...the intent of focus groups is not to infer but to understand, not to generalize...but to provide insights about how people in the groups perceive a situation' (p.66).

One of the benefits of purposive sampling was that groups of colleagues who knew each other, and were comfortable in each other's company, could be approached for participation. This is a crucial factor, and can ensure smooth running of the group, and rich data. As noted by Bender and Ewbank (1994): 'When participants know one another, they will usually prod one another to tell their own stories: in one sense, the prodders become the assistants to the facilitator' (p.66). McLafferty (2004) noted that: 'groups made up of strangers required more moderator intervention' (p.187), which is not always helpful, as Bender and Ewbank (1994) note: 'caution must be exercised lest the too-involved facilitator obtain results that reflect the facilitator's own interests rather than those of the participants' (p.67-68). As a result, it was considered useful to approach groups of

individuals who all worked together, and knew one another; for instance, one school was approached for inclusion in the research to participate on its own, as opposed to several settings, which would have resulted in a focus group comprised of staff from multiple schools. The negative impact of this was that representative views of different schools, such as primary and secondary settings, were not possible. However, the positive impact was that all participants appeared to interact well, and the practical difficulties in organising a focus group around the timetables of a number of different schools were circumnavigated.

Research suggests that focus groups should consist of between 3 and 14 participants (Bloor et al., 2001). However, it is recommended that for non-commercial groups, 5-8 participants is the ideal, as larger groups may limit people's opportunities to share ideas and insights (Krueger and Casey (2009). The overall aim is to ensure that groups are small enough for all participants to be able to fully contribute, but large enough to provide a comprehensive range of views. Additionally, the nature of the research questions may impact upon preferred group size. As noted by Bender and Ewbank (1994): 'Generally, the more narrowly defined the research question is, the more effective will be fewer, rather than more, respondents' (p.65). As the research questions could be considered rather specific in nature, a small sample size was not deemed detrimental to the study. Additionally, McLafferty (2004) noted the benefits of reduced participant numbers, stating: 'smaller groups were more manageable' (p.187), with Rabiee (2004) adding: 'smaller groups show greater potential' (p.656). Numbers and professional roles of participants for each participating group are shown in the tables below:

Table 3: Participating Staff Teams

Team	Number of Participants
CAMHS	4
School	4
Behaviour Support	5
Educational Psychology	3
Parent Support Advisors	3

Table 4: Group Composition

Team	Participants
CAMHS	3 clinical psychologists, 1 counselling psychologist
School	4 teaching assistants
Behaviour Support	5 behaviour support workers
Educational Psychology	3 assistant educational psychologists
Parent Support Advisors	4 parent support advisors

Pilot Group

A pilot focus group was conducted with PSAs, to practice the questioning schedule and coding procedure. As Barbour (2005) notes: 'time spent developing and piloting a topic guide should pay dividends' (p.747). However, participants were asked prior to the running of the group if they wished data to be included within the overall results of the study, if no subsequent changes were made, such as a revision of the questioning schedule. All three participants who took part were happy for this to take place, and signed a consent form of agreement. As no alterations were made in terms of either procedure or questioning, it was therefore considered appropriate to include the data.

Another crucial purpose of a pilot group is to ensure that questions are understood (Krueger and Casey, 2009). Therefore, the only difference between the pilot group and subsequent focus groups was that more time was allowed for the de-brief session with the former, to determine if participants felt the questioning schedule was accessible. Questions were considered to be understandable and succinct, and as a result, no changes were made.

Facilitating the Focus Groups

I ran each focus group personally, with the support of a research assistant, who was recruited from a multi-agency team within the local authority. As noted by McLafferty (2004) 'it is useful for the moderator to be directly involved in the project because they will be sensitive to the issues and the need for methodological rigour' (p.190). The use of a research assistant was for ethical purposes, (see 'Ethical Considerations' below). However, it is widely reported within the literature that a research assistant is a helpful addition in the running of focus groups (Bender and Ewbank, 1994, Krueger and Casey, 2009, Sim, 1998).

Groups lasted for approximately one hour, dependent upon participants' time availability, and the flow of conversation. Additional time of approximately 15-30 minutes was incorporated into each session, outside of the formal discussion, to allow light refreshments provided to be enjoyed, and to help put participants at ease. As noted by Powell and Single (1996): 'Researchers should provide participants with an opportunity to meet before the formal discussion begins. One way to do this is to set aside time for informal conversation at the beginning of the meeting and provide light refreshments for participants' (p.501).

Following each focus group, a short debriefing session was undertaken with the research assistant. This is considered a useful activity, allowing an exploration of elements which went well and factors which did not, and discuss factors which may affect analysis, such as group dynamics (Kidd and Parshall, 2000). However, the assistant researcher noted that due to the time-consuming nature of maintaining a running record, it was difficult to additionally attend to group dynamics, or emerging themes.

Participants were offered a choice of venue for the running of the groups, one of which was their place of work, to minimise disruptions to their working day, or inconvenience. As participants from some teams were co-located, an alternative venue was offered as near as possible to all participants, which was utilised for 3 out of 5 groups.

Ethical Considerations

Ethical considerations pertinent to the study were examined prior to completing the research, utilising the University of Birmingham's Ethical Review protocol, which was compiled in consultation with the British Educational Research Association's Ethical Guidelines for Educational Research (BERA, 2011) document. This document stipulates that participant consent must be informed and voluntary, and that openness and disclosure be paramount.

The document also draws attention to participants' rights to withdraw from the study. This was an area which required careful consideration, as the need for participant anonymity, coupled with the ability to identify participant data should they wish to withdraw, needed to

be addressed. Utilising video recording equipment was considered inappropriate, as Krueger and Casey (2009) note: 'video...intimidates some participants' (p.96). Consequently, I deployed a research assistant, who coded each participant at the beginning of the session, and drew an accompanying seating plan to aid with recall. The assistant then maintained a running record of each group, by writing the first few words spoken by a participant, alongside their code. In this way, participants could be matched to their comments, and removed from the study, as appropriate. An information sheet, stored safely, recorded participant names alongside their codes, in order to identify them, should they wish to withdraw from the study at a later date. This is a technique suggested by Krueger and Casey (2009).

At the beginning of each session, participants were provided with the opportunity to read through research information sheets, and asked to sign their formal consent. (See Appendix 1 for the participant information sheet, and Appendix 2 for the consent sheet). In accordance with ethical guidelines (BERA, 2011), participants were at this time given the opportunity to elect whether or not they wished for an individual research briefing document upon completion of the study.

Data Analysis

Data were collected via audio recording, and transferred electronically to a computer software package, which assists in transcription by allowing the rate of speech to be manually adjusted. I personally transcribed the data verbatim, due to research findings indicating that this was most beneficial. For instance, Bozic et al. (1998) note the

importance of transcribing your own data, stating: 'Despite the time consuming nature of transcription it is important not to see it as an activity which can be left to secretaries and other assistants. The act of transcribing recordings makes one listen very carefully to what is actually being said' (p.67). This process, accompanied by repeated re-reading of resulting transcriptions, enabled my emersion in the data.

Upon analysing data, it is important to consider the epistemological and ontological foundations of the study. For instance, Rabiee (2004) notes: 'The process of qualitative analysis aims to bring meaning to a situation rather than the search for truth focused on by quantitative research' (p.657). As a result, a search for themes, as opposed to uncovering perceived underlying truths or laws was paramount. Consequently, the data were analysed using thematic analysis.

Although other means of data analysis were considered, none were deemed as appropriate, for various reasons. For instance, Interpretive Phenomenological Analysis (IPA) was discarded, due to its particular focus on small sample sizes, case-by-case style of analysis, and desire for homogeneous samples (Smith and Osborn, 2008). As the researcher was interested in exploring the views of a range of professionals, with a view to exploring children's mental health provision across contexts, IPA was not considered appropriate, as staffing groups were inherently disparate to some extent. Additionally, an approach such as grounded theory was considered inappropriate due to its requirement for exhaustive data collection to the point of saturation (Cohen et al., 2007), which as previously stated, was not possible. Theory generation was also not considered essential or desirable to the research in question.

Thematic analysis was deemed a useful, flexible tool, appropriate for the analysis of qualitative data. Furthermore, it is a technique deemed 'independent of theory and epistemology...[and] compatible with both essentialist and constructionist paradigms...' (Braun and Clarke, 2006, p.5). As the focus of this research was constructionist in nature, concerned with how individuals develop and create their own knowledge and understanding, it was considered an appropriate tool to assist with identifying themes and patterns in the data with regard to how individuals construed the topic of mental health.

When examining the data, attention was given to the overall purpose of the study, and the types of information sought from the focus groups. As the study was exploratory in nature, it was considered detrimental to impose a pre-existing framework, or coding system, on the data, which could result in attempts to fit data into themes which did not naturally occur. As a result, inductive analysis was conducted, with codes arising out of the data. It is, however, worth noting that the particular questions asked inevitably impacted upon data acquired.

Researchers have been warned of the dangers of the flexibility thematic analysis affords, and to safeguarded against an 'anything goes' approach (Braun and Clarke, 2006). The data were therefore analysed using 'thematic networks' (Attride-Stirling, 2001), which are described as 'a robust and highly sensitive tool for the systematization and presentation of qualitative analyses' (Attride-Stirling, 2001, p.385). Concerns have been raised with regard to the availability of adequate tools to analyse qualitative data (Braun and Clarke, 2006,

Attride-Stirling, 2001), and as a result, the implementation of a robust framework could be considered to add rigour to the process.

Reliability and Validity

Bryman (2008) describes validity as 'concerned with the integrity of the conclusions that are generated from a piece of research' (p.32), and reliability as 'concerned with issues of consistency of measures' (p.149). Qualitative research has been criticised for not conforming to the scientific rigour of other, more positivist approaches, with little adherence to the concepts of reliability and validity (Barbour, 2001), and arguably idiosyncratic analysis techniques (Reed and Payton, 1997). However, a fundamental issue here pertains to the fact that these concepts could not be considered compatible with qualitative research, which is concerned not with measurement, but interpretation, of the social environment. As noted by Denzin and Lincoln (eds., 2011): '*the social world is an interpreted world, not a literal world, always under symbolic construction*' (p.585). Indeed, the concepts of validity and reliability within qualitative research have been somewhat rejected, with Freeman (2006) stating: 'It is widely recognized that the direct application of quantitative concepts of rigour, such as objectivity, validity and reliability, is inappropriate in qualitative research' (p.492).

Furthermore, such concepts are incompatible with constructionist principles, the foundations of this research. As Freeman (2006) goes on to add: '...qualitative researchers informed by a constructionist epistemology reject the assumption of a single reality, available to all and revealed through the 'correct' application of method. In contrast,

knowledge is characterized as provisional and context dependent, and consequently the re-formulation of criteria such as objectivity and reliability is rejected, in favour of strategies such as reflexivity or articulation of researcher perspective' (p.492,). Indeed, social constructionist perspectives would argue that such positivist principles pay little attention to contextual factors, and therefore lack ecological validity.

Ecological validity is described as 'concerned with the question of whether social scientific findings are applicable to people's everyday, natural social settings' (Bryman, 2008, p.32). As a result, it could be considered a branch of validity deemed somewhat applicable to qualitative research. However, there are particular challenges in achieving this, as noted by Cohen et al. (2007):

'For ecological validity to be demonstrated it is important to include and address in the research as many characteristics in, and factors of, a given situation as possible. The difficulty for this is that the more characteristics are included and described, the more difficult it is to abide by central ethical tenets of much research- non-traceability, anonymity and non-identifiability' (p.138-9).

Nevertheless, the research in question could be considered to some extent ecologically valid, due to the fact that the findings could be deemed applicable to relevant professionals' working lives and contexts. However, due to the adherence to ethical guidelines, it was not possible to include a rich description of the contextual situations of participants.

An alternative perspective of reliability and validity in the context of qualitative research is offered by Guba and Lincoln (1994), who propose different criteria for assessing the worth of a qualitative study, namely 'trustworthiness' and 'authenticity'. The former is divided into four sub-sections; 'credibility', replacing internal validity; 'transferability', replacing external validity; 'dependability', replacing reliability; and 'confirmability', replacing objectivity, constructs which are widely accepted within qualitative research (Shenton, 2004). Of all factors, 'credibility' is considered particularly important in establishing trustworthiness (Lincoln and Guba, 1994). Shenton (2004) provided steps which could be taken to ensure credibility, including 'the development of an early familiarity with the culture of participating organisations' (p.65). This could be said to have been achieved, as I conducted the research with staffing teams located within the same local authority within which I worked, affording relevant knowledge of contextual factors. Additionally, the act of triangulation is frequently highlighted within the literature (Shenton, 2004, Reed and Payton, 1997, Freeman et al., 2007). Attempts were made to address this by including a range of professionals from different working contexts within the study. As stated by Shenton (2004): 'Where similar results emerge at different sites, findings may have greater credibility in the eyes of the reader. The sampling of a range of people in different organisations may be employed...' (p.66).

With regard to the latter criteria of 'authenticity', Lincoln and Guba (1994) refer to 'educative authenticity', which is concerned with assisting participants in better understanding the perspectives of others. This could have been said to have been achieved by providing written feedback to participants upon completion of the research, detailing the perceptions and constructions of other groups. Lincoln and Guba (1994) also allude to

'catalytic authenticity', which is concerned with providing participants with the motivation to engage in action to bring about change. This could have been said to have occurred at a strategic level, as recommendations as a result of research findings could be said to have implications for ensuing action.

Critique

Although focus groups were considered the most appropriate means of data collection, the process is not without its disadvantages. Bryman (2008) noted potential difficulties associated with group effects, such as variability in contributions, with more reticent members perhaps opting to say less, and more vocal participants talking for greater lengths of time, overall affecting the data collected. Additionally, participants can talk over one another, and speak at varying pitches, making accurate transcription problematic. Cohen et al. (2007) added to issues surrounding group dynamics, stating that disagreements and conflicts can also arise amongst participants. Although this did not seemingly occur, there were occasions where some participants contributed more than others, requiring gentle prompting, and encouragement for all to become involved in discussions.

Fundamental criticisms of focus groups as a means of data collection have been levied, with Sim (1998) stating: 'It is difficult, and probably misguided, to attempt to infer an attitudinal consensus from focus group data',... inferences may be drawn as to the presence or absence of certain views or issues across groups, but not in terms of their relative strength [and]... both methodological and epistemological objections can be raised against attempts to generalize from focus group data' (p.345). This criticism highlights the limitations of focus

group research with regard to the applicability of findings across contexts. Whilst this could be considered a limitation, it was not the purpose of this research to produce generalisable findings, as the epistemological location of the study considered knowledge as context-bound, personally constructed, and inseparable from situational and environmental factors.

It has been acknowledged that regardless of criticisms faced by qualitative means of data collection, no method is free from researcher bias. Rabiee (2004) purports that all research possesses some level of subjectivity, stating: 'It is important to acknowledge that regardless of the type of research (qualitative or quantitative) an extent of subjectivity exists. The distinction should be seen more in relation to the stage of the process rather than just the type of subjectivity. For example, the issue of subjectivity in surveys is often at the stage of designing the questionnaire' (p.657).

Aside from criticisms of focus groups per se, a factor associated with the credibility of the study pertains to the single method of data collection. For instance, it has been suggested that to assist with credibility (internal validity), triangulation is recommended (Cohen et al., 2007). Utilising several methods of collecting data could arguably be said to result in enhanced validity of findings. However, mixed-methods approaches have met with criticism too, with Barbour (2001) stating: '...triangulation is difficult to perform properly: data collected using different methods come in different forms and defy direct comparison' (p.1117).

Furthermore, it is important to acknowledge that one of the purposes for the selection of focus groups as a means of data collection was to access a larger sample size than afforded

by other, more labour-intensive means, such as individual interviews. However, the overall sample size of 19 could be considered somewhat small, and slightly larger numbers of participants may have added greater dependability to the results. This, though, was not always possible, as overall staffing teams varied in size, some consisting of only 5 in number, and this, coupled with the inevitably voluntary nature of participation, could have been said to have resulted in such small numbers. However, due to the small staffing sizes of some teams, overall participant representation was high, and findings could therefore be considered somewhat representative.

RESULTS, ANALYSIS AND DISCUSSION

Chapter Overview

This chapter explores the findings in relation to the research questions, as well as discussing other areas of interest which emerged from the data. It begins with a consideration of paradigmatic factors, as these are fundamental in shaping the overall design of the study, and therefore have implications for what is considered data, and how it is collected. Following this, an explanation of the means of analysis is provided, including the coding and organisation of data, and a diagrammatic representation of a thematic network. Themes are then depicted in a series of tables, which allow for a representation of each group's responses to be incorporated. Themes are explored individually, with text immediately following each table, to facilitate continuity for the reader.

Paradigmatic Considerations

This chapter seeks to interpret the research findings, and consider subsequent implications. In doing so, it is important to consider researcher perspective, which is inextricably linked to research methods, elicited findings, and subsequent interpretation of results. In conducting qualitative research, the challenges faced by the researcher have been highlighted by Braun and Clarke (2006) who speak of 'the dual position that analysts need to take: as both cultural *members* and cultural *commentators*' (p.24).

Indeed, this research was located within the constructionist paradigm, which is concerned with how individuals create meaning, and shape their view of the world, according to the perspectives they adopt. As a result, findings were not concerned with uncovering definitive truths, or establishing 'realities', as the researcher considers that reality is itself shaped in accordance with one's individual constructions, and is therefore personal in nature. Within this paradigm, the researcher is also considered to possess their own constructions of the world, and as a result, can become enmeshed in the double hermeneutic of interpreting others' perspectives, through the lens of their own individually constructed realities. However, it is important to note that no research is infallible from subjectivity (Rabiee, 2004), and acknowledging potential limitations as a result of paradigmatic factors could be considered an integral part of research.

There were key advantages in adopting the constructionist paradigm to explore the research areas in question. For instance, it allowed real-life factors, such as individual perspectives and constructions, which arguably inevitably impact upon practice, to be explored. Within the context of this research, understanding how people construe an issue, in accordance with their own perspectives of the world, facilitated greater awareness of how these factors can impact upon their ability to support children's mental health. As noted by Hayden (2007), one's professional 'lens' through which an issue is construed has implications for subsequent approaches adopted, and interventions provided.

Analysis

The results were analysed using thematic networks, a tool for assisting with the organisation of qualitative data, described by Attride-Stirling (2001). As previously noted, the implementation of a framework to assist with data analysis was considered helpful to add rigour to the process. Braun and Clark (2006) state: 'One of the criticisms of qualitative research from those outside the field is the perception that "anything goes"' (p.26). Thematic networks were considered a useful tool, as the analytic stages are outlined clearly and concisely, and additionally comprise a visual framework for representing the data, which was deemed helpful in ensuring accessibility of the findings. The framework incorporates three levels of analysis:

Stage 1: Coding

The primary purpose of this stage is to reduce the data down into 'manageable and meaningful text segments' (Attride-Stirling, 2001, p.390), as part of the coding process. The act of coding in qualitative research is considered the typical start point (Bryman, 2008), requiring both 'great rigour and attention to detail' (Attride-Stirling, 2001, p.391). The importance of applying a systematic approach to this process is emphasised by Krueger and Casey (2009), and can attempt to nullify criticisms regarding the rigour and quality of qualitative means of data analysis.

As a result, a consistent, rigorous approach was adopted across all transcribed data. Analysis began with each transcription examined individually, after numerous re-readings of

the text to assist with immersion in the data. Each section of text was given a number and letter code, in order to delineate location within the transcript, and the professional group to which it belonged respectively, to assist with identification and transparency of process, as a lack of transparency regarding how qualitative researchers arrive at findings has been raised by Bryman (2008). (See Appendix 7 for a demonstration of the coding process). Very few data were not included within the data analysis, with only text which was fragmentary in nature, or considered a linguistic filler, such as 'mmm', or 'yeah', not considered to add to the data, and therefore discounted.

Sections of text, ranging from single word level, to passages akin to small paragraphs, were individually coded, according to the perceived topic of each item. The size of each text segment was not considered relevant, and as much of the surrounding text as was considered necessary to convey meaning and context was included. As noted by Bryman (2008): 'By plucking chunks of text out of the context within which they appeared... the social setting can be lost' (p.553).

