Perspectives in measuring organisational performance in public Child and Adolescent Mental Health Services (CAMHS)

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Declaration

I certify that except where due acknowledgement has been made, the work is that of the author alone; the work has not been submitted previously, in whole or in part, to qualify for any other academic award; the content of the Thesis entitled *Perspectives in measuring organisational performance in public Child and Adolescent Mental Health Services (CAMHS)* is the result of work which has been carried out since the official commencement date of the approved research program; any editorial work, paid or unpaid, carried out by a third party is acknowledged; and, ethics procedures and guidelines have been followed. I acknowledge the support I have received for my research through the provision of an Australian Government Research Training Program Scholarship

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When I embarked on this study I was inspired by colleagues in the clinical settings within which I worked, passionate about the work of those researchers who had set in train the art of enquiry, encouraged by family and strengthened by friends. Now, as I submit this work, my reflection would be that these experiences have only been enhanced and intensified.

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Finally, I wish to dedicate this work in two ways.

Firstly, to my late brother Peter who as a young doctor in public hospital settings sought in his own practice to balance integrity and quality of care with efficiency. He planted the seeds of challenge to a system that can't do it all and must make difficult choices about priorities and what matters most. He inspires us still.

Secondly, this work is for the children, young people and families.

Let's make things better.

TABLE OF CONTENTS

LIST of TABLES

LIST OF FIGURES

ABSTRACT

As part of the public health system in Australia and internationally, the Child and Adolescent Mental Health Services (CAMHS) setting is a small, specialised, and unique environment – sharing the developmental context of paediatric health and the clinical mental health service delivery domains with adult and aged person's psychiatric services (Kelvin, 2005; Ford, 2007). CAMHS services are grappling with a set of expectations imposed by a stressed social welfare system to manage the sequelae of extreme trauma, challenging behaviour and the impact of family violence and trauma on children and adolescents in their care (Wolpert et al., 2014; Bor et al., 2014).

CAMHS settings are subject to a pervasive set of expectations emerging from elected government regimes linked with the voting community regarding accountability, efficiency, and effectiveness. The rise of the transparency and accountability agenda within the public sector has been documented extensively (Armstrong, 2005; Gaventa & McGee, 2013; Van Belle & Mayhew, 2016). In such a paradigm, accountability is neatly and simplistically measured by the articulation of the task of the organisation and the application of metrics to assess performance against that task. The current study aimed to explore and better understand differences in assumptions, perceptions, and experiences of the organisation of public Child and Adolescent Mental Health Services (CAMHS). Further, the implications these differences have for clinical care, management, and leadership within the organisation itself but also for government in its performance-monitoring role of CAMHS services more broadly are also examined and described.

The current study sought to highlight individual perspectives and experiences as they relate to measuring organisational performance beyond finance, activity, and outcomes towards sustainability, process, emotional climate, culture, and organisational dynamics. Thus, the current study aimed to critically review current frameworks for measuring organisational performance and, through analyses of theoretical constructs and qualitative methodologies, to explore experiences, processes, and meaning. A framework is then

proposed for considering organisational performance in public CAMHS that takes account of these new meanings and proposes the measurement of organisational performance across a range of domains.

The focus of interest was in what personal experience might convey about broader shared issues and themes at an organisational level, and the key data collection tool used was semi-structured in-depth interviews. To elicit data on personal experience, participants who were stakeholders of CAMHS as clients, families, referrers, clinicians, managers, policy leaders, and collaborative partners were the focus of sampling. The data was initially segmented and filtered across broad themes and then coded and gathered into more detailed categories.

Themes emerged relating to the expectations and impressions of CAMHS, the clients themselves and their stories of complexity and trauma, the experience of CAMHS clinicians, barriers to accessing services, the experience of services provided once ‘in’ the system, issues related to the interface between CAMHS and other services and stakeholders, and impressions on what factors might make a ‘good’ CAMHS. Overall, the findings underlined the view that CAMHS services should take an integrated multi-theoretical perspective, support wisdom in leadership, be accessible, and have sophisticated collaborative capacity. Furthermore a theme of shared power in decision making across a team including children, young people and their families, and other services emerged. Overall the findings are indicative of the fact that a performance framework that adequately addresses these complexities works against the risk that authenticity is lost when measures of organisational performance are reduced to one or two examples.

Recommendations for a performance framework for CAMHS are proposed. This includes a robust synthesis of the policy environment, a developmental lens across infant, child, adolescent and youth age groups, a clear definition of the primary task for CAMHS along with an understanding of the target client group, directly addressing the broadly conflicted interface between CAMHS and child protection services, attending to the organisational climate within CAMHS, and defining appropriate accountability measures.

Future research must focus on defining the target group for CAMHS, the best and most efficacious treatment models and clients experience of care. It is further recommended that future research explore models for understanding and leading or managing the unique organisational climate in CAMHS settings and particularly on the roles of clinical staff and leaders in the CAMHS settings. A particular area of focus should be in relation to the inherent stress of working in this setting, noting that this is not seen as weakness or poor performance, but rather as a a natural consequence of engagement in the task.

A key strength of the current study was that it sought to highlight individual perspectives and experiences as they related to measuring organisational performance and to explicitly place the roles and perspective of the researcher into this frame. The focus of interest was in what personal experience might convey about broader shared issues and themes at an organisational level.

In terms of limitations, the most significant was the fact that no child informants could be sourced, and that the time frame and design limited the number of participants and therefore possible perspectives. The qualitative research design did not use a mixed methods model to confirm findings and the generalizability is thought to be limited. The narrow theoretical lens for the research may be also considered a limitation (Chowdery, 2017). However, the theoretical model was chosen carefully as a sound platform on which to consider the complex issues presented from an organisational perspective.

In summary, the thesis seeks to make recommendations for a performance framework for CAMHS, and in doing so the author has sought to draw together the key elements emerging from the findings supported by the research community. If the comprehensive network of elements identified in the current thesis were all adequately addressed, it would have the potential to reliably bind public child and adolescent mental health services with a unique clarity of purpose in a community of care for children, adolescents, and their families.

Chapter 1 Introduction

1.1 The context and background

Many psychiatric disorders emerge early in life and have broad impact on families and communities (Gathright, 2016; Costello et al., 2005). Families who face the challenge of mental ill-health in the children and adolescents they are caring for are likely to seek help from specialist child and adolescent mental health services. Service delivery at this early age is likely to ease the longer-term negative impact of mental ill health on the child's life trajectory (Benjamin et al., 2013; Patel et al., 2007; Belfer, 2008). This current thesis aimed to explore and better understand differences in assumptions, perceptions, and experiences of the organisation of public Child and Adolescent Mental Health Services (CAMHS). The implications these differences have for the clinical care, management, and leadership within the organisation itself but also for government in its performance-monitoring role of CAMHS services more broadly are examined and described.

Child and adolescent psychiatry as a defined field of health care has relatively recently evolved, in line with the emergence of sociological understanding of childhood as a unique developmental phase in life (Levine, 2015). According to Rey et al., (2015) across the world CAMHS services have evolved in some public health systems as separate branches of care or as subsets of paediatric health or, as in the case of Australia, within the broader psychiatric service system. Wolpert et al., (2014) add a helpful third dimension indicating that although CAMHS "descended from the child guidance movement of the 1920s" (p. 5) it also has strong psychiatry history. It is important to recognise that in recent times the focus on managing risk in community service domains has become an important component of the service delivery environment.

Tension, again according to Wolpert et al., (2014) has emerged between the symbolism of education and promoting wellbeing, health and illness paradigms, and social services models where risk management dominates. As part of the public health system in Australia and internationally, the CAMHS

setting is traditionally a small, specialised, and unique environment – sharing the developmental context of paediatric health and the clinical mental health service delivery domains with adult and aged person's psychiatric services (Kelvin, 2005; Ford, 2007). CAMHS are grappling with a set of expectations imposed by a stressed social welfare systems seeking to manage the sequelae of extreme trauma, challenging behaviour and impact of family violence and trauma on children and adolescents in their care (Wolpert et al., 2014; Bor et al., 2014).

Traditionally and historically, clinical expertise in child and adolescent mental health has been framed within the psychodynamic psychotherapeutic orientation of the expert clinician and/or the medical expertise of the psychiatrists. More recently it has encompassed the systemic, narrative, and cognitive-behavioural theoretical orientations emerging within the field (Cottrell, 2005; Briggs et al., 2015; Thompson et al., 2013). Underpinning all of these models is an understanding of the developmental trajectory of children in the context of bio-psychosocial development, family and social structures, dynamics and relationships (Bailey, 2005; Bickman, 1996; Hoagwood et al., 2001).

CAMHS clinicians seek to provide more than symptom relief, crisis management, and bed-based care to children, adolescents, and their families who are clients of the service (Kazdin, 1996; Wolpert, 2009). Indeed, they undertake specialist assessments, provide an analysis and formulation of the problems presented, devise a treatment plan, and provide direct therapeutic interventions and treatment which may include individual, group, and family therapy over a number of months or even years (Kazdin & Nock, 2003; Belfer, 2008). In addition, indirect interventions such as collaborative service planning and provision, consultation with and to other providers, and referral to other specialists also form part of their mental health service plan (Ko et al., 2008; Worrall-Davies & Cottrell, 2009; Thompson et al., 2013).

Thus, the demands of the clinical endeavour for CAMHS clinicians are complex (Lambie & Stewart, 2010). They are required to manage a range of tasks across multiple domains both within the care provided to each individual

child and family (typically many of whom present with very complex and personally confronting difficulties) while also expected to collaborate and partner with others to ensure integrated and comprehensive care packages. (Littlewood et al., 2003). Further, CAMHS clinicians are expected to provide expert consultation to other providers and take on supervisory and training roles (Pettit, 2003; Worrall-Davies & Cottrell, 2009).

Such clinical demands occur at a time when the health system in Australia, like other such countries, has developed to a point where the political imperative for governments is to deliver high quality and highly accountable efficient and effective service outcomes. This has been translated in practice to a set of identifiable measures that purport to assess a number of elements ranging from the adequacy and safety of care to clinical outcomes to the financial sustainability of the health service (Eager et al., 2003).

Importantly, mental health services, whilst acknowledged to be a sub-component of the healthcare domain, have not traditionally received prioritisation for comprehensive development and resource allocations, and are perceived to be somewhat “behind” in the commissioning of relevant and appropriate performance and accountability measures (Kilbourne et al., 2010; Fisher et al., 2013). There have been accusations made of certainly lagging many years behind in the delivery of funding models that then creates a discernible link between cost of service delivery, the price paid for the services, and the outcomes delivered to patients (Rosen et al., 2012; Rosenberg & Hickie, 2013; Eagar et al., 2003).

What drives the imperative to measure and monitor performance is a broader question that requires further exploration and is the focus of the current thesis.

This then delineates a basis for the initial set of research questions, namely, what are the current frameworks used to measure performance in mental health organisations, in particular CAMHS, and how effective are they? What is the expectation for CAMHS service delivery, and how is achievement and performance measured against that expectation? What are the cultural elements? What explanatory model better accounts for what, on the basis of

the author's experience, appears to be a very strong influence on the culture of both the service delivery task itself and also on people's experience and feelings about it?

To begin to address such questions, it is critical that the multi-dimensional influences on the CAHMS system are better understood so that appropriate multi-dimensional measures can be utilised (Strike et al., 2002; Rosen, O'Halloran & Mezzina, 2012). Conceptualising these multi-dimensional influences as a set of domains provides an initial framework (Lin & Durbin, 2002). Some domains such as numbers of clients accessing care, length of treatment, and diagnosis are readily evaluated through quantified measures, while other domains such as client outcomes and client experience of care are more amorphous and where evaluation through qualitative measures is, at best, in its infancy (Bickman, 2008). This underdeveloped landscape links directly to the limitations of the policy framework for child and adolescent mental health services including those related to efficiency (Furber & Segal, 2012). Indeed, Vostanis (2005) indicates that "only 18% of countries worldwide have been found to have mental health policies that impact or address children's mental health needs" (p.131).

As public sector entities, and as part of the public health system in Australia, CAMHS settings are subject to a pervasive set of expectations emerging from elected government regimes linked with the voting community about accountability, efficiency, and effectiveness. The rise of the transparency and accountability agenda within the public sector has been documented extensively (Armstrong, 2005; Gaventa & McGee, 2013; Van Belle & Mayhew, 2016). In such a paradigm, accountability is neatly and simplistically measured by the articulation of the task of the organisation and the application of metrics to assess performance against that task.

Rice (1965) identifies the "primary task" as that which an organisation must perform in order to survive as an entity. Thomson and Hoggett (1996) argue that the primary task in the public sector is never a simple primary task but a multiplicity of interrelated tasks. Within this, different groups may argue their view of what the primary tasks should be (Lawrence, 1977). Further,

Thomson and Hoggett (1996) contend that multiple stakeholders present different views of the primary task, and the political struggles between the different stakeholders have a large influence on the way the primary task is understood. In fact, Hoggett (2006) has argued that the search for the primary task for a public service organisation is “both misleading and fruitless” (p.176). Instead, he argues that the multiple and sometimes competing and contradictory tasks undertaken by public service organisations should be recognised and understood.

Researchers (Bott, 1976; Fineman, 1997) have reported that unique differences exist between other organisations and psychiatric institutions while Willshire (1999) proposes that these differences are generated from differences in the primary task – that of organising or working with what she describes as “madness” (p. 775). Further, Willshire (1999) argues that to control and manage madness is impossible and that organisations seeking to do so are attempting impossibility. Instead, she suggests that rather than seek organisational solutions to such an impossible task (which are bound to fail because the task itself is impossible), psychiatric organisations should identify those elements of the task that make it impossible. This then provides containment of anxiety for staff, prevents unconscious expression in unhelpful or destructive ways, and thus makes the organisation essentially more bearable in which to work.

Within this context, then, the complex nature of an organisational system such as CAMHS, with multiple influences and multiple internal structures and dynamics, requires careful consideration. Starting this consideration of the organisational system with defining its primary purpose and then its primary task linked to that purpose, is therefore critical.

In child and adolescent mental health settings the primary task is less about containing so-called madness and more about understanding fractured development jeopardised by trauma, behavioural and social difficulties, and the intensity and at times abusive relationships between adults, children, and youth (Freidman & Hernandez, 2002). It could be argued that, in general, in Victoria CAMHS clinical models are not as symptom-focussed as they are in adult psychiatric settings, take a more therapeutic healing stance with children and

families, and are fundamentally psychosocially and psychoanalytically orientated (Briggs et al., 2015; McDougall, 2014). Further, CAMHS clinical models therefore imply that a family or relational context is also the treatment context.

The primary task therefore, for CAMHS, could at this preliminary stage perhaps be described as seeking to understand and provide a healing space for a child or young person within their social context. The current study therefore yields a more developed definition of the primary task because it examines the primary task from the perspectives of different stakeholders. The cognitive model of the primary task held by different stakeholders will drive assumptions about performance (i.e., how well an organisation achieves its primary task). Defining the primary task thus becomes a politicised intergroup exercise and indeed has been examined in that context throughout the current study (Fraher, 2004; Vince & French, 1999; Obholzer, 2004).

Cardona (1999) discusses the way the impact of the primary task of the organisation can also emerge in the consulting relationship with a team. She uses an example of a centre for abused children where she was providing consultation to the team. Drawing an analogy with children from troubled families, where the children have suffered abuse, she describes the staff as often feeling abandoned and unworthy of proper attention, leadership, and care. She writes, "…the team react as is if they are incapable of exercising control or authority, or as if they are unworthy of proper leadership and guidance" (p. 243). Mawson (1994) likewise describes a situation where the clinical team working with troubled teenagers were left with feelings of "inadequacy" that were "demoralising" (p. 71). The emerging picture is one where the actual service delivery (i.e., engagement with damaged and deeply troubled children) has a direct and painful impact on the workers.

In contrast to an adult psychiatric setting and as discussed above, the anxieties created for staff in CAMHS may not be about the impossible task of containing madness, but instead about the perhaps equally impossible task of bearing the pain of feeling worthless and powerless to heal and protect vulnerable children (Mawson, 1994; Cardona, 1999; Obholzer, 1987, 1994;

Roberts, 1994). It is possible that teams mirror relationships of dysfunctional families, exert and collude with distorted authority, abuse power, develop twisted intimacy, experience extreme vulnerability, and so forth (Bain, 1999; Carr, 2002; French & Vince, 1999; Cardona, 1999). How these dynamics can be better understood both as phenomenology and in relation to the impact on how the team achieves its primary task is the subject of the current research.

It is these and other dynamics that are explored through a systems psychodynamic framework within the current study. This framework was chosen along with the theoretical foundation for the study following critical analysis of other possible paradigms and research literature that could guide the study, and are described in more detail in Chapter Three.

This model delivers particular insights about how an organisation operates which are not captured by other more linear and uni-dimensional frameworks (Newton, Long, & Sievers, 2006). For example, power and authority dynamics whether enacted with positive impact or otherwise are integral to the internal life of any organisation, including a CAMHS (Hoggett et al., 2006; Long, 2008). They become evident in the way people take up roles and the way things are organised (Hirschorn, 1990; Tyson, 1998). Beyond this, and critical to the work, are the power and authority dynamics of the clinical interface within which interpersonal and indeed positional or role-based power may be exerted both by clinicians and young people and their families (Sakamoto & Pitner, 2005; Minkoff, 2015; Carr, 2007). Furthermore, these matters are compounded by the very personal developmental endeavour the children and young people are undertaking as they seek to individuate from parents by testing their own power and authority and challenging that of those around them (Bergman & Andersson, 2015).

As has previously been noted public CAMHS services sit nestled within general health and psychiatry domains and are uniquely identified by the focus of endeavour. In a socio-political context that is increasingly focussed on the so-called performance of public entities, neither the health field, nor the psychiatry field have developed a comprehensive model for understanding the primary task of CAMHS or performance metrics. Approaching this challenge

means taking into account the impact of the work on clinicians and on the organisation itself.

What drives the imperative to measure and monitor performance is a broader question and requires further exploration – particularly how it might be relevant for a CAMHS setting, and is the focus of the current thesis. The next section describes the foundation for how the thesis has been structured.

1.2 The structure of the thesis.

A CAMHS organisation is unique in a series of ways and particularly in relation to the primary task. This is the focus of Chapter One. Chapter Two takes a detailed view of the context of this organisational phenomenon and examines it within the health services and children services delivery system in Australia. CAMHS services, have primarily developed within the medical model of service delivery emphasising diagnosis and treatment, rather than within a social services framework, and have generally been small offshoots of larger psychiatric institutional services. Furthermore, it could be argued that CAMHS has both a primary health and primary care function for families where a child is experiencing mental ill health. These contextual factors are critical to understanding how the organisational dynamics of CAMHS have evolved.

Chapter Three examines the broad theoretical framework underpinning the present study with a particular focus on systems psychodynamics. Bion's (1985) work on group culture and the theoretical tradition of social defences against anxiety as they are expressed within groups and organisations developed following Menzies-Lyth (1971) are explored. Fraher (2004) identifies systems psychodynamics as an interdisciplinary field that integrates three disciplines - psychoanalysis, group relations, and open systems.

These three foundational perspectives and their development as an integrated framework are the focus of Chapter Four which places this study within that framework. Gabriel and Griffiths (2002) argue that the psychoanalytic approach to understanding relationships offers a model that theorises the complexity of what it is that faces people as they work together. This research highlights what the capacity of the systems psychoanalytic

theoretical framework might be in enhancing our understanding of how a CAMHS and how the individual CAMHS clinicians might operate. In particular, the research examined unconscious organisational processes described through language, conversation, dialogue, and the discourse these illuminate in order to develop some understanding of the dynamics that compel people and their behaviour in mental health organisations, particularly a CAMHS (Long, 1999).

Health, illness, and treatment paradigms are examined in more detail in Chapter Five. This work in particular seeks to consider the developmental context within which children with mental ill health present and how this context may be constructed within the health paradigm (Price, 2015; Hernandez et al., 2015; Koot & Wallander, 2014). At the heart of this is the endemic tension inherent within the field of psychiatry related to illness versus social malaise paradigms (Timini, 2014). That is, the extent to which various mental illnesses may be constructed as primarily a health condition with social implications or primarily a social condition with interfaces to ill health (Pescosolido et al., 2013; Timini & Maitra, 2006).

Furthermore, the very basis of action to “deliver” on the primary task in CAMHS (arguably the treatment or therapeutic function) is itself heavily influenced by the theoretical framework articulated above, with particular reference to object relations theory (Summers, 2014), attachment theory (Bowlby & Ainsworth, 2013), systems theory as it is applied to clinical settings (Gurman et al., 2014), and more recently feminist critique of Attachment Theory, for example by Buchannan (2013), in particular to examining the impact of family violence. More recent influences in clinical techniques practiced within CAMHS include the use of new medicines, cognitive behavioural models, and narrative therapies and will be discussed in further detail Chapter Five (Goodman & Scott, 2012; Jorring & Jacobsen, 2014).

Rice (1965) has described the primary task as that which a group must perform “if it is to survive” (p.17). Chapter Six seeks to draw together the threads of understanding articulated in the first chapters and surface questions that emerge from the theoretical and contextual landscape as a background for

the present study, such as what is indeed the primary task for CAMHS, and whether CAMHS will survive as an organisational construct or function.

Following this, Chapter Seven outlines the design and methodology of the study, placing these within the qualitative research (social constructionist) paradigm and body of literature. There follows a description of the procedure of the study, including the data-gathering model employed and data analysis process undertaken.

Chapter Eight articulates the detailed findings of the study, grouping these into themes and illuminating the threads that have woven these themes using direct quotes from the data set.

In Chapter Nine the findings are subjected to review and discussion in line within the relevant theoretical framework. The implications of these findings and theoretically-informed ideas for conceptualising organisational performance parameters are then discussed and conclusions drawn. This chapter describes an enhanced understanding of the complexities under examination through detailed discussion of the findings. The final discussion delivers a framework for consideration in CAMHS performance monitoring based on the data and theoretical linkages made in the discussion. It articulates responses to questions posed early in the study, strengthens links to theoretical underpinnings, expands on the complexity of understanding the primary task of a CAMHS, and proposes elements of an enhanced framework for organisational performance measurement. How this may be implemented and evaluated, and what impact might be expected in current practical and organisational terms is explored. Limitations to the present study are examined and opportunities for further research are identified. In Chapter Ten recommendations are made based on the findings and discussion, and provides a conclusion to the study.

This present chapter introduced the whole thesis with background and context of CAMHS services, and mapped out the structure of the thesis. The next chapter will describe in more detail the context of the Australian health care system and where CAMHS services sit within this.

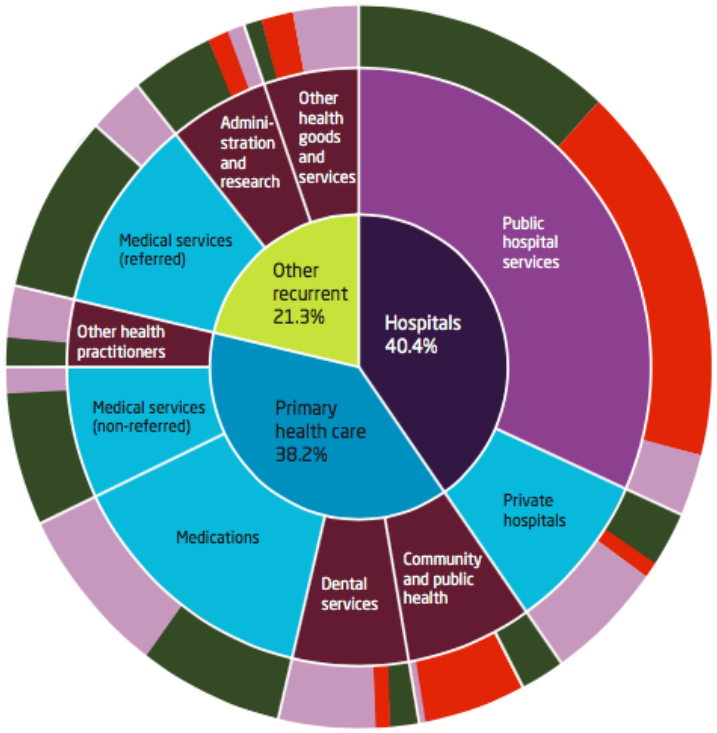
Chapter 2 Environment: health service delivery in Australia and Victoria.

2.1 The system of health care

Australia is widely acknowledged to have an advanced health care system built through key government initiatives commencing with the introduction of Medicare in the 1970s, which sought to generate universal public access to health care (Podger et al., 2014; Armstrong et al., 2007; Hall 2015). Access to public primary health care is delivered by the Federal government in Australia through this system. Secondary (specialist) care can also be accessed through Medicare (Meadows et al, 2015; Gleeson et al., 2007). Hospital based acute care is delivered by states through Local Hospital Networks, and funded both through state and commonwealth shared funding models (Duckett & Griffiths, 2016; Hall, 2015). Private providers deliver primary, secondary, and tertiary care in addition to the available public services. This includes mental health care where in fact more "bed days" of mental health care were provided by private hospitals across Australia during 2013-14 than were provided in the public mental health system (Ham & Timmins, 2015; Commonwealth MBS data).

The responsibility for funding and delivery of health care in Australia across these domains is difficult to describe and more complicated than most systems (Ham & Timmins, 2015; Kay & Boxall, 2015). The Australian Institute of Health and Welfare indicates that the mixture of public and private funding that makes up Australia's health system involves diffuse lines of responsibility, multiple providers, a variety of regulatory regimes, and is multifaceted (AIHW, 2013). Ham and Timmins (2015) indicated in a report commissioned by the Victorian government that the Australian government spends 9.3% of Gross Domestic Product on health care across the range of jurisdictions and private providers. They graphed these relationships utilizing data from the Australian Institute of Health and Welfare and reproduced in Figure 1.

Figure 1 Funding and provision of Australia's health services



Share of expenditure
- Hospitals
- Primary health care
- Other recurrent

Responsibility for services
- Combined private sector and public sector – all levels of government
- State and territory governments
- Private providers

Funding
- Australian government funding share
- State/territory government funding share
- Private funding share

Source: Australian Institute of Health and Welfare 2014b

At a macro (system) level, the arrangements are complicated. For individual Australians seeking healthcare, it can be particularly confusing because the funding models and responsibility challenges can give rise to access problems and subsequently costly outcomes in health and expenditure terms (Kellaher et al., 2014). For example, a recent report released by the Grattan Institute argued with comprehensive data analysis that the system "is not working anywhere near as well as it should because the way we pay for and organise services goes against what we know works" (2006, p.1). The report identified that people with chronic illnesses such as diabetes and asthma are not being managed in community and primary care settings in an integrated

and routine way to address their illnesses and prevent deterioration, and many are subsequently hospitalised at a higher unit cost with attendant health and social impacts such as employment and social disruption. Of particular relevance to the present study, they indicate that mental ill health is one of the chronic conditions potentially inadequately serviced through the primary care system, despite expenditure for primary mental health care at an all-time high (Wilcox, 2014)

Notwithstanding the apparent complexity of delivery arrangements, Australia's health outcomes measured against international benchmarks appear to be comparatively positive and comparatively efficient. The global financial analytics firm, Bloomberg, ranked Australia as the sixth most cost effective system in the world for 2014, up from seventh the previous year (Bloomberg Visual Data, 2014). Furthermore, whilst measuring health outcomes is at best an inexact science, in 2015 the World Health Organisation ranked Australia at number 32 in the world in relation to health outcomes and system effectiveness (W.H.O., 2015). There is much debate in relation to how such rankings are derived and on the basis of what data (Duckett, 2014; Moodie et al., 2014). Furthermore, Ham and Timmins (2015) argue that these results for the Australian system are achieved notwithstanding the complexities in responsibility for health care provision.

Policy settings for the delivery of health care are critical socio-political matters, largely due to the cost of delivering health care and increasingly contested issue of the role of government in direct delivery of services (Nutley, 2003). As Lupton and Najman (1995) argue, actual health outcomes are only one factor that drives the health system, others being technological advances, political positions, and economic matters. Voters often acknowledge access to health care as a key issue in the lead up to both national and state elections. In the Medical Journal of Australia, Armstrong et al., (2007) laid out the most critical issues facing a new Australian government in funding and delivery of health care. They underlined the critical need for whole of system planning and measuring rather than focussing on sub-components of the system. An example is reforming hospital-funding models, which, whilst welcomed by

Armstrong and team, was likened to changing tyres on a vehicle that in the end is not the right one for the journey.

In 2011 the Federal and State Governments signed an historic agreement delivering a new system to fund, monitor and manage hospital based care across jurisdictional boundaries (COAG, 2011; NHFB, 2011). This National Health Reform Agreement (NHRA) effectively set a “price” for delivery of hospital based care, a method for capturing the activity delivered and a set of targets for delivery of “outputs” linked to the targets (Parliament of Australia, 2015). It introduced revised governance arrangements for public hospitals, primary health services, and aged care. The new agreed model derived directly from the funding and performance model developed and implemented in Victoria by successive governments over the past two decades, and essentially set funding flows to local hospitals across Australia based on the numbers and kinds of services they provide and linked to an independently determined efficient price for each service (DHHS, 2016). The funding model essentially sets a price for delivery of health care based on specific diagnostic profiles and the setting within which care is delivered, and sets targets on a range of outputs and outcomes including delivering episodes of care, access or timeliness, and safety.

To support the system a number of elements are required. These include setting the price for care (called the “National Efficient Price”) and setting targets for care such as expected maximum waiting times for treatment in emergency departments. It includes determining the settings for such care (hospital, home, outpatients), setting block funding arrangements for services that are not yet, or not appropriately, delivered on an activity basis (called the “National Efficient Cost”), monitoring and reporting performance against targets, and providing the funding linked to performance outcomes (NHFB, 2011).

This new agreement required the establishment of the Independent Hospital Pricing Authority (IHPA) to set the national price for funding health services on an activity basis, a National Health Funding Pool to make payments to hospitals, and a National Health Performance Authority to monitor and report

on hospital performance. Similar models set up in the National Health System in UK in the 2000s drew criticism by authors such as Bevan and Hood (2006) who identified the performance management framework that emanated from the model as management by “targets and terror” (p. 517).

In Victoria the policy and performance settings are constantly in development and sit within a devolved governance structure which has been developed and consolidated over a number of years (Ham & Timmins, 2015). The new approach, seeking national consistency, was built into the existing Victorian framework. In short, each of the states 80 hospitals and health services has a Board of Governance which is appointed by the State Minister for Health, but acts independently to govern all aspects of the organisation and negotiates a Statement of Priorities identifying service delivery targets, setting funding expectations, and a performance program (DHHS, 2015).

2.2 Public mental health service delivery

Part of the National Health Reform Agreement (COAG, 2011) included an agreement to move mental health service delivery into the mainstream acute health activity based funding model. At the time no jurisdictions utilised such a model to fund and monitor the delivery of mental health care. Whilst a range of actions have been underway to develop this model, timelines have been exceeded and by 2016 no funding in Australia for mental health care was yet delivered as an activity based model as described above (Rosenberg & Hickie, 2013; Allison et al., 2015).

Clinical mental health services, delivered through Victorian public hospitals as a program within the acute health care system, are provided for people with severe and acute mental illness. Services are provided on a catchment basis and people can refer themselves or be referred by family or another service provider for assessment and treatment in the most appropriate setting (inpatient or outpatient or home based settings) depending on the needs assessment (DHHS, 2016).

In Victoria a current legislative framework governing the compulsory assessment and treatment of people with a mental illness came into effect on 1 July, 2014 – the *Mental Health Act 2014* (the Act). The underlying principles of this Act are inherently congruent with the *Victorian Charter of Human Rights (2006)*, seeking to deliver safeguards and close monitoring where people are required to receive assessment or treatment due to their illness (Victorian Government, 2014).

Multidisciplinary teams usually including psychiatrists, psychologists, nurses, social workers, and occupational therapists provide clinical mental health services in Victoria. In addition to undergraduate training, some clinicians also undertake postgraduate training in a specialist treatment modality such as individual, group, or family therapy. Postgraduate qualifications and specialist clinical expertise is most prevalent in child and adolescent mental health services (Productivity Commission, 2006; McDougall, 2007; Hill-Smith et al., 2012).

Both the Federal and State Governments fund a range of non-government specialist community based mental health service providers to support clients to live well in the community (National Mental Health Commission, 2014). These services are largely for adults with established severe and persistent mental illness and associated disability. These services are clearly in scope to become part of the National Disability Insurance Scheme being currently implemented across Australia (Williams & Smith, 2014). However, they do not provide services to children and families. In Victoria, the funding allocated to these services was more than $100m in 2013-14 (Victorian Department of Health, Policy and Funding Guidelines, 2013). By contrast, in 2013-14, the State spent more than $1.2 billion on public mental health bed-based and community clinical care delivered through hospital services and divided across three age groups (0 -18 year olds; those aged 16-65; and those over 65) (AIHW, 2015).

In 2015 the Victorian Government released the “10 Year Plan for Mental Health” (published November 2015). A scheme was developed for understanding the public health investment across the prevalence of disorders

for adult illnesses (reproduced below Figure 2) and a similar model (un-published) for child and adolescent services (Figure 3). The model seeks to demonstrate the extent of mental ill health in the population and the role of different layers of government in funding aspects of the spectrum of services required. Of particular note is that of the estimated 3% of people with severe mental illness, only one-third is actually accessing care in the acute mental health system. The response capacity is significantly compromised and, in effect, this means only those with extremely acute needs are able to access acute clinical treatment (Whiteford et al., 2014; Gould et al., 2012).

Figure 2 From Victoria's 10 Year Mental Health Plan

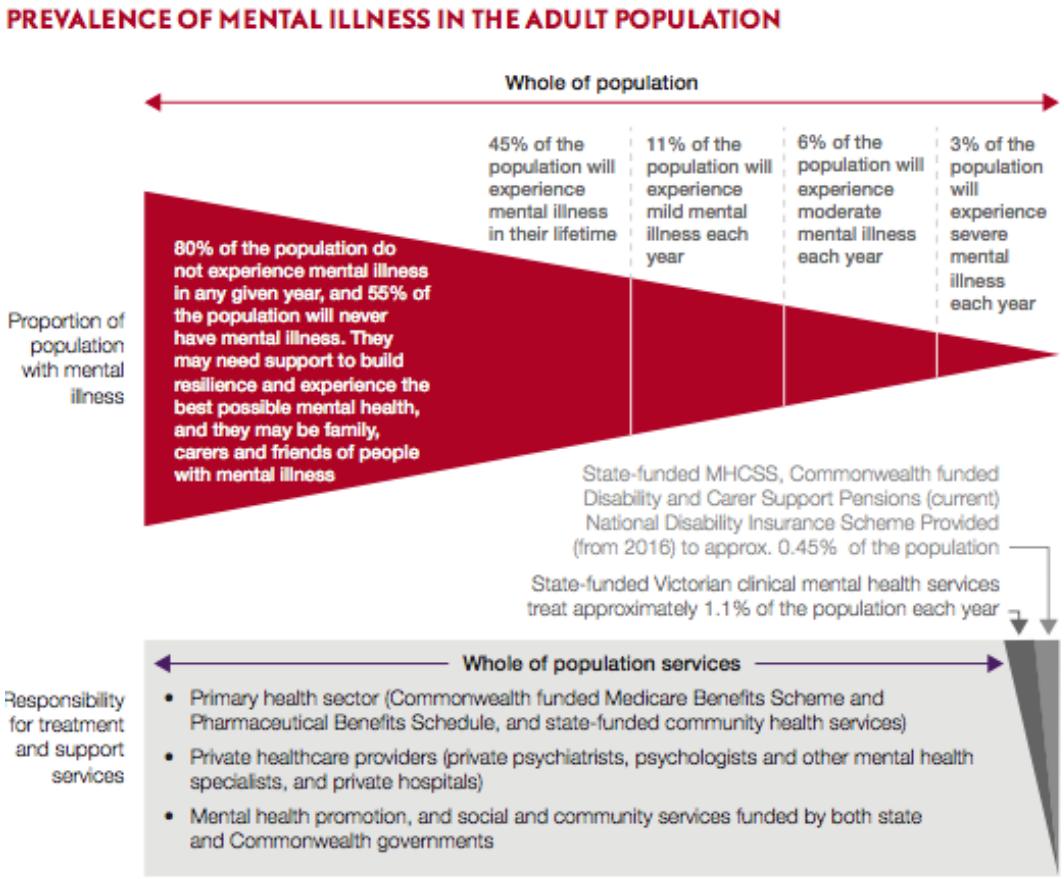
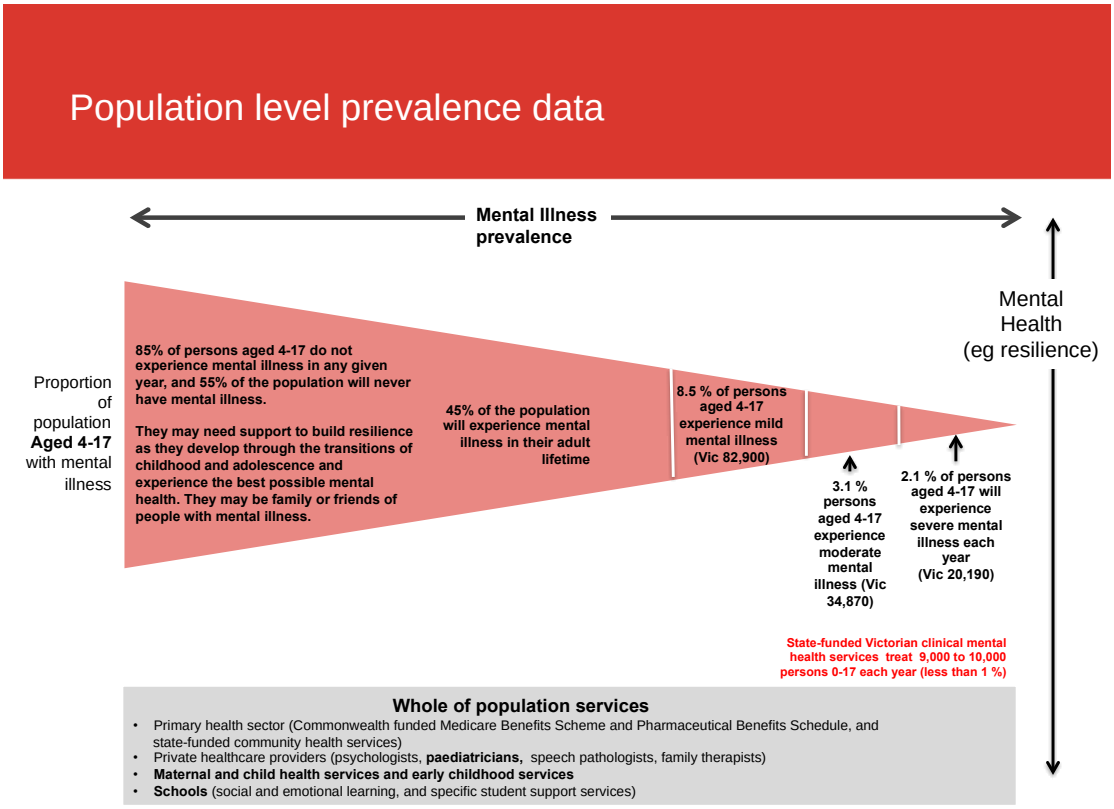


Figure 3 – Child and youth population prevalence data



2.3 Mental health service performance: structures and processes

The challenges facing governments and the funded health service delivery system has driven the development of increasingly rigorous accountability systems for expenditure against activity (Glynn & Murphy 1996; Hawke, 2012). Changing public sector accountabilities have been studied and described by key analysts over the past 20 years, as governments across the world reform their functions seeking efficiency and effectiveness in delivery of public services through, for example, directing functions previously provided by government to private industry and not-for-profit government providers (Monfardini, 2010; Goh, 2012).

Fryer, Antony, and Ogden (2009) examined the effects of the changes implemented by the UK government in the 1990s and 2000s, and concluded that the intended improvements across a range of domains such as transparency and value for money “had not yet materialized” (p. 480). They argued that the problems inherent in developing and implementing

performance management systems successfully as falling into three areas: technical (problems with setting indicators and gathering data); systems (problems with integrating a performance management framework into an organisations existing systems and strategic agenda); and “involvement” which gathered issues such as leadership, staff engagement and stakeholder inclusion (p. 489).

In Australia, recently introduced health reforms described above are still taking effect and are yet to be properly evaluated (Veronesi et al., 2014). However an extensive system has been generated through the requirements for setting an efficient price for acute health services, setting performance targets, monitoring performance, and delivering funding. As Robertson et al. (2016) note in their examination of health care’s spending, “increasing demand for services and rising health care costs create pressures within the Australian health care system and result in higher health insurance premiums and out-of-pocket costs for consumers” (p. 1). The effect of this may indeed be a focus on the pragmatics of accounting for expenditure rather than demonstrating effective and efficient impact of this expenditure, particularly in relation to the clinical outcomes and impact of care on the lives of people seeking treatment (McLoughlin & Leatherman, 2003). This is primarily thought to be due to the fact that government representing communities want increased accountability for the expenditure of public funding and reliable delivery of value for money (Gardner et al., 2016; Veronesi et al., 2014).

The Victorian government has sought to generate improved performance of health services through articulating a sound policy framework, overseeing solid service and quality design and implementation planning, setting and communicating clear and negotiated targets, resourcing services appropriately, contracting for outcomes, and providing transparency of data (Department of Health, 2011). Services (including mental health services) use data to understand their service delivery, benchmark against each other, and improve their services. Government uses data, standards accreditation, and financial sustainability measures to understand how services do their business and work with them to deliver service integrity, sustainability, and excellence (DHHS, 2016).

Building a picture of health service performance, then, in Victoria includes compliance with all relevant legislation, compliance with quality and clinical standards, and compliance with funding and service agreements or *Statements of Priority*. The latter includes targets and indicators for client care and other quality indicators (e.g., health and safety, financial sustainability, staff retention, sick leave etc.). In 2010 the Australian Commission on Safety and Quality in Health Care developed the National Safety and Quality Health Service Standards (NSQHSS) which were widely consulted and endorsed by governments, setting a nationally consistent framework of measures for safety and quality across a variety of health care settings. Accreditation against these measures is an organisation-wide process. In addition, services delivering mental health care are accredited against specific National Mental Health Standards released in 2010.

Current data reporting for mental health care in Victoria covers more than 90 indicators which are openly reported in a publicly accessible web site (http://performance.health.vic.gov.au). These include activity (occupancy of beds, volume of throughput, community service hours delivered); access to services and responsiveness (percentage of new clients, triage response times, waiting times in emergency departments for a mental health beds, lengths of stay); quality of care (lengths of stay, 28 day readmission rates); client outcomes; continuity of care (pre-and post-discharge contacts); and safety for patients (seclusion rates, mechanical, and physical restraint rates).

Policy development has a direct effect, in some instances, on the domains singled out for priority enhancement in performance reporting. For example, utilizing a national focus on safety for women and reducing seclusion has supported the Victorian quality improvement agenda at a policy and performance level. In relation to safety for women, $6m has been expended in the past four years to create safe corridors, ensure every door can be locked from the inside with swipe access so women are safe in their bedrooms, and ensure women have access to a females-only bathroom (DHHS, 2014). The Government also released gender-safe guidelines for services and noted a broader impact for services in thinking about systems to support safety and care in their inpatient settings. One such example was the introduction of a

model for service enhancement focused on changing nursing practice and workflow entitled “Safe Ward” (Bowers et al., 2014). Furthermore, reporting nationally as part of funding agreements between the Commonwealth and the State means that comparative data related to seclusion reduction is routinely reported nationally and creates a community of accountability across the system (AIHW, 2013; 2014; 2015).

However, there are many indicators that developed in less systematic or evidence-driven ways that require further review. For example, the 28-day readmission rate is one that is publicly reported by unit and service across Victoria (Fischer et al., 2014). That is, a readmission is counted as having occurred when someone, once discharged, returns for unplanned admitted care within 28 days. This measure is a critical indicator for acute health care, often pointing to post-discharge complications and poor discharge planning – effectively a failure of care. Whilst relatively low (average between 2-3% across Australia), this is an important quality indicator (AIHW, 2015).

The mental health service sector advises there is limited sense in setting the exact same measure as if it is directly transferrable from an acute health service model. A 28-day readmission rate indicator set many years ago was effectively the acute health measure contorted into the adult mental health system with some limited utility, noting that often clients return for care as a positive and pre-emptive help-seeking behaviour, and should not be routinely assessed as a failure of care (Hyland et al., 2008). However, an arbitrary target was set (14%) and services were required to meet the target for reduced re-admissions. Then it was further translated without modification for the CAMHS target setting and its utility was immediately lost. Importantly, young people return to services (particularly bed-based services) at comparatively high rates, and clinicians frequently view this as effective help-seeking behaviour rather than an automatic failure of care (James et al., 2010; Romansky et al., 2003).

The mental health system could be described as any and all parts of the health system addressing mental ill health. It should be noted that with this definition, much of Victoria's mental health system sits outside the direct control of the State government, and situates with the primary care and private health

systems. It should also be noted that a great deal of investment is made through education, courts, drug treatment, justice and corrections, police, disability, housing and the family support system that directly addresses and delivers programs targeted to those with mental illness. To better understand the current state of mental health care in Victoria at present, one needs to be aware of what constitutes 'the system', how problems should be identified, what the levers for change are, and how these should be approached in order to be managed either directly or indirectly.

Whilst it makes sense to focus on the state-funded mental health service system managed through the mental health portfolio, caution is warranted (Rosenberg & Hickie, 2013). Those who deliver care outside this directly funded system to people with mild, moderate and even severe mental illness are some of the strongest critics of the current access and service delivery issues. Namely, there is ambivalence for them in engaging with this group of constituents, as it is as if the mental ill health component of their presentation “trumps” all other aspects. For example, there is a significant body of literature examining the impact on psychiatric and non-psychiatric patients and on staff of having those with mental health needs being treated in an emergency department (van Nieuwenhuizen et al., 2013; Felker et al., 1996; Younis et al., 2014). There are views that such treatment should be separated, as well as views that emergency health care is a universal model of integrated care and directly addresses the stigma experienced by mental health patients (Prener & Lincoln, 2015; Tintinalli, 1994; Lawrence & Fulbrook, 2015). The differences in view is postulated to relate directly to the fear of (and sometimes real challenges inherent in) dealing with people with mental illness even if their presenting issue is a broken leg, dental ill health, homelessness, unemployment, or intoxication.

It may be that this problem relates directly to community discourse in relation to mentally ill people particularly linked to the idea that all people who are mentally ill are violent and all violence is linked with mental illness if it is not terrorism (Phelan & Link, 1998; Corner & Gill, 2015; Pandiani et al., 2005; Parcesepe & Cabassa (2013). Whilst this is factually incorrect, the momentum in this discourse is being fuelled by individual case scenarios such as the death

of Luke Batty (Ferrier & Gildersleeve, 2015) and by the work of the relevant industrial bodies who in seeking to protect the safety of their members and workers in mental health settings risk demonizing the patients (Happell, 2008). Complexities arise also as the community seeks to make sense of sexual violence (Winick, 1998) and unusual behaviors (Cumings et al., 2013; Kenny, 2001; Stuart & Arboleda-Flórez, 2012). It is noted that in western medicine only recently have several conditions been removed from the list of recognized psychiatric disorders including epilepsy and homosexuality demonstrating the historic confusion that has led to mental illness being a 'catch-all' for labeling unusual behavior (APA, 2016).

The newly implemented mental health legislation in Victoria (*Mental Health Act 2014*) seeks to empower people with mental illness to take charge of their own recovery journey, regulates and limits compulsory assessment, detention and treatment, and is already impacting on the proportion of people living in the community unrestricted by compulsory orders (Victorian Government, 2014; O'Donoghue et al., 2016; Vine et al., 2015; Mental Health Tribunal, 2016). The tension these two phenomena create is evident. On the one hand, clinicians are being encouraged, through legislative limitations, to support decision-making by a person even if that decision may imply a degree of risk. At the same time, community tolerance and anxiety are high with rare but horrific violence amplifying the anxiety and creating a surge of fear and concern. It should be noted that there is nuance in this community discourse, especially in relation to the developmental context in which it is nested. There has been much progress made across Australia and within Victoria itself in identifying and responding with services to the needs of young people with emerging mental illness (Muir et al., 2009).

Furthermore, some specific disorders or diagnoses seem to shift the community discourse towards more sympathy and respect, including: post-natal depression, eating disorders, and disaster-related and work-related trauma (e.g., bushfires, ambulance, police). Notably this more sympathetic stance can be limited when applied to other forms of trauma, such as that related to racial discrimination or refugee status (Morris et al., 2009; Silove et al., 2007; Morrice, 2013).

2.4 Demand for Victorian mental health services

Another contextual challenge is the burgeoning demand for adult acute care (Allison & Bastiampillai, 2015). The funded clinical mental health system is more stretched than it has ever been in meeting the demand for acute inpatient care (Allison et al., 2015; Long, 2014). This demand has been building over time and is not seen as related to the introduction of the Mental Health Act, 2014. Public data in Victoria, reviewed for the years 2013-16, indicate that the service system is under extreme pressure (DHHS, 2016). Separations (i.e., discharges from mental health inpatient care) have increased at a rate of 8% every year for a number of years, and this is primarily in relation to adult (aged 16-65 years) demand (AIHW, 2015). During this time, few new acute beds have been opened, indicating a level of "churn" where admissions and discharges are both occurring at higher rates, while lengths of stay are reducing to accommodate rising intensity in demand. At the same time, readmission rates have remained stable, linked to high levels of post discharge support, and notably seclusion rates have dropped significantly (AIHW, 2016). Recent data on bed access from emergency departments within 8 hours has, after making steady gains over a number of years, begun to decline and the number of inpatient units recording over 100% occupancy routinely has increased (DHHS, 2016). Furthermore, when a unit reports more than 100% occupancy, it demonstrates that, in the event where a patient has been placed on leave, rather than maintaining their bed as vacant in case they need to return, another person is admitted to that bed (http://performance.health.vic.gov.au).

There is a range of factors to consider in relation to this demand for acute mental health care. One such reason relates to the fact that services have been provided with a range of funding inputs targeting safety, quality improvements, and innovative service delivery in the community. These programs have been well subscribed but have not offset the steadily growing demand. For example, the funding delivered to support reform in 2009 was provided for service enhancements, sub-acute community models, and integrated care models, and stretched the scope of care and only marginally addressed the need for more acute mental health beds but not the expansion of regular community outpatient care (Victorian Government, Budget Paper 3, 2009). Volume

investment continues to be targeted to adult services, despite the evidence that intervening early in life and early within the course of an episode of acute illness will offset some burden of disease related to adult presentations (Shonkoff et al., 2012; McGorry, 2013).

Population growth is clearly another factor for consideration, but does not solely account for the problem being encountered. It should be noted that population growth in the age group 65+ has yet to impact on service demand, as mental health services within this age cohort continue to deliver accessible care with relatively low occupancy rates in both their residential facilities and their acute facilities (DHHS, 2016 http://performance.health.vic.gov.au).

As the threshold increases in terms of the level of acuity that initiates access to clinical mental health services, the community of providers surrounding mental health services has found themselves holding and caring for larger numbers of seriously unwell people. At the same time, funding for service delivery has become more targeted in relation to specific groups or categories of need (e.g., homelessness agencies, disability services) and it may be that what was previously offered by a range of providers in an open system is being slowly reduced as an unintended consequence of the targeting of care. The net impact of this would be an increase in acuity that is likely to drive up demand for acute inpatient beds.

The provisions of the Mental Health Act (2014) target the reduction in use of compulsory treatment orders and the length of such orders. This is likely to have some impact for people who, without such an order, may struggle with compliance to an agreed treatment regime and become more unwell, prompting the need for acute inpatient care. It has been suggested that patients may be being discharged earlier than clinically warranted in order to create access and reduce bed blockage (Chief Psychiatrists Annual Report, 2013). Whilst clinical decision making sits at the heart of each of these decisions, doctors can experience real pressure when reviewing progress with each case especially when they know a number of people are waiting in the emergency department and need a bed (Canvin et al., 2013; Chaimowitz et al., 2010; Impey & Milner, 2013).

The current funding model has limitations, which are the subject of further planning work being undertaken within Victorian and Australian governments (DHHS, 2016). Understanding the cost of care and appropriately funding for efficiency and effectiveness remains a work in progress. Insofar as this matter relates to the demand for services, the level of funding per inpatient bed affects the capacity of services to manage extreme acuity effectively, and this may have an impact on therapeutic programs being able to be offered and possibly on the capacity to deliver focussed clinical outcomes.

As previously mentioned, metrics for measuring mental health service delivery are inadequate by comparison to acute health models. However, recent data indicates that Victoria's expenditure on mental health service delivery per head of population across all forms of care was the lowest in Australia, and that the cost of delivering an acute adult mental health bed in Victoria in 2014-15 was also the lowest at $830 compared with a national average of $983 (AIHW, 2015). Furthermore, the breadth of what is recognised as severe mental illness and the improvements in evidence-based practice have expanded the group who legitimately access acute adult mental health beds. People with depression, eating disorders, personality disorders, trauma-related problems, and extreme anxiety are now admitted to inpatient settings alongside those with schizophrenia. Thus, the patient mix has changed over time and the challenge in providing care to complex mix of individuals likewise has shifted.

Concurrently, the mental health services workforce (e.g., nurses, psychiatrists, social workers, occupational therapists and psychologists employed in mental health settings) continues to be the subject of much focus. Clinical assessment and treatment in mental health services relies heavily on the skill base of the staff providing treatment. When the focus of treatment is on a basic goal such as personal safety, as it currently is, the challenge to improve the sophistication and capacity of the staff to deliver evidence-based care may be compromised. In addition to the mental health workforce some services also provide specialists in speech pathology, music therapy, and art therapy. This scoping definition is made pointedly to underline the multidisciplinary nature of the mental health service system, which can often be

hijacked by a focus on doctors and nurses as a priority. An example is Crettenden et al. (2014) whose research on the future dilemmas for health workforce planning in Australia only discusses doctors and nurses and does not reference any other allied health providers.

2.5 Child and Adolescent Mental Health Services in Victoria

Victoria's public mental health system designates child and adolescent services as those for 0-18 year olds (DHHS, 2016). However a number of issues arise with this delineation. Firstly, mother-baby or infant services are funded as adult services, despite their very real role in monitoring the mental well-being of the infant in the mother-baby dyad (Meltzer-Brody, 2014; Bisognano et al., 2014). Secondly, services for young adults starting at age 16 are funded through the adult mental health system (DHHS, 2016). Thirdly, the Commonwealth has defined youth services as commencing at age 12 and finishing at age 25, underlined by an extensive funding program for primary mental health care over the past decade through the "Headspace" initiative (Headspace, 2016). These latter two issues create overlaps and confusion related to age which can be challenging for the community to understand and access services (DHS, 2008)

Alongside these structural challenges within the service system itself, children's difficulties emerge in the context of their families and social sphere. Lives are impacted within families but also more broadly at school and in the community. Thus, the service system that sits around a child and their family can become both part of the problem and part of a solution (Department of Human Services, 2006). As a result, CAMHS clinicians working with a child will most likely need to integrate and coordinate care with families, school support providers, the family's primary care provider (e.g., General Practitioner) and possibly private providers. This case coordination or shared care function is often critical in providing a consistent approach to a child and family who are distressed and dealing with challenging emotions and behaviour. It should be noted that public CAMHS services are targeted for the most severe problems for children of all ages including those less than four years. This provides a

general illustration of the breadth of engagement and depth of skill required by clinicians working in the CAMHS setting.

All but one CAMHS in Victoria are governed by a generally much larger adult mental health service, which in turn sits within a hospital or health service network (DHHS, 2016). This means that the main organizing domain is the delivery of mental health care rather than the developmental context within which the problems emerge. The one CAMHS that is not managed by an adult mental health service is managed by a paediatric hospital and functions in effect as another medical specialty of that tertiary hospital.

Notably, there are differences between the delivery of mental health treatment in adult and CAMHS settings. For example as has been previously discussed the focus in CAMHS is primarily on consultation to other community, family, and school support providers to the family as well as to the client. Further, inpatient treatment is rare and only undertaken in extreme circumstances. Whilst in adult services, prioritizing community care to prevent admissions is an accepted notion, in practice acute and bed-based care draws the funding for staffing to manage demand for admissions away from community-based care.

Contrasts between adult and CAMHS services are therefore driven by the developmental context of the presenting client and the types of problems presented. For children and adolescents, these are largely relational and inter-personal, while the problems are largely psychosis-related in adult acute services. These issues then drive the service configuration, including more consultation to other services, more outpatient clinical care, and less bed based treatment, and the training levels of staff who in CAMHS (unlike in adult service) are highly likely to have post graduate training in “talking therapies” such as psychodynamic child psychotherapy, cognitive behavioral therapy, narrative models and family therapy (Thompson et al., 2013; Henderson, 2015; Nixon, 2015; Lucey & Pol 2013).

2.6 Current issues and challenges

In considering how to better understand the performance of CAMHS services, the following contextual issues require consideration and initiate the underlying questions for the current study. The metrics generated through the regular acute and primary health system are still in development and are not currently fully implemented and evaluated. Further, accountability models linked to cost of and price provided for the delivery of care have not yet been adequately consolidated within the Australian public health care model. In addition, there are fundamental differences in approach to understanding and treatment of mental ill health and physical ill health, and these are examined in further detail in Chapter Five.

Despite commitments otherwise, mental health services are yet to be comprehensively included in the performance frameworks that the service components are subject to, and successive governments are working to develop cogent models for activity-based funding that address the very real differences in the approach to mental health versus acute health care. Furthermore, performance frameworks that are emerging for mental health care will no doubt be adult focused at least initially and take some time to develop. This is already evident in the early versions of the models being tested (Fugard et al., 2015) and as Lye (2004) indicates, “in designing performance measurement systems researchers have failed to comprehensively examine the rich interdependencies between contextual factors and the use of performance measures” (p. 2).

In relation then to the present study, focus will be placed on an examination of the differences and complexities of mental health service delivery for children and adolescents and their families with the proposition made that a different, tailored and nuanced approach is warranted with consideration to performance frameworks. This chapter has provided a broad explanation of the Australian public health and mental health service models and provided a background in relation to the research question. The next chapter examines the literature in relation to methodological considerations and frames the approach taken to the research.

Chapter 3 Critical analysis of development, implementation and evaluation of current service provision

3.1 The emergence of organizational performance frameworks

In seeking to understand the scope and dynamics for a performance framework in CAMHS, the development of performance measurement as an organizational phenomenon are summarized below and research models reviewed and analyzed. This chapter critically scans the landscape of research in this area and identifies the scope of this present study within that landscape.

Management historians such as Chandler (1977) identify that the inception of performance management corresponds to the development of the complex organization - most notably during the 19th Century as part of the impact of industrial revolution. The underlying driver for business performance research has clearly focussed primarily on profitability and also on organisational sustainability (Radnor & Barnes, 2007; Kettinger et al., 1994; Lega et al., 2013).