Text segments were subsequently grouped according to emerging topics. As the process was inductive in nature, codes emerged as a result of the data. However, careful attention was given to ensure that each code was discrete, as: 'The codes in the coding framework should have quite explicit boundaries (definitions), so that they are not interchangeable or redundant' (Attride-Stirling, 2001, p.391). As a result, the process was not entirely linear, and resulted in on-going revision and refining of codes, prior to embarking upon the next stage of analysis.

It is also important to note that text segments at the coding stage were sometimes multiply coded, as deemed appropriate, as some items were considered to pertain to several themes. This is considered appropriate, and indeed required at times, as Attride-Stirling (2001) notes: ‘a given quotation could be classified under more than one code’ (p.394). Braun and Clarke (2006) also state: ‘you can code individual extracts of data in as many different “themes” as they fit into’ (p.19).

Examples of multiply coded items are shown below:

Table 5: Example of a Multiply Coded Text Segment Within a Global Theme

Global Theme	Organising Theme	Basic Theme	Text Segment
conceptualisations of mental health	changes in mental health	mental health as a continuum	No, what I’m saying is, you know the autistic spectrum is from like here to here isn’t it, and I’m guessing that mental health is from here to here, because you’ve got like a big range.
	breadth of mental health	range of mental health difficulties	

Table 6: Example of a Multiply Coded Text Segment Across Global Themes

Global Theme	Organising Theme	Basic Theme	Text Segment
barriers to supporting children’s mental health difficulties	practitioners’ perceived inability to support and identify difficulties	perception of mental health as a specialist area	I mean that’s where we need to work with other agencies, isn’t it, because if it is mental health, you know, more medical, that sort of goes out of our sort of role.
facilitative factors for supporting children’s mental health	multi-agency factors	joint working	
practitioner skills, knowledge and experience for supporting children’s mental health	intrapersonal skills	awareness of own skill boundaries/ limitations	

Stage 2: Organising Themes

At this stage of analysis, codes are sorted into clusters of related topics. Text segments were re-read in conjunction with other segments placed within the same code, as advised by Attride-Stirling (2001). Doing so allowed themes to emerge in a bottom-up manner. Following this initial process, themes were refined in order to ensure the balance between discrete categories, yet sufficient breadth, to facilitate the inclusion of a number of text segments relevant to each topic. Attride-Stirling (2001) advises: 'each theme has to be specific enough to pertain to one idea, but broad enough to find incarnations in various different text segments' (p.392).

This process results in a more manageable data set. It is a time-consuming process, requiring a considerable amount of interpretation by the researcher. As Braun and Clarke (2006) note: 'The researcher needs to make sure that their interpretations and analytic points are consistent with the data extracts' (p.25-6). This process therefore required extensive reading and re-reading of text segments to ensure themes 'held together', and appropriately reflected the data. However, it is important to note that researcher interpretation is an integral part of qualitative analysis, and as such, will impact upon subsequent findings.

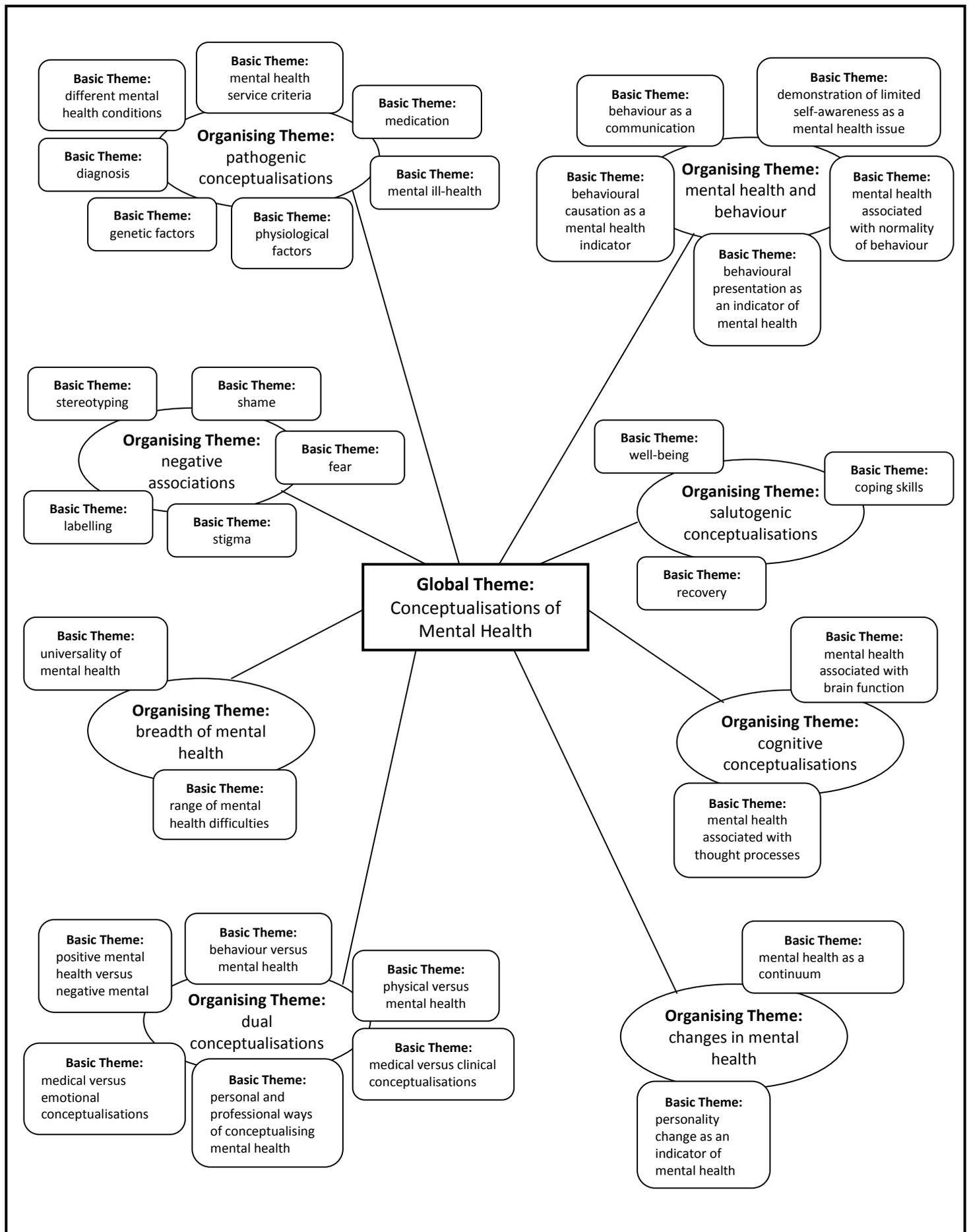
Stage 3: Global Themes

The final stage of the process involves arranging the organising themes into groups, according to topic. The super-ordinate global themes are therefore consequently comprised

of a set of related sub-themes (organising themes), with associated subordinate (coded) themes within them. Attride-Stirling (2001) suggests that fewer than 4 themes, or numbers in excess of 15 may be inappropriate, due to too small an amount to give credit to the data, and too large a number to prove manageable respectively. The completed analysis revealed that 6 global themes emerged from the data, therefore within recommended guidelines. At this point, the initial coded segments of text become known as 'basic themes', which are clustered around organising themes, which are subsequently grouped around a particular global theme.

Following completion of global theme development, a comparable process to that which occurred upon analysing organising themes occurred, whereby all themes were examined, to ensure they reflected the data, and were clear and distinct. An example of a completed thematic network is provided in the diagram below, representing one of the 6 global themes from the data set:

Diagram 3: Thematic Network



Post-Analysis Considerations

Upon completion of analysis, data were not given weightings, or considered hierarchically in accordance with frequency, as this is not in keeping with qualitative analysis. The relevance or importance of an item of qualitative data is not dependent upon its frequency. As noted by Braun and Clark (2006): 'more instances do not *necessarily* mean the theme itself is more crucial' (p.10). Indeed, topics discussed on single occasions were included. Although total numbers of text segments pertaining to each code are provided, this is for the possible interest of the reader, rather than a means of quantifying perceived importance of a given theme over another.

Findings

Shown below are tables encompassing all themes derived from the data set. The key indicates which professional groups are represented by the letters A-E. 'Total' refers to the total number of responses for each basic theme, and could include multiple references by the same participant, as opposed to the total number of participants who referred to the item. An exploration and interpretation of the findings follows each table.

Table 7: Key of Professional Groups

Professional Group Key	Group A	Group B	Group C	Group D	Group E
	teaching assistants	parent support advisors	CAMHS	assistant educational psychologists	behaviour support workers

Research Question 1: What are the ways in which professionals view children’s mental health?

Table 8: Conceptualisations of Mental Health

Global Theme	Organising Theme	Basic Themes	Group A	Group B	Group C	Group D	Group E	Total	
conceptualisations of mental health	negative associations	stereotyping	✓					1	
		fear	✓			✓	✓	6	
		labelling		✓	✓			5	
		stigma			✓	✓	✓	7	
		shame				✓		2	
	pathogenic conceptualisations	different mental health conditions		✓			✓	✓	6
		mental health service criteria				✓			12
		diagnosis				✓			2
		genetic factors		✓	✓				3
		medication		✓					1
		physiological factors					✓	✓	3
		mental ill-health				✓	✓	✓	9
	salutogenic conceptualisations	well-being		✓	✓	✓			5
		coping skills				✓		✓	4
		recovery						✓	1
	cognitive conceptualisations	mental health associated with brain function	✓	✓			✓	✓	5
		mental health associated with thought processes			✓			✓	4
	mental health and behaviour	mental health associated with normality of behaviour	✓						3
		behavioural presentation as an indicator of mental health	✓	✓				✓	4
		behaviour as a communication						✓	4

		behavioural causation as a mental health indicator	✓	✓			✓	12
		demonstration of limited self-awareness as a mental health issue	✓				✓	3
	dual conceptualisations	medical/clinical versus emotional conceptualisations		✓	✓			5
		physical versus mental health		✓			✓	2
		behaviour versus mental health	✓	✓			✓	5
		medical versus social conceptualisations			✓			3
		positive mental health versus negative mental health					✓	1
		personal and professional ways of conceptualising mental health					✓	1
	changes in mental health	personality change as an indicator of mental health	✓					4
		mental health as a continuum	✓		✓		✓	14
	breadth of mental health	range of mental health difficulties	✓			✓	✓	7
		universality of mental health			✓		✓	2

This data was most relevant to the research question: ‘What are the ways in which professionals view children’s mental health?’ Participants were asked how they would define the concept of mental health, resulting in responses which were the most diverse of all themes. However, all participants discussed various negative conceptualisations,

including the pathologisation of mental health issues, and raised a number of concerns regarding this, stating:

'It's mental ill-health isn't it? And I think that's generally what people do, when you say... well, because I've worked in adult mental health, they're like 'arggh, how can you have done that?'. They're quite fearful.'

'I do think generally mental health, that when you say 'mental health', I think, I don't know why, but generally people do think more negative, don't they?'

These views particularly echo Weare's (2005) concerns that mental health is often considered synonymous to mental illness, which participants universally deemed undesirable. However, participants did not discuss in particular depth or length alternative, positive conceptualisations, such as salutogenic perspectives. Comments were made with regard to well-being, coping and recovery, but not across all groups. Indeed, the school group did not refer to positive conceptualisations at all, which stands in stark contrast to Weare's (2005) suggestion that there is now a considerable focus in schools upon emotional well-being and promoting children's mental health. This finding could also be deemed contradictory, considering the fact that all groups universally viewed their role as involving awareness-raising and promotion of mental health, which arguably incorporates salutogenic aspects, such as well-being. Braun and Clarke (2006), however, draw attention to the fact that inconsistency across a data set is not uncommon, and encourage its acknowledgement.

Other negative conceptualisations pertained to fear, shame (i.e. the embarrassment of being associated with, or possessing, mental health difficulties), and stigma, with participants again expressing concern at such destructive popular perceptions, commenting:

'I think some of these young children, if they get pathologised as having a mental health... I think they can end up being stigmatised...'

'Yeh, I think people are scared of it, aren't they? Just the word makes people a bit... and I think people with mental health conditions are fearful of telling people that they have got so and so issue because of... they know people judge them, and I think that's a problem too'.

However, some participants reported that they themselves could experience fear, stating:

'I think if you haven't been around people who have had it, you sort of back off from it as well don't you? You think 'oh, the mad woman...'

Such fear and stigma associated with mental health has been widely reported (Sartorius, 2007, Nordt et al., 2006, Learoyd-Smith, 2010). More specifically, such stigma has been reported to expand beyond the individual, to those providing mental health services, such as mental health workers, and even buildings (Sartorius, 2007). It was perhaps no surprise, then, that this fact was alluded to by the CAMHS group, who expressed concerns about potential stigma children and families may face in accessing support. They stressed their attempts to alleviate negative associations, referring to the fact the name of their service

had been adapted from 'CAMHS' to a generic children's service, in order to safeguard against the undesirable effects of stigma.

Upon exploring conceptualisations of mental health, there appeared to be a difference across services with regard to language use and the focus of discussion. For instance, the CAMHS group were the only professionals to talk of 'criteria' and 'diagnosis' with regard to children's mental health difficulties. By contrast, school-based staff more frequently referred to social, emotional and behavioural difficulties, in keeping with findings by Rothí et al. (2005). Indeed, school staff discussed behavioural considerations on a number of occasions, only slightly less frequently than the behaviour workers.

The associations and connections between behaviour and mental health were discussed in a number of guises. In particular, the role behaviour plays in assisting with identifying mental health difficulties, or indicating to the observer the emotional functioning of a child, were discussed at length. Furthermore, the justification of behavioural difficulties, as a result of social or environmental factors was alluded to, with behavioural causation considered pertinent in determining whether or not a child possessed mental health difficulties. This was discussed at length, and comments included:

'Behaviour's almost what they do, it's kind of how they act it out really, isn't it?'

'Behaviour is the language isn't it?'

‘...the behaviour is telling you what’s going on, and that’s where I always start. It’s just having a good look at the behaviour that is being displayed and what’s the story behind it, and you haven’t got to dig very far and you’ll find out that they’re trying to communicate something to you.’

‘The difference for me is a child that’s being really, really naughty, and a child who has been naughty, but there’s like a reason at home, because of what’s going on or... I don’t know, it might not be acceptable, but then you can...’

‘Behavioural difficulties to me would suggest a choice in the matter, whereas a mental health difficulty, they wouldn’t be choosing to do, they wouldn’t be in control of.’

The focus upon behavioural concerns, however, was not the sole domain of school-based staff, and could be considered unsurprising, given that literature points towards associations between behavioural presentation and associated mental health difficulties (Alexander, 2005). It is interesting to note, however, that different professional groups talked about behaviour in diverse manners, with school staff using vocabulary such as ‘naughty’, and discussing choice, justification, and the management of difficulties, whereas by contrast, behaviour workers more commonly referred to behaviour as a communication, and the role it plays in assisting with identifying mental health difficulties. Neither CAMHS nor the AEPs mentioned behaviour at all, which could indicate varying terminology, as opposed to a necessarily perceived lesser importance. As previously noted by Hayden (2007), the terminology used is dependent upon the perspective one adopts.

Cognitive factors were also discussed, with participants alluding to the importance of thinking processes, considering 'being able to think clearly or rationally' an indication of positive mental health. Interestingly, CAMHS were the only group to not mention cognitive factors with regard to mental health, which could be deemed unexpected, particularly with regard to the training of some mental health professionals in therapeutic approaches concerned with challenging thought processes as a means of addressing mental health issues, such as CBT (McHugh and Barlow, 2010). Indeed, CBT was discussed, but by the AEP group, which could be considered to reflect the expectation for EPs to adopt a lead role in supporting children's mental health (Perfect and Morris, 2011), and whilst although not a recent phenomenon, could be considered more firmly embedded due to recent government legislation, such as the CAMHS Four-Tier Strategic Framework (DfES & DH, 2004).

As well as positive and negative conceptualisations, a number of themes emerged which were neutral in nature. By neutral, this means they had neither particularly positive nor negative connotations. For instance, the concept of mental health as a continuum was referred to by various groups on numerous occasions, with participants defining it as:

"Something that fluctuates."

"You might explain it as being on a spectrum at different times of your life; depending on experiences, you might kind of move between up and down the spectrum. I think you probably think, explain it as, you can have positive mental health, and you can have times when your mental health might be more challenged or impaired depending on your life circumstances."

“I thought exactly the same. It can be positive mental health as well as negative mental health, and it’s a continuum, and most people move up and down in quite a lot. I know I do!”

The above noted potential for mental health fluctuation, as a result of changing circumstances in particular, was a sentiment shared by Meltzer et al. (2000), who drew attention to circumstantial factors deemed to impact upon children’s mental health, such as divorce.

Furthermore, it is important to note that the way a professional may conceptualise mental health may also be subject to change, sometimes in accordance with access to new learning experiences. For instance, one participant commented upon how multi-disciplinary working could impact upon the way a professional group may define mental health, stating:

“I think as well working in a multi-disciplinary team, comparing our own approach and understanding in contrast to how like a psychiatrist may think about certain mental health problems. I suppose that helps to define the way we think about it as well. So kind of through working with different professionals...”

Research Question 2: What are the perceived barriers in supporting children’s mental health?

Table 9: Barriers to Supporting Children’s Mental Health Difficulties

Global Theme	Organising Theme	Basic Themes	Group A	Group B	Group C	Group D	Group E	Total
barriers to supporting children’s mental health difficulties	systemic factors	negative culture	✓		✓	✓	✓	11
		resources/ financial factors	✓	✓	✓			12
		legislative pressures	✓					2
		insufficient team support	✓			✓	✓	7
		staffing/workload	✓			✓	✓	5
		insufficient time	✓	✓		✓	✓	15
		inadequate access/ desirability of access for parents		✓	✓			12
		inconsistency of advice across services		✓				2
		insufficient focus on early intervention		✓				5
		lack of professional support available to parents		✓		✓		2
		lack of access to specialist and/or regular supervision				✓	✓	5
		insufficiently strong links across agencies				✓	✓	3
	practitioners’ perceived inability to support and identify difficulties	perceived general low level of confidence		✓			✓	4
		perceived varying low levels of confidence, depending upon mental health difficulty	✓	✓		✓	✓	7
		uncertainty regarding how to support difficulties	✓		✓	✓	✓	8
		uncertainty regarding	✓			✓	✓	5

		how to define mental health						
		perception of being de-skilled				✓	✓	6
		perception of mental health as a specialist area		✓		✓	✓	4
		uncertainty regarding how to identify difficulties	✓		✓	✓	✓	4
		uncertainty regarding processes/ procedures	✓	✓				3
		uncertainty regarding causation of mental health difficulties	✓				✓	4
	parent factors	parental mental health difficulties	✓			✓		2
		inadequate/inconsistent parental disclosure of information to professionals	✓	✓				3
		inadequate parenting skills		✓			✓	6
		low parental engagement	✓	✓			✓	4
		parental fear of mental health issues				✓		2
		degree of parental awareness of difficulties		✓	✓			2
	child factors	case complexity	✓		✓		✓	6
		managing challenging behaviour	✓					2
	training issues	insufficient training opportunities	✓		✓	✓		7
		lack of relevant/appropriate training		✓				2
		lack of choice regarding training			✓			2
		lack of opportunities to utilise training	✓					3
	communication issues	breakdown of communication within organisations	✓					11

		breakdown of communication across organisations		✓	✓	✓	✓	8
		lack of knowledge of who to signpost service users to		✓	✓			3
	professional differences of opinion/ approach	different interpersonal approaches	✓				✓	11
		variable commitment to supporting mental health	✓		✓	✓	✓	4
		academic versus social and emotional support	✓			✓	✓	16
		professional differences regarding how best to meet children's needs	✓		✓	✓		6
		variable degree of inclusive practice	✓					2
		differing priorities/ expectations			✓	✓		9

This data pertains largely to the research question: ‘What are the perceived barriers in supporting children’s mental health? Participants were not asked a direct question asked about this. Dedicating specific questions to negative factors was considered undesirable, as it was deemed very likely that participants would mention areas of difficulty organically throughout the course of the focus groups, within the context of discussion, as research has indicated that there is a tendency to focus more heavily upon negative events and issues than those positive in nature (Baumeister et al., 2001). As predicted, regardless of the fact that no such specific questions regarding barriers and challenges were included, many participants discussed a range of difficulties.

With regard to how the data answered the research questions, some participant responses, particularly those which highlighted systemic barriers to supporting children’s mental health, could be considered relevant to the research question of ‘What are professionals’

views on working culture in relation to supporting children's mental health?'. Although this question is answered in greater detail later, participants provided some responses relevant to this in the current section.

All groups drew attention to the fact that inadequate communication, either within or between teams, could be particularly problematic. The school group reported a number of issues with regard to information sharing practices within the establishment, whereas all other groups highlighted communication issues across teams as a more significant area of concern, which could perhaps be indicative of working roles, with the latter arguably more likely to be involved in frequent liaison with other organisations, due to the particular emphasis upon multi-agency working within the target local authority. One participant drew attention to the challenges created by inadequate information sharing and communication, stating:

"...we could be doing some of the same things, and really we don't know..."

This finding is consistent with research exploring multi-agency teams, which has highlighted the serious threat to effective working posed by inadequate lines of communication (Atkinson et al., 2002). Furthermore, this participant comment could also be said to closely correspond to findings by Darlington and Feeney (2008), which highlight that a lack of information regarding other services, including the support they offer, and the roles of staff, serve as key challenges in effective multi-agency working.

Participants also commented upon a number of systemic factors considered to impede effective practice. Some of these pertained to resources, such as financial factors,

inadequate staffing, large workloads, and insufficient time, whereas other considerations were associated with team culture, and included a perceived negative environment, and insufficient focus on early intervention. A desired focus upon the latter could be considered crucial, as a key element of supporting children's mental health involves preventative and awareness-raising activities, particularly for Tier 1 staff, as it can reduce stigmatization (Weare, 2005), and prevent difficulties from becoming serious, entrenched, and potentially fatal, as children progress into adulthood (HMG and DH, 2011).

Early intervention with regard to mental health is perceived as a systemic issue (Nelson and Mann, 2011), supported at a policy level. Although no staff groups discussed policies which supported early intervention, a number of participants drew attention to systemic considerations, such as the fact that financial factors and limited resources impacted detrimentally upon their ability to provide appropriate early support, particularly with regard to staffing and time available. One participant commented:

"I think time pressures, and caseload. Although you might be able to have time to identify them, to offer weekly support to all those children that are then identified is really not possible."

With regard to the above mentioned finding that some participants considered a negative environment a key systemic challenge, it is important to note that this has also been highlighted in the literature. Indeed, the finding by Rossberg et al. (2008) that the working environment can have implications for service user satisfaction, and success of interventions, is particularly relevant. Although these factors were not specifically referred

to by participants, some did comment upon the undesirability of the physical space in which work was frequently conducted with clients, noting that working in schools with individual children was commonly problematic, with practitioners sometimes provided with rooms which were insufficiently private.

Furthermore, participants drew attention to a number of undesirable negative features of their working culture, alluding variously to hierarchy within their organisation, low morale, a general negative, or even hostile, atmosphere, and cultural differences across organisations impacting detrimentally upon their capacity to support children's mental health. For instance, participants stated:

"I can say 'actually, I don't agree', but because we are only TAs, we haven't got...
That hierarchy..."

"And I suppose, you know, the working culture, you know, of what we might do in our service doesn't match with the working culture of other services, in particular residential homes, or social services."

"Because I've noticed morale be quite low, you know, in our office, over the last few months, and that makes it difficult because your work can be quite heavy, and sessions quite heavy, and there's no lightness around to kind of balance that."

"The work environment for me is not a good place to help me help other people at the moment."

Also in accordance with participant comments, adequate time, funding and resources were all identified in the literature as crucial factors by a range of professionals, particularly when working in a multi-agency context (Atkinson et al., 2002). The fact that all groups, with the exception of CAMHS staff, reported insufficient time, and burgeoning caseloads, suggested some cause for concern with regard to practitioners' abilities to appropriately support children's mental health. The fact that CAMHS staff did not allude to such time pressures was surprising, and in stark contrast with research findings and nationally reported concerns regarding lengthy waiting lists, and incidents of unmet need (DCSF and DH, 2008).

Another factor considered a particular barrier pertained to differences of opinion across professional groups. Most groups referred to problems in this domain, and frequently noted conflicts between practitioner perceptions of difficulties, and ensuing interventions or actions. Participants stated:

"I have to rely on colleagues in other agencies. Sometimes they might make decisions that aren't the best for the mental health of the child. Sometimes that's quite tricky, in terms of kind of working and trying to meet the needs of the child, sort of systemic issues come in to play sometimes."

"I was working with a young person for quite a while, and I felt that his difficulties were more from like attachment issues. We had a referral to the... [CAMHS team], and he ended up being diagnosed with ADHD, ASD and Tourettes, and I was quite concerned that after two hours someone could make that diagnosis, and he was then medicated...".

These conflicts highlight the difficulties encountered by professionals in working with others whose perspectives differ from their own. For instance, in the above example, the perception by the participant was that their colleague in another team considered the difficulties to be located within the child, hence the resultant medication, whereas their view was that the problem was more systemic in nature. This is a clear example of how perspectives shape interventions and actions (Mezirow, 1990, Hayden, 2007), and perhaps indicates that some practitioners may consider a divide to exist between pathogenic perspectives, and conceptualisations which are more socially oriented.

An issue raised on a number of occasions pertained to the perceived ability of practitioners to support needs. All groups reported some uncertainty with regard to supporting children's mental health, including those considered to possess specialist skills and knowledge in the area, in accordance with research findings (Edwards et al., 2008, Browne et al., 2007, Rothí et al., 2005). Of particular significance was the perception of mental health as a specialist area, and the resultant feelings of disempowerment a practitioner may subsequently experience serving as a barrier to providing support. For instance, one participant stated:

"...when you start talking about, you know, can you pick up on mental health issues, I wouldn't say overly-confident, because it's another field."

Associated with this, a number of participants also reported feelings of confidence for certain mental health difficulties, but lower levels for other aspects, often dependent on

previous experience, or perceptions of appropriate training or qualifications. For instance, participants stated:

“I think it does depend on your experience as well. Like, I’ve worked with...children that do present certain mental health, you know, problems, so if I was to work then with a child that was similar, I’d feel quite confident, but then there’s other things that I might be a bit more like... I haven’t really...”

“I wouldn’t feel confident saying ‘this pupil’s got anxiety’ as a diagnosis. Not at all, do you know what I mean? I don’t feel qualified for that sort of thing. If they’ve got depression... I could say I think they’re depressed.”

These findings reveal the importance of practitioner confidence in supporting mental health difficulties, for if staff do not feel self-assured in undertaking activities in this domain, then they may arguably be reluctant to do so, which could result in children not receiving the required support. Confidence could be described as the conviction of one’s abilities to effectively support children’s mental health needs, and does not necessarily pertain to actual efficacy.

The identification of practitioner confidence as a key factor in providing mental health support in particular was highlighted in the literature by Cleary et al. (2011), and more generally by Eraut (2004). Although Rothí et al. (2005) discovered that teachers reported low levels of confidence in meeting children’s mental health difficulties, and frequently felt burdened by them, the findings of this research revealed that even those with specialist

skills in children's mental health considered themselves to experience difficulties in some areas. For instance, a participant from the CAMHS team stated:

"I think it is still quite difficult, because I work with looked after children, and they've all had a rubbish, most of them, had kind of a rubbish experience, and that's generally the reason for their problems, and it's hard to say, I think, sometimes whether that's a mental health issue or not."

This could indicate the breadth and complexity of the area of mental health, already deemed considerable by participants. Indeed, it highlights the challenges of complex casework, noted by several groups. Furthermore, it emphasises the need to support practitioner confidence at a professional level, which could be conducted via the supervision process. The supervisory process was considered to increase confidence by some participants, with one stating:

"...then when we had some training from a psychologist in a different (team), she left us thinking, 'actually, it is ok, I can deal with it, and I know a bit more about how to deal with it now', whereas... so I think it's all supervision, and gaining experience from others."

However, a number of participants reported difficulties with regard to accessing appropriate or sufficient supervision, which could be considered to result in reduced confidence in addressing difficulties.

Research Question 3: What are the skills and qualities considered necessary for staff to effectively support children’s mental health difficulties?

Table 10: Practitioner Skills, Knowledge and Experience Considered Necessary to Support Children’s Mental Health Difficulties

Global Theme	Organising Theme	Basic Themes	Group A	Group B	Group C	Group D	Group E	Total	
practitioner skills, knowledge and experience for supporting children’s mental health	personal factors	life experience	✓	✓	✓	✓	✓	17	
		popular perceptions/misconceptions			✓			1	
		media influence	✓	✓		✓		3	
		extent of personal interest			✓			2	
	intrapersonal skills	self-awareness/reflection						✓	3
		confidence	✓					✓	2
		awareness of own skill boundaries/limitations		✓	✓	✓	✓		11
		positivity	✓						2
		persistence	✓						1
		open-mindedness/non-judgemental		✓	✓	✓	✓	✓	5
		sensitivity				✓	✓		3
		flexibility					✓		1
		calmness					✓	✓	4
		ability to hide feelings						✓	2
		consistency/reliability						✓	3
		honesty						✓	1
	willingness to try out strategies/experiment						✓	1	
	interpersonal skills	empathy	✓	✓			✓	✓	6
		relationship-building skills	✓	✓			✓	✓	7
		listening skills		✓				✓	3
		ability to read body language		✓					1
		advocacy/promoting the voice of the child		✓				✓	2
		therapeutic skills		✓			✓	✓	6
		ability to defuse situations		✓					1
		ability to maintain confidentiality					✓	✓	4
		ability to provide emotional						✓	1

		containment							
		ability to provide a safe space/put child at ease genuineness						✓	4
	professional skills	information-gathering/handling			✓	✓			4
		skills in formulation			✓	✓	✓		7
		specialist therapeutic skills			✓				1
		identification skills			✓		✓		3
		assessment skills			✓	✓			2
	professional experiences	experience gained from working alongside colleagues		✓				✓	3
		generic work experiences	✓	✓	✓	✓	✓		13
		supervision			✓				3
		experience of multi-disciplinary working			✓	✓			4
	professional knowledge	knowledge of procedures/protocols/referral processes	✓	✓	✓	✓			7
		knowledge and awareness of mental health issues	✓		✓	✓			4
		psychological knowledge			✓				2
		degree/formal training			✓	✓			3
		knowledge gained from training		✓					4
		knowledge and awareness of contextual factors affecting children's mental health				✓			2
	communication skills	networking skills		✓	✓			✓	6
		skills in conducting informal communications		✓	✓			✓	6
		ability to appropriately communicate details of children's mental health				✓	✓		4

The above data could be said to address the research question of: 'What are the skills and qualities considered necessary for staff to effectively support children's mental health difficulties?'. Participants were asked what skills and qualities were considered desirable in order to effectively support children's mental health. Overwhelmingly, skills in interacting with others were considered of paramount importance, with all groups alluding to

capabilities for forming relationships, or relating effectively with service users in some capacity. Intrapersonal skills pertained to within-person qualities, and were not necessarily associated with relationship-forming, whereas interpersonal skills referred to those qualities which were most evident during times of interaction with others. Most groups alluded to the importance of being open-minded, aware of own skill limitations, and having a well-developed sense of empathy. A number of groups also referred to the desirability of therapeutic skills.

Interestingly, some groups who did not necessarily have a remit for specifically employing such skills, such as PSAs, considered them especially important. Indeed, participants stated:

“...the other PSAs that haven’t got it say they want the counselling training.”

“...we need more sort of practical, like you say, sort of more counselling type courses...”

The remit for PSAs involves engaging parents, requiring the capacity to form positive relationships (Lindsay et al., 2007), whereby basic counselling skills could consequently be considered helpful. This has implications for training, to ensure all staff have sufficient skills and knowledge to undertake tasks and methods of working deemed appropriate within one’s role, as failure to do so can result in feeling over-burdened (Lindsay et al., 2007). Furthermore, such training could be considered to safeguard staff against criticism, levied by some, such as Indoe (1998), regarding the appropriateness of certain professional groups conducting activities relevant to mental health.

By contrast to intrapersonal and interpersonal skills, participants also commented upon various professional abilities, such as assessment, identification, and formulation. CAMHS staff referred to the widest range of professional skills, commenting upon all areas mentioned, whereas by contrast, some groups did not allude to such skills at all. This could be considered in keeping with the expectations of Tier 3 services, whose main roles are considered to be assessment of, and specialist interventions to address, children's mental health difficulties (Edwards et al., 2008).

As previously noted, the importance of appropriate communication skills in order to effectively support children's mental health was highlighted as a particular issue. Similarly, within this domain, it was again discussed, with skills in networking, and communicating effectively with other teams, highlighted as a particularly desirable capacity. This finding is in keeping with those identified by Atkinson et al. (2002), who noted not only were practitioner skills in communication paramount, but that a particular barrier to effective working was inadequate opportunities for information-sharing.

All groups considered the role of life experience as important, with the largest number of responses in this area. Participants placed particular emphasis upon exposure to people with mental health difficulties in their personal lives, with comments including:

"I just learnt through other people when they reached the point that someone did have mental health."

“From that experience I know how to, well hopefully, because the experience, you actually have the experience. That is better to me than all the training, because you’ve actually had the experience.”

“I think a lot of it really is what you come into the job with, your past experiences and knowledge...”

Interestingly, personal experience was not evident within the literature. By contrast, a number of allusions were instead found in relation to work-based experiences. For instance, experience gained from working alongside colleagues was highlighted as particularly beneficial, particularly for trainees in the field of mental health, and termed ‘experiential learning’, described by Cleary et al. (2011). Additionally, the role of professional experience in supporting one’s capacity as a practitioner to perform required tasks is identified by the HPC (2009), referred to as the ‘scope of practise’, and incorporates professional knowledge, skills and experience.

It could be considered particularly difficult to account for an individual’s personal experiences when considering their appropriateness and competence in supporting children’s mental health, as it is arguably significantly more difficult to control for than professional working experiences, which an employer is able to shape to a large extent. This could therefore pose a significant challenge, as one of the key factors considered useful by practitioners in terms of supporting children’s mental health difficulties has been highlighted as a personal factor, which may therefore not be able to be supported by the workplace.

Research Question 4: How do staff see their role with regard to children’s mental health promotion, identification and support?

Table 11: Practitioner Perceptions Impacting Upon the Support of Children’s Mental Health

Global Theme	Organising Theme	Basic Themes	Group A	Group B	Group C	Group D	Group E	Total
practitioner perceptions impacting upon the support of children’s mental health	perceived staff awareness	reflection					✓	3
		awareness of own skill boundaries/limitations		✓	✓	✓	✓	11
		awareness of contextual factors			✓	✓		3
	perceived staff role	assessment of children’s mental health needs	✓	✓	✓	✓	✓	13
		informal support for children	✓					2
		joint working with parents and children		✓	✓			2
		identification of children’s and family’s mental health needs		✓	✓	✓	✓	13
		reducing stigma				✓		1
		mediation between children and school staff					✓	1
		supporting parents	✓	✓				5
		reassuring children, parents, and teachers				✓	✓	4
		raising awareness/promoting mental health with children, parents, and schools	✓	✓	✓	✓	✓	9
		normalising children’s mental health difficulties		✓		✓	✓	3
		general, unspecified support for children	✓					1
	perceived staff	low confidence		✓			✓	4
		varying confidence	✓	✓		✓	✓	7

	efficacy	depending upon mental health difficulty						
		growing confidence				✓	✓	2
		high confidence					✓	2
		perception of mental health as specialist/out of remit		✓		✓	✓	4
		perception of being de-skilled				✓	✓	6

The data contained above could be considered to answer the research question of: ‘How do staff see as their role with regard to children’s mental health promotion, identification and support?’. Staff were asked to consider what they perceived their role to be with regard to supporting children’s mental health. As the underlying factor considered important was what staff perceive their role to be, as opposed to uncovering ‘truths’ with regard to what their role involved, this area was located within a theme which explored a range of perceptions considered to impact upon the support provided by practitioners.

Staff role perception was considered an important area to explore, as the duties and tasks one considers necessary to carry out with regard to children’s mental health arguably impact upon the form and extent of support provided. For instance, if one considers multi-agency liaison of key importance, then a commitment to sharing knowledge, skills and experience with professionals in other services may be evident, important in meeting children’s multifarious needs, as children’s difficulties, particularly when complex, do not necessarily fit neatly into service categories and areas of responsibility (Salmon, 2004).

Interestingly, all professionals except the school group considered identification to form an element of their role. As a Tier 1 service, identification is arguably a crucial element for

schools, as children are considered dependent upon professionals to recognise needs, and seek appropriate support for them (Simpson et al., 2009). As a result, it was somewhat unexpected that no allusion was made to identifying difficulties by school staff. However, it may have been the case that professional groups defined their roles differently, and may indeed carry out a number of identification tasks without explicitly perceiving or delineating them as such. As noted by DH (2001), many practitioners are involved in conducting mental health activities that they may not explicitly describe or acknowledge as such. Additionally, the school group did consider mental health promotion and awareness-raising to be part of their role, arguably another crucial Tier 1 activity.

Perhaps somewhat surprisingly, all groups considered awareness-raising to be part of their role. The principal activities of Tier 3 services such as CAMHS are considered to be specialist assessment and intervention (Edwards et al., 2008), yet this group also drew attention to the important role they can play in raising awareness. However, perhaps the main difference was that CAMHS staff perceived their role to involve awareness-raising within the context of casework and associated interventions, as opposed to generic, universal awareness-raising. For instance, the CAMHS staff stated:

“You do get, some young people, I think they do have more chronic mental health difficulties, but even their mental health will fluctuate, even though it will be at a significant sort of level, that will even still fluctuate, and then you get sort of more transient mental health problems, which are like reactive depression, something that’s around a specific trigger, which is quite helpful when you explain to the child then in terms of something that can fluctuate because of an event.”

By contrast, other groups considered their role to incorporate more generic awareness-raising, such as working with children, parents, and teachers to promote knowledge of mental health issues. Groups who provide services to schools, such as AEPs and behaviour workers, commonly alluded to their role in terms of supporting teachers, variously stating:

“And it does come back, doesn’t it, to what we believe our role to be... making staff and teachers more aware of what to look for, you know, like what you were saying... the quieter children that maybe you wouldn’t pick up on.”

“A lot of my job is trying to explain to teachers that the aggression you’re seeing is actually something else, usually anxiety, but there’s something behind it. They’re not just an aggressive child.”

School staff, however, identified a possible role in working at a whole-class level with pupils to raise awareness, tailoring the issues to given pupils, stating:

“What about teaching the other children in the class, if the child’s got autism or whatever... telling the other children how to...”

These disparities could be considered in keeping with the individual place and type of work associated with given roles. The variation in awareness-raising and early intervention activities across groups highlights ways in which these undertakings can be incorporated into all roles, suggesting that it not necessarily be the remit of earlier tiers. This stands in

contrast to the roles and responsibilities outlined in the comprehensive CAMHS framework, which refers to early identification and promotion within Tier 1 only. Here lies a dilemma, as the importance of a mental health framework which operates smooth transitions according to severity of need has been identified (Stiffman et al., 2010), which suggests a clear rationale for distinction of tasks across groups. However, as previously noted, children's needs do not neatly fit into the categories we create for them (Salmon, 2004), suggesting the need for greater overlap of skills and activities across tiers.

With regard to the perceived role of staff in supporting children's mental health difficulties, many practitioners identified the importance in providing reassurance to children, and those involved in their lives, including schools and families. Associated with this, several groups referred to the importance of normalising children's difficulties, suggesting that feelings of difference could be detrimental, perhaps resulting in anxiety or confusion. One participant stated:

"And I suppose providing reassurance for them, to say, like what their experience... is quite common, and other people experience the same sort of things. Because there isn't that sort of awareness around it, they might be thinking it's only them experiencing it, or might be quite concerned about why they're thinking certain things..."