The study of organisational performance measurement and performance management is a modern phenomenon with a broad first world focus in the 1980s and 1990s on the development of systems that would reliably deliver information on aspects of organisational functioning particularly beyond financial-only outcomes (Felicio et al., 2013; Yadav, & Sagar, 2013). It seems that the post-World War Two rise of the Japanese quality management movement within the 1970s and 1980s challenged the short-term profit focus of US businesses and, through the competitive environment, companies sought new ways to identify, measure, and manage aspects of their businesses that could conceivably impact on outputs for more than short term profit or shareholder gain at the cost of longer term sustainability measures such as quality of products or staff development (Pecht & Boulton, 1995; Johnson & Kaplan, 1987; Langfield-Smith et al., 2012)

Taking a step back, the question as to why performance measurement has become such a critical focus of organisational review needs to be examined. Neely (1999), a widely published commentator, proposed the following answer after a review of research in the field. In his view, the "changing nature of work, increasing competition, specific improvement initiatives, national and international quality awards, changing organisational roles, changing external demands, and the power of information technology" have all been contributing dynamics to the drive for improved performance measurement frameworks (p. 205). Furthermore, there has been a corresponding shift to a privatization model and the notion that all organizations including health care must be cost-effective and therefore sustainable (Krachler & Greer, 2015; Myddelton, 2014).

Performance measurement has a range of definitions, which continue to evolve in response to research, practice and concept development and as a result of other dynamics impacting on organisations (Franco-Santos et al., 2007; 2013). The term is also often used interchangeably with performance management, despite notable differences between the two terms. According to Lebas (1995)

> "Performance Measurement includes measures based on key success factors, measures for detection of deviations, measures to track past achievements, measures to describe the status potential, measures of output, and measures of input, while Performance Management involves training, team work, dialogue, management style, attitudes, shared vision, employee involvement, multi-competence, incentives and rewards " (p. 23)

It is the contention of the current study that each component of a framework – the performance measures themselves and what is then done with them (the management response) - are distinct processes.

Another term often used interchangeably with performance management and measurement is organisational effectiveness. In literature addressing effectiveness, Steers (1975) indicates that an understanding of an

organization's operational context and sector interfaces are critical to assessing this effectiveness. The "holy grail" of the research endeavor in this area may be expected to be understanding and making sense of the link between performance measurement and organizational effectiveness (including where relevant, profitability). However, research on such links has been very limited both in volume and in research model base. For example, Upadhaya and colleagues (2014) studying these links in accountancy firms in Nepal used a self-report survey to identify whether a Performance Measurement System was in place within a class of businesses and then whether it was perceived by the Chief Finance Officer to be contributing to organizational effectiveness. Whilst acknowledging that this study was measuring perception, strong statements were made about the importance of Performance Measurement Systems on organizational effectiveness, but with little real evidence.

In a systematic literature review focused on definitional dilemmas in relation to "business" performance management systems and their impact on the research field, Franco-Santos et al. (2007) proposed a range of elements that could constitute the metrics of such a system – setting these under features (they must have "performance measures" and "supporting infrastructure"), roles (they "measure performance" by necessity but can also contribute to organizational learning, communication and strategic development) and processes *(*"information provision", "measure design and selection" and "data capture) (p799). In a longitudinal examination of educational organisations in New Zealand, Fowler (2009) found that as such entities moved from largely private to public providers in the mid-1900s, performance management practices such as budgeting and output monitoring were linked directly to "their need to obtain legitimacy and procure resources" (p. 195).

It should also be noted that in defining their scope as "business-focused", Franco-Santos et al. (2007) set a boundary excluding public and not for profit organizations and focused only on for-profit businesses. Having reviewed more than 300 articles and studies and finding only 17 with definitions described, they postulated that the lack of a consistent definition was a critical problem for researchers who were evidently making assumptions about what

was meant by the term performance management system rather than taking care to define it. This, in their view then had a subsequent and significant impact on the generalizability of comparative research endeavors. Furthermore, Neely (1997) argues that research across performance domains is undertaken by different disciplines whose work provides learning but often for a discipline silo rather than across boundaries including across research models and paradigms. This is further compounded by the broad applicability of the almost universal tool described below which essentially focuses a performance framework model that is internally generated and locally idiosyncratic by nature and therefore not comparative across organizations and disciplines.

The “Balanced Scorecard” model developed by Kaplan and Norton (1992) is, according to Neely (2004) the most utilised performance measurement tool across international companies as well as across the United States (US). While not the first model to take account of non-financial organisational domains or measures (Lewis, 1955; Kleine & Weißenberger, 2014), this model and subsequent iterations have sought to deliver a framework to enable companies to choose typically a small set of financial and non-financial measures against which to track and report progress against their strategic agenda.

The original work sought to make a link between the overall organisational strategy and the measures chosen for routine monitoring, and focussed on four areas, namely financial, customers, internal business process, and learning, and growth. The aim of the original research was to identify and measure the “intangible” assets that add value within an organisation. There is by extension as assumption that once identified and measured, management executives will then manage for improved outcome, including setting personal performance objectives against the company strategies, although this final step is not articulated in the early Kaplan and Norton publications, nor in Kaplan’s summary paper published in 2010. This assumption, that once performance indicators are identified managers will suddenly act intuitively to impact on them, requires further analysis, although this is not the subject of the current paper.

This section has identified key aspects of the emergence of organisational performance management systems initially in business settings and the subsequent expansion of these to the public sector. What follows is an examination of the development of such frameworks within the public sector and more specifically in the public health system.

3.2 Performance frameworks in the public sector

As indicated above, the Balanced Scorecard model, whilst developed and applied within private industry, was extended to not for profit and public sector entities in the 1990s. Kaplan (2010) notes that this moved it away from a focus on ultimate financial output measures to include what was delivered to the clients of these services. He asserts that within these organisations the strategy ultimately has two sets of deliverables – to funders and to stakeholders. It is further argued notably by one of the architects of the model that it directly assisted organisations to measure "their social impact and mission, such as reducing poverty, pollution, diseases, or school dropout rates, or improving health, biodiversity, education, and economic opportunities" (p. 23).

Early management literature (e.g., Drucker, 1955) sought to make explicit links between company goals and the individual management task. A range of management research and literature has subsequently ensued from the expanded influence of the Balanced Scorecard model seeking to examine and support leadership actions and capabilities in delivering outcome based management practices (Andersen, Lawrie, & Savic 2004). It has also extended the development of strategy management systems, which evidently incorporated the idea of utilising feedback within the open system to generate engagement and continuous improvement (Simons, 1995).

Closer examination, given the focus of the present study, is required in relation to the nature and impact of performance measurement metrics from private business into the public sector. Whilst Kaplan (2010) argues that the range of models of the Balanced Scorecard have been successfully applied to both the public and not for profit sector, Bolton (2003) and others take a broader

view noting that the community would now appear to be seeking a “private sector performance focus but public sector accountability” thereby adding new complexity to performance measurement.

Bird (2003) indicates there are three reasons to pursue measurement of public services, namely to identify what works (and thereby contribute to an evidence base for policy development), to identify functional competencies (and then compare these across organisations such as through school or hospital league tables) and for public accountability (a largely politicised activity based very much on what is reported, how it is reported and how it is understood in the community). The community via the elected government essentially funds these services and seeks value for money and the reform of the public sector to better demonstrate value for money. This model has been driven initially by conservative governments across the world, perhaps most notably in the UK (Fryer et al., 2003).

The private sector models are largely internally focussed, and what is ultimately measured is profit margin and therefore organisational sustainability (Radnor & Barnes, 2007; Felicio et al., 2013). Financially the stakes are high and there has been real impact in executive remuneration and performance outcomes linked to the business profitability (Murphy, 1985; Frydman & Saks, 2010; Hill et al., 2016). The private sector business model is more simply linear, with little research explicitly able to provide evidence linking aspects of organisational performance uniquely to business profitability (Nealy, 1997; Acito & Khatri, 2014).

In describing and reviewing the efficacy of public sector performance models, a requirement emerges - that is for a clearer description of the organisational elements and the function of the organisation, and the interface between these. It is here that a critical difference emerges between private and public sector performance measurement models. Hoggett (1994) argues that performance measurement and management are components of public sector organisational control, as are the introduction of competition and the centralising of strategy combined with decentralising of operations. The author views these as key contested issues at the heart of current public sector mental

health service performance frameworks, where central strategic leadership is emphasised, competition is encouraged, and day to day operational and clinical risk is devolved to the decentralised services. These matters have very real impact on the manner in which performance frameworks are being conceptualised and developed.

In a review of the United Kingdom public sector performance issues, Pidd (2005) identifies the clear inadequacy of prioritising “hard quantitative data over soft qualitative data” (Miller, 2002, p.72) which can effectively override knowledge of what the organisation is actually there to do. He argues that, in this context, resources can be inappropriately applied to the reporting of measures rather than in understanding the organisation. Pidd (2005) further argues that one of the problems emerging is when public sector measures are not appropriately applied across the range of functions. That is, where a public sector worker has limited discretion in action, with very tight parameters for delivery of the service, compared to a public sector practitioner (such as a medical doctor) who has much discretionary decision making in service delivery. Fryer et al. (2003) purport that “the expected improvements in performance, accountability, transparency, quality of service and value for money have not yet materialised in the public sector” (p. 496).

In summary, both within private industry and the public sector, performance measurement has developed in response to competition for profit and resources respectively with accountability to stakeholders (however described) as a core element. Performance measurement notions, frameworks and tools have been widely enacted over the past two decades, but as yet have arguably limited empirical evidence linking actions and performance measures with profitability (De Waal & Kourtit, 2013; Franco-Santos, Lucianetti, & Bourne, 2012). Research efforts have focussed on particular functional areas (such as the accounting industry or the engineering industry) and have also focussed in the positivist paradigm that seeks truth through measurable knowledge (Holloway, 2009; Thorpe & Holloway, 2008). Unfortunately, to date, research outcomes have been limited in this model (Radnor & Barnes, 2007; Pettigrew, 1992; Radnor & MacGuire, 2004).

3.3 Performance frameworks in public health

It is important to examine more closely the performance measurement frameworks currently enacted for public health, public mental health, and public child and adolescent mental health services and the research endeavour related to these. The metrics generated through the regular acute and primary health system have been discussed, and noted to be still in development and not fully implemented or evaluated. Accountability models have also been described as being linked to cost of and price provided for the delivery of care were noted not to be adequately consolidated as yet within the Australian public health care model (Duckett et al., 2014; Robertson et al., 2016).

The history of review and monitoring of service delivery within health services dates back some 150 years. In the 1860s Florence Nightingale initiated comparative hospital data to understand performance, and indeed this practice is not new to health (Smith, 2005). The most developed performance measurement system in public health is arguably the one developed by the National Health Service in the UK. It should be noted that the performance measurement framework clearly articulates that its purpose is to set “clear thresholds for intervention in underperforming organisations and a rules-based process for escalation, including defined timescales for demonstrating improved performance” (Smith, 2005 p. 215).

Organisational performance is assessed against a series of indicators using the most current data available, and the results trigger intervention “…in the case of performance concerns” (Chang, 2007, p102). It can be proposed that this effectively makes it a performance management system incorporating measurement. Further, this links with Smith’s (2005) assertion that performance management is the design of performance information and incentives that deliver the objectives or outcomes sought. This then leads to the concept of accountability, which in health includes a complex web of agents – people using services (patients), their families and broader communities (patients-to-be, taxpayers), people delivering services (clinicians), their representative professional groups, advocacy bodies and employing

organisations (managers) and governments (Tritter, 2009; Maritt et al., 2013; Keele et al., 1987).

Performance measures themselves are apparently set in consultation with stakeholders, governments, professional bodies including the community, service users, and service providers, and they are continually reviewed and improved on the basis of feedback, improvements in evidence, and data management and reporting (AIHW, 2016). However, Smith (2005) argues that measures are aimed directly at managers within health services, and that clinicians are less engaged. In fact one problem with the measurement system is that it effectively alienates clinicians who see their discretion in decision making as potentially compromised by the drive for performance in a range of domains.

The drive for transparency of reporting for public accountability has delivered very extensive data reports, but how these are used to drive quality improvements, regulate services, and manage efficiencies is still at an early stage of development. Cowling et al., (2009) identify a set of additional complexities within the US health system which includes a broader managed health care domain seeking to reduce costs, while at the same time as delivering quality care in a competitive environment both for access to patients and for professional staff to deliver care. Cowling et al., (2009) further argue that in this context, whilst not describing it as such, a performance framework would need to include domains of service, outcomes, and resource stewardship. They propose a model integrating a business-management model for health care and calling for empirical research given the rarity of such research in the literature.

Victoria's public health performance framework developed over the past 25 years is modelled on the work in the UK, while the Australian model build over the past five years is based largely on the metrics developed in Victoria (Hort et al., 2013; Ham & Timmins, 2015). The Victorian government publishes a performance monitoring framework each year and is currently focusing strategic directions on the patient experience and outcomes; governance, leadership and culture; safety and quality and financial sustainability (DHHS,

2015). Measures are collaboratively set within each of these domains, services are provided with funding and targets to deliver against these and the measurement and monitoring commences – accompanied by a performance management regime that targets under-performance. The agreement between government and each health service that details the strategy, targets, funding and program of work is entitled a Statement of Priorities (SoP). Each SoP is signed by the Victorian Health Minister and placed on an accessible web-site for public access. Mental health targets are included in the SoP where a health service is funded to deliver specialist mental health care.

Formal research evidence for the performance measurement and management programs of work in health is largely limited to a focus on the efficacy of particular individual measures and metrics (Grol et al., 2013; Muennig & Bounthavong, 2016). As has been discussed earlier, within the business performance field, research into performance frameworks is limited, identifying a field very early its development (Neely, 2004; Franco-Santos et al., 2007).

3.4 Public mental health services: an evaluation of performance measures

As has been previously discussed, current frameworks for measuring the organisational performance of public mental health services have evolved in the context of government policy drivers, which attempt to match funding with performance outputs (DHHS, 2016). However, in the key mental health policy document released in 2008 mapping plans for strategic change within the mental health system, the then Victorian Department of Human Services (within which the funding and policy leadership for mental health services sits) acknowledged that ”there are potential distortions and an inadequate focus on quality, performance and outcome issues in current funding arrangements” (DHS, 2008, p. 58). The document then went on to commit government to develop “new monitoring and accountability arrangements based on a shared whole-of-system outcomes framework incorporating health and social indicators that reflect broader individual and community goals” (DHS, 2008 p. 17).

However, even once determined and applied, Ciavardone (2006) argues that mental health service leaders and staff may be the last to understand that the performance standards applied by government are real and are relevant directly to them and the services for whom they work. Whiteford (2005) argues that mental health services will never be taken seriously if they can't find a way to develop a model of funding based on outputs rather than inputs. This demonstrates the timely focus of this study as it examines performance frameworks in more detail. It also demonstrates the staged nature of implementation required to develop and implement a performance framework - that is, setting performance standards and then engaging services in the implementation thereof.

Multiple stakeholders exist for public mental health services, including the clients themselves and their families and social networks, potential service users, related community support services, the service providers (clinical staff), service leaders, auspicing hospital networks, policy leaders and government funding providers (Fiorillo et al., 2013; Shapiro et al., 2015; Hawkins et al., 2014). It should be noted that with the emergence of a broader socio-political discourse in relation to mental health and mental ill health, the broader community is increasingly becoming more informed and more demanding as stakeholders in public mental health service delivery (Jakubec & Rankin, 2016; Lewis, 2014; Thoits, 2013). Furthermore, each stakeholder group is likely to have a different perspective on what constitutes a 'high performing' mental health service (Patel, 2014; Rogers & Pilgrim, 2014)

Published research in this area initially focussed on the development of individual measures largely related to patient flow indicators and how they are reported (Epstein, 1995; Sorenson et al., 1987; Clarkson & Challis 2002). For example, in a large study of Veteran's mental health services in the US, the development of the measures and their applicability in comparing performance of similar business units was described in detail and with sound rationale. The framework proposed was clear and unambiguous, the drawbacks or risks clearly identified, and further work to be undertaken was also identified (Rosenheck & Cicchetti, 1998; Teague 1998). However, many assumptions

were made about service context and delivery, rendering a reader or a prospective researcher unclear about the context for the indicators.

It is therefore an aim of the current study to examine what frameworks exist currently for understanding performance as they relate to public child and adolescent mental health services, and to analyse what may be missing in these frameworks. As has been described above, particularly in relation to public health reporting in the UK, what is measured and reported creates a risk for a real understanding of service performance. Further, in comparing performance frameworks within the business sector, it was found that an important factor in understanding performance was a description of the context and organisational culture within which the measurement targets are developed and reported.

This present study seeks to explore different perspectives to understand the performance of a service and make suggestions based on emerging knowledge that enhance performance frameworks and deal with possibly inadequate explanatory models. As an endpoint, the study seeks to propose a framework of domains for consideration when seeking to understand organisational performance within which the discourse of personal experience is integrated (Fossey et al., 2002) and which can make sense to funders, clinicians, and service users alike.

At a service level, current models for measuring performance of a Child and Adolescent Mental Health Service have been shaped by production management theory, health management academics, and adult mental health service managers (Birleson, 2008; Burgess et al., 2004). Whilst there is an expressed desire to do so, they are not yet systematically informed by research, by clinicians themselves, by service users, or by other community stakeholders. As access barriers and demand pressures increase, so too does pressure on governments to improve productivity, funding and policy frameworks who are all seeking to deliver more efficient services (outputs and productivity) and more effective services (quality) (Hilty et al., 2013; Priebe et al., 2013; Collins et al., 2013; Santucci et al., 2015)

Studies of service quality are extensive in the mental health field, including child and adolescent mental health and are largely linked to particular clinical interventions for particular client cohorts. Linking clinical inputs to clinical outcomes is more challenging in mental health research than in regular health care. Furthermore, measuring the actual experience of clients is an emerging field of research. In a study of 6224 clients, Miller et al., (2006) provided therapists with ongoing real time feedback regarding the client's experiences of the therapeutic alliance and progress towards the client's goals. This practise-based evidence not only resulted in higher retention rates of clients in therapy, but also doubled the overall effect size of services offered. It was noted in this study that for sound implementation of this, services have to believe that privileging the client is a good idea and have to want to be accountable (to the client) for service quality.

By contrast, studies in the domains notionally related to efficiency (i.e., outputs and productivity) are more limited in health care than in broader public or private enterprises, and are generally focussed on patient flow metrics, such as how long someone waits for care in an emergency department, or the relative investment logic of earlier intervention or less expensive primary care in the community than forced acute care in more expensive hospital settings (Grattan Institute, 2016; Kings Fund, 2016). In mental health settings, these general health measures can also be utilised, however research is currently even further limited.

Halsteinli et al., (2010) examined a productivity model in Norwegian CAMHS testing the government hypothesis that CAMHS services were under-productive, and that seeing clients for more sessions would improve productivity. They had no routine measures for outcomes for clients, unlike Australia where we have a contested but nonetheless nationally agreed model for measuring client outcomes in mental health. It was identified that variables such as what type of clinician (psychiatrist, psychologist, social worker) was involved and the case complexity linked to diagnostic profile of the client contributed to the capacity of services to deliver the so-called gains. This

means that further analyses of clinician-delivered treatments and patient cohort differences are required to improve the reliability of productivity measurement.

Health economics, a discipline “concerned with the efficient and equitable allocation of healthcare resources” has a great deal to offer CAMHS (Furber & Segal, 2011 p. 71). The focus should be examining cost and benefit and how these relate to each other, such as calling on services to drill down into cost data to determine (based on salaries) cost of a client service hour by clinician and client cohort group. The point is to understand in whatever detail is possible how services are configured and delivered, to whom and at what costs, thereby allowing (as per the Balanced Scorecard model) service leaders to determine where management effort to improve performance would best be targeted.

Salmon and Farris (2004) identify that funding and management personnel hold different and at times competing agendas from the clinicians at the front-line, leading to confusion as to what is and is not effective practice. What is therefore required is a performance framework that extends beyond current indicators such as expenditure, activity, and outputs and encompasses clinical outcomes, sustainability, the emotional climate, safety, and other indicators. It also takes into account of the task of the organisation – that is the clinical care of distressed children and families and the impact of this task on those who undertake it (Bowerman, 2000). It follows that such a framework may require attention to the culture of services, the competencies of staff in known evidence-based or informed practices, and empowerment for clients and families regarding choice about the type of services and outcomes they want.

The task of the organisation is described by its boundaries and aims or definition of primary task (Rice, 1963). With the organisational primary task, different role holders engage with the task from different perspectives – and it may be that the primary task itself is disputed. Hoggett (2006) challenges the notion that it is possible to define a public organisation’s primary task writing “such organisations have multiple tasks which are often in contradiction, they are certainly beset by conflicting notions of what they should be doing” (p 176). Either way, what people expect of a service, from whatever role perspective

they take is a critical matter for hypothesis in this study because how measures are developed and reported will be linked to what people expect the service to be and to deliver.

This study does not propose to examine organisational theory in detail but it is instructive to consider Hutton (1997) who contrasts institutions (the spirit, which needs leadership) and organisations (the body, which needs management). Whether CAMHS is an institution or an organisation or both and how do people's expectations impact on performance frameworks remains to be investigated.

The notion of a spiritual or an emotional sub-text in organisations was discussed by Domagalski (1999) in describing the fact that performance models have largely emphasised rationality. This takes Kaplan's (1992) idea of the balanced score card discussed above and extends it further, identifying both financial and non-financial aspects of an organisations functioning as well as the (potentially more difficult to measure and describe) spiritual and emotional aspects. It is possible that these aspects of an organisation could be identified as contributing to the culture of that organisation.

Organisational culture can be defined as "the way we do things here" (Lundy & Cowling, 1996 p. 168) or more specifically the lens through which an organisation may be viewed, including the cognitive and symbolic models (Parmelli et al., 2011; Scott et al., 2003; Schein, 1995). There has been some, albeit limited, research effort to measure impact of culture on performance, and this has by necessity commenced with the definitional challenge the term culture poses, which emerges from a range of theoretical paradigms, most notably anthropology. Wilson's (2001) commentary on Schein's work stands out to me in the field of definitional discourse. Unlike many authors who determined culture to sit across two domains – the visible aspects (language used, behaviours observed) and the deeper and less visible aspects (norms, values) Schein articulated culture as a primarily being constructed of these less visible elements. Organisational culture is seen by many writers to be influenced by the business context (internal task, external environment); the leadership model, management and "formal socialisation" practices, and

informal socialisation practices - in which Schein and others argue that the theory of group dynamics can assist in understanding elements of relatedness (Wilson, 2001).

In health, some studies have been completed in an attempt to link organisational culture with improved performance but have not been successful in making the link (Manion et al., 2004; Gilson, 2006; Jacobs et al., 2013). In reviewing these, Scott et al. (2003) noted as prominent their finding that definitional descriptions for culture and performance as distinct variables were apparently very difficult to deliver. This is consistent with earlier examination of research reviews in business performance described above and further underlines the need for careful defining of concepts and surfacing of assumptions in the design of the research model.

3.5 Summary

In examining the research context for performance measurement frameworks in a range of settings, it is apparent that empirical research is limited. It is a field of evidently extensive engagement linked (however notionally) to the competitive context of trying to find ways to increase profits and sustain organisations over the longer term. Models of performance measurement are more likely to be described in particular discipline settings (e.g., accounting, manufacturing, health), and are largely internally focussed to the organisations within which they are developed rather than comparative. The technology of the broadly applied and popular performance measurement model (the Balanced Score Card) essentially requires internal focus on organisation strategy and how progress against the strategy can be measured. Research has been critiqued as generally limited by poor descriptions and definitions of elements and subsequent challenges in research design, which is made more complicated by the important inclusion of non-financial measures however described and defined.

In seeking to draw broader themes and apply research outcomes to practice, progress has been slow and limited in the field particularly in management and business literature, and in commentary on public sector performance measurement models. Making clear links between programs of

measurement and organisational effectiveness has not been demonstrated, despite some claims and earnest attempts to do so.

What emerges is the following set of hypotheses. Firstly, that an organisation's primary task and environmental context is unique, even amongst "like" disciplines. The strategy developed for an organisation to survive and grow is likewise uniquely targeted to these elements. A range of factors is generally thought (despite limited evidence) to contribute to an organisation's effectiveness in addition to task and context and these include leadership, formal relationships and informal interpersonal dynamics. The relative impact of each of these on performance outcomes is not the focus of the study, but rather focus should be given to the specific elements to be considered.

It is therefore the contention of the author that in developing a schema or framework for understanding the performance of a CAMHS service these domains should be explored through the study. In Chapter Two an examination of primary task and environmental context has been described and will be revisited in Chapter Six which will seek to draw the theoretical strands of this study together. Leadership, formal structures and informal interpersonal dynamics are unique perhaps to the world of child and adolescent mental health treatment and/or to each individual CAMHS. Seeking a perspective on these will form the basis of the study. As previously discussed, Schein (1995) has proposed that group dynamics and the less visible interpersonal domains of an organisation are important in understanding culture.

The next chapter describe a systems psychodynamics theoretical context for examining organisational relationships. It gives particular insights about how an organisation might operate, insights which are not captured by other more linear and uni-dimensional frameworks. Gabriel and Griffiths (2002) argue that the psychoanalytic approach to understanding relationships offers a model that theorises the complexity of what it is that faces people as they work together. The research methodology is grounded in a social constructionist paradigm which is chosen for its capacity to most effectively address the research aim – that is to gather perspectives, beliefs and experiences in relation

to the research question from a variety of people across varied contexts and roles to examine these multiple perspectives (Burck, 2005).

The study seeks to explore individual perspectives and experiences as they relate to the broad frameworks for measuring organisational performance and to identify issues beyond finance, activity and outcomes towards sustainability, emotional climate, culture and organisational dynamics. This study critically reviews current frameworks for measuring performance and through analyses of theoretical constructs and qualitative methodologies to explore experiences, processes and meaning. It then proposes a framework for considering organisational performance in a CAMHS that references or takes account of these new meanings.

Chapter 4 A systems psychodynamics perspective to organisations

4.1 Introduction

This chapter explores the theoretical foundations of understanding organisations and applies it to this research design. According to Allcorn (2015), there is “no right way to understand organisational life” and indeed studying organisations should be undertaken from a range of theoretical perspectives (p. 181). In the current study, systems psychodynamics is the theoretical model identified for examining organisational relationships and culture. This theoretical approach has been chosen for a number of reasons.

It has been a long established body of research in organisation and groups that combines research endeavours across the interdisciplinary field of psychoanalysis, group relations, and open systems theory. Miller and Rice (1967) consolidated early work through the Tavistock Institute in the United Kingdom into a description of the model, which effectively launched a comprehensive examination into these aspects of organisations (Al-Haddad & Kotnour, 2015; Boxer, 2014; Kets de Vries, 2006; Lees et al., 2013). The conceptual framework seeks to describe and understand what happens between people in organisations and as such goes to the heart of gaps identified in current models for performance measurement for public CAMHS – the focus of the present study.

It should be noted that psychoanalysis is both a theoretical construct and a therapeutic endeavour. Likewise, the study of organisations through a lens of systems psychodynamics has a theoretical stream and a practical applied stream – most notably through organisational consulting. As with individual therapy, consultants are presented with an identified problem in an organisation and, using their theoretical construct, seek to build understanding and propose or co-design solutions (Long, 2000, 2006; Newton et al., 2006).

Frank (2003) contends that:

> “organizations can function better when consultants and leaders are more attuned to the multiple, competing, and complex meanings, motives and intents - conscious and unconscious - that inform the range of behaviors and actions of organizational members, both as individuals and as groups” (p. 350).

The current study examined these complexities in relation to CAMHS. This chapter will provide a background and analysis of literature in terms of key components of the systems psychodynamics theoretical model, starting with a description of the three sub-components, and then draw these together in the organisation of focus in the present study. In particular, this study examined unconscious organisational processes described through language, conversation, dialogue and the discourse these illuminate in order to develop a better understanding of the dynamics that compel people in mental health organisations – particularly a CAMHS (Abraham, 2013; Long, 1999).

4.2 The three contributing components systems psychodynamics

4.2.1 Psychoanalysis

Originating with Freud’s examination more than a century ago of individual intra-psychic phenomenon and further developed by Melanie Klein into object relations theory, the theoretical underpinnings of psychoanalysis form the foundation of systems psychodynamics (Klein, 1948; Fraher, 2004; Klein & Riviere, 1964; Summers, 2014; Strenger, 2006). Freud (1913) studied adults with mental ill-health and made links with early childhood experiences to understand the development of their emotional and intra-psychic world. He introduced the concept of the conscious and unconscious domains where symptoms or disturbance in individual psychological functioning point to hidden or repressed (unconscious) unresolved conflicts usually from childhood. He also introduced the idea of primitive and internal drives towards life and anti-life, further developed in object-relations theory (see below) to include a drive for interpersonal relatedness. New understandings have evolved as a result of practicing therapists and researchers studying their interactions with others in a recursive reflective cycle (Hoggett, 2000; Frank, 2003; Fraher, 2004; Carr & Gabriel, 2001; Heimann et al., 2013).

Klein's work was also primarily focussed on children and the early development of relationship domains evolving between the infant and mother over the first months and years of life, although she studied it though observation of the infant and mother dyad. She and colleagues developed what is now known as object relations theory - a basic cornerstone of which is the idea that the infant perceives others and self as objects and that the dynamic relations between the external and internal objects is driven by desire to relate/be in relationships (Gould, 2001; Heimann et al., 2013; Allcorn, 2015).

Of particular note and relevance is the concept of "splitting" where the infant manages "good" (nurturing or meeting needs) and "bad" (not meeting needs, abandonment) experiences by splitting them in to good and bad (or anxiety-inducing) internal and external objects. Over time and with maturity, a healthy child can manage to conceptually hold the object (for example, mother) as both good and bad. This leads to what Klein termed the "depressive position" (Gould 2010, p177-178). Psychoanalysts postulate that children or adults who are unable to achieve this, as a result generally of early confusion in boundaries or trauma or other disturbance in the primary relationship, may be unable to integrate the good and bad and thus continue to have a split view known as the paranoid/schizoid position (Segal, 2012). The paranoid/schizoid position is thought to provide the deep developmental basis for passion and action, and the depressive position the basis of reflection and moral concerns (Klein & Riviere, 1964; Obholzer, 1996).

Object Relations theory suggests that a prime motivational drive in every individual is to form relationships with objects and people. The style of relationship that develops in early childhood becomes part of an internal blueprint or a learned way of relating, which is replicated when we establish and maintain future relationships. In this way Klein (1948) argues that early infantile object relations forms the unconscious underpinnings of adult relationships including defense mechanisms against anxiety and guilt. Conversely young people who have experienced trauma in infancy and early childhood may have difficulty in forming and maintaining constructive and healthy relationships (Barton, Gonzalez & Tomlinson, 2012; Dockar-Drysdale, 1990; Winnicott, 1953; 1987; 1990; Cramer, 2015).

Anxiety is postulated to be one of the most distressing experiences and is a response linked to perceived danger (Klein, 1948; Spielberger, 2013; Taylor, 2014). The drive to avoid the experience of anxiety is understood in this theoretical construct to be a significant motivator for action – both conscious and unconscious (Krapf, 1955; Rangell, 1955; Nagera, 2014). Responses to anxiety are universal but the underlying causes are deeply personal and individual. Anxiety and how it is manifest in groups and organisations has been a key focus of researchers and practitioners in this field over many decades (Menzies, 1960 & 1970; Fraher, 2004; Sinason, 2015; Stephenson, 2012; Ogden, 2004).

Along similar lines, Winnicott (1960), a child psychiatrist working with Kleinian theory, described the "holding environment" needed to developmentally manage anxiety. Focusing on the bond between mother and child, he described the elements of the environment needed for fundamental human development to occur (Ogden, 2004; Morgan & Wilson, 2014; Frank et al., 2017; Schore & Newton (2013). The mother has to be "good enough" to be able to tolerate and absorb aggression. Only if the child encounters this maternal capacity will he or she gain a sense of self-worth and discover that powerful drives and feelings can be used creatively and not destroy people or relationships (Lanyado, 1996; Bowlby & Aisworth, 2013). In his study of groups, Bion (1977) described containment as the process through which an entity (the mother, the family, or a social organisation) holds anxiety-ridden aspects of experience within itself in order to detoxify them so that chaotic experience can be converted into independent thinking (Rao, 2013; James, 1984; Ogden, 2004).

4.2.2 Group relations – studying the group as a social system.

A range of contributing researchers and theorists developed the concept of the group being an entity in itself, capable of being studied and influenced. Building on the work of Freud, Klein, and others, Wilfred Bion and colleagues studied groups of returned soldiers after World War 2 and established a theory of group relations that has underpinned much modern understanding of group functioning. As with many conceptual and theoretical developments in this field, the understanding of individual development as it emerged was applied to the group context and later the organisational context. Developmental models are discussed in more detail in the subsequent chapter of this work. Groups having distinct developmental phases therefore became integrated into Bion's theoretical and research work. The underlying concept is that it is possible to understand the behaviour of the group-as-a-whole and examine the shared group mentality (Wells, 1980; Long, 2006; Obholzer, 1996).

Bion (1985) developed the psychoanalytic theories extended by Klein to argue that rather than there being a linear progression through stages, there were two types of functioning possible and as potential in every group. Firstly the Work Group - one that is effectively focussed on its task and knows "the boundary between what is inside and what is outside this group" and secondly the Basic Assumption Group - one that is distracted from its task by internal dynamics and inadequate functioning (De Broad, 1978 p.116; Tyson, 1998; Kets de Vries, 2006; James, 1984; Schneider, 2015).

It was argued that as groups begin to establish themselves they start to share assumptions born from confusion and anxiety within the group, wholly unconscious assumptions, of which there are three general forms. First, the "dependency" assumption where the group-as-a-whole looks to a leader or consultant for resolution. Then, "pairing" where the group somehow identifies a pair within it who are seen as "idealised hope for producing a solution". Finally, "fight/flight" where the group seeks to manage anxiety by resolving to fight or flee from the task (Bion, 1985; Rioche, 1970; Kets de Vries, 2006; Shapiro & Wesley, 2012).

The development of group relation's ideas and applying these to the

study of organisations and sub-groups within organisations has been featured extensively in the literature from the second half of the 20th century (Fraher, 2004; Gabriel, 2016). Research by Jacques (1952) and Menzies (1960) into social systems and how they are used as a defense against anxiety provided roots in which subsequent developments in systems psychodynamics are grounded (Krantz & Gilmour, 1990; Lees et al., 2013; Whittaker, 2011).

These studies have shown how organizations develop mechanisms to defend against the anxiety inherent in the system, noting that such mechanisms can become structures embedded in the organizational function itself – which can become rigid and inflexible (Fraher, 2004; Vince & Broussine, 1996; Long, 2008). An example of this within the health system was studied by Menzies in her original work with nurses in a hospital where she identified activities expected to be undertaken by junior nurses that had been designed by senior staff to be ritualized and create no capacity for discretionary decision making and independent thinking to support prioritizing in a crisis for example (Menzies, 1960). This was seen as a defense against the anxiety generated by the inherent risk in the primary task of caring for very sick patients (Trist & Murray, 1990; Sinason, 2015).

4.2.3 Open systems theory

This theoretical contribution heralds from the work of Lewin (1947), Rice (1958), and Miller (1967) and assumes that an organization can be studied as one might study biological organisms. Open systems theory takes the view that each component of a system (from individuals, to organizations, to the varying sized sub-groups within them) can be described in terms of internal world, external environment, with a boundary function responsible for connecting these. In applying these concepts it was proposed that organisations operate as open systems with porous and protective boundaries interfacing the environment. Hirschorn (1990) argues that the needs of people outside the organization, such as consumers or patients of a health care service, are balanced with the task orientation of the people within the organization. It should be noted that management roles are critical in understanding and balancing these boundaries for good effect in an organization to reduce internal

anxiety and manage external expectations. Managers have a key role to play in setting and managing boundaries in relation to space - where the work occurs and what practical supports are provided such as a desk, meeting rooms, toilets; time (i.e. when we work and how we structure the day); and the task itself (i.e. role content, expectations and authority) (Lawrence, 1999; Obholzer & Roberts, 1994; Lees et al., 2013; Potter, 2006; Van den Berg, 2014).

4.3 Systems psychodynamics – the theory and organisations

Group relations conferences (active participatory reflective groups) at Tavistock Institute in the UK were initiated by Miller and Rice in the 1960s and became opportunities to examine, in a reflective way, how the emerging theoretical models of this new interdisciplinary field could be harnessed to understand and change organisations (Fraher, 2004; Shapiro, 2012). A key aspect of the theoretical development focused on Rice's work to revise the notion of a group 'task' – that which an organization or group 'must perform if it is to survive' and the role of defenses that emerge in groups might play in hindering the primary task. Using the frame of the open system, Rice argued that the contextual, historical, social, and environmental factors were critical to whether an organization could perform effectively enough to survive (Bion, 1985; Rice, 1965 p.17; Fraher, 2004; Potter, 2006; Rao, 2013).

The theory and psychodynamics of social defences are of particular note. As Hirschorn (1990) explains, feelings of anxiety related directly to the primary tasks of the organization can be the fundamental underlying foundation of dysfunctional relationships at work and can generate social defences. Social defences against paranoid anxiety (such as splitting and projection described above) effectively depersonalise relationships at work as people "retreat from role, task, and organisational boundaries" (p. 10). This behaviour creates a sense of alliance with colleagues creating a "them" (externals) and "us" (internals) scenario. An example on a large scale is where political leaders of a particular country project anxieties onto the enemy in a war. This effectively seeks to make the population feel cohesive, they become patriotic, they feel better, and more internally connected (Walsh et al., 2016; Hoggett, 2006). However, this belies an underlying unacknowledged paranoid and persecutory

anxiety. Social defence systems evolve to meet real need, but can become rapidly institutionalised and rigid which renders them ineffective (Menzies, 1993; Kahn, 2001; Ogden, 2004; Geldenhuys, 2012; Shapiro, 2012).

A key element in this process is the organizational or sub-group boundary and the relationship between the internal and external world of the organization. Much study and writing has ensued examining boundaries and the role of an organization in containing and holding anxiety. For example, Allcorn (2010) examines the difference between organizational culture and organization identity, and defines organizational identity as “the quality of emotional attachments and connectedness and mutual understanding or lack thereof that may be observed to exist in all groups and organisations” (p. 182). Armstrong (2010) has postulated that current developments in the environment and internal structures in post-modern organisations are directly confounding the traditional idea of boundaries. He suggests that emerging structure changes such as the role and influence of shareholders, the function of ownership, and the subcontracting of work components to other organisations, directly confuses and challenges these boundaries.

In Victoria, the practical impact of government reform in sub-contracting services has broadly encompassed direct health care delivery as well as aspects of operational administration. These have been increasingly delivered in a devolved governance model with independent hospital boards provided with funding and output targets and then making operational decisions that impact delivery of care. Examples include the closure of hospital laundries and outsourcing of the contract to clean, disinfect and return hospital linen. This example highlights the critical matter of managing infection in hospitals (a key problem in safety and quality care) and how this risk is mitigated and how these boundaries are managed. In a study of state social services and Medicaid contracts in the U.S., Johnston and Romzek (2005) found that accountability was effectively managed through utilizing contracts to specify accountability levers but is weakened through engaging competitively with multiple providers, the universal challenge of implementing new technologies, and “risk shifting” (p. 436)

There are two particular issues that require specific, albeit brief, attention in this section given the nature and focus of the current study. One is the concept of the “organisation-in-mind” and the other is that of the complexity of collaboration across organisational boundaries.

The “organization-in-mind” (Armstrong & French, 2005) or “workplace within” (Hirschhorn, 1990) describe the mental models that individuals might hold in relation to the organization within which they work. What is important about this is that it is a synthesis of their unique and individual experiences and conceptualizations of the organization both conscious and unconscious. The organization is essentially constructed by each member in this way by the assumptions they make about the “aim, task, authority, power, accountability and so on” (Armstrong & French, 2005 p. 7).

The other important note relates to the collaboration or the specific dynamics of the intergroup context. Noting the link with organization-in-mind, Miller and Rice (1990) originally described how an individual carries with them ‘”mages of their own and other groups” into new collaborative activities. The primary task systems that are then generated transgress the boundaries of the participating groups. This may then generate additional anxieties and works more effectively when each component group has strong boundaries and is therefore clear about its own identity (Farmer, 2015 p. 261).

Long and Harding (2012, p. 3) describe three stages to developing collaboration: pre-collaboration (group members primarily located in the agendas and dynamics of their “home group”, stressing the limits of their own resources); transitional (most parties convinced of and committed to the collaborative group's primary task and begin taking up roles towards its purpose); and finally collaboration (all parties committed to and collectively engaged with the purpose and tasks of the group, and working together to achieve outcomes). What is described is a model for addressing challenges or advancing inter-group collaboration.

Of interest in the present study is the expectation that emerges between one organisation and another that influences the organisation-in-mind and ultimately the underlying framework for collaboration in serving a child and

family. Within the context of the current study, children and families become engaged with CAMHS frequently as a result often of referrals made or suggested by their medical practitioners, schools, child protection services or other family support programs. How these referring agencies interact with CAMHS is expected to be a matter for examination in the study.

From a systems psychodynamics perspective, inter-organisational relationships are different in key ways, according to Loughran (1986), including that they have less functional hierarchical structures and are generally more complex (Farmer, 2015). Inter-organisational domains such as who the stakeholders are and how two organisations collaborate are the subject of a range of research studies (Trist, 1979; Long, 2013; Morgan, 2010). Alderfer (1987) explores the dynamics between groups posing a theory of intergroup relations for organisations – group boundaries, power differences, affective patterns, cognitive patterns including where those become distortion, and leadership behaviour. As discussed above Long and Harding (2012) describe three stages to developing collaboration starting with the defining of each agency's boundaries consistent with Farmer (2015), then moving to a focus on developing a shared primary goal and eventually action in working together to achieve these collaborative goals.

It is timely, finally, to focus some attention here to the concept of organisational role, which in the application of these theories has assisted consultants to understand and facilitate change in organisations. Individual, organisation and role work as a triangle. How one conceptualises and adopts their role in an organisation is the key to this work and a consultant or executive coach involved would focus on assisting the individual to understand and change the role where there are perceived problems – not change the person of the individual nor the organisation (Borwick in Newton et al., 2006; Stevens, 2016).

The phenomenon of organisational role, triangulated with individual personality and the organisation itself is spotlighted here as a reminder that the domain under review has a range perspectives and layers of complexity. How someone might experience a service like CAMHS as a worker or client, as a

manager or policy maker, as a collaborative service partner or a community member will be affected by what they themselves bring, what role they hold or are ascribed and the culture, dynamics, structures and processes of the organisation itself (Hoggett, 2010; Walsh et al., 2016).

In summary, a century of theory and research has been briefly described, focussing on the macro theoretical concepts that have been soundly described and tested through psychotherapy and consulting practices. Researchers use theory to explain, interpret and then to suggest or intervene, and what has been important has been to remain focussed on the scope of the present research question – that is, what domains may need to be considered in developing a performance framework for child and adolescent services. What has been described above provides a conceptual model for thinking about aspects of the internal world of the organisation as it is experienced and constructed by the people in the organisation. The following chapter examines the health-illness paradigm as it relates to this study and then Chapter Six synthesises the theoretical landscape to frame the research method and findings.

Chapter 5 The health-illness paradigm and diagnosis

The purpose of this chapter is to examine the history and complexity of the process of diagnosis and treatment in child and adolescent mental health service delivery by, as previously highlighted, traversing first the general health, mental health and then sub-specialty area itself. This is important to make distinct from the global, organizational and policy context (Chapter Two), the research context (Chapter Three), and the theoretical context (Chapter Four), largely because the technology of mental health care at the interface between clients and clinicians demands particular attention. Furthermore, what people now expect of themselves and each other as clients and clinicians in mental health services creates a background for how they engage with the endeavour of diagnosis and treatment (Taylor & Hill, 2014). It is also particularly important to review the social context of the emergence and impact of distress and disorder in children, adolescents and their families.

Archaeologists and historians have dated the first surgical intervention to 4,900 B.C., and ancient healing practices such as the use of plants as medicines to early civilizations such as India and China (Magner, 1992; Bynum & Porter, 2013; Sigerist, 1987). The notion of diagnosis emerged in early Greek culture as did the Hippocratic Oath (5th Century BC) in which physicians, even today, make a commitment to uphold what could be characterized in modern terms as ethical medical practice (Gracia, 2001; Veatch, 1981). Advances in science and medical practice have been incremental, constant and relatively fast, particularly in the past two centuries. Whole fields of study have developed in relation to aspects of health, illness, and well-being and have not been sequential but rather branched and linked recursively, variously linked with advances in technology, changes in socio-political discourse and the impact of medical discoveries (Wear, 1992). Areas of development have therefore included public health, illness prevention, medical ethics, the identification and treatment of specific illnesses, specialist medicine, the development of medical technologies including medicines, the expansion and diversification of nursing

and allied health practice, the emergence of so-called alternative therapies, and the re-emergence of ancient therapies such as Chinese medicine and the training of practitioners, etc. (Porter, 1999; Wear, 1992; Lillie, 1998; Nutton, 2013).

Health is a term that has traditionally been defined as the absence of disease but this definition has been challenged to include a focus on wellbeing (W.H.O., 1989; Almedom & Glandon, 2007). Given the determinants of health and well-being include genetics and social environmental factors including: lifestyle factors, access to health services, housing, employment and education level and health literacy, an accurate, comprehensive and clear definition of health is a challenge (Krug et al., 2002; Nutbeam, 2000; Bircher, 2005).

The World Health Organisation defines health as “the state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity” (W.H.O., 2016). It is argued that health is essentially a personal concept because it needs to balance all these domains (Morgan, 2016; Sturmberg, 2010). The health research community has explored genetic factors in the development of illness and its diagnosis, and also what are known as “lifestyle” factors – those that can be influenced directly through the manipulation of lifestyle choices.

Health care has two basic elements – firstly diagnosis (that is, classifying the patient’s illness or presentation) and secondly providing treatment (that is, management, therapy and care for a patient). These two activities are linked in that treatment is targeted to relieve symptoms associated with a particular diagnosis. The following section addresses, firstly, diagnosis, along with prognosis (the probable course) of an illness.

5.1 Diagnosis and prognosis in general health care

Jutel (2011) paints a complex picture of classification practices, including diagnosis in medicine. She says,

> “at an individual level, the clinician will classify the patient complaint, assessing symptoms for characteristics that bring to mind a particular pathology, a previous case, a textbook memory. Collectively,

> classification of diseases validates, locates, and distributes: designating if a disease is real, if it is psychological or physical, under what sub-disciplinary jurisdiction it falls, what treatment it requires, how many resources should be assigned to it, and so on" (p. 190).

There is much research and scientific endeavor that sits behind diagnostic systems and that support medical diagnoses, including the comprehensive World Health Organization International Classification of Disorders (W.H.O., 2016).

> The W.H.O. website indicates the following:
> "[that] the ICD is the standard diagnostic reference book, published online and in print, for epidemiology, health management and clinical practice. ICD contains codes for thousands of diseases and health conditions and is used by health workers, researchers, health information managers and coders, health information technology workers, policy-makers, insurers and patient organizations" (W.H.O., 2016).

Of particular relevance to the present study is the capture and reporting of the data on disease incidence and prevalence. Such data directly influences the funding models, policy and investment decisions generated, and creates a critical landscape for applied research (De Coster et al., 2007; Sponheim & Skjeldal, 1998).

The practice of diagnosis is a technology at the basis of care for those who are ill. It also drives health promotion and prevention activities through the identification of illness symptoms and factors influencing these, which can then be impacted, on a population level (WHO, 2016). It strengthens research, providing clear descriptions of illness and supporting targeted treatment and a basis for positivist and scientific evidence generation. Stanley and Campos (2013) argue that educators and researchers within the medical community have let clinicians down by prioritising evaluation of treatment outcomes over improving diagnostic practice, and that the consequence of this emerges in biased and poor diagnostic conclusions (Langlois, 2002; Knottnerus et al.,

2002).

Despite this criticism, research into diagnostic practices themselves indicates that classification and diagnosis is not value free, despite the so-called scientific approach applied which seeks absolute values and measures and rich descriptions of symptoms against which clinicians can confirm their own diagnostic hypotheses. A case in point discussed at length by Jutel (2006; 2008; 2011) is that of obesity, which she sees as exemplifying the sociological domains of diagnosis. She contends that a coalescing scholarly view across a range of researchers is emerging in relation to obesity, indicating that it resembles “moral panic fuelled by economic interests, neoliberal philosophy, shoddy science, but also by beliefs in an aesthetic of health and the desirability of slender and compact bodies” (2011, p. 204).

Another approach to diagnosis, also possibly socially driven, emerges where the biological is constructed as preferable to the psychological explanatory models or components to a diagnosis – even where including these would create a more comprehensive picture of illness and point clearly to treatment focus (Schwartz & Corcoran, 2010). Wheaton (2011) describes how quickly an interpretation or diagnosis linked to the neurobiological domain is sought, rather than a social or lifestyle explanation (e.g., a heart attack linked to family history and genetics rather than stress). He highlights the impact of this within the context of mental health research funding allocation for studying schizophrenia (a prominent severe mental illness) in the final part of last century in the US, with 96% of funding grants being provided for studies on biological causes and the remaining on the interpersonal aspects of intervention (Wheaton, 2011; Aneshensel, 2005).

5.2 Diagnosis and prognosis in mental health care (psychiatry)

Against the embedded health practice of diagnosis, this section focuses on the unique aspects of diagnostic practice in psychiatry. Rosenberg (2006) notes that psychiatry (the branch of medicine specialising in mental illness diagnosis and treatment) is often the area where patients whose symptoms are complicated or challenging to explain are referred. However, Dumit (2006)

argues that this is a stigmatizing practice that leads directly to shame and subsequent resistance from patients. This has certainly been the case, according to Huibers and Wessley (2006), who have studied the impact of a diagnosis of Chronic Fatigue Syndrome, a relatively recently described phenomenon characterised by debilitating and relapsing fatigue. They contend that it is the implication of the diagnosis and what kind of treatment response it triggers that is the most critical feature for positive outcome, and this can be challenging where there are comorbidities with psychiatric conditions (Chew-Graham et al., 2010).

This takes us to the challenging and conflicted domain of psychiatric diagnosis, which requires particular focus given the themes of this present study (Kirmayer, 2005). The International Classification of Diseases (ICD-WHO) described above has catered directly for mental health conditions since the Sixth Revision in 1949, and provides the same technology of nomenclature and classification coding as with other illnesses (Katsching, 2010)

The Diagnostic Statistical Manual of Mental Disorders (DSM) (American Psychiatric Association, 1994) was first published in 1980, and it delivered a system of categories and diagnostic labels focused on symptom-based clear-cut illnesses, which now effectively compliments the ICD. Prior to this, according to Carey and Gregson (2008), there was emerging dissatisfaction in the psychiatry community with apparently idiosyncratic and arbitrary psychoanalytic categories used to classify mental disorders, which were comparably inconsistent to the scientific categorization of organic medicine. In the domain of child and adolescent mental health, this heralded a classification of disorders describing clinical features, and made these distinct from the relevant risk factors and strengths (Rutter, 2010). As Appleyard and colleagues argue (2005), “even within a categorical diagnosis there are dimensional aspects such as risk and resilience factors, both environmental and genetic, which vary along a continuum to modify outcome in a categorical sense, such as thresholds (or cut offs) and cumulative risk” (p. 435).

In Australia, and in most countries with standardized data gathering capability in relation to disease prevalence, the ICD coding is preferred and

forms the basis of the health and mental health reporting systems (AIHW, 2016). The DSM was, and remains, an important contribution which when it was first published conveyed prestige and indeed legitimacy to a side-lined branch of medicine (Wilson, 1993).

At the time psychiatrists were facing their therapeutic roles being subsumed by other professionals, discretion in their scope of practice being curtailed by new funding models, and what became known as the anti-psychiatry movement in the 1960s and beyond (so called on the basis of a group of clinicians, sociologists and philosophers who questioned the apparent oppression of patients through involuntary treatments and the power dynamic set up between psychiatrist and patient (Nasrallah, 2011; Taylor, 2014). This discourse broadened the engagement of social researchers and philosophers into the world of human distress and mental disorder, and has generated a range of streams of clinical endeavor. For instance, narrative therapy based on early theoretical work of Foucault (Wilkins, 1999) or the work of Levine (2001) who has written extensively on the place of the individual within their context of culture, environment and family experiences (Strand, 2001; Nasrulla, 2011; Wilkins, 1999).

The new DSM manual provided a more comprehensive language to discuss mental illness, and sought to become ‘a biblical textbook specifically designed for scientific research, reimbursement compatibility, and by default, psychopharmacology’ (Mayes & Horwitz, 2005 p. 263). However, criticism of the use of diagnostic practices in psychiatry has continued, such from Snook (2005) questioning whether diagnosing aspects of psychopathology is based on actual medical status or moral and ethical opinion. The Psychodynamic Diagnostic Manual published in 2006 and designed as a partner volume to the DSM provided a metric within which to consider the ‘personality patterns, related social and emotional capacities, unique mental profiles, and personal experiences of symptoms. It provided a framework for improving comprehensive treatment approaches and understanding both the biological and psychological origins of mental health and illness (Lingiardi et al., 2015; Nardone & Portelli, 2005; Silvio, 2007).

In closing this section, which has provided a brief summary of history and issues in the practice of diagnosis in psychiatry, it is pertinent to comment on prognosis – that is, the likely course of an illness. Prognosis in psychiatry affects the design of treatment and expected impact of the illness on the patient and family (Patton et al., 2014; Katona et al., 2015). Appel et al. (1958) stated, ”knowledge of the efficacy of treatment is desired by the psychiatrist in order to establish more precise indications, avoid inadequate or ill-defined methods of treatment, and select the treatment of choice” (p. 459). The expected impact of the illness links directly with research evidence for progress of the illness and effective outcomes and as with broader medical research and discovery, in psychiatry is a recursive and iterative domain of endeavor (Insel, 2014; Priebe et al., 2013; Vermeiren & van der Meer, 2016).

5.3 Diagnosis of mental disorder in children and adolescents.

Of particular relevance to this study is the practice of diagnosing mental disorders in childhood and adolescents. This is a typically complex area, even more so than in adult psychiatry, given largely the social and developmental context within which problems might develop. Rutter (2010) advises that Bowlby’s research and writing was the instigator of a global understanding of the importance of child development and emotional attachments to adults as infants and young children, known as Attachment Theory. Attachment theory describes the psychological but also biological drive to bond with and relate to primary caregivers as fundamental to survival. The ability to trust and relate to others is established in early childhood, through the quality of that infant/primary caregiver relationship and it creates the foundation for behaviour in later life (Becker-Weidman & Shell, 2005; 1979; Bretherton, 1997; Hardy, 2007; Sonkin, 2005).

A number of authors including Salekin and Fricke (2005) and Kolvin and Trowell (2002) assert that understanding development, attachment and a longitudinal approach are critical for diagnosis of child mental disorders. In an interview in 2013 on the occasion marking his 50 year contribution to the field of child psychiatry, Professor John Werry said:

> “The main thing I have learned is that child psychiatry requires much more than medical type knowledge or thinking. Most child and adolescent mental health services in New Zealand [where he is based] have a ratio of 12 non-medical professions like psychologists and social workers to every psychiatrist. Most kids need a multidisciplinary, multisystemic approach, not just a DSM diagnosis and medication” (Werry, 2013 p. 29).

In addition to diagnosis, focus must also be given to treatment as the second broad component of health care, generally linked to diagnosis. Treatment has been defined as the management, therapy and care provided for a patient (Dictionary, 2016). As indicated earlier, diagnosis serves a range of functions and specifically creates a framework for targeted treatment. Identifying the problem guides the design of the solution. The effectiveness of this paired action relies on sound diagnosis and prognosis, and on the availability of, and patient’s engagement with, evidence-based treatment (McPhee et al., 2010; Lingiardi, 2013). Where a diagnosis involves mental disorder, as has been seen, this is not expected to be straightforward – along all parts of that process (diagnosis, availability of evidence based treatments and the engagement of patient in treatments).

> “Even for psychiatric disorders with a strong biological basis, psychological factors contribute to the onset, worsening, and expression of illness. Psychological factors also influence how every patient engages in treatment; the quality of the therapeutic alliance has been shown to be the strongest predictor of outcome for illness in all modalities” (Lingiardi et al., 2015 p. 95).

There are also those who argue that, from a constructivist paradigm, a person would construct their own understanding of the problem, which might not be a diagnosis per se and may include a range of domains, such as social context and personal values (Keeney, 1983).

During the 1800s and early 1900s there were no treatments as we understand them now for people with mental illness; rather people were placed and contained in asylums (Stone, 1997; Scull, 2015). Early last century the

treatments applied were limited to early models of psychoanalyses, which suited only certain diagnostic presentations, and containing people in an acute phase of illness with restraint, confinement, or sedation continued (Wilson, 1993). A Melbourne psychiatrist, John Cade discovered the effectiveness of the drug lithium to treat bipolar disorders in 1948, and this effectively commenced a series of international research breakthroughs in relation to drug treatment for severe mental illness, particularly schizophrenia (Cade, 1949).

Medicines have continually improved over the past fifty years and have included the discovery of the tranquillizer, Valium, and antidepressant medication (Gelenberg et al., 2013; Foerschner, 2010) and they have provided an important facilitator, along with the emergence of psychological therapies, for outpatient treatment as opposed to inpatient and residential care. Refinement and strengthening the evidence base for electroconvulsive treatment, the delivery of electrical currents/shock waves directly to the brain to interrupt and stimulate alternative neural pathways and treat entrenched depressive symptoms. This has ensured that option remains available where indicated (Shorter, 2008) and again can be provided safely on an outpatient basis providing further support for community based recovery.

Psychological therapies (for individuals, groups and families) as part of a suite of treatment options have emerged as important components of treatment (Roth & Fonagy, 2013; Hersen & Van Hasselt, 2013). For example, Australia's National Health and Medical Research Council advises that the treatment for a diagnosis of depression in young people has both components – pharmacological and psychological, and depending on risk and other factors treatments might be provided in a bed based hospital setting or on an outpatient basis in the community (Ellis et al., 2003).

In considering the unique treatment context of child and youth mental health, it is important to return to Kolvin and Trowel (2002) who underlined the critical nature of diagnosis in this age group being developmentally and longitudinally informed. So the treatments need to be also. For example, the developmental context of a pre-school child dictates close work with primary carer and family, particularly where the child may have limited language or may

be deeply anxious and require reassurance. Developmental psychology is a broad area of theoretical and research endeavour of critical import to the understanding of the psychological needs of children and adolescents (Shaffer & Kipp, 2013; Shaie, 2013; Hergenhahn & Henley, 2013).

The developmental context will also inevitably involve school – a critical and important protective factor in improving a child's mental health and wellbeing (Flakierska-Praquin et al., 1997). Salmon and Farris (2006) argue that of critical importance is the multi-agency collaboration that is undertaken by a CAMHS service to support the environmental and contextual factors in delivering comprehensive care that addresses all aspects of the presenting problem. Therefore, services provided for children and families need to include facilitation of interagency or multi-sector care planning for their communities - care pathways within and between services ensuring that responses are aligned with need and risk across the age range (Myors, et al., 2013; Bunger et al., 2014).

Key to collaboration is engagement with families. The all-knowing medical expert paradigm underpinning clinical models in CAMHS arguably works effectively within an acute health paradigm but has limited utility where individuals and families need involvement in decision-making. Such decision-making involves setting priorities in their own lives particularly as service models move past diagnosis to functional impact in someone's life of the troubles they are struggling with (Smith et al., 2015; Shields, 2015). It is the view of the author that there is a challenge in the current system where services are directed to those who are most vulnerable, severe, complex and ill. It is particularly problematic because "diagnosis" has become disproportionally important in determining service access (compared with functional impairment). This mitigates against responding to vulnerability and risk in the individual and caring systems (families). Such a perspective also fails to articulate the contribution of poverty, disadvantage, homelessness, abuse and neglect as both determinants underlying and consequences of mental illness.