Indeed, all groups referred to the part they played in providing reassurance, normalising difficulties, or giving general informal support, with the exception of CAMHS staff. By contrast, they referred exclusively to formal assessment, identification, awareness-raising and joint working with children and parents, perhaps indicating the differences across the

tiers in terms of the level of formality considered appropriate in supporting children's mental health needs. The importance of more informal means of interacting and working in the earlier tiers of intervention was discussed on a number of occasions, with staff highlighting the need for flexibility in responding to children's needs in an unplanned manner, and extolling the potential benefits of more informal means of referral. However, although CAMHS staff did not allude to such means of support for children, they did refer to the significant benefits of informal communication with regard to information sharing, and learning from colleagues. One participant stated:

"I think that's a real strength of our team, certainly is going to someone for a word, and it's always 'yes'. Even the managers have got an open door policy."

The implications of this finding suggest that all staff teams value the role of informal methods of working, in some form or other. Perhaps, therefore, a consideration of systemic means of making this possible would be useful.

Interestingly, only PSAs and CAMHS groups highlighted the importance of joint working with both parents and children. This is to be expected for the PSA group, with their particular remit for working closely with parents. However, the emphasis placed by the CAMHS group upon the importance in working closely with parents could be considered to challenge criticisms suggesting that there is a tendency for mental health services to locate difficulties within the child, conceptualising problems from a pathogenic perspective (Jormfeldt, 2010), and instead indicates that a consideration of factors external to the child, including the home environment and experiences of parenting, are of considerable importance. This

perspective could be considered to some extent out-dated, with the research findings indicating that CAMHS staff may not view children's mental health difficulties from such a narrow standpoint, and indeed may frequently acknowledge, and attempt to adhere to, a more holistic approach (Owens et al., 2010).

All groups considered assessment in some form a part of their role, which could be considered an unexpected finding, as the main tasks of groups at the lower tiers of intervention, such as school staff, could be deemed identification and awareness-raising (DfES & DH, 2004). School staff, however, noted that it was important to gain appropriate background information in order to best support a given child, arguably extending the role from that of solely identification, stating:

"It's working with that child then isn't it, getting a background of it, observing...

Talking to parents as well...

And talking to any other agencies that are involved."

The perceived importance in observing children to gain background information, however, was not consistently deemed appropriate to their role, with another participant from the school group suggesting drawbacks, including reduced contact time spent with children, considered important to develop social skills. One participant stated:

"...we used to sit, and we would work with children, we would sit there playing with them at their games...then this profile came in, the Foundation Profile, with all these things to tick, so then you just started doing your observations, and you're doing that, and the interaction

sort of... if that was changed right from the nursery, to go back to developing the social skills more down there, it's going to have an impact all the way through the school."

Such differences of opinion between focus group members could be considered common, or at the very least expected (Krueger and Casey, 2009), and may even indicate that participants felt at ease enough with one another to feel comfortable offering varying perspectives.

Overall, then, it appears that the main perceived roles of staff were in the areas of assessment, identification, awareness-raising, and supporting others, including families and schools, primarily with regard to giving reassurance, and providing informal means of support. Some findings could have been considered unexpected, with the main area being perceived roles which spanned other tiers of intervention, such as assessment work by tier one staff, and early intervention work by tier three practitioners. This suggested that, despite some overt differences, such as the formal assessment role of CAMHS, many staff groups generally considered it important to incorporate a range of tasks and activities within their working role, which were not necessarily exclusive to their tier.

Research Question 5: What are professionals' views on working culture in relation to supporting children's mental health?

Table 12: Facilitative Factors Associated with Practitioners' Ability to Support Children's Mental Health

Global Theme	Organising Theme	Basic Themes	Group A	Group B	Group C	Group D	Group E	Total
facilitative factors for supporting children's mental health	training	good quality training		✓	✓			3
		empowerment through training and skill-sharing			✓	✓	✓	3
		consistency of training		✓				1
	climate/environment	positive culture			✓			6
		support provided by team		✓	✓	✓	✓	16
		agency over work		✓				1
	multi-agency factors	joint working		✓	✓	✓	✓	5
		effective multi-agency communication/info-sharing		✓	✓	✓	✓	13
		multi-agency learning			✓		✓	4
		importance of multi-agency working			✓			1
		benefits of working as an outside agency					✓	5
		advice-seeking/support from other teams		✓	✓		✓	6

The above data could be considered to answer the research question: 'What are professionals' views on working culture in relation to supporting children's mental health?'.

Participants were asked their views on how the working environment may impact upon their ability to support children's mental health. A number of negative elements were referred to, which have been discussed when considering barriers to supporting children's mental health. However, a number of facilitative factors were also raised, and are shown in the table above. Several areas attracted a degree of attention, and participants frequently referred to the desirability of a positive working culture, and supportive colleagues in particular. With regard to the latter, the relationships of staff within a working organisation have been identified as crucial to its overall functioning (Munro and Hubbard, 2011).

All groups except one alluded to the importance of a positive working culture, with participants stating:

"The team structure, and staffing, and colleagues... you know, if you've got a supportive team, if you know that you are really stuck with whatever issue is going on in the family, you can say 'you know what, I need some support in this, I don't know where to go with it'. I think if you feel that you can, then you're going to feel better."

"In like our office, if we've had a terrible session, we'll just sort of come in and have a laugh or take the mick out of each other in a safe way, you know. I guess it comes under working culture. But yeh, kind of morale..."

This finding is particularly significant, as it indicates the importance placed by participants on positive, effective team functioning in order to best meet children's mental health needs. However, as previously noted, most groups discussed the challenges they faced with regard

to negative team culture, with reports by some of hierarchy, culture clashes across services, and a hostile environment. This indicates that a key challenge in supporting practitioners to meet children's mental health needs involves addressing systemic issues, such as staff relationships, and organisational functioning.

Another area raised by participants was that of training. Access to inadequate training opportunities was previously noted as a particular area of concern. Accordingly, a number of comments were made with regard to the positive impact of accessing training. In particular, being provided with the opportunity to skill-share within and across teams, and access colleagues who may have specialist skills and knowledge in a particular area, was raised. The empowering capacity of being able to draw on colleagues' expertise was remarked on, with one participant stating:

"It's when more senior psychologists speak to you about how they've done it, and what they've learnt on their training, and then you actually realise 'actually, I could do that'."

It is particularly pertinent that participants considered training to be of such importance, as this was an area of considerable concern highlighted in the literature, particularly with regard to the degree and consistency of training for practitioners engaged in supporting children's mental health needs. The fact that no universal training programme exists was deemed concerning, particularly for staff working at the Tier 2 threshold, as the complexities of liaison across tiers 1 and 3 was considered particularly problematic (Bradley et al., 2009). However, the findings revealed that indeed all groups discussed training at some point, whether in the context of a facilitative factor, or to comment upon negative

issues, suggesting that regardless of the tier of working, it is a highly valued component in meeting children's mental health needs.

One participant went further than extolling the benefits of training and expertise from colleagues, stating that access to different views had an impact on the shaping of one's own perspective, which could be considered relevant to the initial research question of how practitioners perceive children's mental health difficulties. The participant stated:

"I sort of agree that sort of being able to draw on so many different professional backgrounds, really sort of working, you know, kind of outside of a hierarchy really, but just working with so many different professional strengths, really sort of shapes your views. I think if you're in a unidisciplinary service, you don't have that on a day-to-day basis."

This comment particularly highlights the benefits of multi-disciplinary working, with the access to other professionals that this affords considered a key benefit. Indeed, a number of comments noted the multifarious benefits of effective multi-agency working. One participant drew attention to role boundaries and scope of skills, highlighting the function colleagues in other teams could play in assisting with cases deemed out of one's remit, stating:

"Obviously our expertise stops at a certain point, and then we would go and say right, I might go to you 'right, this is the presenting behaviour', and then (name) would go... 'oh, ok', and she would help me, so then I would go to other people in other fields."

This comment is in keeping with findings from the literature, which highlighted the complexities of children's mental health difficulties, and the resultant fact that different issues could not be neatly separated out into the professional boundaries within which services may operate (Salmon, 2004), suggesting the need for close working with colleagues in other teams in order to best meet children's needs.

Once again, another key issue noted with regard to multi-agency working was that of communication. Some participants drew particular attention to the important role of informal lines of communication, stating:

"We know that we can phone one of the psychiatrists and just get, even them to come out and do a second opinion, or just to run through something on the phone, just... again, just a multi-disciplinary..."

"It's getting people you can talk to off the record as well. You know, with (name) I know somebody there, and we sort of chat, and I can ring her up and I say 'off the record, what do I do? What's the best?' But it's just being able to communicate, because if you're just dealing with people and it's quite formal you're not going to get the information that you want."

The emphasis placed upon informal contact with colleagues was widely apparent, and could be said to have implications for consequent learning that may take place as a result. Indeed, in the above examples, the purpose of contact with others was to illuminate a particular issue, or receive knowledge and guidance. This finding is significant, as research indicates

that much learning in the workplace takes place in this informal manner, largely without the conscious recognition by the recipient that this in turn may shape consequent behaviour (Eraut, 2007). Behaviour and perceptions could be considered inextricably linked, for, as previously noted, perceptions impact upon resultant behaviour or actions (Mezirow, 1990, Hayden, 2007). As a result, it could be considered that such informal communications and learning opportunities are in fact helping to shape participants' views of mental health.

Overall, then, the facilitative factors participants considered most important in supporting children's mental health generally pertained to systemic elements, such as appropriate training, effective communication, and a positive working environment. Participants placed high importance upon supportive colleagues, and particularly valued opportunities to information share, and informally discuss issues, sometimes with those possessing specialist expertise or knowledge in a particular area.

Table 13: Practitioner Recommendations

Global Theme	Organising Theme	Basic Themes	Group A	Group B	Group C	Group D	Group E	Total
practitioner recommendations	training	up-to-date training		✓	✓	✓		3
		more training in schools				✓		4
		training in mental health assessments				✓		2
		more training across mental health tiers				✓		2
		universal training programme		✓				2
		general mental health training	✓			✓		4
		counselling skills training		✓			✓	4
	changes to more easily access/ engage parents	more adequate building/location/space		✓	✓	✓	✓	17
		use of computer forums/internet to access parents		✓				2
		incentives for parental engagement		✓				1
	practitioner resources	practitioner directory of mental health conditions and associated interventions		✓				4
		menu of work available for service users				✓		3
	organisational/ systemic changes	more informal support/referral		✓	✓			2
		more early intervention practices		✓				5
		greater continuity of services at times of transition		✓				2
		audit of services/ matching of need				✓		4
		more specialist/appropriate supervision					✓	2
	practitioner	ensuring staff			✓			1

	skill and knowledge development	knowledge of protocols						
		greater consistency in practitioner approach		✓			✓	5

Participants were asked in what ways they would choose to influence services if they were given the capacity to do so. As a result, a number of recommendations were made. Potential areas of possible changes to service delivery, and detailed recommendations, were devised in part as a result of these suggestions, and can be found in the concluding chapter.

CONCLUSIONS

Reflections on the Findings

This research sought to explore the perceptions of children's mental health, and associated support, held by practitioners working in children's services. This included an exploration of the understandings different professional teams possess with regard to their role in supporting children's mental health, the skills considered necessary for the task, key challenges, and potential areas for improvement.

Practitioner perceptions of mental health revealed numerous conceptualisations, with a range of sub-themes emerging from the data. These included pathogenic and salutogenic perspectives, negative associations, such as stigma and fear, behaviour and its associations with mental health difficulties, and the overall complexities inherent in supporting children's mental health needs. The findings revealed that whilst all groups alluded to negative factors, not all mentioned conceptualisations centred on well-being. Indeed, the number and breadth of comments focusing upon salutogenic conceptualisations were considerably fewer than those which were negative, or pathogenic in nature. This finding was consistent with literature, which indicated that there appears to be an enduring bias towards negative conceptualisations of mental health (Weare, 2005).

The findings demonstrate that practitioners across various tiers of intervention experience similar challenges in supporting children's mental health, such as inadequate access to

training opportunities, burgeoning caseloads and consequent insufficient time for individual children, and a lack of confidence with regard to supporting particular difficulties. Whilst several of these issues are systemic, and pertain to issues to be addressed at the organisational level, the matter of practitioner confidence is located within the individual, which is arguably more problematic to address. However, access to sufficient training opportunities could arguably increase confidence, accompanied by adequate supervision experiences.

The target local authority within which participants were located had a particular focus upon multi-agency working, with staff in Tier 2 services, in particular, situated in teams with a range of professionals, working in part to support children's mental health. This brought a number of challenges, such as professional differences of opinion on how best to meet children's needs, and inadequate communication processes both within and across organisations. However, participants reported the benefits of working in multi-agency teams, with some drawing attention to the opportunity to informally draw on each other's expertise, and easily access support from fellow professionals.

Reflections of Self as Practitioner

Reflection is considered a key quality which psychologists bring to their work, as noted by Cameron (2006), when discussing the distinctive perspective which is provided by the profession. It is for this reason therefore pertinent to consider the research process in a similarly reflective manner.

When contemplating the research process, it is important to note the almost unique position afforded by EPs as a result of the development of such skills. As noted by Lindsay (1998): 'EPs are the most significant group of professionals working within LEAs to have research training and experience' (p.74). As a result, one key reflection concerns the capacity to support educational organisations by providing skills which are not available from most other services. Such skills could be considered in part one of the distinctive contributions offered by EPs, which has been a key concern for a number of years (Cameron, 2006).

Another key reflection is the usefulness of research skills in a climate which is concerned with evidence-based practice. As services increasingly allude to accountability, and measuring impact, research skills could be implemented to assist in the evaluation of interventions, or obtain service user views and feedback.

Excepting the research skills obtained as a result of the process, it is also important to highlight the resultant benefits upon personal and professional development more broadly. The research process fundamentally necessitates the capacity to consider, and consequently provide, a clear rationale for actions, selecting methods and approaches from a wide range available, which is also a crucial element of the EP role. The ability to analyse complex situations, consider multiple courses of action, and consequently select an intervention or approach deemed most appropriate for the situation is a core requirement of the EP role. This process could be deemed comparable to the decision-making procedure within research.

Recommendations

Below are a number of identified recommendations resulting from the research. Many recommendations were directly alluded to by participants, whilst others were considered useful upon analysis and interpretation of the findings.

Training and Support for Staff

A number of staff reported inadequate access to appropriate training opportunities, with some raising concerns that there was no formally recognised package for supporting children's mental health, particularly upon entry into a new role. As a result, the following recommendations may prove useful:

- **Staff operating at the Tier 2 level of intervention may find it helpful to receive basic counselling training.** The benefit of therapeutic skills was alluded to by a number of participants working within Tier 2 service delivery. When considering the skills and qualities considered necessary to support children's mental health, a number of intrapersonal and interpersonal skills were listed as important, which could be developed with the assistance of counselling skills training.
- **A universal, basic training programme for practitioners with a responsibility in supporting children's mental health could be established.** Some participants referred directly to the idea of a universal training programme, to help all staff involved in

supporting children's mental health. This was considered particularly beneficial for staff new to the role, and as a result, it could be incorporated within existing induction programmes. It could include protocols and procedures, such as referral on to other agencies, and mental health support available across all tiers. Earlier tiers of intervention may also benefit from the inclusion of material concerning identification and support of children's mental health difficulties. For staff working at higher levels of intervention, more specialist skills in assessment could also be incorporated. Such a programme could assist in developing greater consistency of approach, considered by some participants particularly problematic at present.

- **A review of supervision practices within relevant services may be useful.** In services where clinical supervision is required in order to safely and appropriately support children, it may be appropriate to conduct an audit of supervisor skills, to address concerns by some participants of inadequate supervision, and facilitate access to those with specialist skills, as required. This would also help address the barrier reported by some participants of case complexity, as supervision is the principle forum to discuss such children, and plan ensuing actions.

Resource Development

Some participants reported that there were insufficient mental health resources available to them in the workplace, and that they were sometimes unsure how to identify particular mental health conditions, and further unclear as to appropriate interventions. Participants recommended both of the following actions in order to address this:

- **The development of a practitioner guide of mental health difficulties, with associated interventions, could be developed.** Some participants, particularly those in earlier tiers of intervention, considered a resource to assist in identifying difficulties, and selecting and devising appropriate interventions, to be a particularly good idea. It was suggested that the resource be written in accessible language, so that it could also be shared with parents, as appropriate.
- **A menu of services, including the range of training, interventions, and support, across tiers of intervention, may be useful.** The resource could include ‘family’ and ‘professional’ versions, to assist both staff and parents/carers in accessing the appropriate mental health support. The resource could also build upon any existing such documentation which services may possess, by collating it, and representing it in the appropriate manner for a given audience.

Systemic

Participants reported a number of systemic barriers which impacted upon their ability to support children’s mental health difficulties. As a result, the following recommendations may be useful:

- **An audit of the client demographic accessing CAMHS in the target local authority could be conducted, to better match client need to practitioner skills.** This was raised by the CAMHS group as an area of concern, with some participants noting that children

accessing the service were not always matched with a practitioner with relevant skills for given issues. This was considered in part to be a result of caseloads, with staff members sometimes at full capacity, and therefore unable to accept a child for whom they may be most appropriate to support. As a result, the audit may wish to incorporate an audit of current staff caseloads.

- **A mental health forum could be established.** Some participants reported difficulties with regard to communication across services, and a limited understanding of each other's roles. A mental health forum could address this. It could be attended by staff members across tiers, to facilitate networking, access to joint training, develop enhanced communication across services, and facilitate better understanding of one another's roles.
- **Training for management teams in children's services and schools in developing a positive working culture may be helpful for some organisations and establishments.** This recommendation is due to the finding that some participants considered the environment in which they worked to be detrimental in attempting to support children's mental health difficulties.
- **Opportunities for informal, yet structured, team-building activities may be helpful.** Staff reported the benefits of informal contact with colleagues. Furthermore, such opportunities could strengthen teams in which participants reported negative working environments, and may help to develop staff relationships, and facilitate positive organisational climates, where necessary.

- **A review of case closure protocols at transition times may be useful.** This could support with reported difficulties with regard to an insufficient focus upon early intervention. The possible introduction of an obligatory referral on to a receiving service at times of transition may be helpful in ensuring children do not ‘fall through the gaps’, and are supported early.

Access to, and Engagement with, Services by Parents

Some participants reported that parental engagement with some services was problematic, sometimes as a result of barriers such as childcare. The following recommendations were all made by participants to address this:

- **Consideration could be given to the development of an online forum/website to support parents with concerns regarding their children’s mental health.** Such a service may wish to provide links to appropriate services, resources, and a live chat capacity, operated by staff with appropriate skills and training in supporting children’s mental health, such as a psychologist or psychiatrist, who can have an online discussion with parents. Alternatively, there could be a message board, for parents to post concerns, with later follow-up from professionals.
- **Consideration could be given to incentives to facilitate parental engagement.** These could include vouchers for products appropriate to supporting their children, access to free workshops/drop-ins, and the provision of free childcare whilst accessing services.

- **Consideration could be given to crèche facilities in services which are involved in offering support and interventions for families.** A lack of available childcare was reported by some participants as a significant barrier to accessing services. The PSA group especially highlighted that parents sometimes reported not accessing parenting programmes due to such difficulties.

Dissemination of findings

Some consideration of the broad dissemination of findings is considered appropriate, as, whilst the generalisability of the research requires caution, due to the small sample size, the resultant recommendations may be of benefit outside of the target local authority, due to the literature review highlighting a lack of emphasis upon mental health support across tiers of intervention. It is important to note that formal publication of the findings is not the only method of ensuring the availability of information to local authorities. Opportunities to attend mental health conferences, workshops, or training and awareness sessions may provide appropriate forums to share findings, and disseminate recommendations. A research brief or brochure could be developed for this purpose, and disseminated amongst attendees. Sharing a summary of the research findings on an online website, such as a forum for the educational psychology community, may also be an appropriate means of distribution.

Limitations of the Research

Although attempts were made to conduct a rigorous piece of research, and consider factors which can affect authenticity and trustworthiness, there were some limitations. Firstly, the multiple-category design meant that participant views from each professional group were not exhaustive, which is desirable when employing focus group methodology. Coupled with small sample sizes for many of the focus groups, this could arguably result in reduced trustworthiness. However, as previously noted, due to time constraints, and overall low numbers of participants available within a particular professional group, increased sample sizes were not always possible.

Furthermore, samples were not always entirely representative of a particular professional group. For instance, the school group represented participants from a primary setting, and therefore did not take into consideration the views of staff in secondary provisions. In order to counter this, more groups, which contained staff from other settings, such as secondary or specialist provisions may have been useful, although was deemed too time-consuming, given the constraints of the research.

There are also difficulties associated with representing the views of participants in qualitative research, due to the interpretive nature of analysis. To counter this, it would have been helpful to have a research assistant cross-referencing interpretations. This was difficult in this instance, as the research assistant who supported the focus groups was responsible for a task associated with ethical factors, which took continued efforts to carry out, and therefore made it problematic to follow the flow of conversation. A joint analysis

of the written transcripts would therefore have been helpful, but was considered too time-consuming for the research assistant, in the context of their working role, which was not associated with the research in question.

Finally, whilst focus groups were deemed most appropriate in order to explore the research questions, it is important to note the limitations to the approach. Bryman (2008) drew attention to a number of concerns, noting, for instance, a potential lack of control over proceedings by the researcher, as the conversational flow of a group adopts its own dynamic, most disparate in quality to that of the structure of an individual interview. As this was considered to some extent a benefit of utilising the approach, due to the rich data acquired as a result, it cannot be ignored that the risk of research questions potentially not being answered, due to participants taking over, is a possibility. Bryman (2008) raised a number of practical concerns, such as difficulties organising groups, analysing data, and transcribing recordings, due to variations in voice pitch, and the possibility of participants talking over one another. An awareness of these potential difficulties resulted in the adoption of a framework to analyse findings. However, a research assistant may have proved helpful in the transcription process, for the occasional incidence of participants talking over one another, resulting in consequent difficulties determining speech. Lastly, the negative aspects of group effects were highlighted, including variable contributions, as a result of such factors as reluctant participants, or a tendency by some to 'hog the stage' (Bryman, 2008, p.489). Whilst this was attempted to be addressed by asking all participants an opening question, individually, to encourage their participation at an early stage, the fact that variable contributions occurred nonetheless cannot be ignored. Furthermore, Bryman (2008) also considers that the group dynamic can result in participants being 'prone to

expressing culturally expected views' (p.489), which clearly could not occur within an individual interview process.

Summary

This research has contributed to existing knowledge and literature exploring children's mental health by considering the implementation of services across tiers of intervention. It has examined the perspectives of a range of practitioners all working within the context of the same local authority, an area not previously evident in current research, which instead commonly focuses upon one particular professional group, or common area, such as health or education. Incorporating a number of staffing groups has allowed insights to be gained from a range of perspectives, and facilitated recommendations which are multi-dimensional in nature.

Due to budgetary cuts, and a current economic climate of austerity, it is understandable that recommendations with considerable financial implications may be difficult to implement. However, their inclusion was considered important, in order to reflect the views of participants. The findings will be shared with the target local authority via a briefing paper, summarising the above recommendations, for consideration.

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Appendix 1: Participant Information Sheet

What the Research is About

This research is aimed at exploring professionals' views of mental health, with regard to children and young people. In particular, it is interested in:

1. Professionals' views of mental health, and how these may be affected by their workplace or the job they do.
2. Professionals' roles with regard to mental health promotion, identification and support.
3. What skills people think are needed to be able to identify and support mental health difficulties.
4. Any effects which professionals' working environments might have upon their ability to identify and support mental health difficulties.

What Methods Will Be Used

This research will try to explore professionals' views by using focus groups. A focus group is a special type of group discussion with between 4-12 people. The researcher asks questions, and lets the discussion flow, without getting too involved. The people involved in a focus group all share something in common. In your case, the thing you share in common is that you all work together, doing the same sort of job. The aim is to get the full range of views for the questions asked. It is people's opinions that are important, and coming up with a final answer to each question is not the point of a focus group.

The focus group will be audio taped, so that I can have an accurate record of what has been said. I will then transcribe all of the information, and analyse it into different themes. Once all the information has been analysed, I will write up the findings.

What You Will Be Asked To Do

If you choose to take part in the research, you will be asked to sign a form and fill in a few brief details, to give your consent.

You will be asked to take part in a focus group with some of your colleagues. The focus group will take approximately 60 minutes to complete. The focus group will take place somewhere you feel comfortable with, and which is of little inconvenience to yourself, such as a meeting room in your place of work.

Your Rights

This study is conducted in accordance with British Psychological Society, and University of Birmingham ethics guidelines, and compliance with the Data Protection Act and Freedom of Information Act is assured. Your rights as a participant, including the right to withdraw at any point without penalty, are ensured.

All information that you provide will be anonymous, so that comments you make within the focus group cannot be traced directly back to you. However, comments can be traced back to your professional group (other groups of professionals are taking part).

You are free to leave the focus group, or request a break, at any time.

You are free to ask questions about the research at any point, including during the focus group. To discuss the research with me prior to the focus group taking place, please contact me on the details provided below.

You are free to decline to offer particular information requested by the researcher.

You are free to withdraw from the focus group at any time. If you withdraw, there will be no repercussions, and you can choose to have any comments you have made in the focus group up to that time destroyed. After taking part in the research, you have up to 2 weeks after the date of the focus group to decide if you wish your data to be included in the research. After this time, data will begin to be anonymously collated, making it not possible to identify your data after this time. If you choose to withdraw from the study during this time, contact the researcher, who will destroy the data you provided.

Follow-Up

You can choose whether or not to receive a brief summary report, after the findings have been written up.

After the research has been completed and written up, it will be published as a doctoral thesis. The overall aim of this research is to provide insight into the perceptions of children's mental health, and possible implications for practice. Upon completion of the study, recommendations will be provided to the organisations involved in the study.

Contact Information

Researcher:

Caroline King
Trainee Educational Psychologist
Tel. xxxxx
Email: xxxxx

Supervisor:

xxxxx
Address: xxxxx
Tel. xxxxx
Email: xxxxx

Appendix 2: Participant Consent Form

Name of Participant:

Organisation:

Title of Project:

Exploring professionals' perceptions of children's mental health: an exploratory study using focus groups.

Researcher's Contact Details:

Caroline King
Tel. xxxxx
Email: xxxxx

I agree to take part in the above research. I have read the Participant Information Sheet, and understand what my role will be in this research. All my questions have been answered to my satisfaction.

I understand that I am free to withdraw from the research at any time prior to, or during the study, for any reason, and without prejudice, and have a two week period following the focus group to decide if I wish my data to be included.

I have been informed about confidentiality and anonymity, and understand that the information I provide will be safeguarded.

I am free to ask questions at any time before and during the study.

I have been provided with a copy of this form and the Participant Information Sheet.

I agree to the University processing personal data that I have supplied. I agree to the processing of such data for any purposes connected with the research project as outlined to me.

Signed **Date**

Please place a ✓ in the box if you wish to receive a briefing report, which will outline the findings of the research.

Appendix 3: Letter of Recruitment

Dear Sir/Madam,

I am a Trainee Educational Psychologist, working for xxxxx (council). I am undertaking my doctoral training at the University of Birmingham.

As you are most likely aware, the concern with regard to children and young people's mental health needs has risen considerably in profile over recent years. As a result, I am interested in exploring how staff perceive these needs, and define their role with regard to the identification and support of difficulties.

I am attempting to conduct a number of focus groups with different groups of staff across the city in order to collect a comprehensive range of views and opinions on the topic. I hope that by undertaking this, I will be able to compile some subsequent recommendations or suggestions for practice, which will hopefully be helpful to all involved.

I am seeking your support with my research project, and hope you will favourably receive my request for members from your staff team to participate. It would involve approximately one hour of time in total, and ideally requires between 5-8 staff members to take part in a focus group, which could be held at your place of work for convenience, if you desire.

I will be in telephone contact shortly, to discuss any questions or concerns you may have, and hopefully secure your participation with your project.

Thank you for taking the time to consider this request.

Kind regards,

Caroline King
Trainee Educational Psychologist

Contact Information

Researcher:
Caroline King
Trainee Educational Psychologist
Tel. xxxxx
Email: xxxxx

Supervisor:
xxxxx
Address: xxxxx
Tel. xxxxx
Email: xxxxx

Appendix 4: Questioning Schedule

Opening Question: What is the thing you enjoy most about your job?

1. What are the first things you think of when you hear the phrase 'mental health'?
2. How would you describe the term 'mental health'?
3. Think back throughout your life. What has helped shape your views of mental health?
4. What do you think your role is in identifying and supporting children's mental health difficulties?
5. How do you work out if a child has behavioural difficulties, mental health difficulties, or both?
6. What skills and qualities do you think people need to effectively identify and support mental health difficulties?
7. What do you think helps to develop these skills?
8. How confident do you feel in identifying and supporting children's mental health difficulties?
9. How does your work environment affect how you identify and support children's mental health difficulties?
10. If you had the chance to influence how children's mental health difficulties are identified and supported within your organisation, what changes would you make?

Closing Questions

- Of all the areas we have discussed, which one is most important to you?
- Have we missed anything? Is there anything we should have talked about?

Appendix 5: Public Domain Briefing

Public Domain Briefing: Summary Report

Introduction

The domain of mental health could be considered complex, in part due to a lack of consensus about its definition, and treatment. Even professionals with particular expertise in the area may have difficulties arriving at a universal definition or shared understanding. As noted by Morant (2006): 'Mental health experts rarely agree about even what mental ill-health is, let alone about causation or treatment' (p.819).

Supporting children's mental health has become a particular area of concern over recent decades, particularly in the light of findings which indicate that unaddressed needs in childhood can result in more substantial problems in adult life. As noted by Sayal et al. (2010): 'difficulties often persist over time and present risks for later development and impaired functioning in adulthood' (p.476).

However, a number of concerns with regard to supporting children's mental health difficulties have been noted, with reports of practitioners 'becoming 'overloaded' with problems...' (Lindsay et al., 2007, p.45). Furthermore, the degree and consistency of practitioners' training, and consequent ability to appropriately support children's mental health needs have been questioned, with Bradley et al. (2009) noting, when considering the role of tier 2 staff in particular: 'there has been little exploration of the attributes required to successfully deliver this demanding and complex interface role'.

Such ongoing concerns resulted in explorations into current support and practice, including the Child and Adolescent Mental Health Service (CAMHS) Review of 2008. This document noted continuing apprehensions, despite some positive changes, stating: 'improvements in mental health and psychological wellbeing are still not as comprehensive, as consistent or as good as they could be' (DCSF and DH, 2008, p.8).

Furthermore, the diversity of staff now considered responsible for supporting children's mental health needs, highlighted by the comprehensive CAMHS framework, first alluded to in 2002, coupled with the variation in organisational and systemic factors in children's mental health services, could be said to compound the challenges faced in supporting needs. Such systemic factors could be considered significant, as Glisson et al. (2008) note that: 'The organizational social context in which mental health services are provided is believed to affect the adoption and implementation of evidence-based practices (EBPs) as well as the quality and outcomes of the services' (p.98).

As a result, supporting children's mental health remains an issue of paramount concern, and could therefore be considered worthy of further enquiry. The consequent research

questions were developed following an exploration of the relevant literature in the above-mentioned areas.

Research Questions

- What are the ways in which professionals view children's mental health?
- How do staff see their role with regard to children's mental health promotion, identification and support?
- What are the skills and qualities considered necessary for staff to effectively support children's mental health difficulties?
- What are the perceived barriers in supporting children's mental health?
- What are professionals' views on working culture in relation to supporting children's mental health?

Methodology

The research utilised focus groups in order to collect data. Five groups were conducted in total, including school staff, CAMHS, behaviour workers, parent support workers, and educational psychology. Each group lasted for approximately one hour, and was facilitated by the researcher. A research assistant was present at all groups, for ethical reasons, to assist in the deletion of data should any participant choose to withdraw from the study. The role involved keeping a running log of participants' comments, whose data was identified using individual codes.

Focus group data was analysed using thematic analysis, which involves grouping segments of text together according to similar topics. A framework called 'thematic networks' was utilised to further refine the topics, which results in a visual organisation of the data into clusters. Several over-arching themes were developed, each linked with clusters of key topics, followed by a number of lower-order, basic themes. An example of a thematic network from the data is shown in the 'Findings' section below.

Findings

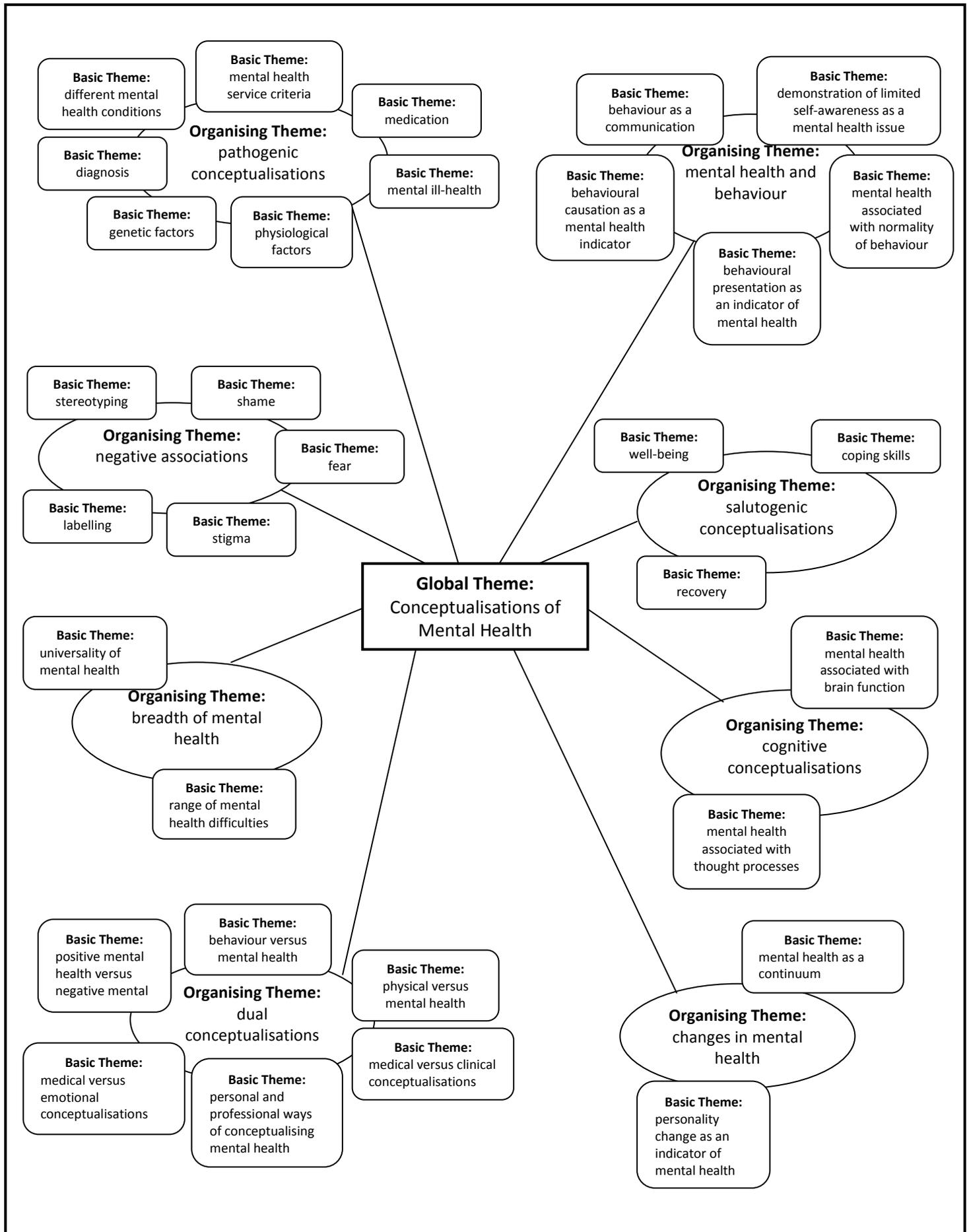
The over-arching themes arrived at following data analysis were as follows:

- Conceptualisations of mental health.
- Barriers to supporting children's mental health difficulties.
- Practitioner skills, knowledge and experience considered necessary to support children's mental health difficulties.
- Practitioner perceptions impacting upon the support of children's mental health.
- Facilitative factors associated with practitioners' ability to support children's mental health.

- Practitioner recommendations.

A brief summary of the key findings for each theme will now be presented below, with the exception of the first theme, 'Conceptualisations of Mental Health', which is instead depicted visually as a thematic network:

Thematic Network for Conceptualisations of Mental Health



Barriers to Supporting Children's Mental Health Difficulties

Participants reported a number of barriers which impacted upon their ability to support children's mental health difficulties, the majority of which were as follows:

- Systemic factors, including negative work environment, limited resources/finances, staffing, workload, insufficient time, and inadequate/ irregular supervision.
- Practitioner factors, including a perceived lack of confidence in supporting mental health difficulties, and a perception of mental health as a specialist area, so staff resultantly feeling de-skilled.
- Parent factors, including parental mental health difficulties, inadequate parenting skills, low levels of engagement, and failure to consistently/ appropriately disclose required information to practitioners.
- Child factors, including case complexity and managing behaviour difficulties associated with mental health needs.
- Training issues, including insufficient training opportunities, lack of relevant, appropriate training, and lack of opportunities to put training into practice.
- Communication issues, including a breakdown of communication both within and across organisations, and consequent lack of knowledge regarding who to signpost service users to.
- Professional differences of approach/ opinion, including different interpersonal skills/ ways of dealing with/ interacting with service users, differences of opinion regarding how best to meet children's needs, differing priorities and expectations, and varying degrees of emphasis upon academic, as opposed to social and emotional, development.

Practitioner Skills, Knowledge and Experience Considered Necessary to Support Children's Mental Health Difficulties

Participants reported a range of skills, knowledge and experiences as useful in order to support children's mental health. The main areas discussed are shown below:

- Personal factors, such as life experience and personal interest in supporting children's mental health.
- Intrapersonal skills, including awareness of own skill boundaries, open-mindedness, calmness, confidence, reflection, sensitivity, positivity, and consistency/ reliability.
- Interpersonal skills, including empathy, ability to build positive relationships, listening skills, therapeutic skills, ability to maintain confidentiality, and ability to put children at ease/ provide a safe space emotionally.
- Professional skills, such as information-gathering, case formulation, and skills in assessment and identification.
- Professional experiences considered useful were working alongside more experienced colleagues, good quality supervision, and experience of multi-disciplinary working.

- Professional knowledge considered necessary included familiarity with processes, procedures and referral protocols, awareness of mental health issues, psychological knowledge, and knowledge of contextual factors affecting children’s mental health.
- Communication skills deemed necessary included networking skills, the ability to appropriately conduct informal communications, and the ability to appropriately communicate details of children’s mental health.

Practitioner Perceptions Impacting Upon the Support of Children’s Mental Health

Upon data analysis, it appeared that the ways in which participants perceived certain factors could impact upon the support provided for children’s mental health needs. For instance, how staff perceived their role could be said to impact upon what particular tasks were carried out, and how. Furthermore, if staff do not consider themselves knowledgeable or capable to support children’s mental health needs, they may arguably be less likely to provide such support. The main areas raised are shown below:

- Perceived staff awareness, including self reflection, awareness of own skill boundaries, and awareness of contextual factors.
- Perceived staff role included a range of tasks, including assessment of children’s needs, joint working with parents, identification of mental health difficulties, reducing stigma, mediation, providing reassurance to others, supporting parents, and normalising children’s difficulties.
- Perceived staff efficacy, including low levels of confidence in supporting children’s mental health difficulties, variable levels of confidence depending upon the mental health difficulty, perception of mental health as a specialist area, and feelings of being de-skilled.

Facilitative Factors Associated with Practitioners’ Ability to Support Children’s Mental Health

In contrast to barriers, participants identified a number of factors which assist in their supporting children’s mental health difficulties. The main areas are shown below:

- Training, including consistency of training within and across services, good quality training, and empowerment as a result of training and skill-sharing.
- Work climate, including a positive environment, agency over work, and supportive colleagues.
- Multi-agency factors, including joint working, effective communication across teams, advice-seeking/ support from other teams, and the benefits of working as an outside team, particularly in a school context.