In summary, this chapter has sought to provide an overview of the history and context of diagnosis and treatment in psychiatry and in particular,

child psychiatry, consistent with earlier chapters where the issues are flagged but not examined in detail. The intention was to take readers through a contested landscape and note the polarisation of views that leave clinicians at the coal-face of care with the challenge of making sense of a problem in context and in collaboration with a child, young person, and family. The next chapter ties the global, organizational and policy context (Chapter Two), the research context (Chapter Three), the theoretical context (Chapter Four), and the health care context together to distil the agenda for the current study.

Chapter 6 Synthesis and emerging research questions

> "In the absence of systematic monitoring systems, shrinking health care budgets and rapid organizational change will leave mental health care vulnerable to disproportionate cutbacks in funding and to concomitant reductions in quality. There is, thus, an urgent need for comprehensive monitoring systems for mental health care in both private and public sectors". Rosenheck and Cichetti (1998, p. 22)

To date, in the current study, a number of themes have been examined in some detail, namely measuring organisational performance particularly in the public sector and in health care, secondly the theoretical context of systems psychodynamics, and thirdly the health care (diagnosis and treatment) paradigm as it relates particularly to mental health services. This chapter will synthesise the landscape traversed so far and generate the frame for current study. It will summarise the threads and examine the questions – what is the primary task of CAMHS and what challenges does it as a broad organisational construct face? What do we know and what do we need to know about CAMHS? What domains of knowledge should we be seeking to include in thinking about and understanding the performance of CAMHS services? How will these questions be examined in the present study and how will the research be designed to meet the objectives?

This study was developed from the writer's personal experience in managing CAMHS services, which were being assessed in external performance measurement terms on what appeared to be a rubric of objective performance indicators. This simply did not make sense in relation to the context, nor did it provide a meaningful account of the work of the services. As the senior leader, the writer was obliged to lead a service to perform at its best and therefore needed to understand what the deliverables were, who the service was accountable to and for what and how one might measure success against these expectations. The consequent task as the leader was of course

to manage the people to these deliverables. The system and framework for performance measurement has been articulated in earlier chapters.

In summary, however, through exploring the articulated framework from government, the actual messages sent to and generated within services about performance, and the comparative literature on the matter, it became clear that the dimensions of these explanations were limited and limiting. How can the same inputs be provided to a set of organisations who ostensibly have the same primary task, and then the effects however described or experienced be so different? What are the variables at play and how might organisations seek to understand these more, thereby impacting on them for change? From a system psychodynamics perspective the key questions are: what is the primary task understood to be for these services, and how is this primary task understood through the lens of one's role in relation to the service (child or parent service recipient, collaborative service provider, clinician, manager, policy or government authority)?

A note of caution, however, has been sounded by Hoggett (2006) who challenges readers to consider the complexity of defining the primary task of an organisation. He contends that "for public organizations, the search for an organization's primary task is both misleading and fruitless". (p. 193) He further argues that the concept of an organizations primary task predates more modern research, demonstrating that he is evidently guided by post-modern concepts that there is no absolute truth and that an organization's primary task is at best a construction (not his term). However, he then argues that public sector organizations are much more complex than private ones as they are not seeking to identify what they must do to endure but what they must do to "survive with value" and contribute to the community (p. 190). He invokes Armstrong's work (2004) noting that a "key role for public sector organizations is the emotional work it unconsciously performs for the rest of society - keeping death at bay, managing vulnerability, containing madness or violence, and so on" (p. 80).

It was important, in the course of this present study on frameworks for measuring performance, to examine what might echo with this contention of

the complex role and task of public sector organizations noting that perhaps the greatest value of the public sector is that it is freed from the profit agenda altogether. Domagalski (1999*)* suggests that the focus on rational models of performance measurement in organisations has delivered inattentiveness to the underlying hint of subjective and perhaps unconscious emotional world in organisations.

There may be a range of perspectives on the primary task of a service or entity and this further complicates the endeavour of an accurate definition. Different perspectives emanate from the various roles people have in relation to that service, such as the general community, politicians, government workers, other service providers and referrers, service users, staff, management executives and so on. Expectations of what a service should be doing, what services will be delivered, how, and to what effect is at the heart of how performance might be understood. Ascertaining the perspective and the expectations inherent within it will also clarify performance domains. As Duffy (2000) indicated in his study in the UK of relative public sector performance in low socioeconomic settings, the perception of performance is partly due to lower community expectations.

The perspective of government has driven both the explicit description of the primary task for CAMHS and also performance frameworks. Whilst Corrigan (2004) and others have indicated that clinical research and service evaluation delivers treatment frameworks and guidelines for service delivery and extrapolated clinical performance frameworks, Denhardt and Denhardt (2000) remind us that the public sector reform movement of the past 20 years has been built on citizenship and humanism, focussed on engaging and meeting the interests of citizens. Their study indicates that the expectation of public sector is now “marked by [an explicit expectation of] integrity and responsiveness” (p.557).

Notwithstanding the above, and as discussed earlier, the function (primary task) of child and adolescent mental health settings is explicitly described by the Victorian government website as follows:

“Child and adolescent mental health services (CAMHS) provide specialist

> mental health treatment and care to children and adolescents up to 18 years of age. These services assess and treat children and adolescents (0-18 years) with moderate to severe, complex and disabling problems and disorders, and assist those with less severe problems with information and advice about where and how to get help and facilitate referral as appropriate. Vulnerable children and young people and families, including those involved in statutory services, are prioritized." (DHHS, 2016)

In essence, the task at a clinical level is to understand fractured development jeopardised by trauma, behavioural and social difficulties and the intensity and at times abusive relationships between adults and children and youth.

It could be argued that, in general, in Victoria CAMHS clinical models are not as symptom-focussed as in adult psychiatric settings, and instead take a more therapeutic healing stance with children and families and are fundamentally psychosocially and psychoanalytically orientated. CAMHS-espoused clinical models therefore imply two critical elements - the developmental context and the family or relational context. These are both central to understanding problems and defining and delivering treatment (Merikangas & He, 2014; Costello et al., 2005; Walter & Buckstein, 2007).

The primary task, therefore, for CAMHS could perhaps be described as seeking to understand and provide a healing space for a child or young person in their social context and congruent with their developmental context. This research will seek to examine the definition of the CAMHS primary task from different perspectives. The link with performance measurement models for the organisation is clear - a person's internal understanding or expectation of CAMHS primary task will drive their assumptions about performance, i.e., how well an organisation achieves its primary task (Morris et al., 2013; Constantino et al., 2012).

Cardonna (1999) discusses the way the primary task of the organisation can emerge as assumptions are surfaced through the consulting relationship

with a team. She uses an example of a centre for abused children where she was providing consultation to the team.

> "Like children from a 'dysfunctional family', the staff often feel (sic) abandoned and unworthy of proper attention, leadership, and care. At the root of their difficulties in creating and maintaining a healthy organisation is the unbearable element at the heart of their task: having to deal with the breaking of the ultimate taboo between adults and children, namely child abuse. Often, when faced with an internal crisis, the team react as if they are incapable of exercising control or authority, or as if they are unworthy of proper leadership and guidance." Cardonna (1999 p. 243)

The impact of the primary task on the functioning of the organisation itself is heralded through this work. Menzies (1960) research work identifying how the structures and functioning within a hospital nursing team was a defensive response driven by the emotional impact of engaging in the care of patients (the primary nursing task) is the most comprehensive early study in this field, and has generated a range of studies in this area since then and across a range of fields including prisons, the army, educational domains and "for profit" businesses (Caldwell, 1956; Long, 2008; Brown, 1967; Svensson & Wood, 2003).

Studies of the impact of the primary task on mental health services has included research by Willshire (1999) who argued that in fact the primary task itself (which she defined essentially as containing madness) was in itself impossible to achieve. She introduces the concept that part of the interaction originates within the person (intrapsychic world) of the staff member and what he or she brings to the relational context of the organisation. In contrast to an adult psychiatric setting, the anxieties created for staff in CAMHS may not be about the so-called impossible task of containing madness, but about the perhaps equally impossible task of bearing the pain of feeling worthless and powerless to heal and protect vulnerable children (Mawson, 1994).

Furthermore, it is possible that as a social defence against the overwhelming anxiety inherent in the work, teams mirror relationships of

dysfunctional families - exerting and collude with distorted authority, abusing power, developing twisted intimacy, experience extreme vulnerability and so forth (Briggs, 2012; Mawson, 2013). How these dynamics can be understood both as phenomenology and in relation to the impact of these dynamics on how the team achieves its primary task is the subject of the current study.

Some have examined the impact of this in relation to individual therapists and their responses. For instance, Zala (2012) examines the critical role of clinical supervision in helping therapists to reflect on the impact of the work both on themselves as individuals and on their work relationships. It is however the group, social and organisational impact that is at the centre of this study. Understanding the domains contributing to organisational performance will not be about an individual clinician's experience of the work, but instead about how an organisation responds to shared anxiety that develops within the group. Linking then to Zala's example, how does an organisation function where issues of shame or powerlessness are experienced by the workers through their clinical work. Further, what do the leaders and managers do in this situation?

Returning to Willshire (1999), it is proposed that part of the way psychiatry services unconsciously manage this level of anxiety is to define madness and sanity (clearly elusive concepts as discussed in earlier chapters) and then project these into the patient and staff groups respectively. This projection effectively focuses and invests all distorted or mad behaviour and interactions into the patients, and all sane behaviour into the staff group - clearly not a likely absolute "truth". It is the view of this writer is that that the practice of diagnosis must always guard against the risk of this occurring.

A case in point is how a specific population of people known as having been diagnosed with a "borderline personality disorder" has fared as a group in relation to treatment. These people have notably been extremely poorly serviced by the public mental health system, and have routinely reported that they experience massive stigma and discrimination from health workers in particular mental health professionals, and are made to feel like they are mischievous rather than suffering from an illness (Sheehan, Nieweglowsk, &

Corrigan, 2016). The response to recognising the stigma and its impact on those with borderline personality disorder in Victoria resulted in the funding and implementation of a new specialist service during the 1990s targeted specifically to provide advice and treatment to people with serious versions of this disorder. However, this may not yet have delivered the intended changes to the way this group is dealt with in the system of care (Beatson & Rao, 2014; Bland et al., 2009).

Recently a local expert in women's mental health, Professor Jayshri Kulkarni, presented a submission to the Royal Commission into Family Violence set up by the Victorian Government (Kulkarni, 2015). In her submission she challenged the well-known diagnosis of Borderline Personality Disorder, stating that she considered it to be entirely inadequate because the word "borderline" effectively invalidates the condition through its implied ambivalence, and the words "personality disorder" implies a fixed problem inherent to the person that is not an illness and therefore cannot be treated and healed.

Echoing the work of Willshire (1999), she argued that this places both client and clinician in a bind of powerlessness and impossibility. She argued for a new diagnostic term (such as Complex Trauma Disorder), which references the trigger well described through research rather than placing the problem in the person. Such strategies also change the discourse within the service delivery community and with clients about what the condition is and where the healing work should be targeted. It may also change the entry and access metrics for clients seeking services, the professional mix of the treating team (away from psychiatrists and medication towards talking therapies known to be effective such as Dialectical Behavioural Therapy), impact on the culture of hopelessness and inadequacy described, and result in evidence-based treatments – even within mental health (Livesley, 2001; Burke, 2007). Changes such as these (in this case led by the clinicians and clients together) would impact on organisational performance directly.

Multiple stakeholders exist for public mental health services, including the clients themselves and their families and social networks, potential service

users, related community support services, the service providers (clinical staff), service leaders, hospital networks, policy leaders, and government funding providers. It should be noted that with the emergence of a broader socio-political discourse in relation to mental health and mental ill health, the community is increasingly becoming more informed and more demanding as stakeholders in public mental health service delivery. Each stakeholder group is likely to have a different perspective on what constitutes a “high performing” mental health service.

It has been the aim of the paper to date to examine what frameworks exist currently for monitoring performance and to analyse what may be missing in these frameworks that thereby risks inadequate understanding. The study seeks to explore different perspectives of how we might understand the performance of a service and make suggestions based on emerging knowledge that enhance performance frameworks and deal with inadequate explanatory models.

Ciavardone (2006) argues that mental health services (termed behavioural health care services) may be the last to understand that the performance standards applied by government are real and do apply to these services. Whiteford et al. (2005) argue that mental health services will never be taken seriously if they can’t find a way to develop a model of funding based on outputs (numbers seen, improvements in individual client functioning, and meeting their own goals, reduced hospital admissions, increased employment access for people living with mental illness, less homelessness, reduced suicides, and so on) rather than inputs (funding, staff mix, designing service models).

As previously discussed, current models for measuring performance of a CAMHS have been shaped by production management theory, health management academics, and adult mental health service managers (Birleson, 2008; Burgess et al., 2004). Salmon and Farris (2004) identify, for example, that funding and management personnel hold different and at times competing agendas from the clinicians at the front-line leading to confusion as to what is and is not effective practice. What is therefore required is a performance

framework that extends beyond current indicators such as expenditure, activity and outputs and encompasses clinical outcomes, sustainability, the emotional climate, safety, and other indicators and also takes account of the task of the organization – that is, the clinical care of distressed children and families, and the impact of this task on those who undertake it (Bowerman, 2000).

Exploration of the nature and effectiveness of a "model of care" must complement service development as a priority. This requires better attending to and understanding of the total client pathway and experience of services and the relationships, engagement and co-ordinated endeavours and technologies that we know improve outcomes. It is the contention of this study that such endeavours demand attention to the culture of services, the competencies of staff in known evidence-based/informed practices (clinical and psycho-social recovery), and empowerment for client and families regarding choice about the type of services and outcomes they want for themselves.

It should be noted that the emergence of a risk-averse culture (as a result of sustained review, increased accountability and attention to quality and safety matters) has impacted on the need to have performance monitoring structures and strongly articulated and delivered clinical governance processes (Callaly, Arya, & Minas, 2005). Further, the mental health consumer advocacy movement continues to provide a context for constant service development and improvement – especially for improved experiences of care (Wahl, 1999; Heard, 2015; Corrigan et al., 2014). This movement was born in 1950s and fueled by those who were challenging the diagnostic practice and guidelines set through the *Diagnostic and Statistical Manual* (American Psychiatric Association) that homosexuality was a form of personality disorder (Strand, 2011).

Bloom and Farragher (2013) have led the development of trauma-informed models of care with children and adolescents and their families in the US for some years. They characterise the service delivery system as having been driven towards efficiencies given escalating costs in delivering care and disintegration of service delivery complicating the already challenging task of

providing healing care in a safe and secure context. It is against this background that the present study is offered.

In summary, the research question was articulated as follows: What can we understand of the unique aspects of a public CAMHS service organisation that might impact on organisational performance and how might a performance framework be conceptualised to take account of these considerations? In undertaking this research it was expected that a broad understanding of the distinctive characteristics of CAMHS organisations would assist in identifying the perceptions of the primary task of CAMHS. This was expected to focus on for whom the service was developed (the target population), what services were being delivered (the content of the model of care including diagnosis and treatment), how the care was delivered (the process undertaken) and what organisational and cultural domains were identified. Further, it was expected that in identifying these characteristics then testing and comparing them against the research literature and theoretical frameworks examined earlier an understanding of the important aspects of organisational performance of CAMHS would be developed.

The next chapter commences with a description of the design methodology reviewed and then chosen to examine the research questions including plans for data analysis and reporting. The ensuing chapters describe the findings and discuss these in detail.

Chapter 7 Methodology and the research design

7.1 Research design

The design of the current study is grounded in a social constructionist paradigm. This paradigm asserts that construction of meaning is generated through reflexivity between an individual and his or her context (Guba & Lincoln, 1994; Sivan, 1986). It is chosen here for its capacity to most effectively address the research aim – that is to gather perspectives, beliefs, and experiences in relation to the research question from a variety of people across varied contexts and to examine these multiple perspectives (Burck, 2005).

Moon et al. (1990) advocate for three characteristics that underpin the qualitative research paradigm, namely (1) clear identification of research bias and presuppositions that may have influenced data collection and analysis; (2) criterion-based sampling and selection strategies focussed on generalisation to theory rather than to population; and (3) collection of data from a variety of sources to provide triangulation and thick description. A pioneer of ethnographic study, Geertz (1972) recognised that researchers inscribe and interpret as they observe and record descriptions. These are 'detailed, context-sensitive and locally informed' (Emerson, Fretz & Shaw, 1995, p.10). What follows provides background to this study, describing how these three elements have been addressed in the design.

The current study sought to highlight individual perspectives and experiences as they relate to measuring organisational performance that is projected will take the exploration beyond finance, activity, and outcomes towards sustainability, process, emotional climate, culture, and organisational dynamics. Thus, the current study aimed to critically review current frameworks for measuring organisational performance and, through analyses of theoretical constructs and qualitative methodologies, to explore experiences, processes, and meaning. A framework is then proposed for considering organisational performance in public CAMHS that takes account of these new meanings and proposes the inclusion of a range of domains.

7.2 Method

The focus of interest was in what personal experience might convey about broader shared issues and themes at an organisational level. To elicit data on personal experience, participants who were stakeholders of CAMHS as clients, families, referrers, clinicians, managers, policy leaders, collaborative partners were the focus for sampling. It was expected that through attention to the sampling model a range of participants with varied perspectives would be sought. This focus on the theoretical sampling created assurance that participant perspectives were relevant, multiple, and different. Overall, this along with recursive and iterative content analysis was driven by theory as the analytic device and sought transparency in articulating development of meaning (Long, 2000); Burke, 2005; Miles & Huberman, 1985; Braun & Clarke, 2006).

The key data collection tool used in the current study was semi-structured in-depth interviews (Minichiello et al., 1995; Boyce & Neale, 2006; Britten, 1995). Consistent with the collaborative and co-generated data model (Redman-MacLaren & Mills, 2015; Mills et al., 2006), the interviews were conducted as a dialogue rather than a question/answer format. In introducing narrative inquiry as a qualitative research method, Webster and Mertovea (2007) conclude, “people make sense of their lives according to the narratives available to them” (p. 2).

The reason this method was chosen for the study is because it provides a context for understanding perception and attributed meaning within a research paradigm that recognises “the influence of experience and culture on the construction of knowledge” (p. 4) while concomitantly having the capacity to cross boundaries between formal research and practice. The main triggers prompting discussion in each interview were generated by issues raised by the literature and both professional and person experience (Burke, 2005).

Data was drawn from audio-taped semi-structured individual discussions between participants and the researcher. Permission was sought from each participant to audio-record the interviews, which were then transcribed and analysed. Data analysis in qualitative work is theoretically

bound and the method for analysis likewise. Inductive reasoning was the basis for the analysis, that is - idea or hypothesis-generating rather than hypothesis-testing (Thorne, 1997). Morse (1994) identifies the actions undertaken in qualitative data analysis to involve

> "comprehending the phenomenon under study; synthesising a portrait of the phenomenon that accounts for relations and linkages within its aspects; theorising about how and why these relations appear as they do, and re-contextualising, or putting the new knowledge about phenomena and relations back into the context of how others have articulated the evolving knowledge." (p. 24)

As Srivasta and Hopwood (2009) recommend, "reflexive iteration is at the heart of visiting and revisiting the data and connecting them with emerging insights, progressively leading to refined focus and understandings" (p. 77). It should also be noted that the researcher alone undertook the direct analysis, although the reflexive process of review against theory and generation of working hypotheses was a shared journey with supervisors and other colleagues in an informal iterative process. Bradley et al. (2007) indicate that

> "some experts argue that a single researcher conducting all the coding is both sufficient and preferred. This is particularly true in studies where being embedded in ongoing relationships with research participants is critical for the quality of the data collected" (p. 1761).

In structuring the description of data analysis undertaken in the present study, the writer has found resonance in descriptions of "constant comparison analysis" within grounded theory (Thorne, 1997 p.120; Glaser & Strauss, 1967) and more specifically in Thomas' (2006) description of "general inductive analysis" where he writes:

> "the following are some of the purposes underlying the development of the general inductive analysis approach, namely to condense extensive and varied raw text data into a brief, summary format; to establish clear links between the research objectives and the summary findings derived from the raw data and to ensure that these links are

both transparent (able to be demonstrated to others) and defensible (justifiable given the objectives of the research); and to develop a model or theory about the underlying structure of experiences or processes that are evident in the text data" (p. 238)

The final categories discussed in the next two chapters (Findings and Discussion) emerged through the systematic comparison across all subcategories and the linking of groups of ideas with the theory and literature (Burke, 2005; Miles & Huberman, 1985).

In relation to the matters of research reliability and validity, Newfield (1990) addresses trustworthiness in this style of study and advises researchers to ensure there is clear articulation of any bias that may have influenced data collection and analysis, the explicit use of generalisation and theory as the basis for criterion-based sampling and selection, and the inclusion of data from a range of sources for triangulation and rich description (Bowen, 2006; Lincoln & Guba, 1985). The present study design has therefore referenced these matters carefully and can demonstrate adherence to the principles articulated.

7.3 Participants

Twelve interviews were undertaken. Participants and their roles are represented in Table 1 in the order in which they were undertaken. Participants were included using, initially, an open advertisement requiring active self-selection. Later theoretical/purposeful sampling was employed in order to examine emerging hypotheses across a broad range of roles and experiences and thus provide a rich data set for review (Newfield, 1990; Thyer, 2001)

People detained as involuntary patients under the (then) Mental Health Act (1986) were specifically excluded because their legal status would indicate an independent assessment had concluded that they were unable to provide consent to their own treatment and were therefore unlikely to be able to provide informed consent to participate in the current study.

TABLE 1 *Interview participants*

Participant	Current 'Role'	Comments.

1	Previous CAMHS clinician now Academic. Educator in developmental and clinical psychology.	Self-selected for interview.
2	Parent of CAMHS consumer. Paid family consultant/advocate employed by a CAMHS at the time of the interview.	Self-selected for interview.
3	Previous CAMHS clinician, working in clinical education and training at the time of the interview. Occupational Therapy, Family Therapy.	Self-selected for interview.
4	Current CAMHS clinician – 5 years' experience. Psychology.	Key informant seeking input from current clinical staff.
5	Private organisational consultant; previous CAMHS clinician and policy/ government. Social Work.	Self-selected for interview.
6	Emergency Department Physician with extensive clinical experience in referring children and young people to CAMHS in crisis.	From referrers to / partner providers of CAMHS with a view to examining access issues
7	Medical general practitioner (GP) with past history of training in mental health/psychiatry	Key informant sought from referrers to / partner providers of CAMHS with a view to examining access issues.
8	Previous CAMHS senior manager; now working in government clinical leadership role. Registered Psychiatric Nurse, Management	An informed view sought from government.
9	Past history of working in housing, justice, child protection, system development and policy Child Psychotherapist. Social Work	Key informant sought from referrers to partner providers for CAMHS – broad systemic view sought.
10	18 year old past CAMHS client approached via the service provider fully consistent with university ethical considerations and approvals.	Consumer/ lived experience view sought.
11	Current CAMHS clinician (Social Work, Psychiatric Nursing, Management)	Senior and experience current clinician sought as informant on issues of resilience in the workforce and service system change over time.
12	Child Protection government leader (Social Work, Management)	Key informant sought from referrers to / partner providers of CAMHS.

It is acknowledged that under Victoria's new Mental Health Act 2014, the situation would be more fluid, and so-called compulsory patients would arguably be in a stronger position legally to decide on their own involvement in

the study. Future study designs may therefore need to better support involvement of such patients. In the current study design, under 18 year olds were asked to sign a consent form which would be countersigned by a parent/guardian.

The study focussed on people choosing to be involved in reflecting, through collaborative dialogue, on their past experience with a CAMHS service. It was unlikely that participating in the study involved any harm to participants except possibly through reflection on past stressful situations or experiences. This risk was monitored and mitigated primarily through the discussion itself, and through the availability of debriefing by an independent third party to the research if needed. There were potential positive benefits for service users and past clinical staff in making a contribution to the development of CAMHS services, and this is likely to have been a motivator for involvement in the study for some participants. The RMIT Ethics Committee approved the Research in February 2009 (BSETAPP34-08- Appendix 1).

7.4 Materials and measures

Interviews were arranged iteratively, in that as participants emerged and sought participation, the interviews were scheduled. The interviews were conversational in format, and participants were asked to comment on their experiences including in relation to the organisational performance of CAMHS. The questions were open-ended and responses took the form of narratives or stories and descriptions of the participants experience as well as conversational dialogue with the writer. The interview questions were broadly inclusive of the following:

- What are your thoughts about CAMHS? What have been your experiences?
- Do you have illustrations or stories that can help me better understand what you mean?
- What are your thoughts about measuring performance of a CAMHS?

Field notes were made after each individual discussion, at times through the process of data analysis, and again following theoretically-driven

discussions with colleagues and supervisor. These provided an individual and personal reflective space for the researcher to record thoughts and experiences of the individual discussions, the dialogue and data for review, as well as emerging themes and working hypotheses. It also provided the opportunity to reference personal experience, and to test ideas and hypotheses through mapping understandings against theory and then testing engaging with personal experience again in the next cycle.

It is important to further underline that those engaged with the CAMHS service system (including myself as a clinician and leader, but also a researcher) notably use language and certain phrases and shorthand to communicate concepts and ideas. Reviewing the field notes as part of the broader data analysis offered the opportunity to deconstruct possible assumptions that underpin such language, test these against theory, and subsequently elicit new meanings (Burke, 2005).

7.5 Procedure

Most participants had no current direct contact/role with a public child and adolescent mental health service or with the principal researcher. They were initially invited via an emailed request to the network of CAMHS providers and newsletter advertisement (for example the Mental Health Carer newsletter). The study was advertised without identifying who was conducting the research. This was to ensure that the role of the writer in the system as a clinician and manager in a CAMHS setting was separated.

People were invited to express interest in being involved through a general invitation, and were then requested to contact directly and give their address details so that they could be sent the attached explanatory statement and be followed up with a phone call and, if requested, a meeting with the principal researcher to further explain the study. The project was designed to limit the involvement of anyone who may develop a dependent relationship with the researcher. However, it was possible that participants may have been vulnerable given past history of involvement with a mental health service. To address this participants only became formally involved in the study when they

had indicated independently their interest in participating, been fully informed about the study, and had confirmed this with a signed consent form. Furthermore, an independent clinician agreed to provide follow-up support on request of the participant following the research interview, should that be considered helpful. Contact details were provided as part of the plain language statement.

7.6 Data analysis

7.6.1 The researcher

Prior to detailing the process of data analysis itself, this section is included providing background to the researcher and identifying the links. It was written in the first person prior to the commencement of the data gathering process. In defining insider researchers Coglan and Brannick (2001) focus the definition of insider research on people researching their own organisation. Strictly this research does not fit this category at all, yet past and current engagement of the researcher with aspects of the system of mental health service delivery for children and young people makes her "insider" of sorts. On this basis the following is provided to explicitly clarify background and place the researcher within context (Williamson & Prosser, 2002; Coghlan & Casey, 2001)

My engagement with the material of the present study has and will be at multiple levels. I commence this work seeking to tease out the details of these overlapping levels so as to leave the reader very clear that as a person, clinician, manager, bureaucrat and researcher I have much "skin in the game".

My many and varied levels of engagement with Child and Adolescent Mental Health Services (CAMHS) means that as researcher I am faced with grappling with three domains. Firstly through holding roles within the system I am studying, secondly with how my perspectives change and evolve as a result of both the changing roles and with the process of the research, and finally what sense can be made of the resultant complexities. What follows is the developmental story of my role ultimately as a researcher as well as a client, clinician, manager and government leader in relation to child and adolescent mental health services.

A "consumer"

When I was 11 years old my family returned to Australia from Tanzania, East Africa where we had spent my (very idyllic) childhood and where my parents were missionaries and teachers. As a result of their decision that their children's secondary school education should be undertaken in Australia we returned permanently. Resettlement began in the outback of South Australia and finished with a move to Melbourne around the time I turned 13. I struggled to manage the move of cultures from Africa to outback Australia and then to busy metropolitan Melbourne at a time when my own adolescence was emerging and I was facing new developmental struggles.

As a result I was referred to a child psychiatrist and the family was seen together the first session. I was then seen once more alone and remember and understand the focus to have been acknowledging the grief and loss associated for me in the move back to Australia and building my resilience to manage further changes. It was not until much later that I came to describing this as 'my time as a consumer of CAMHS'. This early and very positive experience of a therapeutic engagement is likely to have provided a foundation for my later exploration of a clinical career in CAMHS. It also gives me a unique and personal perspective of the developmental and situational complexities regular young people can find themselves facing.

A clinician

I chose to study Occupational Therapy (O.T.) as an under-graduate and focussed my clinical placements and major elective learning components on both paediatrics and mental health – particularly forensic (prison based) services. At this time I also commenced a long association as a volunteer, undertaking camping programs with welfare-referred families. The O.T. training laid a substantial foundation of the developmental and life cycle context within which health problems emerge. These will be discussed in further detail later.

Of particular note is that O.T theory and practice resonated significantly with my own values and understanding of people and social systems. The espoused focus on assisting people to live their lives was critically important to me. The World Federation of Occupational Therapists states "The primary goal

of occupational therapy is to enable people to participate in the activities of everyday life. Occupational therapists achieve this outcome by working with people and communities to enhance their ability to engage in the occupations they want to, need to, or are expected to do, or by modifying the occupation or the environment to better support their occupational engagement" (WFOT 2012, p1).

For me, occupation and meaningful activity (as opposed to a narrow definition of occupation as meaning paid work) are critical enablers for personal well-being. This is true for children and teenagers and it is true for adults of all ages. Capacity for as much independence as possible in daily activities and in life tasks is a cornerstone for one's dignity. I have become more and more sensitive over time to practices including language that dehumanise and depersonalise people (clients, families, clinicians, managers, and policy/government) in a way that denies or submerges the authenticity and reality of day to day interactions.

I commenced my career working as an occupational therapist in CAMHS at a youth focussed mental health service. The underpinning theoretical perspectives of this service at the time were built on a group psychodynamic model, along with developmental models, for understanding and working with teenagers and their families. Systemic theories were beginning to emerge and were also influencing the rich therapeutic endeavour through the clinical leadership of the service. The service was built to maximise the therapeutic experience for young clients and this was understood to critically include layers of professional supervision for all clinical staff both individually and for clinical dyads and group leaders as well as the team more broadly.

What I learned through this formative clinical experience about the clinical therapeutic endeavour was rich and broad. The theoretical underpinnings of psychodynamic constructs that will be described later in this work were well understood by the team and provided the basis for the therapeutic engagement with young people and their families as well as robust engagement with one another in a reflective process.

I began training for a family therapy clinical specialty after briefly commencing but stopping psychotherapy training. At the time I found the psychotherapy (psychodynamic) orientation created a tension for me between

explanations of individual problems through a deficit model, which felt like it was in direct conflict with explanatory models that set individual problems within a social and dynamic context. These tensions will be later explored in light of the resolution that a system psychodynamics theoretical perspective provides. However, my choice at the time was to study the application of systems theory to the understanding of family systems and to the therapeutic endeavour that focussed on the family system rather than individuals.

I began to work as both a group and family therapist until that service was closed by a government that could not endorse an argument that the quality of service delivery warranted the extent of the investment in staff resources. This is not an unfamiliar or rare event but it is in this experience of the closure of the service that my original questions were formed and emerged as a research endeavour. That is, on what basis can measurement be made of the value or performance of a public mental health service such as this one?

My work then took me into high risk adolescent mental health service delivery – again working from a systems perspective but in an outreach capacity with the broader system of care that develops around teenagers at risk. Usually this includes those providing statutory care such as through the child protection and youth justice programs, emergency services such as police, ambulance and emergency departments in hospitals, housing and school programs and other services such as specialist drug treatment programs.

Cross agency collaboration at an individual service delivery level is a challenging endeavour especially where anxieties are high and the risk to a young life of misadventure, death, drug addiction or other harm is perceived to be at stake (Howell et al., 2004). The context of this work is examined in more detail later, however what is critical at this point is to underline the exploration of system anxiety and behaviour as well as issues of authority and power that I was exposed to through this service system. It was the challenge of holding and containing broader system anxiety as a mental health practitioner that pushed me towards further examination of the tensions created in the process across agencies and within the CAMHS services and how they are consciously and unconsciously resolved.

A manager

These challenges also ignited my journey as a manager and leader as I sought to influence the investment in Victoria in building the innovation that was assertive outreach-based work with high-risk adolescents. The investment from government followed our early pioneering work and I began managing teams that worked at this high risk end of care, building therapeutic programs, new policies, and organisational structures that attended to both the clinical needs presented and the integrated staff support needs that I believed were necessary to contain system anxiety.

I studied leadership through RMIT (Master of Business Leadership) and focussed my final project on issues in positional and personal authority as a manager. I spent the subsequent ten years managing services at an increasing senior level including broader public mental health programs that delivered services to adults and older persons, as well as drug treatment services.

These roles coincided with the emergence of public health related performance frameworks led largely by the modernisation movement in the National Health Service (NHS) in the UK and adapted within Victoria and then more recently across Australia through national health reform.

I was exposed to and participated in role in two specific discourses through this time:

1. *The emergence of a performance rubric for health service delivery within Australia and the wholesale engagement of services in the discourse of effective and efficient service delivery, organisational sustainability and value for money within a health service system oft quoted to be one of the best in the world.*
2. *The extent to which public mental health service delivery was or was not seen to be part of the broader health care system and by extension therefore subject (or not) to the same metrics of measurement of quality, sustainability and performance.*

Government role

I moved into Victorian government policy and operational roles to engage further with these two challenges and to work more directly in mental health policy and service design and performance management. These roles

have taken me directly into the executive leadership of performance management for public mental health services in Victoria and also in Australia more broadly and provided opportunities to engage with and develop the broader policy environment within which the two discourses above are activated.

They have provided an even broader perspective on the specific and unique challenges of child and adolescent mental health service delivery system and placed them alongside the broader issues facing mental health, health, and public service delivery across Victoria. This has coloured the contextual framework for me within what is a dynamic and fluid open system and surfaced real dilemmas, complexities and contested spaces (Huesca, 2001) with reference to the role and primary task of child and adolescent mental health services, the relative relevance and appropriateness of performance frameworks for such services, how such services are perceived and by whom and so on.

In summary

As a person, clinician, manager, and bureaucrat and in the current case a researcher I am at a point in a long journey. With hindsight the emergence of the research questions and design have been clearly visible in my thinking and work. The changes in my roles and therefore perspectives have enhanced my understanding but also raised more questions in my mind. This piece of study is an opportunity to grapple with these issues in context of a robust theoretical tradition towards an articulation of the complexities which more thoroughly addresses and perhaps resolves or at least recognises as unresolvable some of the more critical dilemmatic spaces within which this very important human endeavour is enacted – that of holding, understanding, sharing, healing a troubled child.

It is expected that this background piece has provided a detailed context for the researcher's personal and professional engagement with this study. As recommended by Green (2014) in her examination of the methodological challenges in insider qualitative researcher, this provides the reader with 'fuller, richer account of the methods employed … work[s] to ensure that the

participant's voice is heard in the narratives that the researcher shares' (p12). The next section explains how the data gathered through interviews was approached and analyzed for this study.

7.6.2 Process of analysis

In the current study, the 12 interview transcripts (totalling more than 95,000 words) were read initially individually following recommendation from Chase (2005) who advises that "rather than locating distinct themes *across* interviews, narrative researchers should listen first to the voices *within* each narrative" (p. 663). Interviews were completed over an extended period, which allowed for the writer to immerse herself in the narrative of each one repeatedly to identify consistent themes and categories, linking plausibly with the interview questions and recursively with the relevant literature.

Specifically, using a basic word processor, interview data was sorted initially into broad groupings or chunks (40 of these emerged some containing large amounts of data, some more limited). This was done to progress to the next stage of sifting more systematically in groupings related to the content rather than each individual interview. In this way the material, whilst still linked with the participant was dealt with according to content and meaning. The net effect of this, as will be seen in the results and discussion sections, was that material from some participants was more often quoted than others. The data was then further examined in detail, with themes emerging for initial comparison within each chunk and then across these to find links and then grouped again into six final categories. Data in each subcategory was then sifted for themes and ideas emerging that were linked to the research question and study aim. These ideas in each subcategory were then compared with each other and similarities and differences noted and recorded.

In summary, the data was initially segmented and filtered based on broad themes and then the detail coded and gathered up into the final categories. Computer-assisted data analysis was not used; rather the researcher became immersed with the data in detail – working with it directly and becoming very familiar with the voices of the informants and the ideas as

they emerged and making links across themes and categories. Distilled themes, however, surfaced on the basis of the material itself rather than from emphasising the perspective inherent in the role and function of the informant. This is not to say that the perspective was identified as irrelevant, but more that it was not given overt priority in the design of the data analysis.

This chapter has provided a description of the background design, the procedure undertaken, the data gathering method and analysis process. What follows is the detailed report of the findings of the study in Chapter Eight, with a more detailed discussion in Chapter Nine.

Chapter 8 Results

8.1 Introduction

The research question of the current study has previously been summarised as follows: *what are the unique aspects of a public CAMHS service organisation that might impact on organisational performance, and how might a performance framework be conceptualised to take these considerations into account?*

In this chapter the findings are described. In the subsequent chapter the findings are subjected to review and discussion in line within the relevant theoretical framework. The implications of these findings, and theoretically-informed ideas for conceptualising organisational performance parameters, are then discussed and conclusions drawn.

Twelve interviewees were involved in the study and interviews were semi-structured and open-ended. The interview style included asking people to recall situations or examples of what they were saying. Thus many of the discourses included case discussions or particular memories of interpersonal interactions. These were important and extremely valuable in eliciting emotional experience in the engagement with CAMHS, and has created a rich data set and, in some cases, strong emotive language underpinning the ideas being expressed.

All participants were voluntarily involved and presented a diversity of roles, CAMHS experiences, and backgrounds, and therefore a diversity of perspectives. The findings presented below are therefore synthesised across these experiences. However, the role that someone had in relation to CAMHS (for example clinician, referrer, client, manager) is a factor likely to have provided a unique and valuable perspective in itself. In presenting this feedback, consideration of individual perspectives is therefore also highlighted where they add value and richness to the descriptive data and provide enhanced understanding.

The unique aspects of CAMHS and participants' views and considerations about performance (e.g. what makes a "good" CAMHS) are provided below and are grouped in themes with examples of commentary from the descriptively rich data. Then follows a summary of the process comments, as well as researcher commentary made during the interviews themselves, which, on further analysis, clearly served to provide synthesis and summary in-situ for testing of emerging ideas by reflecting these through the interviews back to the interviewee for confirmation. The analysis seeks to explore the different perspectives, rather than find consensus, and therefore the findings are reported below in a narrative style under broad categories where there has been convergence, and focussed on the concepts themselves rather than the interactions between the researcher and the interviewee or between people described in the examples described.

Findings are grouped together in three distinct areas. First, themes about CAMHS itself are described. Within this section there are subsections examining different people's expectations and impressions of the service, themes focussed on the clients themselves, descriptions related to the clinicians, descriptions that related to accessing and entering the service, themes related to the clinical service provided and perspectives on the relationship between CAMHS and other services. Second, themes emerging about organisational performance (what is a "good" CAMHS) are described. Finally, themes that emerged in the researcher's commentary during interviews are reported for completeness. Themes are richly illustrated with quotes from the interviews, and these have been signposted so that the unique perspectives (such as whether it is the voice of the consumer or parent or clinician) are transparent.

8.2 Findings related to CAMHS itself

8.2.1 High hopes about involvement with CAMHS

This section is divided into several subheadings to examine the data in relation to clients and their families, clinicians, government, and external stakeholders. Here the writer broadly reports on expectations and impressions

of CAMHS, which across the perspectives generated a shared theme best described as having 'high hopes' for involvement with CAMHS.

(a) Clients and their families - the challenge to get help

In terms of clients and families, expectations of the service were linked to the strong desire to get help with their family situation. Described by one participant as

"the pain of before [CAMHS]" (Interview 1: Academic).

was the whole experience of deciding that their child needs help and going through the process of trying to work out where to go and how to get it. There was expressed a sense of desperation for assistance rooted in the fear of what was happening to their child and family and a longing for the pain to be taken away. Interviewee 2, did not know what she wanted from CAMHS *"..nobody wakes up in the morning and says, I want to come to CAMHS. You wake up in the morning and say, I want help…People call because they want help."* (Interview 2: Parent).

Likewise, Interviewee 11, a current clinician indicated that in her experience families did not know what they wanted or what to expect from CAMHS.

> *"I think people often, families and young people coming to our service, they don't necessarily know what it is that they want. If they knew what they want, they wouldn't be there half the time*. (Interview 11: Current Clinician)

There was an articulated sense from several participants of expectation about what the service might actually involve which included an assessment of the problem and a treatment much like any health service for any health condition. Here Interviewee 8 compares going to CAMHS with going to a General Practitioner (GP)

> *"I think…I'm going to see a doctor. And so I would want to be reassured that my information will actually be discussed with a doctor... And I'd also want to know that I was getting the best*

treatment for that child for my child's condition. A bit like, you know, shopping around for a good GP, or shopping around for a good orthopod to do your knee surgery." (Interview 8: Past Manager)

There was reported a recognition that a child and adolescent mental health service might be different from other services, but little detail on what those differences might be. The idea that child mental health's services were different from their adult counterparts emerged throughout the interviews and is examined in other sections of this chapter. The following quotes encapsulate participants' perception of this difference, which went to the heart of the presenting clinical problems and treatment imperatives, the style of engagement of the services and the perception of adult services about their workload compared with CAMHS.

Here adult mental health services are distinguished from CAMHS by the practice models employed.

"…the difference between adult and child mental health and that is that adult mental health is for chronicity, child mental health is for change". (Interview 1: Academic)

Collaborative responses to referrers as a work practice is the key difference for Interviewee 6, the ED Physician

"*entirely different from … adult mental health… We seem have to better liaison with the adult mental health workers"* (Interview 6: ED Physician)

In Interview 5 the Organisational Consultant noted a sense of rivalry between adult and CAMHS services related to the primary task and its perceived level of difficulty.

"…Adult Services saw themselves as being the ones who … got the hard end and did the really hard work and that CAMHS was…the favoured child" (Interview 5: Organisational Consultant).

For clients, their families, and referrers seeking help from CAMHS there was a sense that whilst clients and families might be seeking help in a broad

sense expectations of what kind of help that might entail were affected by ones perception of other services such as the GP, and adult mental health service. Nonetheless, there was hope that help will be found and in the next section the experience of clinicians in relation to CAMHS is described.

(b) Clinicians – a conflict between hope for excellence, and the reality of the experience.

In describing CAMHS the clinicians interviewed focussed on valued aspects of the culture. Clinicians reported learning a great deal about the role and service delivery ideals from psychiatrists in particular as this quote demonstrates:

> *"I learnt a lot from the psychiatrists in that way that they did have that commitment to learning and continuing their own development"* (Interview 3: Past clinician).

This culture of continuous learning and improvement extended to professional and personal development through a culture of routine clinical supervision to support good practice, and an indication that this was expected to include personal therapy for the clinicians as noted by Interviewee 5:

> *"you weren't doing good clinical care unless you were creating a reflective space, and even that you had your own psychotherapy if you were doing that kind of work"* (Interview 5: Organisational Consultant).

There was an expectation in CAMHS that one kept improving one's professional capability through training, which was variably supported by the various CAMHS organisations. However this was seen as challenging to sustain organisationally. Interviewee 5, the Organisational Consultant and a past clinician described this as follows:

> *"…people being employed in generic positions and the management structure, certainly seems to water down professional development and particularly things like supervision and training, and it appears to (me) to be one of the first things that goes, and that's problematic.."* (Interview 5: Organisational Consultant).

Reflective spaces thus previously provided as routine in CAMHS for processing and understanding the work and for learning were perceived to have been replaced with more expectations for client "throughput" and are described in these two quotes:

> *"…certainly there's … a lot more paperwork."* (Interview 11: Current Manager)

> *"I just had to leave really. I found it all too exhausting: not the work, it was the paperwork."* (Interview 3: Past Clinician)

The challenges described above that eroded reflective spaces and supervision were also seen to have eroded multidisciplinary teamwork. This erosion was linked to a sense of there being increased pressure on outputs *"see as many cases as you can"* (Interview 3: Past clinician),

It was also linked to where shared quality multidisciplinary work as well as supervision and training were reported as currently being more difficult to obtain.

The reasons for increased documentation and data gathering were reportedly understood as linked to accountability measures, but there was scepticism about whether the intended outcome had been achieved. Interviewee 11 noted:

> *"There's a lot more attention to alleged evidence, and data, but I don't necessarily know that that's produced a better service… it's a little bit like the focus on outcome measures, and all sorts of different audits, and this and that that we need to do now are all in the service of providing better care, and being more accountable. But I actually don't know that that's made… a difference."* (Interview 11: Current Manager)

Likewise Interviewee 3 highlighted her sense that aspects of the paper work required were meaningless:

> *"…that tension between, well so what, so what that we've got this six page assessment report that examines all the psycho social*

aspects of their life. Who cares? Does that help them?" (Interview 3: Past Clinician)

This, and limited organisational change processes, were criticised and there was a frustration expressed by past clinicians about their impressions of some aspects of CAMHS, including the capacity for self-reflection and change, and the internal decision making processes. As described by Interviewee 4:

"So the thing that frustrates me internally about CAMHS is that nothing ever changes. You can try and revolutionise things, but it doesn't really matter what you do; it never actually gets there, unless you kind of do everything yourself… and the problem with CAMHS is that you can't, can't get anything moving." (Interview 4: Past Clinician)

While many of the clinicians interviewed reported that there are challenges in managing change in any organisation, CAMHS was identified as a particularly difficult environment in which to create change, as indicated here by Interviewee 6:

"*There seems to be no desire for involvement to change the system"* (Interview 6: ED Physician).

Further, there was a sense that clinicians were reluctant to engage with change and also defensive in response to the introduction of change as illustrated by Interviewee 8:

"I did find the CAMHS people more reluctant to change, and certainly acted out a lot more, and I found trying to manage some of the blood spill of change." (Interview 8: Past Manager).

The parent interviewed viewed clinicians defensiveness as linked to their own life journey as parents:

"*You're thinking of your own teenagers and it's much more confronting, and I think clinicians in response become very defensive"* (Interview 2: Parent).

In fact, clinicians were observed to behave in child-like ways themselves in response to change process as described by Interviewee 8:

> *"It's a culture that's grown up almost around the stubbornness ... of practice. They work with children, and clinicians become quite child-like themselves"* (Interview 8: Past Manager).

In response to questions about managing change in that context, she answered,

> "*It wasn't easy. It took a lot of courage to stand up to the CAMHS clinicians…"* (Interview 8: Past Manager)

Also articulated was that there had been changes over time in the physical environment of service delivery which had an impact on the impression created of the services. For example, going into an inpatient unit now was seen as resembling going into a prison with swipe cards and security. There was an observation across a number of interviewees that it is not the clients and their presenting issues that have changed but instead the environment and the organisational structures and cultures. This was richly captured by Interview 11:

> *"it's like going in to a prison … modern psychiatric adult units are all built in these big modern buildings; but the old institutions people could walk outside, and there was grounds, and they could move. Whereas now they've got a little courtyard where they can't smoke, you know there's a lot of restrictions put on people now."* (Interview 11: Current manager)

There was reported a sense of disconnection at times between the activities being undertaken by clinicians and their relevance to the role and task of the service. This theme was described by Interviewee 8 as poor time management and prioritising of work:

> *"A fascinating thing in CAMHS land that everyone is always so busy, and yet…I did a time and motion study and found an extraordinary amount of time went on meetings and conversations*

around children, rather than the doing the work with the child." (Interview 8: Past Manager)

Some, Interviewee 8 saw this as an internal staff team focus without effective outcomes for clients and referrers.

"There was an *inordinate amount of time around trouble shooting, and an inward focus on staff dynamics."* (Interview 8: Past Manager)

One interviewee experienced this as then creating confusion about the task. That is, once working inside the service and participating as part of the team, one participant remembered that she

"*wasn't clear about what the objectives were for seeing these children*" (Interview 9: Senior Systems Experience).

There was a conflict described through this theme between hoped-for service delivery excellence based in professional and personal development and whether there was organisational support for this. In practice actual support was perceived to be eroded by organisational demands such as paper work or increased productivity or throughput.

Further, there was a perception that priorities for time allocation within teams were distorted, and that creating and delivering organisational change were particularly challenging within CAMHS. These themes care echoed in the focus of the next section on perceptions of government policy makers of CAMHS.

(c) Government – a perception of variability in performance

The views of government and policy makers were framed in a synthesis of the history of CAMHS service development, as articulated by one interviewee. She created a marker around the significant social and health policy reforms introduced in the early-mid 1990s in Victoria. Prior to this there was a belief that services were

"'*uncontained…not accountable…people were doing their own thing behind closed doors"* (Interview 5: Organisational Consultant).

The impression then articulated by government was that change was required in CAMHS in address these perceptions.

By contrast, it was reported that the clinician community in CAMHS perceived the services as affirming and empowering clinical work. Interviewee 5 indicated that there was an early engagement with the public child welfare services at that time (Child Protection) which worked well in bringing together different expertise. This participant also perceived the teams as working well collaboratively and reported an openness to look at what was needed and flexibly respond. Here she describes the effect of this collaboration:

> *"…we did some incredibly creative and innovative work that was…very responsive to clients and clients' needs … is what needs to be done now in terms of integration, coordination and complexity"* (Interview 5: Organisational Consultant).

The service system was seen by several participants to have responded to the perceived increased scrutiny of CAMHS by government by defining the "*specialness*" of the CAMHS work, perceived by participants to be a "*survival response*" (Interview 5: Organisational Consultant). This theme of 'specialness' of CAMHS is revisited a number of times in the findings of this study and is discussed more extensively in Chapter 9. Interviewee 5 provides the following description of how this specialness was experienced.

> "*I think the boundaries went up in terms of defining yourself by how you were different to others…there was a real arrogance about it, because there was this real sense of we're a very specialised service which implicitly meant, and we're more specialised than you are, we were better, you know, we were superior."* (Interview 5: Organisational Consultant)

This theme of "specialness" of CAMHS is revisited a number of times in the findings of this study and is discussed more extensively in Chapter Nine. Of particular note in relation to what makes CAMHS special was the notion, as

expressed below by Interviewee 11 that CAMHS clinicians were highly experienced, skilled and trained:

> *"the staff that work in a service like CAMHS; there's a lot of experience and specialised understanding of what's going on. [Others] don't necessarily have the full mental health understanding that we've either got by training, or by experience of working in the service".* (Interview 11: Current Manager)

Government and policy makers were seen to have their own myths or perceptions about CAMHS and about particular services within the sector. Here her words find an echo with the "specialness of CAMHS" theme described above:

> *"There was a rigidity in how CAMHS was seen; and in some ways, the sort of myths that were there in the outside, were there, so I think CAMHS was seen as a bit precious as well"* (Interview 5: Organisational Consultant)

There were reportedly some services seen by government policy leaders to be much more willing to consider new policy directions or initiatives compared to other services who were seen as very fixed, rigid and impenetrable. Furthermore, CAMHS services were seen as:

> "*impervious to external influence…in that sense the government is outside of the silo as much as the community is"* (Interview 1: Academic).

Here the Interviewee is drawing a parallel with the community perception of CAMHS being an impenetrable silo and indicating that government leaders also held this perception.

Of note, there was an impression that part of this "silo" mentality might emanate from a limited understanding of the role of the government policy process within the service system, and that leaders in the CAMHS services themselves did not understand or respect the decision making process

and that this led to CAMHS services feeling victimised. Interviewee 11 described the impact of this on the staff team being that of disempowerment:

> *"the same with staff feeling like things being imposed on them, and them being victims …of terrible management structures, or terrible Government requirements, or extra documentation, or as if they're incredibly passive in that process"* (Interview 11: Current Manager)

The dynamic was described in a similar way by Interviewee 5 who saw process develop as a result of a lack of understanding of the role of government:

> *"I never got a sense that they really understood, even kind of the way government operates and the sort of policy decisions that get made and the policy directions …and I think that there's often a sense within the service of being very victimised…"* (Interview 5: Organisational Consultant)

This sense of being victimised was seen as linked to an isolated and insulated organisational structure where they seek to exist in their own right, whereas in practice and reality they exist as part of broader health services. This then led conversely to being perceived by government as being:

> *"a bit like these difficult adolescents, or these difficult intransigent sort of eccentric, ego-syncratic kind of organisations that just went on their way and did their things"* (Interview 5: Organisational Consultant)

What has been reported here is a conflicted set of dynamics between CAMHS services and government where CAMHS have been seen as effectively underperforming, and have experienced moves to improve accountability and responsiveness as attacks, behaving defensively and as victims in response. Government has then been perceived as adopting a stance with services as if they are recalcitrant adolescents. This appears to have become a pattern of circularity in behaviour, which further embeds a view that CAMHS is a silo and is unable to change. Again, the theme of hope versus reality and a conflict between these perceptions is at the heart of this finding.

The next section examines this theme as it relates to other external stakeholders.

(d) External stakeholders – perceiving CAMHS as "special" and impenetrable

This section described the views of interviewees in relation to perceptions and expectation of CAMHS by other service providers and referrers who were invariably were seen as having high expectations of CAMHS. Examples of these expectations included that there would be a clinical assessment and subsequent expert advice provided for workers, families, teachers, and foster carers on how best to manage the issues and help the child following a referral to CAMHS.

Here, Interviewee 7 describes her expectations in referring to CAMHS as focussed on the child receiving a comprehensive assessment:

> *"…[I would refer] a very complicated family perhaps where I knew the parents had significant difficulties themselves that could have a particular influence on the child, apart from their personalities as such… I'd be then looking at a CAMHS to actually be able to provide a good overview of both the family and the child or adolescents' perspective"* (Interview 7: GP)

The notion that the expectation of the service was for responding to children and families with complex needs was described by Interviewee 3:

> "*what other system is there to make sure that this very highly funded, with these very trained people are responding to the most complex cases?"* (Interview 3: Past Clinician)

There was also an expectation that CAMHS work with people as part of a team, both in understanding the child and family, and in designing and delivering a treatment plan but that this was not reliably occurring against a background of what Interviewee 4 describes here as constant tension:

> *"there's a constant tension between DHS and CAMHS I think, but I don't think I really had a great insight in to that at the time"* (Interview 4: Past Clinician)

Further examination of this tension was provided by Interviewee 5 who identified CAMHS leaders as having an important role in this dynamic of tension:

> *"a real dynamic that set up around their service systems that seemed to be predicated on the relationship between DHS and that particular CAMHS leader, whoever it was"* (Interview 5: Organisational Consultant)

There was a sense of a rigid understanding that CAMHS was "closed" to other forms of knowledge and here Interviewee 5 describes a polarised position taken by CAMHS:

> *"CAMHS is very inflexible and very rigid and very, there are very clear boundaries about who they accept and what's done and how it's done"* (Interview 5: Organisational Consultant)

This position is echoed in a further explanatory comment indicating that the sense of impenetrable boundaries was experienced across the stakeholders as well as in the internal management structure; "a range of stakeholders around CAMHS finding it impenetrable such as the clients, or the referrers and stakeholders, it was also the funding people and potentially the management structure" (Interview 5: Organisational consultant)

Together with the reported perceptions of CAMHS "elitism" and "specialness" is a dilemma that will be explored further in the Discussion (Chapter Nine). Nonetheless, Interviewee 12, a senior child protection practitioner defined the problem as the system becoming stuck by CAMHS lack of understanding about trauma in families;

> "*Where I see things getting stuck is where you've got a, a preciousness, or a rigidity that, that comes often from a lack of understanding around the way families work; the way, and I think there's a huge issue in CAMHS around a lack of understanding of trauma*" (Interview 12: Senior Child Protection)

By contrast there also emerged a sense of fascination and longing for working within the CAMHS setting and belonging to that team or family, as if the rigid boundaries described above created a 'grass is greener over there' perception of CAMHS from the outside. Interviewee 4 described her own sense of attraction in the following quote;

> *"I first sort of had exposure to CAMHS because I used to be a protective worker…I found it to be a really kind of fascinating organisation, and I remember as a 23, 24 year old, kind of wanting to be on the other side of the door…where all the offices are".* (Interview 4: Past Clinician)

This sense of fascination or longing was linked to an impression that CAMHS was the ultimate place for a clinician to work. As reported by Interviewee 4:

> "*If you worked there you were the best of the best and there was an aura of specialness about the work".* (Interview 4: Past Clinician)

There was also a sense that CAMHS was delivering high quality clinical treatment through a rigorous framework of supervision of clinicians – although one participant reported that this was not actually happening universally and thus created real disappointment for her in her experience of CAMHS (Interview 9: Senior Systems Experience).

Interviewee 4 described the impact of her longing to join CAMHS was evidenced in her choice of training:

> "*So I deliberately chose to train to work with kids, and adolescents predominantly; and I … knew from the beginning that that's what I wanted to do, and that CAMHS was kind of the…top of the mountain I suppose."* (Interview 4: Past Clinician)

As an illustration of the difference between what was imagined or expected, and what happened in reality, there was an experience relayed by one participant (Interviewee 9) about how an external worker was supported to train in CAMHS therapeutic models and become qualified, but then was never

able to practice as a CAMHS clinician. She described this as "*setting her up*" and said that at the time of the interview some years later she was still deeply disappointed by the experience. Seeking to work in CAMHS and experiencing what she described as extreme disrespect in the interview process left her angry and disappointed. Here she explained that the motivation to exclude here appeared to be fear of the boundary being breached:

> *"What did I make of it? What I thought was maybe they were afraid of somebody coming in who didn't know the rules, who wasn't a part of the clique... somebody from outside."* (Interview 9: Senior Systems Experience)

In summary perceptions from clients, families, clinicians, government and external stakeholders have been explored and illustrated. In each of these sub sections there has been a theme of hope and expectation followed by a sense of disappointment conveyed about these expectations not being met by CAMHS. Whilst the issues were evidently complex, there was a consistent theme of high hopes somehow being dashed by the reality of experience. The next section focuses on specific findings related to the CAMHS client group itself.

8.2.2 Clients and their families – complexity and trauma

In this section the theme of who the target CAMHS client group was seen to be by Interviewees has been described. Overall, they viewed the target client group for CAMHS as those with real complexity in their presentation, often with parents or families who themselves have difficulties. Here this complexity if described by Interviewee 12 as focused in serious disturbance in the child:

> *"so there's complex adversity, and disadvantage there; that's often intergenerational, and but kids are presenting with really serious disturbance*" (Interview 12: Senior Child Protection)

Interviewee 3 illustrated this complexity by describing a case example where significant risk to himself and others was a feature:

"*a boy who came to us and the referral was that he was homicidal and suicidal, and he'd threatened to go to a tall building and throw himself off, and kill some other students"* (Interview 3: Past Clinician)

A current manager, Interviewee 11 indicated that a feature of complexity was the failure of other services to have impacted or assisted the young person where CAMHS became a service of last resort:

"I guess what we see in CAMHS is by the time a young person gets to us, it's not like they haven't been to the school counsellor, or Berry Street, or wherever, or several places, or child protection. I guess what we're seeing is the, is the end of the, it's the last sort of place that young people often get referred. Last resort" (Interview 11: Current Manager)

A key problem was articulated by many of the participants, which was whether CAMHS was providing care the right client group. Here Interviewee 2, a parent, describes her experience of not being heard about the needs of her daughter:

"I just, it's almost that mother feeling. In the pit of your stomach, and just, you know, little things about her behaviour … I'd known for two years that something was fundamentally wrong, and nobody would listen to me; I was the problem (Interview 2: Parent)

This theme of whether the right people were accessing CAMHS was important for Interviewee 10. For her those who were in the service were not always the ones that needed to be there and that those outside were the ones who needed help:

"[that inpatient unit] is usually full, but a lot of the time it's full of people that don't need help and the people that do need help are just left out there, and they're the ones that are committing suicide." (Interview 10: Past client)

This young person clearly struggled with this, noting there were those of her peers who found themselves receiving inpatient mental health treatment

who were "*legit"* and needed therapeutic care versus those who in her view were playing games, knew how to manipulate the system and wanted "bragging rights" (Interview 10, Past Client).

Determining what is wrong and explaining this to children, young people, and families emerged as a theme. Interviewee 3 was sensitive to the stigma associated with attending CAMHS:

> "*for young people, they've been giving us feedback for years and years that they don't want to go to a service that's got mental health in its title, and they don't want to go to a clinical service, and they don't want all that stuff that makes them feel like they're the problem."* (Interview 3: Past Clinician)

There was recognition that often young people and families are actively seeking a diagnosis to explain their symptoms and somehow validate their pain. Interviewee 3 connected this to levels of disturbance. That is, the more troubled the young person was, the more they found a diagnosis helpful:

> *"I think for some of the more disturbed, well you know, the more kind of troubled kids; sometimes (in adolescence) a diagnosis was helpful for them"* (Interview 3: Past clinician).

There was also a sense of needing to take great care with the impact of the messages provided as clinicians, Interviewee 2 noting that what clinicians say can be more powerful for clients and families than they realise:

> "*I'm not sure that people ever say that very much to clinicians; just the impact of any remark that you make can just be, just lifelong…"* (Interview 2: Parent)

It was proposed that clinicians should be explaining why, for good and valid reasons, it is not always appropriate to provide a diagnosis for young people. Interviewee 2 described the experience of being confused by the symptoms her daughter was presenting with, and a lack of understanding about what was happening:

"Even at that point nobody had really kind of clearly defined that what was happening is she was hearing voices that would be called psychotic voices. We weren't really quite still sure that's what it was… or why this was going on" (Interview 2: Parent).

This was linked with a view that clinicians needed to be talking more with families especially where symptoms and diagnosis were not clear.

The practice of trying to determine a clear diagnosis or understand what was happening for a young person was seen by Interviewee 3 as having the potential to become seriously unhelpful:

"*They went so far that way that every person had to do a battery of screening assessments. It felt abusive*." (Interview 3: Past Clinician)

CAMHS was perceived to struggle with complex cases particularly where there was lack of clarity between behaviour problems and mental ill health noting that even such a split as this is controversial. Interviewee 12 provided an example of this from her experience as a child protection leader where CAMHS practice was inadequate:

"*that's a complex scenario no doubt, and what I could see, without being blaming, was there's good people trying to do what they thought was right clinically… but they were missing so much"* (Interview 12: Senior Child Protection)

There were descriptions of the clinical or social presentations of young people where their personal characteristics formed a barrier to access. For example, the young past client (Interviewee 10) talked about there being a sense of power in creating confusion for people working with her by her behaviour and responses. She saw this work effectively to keep people away and protect her vulnerability but also contributed to a cycle of prejudging her based on past behavioural outbursts. Here she demonstrates how she made this work by understanding what triggered access for her to services:

"I always knew I'd make my way back in so that I could get out of the storm so it never really phased me. I knew what to say and I knew what they wanted to hear…" (Interview 10: Past Client)

There was some resonance in this story with another example provided by Interviewee 12 exploring the recursive nature of seeking access to CAMHS as a child protection leader. She described frustrating circularity that served to keep one complex young person away from accessing CAMHS:

"*So the frustration at that point was, you know, it's this chicken and egg; well she hasn't got a stable placement, so we won't offer clinical work. Well she hasn't got a stable placement, because we haven't got any clinical input."* (Interview 12: Senior Child Protection)

There was also the matter of whether CAMHS clinicians understood or were able to respond to various non-mental health issues that were seen to directly impact on a child's development, such as their physical health or on a family situation such as homelessness, illness, poverty. These are described in two quotes from Interviewee 2, the parent participant, both describing the hierarchy of needs a family might have that create additional challenges for them and should be understood by treating CAMHS clinicians. First, focused on housing needs:

"Whose job is it to find a place for the family to live? This needs to be sorted before they can connect with the mental health work" (Interview 2: Parent)

Second, focussed on basic needs for money, food and health care and caring responsibilities:

"You can't come here to CAMHS as a parent trying to deal with little Johnnie's school refusal if the only 90 per cent of your brain is occupied with the fact of, I have no money, there is no food for me to feed my kids tonight, my husband's just lost his job, I'm not feeling very well, and my mother in laws in the hospital." (Interview 2: Parent)

The young person interviewed became emotional during the interview as we examined violence and the role it played in her life both as a victim, an observer, and a perpetrator. It was part of the interview at every stage as she described her family, living situations, inpatient stays, peer relationships, and current life challenges. Here her focus was on peers:

> *"…because I know I've run into several physical altercations with the kids and they knew where my boundary was"* (Interview 10: Past Client).

She saw the staff caring for her as capable of understanding the triggers for her violence and working within these to prevent escalation:

> "*And they knew that if the staff got physical with me I'd get physical with them, so it's like a little power struggle in between, but they never really got involved with me."* (Interview 10: Past Client)

In this quote she describes the intensity of experience of group pressure amongst peers in an inpatient mental health setting:

> "*…who's going to fight with security, who's going to call code greys, who's going to break a window, who's going to grab this, who's got the biggest hole in the wall…"* (Interview 10: Past Client).

Here she describes aggression and assault in a community setting, a traumatic experience to witness:

> *"…the police were a lot rougher. I know one of the kids, they came and they just literally dragged him about three hundred meters by his hair and all the way from his room*" (Interview 10: Past Client)

The language of aggression, when it was in her view justified, and the impact on victims was striking in that she appeared to use it in describing all CAMHS clients, not just herself. In this quote, she indicates a sense of omnipotence and makes a violent threat:

> "*Hopefully something does change in the next few years and I don't lose any more mates. That would be really good but if it doesn't*

happen well, I'll just blow up the whole school." (Interview 10: Past Client)

This section has closed with reports of the nature of violence inherent in the presentation of one young person, Interviewee 10. Complexity in the client group was the theme of the section and a violent presentation was seen as part of such complexity, as was unstable accommodation, a history of trauma, physical ill-health, family problems and mental ill-health; a complex and changing presentation and poverty. There was a sense that CAMHS clinicians were inadequately prepared to deal with many of these matters appropriately. Clinicians were seen to either dismiss these complexities, not address them in discussions with clients and families, or to engage with them inappropriately through batteries of tests that risked being abusive. The next section examines views related to the clinicians themselves.

8.2.3 CAMHS clinicians - perceptions and ambivalence

This section describes perspectives of CAMHS relating particularly to the clinicians. There was a shared view emerging in the data that was best articulated by Interviewee 9, whose description underlined the valued contribution towards growth for children and families.

"*Creating a safe place and watching children and families grow and feeling like you're adding value"* (Interview 9: Senior Systems Experience).

Parent work was also seen to be incredibly rewarding, as well as being able to use one's mental capacity, having to really think, listen, and interact on a very personal human level.

"*No other job would provide that level of reflection and reflective space…puts you on the spot about you as a person"* (Interview 9: Senior Systems Experience).

The work itself was seen to be different to any other work role and this was linked with people who staff the services as described by Interviewee 4:

"one the elements of what makes things work or not work is the personalities of the clinicians" (Interview 4: Past Clinician)

There was congruence across the interviews on what the role of a CAMHS clinician was in relation to clients, namely that clinicians have the task to understand the problems being presented, build understanding and assist generating solutions. Interviewee 11 emphasised the difference between CAMHS and other services in the capacity to understand the client:

"But it's our job to try and make sense of, of their story, and, and to help them to work out how they might navigate that. And I, I don't think that that level of understanding is necessarily available to the staff so often in the non-Government kind of sector." (Interview 11: Current manager)

Having an opportunity to work in a high quality setting undertaking an important and valued role was a feature of the time Interviewee 3 spent in CAMHS:

"…it gave me the opportunity to perform a meaningful role in terms of I think that the service mostly that was provided was of high quality and had integrity" (Interview 3: Past Clinician)

In terms of general impressions of CAMHS clinicians conveyed externally, the theme of an impression of uniqueness or specialness of CAMHS emerged strongly and is expressed here as related to a high degree of training.

"…there's so many people with high needs, we're set up and funded to provide it for the most troubled…what other system is there to make sure that this very highly funded, with these very trained people are responding to the most complex cases." (Interview 3: Past Clinician).

However, this specialness risked becoming what Interviewee 3 termed arrogance:

"So one of the effects was to maybe make us feel so much more special, and so much more expert, because…other people in the community can't do this work. Of course everybody else in the

community is seeing the same people. So …a little bit of arrogance that was created." (Interview 3: Past Clinician)

A version of this arrogance was also conveyed internally to one participant who at the time was a therapist with adolescents. She reported that as she had not worked with children, she was advised that she did not have the appropriate skills for the team, subsequently causing her to leave the service. She conveyed a sense of frustration in having the family work skills dismissed by colleagues due to this:

"…when child psychotherapists would say to me things about my lack of child (experience)….I would think - any family who would see me would be pretty happy thanks" (Interview 3: Past Clinician)

This internal split drew further comment and reflection from Interviewee 8 who found this internal split of child workers and adolescent workers challenging to understand:

"*But I think what CAMHS thrives on is a sense of difference. And a sense that children are different. And trying to conceptualise that in terms of a developmental perspective, because children are different, but not different enough to warrant a different process of treatment. I found it extraordinary difficult, and wondered about who it is that gets attracted to work in CAMHS."* (Interview 8: Past Manager)

Further to this, the practice and service delivery at CAMHS was described by one participant as being driven by the clinicians' interest rather than what the people needing a service requested, needed or wanted. An example was given where:

"*each person saw themselves as a specialist, and we had no generic skills in the team to do basic assessments"* (Interview 8: Past Manager)

This was contrasted with the impression that clinicians were at times inadequately trained and incompetent to do the work - particularly in relation to understanding trauma and family dynamics. Interviewee 12 linked this

inadequacy to a broader gap in understanding about how an informed leadership structure might assist a service to do better with these clients who were particularly impacted by trauma:

> *"…it's coming from a misguided understanding, and they're on a rescue mission, which actually is replicating the trauma dynamics, and re-enacting them*." (Interview 12: Senior Child Protection)

The experience of working in CAMHS as a clinician was described generally favourably overall by participants with highlights reported as the experience of being part of a supportive skilled team or well-informed people, reflective spaces, with good clinical responses to really complex and difficult work. There was a theme of satisfaction of a job well done, a sense of having contributed to positive client outcomes as indicated here by Interviewee 3, who highlighted the chance to perform a meaningful role:

> "*My experience of CAMHS has been incredibly positive… I think that it gave me the opportunity to perform a meaningful role…".* (Interview 3: Past Clinician).

For Interviewee 5 the focus was on what the CAMHS offered the workers:

> "*I loved working in CAMHS; and it was fantastic as a social worker to work in CAMHS because there were a lot of things it offered"* (Interview 5: Organisational Consultant)

For Interviewee 11 the opportunity to work in a setting where your position is respected was highlighted:

> "*I'm lucky to have worked in, in environments where those different positions are respected, and you can have the dialogue"* (Interview 11: Current Manager).

This sense of being respected and valued resonated with the reflection by Interviewee 4:

"*There's no difference in my enthusiasm, and my probably unhealthy desire to do everything, and make everything really great. The difference is that I feel more valued there."* (Interview 4: Past Clinician)

Personal reflections of clinicians who had worked in the service were evocative with emotional descriptions memories of the work such as where a client is relieved that some one understands them at last and helps them get on their journey. Clinicians valued the opportunity to respond with compassion, sensitivity and humanity. Here Interviewee 3 described the impact on her of the experience of finding a way that assisted clients:

"..it's not always the long term work, or the intensive work; it was just I think to be able to offer an experience of caring, soothing, hopefully reflect some understanding; that some burden could be lifted around blame, and shame, and all the stuff that these people carry with them. And they're quite, they're quite lovely moments." (Interview 3: Past Clinician)

There was some consideration of the difficult components of the work for clinicians. There was a report of the emotionally demanding work with distressed children that can "*make you overwhelmed*" (Interview 6: ED Physician) and this was described in particular about the work in inpatient settings where adolescents were seen as "*generally very angry and difficult and attacking*" (Interview 7: GP).

Stress experienced by the clinicians was seen to be about being overwhelmed by need and being unable to respond as indicated by Interviewee 6:

"*I don't think there really is acknowledgement of the impact of their continued stress. It's a high pressure environment, plus it people's distress and pain; and the decision making"* (Interview 6: ED Physician).

In order to feel "contained" yourself you need to understand the problem enough to feel confident you can offer something helpful and here Interviewee 3 describes the impact of being overwhelmed:

"*there is the potential for people to be overwhelmed and shut down even more, the kind of bunker mentality or a conveyor belt*." (Interview 3: Past Clinician)

There is a fear that you will lose your capacity to think and then do bad work:

"*If I can't think, I can't be helpful"* (Interview 3: Past Clinician).

In summary, this section has focussed on the contrasting impressions of special clinicians, with a flip side of arrogance; of high levels of capability, with a flip side of knowledge gaps or inadequacy; of empowering and genuinely helpful clinical contributions, with a flip side of high pressure, stress and lack of containment. It is in this conflicted picture that tension is conveyed. The next section examines perspectives on the experience of the "front door" to CAMHS.

8.2.4 Getting in the door - intake, access and entry

The focus of the following section is the experiences and impressions of the approach and entry to CAMHS services. This was the most comprehensively emergent theme across the interviews. Calling the service and making referrals was described universally as a challenging process. Whilst there was recognition that thresholds were high and in such a situation there was a requirement to '*gate-keep'* there was also a level of frustration conveyed about the at times '*inexplicable process'* of referral and intake. (Interview 12).

The language of description at this entry point was itself a problem for Interviewee 2 who sought clarity for families seeking help:

"*I also believe that intake should not be called intake, it should be called access. I want access to the right place to go"* (Interview 2: Parent)

There was concern expressed that clinicians of any background may not be the first people taking information at the first point of contact and this was

linked to the importance both of making a connection and engaging with the referrer or client. This Interviewee

> *"…was horrified to see that the receptionist of a community health centre was required to take referral information and she was having to take a brief note about the problem* …" (Interview 1: Past Clinician)

The clinical work of intake itself – that is triaging, gatekeeping, on-referring and managing entry into the service was seen a challenging role. Some identified that it was a role no-one wanted to do. The impact of managing the demand was seen as stressful and precipitated structural and functional solutions with varying degrees of success as reported by participants. Here Interviewee 3 described the impact of individual as opposed to a group waiting list:

> *"…I think some services the waiting list sits with a clinician more, which I would find very stressful. [But where I worked] intake held that pressure more, which would have been hard for them. So I didn't feel overly responsible for the people on the waiting list, but I'm sure parts of the system would."* (Interview 3: Past Clinician)

There was a clear theme about obstacles and barriers to access and for Interviewee 3 the barrier that stood in her mind was the barrier or stigma associated with the name and function of the service:

> "*Young people have been giving us feedback for years and years that they don't want to go to a service that's got mental health in its title, and they don't want to go to a clinical service, and they don't want all that stuff that makes them feel like they're the problem. So I think being part of a hospital, a medical frame where we diagnose is a problem."* (Interview 3: Past Clinician)

The parent interviewed said she had tried to get help a number of times and nobody believed her or she didn't have a way of structuring the referral so that someone would listen. Rigid adult based referral systems were seen as unfriendly to teenagers and drew the following comment:

"*You needed the language just to tell somebody what was concerning you*" (Interview 2: Parent).

One CAMHS practice of taking referrals only from tertiary care services was seen at obstructive and limiting access of those who most needed the service. It was observed by Interviewee 1 that this had the effect of reducing workloads in CAMHS but increasing it in the secondary agencies now required to pick up more of the work:

> *"the number of referrals has dropped. They're claiming all sorts of benefits of productivity and whatever by doing that but they've actually blocked out the most vulnerable of the group."* (Interview 1: Past Clinician)

Referring services attempted to find ways of accessing CAMHS using particular techniques including trying to make the needs of the children sound more '*fixable*' so that CAMHS were more likely to '*pick them up'* (Interview 9). Interviewee 5 described the experience of a troubled family who were turned away and could not understand why:

> "*A terribly distressed family and really problematic, and the organisation were really struggling with it, and they couldn't understand how that was not seen as a mental health issue"* (Interview 5: Organisational Consultant)

There was a view that the intake system was not designed to bring attention to the most vulnerable people but rather those more compliant, resourceful and organised (Interview 1: Academic). This resonated with Interviewee 9 who indicated that children were frequently too damaged for the service to take on and she found this to be inconsistent with the concept that CAMHS worked with those most severely troubled children:

> "*But it was as if, as if our children were so badly damaged, and so badly abused that they were too terrible for even that system to pick up"* (Interview 9: Senior Systems Experience)

For clients and families, the impact of high thresholds for entry was raised directly, but generally not by the clients or families themselves as they struggled to feel safe to complain in case they jeopardise the hard-won place in the service. Interviewee 5 provided an example of the impact of this on families where problems then subsequently escalated and more acute responses were required:

> *"…some had got in and some hadn't…and it wasn't until they'd had their first full blown episode that they then actually got in, properly into the system, and most of them … were hospitalised and the parents were really bitter"...* (Interview 5: Organisational Consultant)

Medical people referring into the service were particularly frustrated when they could not talk with other doctors directly as part of a referral, since oftentimes very skilled allied health and nursing clinicians undertook the intake and triaging role. However, this seemed to have the effect that the doctors were being dealt with by a junior person and this was seen as inadequate to the complexity of the service needed (Interview 7: GP). The other Interviewee with a medical background, Interviewee 6 described the obstacles she experienced in trying to refer a client to the inpatient setting:

> "*We know supposedly where they are, but to get, to get to have a conversation, they're saying we would, as part of a system process, I would ring up the intake worker for the child and adolescent unit, and then I have got to jump a whole lot of hurdles."* (Interview 6: ED Clinician)

Furthermore referrers, including doctors, were often left '*holding'* the child or young person due to long wait lists and delays. Several interviewees commented on the negative impact of long waiting times for both clients and families (whose problems often escalated) but also for the services in managing the situation whilst waiting for CAMHS. Interviewee 7 confirmed this as follows:

> *"..be referred in to the public system; and as a GP the public system was seen as something that could be very good once you actually got in to it, but there was often a very long waiting list."* (Interview 7: GP).

There was commentary on more recent developments in primary mental health care delivery which has served to broaden access to private providers and in a sense create more options for referrers.

There was a sense that CAMHS was aware of the challenges facing services that had to manage difficult situations whilst someone was waiting for service in CAMHS. A solution reported by Interviewee 9 was to facilitate support to the services with secondary consultation and advice on the children's needs and care. But for child protection the impression was of a locked door from CAMHS or a '*blame game'* as indicated here by Interviewee 12 here:

> *"It is about, it is about shared meaning, shared understanding, shared culture; and a congruence around respectful partnerships with external agencies, and stopping the blame game"* (Interview 12: Senior Child Protection)

On the whole, CAMHS was not seen, by participants, to understand or had a misguided understanding of sex abuse literature, trauma literature, offenders and offending behaviour, limited knowledge about family dynamics and siblings issues, complex and cumulative trauma and the intersection of abuse and neglect.

Child protection referrals were seen to be treated differently from others. In one instance they were evidently not managed based on clinical need but routinely through a case conference. This was seen as a discriminatory structural barrier by Interviewee 4 for these most vulnerable children given that intake decisions were not made on presenting clinical need but on who was referring:

> *"If you were a child protection case, your needs were never enough to qualify you to directly go in, ever"* (Interview 4: Past Clinician).

There was also postulated a view by the external referrers interviewed that part of the barrier to access CAMHS was generated internally and probably unconsciously to guard against being overcome by floods of referrals. Interviewee 12 here indicates that this is directly linked to resourcing and gate-keeping:

"*It is absolutely about anxiety, and about overwhelm, and scarce resources, and we've got to gate keep. And that's true too."* (Interview 12: Senior Child Protection)

There was a perceived reluctance to take on a child or teenager in the system (particularly when the client was in crisis in Child Protection or in the Emergency Department) and in fact the CAMHS intake system was described as broken. Interviewee 6 considered the obstacles encountered as directly serving to restrict any clients coming into the service:

"There are just hurdle after hurdle, barrier after barrier…and it can be hours later before that child will have access to a child and adolescent health worker. It feels like a real reluctance to take on the task of providing a service to another child" (Interview 6: ED Physician)

This section has underlined the broad perception that barriers to accessing CAMHS were strong and challenging for clients, families and referrers. They were variously linked to structural obstacles (like the name of the service or different procedures for one referrer over another), to inadequate capability and understanding within the CAMHS service of which clients should receive a service, and to the anxiety inherent in managing highly complex cases and systems and overwhelming demand. For those who are taken into the service, the following section describes the themes emerging in the data about assessment and treatment within CAMHS.

8.2.5 Once you are "in" - the service provided

Service delivery was identified as an area for discussion across all interviews including whether families attended the service, the assessment and diagnostic process, discharge and in particular the therapeutic endeavour as an activity in itself. It was reported that the drive for families to attend outpatient sessions seemed to come from the challenge and determination of just getting into the service, the acknowledgement that there has been a problem, "hope that things can change", and "seeking to move forward" (Interview 4, Past Clinician).

(a) Once "in" - problem identification, assessment, and diagnosis

Interviewee 3 indicated that it was not always clear whether clients wanted a full assessment:

> "*getting in was very difficult, and I don't know that clients always wanted a thorough assessment*" (Interview 3: Past Clinician).

However, several other informants highlighted the desire for a diagnostic label, and for a detailed understanding of the problem. Interviewee 2 gave a first-hand account of this experience of her daughter seeking answers:

> *"…she wanted a diagnosis. She was always perceptive about it, she always knew that what was happening was outside of the norm…"* (Interview 2: Parent)

The young person interviewed called for clinicians to "*look at*" and talk with the young people in their care, rather than "*making it hard for themselves*" by relying on "*files, past history, stories of others*". She was strongly of the opinion that staff took a pre-determined view which for her generally missed what the young person wanted and needed – and some young people wanted a diagnosis to help them make sense of what was going on for them (Interview 10, past client). The parent participant, Interviewee 2 talked particularly about the process of discussing or delivering the news about a diagnosis indicating that a poor communication process can have distressing effect:

> *"…[But when they said that] she's just devastated. Yeah, she knew what it was, and she was pretty sure she had schizophrenia…but the way it was done; it was almost like, you know, an informal water cooler conversation. Oh, you've been sick for six months, oh, you must have schizophrenia… It would take me months to rebuild things after stuff like that got said*" (Interview 2: Parent)

The process undertaken within CAMHS of making a psychiatric diagnosis is ideologically contested, and this will be explored more in the next chapter. The utility and benefit of a diagnosis was challenged directly by Interviewee 12 who underlines the importance of understanding context and trauma to make sense of behaviour:

*"…often the spitting, swearing, violent adolescent is, we all know, underneath aching; aching for connection….So instead of diagnosing with a conduct disorder or the disrupted attachment; let's actually factor in the abuse that's happened, and that will make sense of this chaos."(*Interview 12: Senior Child Protection)

The variable impact of receiving a diagnosis was the focus of discourse in several interviews. In Interview 5, the consultant described the impact as one of relief for a family:

"*where the diagnosis came as a relief. Like, even though it was this horrendous on one level we've got a child who's autistic, there was that incredible sense of relief that someone's named it; it is a real issue, it's concrete."* (Interview 5: Organisational Consultant)

By contrast in Interview 12, the child protection leader took the view that even undertaking a diagnostic practice placed the CAMHS at risk of replicating the trauma dynamics and re-enacting them. Resonating with this, Interviewee 8 focused on blame in her examination of the impact of receiving a diagnosis:

"The minute they get that diagnosis [of borderline personality disorder] there's a whole lot of a blame attributed to that, and it prevents that person then from really accessing, or changing their life course, and developing health." (Interview 8: Past Manager)

There was a view that once 'in' CAMHS, a child or teenager received a thorough assessment and that generally people and their issues are understood and they can be assisted make some sense of their situation, although they might not always be seeking such a thorough assessment (Interview 3). Interviewee 6 confirmed a view that once a client is successfully accepted into CAMHS they receive good service:

"*There's kind of real sense of aura around the mental health, child and adolescent mental health service attempts to get in; but that once somebody is in there, the service is good*" (Interview 6: ED Physician)

By contrast there were concerns that people are asked too many intrusive questions that an assessment could be '*pathologising*' and '*medicalised'*, rather than focussed on the social context of the presenting problems. That is, focussing on what was wrong rather than on what has happened to this child. (Interviews 3, 5). Confirming this, Interviewee 12 saw the lack of understanding of family violence and trauma in CAMHS to directly impact on a proper assessment of the presenting issues:

> *"…I get frustrated a lot when kids are whacked on Ritalin when nobody's enquired about the family violence. When you know the prevalence stats and the social demographics of the prevalence of family violence…If you don't ask you are going to miss it, and often it's been missed."* (Interview 12: Senior Child Protection).

There was a shared sense that some people needed thorough assessment and some needed just to sit and talk and hear advice reflected back, but more often than not a rigid process of assessment and feedback to the family was employed routinely. Either way it seemed that the process took extended periods of time and was seen to be too long. Interviewee 8 captured this perception when discussing her impression of the practice of comprehensive assessment process taking too much time:

> "*The other thing I remember feeling quite, almost depressed about was the length of time it took to get an understanding about a young person's wellbeing, to actually delivering some feedback to the family…it can take months…"* (Interview 8: Past Manager)

In this section themes related to assessment and diagnosis have been explored. Whether clients and families wish to have a comprehensive assessment was questioned and the variable impact of providing a diagnosis and how this is done was described with some differences in perceptions about the utility of a making diagnosis, especially where the CAMS clinicians are not seen as fully informed and knowledgeable about the possible presenting problems.

The following sections address themes that emerged in the treatment and case management responses provided to clients and families both on an inpatient and outpatient bases.

(b) Once "in" - treatment – inpatient care

In relation to inpatient care for adolescents, a number of issues were raised. There was a view expressed by Interviewee 8, a past manager that CAMHS inpatient services were not utilising crisis admissions well because they did not understand how potentially therapeutic they could be:

> *"I don't think CAMHS inpatients do the crisis admissions at all well…sometimes the admission itself is a therapy and they don't often understand that"* (Interview 8: Past Manager).

Oftentimes a crisis admission was seen as therapeutic in itself in the way it interrupts the cycle of interaction for a family, except where the young people were seen to be staying in for unnecessarily long stays. This was seen to compromise progress or even do damage by Interviewee 4:

> "*this eternal string of borderline kids, and they were always incredibly long admissions, and very traumatic admissions for me, and for the kids, and for the families and (effect) the entire unit"* (Interview 4: Past Clinician).

The young person interviewed indicated that the admissions for her were like an 'eye in the storm' – a chance to be safe and calm whilst her world raged around her. The challenge for her became the dilemma where getting well-meant being cast out again into the storm without the supports she needed and here view, expressed here that on balance the experience was negative:

> *"The inpatient [unit] is all right but I would say that the bad outweighs the good in there."* (Interview 10: Past Client)

For staff the experience of inpatient service delivery was also a challenging balance between helping and harming a client:

"I never thought that I was damaging the young person myself, as my opinion was dismissed but I often thought I was witnessing damage being done" (Interview 4: Past clinician).

(c) Once "in" - treatment: outpatient care

In relation to outpatient based treatment, there was relief conveyed by families attending the service and a positive experience of the work by clinicians working in that setting, for example:

"they're amazingly grateful straight away" (Interview 4: Past clinician).

However, parents were seen by one participant as being forced into compliance with the treatment regime by their sense that if they can *"hold your breath, clench your teeth, get in get out, it will be ok"* (Interview 1). For Interviewee 2, one outpatient Consultant Psychiatrist was a key to the treatment her daughter received because he conveyed his role in a way that they all understood and could be reassured by, namely:

"*One of our psychiatrists once drew a circle and coloured everything in except one little tiny area; and he said today, everything that's coloured in is your illness. That little circle is you. My job is to switch those. He was a good psychiatrist*…" (Interview 2: Parent)

In local feedback surveys of clients and families undertaken in one service it was reported that:

"the results had been appalling…people were very, very negative" (Interview 5).

The picture of how the service was performing therefore was contested and seemed to be affected by the types of problems being presented and the level of demand and resourcing within the CAMHS itself. Interviewee 12 commented that the complexity of presentations did impact on the kind of services provided:

"I think that at times where CAMHS are feeling under pressure, and…the more challenging families that need a more creative

approach don't get it....there is complex adversity, and disadvantage…that's often intergenerational and kids are presenting with really serious disturbance" (Interview 12: Senior Child Protection)

In terms of the therapy provided, Interviewee 4 talked about having used "*star charts"* and other behavioural methods as a student on placement in CAMHS and "*getting nowhere".* At that time she reported being exposed through local supervision of her work to more psychodynamic approaches including play and using drawings with children. In her view these methods created real engagement and seeding for change, but when presenting her work at university the work was not supported:

"…at uni where we had to present a case, and I was presenting on a, like a four session assessment where I'd done some drawings... two or three very clear things in every picture that he'd done, and my lecturer yelled at me in front of the class….went on this extreme rant about how drawings were ridiculous, and there's no evidence for them, and it's not reality based" (Interview 4: Past Clinician)

There was some reflection on the underlying treatment and therapeutic models being utilised in CAMHS, and a sense that over time these had been changing across the clinicians interviewed. The research contribution to understanding the process of therapy and the outcomes was seen to have had some influence – particularly through the leadership and academic endeavours of the medical leaders in the service. Interviewee 2 here describes the changing nature of interventions noting the shift of power away from the all-knowing therapist to a model that acknowledges and values all perspectives:

"..the culture of therapy has changed over a long period as people started to embrace in different models like narrative therapy, which is about us looking at the world together through our different perspectives. But the original model was analysis - you've got the problem, and I'm the analyst, and I'm going to analyse your problem and help you understand it better. So that the power for understanding and learning was with the therapist." (Interview 2: Parent)

There was also a view expressed that over time clinicians have *"retreated"* to the therapy room, behind closed doors and this means they are cut off from what is going on in the family around the child and in the child's regular daily life. (Interview 1, Academic) This was linked to a lack of understanding about parents and what they might need and also what they offer in a therapeutic engagement. Further, the therapeutic alliance with the identified client/child as a focus for CAMHS work was challenged where it was seen to work against the team focus that has the potential to:

> "*bathe the child in multiple experiences of nurture in order to have reparation from this developmental trauma"* (Interview 12, Senior Child Protection).

The mode of engagement or perhaps better summarised as the quality of engagement and was noted as problematic at times, such as here in Interview 2 where the parent describes clinicians as cutting off the humanity of the family with whom they are sitting:

> *"I sometimes wonder, how can you sit there, and you've got children, and not realise some of this. It's almost as if clinical staff just, I don't know, the whole rest of being a human being just goes away*." (Interview 2: Parent)

Likewise, in the following quote, Interviewee 5 defined the quality of interaction between families and clinicians as rigid and formal:

> *"I remember seeing a family where the mother said to me, you're so much easier to talk to than when we went to that CAMHS place, and I thought they talked down to me or they used words that I didn't understand, and they were very rigid and they were very formal"* (Interview 5: Organisational Consultant)

In this section perceptions about therapeutic interventions have been described including observations on the relationships between families and clinicians, and the utility of interventions. Two other aspects of engagement with clients and families are explored in the next two sections – the case

management role and the collaborative service provision role with other services.

(d) Once “in” - case management – the relationship and role

This section examines perceptions in relation to case coordination or case management as a routine role with clients and families in CAMHS. This was reported broadly as a key component of good care and was affected by the quality of the relationship and engagement developed between client, family and clinician. Interviewee 4 here indicates the central role the case manager had:

> “*the way it seems to work is that the case manager makes all of the decisions, and when they feel like they need a bit of support they go to the consultant, or registrar”* (Interview 4: Past Clinician).

One interviewee (5) related a story about a young and very traumatised woman who *“looked her up”* years after the therapeutic engagement had finished to thank the team for the “*healing*” she had experienced, recognising that the role of system and case management had been pivotal in creating a space for therapy that had made a huge difference in her life:

> *“…she was about 16 and she saw someone there for therapy, and I was the case manager*” (Interview 5: Organisational Consultant).

This positive experience of engagement was confirmed by Interviewee 2:

> *“Overall I think the good experience was her case manager, who engaged well with her, listened to her….”* (Interview 2: Parent).

Likewise, the young person interviewed praised at length her case manager and described why he was so important for her and it related directly to treating her as her own person:

> *“He wasn’t stuck, his head wasn’t up in the clouds, he wasn’t very ‘I am a worker here and you’re the kid here’, he was always, he treated*

me always like an adult and always respected an adult response" (Interview 10: Past Client)

However, participants reported less confident that this kind of coordination was routinely or reliably occurring either within the service itself or across service boundaries. Interviewee 2:

"*We did not engage well with the case manager. It was not a very good thing; and it was really kind of deteriorating*." (Interview 2: Parent).

This was especially true of external stakeholders and referrers. Here Interviewee 8 compares mental health care with chronic illness management in the regular health system and sees mental health services as falling short:

"…the diabetes management, cardiac care. There's a whole lot of chronic health care that gets managed through multi-disciplinary teams. And mental health for some reason, we just can't seem to do it." (Interview 8: Past Manager)

The characteristics and needs of the child and family were seen as sometimes beyond the capacity of the service to understand and manage. Echoing a previously reported theme, Interviewee 12, a child protection leader applies her perception of general inadequacy to case management in CAMHS:

"*And where I see things getting stuck is where you've got a, a preciousness, or a rigidity that, that comes often from a lack of understanding around the way families work; the way, and I think there's a huge issue in CAMHS around a lack of understanding of trauma."(*Interview 12: Senior Child Protection)

Decision-making and reviewing progress in service delivery drew comment in several interviews. The place of medical staff as powerful the health system was a focus for Interviewee 1:

"in fact because the health system is so controlled by medical practitioners ultimately" (Interview 1: Academic).

This was confirmed by Interviewee 5 where the medical staff were in formal positions of authority in the CAMHS:

> *"There was a hierarchy and the doctors were always the team leaders at that stage, and always the directors"* (Interview 5: Organisational Consultant).

This power was dismissed by Interviewee 10 who emphasised instead the role of nurses:

> "*The doctors aren't there twenty-four seven; the nurses are - they see what happens at night. The nurses were the main people there… the doctors … couldn't do much for you."* (Interview 10: Past Client).

Interviewee 2 indicated that others in the helping system such as the school were more effective in assisting her daughter than were the doctors:

> "*the medical profession, through medical treatment and everything may have saved her life; [the school] saved her soul."* (Interview 2: Parent)

The medical role in decision making and the management of risk was a particularly important issue where inpatient care was involved, as revealed in this quote below from past client, Interviewee 10. She describes the need for decision-making power to be shared:

> "*If they shared the power it might be a lot better but the doctors are probably the ones sitting with the power because they can discharge a patient when and where they want to…So I think if the power was shared through everyone it probably would have been better for the kids…."* (Interview 10: Past client)

In relation to discharge from a service, several examples were given of poor discharge processes where the family was left to navigate and manage a risky or distressing situation after the CAMHS were no longer involved. In one case Interviewee 7 stepped in to manage the situation and was able to contact the discharging service but elicited mixed messages from them and confusion about the service offering:

"The client she felt like she was completely unwelcome there" (Interview 7: GP)

Finally, the developmental context of care was seen to be important and ran as a thread through the interviews. It was held up as one of the unique aspects of CAMHS work and here Interviewee 2, a parent describes the need for working developmentally within the child's context:

"…*because you are dealing with children, and young people and still in developmental stages, that we as society still kind of believe that keeping children within the context of a family, and a community, is the best (way) for them to develop"* (Interview 2: Parent).

Further, Interviewee 7 reflects on the developmental context in a particular case with which she was involved:

"really the way she was presenting was within the scope of what you might expect with teenage development. The problem with mental health issues in teenagers is it's very rarely a psychotic illness or something, where it is a frank diagnosable illness." (Interview 7: GP)

By contrast, there was also a view that being developmentally informed was only part of what was needed in CAMHS clinicians. A developmental context for mental health care, described here by Interviewee 8 is required at every age:

"Yes it's a different life phase, but I don't know that it's any more mystical or magical than the adult life phase, or mid-life, or old age" (Interview 8: Past Manager)

Examination of perceptions of treatment and care once clients and families have been accepted into CAMHS with their presenting problems assessed and diagnosed has formed the content of this section. It has focussed on particular treatment settings (inpatient and outpatient care), on case management as a particular function and on aspects of the medical and nursing roles in the treating team. Engagement and genuine understanding of the client and family in their developmental context, and clarity in the clinical role being

undertaken appears to promote positive experiences. There were less positive perceptions about the utility of inpatient treatment and the role of medical staff in leading decision making within CAMHS. The focus of the report now moves to the perception of and interaction between CAMHS and other services.

8.2.6 Between and about CAMHS and other services – a conflicted picture

This section examines perceptions of the interface between CAMHS and other services, it's utility in the service of clients, and the challenges inherent in particular interfaces (community and social services, adult mental health, child protection, schools and primary mental health services). In doing so a sense of tension and conflict became clear.

Firstly, there was a general perception expressed that CAMHS clinicians did not take a positive or optimistic view of the possible contribution or capability of other services. Here Interviewee 5 comments on the lack of capability of services:

> "*Sexual assault service and… it became clear to me how other services really did struggle, because they didn't have those frameworks"* (Interview 5: Organisational Consultant)

In one interview the idea that the system suffered from duplication and lack of coordination was explored. Here Interviewee 3 expressed frustration at the risk of duplication in providing support to schools:

> "*there's so many bloody players out there consulting to everybody … there's a problem in the broader system around duplication of consultation…why don't they just employ a little team in each school that does the work."* (Interview 3: Past Clinician)

There were also attempts to understand why CAMHS services had become passionately dismissive of some other services. Interviewee 12 reflected that this related to limited support internally for CAMHS staff:

> *"where you start seeing the systems as disregulated (sic) and dysfunctional, and where there's hate language about other*

services – there's not been enough therapeutically informed containing supervision that actually is able to hold that" (Interview 12: Senior Child Protection)

At the same time other services were not seeing themselves as owners of the shared solution for families once CAMHS was involved. Interviewee 4 saw this as other services effectively disengaging:

"But in terms of other organisations… CAMHS is seen as this kind of pinnacle of treatment, and if you have CAMHS involved; (a) you'll see progress, but (b) you can kind of step back a little bit, because CAMHS will do all the work." (Interview 4: Past Clinician).

However, Interviewee 9 described a view that best practice would mean shared care:

"*So I think it's around getting the ownership across all of welfare services, around what they can do with a parent, and what they can do with a child."* (Interview 9: Senior Systems Experience).

This was echoed by Interviewee 12 who identified that the strengths of a functional service included working well with other services:

"*where I see CAMHS performing well, it's where they've been able to integrate a multi theoretical perspective, have some wisdom in the leadership, and some accessibility, and some ability to respond in partnership ways in a team approach with other services."* (Interview 12: Senior Child Protection)

A general description of the perceptions of the interface between CAMHS and other services indicated that whilst collaborative work should be routine and leadership in all services should facilitate this work, where there were problems CAMHS clinicians themselves viewed the other service providers as inadequate to work with or understand this client group. Services were perceived to disengage from client care as a direct result of CAMHS becoming involved.

What follows below are descriptions of interface issues that are peculiar to particular sets of services, commencing with community and social services.

(a) Interface Issues: community and social services

In the non-government community sector for children and families there was not seen to be a good understanding of mental health issues in children and this was lack of understanding was reported to result in poor connections between CAMHS and other providers. Interviewee 8 saw this as partly a problem generated by the CAMHS clinicians who blamed schools and services for not acting with skill and wisdom, without providing them with opportunity to engage with the CAMHS assessment and treatment plan:

> "*CAMHS delivered a lot of blame around how the family may wish to function. Often a lot of blame around school systems, and a lack of focussing on the resilience of schools in dealing with difficult children, and the resilience of families….but there'd been no actual conversation around what was your impression of this child, and how did you understand them, and why did you agree for a referral?"* (Interview 8: Past Manager)

There was also reported a sense that external youth and social services and school based workers felt at like they were stigmatising young people if they conceded there were mental health issues and proceeded to refer to mental health services. Interviewee 11 described this as having an impact on her as the sole mental health clinician in a young team:

> *"I found working in a setting where you were the only mental health person there was a lot of barriers to overcome… a lot of workers in the agency felt like they were stigmatising young people if they raised the mental health issues*" (Interview 11: Current Manager).

(b) Interface issues: adult mental health

Adult mental health services are closely aligned with CAMHS in most parts of Victoria and whilst they are generally governed by the same organisations, access rules and processes were reported to be entirely

differently between adult mental health services and CAMHS. With adult services, unlike many CAMHS referrers experienced support from the service as did the client as described by Interviewee 6:

> "*Staff might be exhausted but they were still available"* (Interview 6: ED Physician)

Staff selection in adult mental health services was seen to deliver clinicians who would be available and responsive to referrers and clients. By contrast CAMHS were seen to convey a sense of entitlement and expertise. This created scepticism for Interviewee 8 who described CAMHS clinicians as actively setting themselves apart:

> *"[They conveyed] we do it differently here, this is really …where the bright people go; and you have to be far more skilled to come and work in CAMHS, than any other area of mental health. I wondered about the rapid rise to fame and fortune in CAMHS. You can get a very senior position very quickly*…" (Interview 8: Past Manager)

At the same adult services were seen to be more adept at what was described by Interviewee 5 as "*playing the game*". She described instances where adult services "gamed" the funding system:

> "*whereas the adult services… knew how to play the game better…they would agree to things and yet everyone knew that some of them would just go and use the money for something else anyway"* (Interview 5: Organisational Consultant)

Comparing this experience of adult mental health with CAMHS, it was hard for Interviewee 7 to understand what she saw as system influences that made CAMHS respond in seemingly defensive ways to keep clinical work at bay. This was echoed by Interviewee 9 who observed that:

> "*because adult services recognise crisis; not always, but they're a bit more reliable aren't they than child and adolescent?"* (Interview 9: Senior Systems Experience).

This was also touched on in Interview 5 where adult services were described as doing the really hard end work and that CAMHS was sometimes seen as the "*favoured child*" because the work with children was viewed as somehow softer or easier. Nonetheless Interviewee 5 found working with the adult teams infinitely easier:

> "*The liaison with the adult group has always been easier. Even when we were initiating mainstreaming, there was a real positivity around it."* (Interview 5: Organisational Consultant)

(c) Interface issues: child protection

The dynamics of the relationship between CAMHS and child protection have been reported on earlier in this chapter as part of themes related to the complexity of clients referred and in particular the challenges of access and intake but warrant further attention. These two services were seen to be consumed by their intensity and passion about the other and described as "*hating*" each other (Interview 5: Organisational Consultant). She identified her surprise at hostility expressed by child protection workers towards CAMHS:

> "*That was the eye opener because it was an example of seeing how CAMHS was perceived from probably the most hostile groups, particularly child protection whose … experience of CAMHS was almost like a locked door. But they were consumed in that; and they'd tell all these horror stories and war stories about each other, but with a passion"* (Interview 5: Organisational Consultant)

Interviewees 4, 5, 8 and 12 commented on this theme and more broadly the relationship between child protection and CAMHS, which was described as being like a "*very bad marriage*". However, in contrast there was a theme of longing for support from the other in face of the real challenges in the work and the significant needs of the children involved. Interviewee 4 described her impression of CAMHS as a child protection worker:

> "…*like I worked in the adolescent team at DHS predominantly, and I loved the complexity and the adrenalin and, but got very frustrated with not being able to do anything ... As a protective worker you*

don't do any therapy, you don't actually really see any change. I Identified CAMHS as the people that worked with those kids…[in the way I wanted to work with them] (Interview 4: Past Clinician)

There was an element in this mutual frustration of not being understood, supported and assisted organisationally in what was difficult work in both setting. Interviewee 5 described a sense of CAMHS somehow being seen as withholding expertise from the child protection workers:

"So there was this incredible sense in child protection like, we're left with these really, really difficult kids and you don't help us with them, but we see you as having the skills to do it, but you keep us away…. It's like you've got the missing piece." (Interview 5: Organisational Consultant)

Despite this, there were people in both CAMHS and child protection who were reportedly seen as responsive at times. Interviewee 12 gave a cogent example of good collaborative work as a contrast to the theme of conflict so far described:

"…and conversely we've got really good relationships with a number of CAMHS where there's been… a terrific relationship…between child protection, managers, senior people, and the senior psychiatrist there who was just very responsive, who trusted that we had clinically informed assessments.... he would then privilege, and respond to them, to the most disturbed kids. (Interview 12: Senior Child Protection).

They understood the complexities of the wider system and understood the way in which other services worked and could use this understanding to facilitate shared planning for benefit the young people and families at the centre of the work. In generating system collaboration, Interviewee 5 described how she sought to implement a positive working relationship between the two sectors by ensuring the leader was suitable to both sides:

"*The only way there was going to be any chance of more collaborative [work], was if the person in that position had come from CAMHS and*

therefore was acceptable by CAMHS (Interview 5: Organisational Consultant)

When considering the organisational impact of working with this client group, particularly where there are children who have experienced trauma, Interviewee 5 saw barriers imposed by CAMHS as a way to prevent overwhelming demand:

> "…*the belief that if you let that wall down, we would be run over, particularly by child protection, and all you'd see would be child protection cases"* (Interview 5: Organisational Consultant).

This was seen by Interviewee 12 to be linked to the lack of knowledge in CAMHS generally in relation to trauma, and offenders, and also seen to be the cause of system anxiety:

> *"What happens is that emerging new information is actually refuted, defended against, discarded, because it doesn't fit. Somewhere in that is anxiety. Somewhere in that is ego. And professional pride. And a misguided sense that we're the experts."* (Interview 12: Senior Child Protection)

The young person interviewed described significant benefits for her in the way CAMHS managed the tension that existed with Child Protection. Whenever she was admitted into the inpatient settings CAMHS would be in a position to insist that child protection workers visit and engage in planning and this had the effect of moving the situation forward. Here she describes how the CAMHS case manager understood and conveyed her needs in the face of a range of child protection workers:

> *"Mainly because, if you've got a meeting for example with five people in DHS, it always helps to have that one person that's on your side and that was always [him] for me. And the funniest bit was, whether or not DHS would like to listen to what he said, he was that type of person where, he was kind of like a disabled person, where if he said something he would not move until he got it."* (Interview 10: Past client)

Interviewee 10 also described what she observed as a "*tug of war*" between child protection and CAMHS with parents disengaged and not included in decision-making. The young person identified that as a very difficult situation to be part of. She compared her CAMHS experience with a time she had spent in Secure Welfare (a locked facility for young people who needed safe containment delivered within the statutory framework of Child Protection). There was a sense that she was quite relieved to enter this service, saying she saw the staff as firm, clear, adhering to boundaries but playful:

> *"…the way they work is they're very strict but they also have fun, so they're very down the line, you've got to do what you've got to do, you've got to go to school.* " (Interview 10: Past Client)

The relationship between Child Protection and CAMHS was seen as point of particularly passionate conflict affecting access for children with complex needs, engagement across the services between workers and shared care whilst children and families are in treatment. An examination of the nature of this conflict will be discussed in more detail in Chapter 9.

(d) Interface issues: schools

The role of schools with children and young people using mental health services was most notable in the positive way the experience was described by a parent participant, Interviewee 2 reported:

> *"…the school saved her soul. Absolutely saved her soul. They gave her a reason to get better. And they believed in her."* (Interview 2: Parent).

The collaboration between CAMHS and the school was seen as a real benefit for the young person and contributed to her positive outcomes and this was confirmed in another case example given by Interviewee 3, a past clinician:

> *"I think that the intensity, the group program, the peer support, the individual work, the family work, and liaison with the school; all those things just really helped give him a voice, and also work out a bit who he was"* (Interview 3: Past Clinician).

Other participants did not single out schools for particular note although the impact of the issues children and young people brought to CAMHS services included challenges surfacing or complicating the school environment. Here Interviewee 5 indicated the important role of schools in identifying problems and referring to CAMHS:

> *"it wasn't usually until they got to school or it just became so obvious at kinder or something, that it really became so obvious that there was something wrong that they got them in*" (Interview 5: Organisational Consultant).

Schools can also be blamed, according to Interviewee 4, a past clinician, as families seek to deflect blame from themselves for problems:

> "*my kid's got anger management issues, fix them, or behavioural issues, it's the school's fault or, so there's often not a lot of acknowledgement of what the structure, the family structure is doing, causing"* (Interview 4: Past Clinician).

The universality of engagement of children and teenagers with schools means that interface for CAMHS with schools is of routine importance for CAMHS.

(e) Interface issues: primary mental health

A set of services known as primary mental services were the focus of comments related to their role in the mental health system of care for children and young people. In Australia, these services are provided in clinical based settings the community by private practitioners and accessed through GPs utilising the national health-funding scheme, Medicare. They were of particular note for Interviewee 7:

> "*that's really changed things enormously having private psychologists, including child psychologists, available where there's a Medicare rebate."* (Interview 7: GP)

The variability of primary mental health care observed as resulting from broad regulatory parameters resulted in comments ranging from "*really good*" to "*really hopeless*" and underlining an inadequate regime of accountability. Interviewee 3 focused her view of the reason for this on accountability:

> *"I think that it's hit and miss, the standard of care, there's some really good, there's some really crap. There's not enough accountability that's the problem"* (Interview 3: Past Clinician).

To be accountable, it was thought that clinicians should be transparent, helpful, not hide behind professional jargon and status and be accessible. Interviewee 3 observed:

> "*here's a private psychologist seeing a woman with an eating disorder, without the basic framework about how you would work with somebody and that's disturbing and troubling*" (Interview 3: Past Clinician).

Furthermore it was noted that CAMHS does more than see clients – as a public service they also conduct training, supervise students, consult to and collaborate with other services – all activities that private clinicians generally do not engage with. Interviewee 8 extended her observations about this to the mechanics of funding models to support shared care:

> "*What's not evident is the partnership between private and public. So you've got a child going along to CAMHS that may well benefit for some long term therapy through a private, and there's not good mechanisms I don't think that allow for that funding partnership"* (Interview 8: Past Manager).

This final section examining the interface between CAMHS and other settings draws to a close the reporting of themes synthesised from the data related to the way CAMHS itself was perceived to be functioning. This has included exploration of features of clients, families and clinicians, how care is accessed, provided and experienced, and how CAMHS works with other services at the interface of providing care. The next section focuses on

organisational performance of CAMHS and what the informants perceived as the features of a high performing service - a “good” CAMHS.

8.3 Considerations about performance - a “good” CAMHS

In this section a range of domains are examined related to what would make a “good” CAMHS. These ideas emerged through the data analysis and are reported as a set of concepts for later inclusion in the discussion of a future performance framework for CAMHS. The results are grouped to focus on removing barriers to access; building hope and managing expectations of families; the place of boundaries in quality service delivery; reflective spaces for clinicians; teamwork and leadership in CAMHS; accountability, data and organisational design.

By way of introduction to what a good CAMHS would deliver to families overall, Interviewee 2 described what she thought families most needed from a CAMHS and it focussed on giving permission to them to find a balance:

> *“Families need two things, they need information, and they need, I don’t like respite, I prefer to call it legitimising the balance of life…You know, respite care is a nice concept, but that isn’t all about it. It’s legitimising the fact that you can set a boundary, and that you do not have to become your child’s illness…And they don’t have to become an illness… Oh and siblings need special care – if you don’t engage with them early on you lose them and [the impact for them] is enormous”* (Interview 2: Parent)

8.3.1 Better access and assessment models – removing barriers

Getting the access/entry function right was seen to be the single most critical change required. It was proposed that to “*remodel [CAMHS] one would start with the access system*” (Interview 1: Academic) and “*get the resourcing right for the work*” (Interview 3: Past Clinician). The service could be more community based and more responsive with responsive and focussed single session and risk assessments with minimal documentation, simplified

report writing and no complex case formulation documentation. Interviewee 4 called for a more focussed assessment process:

> *"In outpatients it … takes so long to do an assessment. Like you're doing an assessment for four or five weeks, whereas in the inpatient unit, you do your assessment, and start treatment all on the first day."* (Interview 4: Past Clinician).

There was a sense that keeping children waiting for access to CAMHS was ideally something that should be eliminated and that resourcing to keep children at the centre, work with families directly and keep everyone in the community rather than admitting them to an inpatient setting were all important features of a "good" CAMHS. (Interviews 2, 3, 5, 9, 11). As Interviewee 5 described, a good CAMHS would be:

> *"…a service that clients can get access to… it is about how responsive are they."* (Interview 5: Organisational Consultant)

There was a suggestion that "*clinics*" focussed on solving particular problems which would "*stop the pattern of families waiting for 4 weeks to get feedback which can be annoying and frustrating*" especially in the face of a crisis (Interview 8: Past manager). Further to this there was seen to be a need for more focus on service delivery and less on bureaucratic requirements (Interview 3: Past clinician) and those in crisis or waiting in an ED were seen as the biggest concern as described by Interviewee 6 who proposed a new service that would address the barriers to access:

> "*What I'm wondering with the CAMHS situation is…[could there be] a facility to deal with urgent cases. So that for example the emergency ED physician rings and actually gets some sort of helpful response, rather than a 'we don't want to be involved response."* (Interview 6: ED Physician)

Access for the young people that genuinely need help should be via somewhere to "*hang out*", feel safe, learn to trust and then reach out. Those that self-harm have been through "*a lot of abuse, grief and pain - bullied at school, hit at home*" and are seen to need a softer or more age-appropriate

engagement and entry model. This feedback from Interviewee 10 identifies this as an important alternative entry to the service based on generating safety and trust:

> *"So if they have this place, even if it's once a week, for two or three hours, even that just one bit, I guarantee you that they will pick up kids that do actually need help. And even if it's a situation where you just go there and you don't have to talk, you just eat food or you just chill out, it's still a lot better than the amount of kids they'll lose. And it will help. Because I know my mates [who suicided] would have gone, if they had that they would have gone, they would have definitely been in and done what they needed to, but the places they'd gone to were all places [they] couldn't build trust."* (Interview 10: Past Client)

Access and referral blockages that relate to the complexity of presentation and possible the impact of this on the culture of the organisation, required the system to examine itself according to Interviewee 6:

> "*But the system needs to recognise the problem itself, doesn't it; and really address their own issues before they can be open to addressing the other issues…you're not talking about resources; you're actually talking about engagement, and respect, and being present in the problem."* (Interview 6: ED Physician)

8.3.2 Building hope and managing expectations through good communication with families

Building hope was reported as a key element in good CAMHS service delivery and this was grounded in making sense of the past, engaging with the present and building a vision of the future. Interviewee 12 describes what in her view would contribute to change:

> "*McKee and other people have quantified it: forty per cent what the family bring in; that's the given. What can we change? It's thirty per cent that the quality of the relationship, Fifteen per cent the presence*

of hope, and fifteen per cent the model" (Interview 12: Senior Child Protection).

Interviewee 1 concurred stating that hope was an important driver for families to engage with services:

> *"The four themes that people have when they arrive for therapy. One is hope…One is determination…The third is 'opponent' like when the mother wants to prove to some bastard that the kid has got problems and needs to be there. And the fourth is the pain…"* (Interview 1: Academic)

The parent participant, Interviewee 2 discussed a practical solution by advising that families should be given a journal or note book on entry to CAMHS to keep track of what is happening in their lives and what people are advising them to do:

> "*Write down who did you talk to today, what did you observe in your child, how are you feeling, what time is your next appointment. I also think there should be a responsibility for case managers at the end of the session to write down two or three points; this is what we talked about today, and this is what you're supposed to do before the next appointment*" (Interview 2: Parent)

There was support for access to information about clients and this was seen as critical for families and others in managing alerts and risks despite, as noted by Interviewee 2 the complexities of privacy:

> *"…and of course everyone then brings up the confidentiality and privacy. I think the counter to that is safety and risk, which I've never heard anybody talk about."* (Interview 2: Parent)

Furthermore, information about treatment options was seen to be needed and available for the client and for families so that there is history about what has been tried, what worked and what didn't. Such history can be complex and the details are important according to Interviewee 2:

"*somebody at DHS said about six months ago well why do you need a record?...I said, well what happens if she gets in an automobile accident?"* (Interview 2: Parent).

Resolving issues about information access was seen to need to balance confidentiality with safety and risk and recognise that with information provision comes the responsibility to document the work. Interviewee 3 described what minimal documentation was needed:

"very minimal documentation around the presenting problems, clearly risk, but not complex formulations, but something that documents enough; so that you're providing something to people." (Interview 3: Past Clinician).

Further to this, Interviewee 2, a parent saw the need for comprehensive integration of patient files and suggested she:

"*would like to see an integrated file across all services … even a USB from birth"* (Interview 2: Parent)

Managing expectations (the client, parents, referrers, managers) was an emergent theme across a number of interviews described by Interviewee 2 as services being able to convey their role:

"*What we need is] services that understand what they're there to do, and what they're there not to do. And can communicate that in a way that can be heard."* (Interview 2: Parent).

Services were advised by participants to be clear about what they can and can't do and according to Interviewee 8, a past manager be focussed and time limited:

"The treatment plan should really reflect the assessment, and be meaningful for the family; and actually have a time limit" (Interview 8: Past Manager).

There was reported tension created between what parents want or expect and what young people themselves are seeking through the engagement with CAMHS.

"They just want it all to go away" (Interview 3; past clinician)

8.3.3 The place of boundaries in quality service delivery

Creating a strong culture of boundaries was described as being powerful for the work, impacting directly on sound therapeutic outcomes. Interviewee 5 linked external organisational boundaries directly with sound clinical work:

> "*in some ways maybe the boundaries, the walls around the service have to be fairly tight for that good work to be done."* (Interview 5: Organisational Consultant).

Interviewee 3 described how to build such boundaries and underlined the role of leadership in maintaining this:

> "*how do you create boundaries. It's by saying, this is important, we honour it, and providing the people in leadership the permission, the message that these are essential"* (Interview 3: Past Clinician)

Attending to boundaries between managers and clinicians was also seen as important, demonstrated through "*hierarchy and clarity of rules*" (Interview 7, GP). Interviewee 11 discussed the importance of boundaries in managing role definition:

> *"managing that boundary between manager and clinician, and how that can overlap, or become a problem. I'm not running a half-way house for staff. My responsibility is to the patients"* (Interview 11: Current Manager)

There was a view expressed that CAMHS boundaries were too rigid and that work was needed to ensure that a balance was maintained as articulated by Interviewee 3:

"*Some people have got a real hang up around, oh CAMHS is so boundaried, you know to the point where it's not transparent with families"* (Interview 3: Past Clinician).

This involved thoughtful leadership and attention to managing the balance (Interview 11: Current Manager) as well as managing the impact of boundaries on others as indicated by Interviewee 9

"…explaining the rationale for why they had the boundaries around the service that they did" (Interview 9: Senior Systems Experience).

8.3.4 Reflective spaces for clinicians are critical

To do good quality clinical work with integrity was seen to require active development and maintenance of a reflective space. Here Interviewee 11 described how this would work:

"*a facilitator to do some reflective practice, or the things that are going to be useful to help the staff deal with the impact of their work; and have those sort of structures set up*" (Interview 11: Current Manager).