Practitioner Recommendations

Participants reported that a number of positive changes could be made in order to assist in their supporting children's mental health. These included:

- Training, including up-to-date training, more training in schools, training in mental health assessments, training across mental health tiers, a universal training programme, and counselling skills training.
- Changes to service delivery to more actively access/ engage parents, including more adequate buildings/location/ space, which are more user-friendly in nature, and less formal (e.g. more like adult 'youth clubs'), use of computer forums/ internet to access parents, incentives for parental engagement.
- The development of practitioner resources, including a directory of mental health conditions and associated interventions, and a menu of work available for service users.
- Organisational/ systemic changes, including more informal means of support/ referral, more early intervention practices, greater continuity of services at times of transition, an audit of services/ matching of client need, and more specialist/ appropriate supervision.
- Practitioner skill and knowledge development, including ensuring staff have sufficient knowledge of protocols and procedures, and greater consistency of approach within and across services.

Implications of the Study

It is hoped that the findings from this research will help illuminate some of the challenges faced by practitioners in supporting children's mental health difficulties, and indicate some positive steps which may be helpful in improving services for children, young people and their families. Although some reported barriers may not be able to be removed, particularly those which relate to financial or staffing constraints, all recommendations have been included, to reflect the views of staff teams. The recommendations are as follows:

Overall Recommendations:

Training and Support for Staff

A number of staff reported inadequate access to appropriate training opportunities, with some raising concerns that there was no formally recognised package for supporting children's mental health, particularly upon entry into a new role. As a result, the following recommendations may prove useful:

- **Staff operating at the Tier 2 level of intervention may find it helpful to receive basic counselling training.** The benefit of therapeutic skills was alluded to by a number of participants working within Tier 2 service delivery. When considering the skills and qualities considered necessary to support children's mental health, a number of intrapersonal and interpersonal skills were listed as important, which could be developed with the assistance of counselling skills training.

- **A universal, basic training programme for practitioners with a responsibility in supporting children’s mental health could be established.** Some participants referred directly to the idea of a universal training programme, to help all staff involved in supporting children’s mental health. This was considered particularly beneficial for staff new to the role, and as a result, it could be incorporated within existing induction programmes. It could include protocols and procedures, such as referral on to other agencies, and mental health support available across all tiers. Earlier tiers of intervention may also benefit from the inclusion of material concerning identification and support of children’s mental health difficulties. For staff working at higher levels of intervention, more specialist skills in assessment could also be incorporated. Such a programme could assist in developing greater consistency of approach, considered by some participants particularly problematic at present.
- **A review of supervision practices within relevant services may be useful.** In services where clinical supervision is required in order to safely and appropriately support children, it may be appropriate to conduct an audit of supervisor skills, to address concerns by some participants of inadequate supervision, and facilitate access to those with specialist skills, as required. This would also help address the barrier reported by some participants of case complexity, as supervision is the principle forum to discuss such children, and plan ensuing actions.

Resource Development

Some participants reported that there were insufficient mental health resources available to them in the workplace, and that they were sometimes unsure how to identify particular mental health conditions, and further unclear as to appropriate interventions. Participants recommended both of the following actions in order to address this:

- **The development of a practitioner guide of mental health difficulties, with associated interventions, could be developed.** Some participants, particularly those in earlier tiers of intervention, considered a resource to assist in identifying difficulties, and selecting and devising appropriate interventions, to be a particularly good idea. It was suggested that the resource be written in accessible language, so that it could also be shared with parents, as appropriate.
- **A menu of services, including the range of training, interventions, and support, across tiers of intervention, may be useful.** The resource could include ‘family’ and ‘professional’ versions, to assist both staff and parents/carers in accessing the appropriate mental health support. The resource could also build upon any existing such documentation which services may possess, by collating it, and representing it in the appropriate manner for a given audience.

Systemic

Participants reported a number of systemic barriers which impacted upon their ability to support children's mental health difficulties. As a result, the following recommendations may be useful:

- **An audit of the client demographic accessing CAMHS in the target local authority could be conducted, to better match client need to practitioner skills.** This was raised by the CAMHS group as an area of concern, with some participants noting that children accessing the service were not always matched with a practitioner with relevant skills for given issues. This was considered in part to be a result of caseloads, with staff members sometimes at full capacity, and therefore unable to accept a child for whom they may be most appropriate to support. As a result, the audit may wish to incorporate an audit of current staff caseloads.
- **A mental health forum could be established.** Some participants reported difficulties with regard to communication across services, and a limited understanding of each other's roles. A mental health forum could address this. It could be attended by staff members across tiers, to facilitate networking, access to joint training, develop enhanced communication across services, and facilitate better understanding of one another's roles.
- **Training for management teams in children's services and schools in developing a positive working culture may be helpful for some organisations and establishments.** This recommendation is due to the finding that some participants considered the environment in which they worked to be detrimental in attempting to support children's mental health difficulties.
- **Opportunities for informal, yet structured, team-building activities may be helpful.** Staff reported the benefits of informal contact with colleagues. Furthermore, such opportunities could strengthen teams in which participants reported negative working environments, and may help to develop staff relationships, and facilitate positive organisational climates, where necessary.
- **A review of case closure protocols at transition times may be useful.** This could support with reported difficulties with regard to an insufficient focus upon early intervention. The possible introduction of an obligatory referral on to a receiving service at times of transition may be helpful in ensuring children do not 'fall through the gaps', and are supported early.

Access to, and Engagement with, Services by Parents

Some participants reported that parental engagement with some services was problematic, sometimes as a result of barriers such as childcare. The following recommendations were all made by participants to address this:

- **Consideration could be given to the development of an online forum/website to support parents with concerns regarding their children’s mental health.** Such a service may wish to provide links to appropriate services, resources, and a live chat capacity, operated by staff with appropriate skills and training in supporting children’s mental health, such as a psychologist or psychiatrist, who can have an online discussion with parents. Alternatively, there could be a message board, for parents to post concerns, with later follow-up from professionals.
- **Consideration could be given to incentives to facilitate parental engagement.** These could include vouchers for products appropriate to supporting their children, access to free workshops/drop-ins, and the provision of free childcare whilst accessing services.
- **Consideration could be given to crèche facilities in services which are involved in offering support and interventions for families.** A lack of available childcare was reported by some participants as a significant barrier to accessing services. The PSA group especially highlighted that parents sometimes reported not accessing parenting programmes due to such difficulties.

Appendix 6: Transcript Excerpts

Excerpt from CAMHS group:

Facilitator (F): What are the first things that spring to mind when you hear the phrase mental health?

I think about emotional well-being. Mental health problems.

Sort of a significant threshold, really.

Yeh, I suppose the threshold thing; what I might think of as mental health would be different to maybe what somebody else would think.

If it's a mental health problem, I suppose it's generally how you deal with it, isn't it? We all have mental health, but it's not necessarily an issue, a mental health difficulty.

Just problems, just generally.

I guess in a work capacity you'd be looking of it in terms of a mental health difficulty, rather than a spectrum as such.

And some of the myths around mental health, you know, when you see parents, young people and professionals, what they consider a mental health difficulty and what we do is sometimes quite different. I guess it's just our service criteria really, I think I'm specifically thinking about screenings, where is where we think about eligibility for tier three mental health services as opposed to another provision, or whether it's just sort of more emotional, behavioural concerns that could be dealt with a bit differently without sort of a more intensive or invasive intervention. I'm thinking about it from a screening point of view.

I'm tempted to say diagnosis and labels.

Yeh, that's like the obvious thing that we sort of encounter, certain mental health diagnoses, whereas we tend to work from a formulation point of view.

Excerpt from Assistant Educational Psychologist group:

F: What do you think your role is in identifying and supporting children's mental health difficulties?

I think it's like raising awareness for staff, and I suppose training around different mental health difficulties that people might have, and I suppose the assessments that we do, as I mentioned before, like the Beck Youth Inventory might highlight some potential mental health difficulties that that young person might have.

It could be like reassuring the teachers, like one of my teachers said 'I'm just so sure there's something with that child', and working together with them to see what they think, and their take on things, and just giving them some reassurance, maybe from your own experience, and your own ideas that you could implement, or the teacher could in the classroom, to kind of assist them to... I suppose that's a way.

And I think our role as well is to try and break down that stigma of it being 'it's a mental health problem, it's a problem, we need to sort it out', but... like (name) was saying, you know, like, work with them to support children that need that additional help.

I suppose that raising awareness in terms of the teachers. Because they've got such a big class, they're very good obviously at identifying the children that are acting out, and it's the ones that are quieter that they're not always so good at noticing... and then pick out the types of difficulties that they may be going through.

And also just raising awareness for children themselves, so... especially in primary, and the 5 ways to wellbeing was from TaMHS, you know, it did that didn't it, and it was a nice workshop for them to just get them thinking about mental health, without calling it health, and, you know, just encouraging them to think in different ways, and change their thinking patterns about certain things.

And I suppose providing reassurance for them, to say, like what their experience... is quite common, and other people experience the same sort of things. Because there isn't that sort of awareness around it, they might be thinking it's only them experiencing it, or might be quite concerned about why they're thinking certain things, but I suppose the work we do is sort of reassuring them that other people do experience these things, and there is help out there, and how they can access this support.

And that links into the parents as well, doesn't it, reassuring them as well as the teachers, and... everybody working with the child.

F: So there's a reassurance role...

And therapeutic support as well, you know, when identified, offering direct therapeutic support in school, or... if they're not going to school, out of school, and being quite flexible for their needs, I think.

And maybe even seeking more training yourself, or through your supervision, finding somebody who's more knowledgeable about something that maybe you don't know about, that's come up in a school or a child, so there's that as well.

Excerpt from Parent Support Advisor Group:

F: What sort of skills and qualities do you think people need to effectively identify and support children's mental health difficulties?

I think like we've said, you know, obviously about like their body language and behaviour, you know, even, say, friends, and how confident they are, their self esteem, are they able to make friends? Do they find it difficult? If they do, have there been attachment issues, and things like that? You know obviously, like what we've already said, it's obviously going to take time to maybe recognise some behaviours, and then do they link in with any underlying issues...?

And I think what we're taught on the programmes as well, is if the child is angry, acknowledging that with the child. 'I can see how you feel about that', 'can you try and'... and trying to get the child to explain how they feel, and if they're young, asking them to draw, or if they're older, it's much easier, because you can... I think... I know it's going back to our counselling... the core conditions of counselling... empathy, congruency, respect, regard. And that works, and that will work with a 3-year-old, as well as a 33-year-old.

And it shows... that you're allowed to talk about it, it's ok. It's ok to cry. It's ok to have these feelings. It's ok to get angry, you know, if there's reasons behind it. It's like, ok if you're just having... (inaudible) and there's been no reason, and it's just maybe because they haven't had their own way, then it's maybe more like a tantrum, rather than the underlying feelings, you know, behind it.

And what is it, name the behaviour, not the child. You're not bad, you're not aggressive, you're not... the behaviour that you're displaying is. And that helps them detach a little bit. Otherwise they'll go through life, and whatever label they're given, they can take on that mantle can't they?

F: And what things do you think has helped to develop these skills?

I think a lot of it really is what you come into the job with, your past experiences and knowledge, and then it's obviously experience in the job, and just talking to other colleagues, and it depends what training we receive, isn't it, you know, to further develop.

A complete open mind. You know when you get to the end of the day and you've got a visit coming on, and you think 'oh God', and I feel guilty as soon as I step in the house, and I've talked to the parent, and I always feel guilty for thinking 'oh, not another one', you know, but it's that empathising, and if that empathy comes over with the parent, you will get everywhere with them, absolutely everywhere with them, and you've got to show that 100%.

Yeh, that's it. Good listening skills, isn't it? And really letting them off-load. You know, I was on the telephone to one of the parents last week who I haven't spoken to for a while really and as far as I was concerned certain things that I'd set up had all gone into place, and they hadn't, only because she'd refused them at the time, but, you know, and she was on

the phone, and we were on the phone for a good an half hour or so, and she went 'oh (name)...., thanks, you know, I've just been able to off-load, and you've listened, and I've got it off my chest' and, you know, she said 'oh, it's like I've had a counselling session', but just for her to be able to comfortably talk and de-stress.

F: Can I pick up on the comment 'it's what you come into the job with'. Are there particular skills or experiences that are helpful?

I think it's about being realistic. We have this sort of vision in life of how perhaps family life should be, but the reality is it's not like that for everybody, far from it, and not to be sort of shocked, or you know, stunned by it. But it is about having, you know, some sort of knowledge of reality, and that family life isn't perfect for everybody.

F: You talked about training...what training in particular do you think would be useful?

I think general counselling skills.

Yeh, the other PSAs that haven't got it say they want the counselling training.

Yeh, (name)'s talked about that in great detail, and thinks that we should all... and obviously I'd previously done mine before I started this role, in my previous job, but, you know, that was only because it was what I'd taken on board. But, I think it should be, even if it is only up to maybe level 2, you know, maybe just the basics.

Excerpt from school staff group:

F: What skills and qualities do you think people need to be able to identify and support mental health difficulties?

Lots of understanding. Sympathetic.

Confident. Very confident.

Positive. You need to be positive and not negative.

Have a...

You've got to have knowledge of it before you go anywhere haven't you? You've got to have knowledge about mental health. You've got to have a good understanding of mental health issues before you can go and support it.

It's about experience isn't it really?

I don't know...

No, I know what you're saying, yeh, but for me, that's personal, isn't it, which I understand that, but... If I had a child in my class.

From that experience I know how to, well hopefully, because the experience, you actually have the experience. That is better to me than all the training, because you've actually had the experience. It's like counselling. I could go on a counselling course, in fact I'd have to if I wanted to do counselling, but the fact that I've gone through that myself, and had counselling myself, I know, because I've had experience of that situation. Because I mean you look at some of those people who have been trained, and the classic is like midwives, when you've had a baby, and they come in and tell you what to do, and none of them have had a baby themselves. You know, that's a classic kind of...

What I'm saying, like if I had a child in my class now, and they said 'this child's got bipolar', yes, I might have some experience of working with a different mental issue, but I don't have enough, I don't feel, I wouldn't be confident enough to support that child with bipolar, because I wouldn't have that...

I wouldn't, because I don't know about all the extremes of autism or bipolar, I don't. But I do know about children being depressed, and signs, and, you know, adults... but like you, I don't know about bipolar.

I think even if you do, like, loads of courses, until you've gone through it, you can't put it into practice... and then sometimes you have the courses, and you don't use them, so you go a bit... yeh.

Excerpt from behaviour workers group:

F: How confident do you feel in identifying and supporting mental health difficulties?

I think I've got most of my confidence doing this job because of the psychologists who've always been there for me to speak to and talk to about it, and they're saying 'yes, that sounds good, that sound right', and that gradually built my confidence up to think 'well I am seeing things, and I am making the right sort of judgements', even if it's just me saying 'well, I've got this gut feeling', and that's all I can say, it's a gut feeling. It tends to be the right feeling, so I would say the ed psychs have been fantastic.

Yeh, being so accessible in the (multi agency) team. I'm just thinking in my last job where we had no access to ed psychs, even though working in a PRU you could have done with it.

It's patchy, isn't it? Some people have more access to an ed psych than others. I mean, you share an office with them so...

I do now, but when I first started, I did literally make the links myself to make sure that I was never working on my own, because there was quite a danger of being isolated in the job I do, so I make sure those links are there, and I've always kept them really secure.

I wouldn't feel confident saying 'this pupil's got anxiety' as a diagnosis. Not at all, do you know what I mean? I don't feel qualified for that sort of thing. If they've got depression... I could say I think they're depressed. I don't know if something's causing that at home or at school or they're just depressed because that's the way their state of thinking is. I wouldn't feel confident... I do look for things that might be depressing somebody, do you know what I mean, things in the background, and if there are, I suppose I could hazard a guess, but that's as far as I'd go, and I don't think it would be fair to me with my qualifications to say anything more really.

I feel really confident, sorry. Yeh, I do, and I don't know where it all started really.

I feel really confident, but it's probably misplaced. I think that... I don't really actually work with kids anymore, but I think in my past jobs I did, and I may have got it wrong sometimes, but I don't think I would have ever been in a position where I would have been identifying something on my own, because you work in a team approach don't you? So, you know, when we had (name) in our team, and (name), it was brilliant wasn't it? And also, I was at the (team) in its good era, and we had a couple of really good therapists on that team that I learnt loads off them. But I might say, like you, 'I've got a bit of a feeling about blah blah blah, this young person', and then they would sort of put the meat on the bones, if you see what I mean. You might have a turn, and you might say 'I think I would like to take this line', and they would say either 'no, I think you should do this', or... so you're never really on your own are you, in terms of identifying and then working out a sort of, not a treatment plan, but a sort of way forward.

That support, you know.

I would just like to add that when I talk about my lack of confidence, that's a personal thing. As part of a team, I would say I do find it easy to take something back to educational psychologists. When we had TaMHS workers, it was fantastic. We had two, we did.

I think my confidence has been increased by thinking 'everybody knows the same as me', but when you talk to people, they don't actually, so... A lot of the things I've thought were common sense, having gone into schools, and worked in different... worked in social services, and worked in schools and... people don't, so then I've thought 'actually, I do know quite a bit'.

Appendix 7: A Sample of Coded Data

N.b. Letters in text codes relate to participant group (as shown in results). Numbers relate to position in the transcript.

Conceptualisations of mental health:

Organising Theme: behaviour	Quote & Text Code
normality	<p>A3: Isn't it anything that's not normal behaviour?</p> <p>A20: It's not behaving in an acceptable manner, like social, so socially, how people are perceived. We all act in a certain way, so if somebody's acting not in that way, that's when we think they've got mental problems.</p> <p>A28: Well I suppose I was very quiet for me. That's not normal is it?!</p>
behavioural presentation	<p>A5: But then it's not always behaviour, is it? You might not show it.</p> <p>B42: And what is it, name the behaviour, name the child. You're not bad, you're not aggressive, you're not... the behaviour that you're displaying is. And that helps them detach a little bit. Otherwise they'll go through life, and whatever label they're given, they can take on that mantle can't they?</p> <p>A6: Yeh, so then you can be more into yourself if you've got more of a mental issue.</p> <p>E41: Behaviour's almost what they do, it's kind of how they act it out really, isn't it?</p>
behaviour as a communication	<p>E34: I'm not as involved in it as I would like to be anymore. It's more sort of strategic level. I do do hands on stuff, but it's more training staff. So I guess if... our school on Tuesday are doing a twilight session on SEAL, I then hopefully have influenced 10 teachers to deliver SEAL lessons in a more effective way, and I get my little plugs in about behaviour as a language, and yes, you know, I totally...</p> <p>E42: Behaviour is the language isn't it?</p> <p>E45: But the very little ones haven't got spoken language, so the behaviour is telling you what's going on, and that's where I always start. It's just having a good look at the behaviour that is being displayed and what's the story behind it, and you haven't got to dig very far and you'll find out that they're trying to communicate something to you.</p> <p>E51: I don't know, when people are having a breakdown, or they're completely in a psychotic state or whatever, they'll be doing things that they're not even aware of, and that to me is a real mental health problem. Whereas, if you've got some sort of awareness... A lot of the time they don't know what's going on, and they're hearing voices, or sometimes they'll find themselves miles away and they don't know how they've got there, whereas behaviour is always seen as something that's a behaviour that they're doing... a language, and probably the same as children, but there is some notion of what's going on when they're doing it.</p>
causation/explanation	<p>A36: The difference for me is a child that's being really, really naughty, and a</p>

child who has been naughty, but there's like a reason at home, because of what's going on or... I don't know, it might not be acceptable, but then you can...

A55: If anyone's gone to prison, parents are in prison or anything like that... that can have a massive effect on their behaviour, which it did in the group, my group. Because you can understand the children then. You're not going to punish them for, do you know what I mean... sitting there in a world of their own, or...

B40: And it shows... that you're allowed to talk about it, it's ok. It's ok to cry. It's ok to have these feelings. It's ok to get angry, you know, if there's reasons behind it. It's like, ok if you're just having... (inaudible) and there's been no reason, and it's just maybe because they haven't had their own way, then it's maybe more like a tantrum, rather than the underlying feelings, you know, behind it...

E40: Behavioural difficulties to me would suggest a choice in the matter, whereas a mental health difficulty, they wouldn't be choosing to do, they wouldn't be in control of.

E43: Sometimes there's a means to the end with the behaviour. They're behaving because they want 'this'. There's... whether it's attention, or because they get removed from the class, which is their intention, but the only reason they're doing that is because they want 'this', or it's things at home...