The importance of this for staff was articulated by Interviewee 3:

"…*because it's how you make meaning. You know, if I can't make any meaning of what I'm doing, there doesn't feel much point… I'm a big plug for external people to come in and create it the reflective space. I think when you're part of a system, it's very hard to keep boundaries otherwise…"* (Interview 3: Past Clinician).

This was further endorsed by Interviewee 11 who underlined the importance of the reflective function as routine rather than a luxury:

"…that critical opportunity to discuss how the work impacts, that's seen as something that's a luxury or not needed, or there's something wrong with you if you need that." (Interview 11: Current Manager)

By prioritising this and building a culture where people are expected to make the time to participate, the services were seen to demonstrate professionalism and rigour. This was endorsed by Interviewee 6 who indicated that finding time was a challenge in a busy work environment:

> "*And there's not really often an opportunity to reflect, because you may have to go straight back in to another equally distressing setting"* (Interview 6: ED Physician).

Interviewee 9 endorsed this noting that:

> *"you can have different levels of rigour, but to have that kind of rigour and self-reflection is hugely … important*" (Interview 9: Senior Systems Experience)

That the work undertaken had the capacity to be traumatic for clinicians, and how this might be managed was discussed in a number of interviews and the impact on families was articulated by Interviewee 2:

> *"[Clinicians] build walls around what is their own personal experience of what's going on, and become a little bit over boundaried"* (Interview 2: Parent).

The following quote touches on a number of the issues raised across several interviews and provides an articulate voice for these. What stands out in this quote is the attention to options for action to deal with the issues as they are raised including clinical supervision (agreed across a range of interview) but also of staff performance management recognising that not all these matters can be managed through supervision:

> *"There is some evidence to suggest that if you work with children who've been traumatised, that is going to impact more on the clinician, than working with adults. So there's something that's raw, and confronting, and can make good people feel overwhelmed, and powerless. So they can defend against that by becoming rigid, and directive, and blaming of others. And get in to that classic triangle... So where you start seeing the systems start to look as disregulated, and*

dysfunctional, and where there's hate language about other services, and you know, there's; all of that stuff gets played out, because actually there's not been enough support, enough therapeutically informed containing supervision that actually is able to hold that. Challenging it; and sometimes performance manage. There are some people that shouldn't be in it." (Interview 12: Senior Child Protection)

There was a view expressed in several interviews that where personally challenging situations (such as a client completing suicide) that are not subjected to team review and professional reflection, the longer term impact both for clinicians and for future service delivery can be negative. Interviewee 4 described the effect of working in a team following a client suicide:

"…*it was, it was still very present, and, and I really felt that it impacted on length of stay, and how willing the team was to take a risk with young people…"* (Interview 4: Past Clinician)

8.3.5 The place of teamwork and leadership in a "good" CAMHS

CAMHS is seen to be working well when there is an integrated multi-theoretical perspective, wisdom in leadership, accessibility, and collaborative capacity. For Interviewee 9, the collegial input to an individual clinicians work was critical:

"*what are the skills that you bring in around creating that space with a client, how are you helped to think about what works, and what doesn't work, and then to share that with your colleagues. You don't just go in to your room and shut the door"* (Interview 9: Senior Systems Experience).

This collaboration included shared power in decision making across a team, with young people and their families and with other services and is described here by Interviewee 10, a past client who identified a direct impact on clients where this doesn't happen:

"If they shared the power it might be a lot better but the doctors are probably the ones sitting with the power because they can discharge a

patient when and where they want to. The unit manager can't and neither can the nurses. So I think if the power was shared through everyone it probably would have been better for the kids" (Interview 10: Past Client).

Sound leadership was described as relying on a trusting relationship between the consultant psychiatrist and manager so that

"*without seeing every patient or talking to staff members, if something happens the back-up is there*" (Interview 11, Current Manager).

Interviewee 12, a child protection leader also discussed the ingredients for sound leadership and again highlighted the need for partnership between services:

"…that interface between the organisational performance, leadership, and knowledge...So unless you embed in a very strong way a trauma informed, and a compassionate understanding, and a respectful, an expectation that you will partner with other services; you will respect them, and you will not have the disease of 'expertosis' that causes the head to swell, and the eyes to become blind - like myxomatosis." (Interview 12: Senior Child Protection)

As one of the leaders in a CAMHS, a good consultant psychiatrist was reported to be someone who likes the client group, is continually learning and is prepared to share the risk. The importance and value for clinicians of the modelling from psychiatrists in professional development was described by Interviewee 5:

"I learnt a lot from the psychiatrists in that way that they did have that commitment to learning and continuing their own development." (Interview 5: Organisational Consultant).

The engagement in change for one CAMHS team was linked by Interviewee 8 to the engagement and commitment of the psychiatrists:

"The things that drew the team in was when we were able to get two good psychiatrists that teleconferenced fortnightly" (Interview 8: Past Manager).

External to the CAMHS, Interviewee 12 found the following:

"*…and the senior psychiatrist there who was just very responsive, who trusted that we had clinically informed assessments"* (Interview 12: Senior Child Protection).

8.3.6 Accountability, data and organisational design

The role of research and how it informed CAMHS practice (or not), the place of audit and performance monitoring and the question of measuring the work and its impact were all reported themes. Data that had been used in services to design models of efficacy were challenged, as was the concept of efficacy itself. Interviewee 1 made explicit the challenge faced by service leaders and government in setting efficiency and effectiveness measures:

"…there's a difference between efficacy and effectiveness, the difference between the laboratory and a real clinic don't suit the political aims of senior academic psychologists or of the health department." (Interview 1: Academic).

Consistent with this theme was a comment from Interviewee 3, a past clinician about priorities

"I think there needs to be more focus on service delivery than bureaucratic requirements" (Interview 3: Past Clinician).

Whether it was possible or appropriate to set in advance how many sessions might be routinely provided was criticised as "*sausage machine*" mentality (Interview 3: Past clinician). An alternative model discussed was routine review to ensure care was targeted and accountable and decision were being made that were clinically appropriate and supportable within a team rather than by a clinician on their own. A robust review case review process was seen as an appropriate model for a tertiary level service (Interview 5, 11)

and Interviewee 8 indicated that service models need to be responsive to the needs of the child:

> *"…some kids need your six to eight sessions, and that's enough to go on for a few more years. And sometimes kids, you know, maturity's a great healer; some kids will just grow out of it, but other more damaged children need longer term support. And public mental health can't provide that anymore"* (Interview 8: Past Manager).

This was underlined by a sense that organisational requirements for short term brief therapy, introduced with a view apparently to efficiency, did not appear serve the needs of children in the view of the participants who raised them. This was balanced with the idea needing various service options available for clients and their families. Interviewee 3 commented on

> "*the richness of CAMHS is offering such a range of possibilities for young people and families, there's always tensions between the individual work, family work, assessment*." (Interview 3: Past Clinician)

Doubt was cast on the use of routine outcome measurement and individual service planning, a state-wide public policy commitment as an indicator of good service provision (Interviews 3, 5, 8). Interviewee 11 identified a disconnect between routine client measures and activities, and whether they indeed achieve what was intended:

> "*but administrators, or whoever it is who think that if every patient's got an individual service plan done, and their outcomes measures are done, and they're signed off by the client that means they must be getting a good service. Well I'm not so sure about that"* (Interview 11: Current manager)

In terms of service design, there was a broad view held that CAMHS clinicians should be more family sensitive and family therapy trained and that family work be more reliably a critical part of the treatment regime for CAMHS clients:

"Everybody said to us family therapy will help" (Interview 2: Parent)

Interviewee 1, an academic explained why it helps:

"it's the reason that family therapy with adolescents is the best option because they actually get to speak honestly in the presence of their parents" (Interview 1: Academic).

Even in the absence of families, Interviewee 11 reported:

"there is the opportunity to work with the family…families whether they're present or not are very important, or carers…there's not just the focus on the person who's presenting with the problem" (Interview 11: Current manager)

In summary, CAMHS at best was described by clinicians who experienced it as a highly professional service underpinned by supervision and additional training as described here by Interviewee 5:

"…a specialty of some sort - you specialised in child psychotherapy, family therapy, or group therapy. So there was a culture around [training]" (Interview 5: Organisational Consultant).

CAMHS was seen as service where there was an opportunity to meet families and do something that would make a positive difference in their lives. This was also part of the attraction for others:

"*something about that made me want to be part of it*" (Interview 4: Past Clinician).

There was a sense that CAMHS could work well and this was articulated by Interviewee 8, a past manager when she identified that from an outcomes point of view, clients "were getting better – so it must work. The kids were changing and you wanted more of them to access this or for more workers to train and be able to deliver it." (Interview 8: Past manager). Here Interviewee 12, a child protection leader summarised what was best practice with children and families "understand the abuse or the trauma in the past. You've got to

engage them in the present in safety, but it's all about the future." (Interview 12: Senior Child Protection).

This section has focussed on themes related to what elements were needed for a high performing CAMHS. Building on the perspectives of the interviewees a number of key elements needed for a "good" CAMHS have been identified and described. The key themes that have emerged in the data analysis are further summarised below (Table 2) with brief descriptions and highlighting the elements that underpin these themes. They will be discussed in detail in Chapter 9 following the final brief section of this chapter, which describes additional data captured through the writers' commentary during interviews.

8.4 Researcher commentary during interviews

This section was included to ensure that themes and discourses emerging in the dialogue during interviews were examined and captured in the data set and as part of the findings. Through the analysis process it was observed that the style of the researcher during interviews was to paraphrase and validate understandings for confirmation back with participants.

Confirmation and extension of the ideas and building of dialogue and shared understanding provides further validation of the shared meaning. Given this, it is asserted that the findings sections as catalogued above examined the key themes and therefore what appears below may appear to be repetitive. Nonetheless, it is included for completeness.

The challenge for parents in being heard when they raise concerns about their child either in a school setting or GP or mental health service was

TABLE 2 *Key themes about CAMHS*

Theme	Description
High hopes about involvement with CAMHS	The expectations and impressions of CAMHS which across the perspectives generated a sense of optimism and hope for involvement with CAMHS • Clients and their families – the challenge to get help • Clinicians – a conflict between hope for excellence and the reality of the experience • Government – a perception of variability in performance

	• External Stakeholders experiencing CAMHS as "special" and impenetrable
Clients and their families – complexity and trauma	The target client group was viewed as having real complexity in their presentation, often with parents or families who themselves had difficulties.
CAMHS clinicians – perceptions and ambivalence	Perspectives related to the clinicians themselves. There was a contrasting impression of talented clinicians who made helpful contributions but with a flip side of arrogance, inadequacy, stress and pressure in the work.
Getting in the door – intake, access and entry	Described a perception that barriers to accessing CAMHS were strong and challenging for clients, families and referrers. These were linked to structural obstacles, inadequate clinical capacity and discernment about who should be accessing the service, and a level of anxiety inherent in managing complex cases and overwhelming demand.
Once you are "in" – the service provided.	Focussing on aspects of the care pathway for the client and family (problem identification and diagnostic assessment; inpatient treatment; outpatient treatment; the role of case management).
Between and about CAMHS and other services – a conflicted picture	Collaborative work should be routine and perceptions of the interface between CAMHS and other services providing care to clients were mixed. Specific interfacing services and issues described included • Community and social services • Adult mental health • Child Protection • Schools • Primary mental health

TABLE 3 *Themes on Considerations of a 'Good' CAMHS*

Theme	Description
Better access and assessment models – removing barriers	Getting the access/entry function right was seen to be the single most critical change required
Building hope and managing expectations through good communication with families.	Making sense of the past, engaging with the present and building a vision of future, and managing expectations of all involved.
The place of boundaries in quality service delivery.	Balancing boundaries for sound therapeutic outcomes without being rigid and exclusionary.
Reflective spaces for clinicians are critical	Good clinical work with integrity requires active development and maintenance of a reflective space.
The place of teamwork and leadership in a "good" CAMHS	CAMHS was seen to be working well when there was an integrated multi-theoretical perspective, wisdom in leadership, accessibility and collaborative capacity.
Accountability, data and organisational design	The role of research and how it informed CAMHS practice (or not), the place of performance monitoring and measurement and the impact of data gathering.

discussed a number of times. The dilemma for parents of considering whether to raise problems or dissatisfaction with service delivery discussed in relation to CAMHS was compared to the same day to day issue of raising concerns at a child's school and worrying that this would affect the treatment the child is subjected to or the perception teachers have of them. Here the writer commented on the challenge for parents of raising dissatisfaction with CAMHS:

> *"You know, peril, or their care will be compromised, or you'll be seen as that parent with the reputation of stirring, or whatever the issue is; and it's a big obstacle that you have to get over in order to negotiate the care that you need, and I wonder if there's some similarities."* (From Interview 2)

The tension between what people dream or hope for from CAMHS and what is actually provided was discussed and it was a tension seen to apply across those groups involved – children, parents, external referrers and clinicians. Likewise a tension was described between demand for services and the supply of these and how an organisation or staff in the "*front line*" might manage the anxiety of knowing that people in need were waiting for care, or managing the "*rage of people who are knocking on the door and not getting in*". Further tensions were discussed in relation to the desire (including their own) for an individual to be "*given*" or receive a mental health diagnosis contrasted

with the social context of mental health issues, the social impact of mental illness, and the psychological understanding of trauma.

There was a theme explored in relation to the perceived "*specialness*" of CAMHS and how in a way the demand and access issues (described above) promote or confirm the "*specialness*" of CAMHS making it glorified or idealised. This was coupled with the discourse around the "*impenetrable*" nature of CAMHS from external referrers, government, clients and families. It also underpinned the discourse on managing change internally and this quote underlines the resistance that challenged the past manager in Interview 8:

> *"The team was a brick wall really about having that conversation from the inside with me as Manager that a 12 month waiting list was not okay. It's just not okay and it has to change…"*

The particular issues related to child protection workers seeking access for children in their care to CAMHS drew broad commentary. It was noted that CAMHS had been seen by policy leaders in child protection as so hard to penetrate that they had set up their own "*mental health*" services to provide treatment that could be accessed only through child protection. It was noted that there was powerful pressure on both systems now, particularly child protection (very public pressure on child protection) and a kind of "*scandalised media*" about the lack of good practice, which fuelled the ambivalence of CAMHS in supporting and respecting the work of child protection as captured in this quote from Interview 5:

> '*It's like CAMHS is saying we knew that child protection couldn't do this job'.*

There was some paraphrasing of the research question and underlying theory as part of setting the questions and initiating the discussion. This included testing ideas about what was underlying some of the process issues in child and adolescent mental health, exploring what people expected from and experienced at CAMHS and how all this affected culture and performance of the services. Performance was described as including elements such as

responsiveness, partnership and collaboration and here there is a comment about the uniqueness of the CAMHS culture from Interview 12:

> *"…culture is unique to an environment…what are the themes that most CAMHS services are challenged by around their culture and performance, and how does that affect the performance of the service, and what a quality CAMHS looks like? What are the unique things about a CAMHS environment that's different from an adult environment, or a teaching environment, or the army…."*

The impressions of staff culture in CAMHS drew a range of comments. The idea that as a group they responded as passive recipients of organisationally based attacks emerged in several interviews, notably those with leadership or management experience. Here the writer paraphrased the extreme language being conveyed during the interview about staff responses to imposed accountability structures:

> *"…the same with staff feeling like things being imposed on them, and them being victims somehow of terrible management structures, or terrible Government requirements, or extra documentation, as if they're incredibly passive in that process"* (In Interview 11)

The role of leadership also emerged in the commentary across interviews and best summarised in this quote below from Interview 3.

> *"…. So this is about leadership in the end, and it's about how to understand the organisation you lead. I'm sure an Army organisation leader is quite clear about the hierarchies and that's how they manage risk. They're very clear about being followers, as well as leaders. That's not at all clear in a child and adolescent service …"*

As indicated, including this section recognised that throughout the semi structured interviews undertaken, the writer paraphrased and tested concepts and ideas with the participants. In the data analysis process, this first hand synthesising of material created a recursive review of the ideas and underlined the key concepts that have been highlighted here. The experience of reviewing, analysing and synthesising the data including these commentaries has created

a strong sense of engagement and fluency with the raw data and importantly with the themes emerging from the analysis. The discussion of these themes and how they link to the research literature is the focus of the next chapter.

8.5 Summary and signpost

In summary, this thesis has examined the theoretical, research and policy environment of public health and mental health, in particular CAMHS in Victoria, Australia. In addition the history, development and current practices and policy settings for organisational performance measurement and monitoring in this context have been explored. Based on a systems psychodynamics theoretical framework and a social constructionist qualitative research paradigm a research study was designed.

In Chapter 8 the results from twelve in-depth interviews with volunteer participants who were selected for their unique perspective have been reported. The results were in articulated themes directly informing this study of the distinctive aspects of CAMHS that might impact on organisational performance. These themes were grouped, describing firstly the unique aspects of CAMHS as they emerged in the data analysis. Secondly, descriptions of elements of what makes a “good” CAMHS were reported. These two sets of themes are now examined in some detail in Chapter Nine in a discussion, followed in Chapter Ten by Recommendations for a performance framework for CAMHS.

Chapter 9 Discussion

The focus of the current study has been an investigation of the unique aspects of a public CAMHS service organisation that might impact on organisational performance and how a performance framework can be re-conceptualised to take these considerations into account. In this chapter the findings are briefly summarised and then subjected to review and discussion in line within the relevant theoretical framework and available literature.

The implications of these findings and theoretically-informed ideas for conceptualising organisational performance parameters are then discussed and conclusions drawn. Implications for theory, practice, policy, and further research are drawn out with particular focus on the objectives of the study and therefore through the prism of measuring organisational performance and informing a robust framework.

9.1 Summary of findings

9.1.1 Expectations and impressions of CAMHS

One of the primary findings was that clients and families came into CAMHS with expectations and a strong desire to get help with their family situation. It was found that families expressed a sense of desperation for assistance, rooted in the fear of what was happening to their child and family and a longing for the (psychological) pain to be taken away. Clinicians, on the other hand, when employed, were found to be motivated to work in a sophisticated renowned high quality therapeutic setting for children and adolescents. However, they reported a sense of disconnection between the balance of activities being undertaken by clinicians and their relevance to the role and task of the service.

Furthermore, government policy leaders saw some CAMHS services and individual clinicians as much more willing to consider new policy directions or initiatives compared to other services who were seen as very fixed, rigid, and impenetrable. This emanated from a limited understanding of the role of the government policy process and decision-making. Finally, external stakeholders

reported wanting accessible, collaborative, skillful interventions and were critical that these expectations were not met. CAMHS capacity to work with the most traumatized children and families was perceived by stakeholders as limited.

9.1.2 Clients – complexity and trauma

This study explored the controversial dichotomy between “normal” behaviour problems and mental health issues, the challenge of complex cases and the social-environmental barriers associated with accessing CAMHS. Non-mental health issues were noted by the parent informant and other stakeholders as clearly impacting on a child’s development and were very often part of the presentation of a CAMHS client. These issues included physical health matters or a family social situation such as homelessness, illness, or poverty.

9.1.3 CAMHS clinicians – perceptions and ambivalence

There was a broadly shared view about the work of CAMHS and the role of a CAMHS clinician. Namely, clinicians agreed that their task was to understand the problems being presented, build understanding and assist generating solutions. Clinicians described the work as “good” – caring, soothing, reflecting, understanding, and effective in lifting the burden of blame and shame. However, the practice and service delivery was in part defined by the clinicians’ interest, not what was requested, needed or wanted. Working in CAMHS as a clinician was perceived favourably by participants, with highlights reported as the experience of being part of a supportive skilled team or well-informed people, reflective spaces, and good clinical responses to complex and difficult work. There was a theme of satisfaction of a job well done and a sense of having contributed to positive client outcomes. Despite this, there were personally confronting and difficult components of the work reported by clinicians, with high stress levels perceived as well as a sense of feeling overwhelmed by client need and being unable to respond.

9.1.4 Getting in the door - intake, access and entry

There were significant obstacles and barriers to access reported through all interviews in differing levels of detail. There was recognition that thresholds were high which, in some situations, was a requirement to manage the access. There was also a high level of frustration conveyed about the processes for referral and intake. For example, the work of “intake” was itself seen a particularly challenging role. The impact of managing the demands of intake was seen as stressful and precipitated structural and functional organisational changes such as requiring referrals to be made by another health service provider rather than directly by the client or family – but with reported limited impact.

Referrers reported they were often left “holding” the child or young person due to long wait lists and delays, with negative impact of long waiting times for both clients and families (whose problems often escalated) but also for the services in managing the situation whilst waiting for CAMHS. There was a view that part of the barrier to accessing CAMHS was self-protective, that is, a perceived reluctance generated internally and probably unconsciously to guard against being overwhelmed.

9.1.5 Once you are “in” - the service provided

Once “in” CAMHS, it was perceived that a child or adolescent received a thorough assessment and they were assisted to make some sense of their situation. The assessment and diagnosis process was ideologically contested as was the utility and benefit of a diagnosis. For example, client, carer and past clinician interviewees reported that clients and their families were asked too many intrusive questions and that an assessment was sometimes “pathologising” and “medicalised” rather than focussed on the social context of the presenting problems. There was also a perceived risk that diagnostic practices of CAMHS placed clinicians at risk of replicating the trauma dynamics and re-enacting them, subjecting the children to being traumatised further by the process of engaging with services.

The characteristics and needs of the child and family were seen by referrer, past clinicians, and stakeholders as sometimes beyond the capacity of the service to understand and manage. There was a shared sense that some clients needed thorough assessment while some needed just to sit and talk and hear advice reflected back, but more often than not, a rigid process of assessment and feedback to the family was employed routinely, took extended periods of time, and was perceived to be too long. The underlying treatment and therapeutic models being utilised in CAMHS were perceived to have changed over time. Case management was found to be a key component of good care and was affected by the quality of the relationship and engagement developed between client, family, and clinician.

9.1.6 Between and about CAMHS and other services

CAMHS clinicians did not always take a positive view of the contribution of other services. In the community sector for children and families, the clinicians reported that there was not a good understanding of mental health issues in children and this resulted in poor connections between CAMHS and other providers. Rules and processes were reported to be entirely different between adult mental health services. Key collaborative partners for CAMHS were reported to include schools and child protection amongst others. Dynamics of the relationship between CAMHS and child protection was found to be particularly conflicted. There was an element in this mutual frustration of not being understood, supported and assisted in what was difficult work in either setting. This was linked to the lack of knowledge in CAMHS generally in relation to trauma, and offenders, and also seen to be the cause of system anxiety. Despite this CAMHS was invariably seen by almost all informants as having real expertise to deliver clinical mental health services.

9.1.7 On considerations about performance: a “good” CAMHS

Getting the access/entry function right was seen to be the single most critical performance metric and where the most change was required. It was recommended by some interviewees that the service could be more community based and more responsive with focussed single sessions and risk assessments with minimal documentation, simplified report writing, and no

complex case formulation documentation. Building hope was reported as a key element in good CAMHS service delivery, and this was grounded in making sense of the past, engaging with the present, and building a vision of the future. Managing expectations (the client, parents, referrers, managers) was an emergent theme, and services were advised to be clear about what they can and can't do.

Creating a strong culture of boundaries is powerful for the work, and impacts directly on sound therapeutic outcomes. A strong team model where people perform, and do what they are supposed to do is important to good performance. CAMHS at best was described by clinicians who experienced it as a highly professional service underpinned by supervision and training. There was an opportunity to meet families and do something that would make a positive difference in their lives. This was also part of the attraction for others to come to work at CAMHS.

9.1.8 Additional findings emerging from researcher commentary during interviews.

The disparity between what people dreamed or hoped for from CAMHS and what it actually provided created a tension across all groups involved. Likewise a tension was described between demand for services and the supply of these and how an organisation or staff in the "front line" might manage the anxiety of both knowing that people in need were waiting for care, and also attempting to manage the "rage of people who are knocking on the door and not getting in".

There was a theme explored in relation to the perceived "specialness" of CAMHS and how the demand and access issues (described above) promote or confirm the "specialness" of CAMHS making it glorified or idealised. This was coupled with the discourse around the "impenetrable" nature of CAMHS from clients and families, external referrers, and government, and it also underpinned the discourse on managing change internally. The impressions of staff culture in CAMHS included the idea that as a group they had a tendency to respond to leadership and management activity as passive recipients or victims of perceived organisationally based attacks.

9.2 Discussion

9.2.1 Overview

Analysis and review of the data and the development of the discussion section has in some instances yielded theoretical dilemmas (Honig, 1996; Hoggett, 2006). There has also been consensus and congruence with the literature. Where the discourse places issues in tension or dissonance with each other they have been treated as ambiguous rather than mutually exclusive. Resolving these dilemmas with “absolutes” has been actively resisted in this discussion. This makes it consistent with the underlying social constructionist paradigm informing the research – that is, focused on co-constructed meaning. Alternative views and ideas are valued and seeking conformity has not been an aim. Whilst there is likely to be general consensus in the discussion, there may be tension inherent in solutions proposed (Anderson, 1997; Schwandt, 1994).

As further background prior to detailed discussion of the results of this research, it is important to revisit previous research and theory on the manner is in which organisations create defences to minimize anxiety. The early theoretical groundwork for group relations theory on which psychodynamic organisational understandings have been developed and researched was the work of Klein (Klein & Riviere, 1964; Jacques, 1953, 1955). Building on Freud’s theories of intra-psychic and unconscious processes in individuals, Klein’s research on the infant-mother dyad generated theories which “described how people learn from an early age to cope with unpleasant emotions, and the resultant confusion and anxiety such emotions create by using two predominant psychological defences, splitting and projective identification” (Fraher, 2004 p. 33; Lear, 2005).

Bion (1985) then developed these ideas and examined how adult experiences in groups can create similar intense feelings and defensive responses. The link between a person’s anxiety or internal conflict, feelings or desires and defensive behaviour patterns was helpfully characterised as a triangle by (1963, 1995). Whilst this conceptual triangle was applied to understanding why the individual may behave in defensive ways as she seeks

to avoid feelings or desires that are unpleasant or overwhelming, it also assists in understanding when people come together in groups such as in context of an organisation.

In her review of the work of Jaques in the mid-1950s, Long (2006) attributes his early work on social defences as foundational for future development of models of understanding and theory about "the development and persistence of organisational structures and cultures that sometimes operate more defensively than in pursuit of their primary task…that is, the task is avoided often because of the distressing and unbearable emotions that it arouses" (p. 203). Jaques (1955) original concept was that what drew individuals in an organisation together in a fundamental and subjective way was the avoidance of what he called "psychotic anxiety" through splitting off these difficult feelings and projecting them into aspects of the "life of the social institution" or organisation within which they work. (p. 497)

When anxiety exists in an organisation (as a result of the group task itself, group experiences, or other unconscious processes), functions can emerge across an organisation to "contain" these anxieties such as structures like hierarchical boundary setting, job descriptions, incident and risk-management processes. These may work to contain anxiety, but they may not always do so and instead groups may resort to social defences such as splitting, projection, and denial. (Kets de Vries, 2006; Stephenson, 2012; Rao, 2013; Ogden, 2004)

The findings in the present study are examined within this framework. That is, what anxieties and unbearable emotions may be aroused through the primary task of providing healing care to children and families suffering mental ill health? What organisational structures or cultural responses may be evoked through the collective drive to defend against these strong and unbearable emotional experiences? Are there elements of such organisational defences that are destructive at a task, organisational, people or client/service delivery level or do they serve to support organisational sustainability? What impact might understanding this process more fully have on the development of a performance framework for CAMHS? Firstly, however the findings related to

the impact of expectations and perceptions, who CAMHS is for, and the primary task of CAMHS will be discussed.

9.2.2 The impact of expectations and perceptions

(a) Seeking help

The research findings revealed that clients and families came into CAMHS wanting help. There was a sense that this "help" was imagined or expected to be (in simple terms) about understanding the problem and finding solutions, and that it was framed by the social expectations of health service delivery where a problem is identified generally by a professional, a diagnosis is made, and a solution is offered and taken up which resolves the problem.

The challenge for parents and families to acknowledge problems and seek help for their child and family was described in these findings as a personally painful process potentially filled with shame and a sense of uselessness or failure (Oldershaw et al., 2008; Bjørngaard et al., 2008). Mawson (1994) describes this in detail through an example of an adolescent psychiatric ward as overwhelming feelings of inadequacy in parents who had become demoralized in their parenting, longing to reclaim a time when they experienced strength and affirmation as parents.

This study found that expectations which included an element of desire were high. This might otherwise be charachterised as people having a high level of investment in CAMHS born of high expectations or longing. Clients and families were reportedly disappointed when their expectations were not met. Clinicians came to CAMHS wanting to work in a sophisticated high quality therapeutic setting, but leaders drew attention to poor internal balance in time allocations and service delivery. Those attempting to work within CAMHS identified defensiveness against the fear of external people with some skill coming in and joining the group and perhaps creating unwanted internal competition.

External stakeholders wanted accessible, collaborative skillful interventions – and were critical that these expectations were not being met. The perspectives emerging from one's role in relation to CAMHS was at a

fundamental level not a large factor of variance. In essence, people wanted clients and families to receive responsive care in a health model.

Expectations should be managed if this cycle is to be interrupted (Bone et al., 2015; Coyne et al., 2015). This means clarifying and communicating the primary task and understanding the differences between what people imagine or long for in the service and what they experience (Watt et al., 2012). In relation to CAMHS this points to articulating the role of CAMHS for it's consitutents directly, understanding and managing expectations and holding themselves to account for delivering against those expectations.

The notion of the primary task of CAMHS itself will be examined in more detail later in this chapter, but it is important here to focus further on the issue of expectations and perception. Hoggett (2006) argues that it is the responsibility of government to have to deal with conscious and unconscious expectations from community members. This means that public sector organisations and institutions are in the front line for managing social anxiety and other emotions expressed by communities and citizens (Obholzer & Roberts, 1994; Walsh et al., 2016).

Hoggett (2006) articulates it thus:

> "Indefinable anxiety becomes a tangible fear, the danger within becomes the danger without. It follows, that in the context of welfare societies, the mad, the bad, the sad, the old, the sick, the vulnerable, the failures, and so on, receive not just our compassion but also our fear, contempt and hatred…" (p.183).

It follows that as a public sector organization of government, that same government should manage the expectations and anxieties of clients, families, clinicians, referrers and the broader communities. At a community level this might take the form of a public health communication strategy defining the service system and expectations, as is from time to time implemented by governments in relation to services available linked to particular conditions such as nicotine addiction (US DHHS, 2014), depression (BeyondBlue, 2016) or health literacy programs (Nutbeam, 2000). Services themselves already

provide general information on websites and in hard copy brochures for prospective clients and families (for example, Royal Children's Hospital, 2016). Consumer and family advocacy organizations likewise offer encouragement and advice on using and managing the mental health system (for example, Eating Disorders Victoria, 2016). These solutions assume a level of literacy, an ability to identify the issues facing their child and capacity to resource support in the families, and that interactions delivered by staff as clients and families enter the CAMHS system are reliably consistent with the quality frameworks and service design features promised in the communication material. These matters are linked to the findings related to access barriers for CAMHS and will be examined later in this chapter.

(b) Responsiveness of services

The concept of responsiveness of health services, which was a key theme raised by the interviewees has also been articulated in the research by Valentine et al. (2003) and adopted by the WHO. Domains for measuring performance include: "Confidentiality of personal information; Autonomy (involvement in decisions); Clarity of communication; Dignity (respectful treatment, communication); Access to family and community support (contact with outside world, continuing regular activities); Quality of basic amenities (surroundings); Prompt attention (convenient travel, short waiting times); Choice of health care provider" (p. 590). Bramesfield et al. (2007) examined the applicability of these domains to mental health care identifying that the notion of responsiveness may have specific focus for mental health service delivery because "illness and health care in psychiatry impact on people's sense of dignity and autonomy and raise negative feelings such as anxiety and shame" (p. 880). Notably this research found that two additional domains were relevant for mental health care services: attention (not necessarily prompt attention but where the focus moved more to the experience of empathy and being attended to) and continuity of care. This is an important consideration for CAMHS in that the findings articulated a high level of demand for services and the importance of service planning and communication. What is proposed here is an emphasis on engagement and empathy and continuity of care rather than (necessarily) throughput or urgent responses.

Bramesfield et al.'s (2007) research examining these domains was directly correlated with adult mental health clients and therefore unique aspects of responsiveness for children and families are yet to be examined. This does, however, provide guidance about what aspects to consider for a performance framework on responsiveness to help-seeking of families, and provides an important reminder of the shame and anxiety clients and their families may carry either consciously or not as they enter the CAMHS system and a guide to attending to the presenting issues. Devas and Farber (2001) in their examination of parental attitudes to their child's therapist, confirm that the complexity of parental "feelings and expectations evoked by having to bring a child into treatment, the ways in which these feelings may distort and influence the parent's experience" (p. 165) are critical to the engagement and progress and outcome of treatment for their child.

In regards to the current study, the finding that expectations people (e.g., clients, families, clinical staff, referrers) have of a CAMHS drives engagement, experience, attribution, satisfaction and impacts on outcome finds broad confirmation in the literature (Iskra et al., 2015; Sayal, 2006; Wahlin, 2007; Gulliver et al., 2007). Furthermore, to improve the quality of health care services Cowling et al. (2009) argue that clinicians should primarily attend in particular to the clinician-patient relationship given the evidence that this relationship is positively connected to their experience of the service. This notion of critical nature of the relationship links directly with Bramesfeld et al.'s (2007) research cited earlier that identified a key element of responsiveness in mental health services was the attention and empathy being conveyed by a service provides to the client.

(c) Lack of shared definition of the problem and the goals

In relation to clients and families, it has been found that understanding about CAMHS and its expectations affects parental and child engagement, attendance rates, and clinical outcomes (Ronzoni & Dogra, 2012; Ma, 2000; Westra et al., 2010; Devas & Farber, 2001; Fuhrman, 1995). Of further interest is a set of studies comparing the expectations and goals children and teenagers, their parents and their CAMHS clinicians. In brief these studies have

broadly found that it is highly likely that children and their parents will not agree on even one goal of treatment. Therapists are more likely to agree with parents than the children on the focus of treatment, except where they identify the problem as family centred or environmental (Hawley & Weisz, 2003; Yeh & Weisz, 2001; Garland et al., 2004). These issues point to the need for careful engagement on entry to a service, connecting with all members of a family and potentially allowing more time to generate shared problem definitions and agreements on goals for treatment.

In this present research focused on CAMHS, the expectations on the service to respond to help-seeking appropriately, and resolve deeply distressing problems being managed by other adults (parents, referrers) may be intensified both by the individual thought processes and experiences of those involved, and by a broader community discourse, expectation and perception of CAMHS. Willshire (1999) raises the prospect that elements of the work in adult psychiatry services are impossible because the task itself (containing madness) is impossible. She argues that rather than focus efforts on solutions that are evasive at best, organizations might be better served by making "individual and collective madness more bearable in ways rather than something to be controlled or denied" (p. 775). Extending this notion to CAMHS may not be straightforward in that the task itself is not essentially about containing, removing or eradicating madness or the more recently promoted notion of enhancing recovery (Anthony et al., 1993; Cook et al., 2015; Slade, 2009) although there would be a small group of clients and families where psychosis is a feature in their presentation (Varese et al., 2013).

Consistent with organizational theory, CAMHS would be described an open system where boundary management is critical to the useful functioning of the organization (Roberts, 1994; Hirschorn, 1988; Miller, 1993). The CAMHS primary task is defined (as a result of the outcomes of this present study – see section 9.1.3) as "a public mental health service creating a safe place to develop a shared understanding of the most troubled children and their families, and to foster growth through caring, reflecting and lifting the burden of blame and shame". If this definition resonated with service users, providers and referrers, which the findings of the current study support, it could form the basis

of the management of expectations and subsequently the performance framework.

(d) Clinician expectations

Finally the finding related to the expectations and perceptions of clinicians themselves warrants further consideration. Clinicians came to work in CAMHS wanting to work in a sophisticated renowned high quality therapeutic setting for children and adolescents. Those with leadership and management roles reported a sense of disconnection at times between the balance of activities being undertaken by clinicians and their relevance to the role and task of the service, although there were indications that clinicians guarded their expertise and were at times seen to deliver services they were personally or professionally committed to rather than what was needed for the client and family. This finding provides a hint as to the importance of engaging clinicians in the development and implementation of a performance framework and illustrates the tension between professional judgement and organisational goals (Thompson et al., Cottrell & Kramm, 2005 2013). More importantly it points to further examination of job satisfaction issues and how this might relate to the work clinicians undertake (Klark, 2013). Measures are routinely taken in Victorian public health services across the workforce, through surveys such as the “People Matters Survey” which examines ethics, culture and behaviours in the workplace as viewed by the workers themselves (VPSC, 2016). Findings of this survey are provided to local management and can be disaggregated to team and unit level. This provides a first option for exploring this finding in more detail with services directly. The findings from the current study suggest surveys such as these are an important part of service evaluation.

9.2.3 Who is CAMHS for?

(a) Target group and complexity

The target client group for CAMHS was seen as those with real complexity in their clinical presentation, often with parents who themselves have difficulties (Hutchings & Williams, 2014; Clark et al., 2005). This is broadly consistent with the Victorian government website definition of the target client group for public CAMHS services. The website states that

> "specialist child and adolescent mental health services are provided for children and adolescents up to the age of 18 years with serious emotional disturbance." (DHHS, 2016)

The most recent data published on CAMHS client group in Victoria (DHHS, Quarter 4, 2015-16) indicates that around 30% of registered clients are under 12 years old with the remainder between 12 and 17 years old. In terms of services provided, the average length of engagement with the CAMHS is 220 days and the average intensity of engagement is between 7 and 8 occasions of service/engagement in a 12 week period. Whilst diagnosis is not included in the suite of data published, a possible proxy measure of complexity in presentation is published quarterly. It is considered to be a contextual measure of severity of symptoms which arguably does not measure severity of presentation but is used here as a reasonable proxy in the absence of other options.

The measure, called the HoNOSCA (Health of the Nation Outcome Scales for Children and Adolescents), is a clinician-rated measure of symptom severity required by agreement to be used in CAMHS across Australia. It is a fifteen-item practitioner-rated measure designed specifically for use in the assessment of child and adolescent outcomes in mental health services. Items are rated from 0-4, with 0 indicating "no problem", and a rating of 4 indicating "severe to very severe problem". Therefore the higher the score, the more severe that problem is assessed to be. The higher the aggregate score, the more complex or severe the presentation is thought to be on basis of symptom measures (Garalda et al., 2000).

In terms of measures of complexity, the selected items that are aggregated to deliver a total score for each registered client in CAMHS is published as a mean total score. The mean total scores published for the

relevant reference period is 16.6 across the state (15.6 in rural areas, 17.1 in metro areas). This compares with 17 for the comparable period in 2010-11 and has been relatively consistent over this time. National averages are not published; however the national leadership committee on CAMHS data provides the following caution on the utility of the aggregate HoNOSCA score as a measure of complexity as an indicator to guide funding models and therefore performance measures (IPHA, 2015).

Whilst the HoNOSCA scoring system includes a measure of family life and relationships and one of peer relationships, most measures are individually focused. In practice HoNOSCA is only one aspect of assessment, diagnosis, and case formulation undertaken within CAMHS. Symptom measures do not provide a full picture of the problems for a mental health client and especially a young child or adolescent. It is recognized, however, that the health/illness paradigm sits strongly on a positivist diagnostic model that uses “symptoms” to identify an effective treatment and resolution of difficulties and therefore guides all health services. As evident through this present study, the dilemma with psychiatry and specifically with child and adolescent service delivery is that often the presenting issues are difficult to “box”. Explanatory models are, and perhaps should be socially framed, developmentally informed and interpersonally oriented.

What then results is a tension between both expectations for symptom-driven diagnosis and social models of understanding. This tension will be discussed further below (Section 9.3). It should be noted that diagnosis, whilst not reported routinely in Victoria’s published data, it is gathered and published annually by the Australian Institute of Health and Welfare (AIHW, 2015). It may be that understanding the nature of those accessing CAMHS will need multiple measures such as symptom severity, individual diagnosis and family/social setting indicators of severity.

The findings of the present research bear out this tension, noting that for this service the target group is specifically a group that presents with complexity not just in the identified client but also more broadly in the family or caring system around the client. This can include where the adults involved may

themselves have significant mental health problems.

A key expressed concern about the use of outcome measures such as HoNOSCA is that is measures the client's condition only from the clinician's view point and does not explicitly include the child or adolescent's perspective nor that of a family, teacher or other significant people in that child's life (Rosenberg, 2012). Furthermore, where clients of social and health services are increasingly encouraged to set their own goals (and thus highly personal outcome measures), these may or may not link in the minds of individual families with primarily managing symptoms (Hurn et al., 2006; Cott, 2004). Thus consideration of a range of measures is warranted.

(b) Implications of target group findings for the performance framework

The focus in this study is on informing a performance framework. Whether CAMHS is actually delivering services to the intended target group is the performance corollary with this finding. Notionally as the policy and funding body, government sets the parameters for services it wishes to purchase from providers and within this specifies the target group. However, there was reported a theme across interviews of services and referrers grappling with what was the "right" client group for CAMHS in practice. Setting performance metrics for public services which provide a framework for monitoring and managing performance in addition to setting broad policy parameters for service delivery requires government to consider identifying actual measures that can be implemented. Other findings in this study demonstrate a view that CAMHS is not consistently working with clients who have complex behavioral and psychological presentations and/or trauma related difficulties. Holding services to account for targeting delivery of care to children and teenagers presenting with severity and complexity would require an agreed measure of complexity, which is currently not available. Developing such as measure (perhaps as a score derived across a range of domains) would provide an opportunity to ensure that those at the highest level of complexity were in fact the ones able to access the service.

A further theme that emerged in the data was the complex problem that of the contribution of non-mental health issues (such as homelessness, illness,

poverty) clearly impacting on a child's development such as their physical health or on a family situation and a family's capacity to manage their lives (Jonklin, 2006). The Australian *National Mental Health Commission* released a paper in 2012 examining the current status of performance reporting internationally in relation to mental health. In this report, author Rosenberg states

> "…available data tend to emphasize only aspects of the operation of the health system and largely fail to provide a 'whole of life' picture of the situation and circumstances of people with a mental illness in different countries. Data concerning rates of employment, access to stable housing and measures of quality of life are yet to emerge, either in Australia or overseas" (ANMHC, 2012, p. 11)

Functional integration across domains such as justice, homelessness and poverty with health services is limited at state and federal level, and as discussed in earlier chapters the layers of government in Australia add to the complexity of monitoring and attributing accountability for outcomes (Bovaird, 2014; Glendinning et al., 2006). Policy integration across the relevant social domains rhetorically seeks integration, but has struggled to deliver this (Brand, 2012). The most recent and fundamental structural change introduced recently and in implementation phase is the delivery of care for disability clients (the National Disability Insurance Scheme or NDIS) seeks to integrate responses to a range of individual needs at the point of the individual him or herself with a package of care and support including health, education, housing, justice, and employment. Performance reporting has commenced on this program and aggregates data on areas of need, types of support provided, and costs against type of disability/diagnoses (NDIS, 2016).

This model, whilst in its infancy, may provide a helpful guide in further developing measures of relevance to CAMHS services in terms of the broader domains seen here as contributing factors to the presentations of children and their families such as housing, employment and involvement with the justice system. Psychiatric diagnoses arguably do not have the same role as disability diagnoses do in identifying a broadly reliable set of expected functional impacts

for the individual concerned. They are also not published in this way and not fully supported in the mental health field as an indicator of complexity. For example, Headspace (nationally funded youth mental health services) report presenting issues by symptom as described by the clients themselves including anxiety symptoms, depressive symptoms, anger issues and stress (Headspace, 2015). Nonetheless, the focus of the NDIS reporting across life domains holds promise for a performance framework for CAMHS.

9.2.4 Purpose of CAMHS: notions of a “primary task”

There was a broadly shared view reported in the findings of this study regarding the work of CAMHS and the role of a CAMHS clinician. Namely, clinicians have the task to understand the problems being presented, build understanding and assist generating solutions. Clinicians described the work as “good” – caring, soothing, reflecting, understanding, and lifting the burden of blame and shame. The ensuing discussion has been segmented as with the findings into key themes: evidence-based practice; experience of the work; obstacles and barriers to access; assessment and diagnosis; therapeutic engagement; complex presentations; and, decision making and case review followed by a summary and recommendations based on the findings.

(a) Evidence-based practice

Recent literature on treatment in CAMHS is extensive and focuses primarily on the evidence base for treatment of particular diagnosed conditions (such as Hoagwood et al., 2010; Pelham et al., 1998; Hall et al., 2014), or on the technology of broad therapeutic approaches such as family therapy (Walsh, 2003; Cabana et al., 1999; Doherty & Simmons, 1996;) and cognitive-behavioural therapy (Friedberg & McClure, 2015; Esbjorn et al., 2015) or specific techniques such as diagnostic assessment or parent training programs (Lingiardi, 2015; Pidano & Allen, 2015). These resources are broadly applicable across private practice and within public settings like CAMHS and across the range of services that may be providing care such as through schools and in primary care settings.

As previously discussed, a performance framework for public CAMHS would be generated from a clear policy framework articulating what services are being “purchased” (in the Victorian model) and expectations for delivery. Present-day governments increasingly articulate a commitment to “evidence-based” services in policy development and funded programs (Commonwealth Government, 2009; Wells, 2007; Nuttley, 2003). Monitoring how a CAMHS delivers clinical services in line with a particular evidence base should be considered in development of the performance framework, although this assumes that an evidence base for treatment can find broad agreement and further whether clinicians would be reliably able or willing to implement it once trained (Borntrager et al., 2009; Addis et al., 2000; Rosenberg, 1995).

Mental health clinical services have at times been described as both an art and a science, relying on clinical expertise as well as objective measures to understand the problem presented and apply treatments. Sackett et al. (1996) see this as applying more broadly to the field of medicine, indicating that evidence based practice is about “integrating individual clinical expertise and the best external evidence” (p. 312).

In this study it was found that the practice and service delivery in CAMHS was seen, at times, to be defined by the clinicians’ interest, not what was requested, needed, or wanted. This finding adds further strength to the need for careful engagement on entry to a service, connecting with all members of a family and potentially allowing more time to generate shared problem definitions and agreements on goals for treatment across all family members. It also raises the issue of developing and using treatment packages based on the evidence-base so the clinicians’ individual preferences do not outweigh the best treatment available. An example of such is Wolpert et al.’s (2014) “Thrive” Model. It builds on what they assess to be “increased provider coherence” (p. 6) and conceptualises service development through aligning evidence-based treatment responses more explicitly to assessed complexity and developmental strengths. It further introduces the concept of support alongside treatment noting that in many instances what is needed is family support, not necessarily treatment, as it is traditionally understood.

(b) Experience of the work

Working in CAMHS as a clinician was described generally favourably by participants, with highlights reported as the experience of being part of a supportive skilled team or well-informed people, reflective spaces, with good clinical responses to oftentimes complex and difficult work. There was a theme of satisfaction of a job well done, a sense of having contributed to positive client outcomes. Studies have shown that finding meaningfulness in their work is as important or even more important to workers than pay rates and other work components (Baily & Madden, 2016; Pratt & Ashforth, 2003). The benefits of the work, the positive experiences described in these findings, create a foundation for strengthening the positive aspects of the work to balance the challenging aspects.

Despite this there were personally confronting and difficult components of the work for clinicians, with stress experienced by the clinicians being understood to link to being overwhelmed by need, confronting experiences with clients and families and also feeling unable to respond.

The research on burnout of clinical staff as an impact of the challenge of working in psychiatric settings resonates with the core of this finding (Kilfedder et al., 2001; Hannigan et al., 2004; Rossi et al., 2004). For example, Durall (2011) drew together research across the medical field in relation to the impact of working with dying children and their families, exhorting hospitals to reference the emotional impact of the work on their staff by ensuring policy and procedures reflect frameworks developed by the Institute of Medicine and the American College of Critical Care Medicine. Sansbury et al. (2015) examined and described the differences between vicarious trauma, compassion fatigue and burnout in clinical and counselling staff and challenged individuals and their employing organisations to ensure that support systems were in place to provide an ongoing context to monitor and address the impact of working with stories of trauma.

Consciously identifying and managing individual stressful experiences in the work is likely to be understood and grappled with by leaders and clinicians as a phenomenon (Braum et al., 2010; Rössler, 2010). What is more

challenging is where such anxieties are not immediately understood and available to be examined, hidden unconsciously perhaps because they are painful to experience. This is commonly called denial and involves “pushing certain thoughts, feelings and experiences out of conscious awareness because they have become too anxiety provoking” (Halton, 1994 p. 12).

Mawson (1994) gathers a collective theoretical position contending that there are “‘mental pains to be borne in working at any task” (p. 67) and that to understand the particular complexion of these in each work setting one must understand the inherent anxieties of particular tasks – the organisational or team-specific anxieties (Mawson, 1994; Obholzer & Roberts, 1994). Systems psychodynamic theory would contend that not finding a way to bear anxieties, or to appropriately contain them, may lead to the development of primitive and potentially destructive individual and social defences in an effort to protect against overwhelming anxiety (Halton, 1994; Cramer, 2015; Stephenson, 2012).

The findings of this study, framed in the theoretical approach described above, strongly echo with the theory of defences and anxiety containment discussed earlier. Geldenhuys et al. (2012) draw on Bloom and Farragher’s (2010) work arguing that “the purpose of defense mechanisms is to create the illusion of certainty and safety to keep us from being overwhelmed by anxiety and helplessness” (p. 2). The conscious experiences of anxiety and what it was reported to relate to (service demand, inadequate resourcing) are likely to resonate across groups of clinicians. These are the focus of much effort across the CAMHS in Victoria and professional advocacy groups in making arguments for further resources (Wolpert et al., 2014; Thompson et al., 2013), and in designing and re-designing service models with the aim of meeting or at least better managing demand (Robotham et al., 2010; Fuggle et al., 2016).

However, the theoretical perspective that suggests organisational defences develop to guard against more painful anxieties that may not be experienced consciously or known and shared, prompts an examination about what aspects of CAMHS structure and process might be serving as defences against such anxiety (Jacques, 1958; Menzies, 1960; Long, 2006; Obholzer &

Rogers, 1994). As proposed in the study, the first of these may be found in the obstacles and barriers to access for children and families, which was the most comprehensively supported theme.

(c) Obstacles and barriers to access

There was a clear theme in the findings about obstacles and barriers to accessing the CAMHS service, and it was described as a 'broken' system. Referrers, including doctors, were often left 'holding' the child or young person due to long wait lists and delays. On the face of it, the practicality of resourcing growing demand lies at the heart of this problem. Estimates of population prevalence of mental ill health in 4 – 16 or 17 year olds enough to disrupt family, peer relationships and school (studies in Canada and Australia) is between 14% and 18%. Only about a third to a quarter of these children are receiving help as the rate of mental ill health outstrips service capacity significantly (Sawyer et al., 2001; Vas et al., 2016; Waddell et al., 2002; Kowalewski et al., 2011). Barriers beyond basic demand and supply include practicalities for families in finding, paying for and getting to services; limits in capacity of parents, schools and doctors in identifying problems and seeking professional assistance for the child; and stigma based problems that is, parents not wishing to be subjected to feelings of shame in accessing help (Owens et al., 2002; Shrader & Reid, 2015).

One further aspect of access barriers is critical to examine in this context. A theme emerged in the study related to processes observed in CAMHS was perceived to be creating impossible organisational barriers to manage internal anxiety. This was suggested to emanate from a sense of being overwhelmed, but not by numbers of children referred but by the depth of the perceived impending emotional impact of working with high levels of trauma and conflict, pain and despair. It may be that even with adequate resourcing to meet demand, such barriers might remain. The work of "intake" itself – that is triaging, gatekeeping, on-referring and managing entry into the service was seen as a challenging role (noting that "intake" rather than "access" as a title implies that people will be accepted or taken in to a service – when in fact this is not always the case). This is understood within the context of access barriers

as described above and is an important focus of the design or enhancement of performance frameworks for CAMHS.

Kets de Vries (2006) indicates that where leaders are not adequately containing anxieties within organisation, strategies can be employed to 'help people deal with anxieties, often at the cost of executing the primary task of the organisation' (p314). If these become embedded into the way an organisation functions rather than a temporary measure, they become part of the culture of the organisation. He and colleagues argue that addressing these organisational matters is best undertaken through skilled external consultants assisting the organisation by utilising clinical and group psychodynamic skills to assist the organisation to examine relationships and functioning at an emotional level (Kilburg, 2004; Kets de Vries, 2006; Long, 2006; Levinson, 2002; Bion, 1970).

Applying this model to CAMHS is undertaken at a local level as found in this study utilising external consultants to assist in creating reflective spaces for reviewing and examining the emotional impact of the work. The broader challenge is to consider how this defensive dynamic has apparently become so pervasively obvious across a range of CAMHS organisations that are independently governed, and how this might best be addressed. This will be discussed further later in the chapter.

(d) Assessment and diagnosis

There was a view that once "in" CAMHS, a child or adolescent received a thorough assessment, and that generally the client and family are understood and can be assisted to make some sense of their situation. The assessment process involving diagnosis was ideologically contested in the study due to perceived variability in the utility of a diagnosis. Furthermore, the social characteristics and complex needs of the child and family were seen as sometimes beyond the capacity of the service to understand and manage. Corrigan (2004) examined the role of psychiatric diagnosis in generating stigma and concluded that psychiatric diagnoses are more stigmatizing than regular health conditions, and that certain psychiatric diagnoses (psychotic disorders) attract more community based social stigma than high prevalence disorders such as anxiety and depression.

According to Hebebrand et al. (2006) “with good reason we have come to expect a solid diagnostic procedure based on standard criteria” (p27). However, the discourse in relation to psychiatric diagnosis in children with mental ill health is conflicted, emotionally charged and has both mystical and pragmatic features (Reiff & Feldman, 2014; Baverstock & Wright, 2015). This complexity should be understood as a feature of the work and grappled with in the sector (Cuthbert & Insel, 2013).

By contrast to social models of understanding, a growing area of research in childhood psychiatric disorders has emerged within pediatrics, which focuses on neuroimaging, molecular genetics and molecular biology (Clarke & Moelsh, 2016). This challenges the current phenomenological approaches to defining disorders and is a relatively new field. It also further emphasizes alternate explanatory models for problems and could create further confusion within the referring and client community. Hutchins and Williams (2014) note that as new mental health diagnoses are developed, they are often accompanied by disputes about the aetiology and genesis of the problems. They add that “medicalisation of child behaviour problems” is particularly prevalent in the USA where, without a diagnosis, treatment is not covered by insurance and where levels of prescribed psychotropic medication for children are dramatically higher than in the UK’ (p32).

The contested nature of diagnostic practice with young children and teenagers in CAMHS is likely to continue and perhaps remain unresolved and therefore should be embraced as a feature of this sector. The contested nature of diagnosis should be accommodated and absolutes should be avoided in any performance framework.

As discussed earlier, CAMHS services have primarily developed within the medical model of service delivery emphasising diagnosis and treatment, rather than within a social services framework (Timmi, 2014). The health paradigm with its medical model of service delivery and social model of understanding problems is that treatment is targeted to relieve symptoms associated with a particular diagnosis, and therefore getting a diagnosis correct is apparently critical to healing.

Based on the findings of this present study, there is a challenge within the current system where services are rightly directed to those who are most vulnerable, severe, complex and ill and with the highest level of functional impairment but where there is inadequate agreement about how such a target group is determined. The diagnostic profile does not assist with identifying this target group as discussed above and it also limits understanding of the contribution of poverty, disadvantage, homelessness, abuse and neglect as both determinants underlying mental illness and also its consequences. Further research is critical in building the evidence base for understanding the relative contributions of social, environmental and individual personal and biological characteristics to the development of mental ill health in children and young people, as well as in clinical models and treatment effectiveness.

(e) Therapeutic engagement

The mode of engagement or perhaps better characterised as the quality of engagement was noted as reported in the findings to be problematic at times, linked to a sense that clinicians somehow shelved or denied their humanity and experience as (for instance) parents when they went about trying to build connection and therapeutic engagement with families. There is a strong tradition in the theory and practice of psychotherapy of the role and critical nature of boundaries between the therapist and the client (Malan, 2001; Knox & Cooper, 2015). Boundaries are seen as critical enablers of the work put in place and held by the therapist and they protect the working space for the client (Hill et al., 2014).

Boundaries can be structural (for example, formality of session times and venues) and interpersonal (such as avoiding touch and therapist self-disclosure). The extent of the application of boundaries, from rigid application to relaxed responses to boundary violations is contested within the literature (Simon, 1992; Zur, 2004; Smith & Patrick, 1995). This finding identifies the need for therapists to be more in touch with their own humanity as they seek to connect helpfully with families and may link with the reduction of an experience of stigma for parents in seeking help for their children and family. This is possible for skilled therapists to convey within clear boundaries of the

therapeutic framework, or at least to engage with individually as they seek to understand the context of the presenting difficulties (Zur, 2004).

In relation to treatment models in CAMHS, there was a finding indicating these have changed over time as would be expected in a modern health context seeking to integrate a growing evidence base into practice. Hoagwood et al. (2001) indicated, however, that the basis for child and adolescent mental health care, regardless of what particular service models are utilized, are not relevant or appropriate if they do not fundamentally reference the developmental context of the child's presentation.

The question this raised for the present study was to what extent the service delivery model at each developmental stage would need to be articulated in order to be appropriately and accurately measured. Further, the question is raised about whether in a performance framework the focus can be effectively on client indicators, outputs and outcomes rather than primarily on the inputs such as what therapeutic model is delivered. This illustrates further tension between the underlying paradigm of the medical model versus an arguably more appropriate paradigm build on the social determinants of mental ill health and their impact on relationships between the therapist, client and family.

This tension should be grappled with, seeking a resolution that suitably references the evidence base for assessment, diagnosis and therapeutic intervention. If the evidence base properly is referenced, on the basis of current understandings both a social and medical paradigm will be equally valid and relevant.

(f) Complex presentations

The characteristics and needs of the child and family were seen as sometimes beyond the capacity of the service to understand and manage and this was reported across several interviews. There was a sense of anxiety conveyed that clinicians would often take an expert view but were not actually experts, grounded in knowledge and current evidence-based practice. This was a particular challenge arising from the data and links both to the definition of

the task and the definition of the target group, but also to the reported sense of inadequacy borne by clinicians and a potential for them to be overwhelmed by the distress conveyed by the clients and their families.

It is as if the sense of inadequacy, which for highly trained professionals is perhaps challenging to bear created conflicted feelings, which were being split off (so that they continue to feel good and helpful and that despite their fear, they were experts). It may also be that these feelings were denied, deflected or projected as blame on to other entities outside the organisation. This might perhaps include (linked with other findings in this study) denigration and alienation of child protection and increased suspicion towards government. As discussed previously, the largely unconscious practice of splitting and projection have been described in the psychodynamic literature as a key defence mechanism people use to manage unbearable anxiety (Malan, 1995; Klein, 1959; Longhofer, 2015).

Halton (1994) indicates that the effect of this kind of splitting could include “denigration, competition, hatred, prejudice and paranoia” (p. 15) and indicates that such a situation needs to be examined and understood, dealing with the issues directly so as to ensure proper functioning of the organisation and appropriate collaborative responses to others. Van den Berg (2014) provides an example of how this was managed in a setting where training was being actively resisted by the staff in a residential group home for children. She confirms that “the resistance related to defences which were developed to protect the staff against the painful feelings they experienced while working with the abandoned children” (p. 2). The model employed was as described by Kets De Vires (2006) above, examining the underlying feelings being expressed through workers but strongly linked to the significant needs of the children being cared for. Recognising and understanding these dynamics is critical to managing and acting on these structural defences. This points to and links with the findings of this study that call for a “good” CAMHS to ensure boundaried space for reflection about the clinical work and impact on clinicians. This matter is explored further later in this chapter where the focus is on the internal culture and the relationship between CAMHS and child protection

(g) Decision making and case review

Decision making and reviewing progress in service delivery and an individual's treatment plan was discussed in terms of the place of power for medical staff and the burden this was seen to create for them in managing risk and decisions, as well as the impact this was observed to have on engagement of other staff such as nurses and allied health clinicians in clinical decision making given the extent of their involvement in care. There have been ranges of empirical health studies linking the team composition to clinical outcomes, and studies in mental health and particularly in CAMHS tend to support models that identify aspects of a care package or role with families and locate these in particular professional team members (Hay et al., 2013; Fothergill et al., 2004; Wright et al., 2016).

This is a standard model in general health care but boundaries between professionals are arguably less rigidly ascribed by differences in clinical practice and the professional disciplinary expertise in mental health. This is due to the broad generalizability of skills such as engagement, mental state assessment and even diagnostic formulation across various clinical professional groups (Ke et al., 2014; Patrick et al., 2011; Carsen et al., 2016). A recent study within CAMHS by Kutash et al. (2014) found programs that delivered "higher performance on structures to facilitate teamwork, informal communication mechanisms among team members, and the ability to integrate family support specialists as equal members of the team showed more positive organizational functioning" (p. 55).

This raises the issue of continuous improvement to support high performing multi-disciplinary teams but also the possibility of inter-disciplinary teams, drawing on professional and non-professional staff such as peer workers (Nancarrow et al., 2013). The findings and literature identify the importance of distributed power or at least shared team engagement in decision-making. This directly challenges the nature of the historical medical leadership role within a CAMHS team. At the same time the findings indicated a desire from parents for a diagnosis or at least advice on what the "experts"

think is going on, coupled with the prevailing community discourse that reifies doctors (Smajor, 2013).

This means that there is likely to be tension and therefore anxiety within teams as they seek to provide care to very troubled and complex children, young people and families. In resolving this at client and family intervention level in CAMHS, a focus must be on clarification of role and function and indeed decision-making power in relation to the assessment outcomes and treatment plan for a client and family (Leigh, 2015). Shared decision-making with clients and families themselves should be at the heart of the work in CAMHS (Edbrooke-Childs et al., 2016; Wolpert et al., 2014; Abrines-Jaume et al., 2016).

(h) Drawing together notions of the primary task of CAMHS

As described in detail in earlier chapters, the primary task of an organization has been identified in the group relations theoretical model as being what it must engage with to endure or "survive" (Rice, 1963). As Roberts (1994) contends, "Where there are problems with the definition of primary task there are likely also to be problems with boundaries…" (p. 35). There is a sensible and logical position that follows, that should the primary task of an organization be understood, the staff will be able to articulate their own roles in the delivery of this and that furthermore performance will be able to be measured (Miller & Rice, 1990).

However, tasks may be defined differently and also enacted differently by those within the organization, or by different sub-systems within the organization such as managers and staff (Hoggett, 2006; Hirschorn, 1992). Hoggett (2006) further argues that despite this deep tradition within group relations theory that a primary task is critical to an organizations survival, in the post-modern era these task descriptions are more about the "dominant definition" of what those in power seek to describe as the role of the organization. In his view this means people within organisations are better served by defining "primary dilemmas" or defining what Obholzer (2003) calls a "contested primary task" (p. 176). Articulating the primary task accurately for

human and health service organizations is therefore in practice particularly challenging and can result in bland or overly broad and therefore meaningless rhetoric such as that an organization's primary task is to treat patients (Roberts, 1994; Menzies Lyth 1979; Hoggett, 2006).

In turning to the definition of task, it seems there are a set of steps in this endeavor, all of which have challenges. Firstly, identifying and defining the task or the task component that has strategic priority; secondly how people within the organization engage themselves with the task; and finally how the fulfilling of the task is measured and managed – the organizational performance (Potter, 2006; Hirschorn, 1999). These steps will be examined in turn with reference to the findings of this study.

As has been discussed, the environmental context for CAMHS service delivery is filled with external demands such as constant policy change and enhancement, and internal expectations to deliver contrasting or competing tasks such as direct clinical care (and what kind of clinical care and to whom), staff training, community support and education, and research. The challenge of articulating a single primary task for CAMHS has been brought into sharp relief in this study. This dilemma and the related anxiety that one might somehow choose an erroneous task or task emphasis was named by Hirschorn (1999) as "primary risk". Further, there is risk in the changing theoretical and environmental context within which public health care is delivered. An example in CAMHS is the clinical endeavor where in past the theoretical underpinning and focus was a psychodynamic model and individual therapeutic "talking" therapy with the child (Cottrell & Kraam, 2005; Sharman, 2004; Forman, 2016). Through the inclusion of system family based models, group therapy models, improved medical management of certain conditions, an enhanced legal framework for delivery of compulsory mental health treatment, the growth of consumer and carer advocacy and the introduction of case management technology, the clinical endeavor is in evolution and constant change (Bearsley-Smith et al., 2008). The conflict this is likely to produce internally as clinicians are required to enhance and modify or change practice is also likely to produce high levels of anxiety.

External drivers such as the requirement to improve productivity (that is to see more clients for less time without further resources), to improve quality of care (that is, an adequate dose of treatment to effect change) or to improve accountability (that is, translated as transparent public accounting of funding and outputs) have the potential to escalate anxiety and tension in defining and prioritizing efforts (Saxena et al., 2007; Knitzer, 1993; Plsek & Greenhalg, 2001). The findings underlined the effect of this tension in the perspectives of CAMHS leaders and managers for whom navigating the interface between the internal and external drivers was the focus of their roles (Reynolds & Thornicroft, 1999). Baker (2001) contends that this challenge lies at the heart of a problem in attracting managers into the health system.

Reductionist thinking to resolve complexities in health care is a natural response for leaders “in essence to break down the ambiguity, resolve any paradox, achieve more certainty and agreement” according to Plsek and Greenhalg (2001, p. 620). This kind of reductionist thinking was observed through the data and findings where many of the solutions to the challenges or explanations thereof were uni-dimensional (for instance that problems resided in Child Protection or as a result of government resourcing).

Plsek and Greenhalg (2001) call for a systemic approach that recognizes and tolerates contradiction and not knowing. In systems psychodynamic terms this would be where leaders hold the inherent anxiety and work with it in their endeavors to identify the strategic direction, taking into account the policy and political context of the work. This position would then call for a description of a primary task that properly acknowledges the complexity of the context with internal and external demands and competing agendas, but also sufficiently descriptive to be meaningful to internal and external stakeholders, parents service users and importantly the clients of CAMHS.

The findings in this study would support a task description of CAMHS primary task as follows: ***a public mental health service co-creating a safe place and space to develop a shared understanding of the most troubled children, adolescents and their families, and then to foster growth***

through care, reflection and lifting the burden of blame and shame. This definition acknowledges the public service nature of the CAMHS. The phrase "co-creating…" underlines that this is as being shared endeavor, although the term co-creation is one more routinely used in business and marketing fields where the focus is very much on the customer (Prahalad & Ramaswamy, 2004; Grönroos, 2011).

The phrase "a safe place and space" acknowledges the ethical and moral imperative for mental health care to be provided in a way that does not harm or damage those involved. It also defines both a place or physical location, and a space, denoting a bounded psychological area for review, reflection, and interpersonal engagement (Gabbard, 2014).

The next phrase seeks to underline the need for "shared understanding" and implies a collaborative endeavor in problem definition and service delivery focus, linking to the reported challenges and complexity of providing, receiving and working within a psychiatric diagnosis in CAMHS settings – ensuring that the broad knowledge, experience and perspective represented by those involved is privileged.

The target groups is then referenced and defined as "the most troubled children, adolescents and their families", as comprehensively reported as the focus for CAMHS targeting services denoting specifically those in most relative need. The description proposed uses the word "troubled" as opposed to disturbed, mentally ill or unwell or sick instead referencing a more socially moderate and less stigmatizing paradigm (Corrigan et al., 2012; Corrigan et al., 2014; Hinshaw, 2005) and furthermore, in keeping with the findings. The final phrase describes the intent or outcome sought from the engagement in broad terms as growth, not specifying the child or even the family but implying growth across all involved. This links to the underlying developmental paradigm reported in the findings and underpinned by the literature review described earlier.

The tools for change are described as "care, reflection and lifting the burden of blame and shame" and directly reflect the findings and role described for clinicians by them and consumer and parent participants. It should be noted

that there is no mention here of therapy, pharmacotherapy and case management – phrases generally used in the discourse describing service provided. This includes the language used by participants in this study. However these terms have also not been used here in preference for more widely understood lay terms, because these are more broadly understood and make the discourse more accessible for service users and stakeholders.

What could be described as jargon terms are primarily understood by CAMHS service providers only but have been reported to confuse and alienate clients and families and other providers at times (Kazdin & Cole, 1981; Timimi, 2014). This was echoed in the findings of this study particularly in descriptions of the interface conflcts between CAMHS and Child Protection.

How clinicians within a CAMHS engage themselves with the task once described is a further challenge. In articulating and arguing elements of a primary task description for CAMHS, there is a risk the result could be too broad and rigid and therefore ineffective in meeting the function of creating a shared agenda, creating a boundary and purpose, and enlisting engagement. This is particularly so where the very broadness results in the task being further interpreted or defined differently by individual organizational citizens, or specific groups within the system including external groups of stakeholders (Gould et al., 2006). Miller & Rice (1967) indicate that “if through inadequate appraisal of internal resources and external forces, the leaders of an enterprise define the primary task in inappropriate ways or the members, leaders and followers alike do not agree on the definition, the survival of the enterprise is jeopardized” (p. 27).

The findings of this study have illuminated a range of dilemmas related to the task definition of a CAMHS including where the statewide policy agenda and local engagement and then enactment of the task are in tension, as well as conflicted messages within the policy (see more people and get better outcomes and do this with diminishing resources). This was reported to lead to friction in the relative prioritizing of activities seen to contribute to delivery. The tension created, and anxiety associated with such conflict was reported by past

clinicians in this study as having contributed to their decision exit from the CAMHS service system.

Engaging staff, clients and others (government, providers, stakeholders) in this umbrella description is likely to be straightforward given its breadth and use of generally understood terms. This step creates the opportunity for each service to identify in real terms what the task means for them and how it will be undertaken and to grapple directly with what anxieties and challenges may be evoked through the primary task of providing healing care to children and families suffering mental ill health? Potter (2006) warns following his study of an organisation's internal and ultimately destructive struggle with choosing between options to finalise an agreed strategic primary task definition that the "dilemma was effectively pushed down into the organization as managers and staff felt required to demonstrate their value against strategic criteria linked to one task-idea in an organization created around another" (p.64).

Finally in relation to the discussion of the CAMHS primary task and the focus of the study on a performance framework, the following action is required within CAMHS. As discussed earlier, once clear on task, setting performance measures against the task reinforces that task and provides a framework for feedback on achievement and marking progress towards the achieving the task (Rantanen et al., 2007; Chan, 2004). The findings of this study pointed to a number of measures of both output such as waitlists and waiting times, efficiency and resource management and outcome such as healing, getting better, getting discharged and symptom resolution. An examination of actual performance measures was not the focus of the study, but must certainly form part of the framework proposed.

9.2.5 Internal Organizational Structure

This section is set apart in order to identify what has emerged in the findings in relation to the generation, containment and management of anxiety of clients and families, within CAMHS and with related services and the government. How understanding this assists with setting a performance framework is then explored in the following section.

(a) The impact of anxiety

According to the findings CAMHS clinicians or the organisation as a whole seem to unnecessarily complicate practices of access, diagnosis and treatment. This was suggested by several participants to be about containing, avoiding or managing overwhelming anxiety. The experience of anxiety is described as unbearable and can be both unconsciously and consciously generated in individuals and in groups. As described by Hart (2014) “Defensiveness theories view humans as motivated to maintain psychological resources (e.g. self-esteem, meaning) to counteract anxiety, confer equanimity, and allow people to function without lapsing into psychological disarray” (p20).

Anxiety at various levels (experienced by individuals, within face to face teams, and across and between organizations) can generate in people defence mechanisms aimed to reduce the negative and painful experience of anxiety (Malan, 1963; Rice & Hoffman, 2014; Holloway, 2014). Defenses that are generated within a group in response to anxiety are known as social defences following research by Jacques (1952) and Menzies (1960) into social systems and how they are used as a defense against anxiety. These studies have shown how organizations develop mechanisms to defend against the anxiety inherent in the system, noting that such mechanisms can become structures embedded in the organizational function itself – which can become rigid and inflexible (Fraher, 2004; Vince & Broussine, 1996).

Examples from the findings include examples where CAMHS have comprehensively set up complicated rules and apparent obstacles for access to the service, spending more time than necessary undertaking assessments and over-emphasising diagnosis. The findings would suggest that in the CAMHS workplace a raft of anxieties accompany the actual primary task of the organization (that is, providing mental health care to vulnerable children and young people at considerable developmental and personal risk) and this echoes the research of Menzies (1959) who described defensive techniques within a health care organisation related directly to the primary task. Menzies’ study is “a reference point for most psychoanalytically oriented work in health care organisations” (Hinshelwood & Skogstad, 2002 p5).

In addition, the features of the client group itself discussed earlier as part of the findings may themselves evoke anxiety, features such as hostile behaviour or extreme expressed distress (Russell & Snyder 1963; Obholzer & Roberts, 1994). Clients and their families were reported in the findings to present with multiple difficulties and were described as complex with such complexity noted both in the identified client and more broadly in the family or caring system around the client. This included where the adults involved may themselves have significant mental health problems.

In examining responses to anxiety, the underpinning psychodynamic theoretical background is reviewed here. Bion's (1967) theory of containment was described earlier as having originated from psychodynamic notion that the infant projects into its mother distressing feelings which she then contains by feeling the emotion but not responding. Instead she gives it back to the infant in a form that can be borne and integrated into his/her emotional world. He described containment as the process by which difficult feelings can be understood and endured (Bion, 1967; James, 1984).

Congruent with this notion Winnicott (1987) introduced the concept of a mother's role in creating a holding environment. Holding environments have been helpfully applied and defined in organisational terms by Van Buskirk and McGrath (1999) as "interpersonal or group-based relationships that enable self-reliant workers to manage situations that trigger potentially debilitating anxiety" (p. 805). In Kasinski's (2003) examination of school based learning environments applying this notion, "the quality of the holding environment for staff is the main determinant of the quality of the holding environment that they can provide for children" and noted that a key aspect of this was to seek to meet the professional needs of staff (p. 64).

The findings describe the task of the leaders within the organization as being challenged to contain, using Bion's (1967) term, the clinical teams who are at the frontline of experiencing, bearing and holding this anxiety (Linklater & Kellner, 2008; Hinshelwood & Skogstad, 2002; Long, 2006). This is likely to be in itself highly demanding and anxiety provoking and this notion emerged in the findings particularly in relation to introducing and managing change and in

clinically managing risk in adolescent patients. Obholzer (1994) argues that being aware of the nature of these anxieties is critical to managing staff and resources, and warns that not grappling with them risks “wear and tear on both human and physical resources” (p.169).

Menzies (1989) work on social anxiety identified possible ways organisations act, often unconsciously to contain anxiety through various defences (see Chapter Three). Turning this around, others have sought to apply this learning to assist organisations to manage the potential impact of uncontained anxiety. For example, O’Neill (2014) applied the theory to a university context finding that the “success and indeed well-being of the modern university is intimately connected to techniques used to contain anxiety. Confronting anxiety materially, discursively and symbolically involves addressing issues of governance and well-being through providing opportunities for more dialogue and spaciousness” (p. 3).

The findings of the present study indicated that to deliver quality clinical work with integrity requires attention to the development and maintenance of a reflective space for clinicians. This is achieved by prioritising and actively building a culture where people are expected to make the time to participate. They are supported to do so through being given whatever resources are required for them to engage in supervision sessions (Mawson, 1994; Halton, 1994). Furthermore, the findings underlined the need to create a strong culture of boundaries is powerful for the work and impacts directly on sound therapeutic outcomes as does managing carefully the expectations of all involved – the client, parents, referrers, managers. These findings are consistent with the systems psychodynamic perspective articulated above which focuses action on containing and managing overwhelming anxiety using typologies and descriptions to give language and meaning to what can be very primitive emotional experiences (Obholzer, 1994; French & Vince, 1999; Bion, 1985; Allcorn, 2015).

There was a view expressed in several interviews in that where personally challenging situations (such as a client completing suicide) are not subjected to team review and professional reflection, the longer-term impact

both for clinicians and for future service delivery can be negative. Ting et al. (2011) indicate that such an event has been shown to be one of the most significant stressful situations for a mental health professional adding to experiences of failure and inadequacy. Where this experience is shared in a team the challenges are compounded and the risk of the related anxieties driving defensive responses is increased (Leiper, 1994; Long 2016).

In synthesising the findings, CAMHS was seen to be working well when there was an integrated multi-theoretical perspective, wisdom in leadership, accessibility, and collaborative capacity. This was particularly voiced by a study participant with an extensive child protection background as was the desire expressed that services seek to share meaning, share understanding, share culture, and build congruence around respectful relationships with external interfaces.

Communications of the European society for child and adolescent psychiatry, in describing the Irish Department of Health's Vision for Change (2006) have identified an ideal CAMHS multidisciplinary team as follows: a "consultant child and adolescent psychiatrist, a doctor in training, two psychiatric nurses, two clinical psychologists, two social workers, one occupational therapist, one speech and language therapist and one child care worker" (p.387). Teams are more and more including people with lived experience of mental illness or service users as paid participants in the direct delivery of care (Bland et al., 2007; Farhall, 2007; Corrigan et al., 2000). Kutash et al. (2014) have studied and reported the positive impact of the introduction of these roles on client outcomes.

Whilst identifying and examining relative contributions of specific disciplines was not the focus of this study, the findings articulated comprehensively by the consumer participant as well as past clinicians described the desire for shared power in decision-making across clinical disciplines, with young people, with their families and with other services. This relied, according to the findings on a sound team model where people perform, and do what they are supposed to do and this in turn relied on a good consultant psychiatrist and a good manager and a sound trusting relationship between

them so that without seeing every patient or talking to all staff members. That is, if something happens, the back up is there.

Leadership becomes challenging in this context, and the findings indicated that leading in CAMHS presented particular challenges, especially where established processes or assumptions about the expertise of team members was directly confronted. This was further complicated by the operational requirements for ensuring compliance in reporting and documentation, access and responsiveness and other organisational processes. Schein (1985) advocates for leadership that "manipulates the culture when organisational performance lags" (p317). The leadership role is to manage the boundaries that clearly identify the group and to keep the group focused on the primary task (Chreim et al., 2003; Oldenholf et al., 2016 Tyson, 1998; Vaill 1998).

The findings of the present research indicate that at a broad system level there may not be a functional "work group" model reliably operating in CAMHS. That is, in terms of the psychodynamic model a productive group where all participants understand and are engaged with the primary task of the group "because they have taken full cognizance of its purpose" (Tyson, 1998 p. 31). Groups where functioning is compromised by distraction from the purpose and primary task include three key basic assumptions observed and first described by Bion (1985).

Groups behaving in potentially destructive ways respond by utilising dependency, fight-flight and pairing mechanisms where members respectively behave in immature dependent ways, are hostile to one another, or seek to focus on two members who have connected to each other (Tyson, 1998; Vaill 1998; Obholzer & Robert, 1994; Hirschhorn, 1990). When in basic assumption mode, all members think they are acting rationally making it hard to confront and surface the basic assumptions. This would be the experience described in the findings of the external stakeholders, where their experience of the CAMHS service was of a shared resistance to feedback messages or attempts to connection in genuine collaborative relationships across boundaries. This was seen as a lack of mutual respect by CAMHS of external providers. The theory

would indicate that where a group can understand and achieve insight into such processes they are subject to the assumption that this insight automatically leads to change (Hirschhorn, 1990; Borwick, 2006).

Furthermore, the group or team is understood to hold unconscious processes in tension. The findings indicate that processes were noted within CAMHS teams such as colluding in disrespect for the work of outside agencies, creating an impression of the “impenetrable” nature of CAMHS, working angrily together to resist leadership and apparently working together to avoid particular tasks. It was reported that a feature of staff culture in CAMHS included the idea that as a group they had a tendency to respond to leadership and management activity as passive recipients or victims of organisationally based attacks. These processes can be one way to avoid the task and can make the teams “unproductive because group members are living in a dream” (Hirschhorn, 1990 p. 59). As has been indicated previously this is all undertaken to avoid the task which itself may be anxiety provoking or unbearable in other ways, or may be perceived as less important than the conflict or unconscious needs in the group (Tyson, 1998; Hirschhorn, 1990)

Moving to a complementary perspective to further understand the dynamics at play Newton, Long and Sievers (2006) examined the notion that role is the link between the individual and the organization. Roles are therefore critical to be understood and the interplay between role, the individual and the organization of huge importance in hypothesising about and understanding internal group functioning. Change involves the triangle of the role (rules and processes), the individual (character) and the system/organisation (Borwick 2006). The findings on the clinical role included a general theme of satisfaction of a job well done and a sense of having contributed to positive client outcomes. Despite this, there were personally confronting and difficult components of the work reported by clinicians, with high stress levels reported as well as a sense of feeling overwhelmed by client need and being unable to respond. The impact of the sense of immobilization in the face of overwhelming demand and anxiety may have been the trigger for the basic assumption behaviour described above.

The internal dynamics of the CAMHS were found to be laden with anxiety, risk and leadership challenges as well as opportunities for creating reflective spaces to examine and understand what underlies group behaviour and detracts from the primary task. In terms of the performance framework envisaged as a result of this research it has been critical to become alert to the management of anxiety and possible defensive structures and behaviours that have been observed and reported.

Discourse and debate about the basic structural elements “such as caseloads, resources, client outcomes are frequent, often intense and usually left unresolved” (Eager et al., 2005 p. 8). It is the view of the author that the reason these issues are left unresolved is that attempts to examine and resolve them creates overwhelming anxiety and staff groups choose a more defensive pathway without strong leadership and containment. There is a wider imperative for policy makers and government to assist through definition of the primary task and examination of the cultural dynamics inherent in the delivery of services. Walsh et al. (2016) indicate that psychodynamic theories are an important lens through which to examine “discontinuities in policy-making and the containment of anxiety in organizations” (p. 504).

9.2.6 The interface between CAMHS and other services

This set of findings focus on the interrelationship between CAMHS and other services. CAMHS clinicians did not always take a positive view of the contribution of other services and in fact were experienced as having very strong and negatively dismissive views of certain services such as adult mental health, schools and child protection. These services were not seen to have a good understanding of mental health issues in children and this resulted in a lack of mutual respect and poor connections between CAMHS and other providers. Dynamics of the relationship between CAMHS and child protection was found to be particularly conflicted and there was an element in this mutual frustration of not being understood, supported and assisted in what was difficult work in either setting. This was linked to the apparent lack of knowledge in CAMHS generally in relation to trauma, and offenders, and also seen to be the

cause of system anxiety. Despite this CAMHS was also seen as having real expertise to deliver clinical mental health services.

Dynamics of the relationship between CAMHS and child protection had particular universality and intensity in the findings and for that reason alone deserves significant attention. However there is also a practical imperative to examine this interface given the overlap in service need across the CAMHS and child protection domains (Beecham & Sinclair, 2007; Ford et al., 2007; Timini, 2014; White & Featherstone, 2005). In a study of children involved with child protection services in the UK it was found that they were at high risk of developing or already displaying mental health problems – especially those placed in out of home care (Leslie, 2005). Given the extent of client need facing both service systems, it is critical for these services to seek collaborative solutions to the apparently endemic issue of animosity and defensiveness between the service systems (Salmon, 2004; Holland et al., 2005; Smith et al., 2015).

Allcorn (2015) identifies splitting as an unconscious defensive maneuver in organizations where people assert a polarized view that we are good and they are bad and links it to the experience of feeling under threat. “We may feel attacked and victimized by another individual or group who is naturally experienced as bad. The world can easily become black and white with no middle ground” (Allcorn, 2015 p. 185). Widmark et al. (2016) studied collaboration across schools, social and health services finding that such collaboration is present when dealing with complex needs of children and also that these relationships were at times positive but were more likely characterized by “distrust, unavailability, and uncommunicativeness… adverse attitudes and low expectations’ and with rigid and impenetrable boundaries” (p. 50).

Cooper et al. (2016, p. 236) identified factors that were most likely to strengthen collaboration and these included “good interagency communication, joint trainings, good understandings across agencies, mutual valuing across agencies, senior management support, protocols on interagency collaboration and a named link person”. This was supported by Widmark et al. (2006) who

advised that productive communication was critical to collaboration. It is the author's view that these proposed actions, whilst positive and certainly likely to develop local relationships, do not deal with an underlying broadly shared problematic discourse across CAMHS and child protection services. The feelings described and experienced internally towards and by CAMHS clinicians are strong, primitive and somewhat absolute. These two services were seen to be consumed by their intensity and passion about the other and described in the findings as hating each other. These were likely defensive responses as previously discussed but nonetheless appeared to be negatively impacting on client access (such as where child protection referrals were treated through a policy requirement as needing additional filters prior to accessing assessment). Collaborative care and a shared focus on client needs were impacted with examples of conflict observed and reported by the consumer informant.

For intergroup collaboration to occur Farmer (2015) argues based on the theory developed by Miller & Rice (1990) that each organisation needs to have a strong sense of their own identity. This is linked to earlier discussion of boundary and task clarity (Tyson, 1997; Obholzer & Roberts, 1994). It is also instructive in relation to the Victorian policy situation where the child protection system has been in constant development including regular legislative change, and has become increasingly complex with service components increasingly being devolved to non-government agencies (Lonne et al., 2015; Scott et al., 2016). At the same time CAMHS has been under pressure to develop services that are agile, accessible and responsive, and efficient in terms of "throughput" (Naughton et al., 2017; Kahn & Francis, 2015). These are destabilising factors that create internal dissonance about what the service is here to do (again, the primary task).

As discussed in Chapter Four, Long and Harding (2012) describe three stages to developing collaboration starting with the defining of each agency's boundaries consistent with Farmer (2015), then moving to a focus on developing shared primary goals and eventually action in working together to achieve these collaborative goals. It is the second of these phases in which

action should now occur in policy terms within the Victorian system and relies on action to develop a shared goal for collaboration across the two service sectors. There should not be any doubt that this is needed. Cocker & Scott (2006) articulate a comprehensive argument based on clinical prevalence data in the UK for why it is critical that attention is given to this group of clients in state care. They indicate that there is clear evidence that children in out of home care are significantly more likely to suffer from mental disorders and that the experience of out of home care can negatively impact further on the developmental and educational trajectory.

The “Roadmap for Reform” (Roadmap) released in 2016 (the Victoria Government policy statement for developing children’s and families services) identifies that “research has consistently found that children exposed to family violence have higher levels of emotional and behavioural problems – compared to children who have not been exposed to family violence” (p. 3). Generally such plans are focussed on improving access to mental health services for the adult parents in the scenario, so it is notable that this plan recognises the mental health needs of the children themselves. As an aside, this plan also strengthens a commitment to utilising the platform of schools to promote access to mental health assessments via a doctors-in-schools program.

Most notable in the Roadmap implementation documentation is that the Ministerial Advisory Committee set up to oversee the changes flagged in the Roadmap did not when initiated include one child mental health specialist. From the top down the disconnection between mental health services and child support services is starkly represented in this example. Collaboration of the kind that would create dialogue and work with the almost institutionalised social defence structures will need leadership at all levels particularly as the polarised views are apparently so entrenched and the distance between the service systems very large. The challenges ahead are significant. Devanney and Wistow (2013) reviewed the partnership and collaborative work of the UK Children’s Trusts and found that “when accompanied by the acknowledged difficulties in embedding partnership cultures and the program of austerity in

public services…there is an increasingly challenging environment for establishing effective joint working" (p. 75).

CAMHS was invariably seen in the findings of the research as having real expertise to deliver clinical mental health services and that getting the access/entry function right would be the single most critical performance metric and where the most change was required. This focus on an action that accesses more services is often the default outcome of reviews of CAMHS. Cocker and Scott (2006) indicate that whilst more psychiatrists and psychologists would be always be welcome, this is not enough for children with complex needs whose problems span many spheres of their lives such as school and peer relationships, physical ill health and educational progress. They lament that research is yet to definitively deliver an understanding about what does work and what is needed for these children in terms of mental health care. However, there are also studies of clinical wisdom and depth on this complex client group such as that by Australian clinicians Amos, Segal and Cantor (2015) studying intergenerational abuse and neglect and models of therapy for mothers and children that perhaps need more exposure and joint engagement across the clinical and child protection sectors.

It would be fair to say that in terms of adult mental health services, schools and primary health care providers the boundary interplay with CAMHS is clearer and roles are more defined – perhaps because children involved in these services may have less complicated presentations. Collaboration is less fraught and problematic yielding better opportunities for integrated care. Bradley et al. (2008) in a study on the interface between CAMHS and primary care calls for strong and effective links and identifies that waiting lists at CAMHS frustrate GPs but that this could be managed by better training and support from CAMHS for GPs to manage child and family problems themselves.

9.2.7 Indicators of good performance

This section summarises what has previously been described as the indicators of good performance, what the CAMHS professional's view of these were based on the findings and then introduces options for future development.

In terms of performance indicators against which “good performance” could be identified, current data reporting for mental health care in Victoria covers more than 90 clinical indicators which are openly reported on a publicly accessible web site (DHHS, 2016). It should be noted, as discussed earlier that services are also required to report against financial and other indicators.

Clinical indicators include activity (occupancy of beds, volume of throughput, community service hours delivered); access to services and responsiveness (percentage of new clients, triage response times, waiting times in emergency departments for a mental health beds, lengths of stay); quality of care (lengths of stay, 28 day readmission rates); client outcomes; continuity of care (pre-and post discharge contacts); and safety for patients (seclusion rates, mechanical, and physical restraint rates). These performance indicators relate to aspects of flow and throughput rather than quality, safety or effectiveness and actual targets (by which so-called “good” performance might be identified) are set in a handful of these measures (Furber & Segal, 2012). Recently the Victorian government produced the first Annual Mental Health Report tabled in Parliament and accessible on-line (DHHS, 2016).

Themes in the findings related to performance in CAMHS was notably not related to the details of data and clinical indicators but more to accessing services, capacity to deliver appropriate and timely care, people’s experience of the service at a subjective level, and client outcomes. There was a view expressed that data gathering and other administrative tasks were a burden and somewhat irrelevant – almost as stark as that they were obligations that came with the job but were essentially meaningless. Informed by the findings of this research, the primary task of CAMHS is here described as a public mental health service creating a safe place to develop a shared understanding of the most troubled children and their families, and to foster growth through caring, reflecting and lifting the burden of blame and shame.

Access for those who most need the service at the time they need it was seen as critical. Building hope was a key element in good CAMHS service delivery in the findings and this was grounded in working with clients and families to make sense of the past, engage with the present and build a vision

of the future. CAMHS was seen to be working well when there is an integrated multi-theoretical perspective, wisdom in leadership, accessibility, and collaborative capacity. This included shared power in decision making across a team, with young people and their families and with other services.

The outcome measurement suite utilised in Australia is notionally or theoretically supported by CAMHS clinicians. However, as discussed in Chapter Three and again earlier in this present chapter, the suite is focussed on symptom relief only and is therefore not seen by clinicians according to Garland (2013) to have clinical utility. This was confirmed in the findings where outcome measures were referred to an administrative burden rather than a clinical tool that assists in shared decision-making and team-work. Lambert et al. (1998) indicated two decades ago that "mental health clinics and managed care organizations assess treatment effectiveness with consumer satisfaction measures and ad hoc measures of improvement obtained from a single informant" (p. 270).

Since that time the outcome measurement literature for CAMHS has expanded as researchers and clinicians have sought to demonstrate the effectiveness of treatment models and service offerings. For example Mason, Chmelka and Thompson (2012) found in a study utilising the "Strengths and Difficulties Questionnaire" (which is part of the outcome measurement suite in Australia) that it has utility as a pre-and post measure to determine outcomes or treatment in a context where time is at a premium and brevity is required. Overall the outcomes literature is comprehensive but not absolute or conclusive and perhaps patchy on the effectiveness of particular interventions (Cocker & Scott, 2006; James et al., 2015; Fuggle et al., 2015; Boyce et al., 2014).

In terms of what might be a way forward with performance indicators, Rosenberg (2012) raises the prospect that the "voice of consumers and carers is the key performance measure absent from our reporting system" (p. 47). This might involve consumer and carer satisfaction measures, which have been shown to yield results somewhat incongruent with outcome measures (Manary et al., 2013). In the case of children and adolescents they would need to be

targeted and developmentally appropriate and accessible measures (Wolpert et al., 2014).

Satisfaction is more likely related to process and experience not necessarily just related to clinical outcome although a future focus will likely be on what measures are most meaningful to the client themselves – satisfaction, experience, symptom resolution or even lifestyle outcomes such as being in stable housing or having a partner (Hall et al., 2014; Thornicroft & Slade, 2014). In a personal communication with the author a service user once noted when asked what do they most want answered “someone to love, somewhere to live and something to do”. Noting earlier discussion in this chapter about the challenge in agreeing on goals for therapy between parents, therapists and child it would be important that progress against goals be informed by clients and families themselves rather than only based on observation and clinical assessment by clinicians.

9.3 Implications for a CAMHS Performance Framework

In this section the implications of the matters raised through discussion for a CAMHS performance framework are examined, concluding with a proposed performance framework building on this findings of the current study.

Over the past 30 years the Australian public sector along with other western countries has adopted new public management models which were introduced to comprehensively address cost-effective productivity, accountability (Parker & Bradley, 2000; Dixon et al., 1996). New public management also had a focus on the customer and as the community/consumer oriented discourse drove accountability with the idea of

value-for-money the public sector has developed measures within frameworks across centralised and decentralised functional areas (Bryson et al., 2014; Thomas, 2013; Andrews & Van de Walle, 2013). Furthermore, Smith et al. (2012) argue that in this context “leadership and governance comprising three fundamental functions [is needed]: priority setting, performance monitoring and accountability arrangements” (p. 39). Davies et al. (2000) add that organizational culture in health care affects performance and leadership is therefore critical to supporting a positive culture.

There are a range of challenges described in the literature on public sector performance measurement largely emanating from inadequate description of the organisations themselves, their function and primary task, the governance and structural features, the impact of measurement systems on the focus of services away from care to data, and the strategic context within which they sit (Miller, 2002; Pidd, 2005; Bryson et al., 2014). Challenges have emerged as an effect of the focus on efficiency and price, where the value of the public sector being freed from the profit agenda has a very real value but in the performance metrics is not recognised (Van Dooren et al., 2013; Andrews & Van de Walle, 2013). Health performance frameworks and their efficacy have been discussed at length in Chapter Two.

It is argued by Furber and Segal (2012) that the current performance indicators for Australian CAMHS (readmission rates, service access metrics) relate to aspects of flow and throughput rather than quality, safety or effectiveness. As a result they suggest that health economic capacity in CAMHS services should be developed to enhance understanding of the links between cost, price and treatment delivered as well as outcomes to underpin opportunities to advocate for funding and expansion of services. It is the view of the author that this would also assist CAMHS in defining and articulating role and primary task, and strengthen explanatory models of service delivery.

Furthermore, Cowling et al. (2009) and Brann, Coleman and Luk (2001) insist that performance frameworks cannot be robust without some form of client satisfaction measures which link to supporting client choice. In their work on performance indicators for mental health services in Australia Eager,

Burgess and Buckingham (2003) pull the threads articulated above together and argue that what is needed is a comprehensive measurement framework that helps shift the focus from expenditure to value for money.

How this drive for performance and accountability sits alongside the impact on individuals of the objectification of service metrics remains a concern for Hoggett (2010). He warns that public sector organisations have stepped away from enhancing and developing their services to focus on survival and measurement thereby directly impacting on the values systems of organisations and engagement of staff. O'Neill (2014) concurs extending this idea and postulating that measurement is actually a defensive technique to reduce organisational anxiety but that it has the opposite effect by driving accountability but also disconnection and denial. The implications here and through the findings for the development of a performance framework are that it should have a sufficient value base, meaning and clinical relevance to engage staff.

The Federal Government has committed to leading the development and dissemination of consumer oriented performance measurement strategies including data collection technologies (Commonwealth Government, 2015). It is the view of the author that whilst this may set an appropriate framework for the engagement and delivery of the emerging consumer/community focussed paradigm for measuring organisational performance there is routinely a lag for child and youth services benefitting from such policy work. The secondary step that must be taken to ensure relevance is design by adapting such policy changes to meet the developmental and cultural context of children, adolescents and families is at best slowly attended to once the adult frameworks are reliably set in place. To adapt measures that are respectfully accessible for children and adolescents is a critical step and relies on understanding the developmental context and more and more on the use of modern technology.

In terms of setting performance metrics that address collaborative efforts, the most useful guide was identified in a Finnish study by Kanste et al. (2016) who identified a sub-set of activities grouped them together to define

collaborative management – these are “increasing awareness of services, organizing agreed collaboration practices, overcoming barriers to collaboration, managing difficult relationships, and contributing purposively to the functionality of collaboration” (p. 61).

This management process implies active and systematic engagement with the challenge of collaboration consistent with Long and Harding (2012). They describe three stages to developing collaboration: pre-collaboration (group members primarily located in the agendas and dynamics of their “home group”, stressing the limits of their own resources); transitional (most parties convinced of and committed to the collaborative group's primary task and begin taking up roles towards its purpose); and finally collaboration (all parties committed to and collectively engaged with the purpose and tasks of the group, and working together to achieve outcomes). Strategically and systematically addressing what has been described through the findings of this study as structurally embedded impediments to collaboration between CAMHS and key stakeholders must be directly addressed in a performance framework.

A note of warning is chimed by Glisson and Hemmelgarn (1998) whose research found that “organizational climate … is the primary predictor of positive service outcome (the children’s improved social functioning) and a significant predictor of service quality. In contrast, inter-organisational coordination has a negative effect on service quality and no effect on outcomes” (p. 401). They argued for renewed focus on the internal climate rather than expend what amounted to misplaced effort in encouraging collaboration across service boundaries. Where resources are best placed to yield outcomes for children and families is at the heart of this study and any performance framework must enable to services to make considered judgments in this respect.

9.4 Summary

This chapter has examined the findings comprehensively through the lens provided by the literature and postulated on the many possible implications for CAMHS leaders, clinicians and government policy makers. In Chapter 10

these are gathered into a set of recommendations for a CAMHS performance framework.

However, before moving to the recommendations the following points are highlighted as key challenges for CAMHS arising from the discussion. Firstly, for clinicians in CAMHS, grappling with anxiety as part of the clinical role and organisational belonging contributed to the erection and maintenance of structural and interpersonal barriers to accessing and working with CAMHS. Secondly, clinicians were reported to collude to avoid tasks, resist change and unnecessarily complicate practices of access, diagnosis and treatment. It is suggested that these behaviours result from attempts to contain, avoid or manage overwhelming anxiety. Thirdly, those standing outside CAMHS as clients, referrers, or potential collaborators had high expectations (both conscious and unconscious) of what being involved with CAMHS might mean for them, and were often disappointed.

Understanding and managing these expectations could build engagement and is likely to change the nature of the way CAMHS clinicians engage with those with whom they work and partner. Lastly, for Child Protection, this disappointment appeared to have become an institutionalised conflict, with CAMHS taking an expert position and risking denigrating this and other critical service systems for children.

Chapter 10 Recommendations, limitations and conclusions

10.1 Recommendations - towards a performance framework for CAMHS

What follows below constitutes recommendations for a CAMHS performance framework and includes implementation enablers noting that some factors are already being addressed and some structures are already in place. The performance elements and enablers below have emerged from the synthesis of findings examined through the discussion above and acknowledge work already underway.

There are seven specific recommendations:

10.1.1 Policy scaffolding and robust detailed implementation planning.

There is a substantial and legitimate role for government in planning, oversight, target setting and monitoring of services. Ham (2015) calls it a “proper role” and advises that government capability in Victoria will need to improve to do this role justice (p. 8). The relationship dynamics between different CAMHS services and government (policy setting, funding and performance monitoring) were examined in this research and will need revision to support more robust application of a performance framework.

Building on current strategic intent described by different levels of government and encapsulated in local service design is critical to ensure cohesion in a shared vision for service delivery. Often the policy frameworks create an important guide but risk being adult and individual focused (rather than children and families) and can be too broad to create clarity for authentic implementation at a service level.

This study found that the policy setting for CAMHS, within the much more substantially resourced adult services and the broader acute hospital system may elicit anxiety and confusion in the CAMHS clinical teams. The inherent tension in the dilemmas described in the findings will need to be grappled with and resolved at policy level sufficiently to provide clear direction

for services and clinicians. These dilemmas include an individual focus versus family or system focus; relying on a medical or illness model versus social models of mental health; child oriented versus adult oriented care models; community based versus acute hospital bed based; taking an all-knowing position versus positioning for learning and new knowledge; investing in clinical engagement vs. paper work and documentation. It is the contention of the author that the unresolved tension in these dilemmas creates conscious and unconscious anxiety within the CAMHS.

A performance framework for health services including a CAMHS service should address these tensions directly. It should be grounded in evidence based policy and strategy, solid service design, robust implementation planning, clear target development and communication, resourcing, contracting, consolidating, feedback systems, compliance with legislation, compliance with standards, funding and service agreements, targets and indicators for outputs.

10.1.2 A developmental lens – infants, children, adolescents, youth.

The very real differences and complexities of mental health service delivery for children and for adolescents and their families warrant a different, tailored and nuanced approach to consideration of performance frameworks especially including the developmental psychopathology context. The findings of this study indicated that to provide clinical care with the level of complexity presenting to CAMHS requires understanding of the presenting issues, particularly the impact of trauma. This understanding must be nested in the developmental context of a child or adolescent, and treatment responses should account for the multiple system interfaces in that child's life.

Working structurally to prepare a team adequately for such a response to its client community may lead to segmentation of clinical responses between pre-school, primary school, adolescent and youth age groups making them consistent with education and primary care models to support collaboration.

10.1.3. Define the primary task of CAMHS

The performance framework should be based on an agreed description of the task and role of CAMHS as distinct from the role of other services. Whilst there is a current description of CAMHS it has been found to be inadequate in tailoring consistency of target group, service response and outcomes. This is perhaps as a result of the tendency for large government organisations to seek broadly consistent descriptions of services and measures of outcomes.

Attending to this task will assist directly with managing external expectations and drive internal service development to align to the expressed primary task. It is expected to reduce the anxiety inherent in the system by affirming a description of the work of CAMHS, one that is likely to make sense within CAMHS and across stakeholders. Negotiating and consulting on this definition could provide the first steps in managing expectations. The proposed description informed by the present study is: “a public mental health service creating a safe place to develop a shared understanding of the most troubled children and their families, and to foster growth through caring, reflecting and lifting the burden of blame and shame”.

10.1.4 Comprehensively define the intended target group

Such a definition must include clear descriptions of the client target group. This will then impact on access requirements and define the services to be offered. The definition would need to be confirmed and reconfirmed through broad consultation (clients, families, external referrers, clinicians, government). This recommendation addresses the findings that CAMHS is not seen to be dealing with those who have the most comprehensive difficulties. There is a need to find an agreed way to define and describe this group.

The challenge in this work would be to discern appropriate measures of complexity that do not rely only on diagnosis, given the contested nature of that paradigm in CAMHS. They should also not rely only on measures of severity symptoms as is currently in practice, given again the contested nature of the tools utilized and the individual psychopathology paradigm that does not adequately reference the complexity at play within a family, peer and community system of relationships. Developing a measure of complexity (as formerly discussed) could be based on a score derived across a range of

assessment domains. This would provide an opportunity to ensure that those at the highest level of complexity were in fact the ones able to access the service. Holding services to account for targeting delivery of care to children and teenagers presenting with severity and complexity would require an agreed measure of complexity.

10.1.5 Directly addressing the child protection and CAMHS interface

The performance framework should identify and measure explicitly the impact of collaborative efforts between CAMHS and other providers especially in the service of child protection clients and their families. The findings of this study indicate that this collaborative interface is seriously compromised and requires direct targets and performance requirements if the care provided to clients is to be impacted directly.

There is significant further work to be done in addressing the social defence structures and practices that have been defined in this study and have clearly contributed to a structurally rigid and boundaried functioning in CAMHS. This will require a multilayered commitment to collaboration and guidance and leadership at all levels to examine and work with the structural inhibiters to collaboration, addressing the underlying anxiety experienced in both service systems about the challenges they are faced with that is expressed in ways that alienate them from one another.

Resolving this conflicted situation will require senior government leadership of a policy framework for both child protection and CAMHS that drives expectations for collaboration, models change, calls out and explores the defence mechanisms and engages service leaders in working through options for change.

10.1.6 The importance of organisational climate in CAMHS

The findings pointed to the need for CAMHS clinicians to be provided with boundaried reflective space within which to examine the internal

organizational climate and understand and act on defensive strategies, especially those that may be affecting client access (with structural barriers and interpersonal obstacles), treatment pathway (which decision-making and role conflicts in treating teams) and continuity of care (poorly integrated service interfaces). The performance framework should reference, integrate and therefore legitimize the impact of the work itself on the staff group and actively attend to this as a domain of service function and resourcing.

This means ensuring that managing organizations understand that quality service delivery legitimately includes making space, time and resources for clinical supervision, reflection and review for all staff members individually and as groups. It means additional cost and efforts to balance and demonstrate efficiency against safety, quality and treatment effectiveness.

10.1.7 Accountability

All the elements described to date need performance measures and a reporting regime to ensure services are meeting the espoused and agreed task and are publicly held to account. These should be uniquely focused on the services being provided for this age group across all settings and avoid hybrids of adult mental health or regular health models.

Systems for gathering and the public reporting of clinical data and some data related to staff resources have been well-established in Victoria. However, they are known to have limited utility clinically and are the subject of ongoing deliberations at state and national levels. The challenge here is to report a set of measures that extend past clinical throughput to clinical outcome, experience of care, collaborative efforts, staff engagement and climate – all the elements that have emerged in this study. Integration of research on efficacy, the dynamic and personal impact of the work itself on front line clinicians and on clinical outcomes needs to more directly inform future endeavors.

A summary of the Recommendations is provided in Table 3. By making recommendations for a performance framework for CAMHS the author has sought to draw together the key elements emerging from the findings supported by the research community. They form a comprehensive network of elements

and if all were adequately addressed would reliably bind public child and adolescent mental health services with a unique clarity of purpose in a community of care for children, adolescents and their families.

10.2 Implementation and limitations of the research

10.2.1 Implementing and evaluating

As a consequence of this research, the State Government is already making changes in this area. For example a focus on the developmental differences between infants, children, adolescents and youth and especially in the service system surrounding them has been able to inform the development of new service models for children requiring CAMHS intervention which could be supported with the necessary (Victorian Government Budget, 2016). The research has already been able to support policy development, contribute and impact in this way by strengthening the arguments for segmented investments in each age group rather than across the entire age range which appears to result in the most urgent problems (assessed to be largely in the adult population) being addressed primarily.

Formal publication of this research is expected to be instructive at multiple levels – in policy and organisational settings where CAMHS services are a focus. It provides a template against which performance measures as they are developed within the health system and mental health in particular can be mapped. Further, it challenges the assumption that CAMHS service delivery and quality can somehow be effectively measured and understood utilising a uni-dimensional model or a handful of throughput measures of activity.

TABLE 4: *Recommended Performance Framework for CAMHS*

	ELEMENTS OF A CAMHS PERFORMANCE FRAMEWORK	
	Element	Description
1	Policy Scaffolding and Robust Detailed Implementation Planning	A performance framework for health services including a CAMHS service should be grounded in evidence based policy and strategy, solid service design, robust implementation planning, clear target development and communication, resourcing, contracting, consolidating, feedback systems, compliance with legislation, compliance with standards, funding and service agreements, targets and indicators for outputs.
2	A Developmental Lens – Infants, Children, Adolescents, Youth.	The very real differences and complexities of mental health service delivery for children and for adolescents and their families warrant a different, tailored and nuanced approach to consideration of performance frameworks especially including the developmental psychopathology context.
3	Define the Primary Task of CAMHS	The performance framework should be based on an agreed description of the task and role of CAMHS as distinct from the role of other services noting that whilst there is a current description of CAMHS it has been found to be inadequate in tailoring consistency of target group, service response and outcomes perhaps as a result of the tendency for large government organisations to seek broadly consistent descriptions of services and measures of outcomes.
4	Comprehensively define the intended target group	Such a definition must include clear descriptions of the client target group, access requirements and the services to be offered, confirmed and reconfirmed through broad consultation (clients, families, external referrers, clinicians, government). Holding services to account for targeting delivery of care to children and teenagers presenting with severity and complexity would require an agreed measure of complexity.
5	Child Protection and CAMHS Interface	The performance framework should identify and measure explicitly collaborative efforts especially in the service of child protection clients and their families.
6	The importance of organisational climate in CAMHS	The performance framework should reference, integrate and therefore legitimize the impact of the work itself on the staff group and actively attend to this as a domain of service function and resourcing.
7	Accountability	All these elements need performance measures to ensure services are meeting the espoused task and are held to account. These should be uniquely focused on the services being provided for this age group and avoid hybrids of adult mental health or regular health models.

The most challenging aspect of implementing the recommended performance framework within Victorian public CAMHS settings is expected to be the changing policy context and in particular the proposed focus on the interface between child protection and CAMHS. The focus of the State Government in reforming child and youth "welfare" services, and the Commonwealth Government in reforming the health service delivery system

especially at the primary care interface directly impacts on the policy context of the delivery of CAMHS services.

Furthermore, recent reviews of service delivery, risk management and governance have strengthened the focus in formal contracting for health service performance on metrics such as safety for patients and staff and on clinical risk management. As has been discussed, for CAMHS there is complexity of purpose sitting as it does against the boundary of a so-called welfare system for children but also within a hospital based health care system and part of the stream known as psychiatry or mental health. Nonetheless it is expected that in the dissemination of this framework, which builds on what already exists there will be positive engagement given the nature and salience of the recommendations and their grounding in the broader theoretical field, how they were derived and the opportunity they provide to engage the sector in a multi-dimensional discourse.

The Framework will need to have mechanisms in the structure that prompt regular review, and evaluation of the model once implemented is critical to ensuring it delivers what it purports to. One mechanism may be to include a children's mental health reporting section based on the implementation and progress of the performance framework in the Victorian Government's Mental Health Annual Report (which is a statutory reporting requirement).

10.2.2 Future directions

This study has highlighted aspects of the context of accessing, delivering and collaborating with CAMHS services and has applied this to a recommended possible performance framework. In the public sector in western countries like Australia where there is an ever-increasing desire for accountability and transparency of public expenditure for value (Pollock et al., 2014; Jackson, 1998; Boland & Fowler, 2000; Banke-Thomas et al., 2015), the performance framework requires sufficient responsiveness to be adaptive. This relates to ensuring it remains relevant. In future for example it may be that technologies in the delivery of care change as a result of treatment efficacy

research impacting on the descriptions of service inputs. Another example may be where aspects of the service system boundaries are modified to create different organisational structures (say where CAMHS moves from being governed in a psychiatry stream to being governed in a paediatric health stream) and as a result new interfaces and boundary collaborations are required. The Framework model here recommended is seen as sufficiently agile to account for such developments.

10.2.3 Future research

As has been noted earlier, clinical research into treatment outcomes and efficacy (Cottrell & Kramm, 2005; Barlow et al., 2015; Anglod et al., 1999; Applyby & Phillip, 2013), outcome measurement in CAMHS (Bjørngaard, 2008; Brann et al., 2001; Worrall-Davies & Cottrell, 2009; Bearsley-Smith et al., 2008) and focussing on specific diagnostic groups (Benjamin et al., 2013; Shonkoff et al., 2016; Costello et al., 2005; American Association of Pediatrics, 2000; Baverstock & Wright, 2015; Amos et al., 2015; Costello et al., 2005) has already yielded progress and should continue to grow as part of the medical and health research sector (Belfer, 2008; Charman, 2004).

As previously discussed, studies of clinical complexity and this client group such as that by Amos, Segal and Cantor (2015) are important contributions. They are studying intergenerational abuse and neglect and models of therapy for mothers and children, which will inform joint engagement across the clinical and child protection sectors.

It is recommended that future research explore models for understanding and leading or managing the unique organisational climate in CAMHS settings (Callaly et al., 2005; Charman, 2004; Clarke, 2013) and particularly on the roles of clinical staff and leaders in the CAMHS settings. This would build on the current study but also on early work by Glisson and Hemmelgarn (1998), which pointed to the impact of climate directly on client outcome. Addressing collaborative dissonance across organisational boundaries is another area that has emerged requiring more rigorous study

particularly in how enhancing collaboration impacts of client and family outcomes both in terms of child protection (risk and harm) as well as in mental health terms (Cocker & Scott, 2006; Cooper et al., 2016).

Models of research in this domain should seek to use methodologies and tools that elicit the voice of children, adolescents and families who use the services (Boulter & Rickwood, 2013) The voices of the young consumer and parent as participants in the present study created depth to the findings, providing richness and authenticity in line with the research design. Finally, future research efforts must take account of the effectiveness of performance frameworks in the public sector in terms of their capacity to generate knowledge, drive service quality and outcomes and delivery community benefit across the population. Investment in performance frameworks must themselves be assessed as being a valuable investment.

10.2.4 Strengths and limitations of the study

This research was undertaken within a paradigm that asserts that the construction of meaning is generated through reflexivity between an individual and his or her context (Guba & Lincoln, 1994; Sivan, 1986). It was chosen here for its capacity to most effectively address the research aim – that was to gather perspectives, beliefs, and experiences in relation to the research question from a variety of people across varied contexts and to examine these multiple perspectives (Burck, 2005). A strength of the current study was that it sought to highlight individual perspectives and experiences as they related to measuring organisational performance and to explicitly place the roles and perspective of the researcher into this frame. The focus of interest was in what personal experience might convey about broader shared issues and themes at an organisational level. The study utilised semi-structured in-depth interviews as the tool and as predicted took the exploration beyond finance, activity, and outcomes towards sustainability, process, emotional climate, culture, and organisational dynamics. Overall, this along with recursive and iterative content analysis over a relatively extended time period was driven by theory as the analytic device and sought transparency in articulating development of

meaning (Long, 2000; Burke, 2005; Miles & Huberman, 1985; Braun & Clarke, 2006).

In terms of limitations, the most significant was the fact that no child informants could be sourced. Whilst the study design and ethical framework provided the opportunity for such involvement, it did not occur. The input from a young adult consumer (18 year old) was a welcome addition and her experience scanned many years in CAMHS. A further limitation was that the time frame and design limited the number of participants and therefore the possible perspectives. This was managed through theoretical sampling to seek the broadest input, and themes coalesced during the analysis pointing to saturation of the data (Mason, 2010; Frances et al., 2010).

A limitation of the research design was the qualitative approach that limits the generalization of findings to Victoria and perhaps more broadly in the Australian context but may be more limited globally. With respect to the recommendations call for further action and consultation on a range of items, ensuring broad applicability and the capacity to localize responses. This is in fact consistent with the “Balanced Score Card” model developed by Kaplan (2010), which provided the framework which was then adopted across a range of countries, business sectors and the public service. Furthermore, the service delivery context for CAMHS relies on a range of services including schools and community based family support. Globally this service context is likely to be highly variable, driven by a range of different policy settings and data measurement capability. Therefore the framework as proposed will require local engagement and adoption within such a context.

A further limitation of the research design includes that it did not include a mixed methods paradigm such as including a quantitative survey to confirm findings or a focus group model to test them further. This latter was initially built into the design but discarded early due to time limitations. It would certainly have assisted in confirming and strengthening the findings.

The narrow theoretical lens for the research may be considered a limitation (Chowdery, 2017). The theoretical model was chosen carefully as a

sound platform on which to consider the complex issues presented from an organisational perspective. As indicated in the synthesis of the literature, much research related to CAMHS involves individual service delivery (outcome research) or service model design.

Approaching the sector at a system and organisational level has produced a unique view that supports sector-wide recommendations and a systemic response. This is congruent with the theoretical lens chosen. Future research might seek to approach a system performance framework from the perspective at the clinical care, or from the broader public health performance measurement perspective.

10.3 Conclusions

This study was launched at a time when understanding the competing and complex demands of leading a CAMHS service was a priority. This was particularly in relation to meeting performance targets set by government in a policy context which was not always clear and was often informed by acute general medical care and adult psychiatry service delivery. Senior executives in the health service were not always fully informed about the internal organisational challenges facing the CAMHS service. The focus of the study was therefore envisaged to be on what could be understood of the unique aspects of a public CAMHS that might impact on organisational performance and how a performance framework might be conceptualised to take account of these considerations.

The research design chosen focused on eliciting and describing a range of meanings attributed to experience and moved away from positivist explanatory models of black and white answers and linear causality. It would be the author's view that services tend to default to such uni-dimensional explanatory models when overwhelmed. The findings of the study directly challenged the drive to default when grappling with complexity to such uni-dimensional models. They underlined the view that CAMHS services should take an integrated multi-theoretical perspective, support wisdom in leadership, be accessible, and have sophisticated collaborative capacity. Furthermore

there should be shared power in decision making across a team, with the children and adolescents themselves, and their families, and with other services. A performance framework that adequately addresses these complexities works against the risk that authenticity is lost when measures of organisational performance are reduced to one or two examples.

By making recommendations for a performance framework for CAMHS the author has sought to draw together the key elements emerging from the findings and supported by the research community. They form a comprehensive network of elements and if all were adequately addressed would reliably bind public child and adolescent mental health services with a unique clarity of purpose in a community of care for children, adolescents and their families.

In a public health system in Australia that places different health service components in competition with one another for clinical, research and infrastructure resources, CAMHS faces a significant challenge in arguing for increased funding to respond to overwhelming demand. This is particularly difficult where stakeholder support is conflicted and ambivalent. A further challenge is in arguing for additional funding to resource reflective and supervisory support to address organisational dynamics driven by the work itself.

Without finding new ways to describe the task and the client group, and demonstrate organisational effectiveness, CAMHS risks becoming more bound by structural responses developed as defenses to the overwhelming anxiety that has emerged within the service setting. The performance framework provides scaffolding for systematically addressing what is a complex organisational challenge for a service sector that is critical to support children, adolecents and families living with mental illness.

References

Abbott, D., Townsley, R. and Watson, D. (2005), Multi-agency working in services for disabled children: what impact does it have on professionals? *Health & Social Care in the Community,* 13(2), 155–163. DOI:10.1111/j.1365-2524.2005.00543.x

Abrines-Jaume, N., Midgley, N., Hopkins, K., Hoffman, J., Martin, K., Law, D., & Wolpert, M. (2016). A qualitative analysis of implementing shared decision making in Child and Adolescent Mental Health Services in the United Kingdom: Stages and facilitators. *Clinical child psychology and psychiatry*, 21(1), 19-31. DOI:10.1177/1359104514547596

Acito, F., & Khatri, V. (2014). Business analytics: Why now and what next? *Business Horizons*, 57(5), 565-570.