E44: I usually think that if I can't find any reason why they're doing this or anything, then I think then we have some issues regarding mental health, and I don't know if that's right or wrong, but that's... when I can't really explain. I have one or two pupils that will just do things in class, nothing preceding it, or nothing coming afterwards.

E45: But the very little ones haven't got spoken language, so the behaviour is telling you what's going on, and that's where I always start. It's just having a good look at the behaviour that is being displayed and what's the story behind it, and you haven't got to dig very far and you'll find out that they're trying to communicate something to you.

E47: I think some kids just have to let it out, and behaviour's the way they display it, because they perhaps can't express it any other way.

E48: Well for little ones it's the only way they can tell you very often if they've got a problem, and the aggression that staff are seeing... a lot of my job is trying to explain to teachers that the aggression you're seeing is actually something else, usually anxiety, but there's something behind it. They're not just an aggressive child.

E50: I think my take on it is a bit different, because coming from adult mental health, that was how it was classified. We'd look at someone and think whether it was behavioural, as in an intention, and something that was chosen to do, rather than somebody who was...

E51: I don't know, when people are having a breakdown, or they're completely in a psychotic state or whatever, they'll be doing things that they're not even aware of, and that to me is a real mental health problem. Whereas, if you've got some sort of awareness... A lot of the time they don't

	know what's going on, and they're hearing voices, or sometimes they'll find themselves miles away and they don't know how they've got there, whereas behaviour is always seen as something that's a behaviour that they're doing... a language, and probably the same as children, but there is some notion of what's going on when they're doing it.
demonstration of self awareness	E51: I don't know, when people are having a breakdown, or they're completely in a psychotic state or whatever, they'll be doing things that they're not even aware of, and that to me is a real mental health problem. Whereas, if you've got some sort of awareness... A lot of the time they don't know what's going on, and they're hearing voices, or sometimes they'll find themselves miles away and they don't know how they've got there, whereas behaviour is always seen as something that's a behaviour that they're doing... a language, and probably the same as children, but there is some notion of what's going on when they're doing it. (Several quotes excluded due to personal content.)

Organising Theme: pathogenic	Quote & Text Code
different conditions	B1: Depression I think for a lot of our parents who we're dealing with. D1: Of different mental health problems, so like, names like OD, like. That's the first thing that comes into my head. D2: Yeh, but, necessarily... things like depression, that sort of thing. E1: I think of depression. I don't know why, whenever you say 'mental health', the first thing that comes into my head is depression. E4: For me it's anxiety is that first word that comes into my head, because most of the children that I pick up in early years, there's anxiety there for whatever reason. I would say the majority of our cases, it's anxiety-led behaviour. E29: And for me, I didn't realise that there was such a broad spectrum, should I say, from something like anxiety, all the way through to depression, or even worse.
criteria/ service eligibility	C3: Sort of a significant threshold, really. C4: Yeh, I suppose the threshold thing; what I might think of as mental health would be different to maybe what somebody else would think. C10: I guess it's just our service criteria really. I think I'm specifically thinking about screenings, where is where we think about eligibility for tier three mental health services as opposed to another provision, or whether it's just sort of more emotional, behavioural concerns that could be dealt with a bit differently without sort of a more intensive or invasive intervention. I'm thinking about it from a screening point of view. C18: ...we would screen mental health difficulties or emotional health difficulties... C27: But I guess things like sort of severity, impact on the family system, impact on daily living, whether they're accessing their curriculum, again just risk factors, that's what we screen for. C29: ...we get a lot of people asking, you know, 'are they on the autistic

	<p>spectrum, have they got ADHD, have they got attachment disorder?', and things like this, but actually, I would formulate it that they've just not had a very good experience, and sometimes they might meet those criteria.</p> <p>C30: Is it helpful to go down that route and say 'yes, they meet the criteria for ADHD, let's try some medication'? Sometimes they're helpful, and sometimes it's not, and I do think it is a bit blurred in my mind sometimes, and sometimes whether it's helpful or not, and I think I personally probably look at each case and think 'in this case, what is the most meaningful and helpful way of describing this child's problems?'</p> <p>C31: I mean, they would always meet the criteria for our service, in that they've got, you know, severity of need, and pervasive problems that's affected, you know... various contexts of their lives, you know, school, home, everything, social relationships, you know, it's quite chronic, but sometimes I don't know how helpful it is to say they've got a mental health problem and pathologise these children.</p> <p>C38: They still meet the criteria for our mental health service, but it's just the way it's written on paper, and the way it's communicated to other people in the system perhaps, and people within our own team.</p> <p>C39: We've always cooperated because of our sort of lead has never really believed in... sort of eligibility criteria as such, other than the normal patch and age, and those sort of constraints, but I think the time is coming now where we are going to be developing service criteria anyway...</p> <p>C40: I think it's all very much down to clinical judgement, you know, people with experience doing the screening, and seeing whether it's a mental health issue, and you know, does it require this level of resource, as opposed to someone else that can maybe commit a bit more time, or be more, I don't know, more flexible or more local, or whatever.</p> <p>C44: I've worked in other CAMHS services where they send out like questionnaires or sort of screeners, you know, before they will be allowed in, with cut-offs, thresholds... we don't do that. We have kind of some global measures, but they're done at the screening session, but they're scored afterwards, so nothing sort of hinges as such, they're just pre- and post.</p>
diagnosis	<p>C11: I'm tempted to say diagnosis and labels.</p> <p>C12: Yeh, that's like the obvious thing that we sort of encounter, certain mental health diagnoses, whereas we tend to work from a formulation point of view.</p>
genetic factors	<p>B3: But two levels. There's the mental health that could be something that's genetic, that you're born with; you've actually got a mental abnormality. But then there's mental health which is all to do with emotional well-being. So some can be medicated, some can't. I suppose I would split it maybe into the two.</p> <p>B7: Or they've got a hormone missing or a gene missing then that's quite clinical isn't it?</p> <p>C17: ...but sort of genetic predisposition. You know, we would almost always do a genogram, an extended genogram, sort of at the initial appointment...</p>
medication	<p>B6: But somebody that suffers from manic depression has to be medicated, or bipolar.</p>

physiological factors	<p>D11: I suppose you think of something medical, in terms of like the physiological imbalances in the brain, or something like that.</p> <p>E7: But then there are people who are depressed because they're depressed aren't they? They can't see anything positive. For absolutely no reason... they might have a positive life. I do wonder sometimes whether people's behaviour is down to some medical reason, some abnormality of the brain, that you can detect, or whether it's somewhere deeper in the conscious... I don't know what... I'm really confused about mental health.</p> <p>E23: And I would say, I've had a few up and down phases in my life, especially around the time of having children, because I think, you know, hormonal changes and that kind of thing, but I don't think my way of thinking has changed about it. I just feel that I've got a bit more empathy for people having experienced some ups and downs in my life.</p>
mental ill-health	<p>C2: Mental health problems.</p> <p>C7: Just problems, just generally.</p> <p>C34: I think some of these young children, if they get pathologised as having a mental health... I think they can end up being stigmatised...</p> <p>C37: We've been very clear about that from the offset really, sort of saying 'I still know that you're not pathologised', because it's classed as mental health service, under the guise of, you know... John Smith, he's not pathologised because of that.</p> <p>D1: Of different mental health problems, so like, names like OD, like. That's the first thing that comes into my head.</p> <p>D3: I think of schools talking about it as well, and how they only see mental health as something negative, and that it's mental health and it's quite a big thing, a big deal.</p> <p>E2: It's mental ill-health isn't it? And I think that's generally what people do, when you say... well, because I've worked in adult mental health, they're like 'arggh, how can you have done that?'. They're quite fearful.</p> <p>E9: I do think generally mental health, that when you say 'mental health', I think, I don't know why, but generally people do think more negative, don't they?</p> <p>E10: Mental health problems don't they? The actual title 'mental health' is like health... it should be, but it has the connotations of mental health problems.</p>

Barriers to supporting children's mental health difficulties:

Code: professional differences of opinion/ approach	Quote
interpersonal skills/ approaches of others	<p>A50: It's everybody knowing that if that child has got... a little boy, I sent him somewhere with something, and the teacher had took it off him because she thought it was distracting, and then his behaviour just went 'waaaaayyyyy'.</p> <p>A71: But then training doesn't work though does it? It's changing the person's view, I think. Because I think you can throw as many training</p>

	<p>courses at people, but still they'll... it's changing the view I think... I don't know, am I wrong?</p> <p>A72: You can try, but I think there are certain people, staff... Who are very tunnel vision.</p> <p>Yeh, he or she is just downright naughty, and whatever.</p> <p>A83: It's like being cross with a child... obviously, they've got to be told off, but...</p> <p>A84: It's your background as well, because I know I had like a little thing with one of the teachers about something, maybe because they live in a nice area, and it's all very nice... I was brought up right smack-bang in the middle of (place), I worked in (places) and you know, you get drugs everywhere. It's not just the deprived areas, but this person's very much like 'oh no, not where I live'.</p> <p>I'm very open-minded. I can sympathise and see that it isn't just in the poorer areas at all.</p> <p>A85: Some people are very tunnelled.</p> <p>E36: ...but I am frustrated at how harsh they (teachers) can be. Even though I tell them about SEAL, I do get a lot of my favourite little topics and subjects in there, you know. Maybe what (name) said is really important actually, you know. I think maybe if a teacher was very, very open and caring, and prepared to listen...</p> <p>E49: You don't want them to be written off like that.</p> <p>No! Not at the age of 3.</p> <p>E82: Because that's shocking, isn't it? When you read... remember when we used to get referrals in the (team) meeting, and you think 'oh my God, it sounds like the devil!'. And you meet them, and they're just the most lovely...</p> <p>And you sit there and think 'Well where's this person? They've sent the wrong child to me obviously'. I've had that so many times.</p> <p>Yeh, little pussy cat, and you think 'how can that add up?'.</p> <p>E107: It's really very shocking though when you think about that, that schools are an institution about people, and they don't understand about how you treat people, and make them feel welcome, and it's so important isn't it? It's so important, and I find that so disappointing that they would have so little respect for somebody.</p> <p>E108: He was already nervous. He said to me. I said 'are you ok?'. 'I feel like I'm waiting for the dentist', so he had to sit and wait for the dentist in effect for an hour, so that level of anxiety, waiting for something to happen, it was very difficult.</p>
<p>commitment to supporting children's mental health</p>	<p>A74: There's been a few children... I've gone like 'I've got a great load of stuff on this if you want it', like, from my past school, my past course, I did like counselling, and child behaviours, I've got a great load of stuff like strategies, and you'd think they'd say 'oh yeh, we'll try them'.</p> <p>C60: General interest... some teachers might be interested in this area, some might not. Sort of a general interest really might lead people to find out more, and develop skills.</p> <p>D82: I think sometimes when you say to schools, or you've suggested</p>

	<p>something, they're like 'oh, we've tried that before', or 'oh, it won't work'. You know, and, there's that as well that maybe sometimes... are staff in school willing to change things to meet particular children's needs?</p> <p>E106: I think some of it, I've been working in the same schools for 2 years now, and I've seen a difference, is that, some of it, sometimes they're not interested. They left a (behaviour) worker waiting an hour today to be spoken to, which I could see was annoying him really. It was very demeaning for him. And they used to shove me in the corridor, shove me anywhere. They wouldn't tell me when the school wasn't open or closed, or anything like that. I get a bit more respect now after 2 years, and I can see the difference, and it's like you've got to do your time to earn your respect, or whatever, to then get a different working environment.</p>
<p>academic versus social and emotional support</p>	<p>A80: In Year 1, there's a little girl... blonde... who's been a bit upset, but I don't know why she's upset. I'm not in Year 1, not as much as you. And she sat there just crying, and everybody was moving, and you know, normally she's been... so obviously something's happened, and I don't know, because I haven't been told, so I went straight over to her, and I said 'come here, what's the matter?', and 'I want my mummy, I want my mummy', so I started to explain... and the others started coming into the classroom... and through the corner of my eye it was 'no, no, no, no', and I just ignored it, because that child needed that support, that attention, just for 2 seconds, to know everything's ok, mummy's coming later, but she's going to do some really lovely work now, and mummy will be so proud of her. She went off with a smile on her face. I couldn't let that child go out full of tears, and worrying, like, you know, and I've been watching her, and she's been alright since.</p> <p>A81: I get that we've got to get things done, and I get that there's targets, and I get all of that, but I just think it's all like 'push, push, push', and you've got to do this, and you've got to do this.</p> <p>You feel like you're on a treadmill really.</p> <p>A82: I don't care if it goes 5 minutes into RWI, because I might be the only person that listens to that child all day, because who knows when that child goes home, does their mum and dad listen to them? So that 5 minutes of me going 'oh yeh, did you do that, oh that's lovely'.</p> <p>That's probably meant the world to them for that 5 minutes. I just think there's a bigger picture that we all need to be aware of, and I don't think sometimes people are.</p> <p>A95: Because I work in Reception, and now I go to Year 4. In Reception I do get time to do a lot of circle time, and talk about the social and how you make friends, and how you play with each other, which are important skills.</p> <p>A96: In Reception I do get time to do a lot of circle time, and talk about the social and how you make friends, and how you play with each other, which are important skills, and it's a big difference when you go up to year 4, and I'm looking around the classroom and thinking how many haven't got the social skills to even... you want them to go and play in the playground... they can't even talk to each other in the classroom, let alone play together...</p> <p>There's a bit of a breakdown from when they were in Reception and Year 1, and the school say 'oh well, they're older now, they should know better'.</p>

There should be at least 20 minutes of the day to talk about... I think they could squeeze it in.

A98: ...then this profile came in, the foundation profile, with all these things to tick, so then you just started doing your observations, and you're doing that, and the interaction sort of... if that was changed right from the nursery, to go back to developing the social skills more down there, it's going to have an impact all the way through the school.

A99: The social skills, it just affects everything. If they haven't got that... you wouldn't build a brick and miss out half the bricks would you? You wouldn't build a wall... because it would fall down, and it's just the same. You need it from day one.

A102: I think it's just very academic isn't it, and it's took over the importance of social skills.

A104: I think it's become so 'oh forget the social, it's all literacy, numeracy', all the time.

A105: It's got PSHE on the profile. 'Oh, they're not scoring 6 on PSHE'. 'Well, why do you think that is?. Because they haven't got any social skills'. They're not going to score blooming 6 on the PSHE are they? Do you know what I mean? 'Why haven't they got 6?'. 'Because they haven't got any social skills because we've been doing too much of this this and this, and we've pushed that important thing aside'.

A106: (F) So the academic side has overtaken...

It has overtaken... Homework, and... and that's why you get a lot of children now being more and more insecure in themselves.

A110: I feel now my job is for RWI, getting this done, recording that, photocopying this, doing that... I feel like I've lost... it's about the children. That seems to have gone out the window a little.

D57: It is an issue, because the teachers are so over-loaded with work, and there's so much pressure on them to get the grades, and I think that children's emotional wellbeing and mental health is forgotten about, because the school's so focused on having to get the certain levels or grades, and achieve certain marks, that that's what gets forgotten about.

D58: They don't seem to always recognise the link really between the two that obviously if the child's mental health isn't great, then obviously they're not really going to be in the right frame of mind for learning.

E30: I think one of the roles that I find in schools is, no disrespect to teachers in any way, but they do come to the arena with a completely different sort of script to me, and they're there to teach and I've got a lot of respect to teachers. They've got to manage classrooms full of lots and lots of different... I think the child will sit with me and explain perhaps more what on that day or that week... and it's been quite horrific really, and then you go to the teachers, and 'that's why they've been a bit disruptive', and then it's like 'ohhhhh, ok', so you can be almost a mediator sometimes. It's like 'well this is what's happening'.

E46: I also think that even if they've got communication skills, working with sort of like Key Stage 3-type age pupils, their lack of understanding about how other people are... you know, we did loads of work on how can you tell

	<p>how other people are feeling, as a sort of precursor I suppose to talking about how you're feeling, and then recognising triggers in yourself before you start behaving inappropriately. And they just couldn't really recognise... very obvious, maybe 'happy' and 'sad', but even then, and I don't think kids have got the language to express what they're feeling, and they certainly haven't got the strategies that if they feel stressed that 'it's probably the best time to keep it in now I'm in a lesson'.</p>
<p>professional differences regarding how best to meet children's mental health needs</p>	<p>A49: Or if you don't get people agreeing with what you think... It's knowing what different people think as well, what their views are. Other people might not agree with what you...</p> <p>C71: One of the things in particular for my work with looked after children is that I have to rely on colleagues in other agencies. Sometimes they might make decisions that aren't the best for the mental health of the child. Sometimes that's quite tricky, in terms of kind of working and trying to meet the needs of the child, sort of systemic issues come in to play sometimes.</p> <p>C79: Because a lot of my work feels like kind of a lot of systemic liaison to kind of get the ground right and things to a stable state to be able to do anything sometimes with the children and young people. So, it feels a bit of a roundabout route sometimes; then you start doing something, and somebody starts doing something else. It's not always like that, but particularly in my work, that's, you know, a major factor.</p> <p>D72: It's quite interesting... there is a difference in us and CAMHS in the fact that I was working with a young person for quite a while, and I felt that his difficulties were more from like attachment issues. We had a referral to the (CAMHS team), and he ended up being diagnosed with ADHD, ASD and Tourettes, and I was quite concerned that after 2 hours someone could make that diagnosis, and he was then medicated, when it was really more around the attachments and the issues at home, and I think that it really did concern me that obviously there was that difference of opinion. But they get to see the child in a very sort of clinical se... like, the child in a room, not the child in a situation, which is what we look at don't we? And everything else going on. Like you say, just 2 hours, and then to...</p> <p>D73: I think there is definitely a gap in CAMHS and other professionals. That was the same where I used to work. It seemed very... Like you were saying (name), they don't come to CAFs and things like that, so they're seeing the child completely separately.</p> <p>D74: It's just from what the parents are saying, and obviously this parent in particular didn't think that it was their fault, even though obviously their behaviour had contributed to this behaviour that he was displaying, so they're only really going off... I mean, this person never spoke to me about what I thought. I'd worked with him for quite a while, and there was... and there were lots of people involved. There was actually a counselling psychologist as well, and she didn't think that he had any of those difficulties either. But this one person seemed to think there was. I think that's really concerning.</p>
<p>extent of inclusive practice</p>	<p>A69: But that's not inclusive... you're not including them in that lesson, whereas if you just sat for an extra 10 minutes and just looked at them</p>

	<p>separately on your planning, you might be able to fit them in... you know, if we're going to be inclusive practice, then taking them out for an hour while the others do something else, then that's going to cause a whole... more issues, because they know, when they get to an age, they know they're being took out because they can't do this, so then they're going to resent the teacher, they're going to resent the class because they've have fun while they've been doing something else...</p> <p>But their peers are resenting them as well...</p> <p>Well that's it. You've got the social side then that goes to pot haven't you, so to speak, because they know when they hit a certain age, they know... 'you are going out because it's just more manageable without you in the'...</p> <p>A86: My older nephew, he's got ADHD, and I mean he has good days and he has really awful days, but when we was little, and he was displaying all these signs of it, my dad was like 'oh, he's just naughty, he just can't do as he's told'. He just put it down to naughty, because when my dad was growing up, there was no ADHD. My dad didn't, and my dad's generation was very much like, you know, it's just naughty behaviour. You didn't discuss special needs in dad's generation. They went to, you know, a place on their own. Special needs were out, that was it, they were supposed to be somewhere else, the same as mental health, so it was never really a talking point for me, because it was like 'oh, they've got something wrong with them'. Do you know what I mean? His generation, that's how it was, whereas my generation, is like, I've gone to school with children with special needs. I've gone to school with children with ADHD and things like that. It's people's perspective.</p>
differing priorities/expectations	<p>C72: And I guess that can be the case when you're working with families and stuff, can't it? You know, always wanting to... you know, not everything falls into place that would be the best in terms of meeting the mental health needs of that child, and helping that child. You know, some things just don't work out.</p> <p>C75: Because I feel there's quite a lot of sort of difficult parameters that put constraints on my work, but having dipped into your work, I've got the utmost admiration just because of what you've just said, and you can start to feel a bit useless I think at times, and manage that, because you know what you would like from your perspective for that young person, but it doesn't always fit with the context, does it?</p> <p>C76: And I suppose, you know, the working culture, you know, of what we might do in our service doesn't match with the working culture of other services, in particular residential homes, or social services...</p> <p>D57: It is an issue, because the teachers are so over-loaded with work, and there's so much pressure on them to get the grades, and I think that children's emotional wellbeing and mental health is forgotten about, because the school's so focused on having to get the certain levels or grades, and achieve certain marks, that that's what gets forgotten about.</p> <p>D58: They don't seem to always recognise the link really between the two that obviously if the child's mental health isn't great, then obviously they're not really going to be in the right frame of mind for learning.</p> <p>D86: I suppose the working culture, it's sort of the unrealistic expectations</p>