Addis, M.; Krasnow, A. (2000). A national survey of practicing psychologists' attitudes toward psychotherapy treatment manuals. *Journal of Consulting and Clinical Psychology* 68(2), 331– 339.DOI:10.1037//0022-006X.68.2.

Addis, M.E.; Wade, W.A; Hatgis, C. (1999). Barriers to evidence-based practices: addressing practitioners' concerns about manual-based psychotherapies. *Clinical Psychology: Science and Practice* 6(4), 430–441.

Australian Institute of Health and Welfare (2015*). Mental health services in Australia.*

http://mhsa.aihw.gov.au/resources/expenditure/ (Accessed 6.11.16).

Australian Institute of Health and Welfare (2016) Setting Standards and Performance Measurement (AIHW)

http://www.aihw.gov.au/health-performance/performance-and-accountability-framework/8-setting-standards-performance-measurement/ (Accessed 17.3.17)

Al-Haddad, S., & Kotnour, T. (2015). Integrating the organizational change literature: a model for successful change. *Journal of Organizational Change Management*, 28(2), 234-262. DOI:10.1108/JOCM-11-2013-0215

Allcorn, S. (2015) Understanding Organisational Dynamics and Leadership: A Comparison of Four Perspectives. *Organisational and Social Dynamics* 15(2), 181-209.

Allison, S., Bastiampillai, T., Siskind, D., Roeger, L., & Goldney, R. (2015). The National Mental Health Commission Report: Evidence based or

ideologically driven? *Australian and New Zealand Journal of Psychiatry*, 49(11): 960-962.

Allison, S., & Bastiampillai, T. (2015). Mental health services reach the tipping point in Australian acute hospitals. *Medical Journal of Australia*, 203(11), 432-434. DOI:10.5694/mja15.00782

Almedom, A. M., & Glandon, D. (2007). Resilience is not the absence of PTSD any more than health is the absence of disease. *Journal of loss and Trauma*, 12(2), 127-143. DOI:10.1080/15325020600945962

American Academy of Pediatrics (AAP), Committee on Quality Improvement and Subcommittee on Attention-Deficit/Hyperactivity Disorder (2000). Clinical practice guideline: diagnosis and evaluation of the child with attention - deficit/hyperactivity disorder. *Pediatrics*; 105(5),1158 –1170

American Psychiatric Association (2000), *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition - Text Revision (DSMIV-TR),* American Psychiatric Publication Incorporated, Washington, DC

American Psychiatric Association (2013) *Diagnostic and statistical manual of mental disorders, 5th edition (DSM-5),* Washington, DC, American Psychiatric Press.

Amos, J., Segal, L., & Cantor, C. (2015). Entrapped mother, entrapped child: Agonic mode, hierarchy and appeasement in intergenerational abuse and neglect. *Journal of Child and Family Studies,* 24(5), 1442-1450. DOI:10.1007/s10826-014-9950-3

Andersen, H.V.; Lawrie, G. & Savič, N. (2004). Effective quality management through third-generation balanced scorecard. *International Journal of Productivity and Performance Management* 53(7), 634–645. DOI:10.1108/17410400410561259

Andrews, R., & Van de Walle, S. (2013). New public management and citizens' perceptions of local service efficiency, responsiveness, equity and effectiveness. *Public Management Review*, *15(5),* 762-783.

Aneshensel, C. S. (2005). Research in mental health: Social etiology versus social consequences. *Journal of Health and Social Behavior*, *46(3),* 221-228.

Angold, A., Costello, E.J., Framer, E.M.Z., Burns, B., & Erkanli, A. (1999). Impaired but undiagnosed. *Journal of the American Academy of Child and Adolescent Psychiatry*, 38(2), 129–137 DOI: 10.1097/00004583-199902000-00011

Anthony, W. A. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. *Psychosocial rehabilitation journal*, *16*(4), 11-23. DOI:10.1037/h0095655

Anthony, W.A. (2000) A recovery-oriented service system: Setting some system level standards. *Psychiatric Rehabilitation Journal,* 24(2),159-168. DOI:10.1037/h0095104

Appel, K. E., Myers, J. M., & Schefelen, A. E. (1953). Prognosis in psychiatry: Results of psychiatric treatment. *AMA Archives of Neurology & Psychiatry*, *70*(4), 459-468.

Appleby, J. and Phillips, D. (2013) Enhancing engagement in CAMHS Aotearoa New Zealand *Social Work,* 25(1), 24-34.

Appleyard, K.; Egeland, B.; Van Dulmen, M.; and Sroufe, L.A. (2005) When more is not better: The role of cumulative risk in child behavior outcomes. *Journal of Child Psychology and Psychiatry*. 46(3), 235–245. DOI:10.1111/j.1469-7610.2004.00351.x

Argyris, C. (1990). Inappropriate defenses against the monitoring of organization development practice. *The Journal of applied behavioral science*, *26*(3), 299-312. DOI: 10.1177/0021886390263004

Armstrong, B.K.; Gillespie, J.A.; Leeder, S.R.; Rubin, G.L.; Russell, L.M. (2007) Challenges in health and health care for Australia. *Medical Journal of Australia*. 187(9), 485-489.

Armstrong, D. (1999) The recovery of meaning. In R. French & R. Vince (Eds), *Group relations, management and organization*, (pp. 145-54) Oxford. Oxford University Press.

Armstrong, D. (2004) The analytic object in organizational work. *Free Associations* 11(1), 79-88.

Armstrong, D. (2005) Organization in the Mind: *Psychoanalysis, Group Relations and Organizational Consultancy,* Robert French (Ed.) (pp 2-9) London: Karnac.

Armstrong, D. (2010) Meaning Found and Meaning Lost: On the Boundaries of a Psychoanalytic Study of Organisations *Organisational and Social Dynamics* 10(1): 99-117,151.

Armstrong, E (2005) *Integrity, Transparency and Accountability in Public Administration: Recent Trends, Regional and International Developments and Emerging* Issues (pp 1- 8) United Nations, Economic and Social Affairs.

Atkinson, M., Jones, M., & Lamont, E. (2007). Multi-agency working and its implications for practice. *Reading: CfBT Education Trust*.

https://www.nfer.ac.uk/publications/MAD01/MAD01.pdf

Bailey, C., & Madden, A. (2016). What makes work meaningful - or meaningless? *MIT Sloan Management Review, 57*(4), 53-61.

Bailey, S. (2005). The national service framework: Children come of age. *Child and Adolescent Mental Health, 10*(3), 127-130.

Bain A., (1999) On Socio-Analysis *Socio-Analysis,* 1(1) 1-17.

Bain, A. (1999) On being frozen in time in Vince, V. & French, R.(Eds.) in *Group relations, Management and Organization*, (pp 127-144) Oxford. Oxford University Press

Bain A. (2006) Sources of Authority: The Double Threads of Anxiety and Wonder in Mathur, A.N; Oy, A. (Eds) *Dare to Think the Unthought Known*? (pp 33-39) Finland. Tampere.

Bain, A. (2012). Social and organisational dreaming in Australia. *Socio-analysis*, *14*(2012) 118 -136.

Baker, G.R (2001). Healthcare managers in the complex world of healthcare. *Frontiers of Health Services Management, 18*(2), 23-32.

Banke-Thomas, A. O., Madaj, B., Charles, A., & van den Broek, N. (2015). Social Return on Investment (SROI) methodology to account for value for money of public health interventions: a systematic review. *BioMed Central Public Health*, *15*(1), 582-590. DOI: 10.1186/s12889-015-1935-7

Barlow, J., Schrader‐McMillan, A., Axford, N., Wrigley, Z., Sonthalia, S., Wilkinson, T., ... & Coad, J. (2016). Review: Attachment and attachment-related outcomes in preschool children–a review of recent evidence. *Child and Adolescent Mental Health*, *21*(1), 11-20. DOI: 10.1111/camh.12138

Baverstock, S., & Wright, K. (2015). Borderline personality disorder in young people: the perspectives of frontline professionals in child and adolescent mental health. *Mental Health Nursing (Online)*, *35*(4), 14 -19.

Beatson, J., & Rao, S. (2014). Psychotherapy for borderline personality disorder. *Australasian Psychiatry*, *22*(6), 529-532. DOI:10.1177/1039856214555531

Bearsley-Smith, C., Sellick, K., Chesters, J., Francis, K., & Gippsland Adolescent Depression Research Group. (2008). Treatment content in child

and adolescent mental health services: Development of the treatment recording sheet. *Administration and Policy in Mental Health and Mental Health Services Research*, *35*(5), 423-435. DOI:10.1007/s10488-008-0184-9

Beecham, J. & Sinclair, I. (2007) *Costs and Outcomes in Children's Social Care: Messages from Research* **(**pp 91-114) London. Jessica Kingsley Publishers

Belfer, M. L. (2008), Child and adolescent mental disorders: the magnitude of the problem across the globe. *Journal of Child Psychology and Psychiatry*, 49(3), 226–236. doi:10.1111/j.1469-7610.2007.01855.x

Benjamin, C. L., Harrison, J. P., Settipani, C. A., Brodman, D. M., & Kendall, P. C. (2013). Anxiety and related outcomes in young adults 7 to 19 years after receiving treatment for child anxiety. *Journal of Consulting and Clinical Psychology,* 81(5), 865–876. doi:10.1037/a0033048.

Bergman, L.R., & Andersson, H. (2015). The person and the variable in developmental psychology *Zeitschrift für Psychologie/Journal of Psychology*. 218, (pp. 155-165) DOI: 10.1027/0044-3409/a000025.

Bevan, G. and Hood, C. (2006) What's measured is what matters: Targets and Gaming in the English Public Health System. *Public Administration,* 84(3), 517–538. DOI: 10.1111/j.1467-9299.2006.00600.x

Beyond Blue (2014) Information about Perinatal Mental Health https://www.beyondblue.org.au/about-us/about-our-work/perinatal-mental-health (Accessed 18.11.16)

Bickman, L. (2008) A measurement feedback system (MFS) is necessary to improve mental health outcomes. *Journal of the American Academy of Child and Adolescent Psychiatry* 47(10), 1114 -1119.
DOI: 10.1097/CHI.0b013e3181825af8

Bickman L: (1996) A continuum of care: more is not always better. *American Psychologist* 51(7), 689-701 DOI:10.1037/0003-066X.51.7.689

Bion, W. R., & Rickman, J. (1943). Intra-group tensions in therapy their study as the task of the group. *The Lancet*, *242*(6274), 678-682. DOI:10.1016/S0140-6736(00)88231-8

Bion, W.R., (1946) The Leaderless Group Project, *Bulletin Meninger Clinic*, 10(3), 77 - 8l

Bion, W. R. (1970). *Attention and interpretation*. London: Tavistock Publications.

Bion, W. R. (1985). Container and contained. *Group relations reader*, *2*(8), 127-133.

Bircher, J. (2005). Towards a dynamic definition of health and disease. *Medicine, Health Care and Philosophy*, *8*(3), 335-341. DOI: 10.1007/s11019-005-0538-y

Bird, (2005) in Pidd, M. Perversity in public service performance measurement, *International Journal of Productivity and Performance Management*, 54(5/6), 482 – 493. DOI:10.1108/17410400510604601

Bisognano, M., Cherouny, P. H., & Gullo, S. (2014). Applying a science-based method to improve perinatal care: the institute for healthcare improvement perinatal improvement community. *Obstetrics & Gynecology*, *124*(4), 810-814.DOI: 10.1097/AOG.0000000000000474

Bjørngaard, J. H., Andersson, H. W., Ose, S. O., & Hanssen-Bauer, K. (2008). User satisfaction with child and adolescent mental health services. *Social psychiatry and psychiatric epidemiology*, *43*(8), 635-641. doi:10.1007/s00127-008-

Bland, R., Renouf, N., & Tullgren, A. (2016). Social work practice in mental health: An introduction. *Aotearoa New Zealand Social Work*, *28*(3), 94. DOI:10.11157/anzswj-vol28iss3id253

Bland, R.; Clarke, M., Elsom, S., Epstein, M., Farhall, J., Fielding, J., Fossey, E., Leggatt, M., Liaw, S., Meadows, G., Minas, H. Olsen, A., Roper, C., Rosen, A. & Singh, B. (2007). The active participants in mental health services, In G. Meadows, B. Singh & M. Grigg, *Mental health in Australia: Collaborative community practice*. (pp 190-226) South Melbourne: Oxford University Press.

Blazek, M. (2013). Emotions as practice: Anna Freud's child psychoanalysis and thinking–doing children's emotional geographies. *Emotion, Space and Society*, *9*, 24-32. DOI:10.1016/j.emospa.2013.02.003

Bloom, S.L. & Farragher, B. (2013) *Destroying Sanctuary: The Crisis in Human Service Delivery Systems* (pp 131-154) Oxford. Oxford University Press

Bloom, S. L. (2013). *Creating sanctuary: Toward the evolution of sane societies*. London. Routledge.

Bloomberg Visual Data http://www.bloomberg.com/news/articles/2015-11-30/health-care-check-up-whose-system-is-least-efficient-

Boland, T., & Fowler, A. (2000). A systems perspective of performance management in public sector organisations. *International Journal of Public Sector Management*, *13*(5), 417-446. DOI:10.1108/09513550010350832

Bolton, M. (2003) Public sector performance measurement: delivering greater accountability. *Work Study,* 52(1), 20 – 24 DOI:10.1108/00438020310458697

Bone, C., O'Reilly, M., Karim, K. and Vostanis, P. (2015), 'They're not witches. …' Young children and their parents' perceptions and experiences of Child and Adolescent Mental Health Services. *Child Care Health Dev*, 41(3), 450–458. DOI:10.1111/cch.12161

Borntrager, C.F.; Chorpita, B.F.; Higa-McMillan, C. & Weisz, J.R. (2009) Provider Attitudes Toward Evidence-Based Practices: Are the Concerns With the Evidence or With the Manuals? *Psychiatric Services* 60(5), 677-681 DOI:10.1176/ps.2009.60.5.677

Bor, W., Dean, A. J., Najman, J., & Hayatbakhsh, R. (2014). Are child and adolescent mental health problems increasing in the 21st century? A systematic review. *Australian & New Zealand Journal of Psychiatry*, *48*(7), 606-616. DOI: 10.1177/0004867414533834

Bott, E. (1976) Hospital and society. *British Journal of Medical Psychology*, 49(2), 97-140 DOI: doi:10.1111/j.2044-8341.1976.tb02357.x

Bower, P., Macdonald, W., Sibbald, B., Garralda, E., Kramer, T., Bradley, S., & Harrington, R. (2003). Postal survey of services for child and adolescent mental health problems in general practice in England. *Primary Care Mental Health*, *1*(1), 17-26.

Bowers, L., Alexander, J., Bilgin, H., Botha, M., Dack, C., James, K., … Stewart, D. (2014). Safewards: the empirical basis of the model and a critical appraisal. *Journal of Psychiatric and Mental Health Nursing*, *21*(4), 354–364 DOI:10.1111/jpm.12085

Boxer, P. (2014). Defences against innovation: the conservation of vagueness. In Armstrong, D. & Rustin, M. (Eds) *Social Defences against Anxiety: Explorations in a Paradigm*, (pp 70-87). London. Karnac

Bradley, E. H., Curry, L. A. and Devers, K. J. (2007), Qualitative Data Analysis for Health Services Research: Developing Taxonomy, Themes, and Theory. *Health Services Research*, 42(4), 1758–1772. DOI:10.1111/j.1475-6773.2006.00684.x

Bradley, S., Hickey, N., Kramer, T., & Elena Garralda, M. (2009). What makes a good CAMHS primary mental health worker?. *Child and Adolescent Mental Health*, *14*(1), 15-19. DOI: 10.1111/j.1475-3588.2008.00496.x

Bradley, S.; Kramer, T.; Garralda, E.; Bower, P.; Macdonald, W.; Sibbald, B. & Harrington, R. (2003). Child and Adolescent Mental Health Interface with Primary Services: A survey of NHS provider Trusts. *Child and Adolescent Mental Health,* 8(4), 170–176. DOI: 10.1111/1475-3588.00067

Bramesfeld, A., Klippel, U., Seidel, G., Schwartz, F. W., & Dierks, M. L. (2007). How do patients expect the mental health service system to act? Testing the WHO responsiveness concept for its appropriateness in mental health care. *Social science & medicine*, *65*(5), 880-889. DOI: 10.1016/j.socscimed.2007.03.056

Brand, D. (2012). Social and health care integration:(1) The individual dimension. *Journal of Integrated Care*, *20*(6), 371-378. DOI: 10.1108/14769011211285174

Brann, P., Coleman, G., & Luk, E. (2001). Routine outcome measurement in a child and adolescent mental health service: an evaluation of HoNOSCA. *Australian and New Zealand Journal of Psychiatry,* 35(3), 370–376.

Braun, M., Schönfeldt-Lecuona, C., Freudenmann, R. W., Mehta, T., Hay, B., Kächele, H., & Beschoner, P. (2010). Depression, burnout and effort-reward imbalance among psychiatrists. *Psychotherapy and psychosomatics*, *79*(5), 326-327. DOI: 10.1159/000319531

Briggs, A. (2012). Under-nourishment and clinical risk: two concerns of CAMHS clinicians. *Journal of Social Work Practice*, *26*(4), 427-441. DOI: 10.1080/02650533.2012.670104

Briggs, S., Maxwell, M., & Keenan, A. (2015). Working with the complexities of adolescent mental health problems: applying time-limited adolescent psychodynamic psychotherapy (TAPP). *Psychoanalytic Psychotherapy*, *29*(4), 314-329. DOI: 10.1080/02668734.2015.1086414

Britten, N. (1995). Qualitative research: qualitative interviews in medical research. *Bmj*, *311*(6999), 251-253. DOI: 10.1136/bmj.311.6999.251

Bryson, J. M., Crosby, B. C., & Bloomberg, L. (2014). Public value governance: Moving beyond traditional public administration and the new public management. *Public Administration Review*, *74*(4), 445-456. DOI:10.1111/puar.12238

Borwick, I in Newton, J.; Long, S.; Sievers, B. Eds. (2006) *Coaching in Depth*. (2006) (pp 3-28). Karnac London

Bowlby, J. & Ainsworth, M. (2013) The origins of attachment theory in Goldberg, S.; Muir, R. & Kerr, J. (Eds) *Attachment Theory: Social, Developmental, and Clinical Perspectives* (pp 45 – 65) London. Routledge.

Boulanger, G. (2015). Seeing double, being double: longing, belonging, recognition, and evasion in psychodynamic work with immigrants. *The American Journal of Psychoanalysis*, *75*(3), 287-303. DOI:10.1057/ajp.2015.27

Bovaird, T. (2014). Attributing outcomes to social policy interventions–'Gold standard' or 'fool's gold'in public policy and management? *Social Policy & Administration*, *48*(1), 1-23. DOI: 10.1111/j.1467-9515.2012.00869.x

Bowen, G. A. (2006). Grounded theory and sensitizing concepts. *International journal of qualitative methods*, *5*(3), 12-23. DOI: 10.1177/160940690600500304

Boulter, E., & Rickwood, D. (2013). Parents' experience of seeking help for children with mental health problems. *Advances in Mental Health*, *11*(2), 131-142. DOI: 10.5172/jamh.2013.11.2.131

Boyce, M. B., Browne, J. P., & Greenhalgh, J. (2014). The experiences of professionals with using information from patient-reported outcome measures to improve the quality of healthcare: a systematic review of qualitative research. *BMJ quality & safety*, bmjqs-2013. DOI: 10.1136/bmjqs-2013-002524

Boyce, C., & Neale, P. (2006). *Conducting in-depth interviews: A guide for designing and conducting in-depth interviews for evaluation input* (pp. 3-7). Watertown, MA: Pathfinder International.

Boyle J.S. (1994) Styles of ethnography. In: JM Morse, (Ed) *Critical issues in qualitative research methods*. (pp 159-85) Thousand Oaks, CA: Sage,

Bunger, A. C., Collins-Camargo, C., McBeath, B., Chuang, E., Pérez-Jolles, M., & Wells, R. (2014). Collaboration, competition, and co-opetition: Interorganizational dynamics between private child welfare agencies and child serving sectors. *Children and youth services review*, *38*, 113-122. DOI: 10.1016/j.childyouth.2014.01.017

Burke, C (2005) Comparing qualitative research methodologies for systemic research: the use of grounded theory, discourse analysis and narrative analysis *Journal of Family Therapy* 27(3), 237–262 DOI: 10.1111/j.1467-6427.2005.00314.x

Bynum, W. F., & Porter, R. (2013) *Companion encyclopedia of the history of medicine*. Routledge. London

Cabana, M.D.; Rand, C.; Powe, N.R.; Wu, A.W.; Wilson, M.; Abboud, P.C.; Rubin, H.R. (1999) Why Don't Physicians Follow Clinical Practice Guidelines? A Framework for Improvement *JAMA* ; 282(15),1458-1465

DOI: 10.1001/jama.282.15.1458

Cade, J.F.J. (1949). Lithium salts in the treatment of psychotic excitement. *Medical Journal of Australia*. 2(36), 349–352.

Caldwell, M. G. (1956). Group dynamics in the prison community. *The Journal of Criminal Law, Criminology, and Police Science*, *46*(5), 648-657. DOI: 10.2307/1139377

Callaly, T., Arya, D., & Minas, H. (2005). Quality, risk management and governance in mental health: an overview. *Australasian Psychiatry*, *13*(1), 16-20. DOI: 10.1111/j.1440-1665.2004.02144.x

Campos, P., Saguy, A., Ernsberger, P., Oliver, E., & Gaesser, G. (2006). The epidemiology of overweight and obesity: public health crisis or moral panic?. *International journal of epidemiology*, *35*(1), 55-60. DOI: 10.1093/ije/dyi254

Canvin, K., Rugkåsa, J., Sinclair, J., & Burns, T. (2013) Leverage and other informal pressures in community psychiatry in England. *International journal of law and psychiatry*, *36*(2), 100-106. DOI: 10.1016/j.ijlp.2013.01.002

Cardona, F. (1994) Facing an Uncertain Future in Obholzer, A & Roberts, V.Z. (Eds) *The Unconscious at Work*. (pp 139-146) Routledge. London

Cardona, F. (1999) The Team as a Sponge. How the Nature of the Task Affects the Behaviour and Mental Life of a Team, in Vince V. & French R (Eds.) in *Group relations, management and Organization*, (pp 239-250) Oxford University Press. Oxford

Carson, S., Powis, P., & Imperato, J. (2016). Consolidating homeless support by the early years family team in Cardiff flying start. *Community Practitioner, 89*(7), 43-47

Carr, A. (2002) Jung, archetypes and mirroring in organizational change management: Lessons from a longitudinal case study. *Journal of Organizational Change Management* 15(5) 477-489. DOI:10.1108/09534810210440388

Carr, A., & Gabriel, Y. (2001). The psychodynamics of organizational change management: An overview. *Journal of Organizational change management*, *14*(5), 415-421. DOI: 10.1108/EUM0000000005872

Carr, S. (2007) Participation, power, conflict and change: Theorizing dynamics of service user participation in the social care system of England

and Wales. *Critical social policy* 27(2): 266-276. DOI:10.1177/0261018306075717

Case, P., & Littlewood, S. (1999). Alarming levels of stress and burn-out. *The Psychiatrist*, *23*(8), 506-506. DOI: 10.1192/pb.23.8.506-a

Chang, Li‐cheng, (2007) The NHS performance assessment framework as a balanced scorecard approach: Limitations and implications. *International Journal of Public Sector Management* 20(2), 101-117 DOI:10.1108/09513550710731472

Chaimowitz, G.; Milev, R.; and Janice, B (2010). The fiduciary duty of psychiatrists. *Canadian Journal of Psychiatry, 55*(3), S1-S6.

Charman, S. (2004). Mental health services for children and young people: the past, present and future of service development and policy. *Mental Health Review Journal*, *9*(2), 6-14.DOI: 10.1108/13619322200400014

Chan, Y. C. (2004). Performance measurement and adoption of balanced scorecards: a survey of municipal governments in the USA and Canada. *International journal of public sector management*, *17*(3), 204-221.DOI: 10.1108/09513550410530144

Chenhall, R. H. (2003). Management control systems design within its organizational context: findings from contingency-based research and directions for the future. *Accounting, Organizations and Society*, *28*(2/3), 127–168 DOI:10.1016/S0361-3682(01)00027-7

Chew-Graham, C., Dowrick, C., Wearden, A., Richardson, V., & Peters, S. (2010). Making the diagnosis of Chronic Fatigue Syndrome/Myalgic Encephalitis in primary care: a qualitative study. *BMC Family Practice*, *11*(1), 1. DOI: 10.1186/1471-2296-11-16

Chreim, S., Langley, A., Comeau-Vallée, M., Huq, J. L., & Reay, T. (2013). Leadership as boundary work in healthcare teams. *Leadership*, *9*(2), 201-228.DOI: 10.1177/1742715012468781

Chowdhury, R. (2017). Rana Plaza Fieldwork and Academic Anxiety: Some Reflections. *Journal of Management Studies*. DOI:10.1111/joms.12262

Clark, A. F., O'Malley, A., Woodham, A., Barrett, B., & Byford, S. (2005). Children with complex mental health problems: Needs, costs and predictors over one year. *Child and Adolescent Mental Health, 10*(4), 170-178.DOI: 10.1111/j.1475-3588.2005.00349.x

Clark, Peter A. (2000) Disease and Diagnosis: Value-Dependent Realism*Theological Studies* 61(4): 795-796

Clark, K. (2013). Staff Needs When Working in Secure Forensic Child and Adolescent Mental Health. *Journal of forensic nursing*, *9*(4), 217-224.DOI: 10.1097/JFN.0b013e318283457f

Clarke, J. N., & Mosleh, D. (2016). The Uses of Biological Sciences to Justify the Risks of Children's Mental Health and Developmental Disorders in North American News Magazines: 1990–2012. In *Communicating Risk* (pp. 267-284). Palgrave Macmillan UK.

Clarke, J., Newman, J., Smith, N., Vidler, E., & Westmarland, L. (2007). *Creating citizen-consumers: Changing publics and changing public services*. Pine Forge Press.

Clarkson, P., & Challis, D. (2002). Developing performance indicators for mental health care. *Journal of Mental Health*, *11*(3), 281-293. DOI:10.1080/09638230020023660

Cocker, C., & Scott, S. (2006). Improving the mental and emotional well-being of looked after children: Connecting research, policy and practice. *The Journal of the Royal Society for the Promotion of Health, 126*(1), 18-23. DOI:10.1177/1466424006061169

Coghlan, D. and Casey, M. (2001), Action research from the inside: issues and challenges in doing action research in your own hospital. *Journal of Advanced Nursing,* 35(5), 674–682. DOI:10.1046/j.1365-2648.2001.01899.x

Collins, P. Y., Insel, T. R., Chockalingam, A., Daar, A., & Maddox, Y. T. (2013). Grand challenges in global mental health: integration in research, policy, and practice. *PLoS Med*, *10*(4), e1001434. DOI:10.1371/journal.pmed.1001434

Commonwealth Government (2009) Evidence Based Practice http://www.health.gov.au/internet/publications/publishing.nsf/Content/mental-pubs-n-pol08-toc~mental-pubs-n-pol08-2~mental-pubs-n-pol08-2-10

Commonwealth Government COAG (2011) National Health Reform Agreement http://www.coag.gov.au/node/96

Commonwealth Government COAG (2011) https://www.coag.gov.au/meeting-outcomes/coag-meeting-communiqué-13-february-2011

Commonwealth Government (2016) http://aihw.gov.au/mental-health-services-publications

Commonwealth Government Response to "Contributing Lives, Thriving Communities – Review of Mental Health Programmes and Services" (2015)

http://www.health.gov.au/internet/main/publishing.nsf/Content/0DBEF2D78F7CB9E7CA257F07001ACC6D/$File/response.pdf

Commonwealth Government (2015) https://myplace.ndis.gov.au/ndisstorefront/html/sites/default/files/documents/Quarterly-Reports/11-report-coag.pdf

Commonwealth Government (2015) http://www.health.gov.au/internet/main/publishing.nsf/Content/0DBEF2D78F7CB9E7CA257F07001ACC6D/$File/response.pdf

Constantino, M. J., Ametrano, R. M., & Greenberg, R. P. (2012). Clinician interventions and participant characteristics that foster adaptive patient expectations for psychotherapy and psychotherapeutic change. *Psychotherapy*, *49*(4), 557.DOI: 10.1037/a0029440

Cook, J. A., Copeland, M. E., Hamilton, M. M., Jonikas, J. A., Razzano, L. A., Floyd, C. B., ... & Grey, D. D. (2015). Initial outcomes of a mental illness self-management program based on wellness recovery action planning. *Psychiatric Services*. *60*(2), 246-249. DOI: 10.1176/ps.2009.60.2.246

Cooper, M., Evans, Y., and Pybis, J. (2016) Interagency collaboration in children and young people's mental health: a systematic review of outcomes, facilitating factors and inhibiting factors. *Child: Care, Health and Development,* 42, 325–342. DOI: 10.1111/cch.12322.

Corner, E., & Gill, P. (2015). A false dichotomy? mental illness and lone-actor terrorism. *Law and Human Behavior, 39*(1), 23-34. DOI 10.1037/lhb0000102

Corrigan, P. (2004) How Stigma Interferes With Mental Health Care *American Psychologist* 59(7) 614-625.

Corrigan, P. W., Druss, B. G., & Perlick, D. A. (2014). The impact of mental illness stigma on seeking and participating in mental health care. *Psychological Science in the Public Interest*, *15*(2), 37-70. DOI:10.1177/1529100614531398

Corrigan, P. W., Lickey, S. E., Campion, J., & Rashid, F. (2000). Mental health leadership and consumer's satisfaction and quality of life. *Psychiatric Services, 51*(6), 781-785. DOI: 10.1176/appi.ps.51.6.781

Corrigan, P. W., Morris, S. B., Michaels, P. J., Rafacz, J. D., & Rüsch, N. (2012). Challenging the public stigma of mental illness: a meta-analysis of outcome studies. *Psychiatric Services*, *63*(10), 963-973. DOI:10.1176/appi.ps.201100529

Costello, E. J., Egger, H., & Angold, A. (2005). 10-year research update

review: the epidemiology of child and adolescent psychiatric disorders: I. Methods and public health burden. *Journal of the American Academy of Child & Adolescent Psychiatry*, *44*(10), 972-986. DOI:10.1097/01.chi.0000172552.41596.6f

Cott, C. (2004). Client-centred rehabilitation: client perspectives. *Disability and rehabilitation*, *26*(24), 1411-1422.DOI: 10.1080/09638280400000237

Cottrell, D. and Kraam, A. (2005), Growing Up? A History of CAMHS (1987–2005). *Child and Adolescent Mental* Health*,* 10(3), 111–117. DOI:10.1111/j.1475-3588.2005.00366.x

Cowling. M.; Davino-ramaya, C.; Ramaya, K.; and Szmerekovsky, J. (2009) Health Care Delivery Performance: Service, Outcomes, and Resource Stewardship *The Permanente Journal* 13(4): 72-77

Coyne, I., McNamara, N., Healy, M., Gower, C., Sarkar, M., & McNicholas, F. (2015). Adolescents' and parents' views of child and adolescent mental health services (CAMHS) in Ireland. *Journal of psychiatric and mental health nursing*, *22*(8), 561-569. DOI:10.1111/jpm.12215.

Cramer, P. (2015). Defense mechanisms: 40 years of empirical research. *Journal of personality assessment*, *97*(2), 114-122. DOI:10.1080/00223891.2014.947997

Crettenden, I. F., McCarty, M. V., Fenech, B. J., Heywood, T., Taitz, M. C., & Tudman, S. (2014). How evidence-based workforce planning in Australia is informing policy development in the retention and distribution of the health workforce. *Human resources for health*, *12*(1), 7-20. DOI: 10.1186/1478-4491-12-7

Cummings, J. R.; Lucas, S. M., & Druss, Benjamin G, (2013). Addressing public stigma and disparities among persons with mental illness: The role of federal policy. *American Journal of Public Health, 103*(5), 781-5. DOI:10.2105/AJPH.2013.301224

Cuthbert, B. N., & Insel, T. R. (2013). Toward the future of psychiatric diagnosis: the seven pillars of RDoC. *BMC medicine*, *11*(1), 126-134. DOI:10.1186/1741-7015-11-126

Dane, B. (2000). Child welfare workers: An innovative approach for interacting with secondary trauma. *Journal of Social Work Education, 36*(1), 27-38.

Davies, H.T.O.; Nutley, S.M.; Mannion, R. (2000) Organisational culture and quality of health care *Quality in Health Care*; 9(2):111–119 DOI:10.1136/qhc.9.2.111

De Vries, M. & Nemec, J. (2013) Public sector reform: an overview of recent

literature and research on NPM and alternative paths. *International Journal of Public Sector Management*, 26(1), 4 - 16 DOI:10.1108/09513551311293408

De Waal, A. and Kourtit K. (2013) Performance measurement and management in practice : Advantages, disadvantages and reasons for use, *International Journal of Productivity and Performance Management* 62(5), 446 – 47 DOI:10.1108/IJPPM-10-2012-0118

Denhardt, R. B. and Denhardt, J. V. (2000), The New Public Service: Serving Rather than Steering. *Public Administration Review*, 60(6) 549–559. DOI:10.1111/0033-3352.00117

Department of Health Ireland (2006*) A Vision for Change* http://health.gov.ie/future-health/reforming-social-and-continuing-care-2/mental-health-a-vision-for-change/a-vision-for-change/

De Coster, C., Quan, H., Finlayson, A., Gao, M., Halfon, P., Humphries, K. H., ... & Romano, P. S. (2006). Identifying priorities in methodological research using ICD-9-CM and ICD-10 administrative data: report from an international consortium. *BMC health services research*, *6*(1), 77-83. DOI:10.1186/1472-6963-6-77

Devanney, C., & Wistow, R. (2013). Mapping the implementation of children's trust arrangements. *Journal of Children's Services, 8*(1), 65-77. DOI:10.1108/17466661311309790

Doherty, W. J., & Simmons, D. S. (1996). Clinical practice patterns of marriage and family therapists: A national survey of therapists and thier clients. *Journal of Marital and Family therapy*, *22*(1), 9-25. DOI:10.1111/j.1752-0606.1996.tb00183.x

Dolen, W., Ruyter, K. & Lemmink, J. (2004) An empirical assessment of the influence of customer emotions and contact employee performance on encounter and relationship satisfaction, *Journal of Business Research,* 57(4) 437–444. DOI: 10.1016/S0148-2963(02)00277-1

Donald, D. (2016) “Some things cannot be measured’: the limits of evidence-based policy” PUBLISHED ON LINE http://www.themandarin.com.au/68995-things-cannot-measured-limits-evidence-based-policy

Doody, B. (2013). Communications of the European society for child and adolescent psychiatry. *European Child & Adolescent Psychiatry, 22*(6), 385-6. DOI 10.1007/s00787-013-0418-6

Drucker, P. (1954) *The Practice of Management*, *The study of the most important function in American society*. New York: HarperCollins

Duffy, B (2000) Satisfaction and Expectations: Attitudes to Public Services in Deprived Areas. LSE STICERD Research Paper No. CASE045. https://ssrn.com/abstract=1158936

Duckett, S. (2014). Opinion: Australian health care: Where do we stand internationally? *Australian Medicine*, *26*(17), 29.

Duckett, S. J., Breadon, P., Weidmann, B., & Nicola, I. (2014). *Controlling costly care: a billion-dollar hospital opportunity*. Carlton: Grattan Institute.

Duckett, S. & Griffiths (2016) *Perils of Place. Identifying hotspots of health inequality.* Grattan Institute

Dumit, J. (2006). Illnesses you have to fight to get: Facts as forces in uncertain, emergent illnesses. *Social science & medicine*, *62*(3), 577-590. DOI: 10.1016/j.socscimed.2005.06.018

Durall, A. (2011). Care of the caretaker: Managing the grief process of health care professionals. *Pediatric Annals, 40*(5), 266-73. DOI:10.3928/00904481-20110412-08

Eagar, K., Burgess, P., & Buckingham, B. (2003). *Towards national benchmarks for Australian mental health services* (Vol. 4, pp. 1-58). Commonwealth Department of Health and Ageing.

Edbrooke- Childs, J., Jacob, J., Law, D., Deighton, J., & Wolpert, M. (2015). Interpreting standardized and idiographic outcome measures in CAMHS: What does change mean and how does it relate to functioning and experience? *Child and Adolescent Mental Health, 20*(3), 142-148. DOI:10.1111/camh.12107

Edbrooke-Childs, J., Jacob, J., Argent, R., Patalay, P., Deighton, J., & Wolpert, M. (2016). The relationship between child-and parent-reported shared decision making and child-, parent-, and clinician-reported treatment outcome in routinely collected child mental health services data. *Clinical child psychology and psychiatry*, *21*(2), 324-338. DOI:10.1177/1359104515591226

Eilenberg, J., Townsend, E. J., & Oudens, E. (2000). Who's in charge here anyway? Managing the management split in mental health organizations. *Administration and Policy in Mental Health and Mental Health Services Research*, *27*(5), 287-297. DOI:10.1023/A:1021984911579

Ellis, P. M., Hickie, I. B., & Smith, D. A. (2003). Summary of guideline for the treatment of depression. *Australasian Psychiatry*, *11*(1), 34-38. DOI: 10.1046/j.1440-1665.2003.00530.x

Emerson, R., Fretz, R., & Shaw, L. (1995). Writing Ethnographic Fieldnotes. Chicago: University of Chicago Press.

Epstein A (1995) Performance reports on quality— prototypes, problems and prospects. *New England Journal of Medicine* 333, 57–61. DOI:10.1056/NEJM199507063330114

Esbjørn, B.H; Reinholdt-Dunne, M.L; Nielsen, S.K.; Smith, A.C; Breinholst, S. & Leth, I. (2015). Exploring the Effect of Case Formulation Driven CBT for Children with Anxiety Disorders: A Feasibility Study. *Behavioural and Cognitive Psychotherapy*, 43(01), 20-30. DOI:10.1017/S1352465813000702

Farhall, J. (2001). Clinical psychology and the common good. *Australasian Psychiatry, 9(2),* 139-141. DOI: 10.1046/j.1440-1665.2001.00319.x

Farmer, Caroline. (2015) Addressing the Chasm. *Organisational and Social Dynamics 15(2*): 263-278.

Felker, B., Yazel, J. J., & Short, D. (1996). Mortality and medical comorbidity among psychiatric patients: A review. *Psychiatric Services 47*(12), 1356-1363. DOI:10.1176/ps.47.12.1356

Felício, J. A., Gonçalves, H. M., & da Conceição Gonçalves, V. (2013). Social value and organizational performance in non-profit social organizations: Social entrepreneurship, leadership, and socioeconomic context effects. *Journal of Business Research*, *66*(10), 2139-2146. DOI:10.1016/j.jbusres.2013.02.040

Ferrier, C., & Gildersleeve, J. (2015). Editorial. *Hecate, 41*(1), 4-6. Retrieved from https://search-proquest-com.ezproxy.lib.rmit.edu.au/docview/1822033972?accountid=13552

Fineman, S. (1997). Emotion and management learning. *Management Learning*, *28*(1), 13-25. DOI: 10.1177/1350507697281002

Fiorillo, A., Luciano, M., Vecchio, V., Sampogna, G., Obradors‐Tarragó, C., & Maj, M. (2013). Priorities for mental health research in Europe: A survey among national stakeholders' associations within the ROAMER project. *World Psychiatry*, *12*(2), 165-170. DOI:10.1002/wps.20052

Fischer, C., Lingsma, H. F., Marang-van de Mheen, P. J., Kringos, D. S., Klazinga, N. S., & Steyerberg, E. W. (2014). Is the Readmission Rate a Valid Quality Indicator? A Review of the Evidence. *PLoS ONE*, *9*(11), e112282.

DOI:10.1371/journal.pone.0112282

Fisher, C.E; Spaeth-Rublee, B.; & Pincus, H.A. for the IIMHL Clinical Leaders Group (2013) Developing mental health-care quality indicators: toward a common framework *International Journal for Quality in Health Care* 25(1), 75-80; DOI:10.1093/intqhc/mzs074

Flakierska-Praquin, N., Lindström, M., & Gillberg, C. (1997). School phobia with separation anxiety disorder: A comparative 20-to 29-year follow-up study of 35 school refusers. *Comprehensive Psychiatry*, 38(1), 17-2 DOI:10.1016/S0010-440X(97)90048-1

Foerschner, A. M. (2010). The History of Mental Illness: From 'Skull Drills' to 'Happy Pills'. *Student Pulse*, *2*(9), 1-4. Retrieved from http://www.inquiriesjournal.com/a?id=283

Ford T., Vostanis P., Meltzer H., Goodman R. (2007). Psychiatric disorder among British children looked after by local authorities: Comparison with children living in private households. *British Journal of Psychiatry*, 190(4), 319–325. DOI: 10.1192/bjp.bp.106.025023

Fothergill, A., Edwards, D., & Burnard, P. (2004). Stress, burnout, coping and stress management in psychiatrists: findings from a systematic review. *International Journal of Social Psychiatry*, *50*(1), 54-65. DOI:10.1177/0020764004040953

Fraher, A.L. (2004) *A History of Group Study and Psychodynamic Organisations*. London Free Association Books

Frances, A. (2013). The new crisis of confidence in psychiatric diagnosis" *Annals of Internal Medicine* 159(2), 221–222. DOI: 10.7326/0003-4819-159-3-201308060-00655

Francis, J. J., Johnston, M., Robertson, C., Glidewell, L., Entwistle, V., Eccles, M. P., & Grimshaw, J. M. (2010). What is an adequate sample size? Operationalising data saturation for theory-based interview studies. *Psychology and Health*, *25*(10), 1229-1245. DOI:10.1080/08870440903194015

Franco-Santos, M.; Kennerley, M.; Micheli, P.; Martinez, V.; Mason, S.; Marr, B. ;Gray, D. & Neely, A. (2007),Towards a definition of a business performance measurement system *International Journal of Operations & Production Management,* 27(8) 784 - 801 DOI: 10.1108/01443570710763778

Franco-Santos, M., Lucianetti, L., & Bourne, M. (2012). Contemporary performance measurement systems: A review of their consequences and a

framework for research. *Management Accounting Research*, *23*(2), 79-119. DOI: 10.1016/j.mar.2012.04.001

Frank, D.B. (2003) The systems psychodynamics of organizations: Integrating the group relations approach, psychoanalytic, and open systems perspectives *Human Relations*;56(3), 349-354.

Frank, M. C., Bergelson, E., Bergmann, C., Cristia, A., Floccia, C., Gervain, J., Hamlin, J. K., Hannon, E. E., Kline, M., Levelt, C., Lew-Williams, C., Nazzi, T., Panneton, R., Rabagliati, H., Soderstrom, M., Sullivan, J., Waxman, S. and Yurovsky, D. (2017), A Collaborative Approach to Infant Research: Promoting Reproducibility, Best Practices, and Theory-Building. *Infancy.* doi:10.1111/infa.12182

French, R. & Vince, R (1999) Eds. *Group Relations, Management and Organisation.* New York, Oxford

Friedberg, R.D. & McClure, J.M (2015) *Clinical practice of cognitive therapy with children and adolescents: The nuts and bolts*. (pp 81-97) Guilford Publications.

Friedman, R. M., & Hernandez, M. (2002). The national evaluation of the comprehensive community mental health services for children and their families program: A commentary. *Children's Services: Social Policy, Research, and Practice,* 5(1), 67–74. DOI: 10.1207/S15326918CS0501_6

Fryer, K., Antony, J., & Ogden, S. (2009). Performance management in the public sector. *International Journal of Public Sector Management*, *22*(6), 478-498 DOI: 10.1108/09513550910982850

Frydman, C., & Saks, R. E. (2010). Executive compensation: A new view from a long-term perspective, 1936–2005. *Review of Financial Studies*, hhp120. DOI: 10.1093/rfs/hhp120

Freud, S. (1913) *Totem and Taboo* New York: Vintage Books

Ford, T., Hamilton, H., Meltzer, H. and Goodman, R. (2007), Child Mental Health is Everybody's Business: The Prevalence of Contact with Public Sector Services by Type of Disorder Among British School Children in a Three-Year Period. *Child and Adolescent Mental Health,* 12(1), 13–20. doi:10.1111/j.1475-3588.2006.00414.x

Foreman, D. M. (2016). Exploring unintended consequences of policy initiatives in mental health: the example of Child and Adolescent Mental Health Services (CAMHS) in England. *BMJ open*, *6*(8), e010714. DOI:10.1136/bmjopen-2015-010714

Fowler, C. (2009) Performance management, budgeting, and legitimacy-based change in educational organisations *Journal of Accounting & Organizational Change*; 5(2), 168-196. DOI:10.1108/18325910910963427

Fugard, A. J. B., Stapley, E., Ford, T., Law, D., Wolpert, M., & York, A. (2015). Analysing and reporting UK CAMHS outcomes: An application of funnel plots. *Child and Adolescent Mental Health, 20*(3), 155-162. DOI:10.1111/camh.12086

Fuggle, P., McHugh, A., Gore, L., Dixon, E., Curran, D., & Cutinha, D. (2016). Can we improve service efficiency in CAMHS using the CAPA approach without reducing treatment effectiveness? *Journal of Child Health Care*, *20*(2), 195-204. DOI:10.1177/1367493514563856

Furber, G. & Segal, L. (2012) Give your child and adolescent mental health service a health economics makeover. *Children and Youth Services Review* 34(1), 71-75. DOI:10.1016/j.childyouth.2011.09.001

Gabbard, G. O. (2014). *Psychodynamic psychiatry in clinical practice*. American Psychiatric Pub.

Gabriel, Y. (1999). *Organizations in depth.* Thousand Oaks, CA: Sage

Gabriel, Y. (2016). Psychoanalysis and the study of organization in Mir, R.; Willmott, H.; and, Greenwood, M. (Eds) *Routledge Companion to Philosophy in Organization Studies*, (pp 212-225). Routledge New York

Gabriel, Y. & Griffiths, D. S. (2002). Emotion, learning and organizing. *The Learning Organization,* 9(5), 214-221. DOI: 10.1108/09696470210442169

Gardner, K., Davies, G. P., Edwards, K., McDonald, J., Findlay, T., Kearns, R., ... & Harris, M. (2016). A rapid review of the impact of commissioning on service use, quality, outcomes and value for money: implications for Australian policy. *Australian Journal of Primary Health*, *22*(1), 40-49. DOI:10.1071/PY15148

Garland, A. F., Kruse, M., & Aarons, G. A. (2003). Clinicians and outcome measurement: What's the use?. *The Journal of Behavioral Health Services and Research*, *30*(4), 393-405. DOI:10.1007/BF02287427

Garland, A. F., Lewczyk-Boxmeyer, C. M., Gabayan, E. N., & Hawley, K. M. (2004). Multiple stakeholder agreement on desired outcomes for adolescents' mental health services. *Psychiatric Services*, *55*(6), 671-676. DOI:10.1176/appi.ps.55.6.671

Garralda, M. E., Yates, P., & Higginson, I. (2000). Child and adolescent mental health service use. *The British Journal of Psychiatry*, *177*(1), 52-58. DOI: 10.1192/bjp.177.1.52

Gathright, M. M., Holmes, K. J., Morris, E. M., & Gatlin, D. A. (2016). An Innovative, Interdisciplinary Model of Care for Inpatient Child Psychiatry: an Overview. *The journal of behavioral health services & research*, *43*(4), 648-660. DOI:10.1007/s11414-015-9484-5

Gaventa, J., & McGee, R. (2013). The impact of transparency and accountability initiatives. *Development Policy Review*, *31*(s1). DOI:10.1111/dpr.12017

Geertz, C. (1973). *The Interpretation of Cultures*. New York: Basic Books

Geldenhuys, D. J., Levin, M. M., & Van Niekerk, A. (2012). Risk management as a social defence against anxiety. *SA Journal of Industrial Psychology*, *38*(2), 65-74. http://www.scielo.org.za/scielo.php?script=sci_arttext&pid=S2071-07632012000200009&lng=en&tlng=en.

Gelenberg, A. J., Bassuk, E. L., & Schoonover, S. C. (2013). *The practitioner's guide to psychoactive drugs*. Springer Science & Business Media.

Gerrish, E. (2016), The Impact of Performance Management on Performance in Public Organizations: A Meta-Analysis. *Public Admin Rev*, 76(1), 48–66. DOI:10.1111/puar.12433

Gilson, L. (2006). Trust in health care: theoretical perspectives and research needs. *Journal of health organization and management*, *20*(5), 359-375. DOI:10.1108/14777260610701768

Glaser, B.G. & Strauss, A.L. (1967) *The discovery of grounded theory*. Hawthorne, NY: Aldine.

Gleeson, D. H., Legge, D. G., & O'Neill, D. (2009). Evaluating health policy capacity: Learning from international and Australian experience. *Australia and New Zealand health policy*, *6*(1), 1-15. DOI:10.1186/1743-8462-6-3

Glisson C & Hemmelgarn A. (1998) The effects of organizational climate and interorganizational coordination on the quality and outcomes of children's service systems. *Child Abuse and Neglect*; *22*(5), 401-421. DOI:10.1016/S0145-2134(98)00005-2

Glendinning, C., Clarke, S., Hare, P., Kotchetkova, I., Maddison, J., & Newbronner, L. (2006) Outcomes-focused Services for Older People. *SCIE Knowledge Review*, 13. Bristol: Social Care Institute for Excellence

Glynn, J. J., & Murphy, M. P. (1996). Public management failing accountabilities and failing performance review. *The International Journal of Public Sector Management, 9*(5), 125-137. DOI:10.1108/09513559610146492

Goh, S. C. (2012). Making performance measurement systems more effective in public sector organizations. *Measuring Business Excellence, 16*(1), 31-42. DOI:10.1108/13683041211204653

Gonzalez, R., Cameron, C., & Klendo, L. (2012). The therapeutic family model of care: An attachment and trauma informed approach to transitional planning. *Developing Practice: The Child, Youth and Family Work Journal*, (32), 13-23.

Goodman, R., & Scott, S. (2012). *Child and adolescent psychiatry*. John Wiley & Sons.

Gould, L.; Stapley, L.F. & Stein, M. (2006) *Systems Psychodynamics of Organizations* London Karnac Books

Gould, L. J. (2010) 'Barack Obama's postpartisan dream: leadership and the limits of the depressive position', in H. Brunning and M. Perini (Eds), *Psychoanalytic Perspectives on a Turbulent World* (pp. 159-178). London Karnac.

Gould, S. R., Beals-erickson, S., & Roberts, M. C. (2012). Gaps and barriers in services for children in state mental health plans. *Journal of Child and Family Studies, 21*(5), 767-774. DOI:10.1007/s10826-011-9529-1

Gracia, D. (2001). History of medical ethics. In ten Have, H. and, Gordijn, B. (Eds) *Bioethics in a European perspective* (pp. 17-50). Springer Netherlands. DOI:10.1007/978-94-015-9706-7

Greene, M. J. (2014). On the Inside Looking In: Methodological Insights and Challenges in Conducting Qualitative Insider Research. *The Qualitative Report, 19(29), 1-13*. Retrieved from http://nsuworks.nova.edu/tqr/vol19/iss29/3

Grol, R., Wensing, M., Eccles, M., & Davis, D. (Eds.). (2013). *Improving patient care: the implementation of change in health care*. John Wiley & Sons.

Grönroos, C. (2011). Value co-creation in service logic: A critical analysis. *Marketing theory*, *11*(3), 279-301. DOI: 10.1177/1470593111408177

Guba, E. G., & Lincoln, Y. S. (1994). Competing paradigms in qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research (*pp 105-117). Thousand Oaks, CA: Sage.

Gulliver, A., Griffiths, K. M., & Christensen, H. (2010). Perceived barriers and facilitators to mental health help-seeking in young people: a systematic review. *BMC psychiatry*, *10*(1), 113. DOI:10.1186/1471-244X-10-113

Gurman, A. S., Lebow, J. L., & Snyder, D. K. (Eds.) (2015). *Clinical handbook of couple therapy*. Guilford Publications.

Hall, C. L., Moldavsky, M., Taylor, J., Sayal, K., Marriott, M., Batty, M. J., . . . Hollis, C. (2014). Implementation of routine outcome measurement in child and adolescent mental health services in the united kingdom: A critical perspective. *European Child & Adolescent Psychiatry, 23*(4), 239-242. DOI:10.1007/s00787-013-0454-2

Hall, J. (2015). Australian health care -- the challenge of reform in a fragmented system. *The New England Journal of Medicine, 373*(6), 493-497. DOI: 10.1056/NEJMp1410737

Halsteinli, V.; Sverre, A.; Kittelsen; Magnussen, J. (2010) Productivity growth in outpatient child and adolescent mental health services: The impact of case-mix adjustment *Social Science & Medicine* 70(3), 439–446 DOI:10.1016/j.socscimed.2009.11.002

Halton, W (1994) Unconscious aspects of organizational life, in Obholder, A. and Zagier Roberts, V. (Eds) *The unconscious at work (*pp 11-18) Routledge, London

Ham, C. & Timmins, N. (2015) Managing health services through devolved governance: A perspective from Victoria, Australia. *The Kings Fund*. London. https://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/Devolved-governance-Victoria-Kings-Fund-November-2015.pdf

Hannigan, B., Edwards, D., & Burnard, P. (2004). Stress and stress management in clinical psychology: Findings from a systematic review. *Journal of Mental Health*, *13*(3), 235-245. DOI:10.1080/09638230410001700871

Happell, B. (2008). Putting all the pieces together: Exploring workforce issues in mental health nursing. *Contemporary Nurse : A Journal for the Australian Nursing Profession, 29*(1), 43-52. DOI: 10.5172/conu.673.29.1.43

Hawke, L. (2012). Australian public sector performance management: Success or stagnation? *International Journal of Productivity and Performance Management, 61*(3), 310-328. DOI: 10.1108/17410401211205669

Hawkins, J. D., Catalano, R. F., & Kuklinski, M. R. (2014). Communities that care. In *Encyclopedia of Criminology and Criminal Justice* (pp. 393-408). Springer New York.

Hawley, K. M., & Weisz, J. R. (2003). Child, parent and therapist (dis) agreement on target problems in outpatient therapy: The therapist's dilemma and its implications. *Journal of consulting and clinical psychology*, *71*(1), 62. DOI: 10.1037/0022-006X.71.1.62

Hay, A., Majumder, P., Fosker, H., Karim, K., & O'Reilly, M. (2013). The views and opinions of CAMHS professionals on their role and the role of others in attending to children who self-harm. *Clinical child psychology and psychiatry*, *20*(2), 289-303. DOI:10.1177/1359104513514068

Headspace (2016) *Who we are* https://headspace.org.au/about-us/who-we-are/ (Accessed 6.11.16) https://headspace.org.au/assets/headspace-overview.pdf)

Heard, C. P., & Scott, J. (2015). Walking the Labyrinth: Considering Mental Health Consumer Experience, Meaning Making, and the Illumination of the Sacred in a Forensic Mental Health Setting. *Journal of Pastoral Care & Counseling*, *69*(4), 240-250. DOI: 10.1177/1542305015616102

Heberbrand, J.; Reichwald, K.; Schimmelmann, B.G.; Hinney, A. (2006) “Identifying Genes underlying Child and Adolescent psychiatric disorders” in Garralda, M.E. and Flament, M. (Eds) *Working with Children and Adolescents. An Evidence-Based Approach to Risk and Resilience*. Jason Aronson, Oxford UK

Heimann, P., Klein, M., & Money-Kyrle, R. E. (2013). *New directions in psycho-analysis: The significance of infant conflict in the pattern of adult behaviour* (Vol. 7). Routledge.

Henderson, P., Batten, R., & Richmond, J. (2015). Perceptions of the Role of Occupational Therapy in Community Child and Adolescent Mental Health Services. *Occupational Therapy in Mental Health*, *31*(2), 155-167. DOI:10.1080/0164212X.2015.1035475

Hernandez, M., Nesman, T., Mowery, D., Acevedo-Polakovich, I. D., & Callejas, L. M. (2015). Cultural competence: A literature review and conceptual model for mental health services. *Psychiatric Services*. *60*(8), 1046-1050. DOI: 10.1176/ps.2009.60.8.1046

Hergenhahn, B. R., & Henley, T. (2013). *An introduction to the history of psychology*. Cengage Learning.

Hersen, M., & Van Hasselt, V. B. (Eds.). (2013). *Sourcebook of psychological*

treatment manuals for adult disorders. Springer Science & Business Media.

Huesca, R. (2001). Conceptual contributions of new social movements to development communication research. *Communication theory*, *11*(4), 415-433.

Higgin, G. & Bridger, H. (1965). *The Psychodynamics of an Inter-Group Experience. Tavistock Pamphlet No. 10*. London: Tavistock Publications.

Higgins, A., Morrissey, J., Doyle, L., Bailey, J., & Gill, A. (2015). Best practice principles for risk assessment and safety planning for nurses working in mental health services. *Lensus* http://www.lenus.ie/hse/handle/10147/559255

Hill, C. E., Gelso, C. J., Chui, H., Spangler, P. T., Hummel, A., Huang, T., ... & Gupta, S. (2014). To be or not to be immediate with clients: The use and perceived effects of immediacy in psychodynamic/interpersonal psychotherapy. *Psychotherapy Research*, *24*(3), 299-315. DOI:10.1080/10503307.2013.812262

Hill, M. S., Lopez, T. J., & Reitenga, A. L. (2016). CEO excess compensation: The impact of firm size and managerial power. *Advances in Accounting*, *33*, 35-46. DOI:10.1016/j.adiac.2016.04.007

Hill-Smith, A., Taverner, R., Greensmith, H., & Parsons, D. (2012). Staff Reationships in Multidisciplinary Teams *Mental Health Practice (through 2013), 15*(8), 14-19. DOI: 10.7748/mhp2012.05.15.8.14.c9097

Hilty, D. M., Ferrer, D. C., Parish, M. B., Johnston, B., Callahan, E. J., & Yellowlees, P. M. (2013). The effectiveness of telemental health: a 2013 review. *Telemedicine and e-Health*, *19*(6), 444-454. DOI:10.1089/tmj.2013.0075.

Hinshaw, S. P. (2005). The stigmatization of mental illness in children and parents: Developmental issues, family concerns, and research needs. *Journal of Child Psychology and Psychiatry*, *46*(7), 714-734. DOI:10.1111/j.1469-7610.2005.01456.x

Hinshelwood, R. D., & Skogstad, W. (Eds.). (2002). *Observing organisations: Anxiety, defence and culture in health care*. London Routledge.

Hirschhorn, L. (1993). *The workplace within: psychodynamics of organizational life*. Cambridge, MA: MIT Press.

Hirschhorn, L. (1999). The primary risk. *Human Relations*, *52*(1), 5-23. DOI:10.1177/001872679905200102

Hirschhorn, L. & Gilmore, T. (1992) The new boundaries of the ‘boundaryless’ company. *Harvard Business Review* May-June 1992, 104-115

Hoagwood, K. ; Burns, B.J; Kiser, L.; Ringeisen, H.; Schoenwald, S.K. (2001) Evidence-Based Practice in Child and Adolescent Mental Health Services *Psychiatric Services* 52(9), 1179-1189 DOI: 10.1176/appi.ps.52.9.1179

Hodges, S.D. and Wegner, D.M. (1997) Automatic and controlled empathy. In: Ickes WJ (Ed.) *Empathic accuracy.* New York, NY: Guilford Press. pp. 311–340.