	<p>for school, because sometimes you find the schools just want you to come and do an assessment, give them the report, and then go to (name) panel, or something else... They don't really want you to spend that time with the young person trying to identify all their needs. They want it to get some support from the (name) panel, and that's it, so it's managing those expectations from the schools from outset really about what you're going to be doing.</p> <p>D87: How your team members expect you to prioritise the casework coming in. So, say for a, I don't know, for a school or a (name) team, it might be that 'well actually, this kid hasn't been in school for a month, and they need a panel report, and they need to go to panel now', and there are actually 5 kids that you now need panel reports for, and so how then do you fit in the children that aren't actually accessing any education, or the children that really need your therapeutic support in school?</p> <p>D88: And it's the time... it comes back to time and workload again, but really the priority then would in many people's eyes be seen as 'well these children aren't even accessing education. That kid is, so you need to get these into school'.</p> <p>D89: And I suppose it goes back to that quiet child in the classroom... he's probably not accessing school either, but you have to prioritise the ones that are actually physically out of school, not accessing... the poor children who are still in school, but not engaging. They're missing out on school as well. And that isn't recognised, is it?</p> <p>No.</p>
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Organising Theme: systemic factors	Quote & Text Code
negative culture	<p>A73: I can say 'actually, I don't agree', but because we are only TAs, we haven't got... That hierarchy... Your point of view really isn't... or, it's taken on board, but then it's not like you want thanks or anything... but it's... 'thank you for that, that was really well spotted', because then you think... 'yeh'...</p> <p>A76: Yeh 'we know better than you do'. And... you feel very low down the scale because you're not as qualified, but like I said before, you can be qualified to the hilt, but if you have experience, perhaps, you know, in life, like some people have, and they still don't... I don't know...</p> <p>A87: We talked a little bit about team structure... the hierarchy.</p> <p>C76: And I suppose, you know, the working culture, you know, of what we might do in our service doesn't match with the working culture of other services, in particular residential homes, or social services...</p> <p>C81: Because I've noticed morale be quite low, you know, in our office, over the last few months, and that makes it difficult because your work can be quite heavy, and sessions quite heavy, and there's no lightness around to kind of balance that. Yeh, so I think that is kind a factor that can...</p> <p>D82: I think sometimes when you say to schools, or you've suggested</p>

	<p>something, they're like 'oh, we've tried that before', or 'oh, it won't work'. You know, and, there's that as well that maybe sometimes... are staff in school willing to change things to meet particular children's needs?</p> <p>D86: I suppose the working culture, it's sort of the unrealistic expectations for school, because sometimes you find the schools just want you to come and do an assessment, give them the report, and then go to (name) panel, or something else... They don't really want you to spend that time with the young person trying to identify all their needs. They want it to get some support from the (name) panel, and that's it, so it's managing those expectations from the schools from outset really about what you're going to be doing.</p> <p>E100: Having just come from sitting in a room when I was talking to you on the phone and having two people going hammer and tongue, really shouting and banging things around, I felt anxious on the phone, and I was really trying to concentrate on what I was saying to you. The work environment for me is not a good place to help me help other people at the moment. It's a massive issue, isn't it? It's a massive issue for new staff members.</p> <p>E101: For me, I mean I've been there 2 years, and I'm a very resilient person. It's still made me feel very uncomfortable, and I'm trying to focus on your conversation which is really important, and... but if the (behaviour) workers have been here, just started, and then been party to that, I just think... and it's not a one-off. So I have to separate myself from my workplace, and I'm able to do that because I'm confident to do that.</p> <p>E102: It's so patchy it's untrue, and I'm not sort of at any one particular, you know... but you can see for the new staff that I'm supporting, it's not fair. Some of them are put in immensely supportive teams... And you can see the difference probably. Yeh, and their anxiety... you can see the anxiety all over their faces, but I'm constantly trying to put that right and saying things to...</p> <p>E106: I think some of it, I've been working in the same schools for 2 years now, and I've seen a difference, is that, some of it, sometimes they're not interested. They left a (behaviour) worker waiting an hour today to be spoken to, which I could see was annoying him really. It was very demeaning for him. And they used to shove me in the corridor, shove me anywhere. They wouldn't tell me when the school wasn't open or closed, or anything like that. I get a bit more respect now after 2 years, and I can see the difference, and it's like you've got to do your time to earn your respect, or whatever, to then get a different working environment.</p>
resources/ financial factors	<p>A89: Resources... we've got lots for reading and writing and numeracy, but have we really got... could you go now to a room and say there's all the behaviour stuff, there's a folder with all the strategies in that we've ever used. There isn't is there? I'm getting a bit passionate now aren't I?! But there isn't is there? I can go 'well I know where all the RWI stuff is, I know where all the (name) is... oh this child's playing up... where can I go? What can I use?'</p> <p>B112: Because sometimes we do have to think 'who can we signpost these people to?'. We haven't got sort of this ready-made like directory, pack or</p>

	<p>any...</p> <p>B113: We don't have like an official directory, have we? You have to do it yourself.</p> <p>C77: I think it's just all these competing needs, and the complexity of it, and also I think funding issues and so on come into it, and resources. You know, what might be an ideal place on paper can't get funded, you know. It's those kind of constraints that are very difficult to work with.</p> <p>C78: So you might do like a big assessment, you know, the best sort of placement for this child based on... That's never going to happen, so you think, 'ok', so you feel kind of compromised.</p> <p>C82: I was thinking, kind of, access to the service, and me accessing young people. I like to go out and do a lot of community work, and it's not the case for everybody. We used to have a (name) bus which could bring families to the building, and I know quite a few families who now don't come or can't come, and I think that limits the support that we can offer, being able to get to people, or get them to us.</p> <p>C83: Because we used to have 2 bases, didn't we years ago, one in the west of the city, one in the east.</p> <p>C85: Sometimes we struggle for office space in terms of rooms to see people. Yeh, that's quite difficult isn't it? To have a choice on that, say like after school times it's all a bit chock a block isn't it? Certain clinics kind of book out things, and that's difficult, because you want to give families choice, you know, so they can come at convenient times, and that's not always possible is it?</p> <p>C90: Whereas now, if I wanted to go, they'd probably say 'well actually, we've got 3 practitioners trained in EMDR', so it's... I think that does impact on your attitude to your work and your morale, because obviously you want to continuously and develop and focus on your CPD, and yes, times are changing, and that's less...</p> <p>C93: I think that's an issue for supervision, because what I'm struggling with is if I'm going to do that, and progress in that, I need a supervisor in that particular... and that costs money.</p> <p>C94: Some of the people that have trained in the dyadic developmental psychotherapy approach which is good for attachment difficulties, but again you would need to be supervised in that, so the more kind of specialist you get, the harder it is then to do it in house, because you need supervision, because you don't want to practice unsafely, these kind of specialist things.</p> <p>C95: Because I think we have had a really nice service here, and I think it has been open door for any families who are struggling with whatever in (local authority), we open our doors and try and... or signpost them to other places, and it would be nice to keep that going, but I think given the reality, with the changes...</p>
legislative pressures	<p>A93: Ofsted... all these pressures, and then you don't have the time to spend with the children who need it the most, or if you have the situation where the children are in the class with you, the lack of communication, you know, that's where that comes in.</p>

	<p>A97: It started before then though (name), because if you think about going back to nursery, the first time I worked in nursery, we used to be as a staff... we used to sit, and we would work with children, we would sit there playing with them at their games, and we would sit in the home corner, and we would do the home corner activity with them, and then this profile came in, the foundation profile, with all these things to tick, so then you just started doing your observations, and you're doing that, and the interaction sort of... if that was changed right from the nursery, to go back to developing the social skills more down there, it's going to have an impact all the way through the school.</p>
<p>staffing/workload</p>	<p>A94: You're not being able to... you can't concentrate on... the only thing that like you could do with doing in our situation, certainly in the classroom... you've got a lot of children in that classroom... and 2 people to support. You need something for those children to be able to do independently, so it's important to give that help to a certain amount of children sitting on the green table, because you've got others from other tables coming over to you, so you're still not focusing on that group of children, who are getting more and more upset because they can't cope.</p> <p>D80: Yeh, there's not enough staff really. I don't think even two members... two EPs in a team is like enough really, because the workload... you can't give the support that you'd like to. So we've got this locum EP at the moment, and he's always saying that we're workaholics, and I think he's written like 2 reports in 2 months or something because he's just so thorough, which is fantastic, but we've not got the time to be doing things as thoroughly as he obviously wants to, and we would like to do. But I think that is a real issue, is time pressures and staffing levels.</p> <p>D92: More staff! More staff, definitely.</p> <p>E103: You missed workload off that. I mean, balance. I've either got not enough to do... Really? Yeh, it goes in patches, seriously. All of a sudden, there's tons to be done in less than a week or something, and I find it so difficult to pace it all. In fact, I can't because things come and go.</p> <p>E104: I like it just to be on the edge of just that slight bit too much, so you've always got something to do. You need that slight bit of stress sometimes, do you know what I mean, to keep you going. So I would say workload's important.</p>
<p>insufficient time</p>	<p>A92: And time. Time. Time to... have the time to be with that child. As I say, we're all on that treadmill aren't we? A96: In Reception I do get time to do a lot of circle time, and talk about the social and how you make friends, and how you play with each other, which are important skills, and it's a big difference when you go up to year 4, and I'm looking around the classroom and thinking how many haven't got the social skills to even... you want them to go and play in the playground... they can't even talk to each other in the classroom, let alone play together... There's a bit of a breakdown from when they were in Reception and Year 1,</p>

and the school say 'oh well, they're older now, they should know better'. There should be at least 20 minutes of the day to talk about... I think they could squeeze it in.

A107: You expect a child to talk to you. You expect a child to give you the answers, so then why can't you find the time to talk to them... if you don't take the time with them... as they get to an age, they're going to think 'sod it, I'm not going to tell her nothing, she doesn't listen to me'.

A108: As a TA, do you know, we do the reading, that reading time with a 1-1 child, which is a really nice time, but it used to be that you could find out a bit more about the child, but you can't because you've got to get through so many readers.

B90: I find, that if you allow it, that parents would have you round their house every week, but unfortunately, practically you haven't got the time to do that...

B115: And I mean it was discussed, like, talking about in the (team) meeting, you know, about doing a toolbox and everything else, and yeh the idea is great, but the time that it's going to take, when realistically, the information is already somewhere. Do you know what I mean? But I mean doing a toolbox and looking at different areas and everything else, fine, but you need the time to do it because you haven't got enough time to do your own job anyway.

D56: And having that time to build that relationship, because they don't... I mean, you sit in some CAFs and things, and teachers aren't there, and actually they're the person that's spending that most time with the child, that's presenting however many difficulties, and it's having that time for then the teacher to link up with the other professionals as well, so I think that's important.

D60: Enough time, I suppose.

D79: I think time pressures, and caseload. Although you might be able to have time to identify them, to offer weekly support to all those children that are then identified is really not possible. We haven't got the capacity to do it, and I think that's maybe... would inform your decision even more to refer on to CAMHS. Even if you thought 'I have got the ability to do this, and support this child therapeutically', you might think, well actually I have, but I can't physically fit it in.

D80: Yeh, there's not enough staff really. I don't think even two members... two EPs in a team is like enough really, because the workload... you can't give the support that you'd like to. So we've got this locum EP at the moment, and he's always saying that we're workaholics, and I think he's written like 2 reports in 2 months or something because he's just so thorough, which is fantastic, but we've not got the time to be doing things as thoroughly as he obviously wants to, and we would like to do. But I think that is a real issue, is time pressures and staffing levels.

D81: I think that reflects in school, doesn't it as well? Parents and things. They're quite aware that there is a lot of time pressures.

D88: And it's the time... it comes back to time and workload again, but really the priority then would in many people's eyes be seen as 'well these children

	<p>aren't even accessing education. That kid is, so you need to get these into school'.</p> <p>E31: You know, they genuinely can't devote that time, and I go into schools and they say 'I'm so glad you've come... they can off-load... because we haven't got the time', and they're trying to tell even the secretaries... but the secretary's in the office, and I feel bad because they haven't got the time, and they haven't got their own... they appreciate me coming in just as an off-load and I appreciate the fact that teachers cannot do that, and I think the children appreciate it.</p> <p>E53: You need the time. I think like what (name) said before, often teachers and that aren't the right people, because you need somebody who's got the time dedicated to that young person, who can come along on a regular basis, so I think that's a definite quality... well, not a quality as such, but...</p> <p>E54: ...we've done training before on identifying your personal network, and one of the things is that you need to have somebody in your personal network who's got the time for you...</p> <p>E69: Not a lot of people have that actually if you think about it, especially school, you know. It's on the go all the time. They are in school, they learn, and then go home; you watch TV. They don't really have, you know, that much time.</p>
<p>inadequate access/desirability of access for parents</p>	<p>B64: I suppose a negative is that we're attached to a school building. A lot of the parents don't like coming into an official building, especially if it's attached to a school, so my biggest stumbling block, the negative would be where...</p> <p>B69: Yeh, I mean I think you've got some parents that are quite happy aren't they to walk into, you know, say, our building, and I know obviously it's away from the school, feel happy, feel comfortable to do it, and you've got other ones who I still don't think would walk through the door.</p> <p>B70: No because it is still very formal isn't it? And I think for us as well I find it's the child care facilities as well which can be a barrier. People want to come on courses, or just want to come in and have a coffee and a chat, but if they've got children, you know, pre-school, then sometimes it would be nice to have some more family centre-type environment, where it would be easier to accommodate that need, and that is the trouble sometimes with the parenting programmes, it's 'well I haven't got anybody to babysit', and then we're ringing round, 'have you got spaces at a childcare centre', 'no, they're fully booked that day', and then they don't come on the courses then. It is a barrier definitely.</p> <p>B72: It's very official here as well, especially being with (company). Personally at the moment, we haven't even got a reception, so they're having to deal with someone else before they can deal with us.</p> <p>B73: Yeh, in a children's centre as the parents are dropping off their children, you could actually say 'come in for a tea and coffee tomorrow', and they'll go 'yeh alright, I'll stay'. We can't do that in our buildings.</p> <p>B77: A lot of parents... especially schools, they don't want to be seen walking into them, you know. But at least a family centre, they're dropping off their children anyway. You know, we don't get that at all.</p>

	<p>B89: And I think really the building and the office space, it is a big thing, because sometimes we do need to get parents... To sort of say 'well come and see me at work', and then you bring them here, it's not exactly very relaxing either...</p> <p>B97: I mean, really as a member of staff, we've got a lovely environment to work in, whereas in what we're actually trying to do with families it's not... it doesn't meet the needs.</p> <p>C82: I was thinking, kind of, access to the service, and me accessing young people. I like to go out and do a lot of community work, and it's not the case for everybody. We used to have a (name) bus which could bring families to the building, and I know quite a few families who now don't come or can't come, and I think that limits the support that we can offer, being able to get to people, or get them to us.</p> <p>C83: Because we used to have 2 bases, didn't we years ago, one in the west of the city, one in the east.</p> <p>C84: It is, and I don't think there's a very good public transport link here is there? So that can be a struggle.</p> <p>C88: I think it's nice because it's a child's service, and they are used to coming perhaps if they needed physiotherapy or speech and language, or... it's not... we're called the Child and Family service. It's not like we're the mental health lot over there. So I think the kids get used to this building, and being in the community. There's only this one place for the whole of (local authority), but I think it's quite positive.</p>
<p>inconsistency of advice across services</p>	<p>B81: ...it seems that you've got certain parent advisors that are working for the family centres, you've got (team name) workers, which are family workers that work for social care, you've probably got something in the national health system, we've got us in (team name), and I know that there are families that are going to the (place), and being given parenting strategies and advice that is not really, well it's not really what we'd... and I'm thinking we're referring families to CAMHS, to (place), to do some family support therapy, and they're saying things that we're not being taught to say to parents, and that worries me.</p> <p>B82: if (local authority) and all the other counsellors are saying Triple P, Solihull, Nurture, they all intertwine, they all end up at the same point, then how come we would refer to somebody above us, and they're giving advice that doesn't relate to any of those? And that's what worries me, and it's not fair on parents either. It should be across the board.</p>
<p>insufficient focus on early intervention</p>	<p>B100: I mean early intervention... but sometimes we're brought in, like you say, it's past it. It's not early intervention.</p> <p>B101: Because with you doing a teen programme, the parent has been like that for so long... 16 years, so the parent's got mental health issues, or issues from the past. They've had that for an extra 15 years, whereas if you could have had that when the baby was 1, the child might never have those mental health issues, because you've dealt with the parent's issues there and then...</p> <p>B103: I'm just thinking of one family. She's obviously been with a number of children's centres (lists names)... then obviously, her youngest daughter was five, so that was kind of the end of it. Then she went to school, and then</p>

	<p>school expressed concerns about the family, and it wasn't until we looked back at the information that she'd been involved with the children's centres previously, but if they came straight to the (multi-agency team) to continue that support, rather than the support going for a year, the issues getting worse...</p> <p>B105: ...the children's centres are going to know they're vulnerable parents aren't they? They're going to know the ones that need more help...</p> <p>B109: Whereas they finish at 5 and then it goes back into crisis and then we go in to pick up the pieces.</p>
insufficient team support	<p>A78: but if we were just given the support from... We need the support from our teachers.</p> <p>D59: I suppose we would need, as well, the regular supervision, because it is quite hard on your own emotional wellbeing when you're dealing with young people with mental health difficulties, and it is quite draining really, so I suppose you do need that support from your line manager.</p> <p>D61: It would be good to get a specialist in at some point if we're doing CBT... therapeutic work, some supervision from a specialist would be useful, because we don't really have that anymore.</p> <p>D78: I think it is really down to the training as well, and I know we've spoken about it in our psychology service meetings, and senior members of staff felt that all psychologists could deliver bereavement counselling. I think that's very specialist, and you do need specific training. I think it's that support really needed from higher management really, and the awareness of really what we are capable of doing, and we... expectations within the services what we can deliver.</p> <p>E85: Yeh, being so accessible in the (multi agency) team. I'm just thinking in my last job where we had no access to ed psychs, even though working in a PRU you could have done with it.</p> <p>E86: It's patchy, isn't it? Some people have more access to an ed psych than others. I mean, you share an office with them so...</p> <p>E95: That support, you know.</p>
lack of access to specialist and/or regular supervision	<p>C93: I think that's an issue for supervision, because what I'm struggling with is if I'm going to do that, and progress in that, I need a supervisor in that particular... and that costs money.</p> <p>C94: Some of the people that have trained in the dyadic developmental psychotherapy approach which is good for attachment difficulties, but again you would need to be supervised in that, so the more kind of specialist you get, the harder it is then to do it in house, because you need supervision, because you don't want to practice unsafely, these kind of specialist things.</p> <p>D59: I suppose we would need, as well, the regular supervision, because it is quite hard on your own emotional wellbeing when you're dealing with young people with mental health difficulties, and it is quite draining really, so I suppose you do need that support from your line manager.</p> <p>D61: It would be good to get a specialist in at some point if we're doing CBT... therapeutic work, some supervision from a specialist would be useful, because we don't really have that anymore.</p> <p>D85: And supervision. Like, the level of supervision that you get, and how</p>

	<p>accessible that is would also either encourage or discourage you to go into schools and do that kind of work. If I knew that after each session I could have a 5-minute debrief of what I've been doing, and am I going along the right lines, and is this a good idea to move to here and do this next? If I had that, I'd be much more confident to go and do it, and... but without that, I think I'd be much more inclined to refer on, or not do it.</p>
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