Hofstede, G. (1981). Management control of public and not-for-profit activities. *Accounting, Organizations and society*, *6*(3), 193-211. DOI:10.1016/0361-3682(81)90026-X

Hoggett, Paul (1994), New Modes of Control Within the Public Sector, *Management Research News, 17*(7/8/9), 17-19. DOI:10.1108/eb028347

Hoggett, Paul (2000) *Emotional life and the politics of welfare.* London MacMillan Press

Hoggett, Paul (2006) *Conflict, ambivalence, and the contested purpose of public organizations* Human Relations 59(2) 175-194. DOI:10.1177/0018726706062731

Hoggett, P.; Mayo, M. & Miller, C. (2006) On good authority *Socio-analysis* 8: 1-16.

Hoggett, P. (2010). Government and the perverse social defence. *British Journal of Psychotherapy*, *26*(2), 202-212. DOI: 10.1111/j.1752-0118.2010.01174.x

Holland, S., Faulkner, A., & Perez- del- Aguila, R. (2005). Promoting stability and continuity of care for looked after children: A survey and critical review. *Child & Family Social Work*, *10*(1), 29-41. DOI: 10.1111/j.1365-2206.2004.00339.x

Holloway I. (1997) *Basic concepts for qualitative research*. Oxford: Blackwell Science

Holloway, J. (2009) Performance management from multiple perspectives: taking stock, *International Journal of Productivity and Performance Management,* 58(4), 391 – 399 DOI: 10.1108/17410400910951035

Hollway, W. (2014). Defense Mechanisms. In *Encyclopedia of Critical Psychology* pp 378-380. Springer New York.

Honig, B. (1996) Difference, dilemmas and the politics of home. In S.

Benhabib (Ed.), *Democracy and difference: Contesting the boundaries of the political. (*pp 257-77) Princeton, NJ: Princeton University Press.

Hort, K., Djasri, H., & Utarini, A. (2013). Regulating the quality of health care: Lessons from hospital accreditation in Australia and Indonesia. *The Nossal Institute for Global Health, Working Paper Series*, *28*. http://ni.unimelb.edu.au/__data/assets/pdf_file/0006/782115/WP_28.pdf

Howell, J.C; Kelly, M.R.; Palmer, J.; Mangum, R. L. (2004) *Integrating Child Welfare, Juvenile Justice, and Other Agencies in a Continuum of Services* Child Welfare; Arlington 83(2) 143-56.

Huibers, M.J.H. & Wessley, S. (2006) The act of diagnosis: pros and cons of labelling chronic fatigue syndrome. *Psychological Medicine* 36(7) 895-90. DOI: 10.1017/S0033291705006926

Hurn, J., Kneebone, I., & Cropley, M. (2006). Goal setting as an outcome measure: a systematic review. *Clinical rehabilitation*, *20*(9), 756-772. DOI:10.1177/0269215506070793

Hutchings, J., & Williams, M. E. (2014). Joined-up thinking, joined-up services, exploring coalface challenges for making services work for families with complex needs. *Journal of Children's Services, 9*(1), 31-41. DOI:10.1108/JCS-08-2013-0027

Hyland, M., Hoey, W., Finn, M., & Whitecross, F. (2008). National Mental Health Benchmarking Project: Reducing 28- day Readmissions- Project Report. *Sydney: Australian Mental Health Outcomes and Classification Network*.

Illiffe, S., Gledhill, J., da Cunha, F., Kramer, T., & Garralda, E. (2004). The recognition of adolescent depression in general practice: Issues in the acquisition of new skills. *Primary Care Psychiatry 9*(2), 51-56. http://discovery.ucl.ac.uk/id/eprint/63282

Impey, M., & Milner, E. (2013). Delayed discharge from mental health inpatient care in the UK: Matthew Impey and Erik Milner compare the results of two surveys taken ten years apart that show the duration of patients' stays in hospital and reasons for prolonged admissions. *Mental Health Practice*, *16*(9), 31-35. DOI: 10.7748/mhp2013.06.16.9.31.e777

Insel, T. R. (2014). The NIMH research domain criteria (RDoC) project: precision medicine for psychiatry. *American Journal of Psychiatry*, *171*(4), 395-397. DOI: 10.1176/appi.ajp.2014.14020138

Iskra, W., Deane, F. P., Wahlin, T. and Davis, E. L. (2015), Parental perceptions of barriers to mental health services for young people. *Early*

Intervention in Psychiatry. DOI:10.1111/eip.12281

IPHA, Independent Hospital Pricing Authority (2015)

https://www.ihpa.gov.au/sites/g/files/net636/f/9_-_child_and_adolescent_mental_health_information_development_expert_advisory_panel.pdf

Jackson, P. (1988). The management of performance in the public sector. *Public Money & Management*, *8*(4), 11-16. DOI:10.1080/09540968809387501

Jacobs, R., Mannion, R., Davies, H. T., Harrison, S., Konteh, F., & Walshe, K. (2013). The relationship between organizational culture and performance in acute hospitals. *Social science & medicine*, *76*, 115-125. DOI:10.1016/j.socscimed.2012.10.014

Jakubec, S. L., & Rankin, J. M. (2016). Interrogating the Rights Discourse and Knowledge-Making Regimes of the "Movement for Global Mental Health". In Burstow, B. (Ed) *Psychiatry Interrogated* (pp. 103-123). Springer International Publishing. DOI:10.1007/978-3-319-41174-3_6

James, D. C. (1984). Bion's "containing" and Winnicott's "holding" in the context of the group matrix. *International Journal of Group Psychotherapy*, *34*(2), 201-213.

James, S., Charlemagne, S. J., Gilman, A. B., Alemi, Q., Smith, R. L., Tharayil, P. R., & Freeman, K. (2010). Post-discharge services and psychiatric rehospitalization among children and youth. *Administration and Policy in Mental Health and Mental Health Services Research*, *37*(5), 433-445. DOI:10.1007/s10488-009-0263-6

James, K., Elgie, S., Adams, J., Henderson, T., & Salkovskis, P. (2015). Session-by-session outcome monitoring in CAMHS: clinicians' beliefs. *The Cognitive Behaviour Therapist*, *8*, e26. DOI: 10.1017/S1754470X15000653

Jaques, E. (1951) *The Changing Culture of a Factory*, London, Tavistock

Jaques, E. (1955) Social Systems as a Defence against Persecutory and Depressive Anxiety, in Klein, M. et. al. (Eds.) *New Directions in Psycho-analysis,* London, Tavistock

Jaques, E. (1953). On the Dynamics of Social Structure A Contribution to the Psycho-Analytical Study of Social Phenomena. *Human Relations*, *6*(1), 3-24.DOI: 10.1177/001872675300600101

Jason, L.A.; Richman, J.A.; Friedberg, F.; Wagner, L. & Taylor, R. (1997) Politics, science, and the emergence of a new disease: *The case of chronic fatigue syndrome*. American Psychologist 52(9) 973-983.DOI: /10.1037/0003-

066X.52.9.973

Johnson, H. T. and Kaplan, R.S. (1987) *Relevance Lost: The Rise and Fall of Management Accounting*, Boston: Harvard Business School Press

Jørring, N. T., & Jacobsen, C. B. (2014). Narrative Therapy in CAMHS: Creating Multistoried Treatments. *Journal of Systemic Therapies*, *33*(1), 89-101. DOI:10.1521/jsyt.2014.33.1.89

Jutel, A. (2006). The emergence of overweight as a disease entity: Measuring up normality. *Social Science & Medicine*, *63*(9), 2268-2276. DOI:10.1016/j.socscimed.2006.05.028

Jutel, A. (2008). Doctor's orders: Diagnosis , medicalisation and the exploitation of anti-fat stigma. In Wright, J. and Harwood, V. *Biopolitics and the "obesity epidemic": Governing bodies*. (pp 60-75) Milton Park, UK. Taylor and Francis.

Jutel, A (2011) Classification, disease and diagnosis. *Perspectives in Biology and Medicine* 54(2) 189-205. DOI: 10.1353/pbm.2011.0015

Kahn, W. A. (2001). Holding environments at work. *The Journal of Applied Behavioral Science*, *37*(3), 260-279. DOI: 10.1177/0021886301373001

Khan, A., & Francis, A. (2015). Strengths Based Practice with Children with a Mental Health Condition. *International Journal of Social Work and Human Services Practice*, *3*(1), 9-19. DOI: 10.13189/ijrh.2015.030102

Kanste, O., Halme, N., & Perälä, M. (2016). The collaboration management and employee views of work and skills in services for children and families in Finnish municipalities: The collaboration management and employee views of work and skills. *Nordic Journal of Working Life Studies, 6*(1), 61-81 DOI:10.19154/njwls.v6il.4910

Kasinski, K. (2003). The roots of the work: definitions, origins and influences. In Ward, A.; Kasinski, K.; Pooley, J. and Worthington, A. (Eds) *Therapeutic communities for children and young people*, (pp 43-64). London: Jessica Kingsley Publishers

Katona, C., Cooper, C., & Robertson, M. (2015) *Psychiatry at a Glance*. John Wiley & Sons.

Katsching, H. (2010) Are psychiatrists an endangered species? Observations on internal and external challenges to the profession. *World Psychiatry* 9(1): 21–28. DOI: 10.1002/j.2051-5545.2010.tb00257.x

Kaplan, R. S. and Norton, D.P (1992) The Balanced Scorecard: Measures that Drive Performance, *Harvard Business Review,* (January-February): 71-79.

Kaplan, R. S. (2009). Conceptual foundations of the balanced scorecard. *Handbooks of management accounting research*, (*3)*, 1253-1269. DOI:10.1016/S1751-3243(07)03003-9

Kay, A., & Boxall, A. M. (2015). Success and Failure in Public Policy: Twin Imposters or Avenues for Reform? Selected Evidence from 40 Years of Health-care Reform in Australia. *Australian Journal of Public Administration*, *74*(1), 33-41. DOI:10.1111/1467-8500.12135

Kazdin A.E. (1996) Combined and multimodal treatments in child and adolescent psychotherapy: Issues, challenges, and research directions. *Clinical Psychology: Science and Practice.* 3(1) 69–100. DOI:10.1111/j.1468-2850.1996.tb00059.x

Kazdin, A. E., & Cole, P. M. (1981). Attitudes and labeling biases toward behavior modification: The effects of labels, content, and jargon. *Behavior Therapy*, *12*(1), 56-68.DOI:10.1016/S0005-7894(81)80106-2

Kazdin, A. E. and Nock, M. K. (2003), Delineating mechanisms of change in child and adolescent therapy: methodological issues and research recommendations. *Journal of Child Psychology and Psychiatry*, 44(8) 1116–1129. DOI:10.1111/1469-7610.00195

Ke, K. M., Blazeby, J. M., Strong, S., Carroll, F. E., Ness, A. R., & Hollingworth, W. (2013). Are multidisciplinary teams in secondary care cost-effective? A systematic review of the literature. *Cost Effectiveness and Resource Allocation*, *11*(1), 7-20. DOI:10.1186/1478-7547-11-7

Keele, R.L.; Buckner, K.; Bushnell, S. (1987) Identifying health care stakeholders: a key to strategic implementation. *Health care strategic management* 5(9), 4-10.

Kelvin, R. G. (2005) Capacity of tier 2/3 CAMHS and service specification: A model to enable evidence based service development. *Child and Adolescent Mental Health* 10(2) 63-73. DOI: 10.1111/j.1475-3588.2005.00120.x

Kenny, J. E. (2001). Mental illness: Cloaked in secrecy and shame. *The Canadian Nurse, 97*(1), 20-4. Retrieved from http://search.proquest.com.ezproxy.lib.rmit.edu.au/docview/232089913?accountid=13552

Kets De Vries, F. R. (1991). *Organizations on the couch: handbook of psychoanalysis and Management*. New York: Jossey-Bass.

Kets De Vries, F.R. (2006) *The Leader on the Couch. A clinical approach to changing people and organisations.* West Sussex. John Wiley & Sons

Kettinger, W. J., Grover, V., Guha, S., & Segars, A. H. (1994). Strategic information systems revisited: a study in sustainability and performance. *MIS quarterly* 31-58. DOI: 10.2307/249609

Kilber, R.R. (2004) When shadows fall: Using psychodynamic Approaches in Executive Coaching *Consulting Psychology Journal: Practice and Research* 56(4) 246-268

Kilbourne, A. M., Keyser, D. & Pincus, H.A. (2010) Challenges and opportunities in measuring the quality of mental health care *The Canadian Journal of Psychiatry* 55(9) 549-557. DOI: 10.1177/070674371005500903

Kilfedder, C. J., Power, K. G., & Wells, T. J. (2001). Burnout in psychiatric nursing. *Journal of Advanced Nursing*, *34*(3), 383-396. DOI:10.1046/j.1365-2648.2001.01769.x

Kirmayer, L. J. (2005). Culture, context and experience in psychiatric diagnosis. *Psychopathology*, *38*(4), 192-196. DOI: 10.1159/000086090

Klein, M. (1948) *Contributions to Psycho-analysis 1921-1945.* London: Hogarth

Klein, M. & Riviere, J. (1964) *Love, Hate and Reparation.* New York: Norton

Kleine, C., & Weißenberger, B. E. (2014). Leadership impact on organizational commitment: the mediating role of management control systems choice. *Journal of Management Control*, *24*(3), 241-266. DOI:10.1007/s00187-013-0181-3

Knitzer, J. (1993). Children's mental health policy: Challenging the future. *Journal of Emotional and Behavioral Disorders*, *1*(1), 8-16. DOI:10.1177/106342669300100104

Knottnerus, J. A., van Weel, C., & Muris, J. W. (2002). Evaluation of diagnostic procedures. *British Medical Journal*, *324*(7335), 477-480

Knox, R., & Cooper, M. (2015). *The Therapeutic Relationship in Counselling and Psychotherapy*. SAGE.

Ko, S. J., Ford, J. D., Kassam-Adams, N., Berkowitz, S. J., Wilson, C., Wong, M., ... & Layne, C. M. (2008). Creating trauma-informed systems: child welfare, education, first responders, health care, juvenile justice. *Professional*

Psychology: Research and Practice, *39*(4), 396-404. DOI:10.1037/0735-7028.39.4.396

Kolvin, I.; Trowell, J. (2002) Diagnosis and classification in child and adolescent psychiatry: The case of unipolar affective disorder *Psychopathology* 35(2-3) 117-121. DOI: 10.1159/000065130

Konteh, F.H.; Mannion, R.; Davies, H. (2008) Clinical governance views on culture and quality improvement. *Clinical Governance: An International Journal* 13(3) 200-207. DOI: 10.1108/14777270810892610

Koot, H., & Wallander, J. (2014). *Quality of life in child and adolescent illness: Concepts, methods and findings*. Routledge.

Kowalewski, K., Mclennan, J. D., & McGrath, P. J. (2011). A Preliminary investigation of wait times for child and adolescent mental health services in Canada. *Journal of the American Academy of Child and Adolescent Psychiatry,* 20(2) 112–119.

Krachler, N., & Greer, I. (2015). When does marketisation lead to privatisation? Profit-making in English health services after the 2012 Health and Social Care Act. *Social Science & Medicine*, *124*, 215-223. DOI:10.1016/j.socscimed.2014.11.045

Kraemer, S. (2011) The dangers of this atmosphere: a Quaker connection in the Tavistock Clinic's development *History of the Human Sciences* 24(2) 82–102. DOI:10.1177/0952695111398570

Krantz, J., & Gilmore, T. N. (1990). The splitting of leadership and management as a social defense. *Human Relations*, *43*(2), 183-204. DOI:10.1177/001872679004300206

Krapf, E. E. (1955). The choice of language in polyglot psychoanalysis. *The Psychoanalytic Quarterly*. 24. 343-357

Krug, E. G., Mercy, J. A., Dahlberg, L. L., & Zwi, A. B. (2002). The world report on violence and health. *The lancet*, *360*(9339), 1083-1088. DOI:10.1016/S0140-6736(02)11133-0

Kulkarni, J. (2015) *Witness Statement to Victoria's Royal Commission into Family Violence:* WIT-0067-001-0001-Kulkarni-8

Kutash, K., Acri, M., Pollock, M., Armusewicz, K., Serene Olin, S., & Hoagwood, K. E. (2014). Quality indicators for multidisciplinary team functioning in community-based children's mental health services.

Administration and Policy in Mental Health and Mental Health Services Research, 41(1), 55-68. DOI: 10.1007/s10488-013-0508-2

Lambert, W.; Salzer, M. S.; Bickman, L. (1998) Clinical outcome, consumer satisfaction, and ad hoc ratings of improvement in children's mental health. *Journal of Consulting and Clinical Psychology* 66(2), 270-279.

Lambie, I. and Stewart, M. W. (2010), Workforce Factors for Psychologists in CAMHS in New Zealand. *Child and Adolescent Mental Health,* 15(3), 164–170. DOI:10.1111/j.1475-3588.2010.00561.x

Langfield-Smith, K., Thorne, H. and Hilton, R. (2012), *Management Accounting: Information for Creating and Managing Value*, 6th ed., McGraw-Hill North Ryde, NSW quoted in Upadhaya, B. & Munir, R. (2014) Association between performance measurement systems and organisational effectiveness. *International Journal of Operations & Production Management* 34(7), 875-853

Langlois, J. P. (2002). Making a diagnosis. In Mengel, M.B; Holleman, W.L.; Fileds, S.A. (Eds) *Fundamentals of clinical practice* (pp 197-217) Springer US.

Lanyado, M. (1996). Winnicott's children: The holding environment and therapeutic communication in brief and non-intensive work. *Journal of Child Psychotherapy*, *22*(3), 423-443. DOI: 10.1080/00754179608254517

Lawrence, G. (1977). Management development… some ideals, images and realities. *Journal of European Industrial Training*, *1*(2), 21-25. DOI:10.1108/eb014148

Lawrence, P., & Fulbrook, P. (2015). Protocol for a pragmatic randomised controlled trial to evaluate effects of a brief intervention for emergency department attendees who present with moderate or high levels of non-specific psychological distress: a pilot study. *Pilot and Feasibility Studies*, *1*(1), 33. DOI: 10.1186/s40814-015-0028-9

Lawrence, W. G. (1999). *Exploring individual and organizational boundaries. A Tavistock open systems approach*. London: Karnac

Lebas, M.J. (1995) Performance measurement and performance management, *International Journal of Production Economics*, 41(1) 23-35. DOI: 10.1016/0925-5273(95)00081-X

Lees, A., Meyer, E., & Rafferty, J. (2013). From Menzies Lyth to Munro: the problem of managerialism. *British Journal of Social Work*, *43*(3), 542-558. DOI: 10.1093/bjsw/bcr183

Lega, F., Prenestini, A., & Spurgeon, P. (2013). Is management essential to

improving the performance and sustainability of health care systems and organizations? A systematic review and a roadmap for future studies. *Value in health*, *16*(1), S46-S51. DOI: 10.1016/j.jval.2012.10.004

Liegghio, M., Nelson, G., & Evans, S. D. (2010). Partnering with children diagnosed with mental health issues: Contributions of a sociology of childhood perspective to participatory action research. *American Journal of Community Psychology*, *46*(1-2), 84-99. DOI:10.1007/s10464-010-9323-z

Leslie, L. K., Hurlburt, M. S., James, S., Landsverk, J., Slymen, D. J., & Zhang, J. (2005). Relationship between entry into child welfare and mental health service use. *Psychiatric Services, 56*(8), 981-7. DOI:10.1176/appi.ps.56.8.981

Leigh, H. (2015). Systems and Ethical Issues in CL Psychiatry: Hospital as a Social System, Sick Role and Doctor Role, Ethical and Legal Issues. In Leigh, H. and Streltzer, J. (Eds) *Handbook of Consultation-Liaison Psychiatry* (pp. 129-137). Springer International Publishing. DOI:10.1007/978-3-319-11005-9_10

Levine, M. (2015). Children come first? A brief history of children's mental health services. *American Journal of Orthopsychiatry, 85*(5), S22-S28. DOI: 10.1037/ort0000115

Levison, H. (2002) *Organisational Assessment.* Washington DC. American Psychological Association

Lewis, L. (2014). User involvement in mental health services: a case of power over discourse. *Sociological Research Online*, *19*(1), 6-12.

Lewis, R. W. (1955) Measuring, Reporting and Appraising Results of Operations with Reference to Goals, Plans and Budgets, *Planning, Managing and Measuring the Business: A case study of management planning and control at General Electric Company,* New York: Controllwership Foundation

Lillie, M. C. 1998. Cranial surgery dates back to Mesolithic. *Nature* 391(6670) 854.

Lin, E. & Durbin, J. (2002) Accountability and performance measurement in mental health care: The feasibility of the balanced scorecard. *The 130th Annual Meeting of APHA*.

Lingiardi, V. (2013). Trying to be useful: three different interventions for

one therapeutic stance. *Psychotherapy*, *50*(3), 413-418 DOI:10.1037/a0032195

Lingiardi, V.; McWilliams, N.; Bornstein, R.F.; Gazzillo, F.; Gordon, R. M. (2015) The Psychodynamic Diagnostic Manual Version 2 (PDM-2): Assessing patients for improved clinical practice and research. *Psychoanalytic Psychology*, 32(1), 94-115 DOI:10.1037/a0038546

Linklater, J., & Kellner, K. (2008). Don't just do something… stand there: using action learning to help organisations work with anxiety. *Action learning: Research and Practice*, *5*(2), 167-172. DOI:10.1080/14767330802185855

Littlewood, S; Case, P.; Gater, R.; & Lindsey, C. (2003) Recruitment, retention, satisfaction and stress in child and adolescent psychiatrists *The Psychiatrist*, 27(2) 61-67. DOI:10.1192/pb.02-084

Long, R. (2014). Acute psychiatry bed shortage contributing to iatrogenic deterioration in general hospital wards. *Australian and New Zealand Journal of Psychiatry*, DOI:0004867414561530.

Long, S. (2000) Engaging the Task: a socio-analytic discussion of task presence and absence. *Socio-Analysis*, 2(1), 80-110.

Long, S. (2006). Organisational defenses against anxiety: what has happened since the 1955 Jaques paper*? International Journal of Applied Psychoanalytic Studies* 3(4), 279–295. DOI:10.1002/aps.111

Long, S. (2008) *The Perverse Organisations and its Deadly Sins* London: Karnac

Long, S. (2013). *Socioanalytic Methods.* London: Karnac

Long, S (2016) *Transforming Experience in Organisations* London, Karnac

Long, S., & Harding, W. (2012, June). Collaboration for adaptation to climate change: facing risks through collaboration. In *29th Annual Meeting of the International Society for the Psychoanalytic Study of Organizations, San Diego* pp 4-10.

Longhofer, J. (2015). *AZ of Psychodynamic Practice*. Palgrave Macmillan.

Lonne, B., Brown, G., Wagner, I., & Gillespie, K. (2015). Victoria's Child FIRST and IFS differential response system: Progress and issues. *Child abuse & neglect*, *39*, 41-49. DOI:10.1016/j.chiabu.2014.08.003

Lye, J. (2004), Performance measurement in the public sector: a clarification and agenda for research, Paper presented at the Fourth Asia Pacific Interdisciplinary Research in Accounting Conference, Singapore quoted in Goh, S. C. (2012). Making performance measurement systems more effective in public sector organizations. *Measuring Business Excellence, 16*(1), 31-42. DOI:10.1108/13683041211204653\

Lundy, O. and Cowling, A. (1996), *Strategic Human Resource Management (*pp168 -173) London Routledge

Lupton G & Najman J (Eds) (1995): *Sociology of health and illness: Australian readings.* Macmillan Education Australia, Melbourne

Ma, J. L.C. (2000), Treatment Expectations and Treatment Experience of Chinese Families Towards Family Therapy: appraisal of a common belief. *Journal of Family Therapy* 22(3), 296–307. DOI: 10.1111/1467-6427.00153

MacNair-Semands, R. R. (2002) Predicting attendance and expectations for group therapy. *Group Dynamics: Theory, Research, and Practice,* 6(3), 219-228.

Magner, L. N. (1992). *A history of medicine*. CRC Press.

Main, T. (1977) The Concept of the Therapeutic Community: Variations and Vicissitudes, *Group Analysis*, *10*(2), S2-S16. DOI:10.1177/053331647701000212

Malan, D.H. (1963*) A study of brief psychotherapy* New York. Plenum.

Malan, D,H, (1995) *Individual psychotherapy and the science of psychodynamics*. Great Britain Butterworth Heineman

Manary, M. P., Boulding, W., Staelin, R., & Glickman, S. W. (2013). The patient experience and health outcomes. *New England Journal of Medicine*, *368*(3), 201-203. DOI: 10.1056/NEJMp1211775

Mannion, R., Davies, H., & Marshall, M. (2004). *Cultures for performance in health care*. McGraw-Hill Education (UK).

Marmarosh, C.L. & Mann, S. (2014) Patients selfobject needs in psychodynamic psychotherapy: How they relate to Client Attachment, Symptoms and the Therapy Alliance. *Psychoanalytic Psychology American Psychological Association* 31(3) 297–313 DOI:10.1037/a0036866

Martins, E. C., & Terblanche, F. (2003). Building organisational culture that stimulates creativity and innovation. *European journal of innovation management*, *6*(1), 64-74. DOI: 10.1108/14601060310456337

Mason, M. (2010, August). Sample size and saturation in PhD studies using qualitative interviews. *Forum qualitative Sozialforschung/Forum: qualitative social research* 11(3). http://www.qualitative-research.net/index.php/fqs/article/view/1428

Mason, W. A., Chmelka, M. B., & Thompson, R. W. (2012). Responsiveness of the strengths and difficulties questionnaire (SDQ) in a sample of high-risk youth in residential treatment. *Child & Youth Care Forum, 41*(5), 479-492. DOI: 10.1007/s10566-012-9179-5

Mawson, C. (1994) 'Work with damaged children" in Obholder, A. and Roberts, V. Z. (Eds) *The unconscious at work* (pp 67-74) London Routledge.

Mawson, C. (2013). *Bion today*. London Routledge.

McDougall, T. (2007). Target practice: are children's mental health services up to scratch? *Mental Health Practice*, *10*(6), 12-14. DOI:10.7748/mhp2007.03.10.6.12.c4293

McDougall, T. (2014) Child Mental Health Policy in the UK. In Hulatt, I. (Ed) *Mental Health Policy for Nurses*, (pp 192-206) Sage DOI:10.4135/9781446252512.n11

McGorry, P. (2013). Prevention, innovation and implementation science in mental health: the next wave of reform. *The British Journal of Psychiatry*, *202*(s54), s3-s4. DOI:10.1192/bjp.bp.112.119222

McGorry, P. D., Goldstone, S., Pennell, K., & Hamilton, M. (2016). Response to Allison et al., The National Mental Health Commission Report: Evidence based or ideologically driven? *Australian and New Zealand Journal of Psychiatry*, *50*(1), 11-12. DOI: 10.1177/0004867415624552

McLoughlin, V., & Leatherman, S. (2003). Quality or financing: What drives design of the health care system? *Quality & Safety in Health Care, 12*(2), 136-142. DOI:10.1136/qhc.12.2.136

McPhee, S. J., Papadakis, M. A., & Tierney, L. M. (Eds.). (2010). *Current medical diagnosis & treatment 2010*. New York: McGraw-Hill Medical.

Meadows, G.M; Enticott, J.E.; Inder, B.; Russell, G.M & Gurr, R. (2015) Better access to mental health care and the failure of the Medicare principle of universality *Medical Journal of Australia* 202(4), 190-194. DOI:10.5694/mja14.00330

Mental Health Tribunal (2016) Annual Report 2015-16 http://www.mht.vic.gov.au/wp-content/uploads/2016/10/MHT-2015-2016-Annual-Report.pdf Accessed 6.11.16

Meltzer-Brody, S., Brandon, A. R., Pearson, B., Burns, L., Raines, C., Bullard, E., & Rubinow, D. (2014). Evaluating the clinical effectiveness of a specialized perinatal psychiatry inpatient unit. *Archives of women's mental health*, *17*(2), 107-113. DOI:10.1007/s00737-013-0390-7

Menzies, I. (1960) The functioning of social systems as a defense against anxiety: a report on a study of the nursing service of a general hospital, Human Relations, 13, 95-121, reprinted in Menzies Lyth, I. (1988) *Containing Anxiety in Institutions*. London: Free Association Books.

Menzies, I E P (1965) Some mutual interactions between organisations and their members. *Psychotherapy and psychosomatics* 13(1-3) 194-200. DOI:10.1159/000285768

Menzies, I. (1970) *The Functioning of Social Systems as a Defence Against Anxiety* London, Tavistock Institute of Human Relations

Menzies Lyth, I. E. P. (1975). A case study in the functioning of social systems as a defense against anxiety. In: D. A. Colman & W. H. Bexton (Eds.), *Group Relations Reader* (pp. 281–312). Sausalito, CA:

Menzies-Lyth, I. (1988). *Containing anxiety in institutions: Selected essays, Vol. 1.* London: Free Association Books

Merikangas, K. R., & He, J. (2014). Epidemiology of mental disorders in children and adolescents In Raynaud, J.P.; Hodes, M.; Shur-Fen Gau, S. (Eds) *From Research to Practice in Child and Adolescent Mental Health*, pp 19 - 48. Maryland. Rowman and Littlefield

Midgley, N., Holmes, J., Parkinson, S., Stapley, E., Eatough, V., & Target, M. (2016). “Just like talking to someone about like shit in your life and stuff, and they help you”: Hopes and expectations for therapy among depressed adolescents. *Psychotherapy Research*, *26*(1), 11-21. DOI:10.1080/10503307.2014.973922

Miller, E. J. (1993). *From dependency to autonomy: Studies in organization and change*. London: Free Association Books.

Miller, E.J. (2002) The vicissitudes of identity. *Organisational & Social Dynamics* 2(1) 75-88

Miller, E.J, and Rice, A. K.(1967) Systems of Organisation, London, Tavistock

Miller, E. J., & Rice, A. K. (1990). Task and sentient systems and their boundary controls. In E. Trist & H. Murray (Eds.), *The Social Engagement of Social Science* (pp. 260-271). London: Free Association.

Miller, A. L., Rathus, J. H., & Linehan, M. M. (2006). *Dialectical behavior therapy with suicidal adolescents*. Guilford Press.

Mills J., Bonner A., Francis K. (2006). The development of constructivist grounded theory. *International Journal of Qualitative Methods*, 5(1) 25-35.DOI:10.1177/160940690600500103

Minkoff, K. (2015) "Rebranding" community mental health. *Community mental health journal* 51(4) 383 - 402.

Monfardini, P. (2010). Accountability in the new public sector: A comparative case study. *The International Journal of Public Sector Management, 23*(7), 632-646. DOI:10.1108/09513551011078897

Moon, S. M., Dillon, D. R. and Sprenkle, D. H. (1990), *Family Therapy and Qualitative Research*. Journal of Marital and Family Therapy, 16: 357–373. doi:10.1111/j.1752-0606.1990.tb00056.x

Morgan, A. and Wilson, R. (2014). Winnicott's influence on paediatrics then and now in Spelman, M.B. and Thomson-Salo, F. (Eds) *The Winnicott Tradition: Lines of Development—Evolution of Theory and Practice over the Decades*, (pp 371-376) London Karnac

Morgan, G. (2016) 2020 vision for Welsh 'public health'? Proposing 'public sector' footprints *Perspectives in Public Health* 136(2) 81-82

Morgan, J. (2010). A systems psychodynamic framework for inter-agency collaboration. *Socio-analysis*, *12*(2010), 19-37.

Morrice, L. (2013). Refugees in higher education: boundaries of belonging and recognition, stigma and exclusion. *International Journal of Lifelong Education*, *32*(5), 652-668. DOI:10.1080/02601370.2012.761288

Morris, B. J., Jahangir, A. A., & Sethi, M. K. (2013). Patient satisfaction: an emerging health policy issue. *Am Acad Orthop Surg*, *6*, 7-9.

Morris, M. D., Popper, S. T., Rodwell, T. C., Brodine, S. K., & Brouwer, K. C. (2009). Healthcare barriers of refugees post-resettlement. *Journal of community health*, *34*(6) 529-538. DOI: 10.1007/s10900-009-9175-3

Morse, J.M. (1994) "Emerging from the data": the cognitive processes of analysis in qualitative inquiry. In: Morse, J.M. (Ed) *Critical issues in qualitative research methods*. (pp 23-43). Thousand Oaks, CA: Sage

Moodie, R., Friel, S., & Ducket, S. (2014). Australia's Health 2014 report card: Experts respond. *Journal of the Home Economics Institute of Australia*, *21*(3), 17-21.

Muennig, P., & Bounthavong, M. (2016). *Cost-effectiveness analysis in health: a practical approach*. John Wiley & Sons.

Muir, K.; Powell, A.; Patulny, R.; Flaxman, S.; McDermott, S.; Oprea, I; Gendera, S; Vespignani, J.; Sitek, T.; Abello, D. and Katz, I. (2009) *Headspace Evaluation Report Independent Evaluation of headspace: the National Youth Mental Health Foundation.* Social Policy Research Centre. University of New South Wales.

Murphy, K. J. (1985). Corporate performance and managerial remuneration: An empirical analysis. *Journal of accounting and economics*, *7*(1), 11-42. DOI:10.1016/0165-4101(85)90026-6

Myddelton, D. R. (2014). The British approach to privatisation. *Economic Affairs*, *34*(2), 129-138. DOI: 10.1111/ecaf.12063

Myors, K. A., Schmied, V., Johnson, M., & Cleary, M. (2013). Collaboration and integrated services for perinatal mental health: an integrative review. *Child and Adolescent Mental Health*, *18*(1), 1-10. DOI: 10.1111/j.1475-3588.2011.00639.x

Nagera, H. (2014). *Basic psychoanalytic concepts on metapsychology, conflicts, anxiety and other subjects* (Vol. 4). Routledge. London

Nancarrow, S. A., Booth, A., Ariss, S., Smith, T., Enderby, P., & Roots, A. (2013). Ten principles of good interdisciplinary team work. *Human resources for Health*, *11*(1), 1 - 12. DOI: 10.1186/1478-4491-11-19

Nardone, G.; Portelli, C.; Kybernetes (2005) When the diagnosis "invents" the illness 34(3-4) 365-372. DOI: 10.1108/03684920510581549

Nasrallah H.A. (2011). "The antipsychiatry movement: Who and why " *Current Psychiatry*. *10*(12), 4 -12 .

National Health Funding Body (2012) http://www.nhfb.gov.au/health-reform/ (accessed 4.11.16)

National Health Performance Authority (2016) *Performance and Accountability Framework* http://www.nhpa.gov.au/internet/nhpa/publishing.nsf/Content/1CF48F88798490D8CA257B1A0013576F/$File/121105-PAF-for-web.pdf (accessed 10.11.16)

National Mental Health Commission (2014) *Contributing Lives, Thriving Communities* (accessed 4.11.16) http://www.mentalhealthcommission.gov.au/our-reports/contributing-lives,-thriving-communities-review-of-mental-health-programmes-and-services.aspx

Naughton, J. N., Carroll, M., Basu, S., & Maybery, D. (2017). Clinical change after the implementation of the Choice and Partnership Approach within an

Australian Child and Adolescent Mental Health Service. *Child and Adolescent Mental Health*.

Newton, J.; Long, S. & Sievers, B. (Eds) (2006) *Coaching in depth. The organisational role analysis approach.* London. Karnac

Neely, A. (1999) The performance measurement revolution: why now and what next?, *International Journal of Operations & Production Management*, *19*(2), 205-228. DOI: 10.1108/01443579910247437

National Disability Insurance Scheme Quarterly Report (2015) https://myplace.ndis.gov.au/ndisstorefront/html/sites/default/files/documents/Quarterly-Reports/11-report-coag.pdf

Nevas, D. B., & Farber, B. A. (2001). Parents' attitudes toward their child's therapist and therapy. *Professional Psychology: Research and Practice*, *32*(2), 165 -170. DOI:10.1037/0735-7028.32.2.165

Nixon, B. (2015). The Children and Young People's Mental Health Practitioner in Hughes, J. and Lyle, G. (Eds) *Developing Nursing Practice with Children and Young People*, (pp 105-125) John Wiley & Sons

Nutbeam, D. (2000). Health literacy as a public health goal: a challenge for contemporary health education and communication strategies into the 21st century. *Health promotion international*, *15*(3), 259-267. DOI:10.1093/heapro/15.3.259

Nutley, S. (2003). Bridging the policy-research divide: reflections and lessons from the United Kingdom. Edited version of a keynote address to the National Institute for Governance. Conference (2003: Canberra). *Canberra Bulletin of Public Administration*, (108), 19-28.

Nutton, V. (2013) *Ancient Medicine*. Routledge. New York.

Obholzer, A. (1987) Institutional dynamics and resistance to change *Psychoanalytic Psychotherapy*, 2(3) 201-205 DOI:10.1080/02668738600700201

Obholzer, A. (1996) Psychoanalytic contributions to authority and leadership issues *Leadership & Organization Development* Journal 17(6), 53-56. DOI: 10.1108/01437739610152966

Obholzer, A. & Roberts, V. (Eds) (1994*) The unconscious at work: Individual and organizational stress in the human services.* London: Routledge

O'Donoghue, B., Brophy, L., Owens, N., Rasic, M., McCullough, B., Huang, B., ... & McKenna, B. (2016). Rate of community treatment orders and readmission orders following reconfiguration of community mental health

services. *Australasian Psychiatry*, *24*(3), 278-281. DOI:10.1177/1039856216629841

Ogden, T. H. (2004). On holding and containing, being and dreaming. *The International Journal of Psychoanalysis*, *85*(6), 1349-1364. DOI:10.1516/T41H-DGUX-9JY4-GQC7

Oldershaw, A.; Richards, C.; Simic, M. and Schmidt, U. (2008) Parents' perspectives on adolescent self-harm: qualitative study *The British Journal of Psychiatry*, 193(2) 140-144; DOI:10.1192/bjp.bp.107.045930

Oldenhof, L., Oldenhof, L., Stoopendaal, A., Stoopendaal, A., Putters, K., & Putters, K. (2016). From boundaries to boundary work: middle managers creating inter-organizational change. *Journal of Health Organization and Management*, *30*(8), 1204-1220. DOI:10.1108/JHOM-03-2016-0041

O'Neill, M. (2014). The slow university: Work, time and well-being. *Forum: Qualitative Social Research, 15*(3), 4-16

Owens, P.L.; Hoagwood, K.; Horwitz, S.M.; Leaf, P.J.; Poduska, J.M. et al. (2002) Barriers to Children's Mental Health Services. *Journal of the American Academy of Child & Adolescent Psychiatry* 41(6) 731-738 DOI:10.1097/00004583-200206000-00013

Owen, S. (2010). Organisational systems and services for children of parents with mental illness and their families: Processes of change and sustainability. *Administration and Policy in Mental Health and Mental Health Services Research, 37*(5), 399-407. DOI: 10.1007/s10488-009-0256-5

Pandiani, J. A., Knisley, M. B., Banks, S. M., Simon, M., & Blackburn, P. (2005). Involvement in the criminal justice system among recipients of mental health services after September 11. *Psychiatric Services, 56*(1), 80-4. DOI:10.1176/appi.ps.56.1.80

Parker, R. & Bradley, L. (2000) Organisational culture in the public sector: evidence from six organisations *International Journal of Public Sector Management*, 13(2), 125 – 141 DOI:10.1108/09513550010338773

Parliament of Australia, Budget Review 2014/15 (accessed 4.11.16) http://www.aph.gov.au/about_parliament/parliamentary_departments/parliamentary_library/pubs/rp/budgetreview201415/healthfunding

Parmelli, E.; Flodgren, G.; Beyer, F.; Baillie, N.; Schaafsma, M.E. & Eccles, M.P (2011) The effectiveness of strategies to change organisational culture to improve healthcare performance: a systematic review. *Implementation Science 6*(1), 33-41. DOI: 10.1186/1748-5908-6-33

Parcesepe, A. M., & Cabassa, L. J. (2013). Public stigma of mental illness in

the united states: A systematic literature review. *Administration and Policy in Mental Health and Mental Health Services Research, 40*(5), 384-99. DOI:10.1007/s10488-012-0430-z

Patel, V., Flisher, A. J., Hetrick, S., & McGorry, P. (2007). Mental health of young people: a global public-health challenge. *The Lancet*, *369*(9569), 1302-1313. DOI:10.1016/S0140-6736(07)60368-7

Patel, V. (2014). Rethinking mental health care: bridging the credibility gap. *Intervention*, *12*, 15-20. DOI:10.1097/WTF.0000000000000065

Patrick, V., & APN-BC, C. L. I. (2011). Integrated multidisciplinary treatment teams; a mental health model for outpatient settings in the military. *Military Medicine, 176*(9), 986-90

Patton, G. C., Coffey, C., Romaniuk, H., Mackinnon, A., Carlin, J. B., Degenhardt, L., ... & Moran, P. (2014). The prognosis of common mental disorders in adolescents: a 14-year prospective cohort study. *The Lancet*, *383*(9926), 1404-1411. DOI: 10.1016/S0140-6736(13)62116-9

Payton, A. R (2009) Mental Health, Mental Illness, and Psychological Distress: Same Continuum or Distinct Phenomena? *Journal of Health and Social Behavior* 50(2) 213-27 DOI: 10.1177/002214650905000207

Pecht, W & Boulton, R. (1995) *Quality Assurance and Reliability in the Japanese electronics industry.* JTEC Panel Report on Electronic Manufacturing and Packaging in Japan (pp 115-126)

Pelham, W.; Wheeler, T.; Chronis A. (1998) Empirically supported psychological treatments for attention deficit hyperactivity disorder. *Journal of clinical child psychology* 27(2), 190 –205 DOI:10.1207/s15374424jccp2702_6

Pescosolido, B. A., Boyer, C. A., & Medina, T. R. (2013). The social dynamics of responding to mental health problems. In Aneshensel, C,; Phelan, J.C.; Bierman, A. (Eds) *Handbook of the sociology of mental health* (pp. 505-524). Springer Netherlands.

Pettigrew, A. M. (1992). The character and significance of strategy process research. *Strategic management journal*, *13*(S2), 5-16. DOI:10.1002/smj.4250130903

Pettitt, B. (2003) *Effective joint working between child and adolescent mental health services (CAMHS) and schools*. Department for Education and Skills. London

Phelan, J. C., & Link, B. G. (1998). The growing belief that people with mental illnesses are violent: The role of the dangerousness criterion for civil

commitment. *Social Psychiatry and Psychiatric Epidemiology, 33(1)*, S7-S12. DOI: 10.1007/s001270050204

Pidano, A. E., & Allen, A. R. (2015). The incredible years series: A review of the independent research base. *Journal of Child and Family Studies, 24*(7), 1898-1916. DOI: 10.1007/s10826-014-9991-7

Pidd, M. (2005) Perversity in public service performance measurement, *International Journal of Productivity and Performance Management*, 54(5/6), 482 – 493 DOI: 10.1108/17410400510604601

Plsek, P. E., & Greenhalgh, T. (2001). The challenge of complexity in health care. *BMJ: British Medical Journal*, *323*(7313), 625.

Podger, A.; Stanton, D. and Whiteford P. (2014), Designing Social Security Systems: Learning from Australia and other Countries, *Public Administration and Development*, 34, 231–250, DOI:10.1002/pad.1689

Pollock, A. M., Shaoul, J., & Vickers, N. (2002). Private finance and "value for money" in NHS hospitals: a policy in search of a rationale? *BMJ: British Medical Journal*, *324*(7347), 1205.

Porter, Roy (1999). *The Greatest Benefit to Mankind: A Medical History of Humanity from Antiquity to the Present*. London: Fontana

Potter, H (2006). Organisational Consequences of Primary Task Ambiguity and the Associated Dynamics of Task Absence. *Socio-analysis,* 8(2006), 49-66.

Power, M. (1997) *The Audit Society: Rituals of Verification*. Oxford. Oxford University Press.

Prahalad, C. K., & Ramaswamy, V. (2004). Co-creation experiences: The next practice in value creation. *Journal of interactive marketing*, *18*(3), 5-14. DOI:10.1002/dir.20015

Pratt, M.G; and Ashforth, B.E. (2003) Fostering Meaningfulness in Working and at Work, in Cameron, K.S.; Dutton, J.E. & Quinn, R.E. (Eds) *Positive Organizational Scholarship*, (pp 309-327) San Francisco. Berrett-Koehler.

Prener, C., & Lincoln, A. K. (2015). Emergency medical services and “psych calls”: Examining the work of urban EMS providers. *American Journal of Orthopsychiatry, 85*(6), 612-619. DOI: 10.1037/ort0000077

Price, J., Kassam-Adams, N., Alderfer, M. A., Christofferson, J., & Kazak, A. E. (2015). Systematic review: A reevaluation and update of the integrative

(trajectory) model of pediatric medical traumatic stress. *Journal of pediatric psychology*, DOI: 10.1093/jpepsy/jsv074

Priebe, S., Burns, T., & Craig, T. K. (2013). The future of academic psychiatry may be social. *The British Journal of Psychiatry*, *202*(5), 319-320. DOI:10.1192/bjp.bp.112.116905

Productivity Commission. (2006). Australia's health workforce. *Productivity Commission, Government of Australia Research Reports*. https://ideas.repec.org/b/ris/prodcs/18.html

Radnor, Z. & McGuire, M. (2004) Performance management in the public sector: fact or fiction? *International Journal of Productivity and Performance Management*, *53*(3), 245-260. DOI:10.1108/17410400410523783

Radnor, Z. & Barnes, D. (2007) Historical analysis of performance measurement and management in operations management. *International Journal of Productivity and Performance Management* 56(5/6) 384-396. DOI:10.1108/17410400710757105

Rahimi, S. (2014) Power, change, and 'the culture of psychiatry', *Anthropology & Medicine*, 21(3) 312-324, DOI:10.1080/13648470.2014.931096

Rangell, L. (1955). On The Psychoanalytic Theory Of Anxiety1: A Statement of a Unitary Theory. *Journal of the American Psychoanalytic Association*, *3*(3), 389-414. DOI: 10.1177/000306515500300302

Rantanen, H.;Kulmala, H.I.; Lönnqvist, A. & Kujansivu, P. (2007) Performance measurement systems in the Finnish public sector, *International Journal of Public Sector Management*, 20(5) 415 – 433. DOI:10.1108/09513550710772521

Rao, A (2013) Taming Resistance to Thinking: Place of Containment in Organisational Work *Organisational and Social Dynamics* 13(1) 1-21

Ray M.A. (1994) The richness of phenomenology: philosophic, theoretic, and methodologic concerns. In: Morse, J.M. (Editor). *Critical issues in qualitative research methods*. (pp 117-133) Thousand Oaks, CA. Sage

Redman-MacLaren, M., & Mills, J. (2015). Transformational grounded theory: Theory, voice, and action. *International Journal of Qualitative Methods*, *14*(3), 1-12.

Reid, C. H. (1965). The authority cycle in small group development. *Adult Leadership*, *13*, 308-310.

Repie, M. S. (2005). A school mental health issues survey from the perspective of regular and special education teachers, school counselors, and school psychologists. *Education & Treatment of Children, 28*(3), 279-298. Retrieved from http://www.jstor.org/stable/42899850

Reeves, K., Charter, E., & Ford, T. (2016). Measurement Issues: Is standardised diagnostic assessment feasible as an adjunct to clinical practice? A systematic review. *Child and Adolescent Mental Health*, *21*(1), 51-63. DOI: 10.1111/camh.12089

Reiff, M. I., & Feldman, H. M. (2014). Diagnostic and Statistical Manual of Mental Disorders: the solution or the problem? *Journal of Developmental & Behavioral Pediatrics*, *35*(1), 68-70. DOI:10.1097/DBP.0000000000000017

Rey, J.M.; Assumpção, F.B.; Bernad, C.A.; Çuhadaroğlu, F.C.; Evans, B.; Fung, D.; Harper, G.; Loidreau, L.; Ono, Y.; Pūras, D.; Remschmidt, H.; Robertson, B.; Rusakoskaya, O.A.; Schleimer, K. History of child and adolescent psychiatry. In Rey, J.M. (Ed), (2015) *IACAPAP e-Textbook of Child and Adolescent Mental Health*. Geneva: International Association for Child and Adolescent Psychiatry and Allied Professions

Reynolds, A., & Thornicroft, G. (1999). *Managing mental health services*. McGraw-Hill Education (UK).

Rice, A. K. (1958). *Productivity and social organization: The Ahmedabad experiment.* London. Tavistock.

Rice, A. K. (1965). *Learning for leadership*. London: Tavistock

Rice, T. R. & Hoffman, L. (2014). Defense mechanisms and implicit emotion regulation: a comparison of a psychodynamic construct with one from contemporary neuroscience. *Journal of the American Psychoanalytic Association*, 0003065114546746. DOI:10.1177/0003065114546746

Richardson, W. S. (2007) We should overcome the barriers to evidence-based clinical diagnosis! *Journal of Clinical Epidemiology* 60(3) 217-27. DOI:10.1016/j.jclinepi.2006.06.002

Rioch, M. J. (1970). The work of Wilfred Bion on groups. *Psychiatry*, *33*(1), 56-66. DOI: 10.1080/00332747.1970.11023613

Rise, M. B., Solbjør, M., Lara, M. C., Westerlund, H., Grimstad, H. and Steinsbekk, A. (2013), Same description, different values. How service users and providers define patient and public involvement in health care. *Health Expectations*, 16(3) 266–276. DOI:10.1111/j.1369-7625.2011.00713.x

Rittel, H. W., & Webber, M. M. (1973). Dilemmas in a general theory of planning. *Policy sciences*, *4*(2), 155-169. DOI:10.1007/BF01405730

Rhodes, P. (2012). Nothing to fear? Thoughts on the history of family therapy and the potential contribution of research. *Australian and New Zealand Journal of Family Therapy*, *33*(2), 171-182. DOI:10.1017/aft.2012.18

Robertson, J., Newby, D. A., & Walkom, E. J. (2016). Health care spending: Changes in the perceptions of the Australian public. *PLoS One, 11*(6) e0157312. DOI:10.1371/journal.pone.0157312

Robbins, S. P. (1997) *Essentials of organizational behavior*. Upper Saddle River, Prentice Hall.

Robbins, S.P. & Barnwell, N. (2002) *Organisation Theory* Australia. Pearson Education

Roberts, V.Z (1994) Conflict and Collaboration: managing intergroup relations in Obholder, A. and Zagier Roberts, V. (Eds) *The unconscious at work (pp 187-196)* Routledge, London

Robertson, J., Newby, D. A., & Walkom, E. J. (2016). Health Care Spending: Changes in the Perceptions of the Australian Public. *PloS one*, *11*(6), e0157312. DOI:10.1371/journal.pone.0157312

Robotham, D., James, K., & Cyhlarova, E. (2010). Managing demand and capacity within child and adolescent mental health services: an evaluation of the Choice and Partnership Approach. *Mental Health Review Journal*, *15*(3), 22-30. DOI: 10.5042/mhrj.2010.0656

Roch, C.H. & Poister, T.H (2006) Citizens, Accountability and Service Satisfaction – The Influence of expectations. *Urban Affairs Review* – uar.sagepub.com DOI:10.1177/1078087405281124

Rogers, A., & Pilgrim, D. (2014). *A sociology of mental health and illness*. McGraw-Hill Education (UK).

Romansky, J.B.; Lyons, J.S.; Kaufman Lehner, R. and West, C.M. (2003) Factors Related to Psychiatric Hospital Readmission Among Children and Adolescents in State Custody *Psychiatric Services* 54(3), 356-362 DOI:10.1176/appi.ps.54.3.356

Romzek, B.S. & Johnston, J.M. (2005) State Social Services Contracting: Exploring the Determinants of Effective Contract Accountability *Public Administration Review* 65(4) 436–449. DOI:10.1111/j.1540-6210.2005.00470.x

Ronzoni, P.& Dogra, N. (2012) Children, adolescents and their carers'

expectations of child and adolescent mental health services (CAMHS). *International Journal of Social Psychiatry* 58(3) 328-336. DOI:10.1177/0020764010397093.

Rosen, A., McGorry, P. D., Hill, H. R., & Rosenberg, S. P. (2012). The Independent Hospital Pricing Authority and mental health services: It is not a case of" one size fits all". *Medical Journal of Australia*, *196*(11), 675-677.

Rosenberg, S. (2012) *International Benchmarking of Australia's Mental Health Performance – State of Play Review*. Project Report published on website of National Mental Health Commission http://www.mentalhealthcommission.gov.au

Rosenberg S.P. & Hickie I. B. (2013) Making activity-based funding work for mental health. *Australian Health Review* **37**(3), 277-280. DOI: DOI:10.1071/AH13002

Rosenberg, W., & Donald, A. (1995). Evidence based medicine: an approach to clinical problem-solving. *BMJ: British Medical Journal*, *310*(6987), 1122.

Rosenheck, R. & Cicchetti, D. (1998) A mental health program report card: a multidimensional approach to performance monitoring in public sector programs. *Community Mental Health Journal 34*(1), 85-106 DOI:10.1023/A:1018720414126

Rossi, A., Cetrano, G., Pertile, R., Rabbi, L., Donisi, V., Grigoletti, L., ... & Amaddeo, F. (2012). Burnout, compassion fatigue, and compassion satisfaction among staff in community-based mental health services. *Psychiatry Research*, *200*(2), 933-938. DOI:10.1016/j.psychres.2012.07.029

Rössler, W. (2012). Stress, burnout, and job dissatisfaction in mental health workers. *European archives of psychiatry and clinical neuroscience*, *262*(2), 65-69. DOI:10.1007/s00406-012-0353-4

Roth, A., & Fonagy, P. (2013). *What works for whom?: a critical review of psychotherapy research*. Guilford Publications.

Royal Children's' Hospital Mental Health Service – Client Information http://www.rch.org.au/mental-health/for_parents_and_carers/ Accessed 18.11.16

Ruggeri, M. and Dall'Agnola, R. (1993). The development and use of the Verona Expectations for Care Scale (VECS) and the Verona Service Satisfaction Scale (VSSS) for measuring expectations and satisfaction with community-based psychiatric services in patients, relatives and professionals. *Psychological Medicine,* 23(02), 511-523. DOI:10.1017/S0033291700028609

Russell, P. D., & Snyder, W. U. (1963). Counselor anxiety in relation to amount of clinical experience and quality of affect demonstrated by clients. *Journal of Consulting Psychology*, *27*(4), 358-363. DOI:10.1037/h0041498

Rutter, M. (2003). Categories, dimensions, and the mental health of children and adolescents. *Annals of the New York Academy of Sciences*, 1008(1), 11–21 DOI:10.1196/annals.1301.002

Rutter, M. (2010) Child and adolescent psychiatry: past scientific achievements and challenges for the future *European Child & Adolescent Psychiatry* 19(9) 689-703. DOI: 10.1007/s00787-010-0111-y

Rutter, M.; Shaffer, D. and Shepherd, M. (1975) A multiaxial classifi-cation of child psychiatric disorders. *World Health Organization*, Geneva, Switzerland

Sansbury, B. S., Graves, K., & Scott, W. (2015). Managing traumatic stress responses among clinicians: Individual and organizational tools for self-care. *Trauma, 17*(2), 114-122. DOI:10.1177/1460408614551978

Sackett, D. L.; Rosenberg W.M.C; Gray J.A.M.; Haynes, R.B.; Richardson, W.S. (1996) Evidence based medicine: what it is and what it isn't *British Medical Journal*, *312*, 71-76. DOI:10.1136/bmj.312.7023.71

Sakamoto, I. & Pitner, R.O (2005) Use of critical consciousness in anti-oppressive social work practice: Disentangling power dynamics at personal and structural levels. *British Journal of Social Work* 35(4) 435-452. DOI:10.1093/bjsw/bch190

Salmon, G. (2004) Multi- agency collaboration: the challenges for CAMHS. *Child and Adolescent Mental Health* 9(4) 156-161.DOI:10.1111/j.1475-3588.2004.00099.x

Salekin, R. T., & Frick, P. J. (2005). Psychopathy in children and adolescents: The need for a developmental perspective. *Journal of abnormal child psychology*, *33*(4), 403-409. DOI: 10.1007/s10802-005-5722-2.

Santucci, L. C., Thomassin, K., Petrovic, L., & Weisz, J. R. (2015). Building Evidence- Based Interventions for the Youth, Providers, and Contexts of Real- World Mental- Health Care. *Child Development Perspectives*, *9*(2), 67-73. DOI: 10.1111/cdep.12118

Sawyer, M. G., Arney, F. M., Baghurst, P. A., Clark, J. J., Graetz, B. W., Kosky, R. J., ... & Rey, J. M. (2001). The mental health of young people in Australia: key findings from the child and adolescent component of the

national survey of mental health and well-being. *Australian and New Zealand Journal of Psychiatry*, *35*(6), 806-814.

Saxena, S., Thornicroft, G., Knapp, M., & Whiteford, H. (2007). Resources for mental health: scarcity, inequity, and inefficiency. *The lancet*, *370*(9590), 878-889. DOI:10.1016/S0140-6736(07)61239-2

Sayal K (2006) Annotation: Pathways to care for children with mental health problems. *Journal of Child Psychology and Psychiatry, and Allied Disciplines* 47(7), 649-659 DOI: 10.1111/j.1469-7610.2005.01543.x

Schraeder, K. E., & Reid, G. J. (2015). Why wait? The effect of wait-times on subsequent help-seeking among families looking for children's mental health services. *Journal of Abnormal Child Psychology, 43*(3), 553-565. DOI:10.1007/s10802-014-9928-z

Schein, E. (1985). *Organizational Culture and Leadership*. San Francisco, CA: Jossey-Bass.

Schore, A. N., & Newton, R. P. (2013). Using modern attachment theory to guide clinical assessments of early attachment relationships. In Bettman, J.E. and Friedman, D.D. (Eds) *Attachment-based clinical work with children and adolescents* (pp. 61-96). Springer New York.

Schneider, J. A. (2015). Bion's Thinking about Groups: A Study of Influence and Originality. *The Psychoanalytic Quarterly*, *84*(2), 415-440. DOI:10.1002/psaq.12007

Schwandt, Thomas (1994) Constructivist, Interpretivist approaches to human Inquiry, in Denzin, N. & Lincoln, Y.S (Eds) *Handbook of Qualitative Research* (pp 118-137) Thousand Oaks CA Sage

Schwartz, S., & Corcoran, C. (2010). Biological theories of psychiatric disorders: A Sociological Approach in Sheid, T.L and Brown, T.J. (Eds) *A Handbook for the Study of Mental Health* (pp 64-88). Cambridge. Cambridge University Press

Scott, D., Lonne, B., & Higgins, D. (2016). Public health models for preventing child maltreatment: applications from the field of injury prevention. *Trauma, Violence, & Abuse*, *17*(4), 408-419. DOI:10.1177/1524838016658877

Scott, T., Mannion, R., Marshall, M., & Davies, H. (2003). Does organisational culture influence health care performance? A review of the evidence. *Journal of Health Services Research & Policy*, *8*(2), 105-117. DOI:10.1258/135581903321466085

Scull, A. (Ed.). (2015). *Madhouses, mad-doctors, and madmen: The social history of psychiatry in the Victorian era*. University of Pennsylvania Press.

Segal, H. (2012). *Introduction to the work of Melanie Klein*. London. Karnac Books.

Schaie, K. W. (2013). PSYCHOLOGICAL STUDIES OF HUMAN DEVELOPMENT? l. *Determinants of Behavioral Development*, 3.

Shaffer, D. R., & Kipp, K. (2013). *Developmental psychology: Childhood and adolescence*. Cengage Learning

Shapiro, E. R. & Carr, A. W. (1991). *Lost in Familiar Places: Creating new connections between the individual and society*. London: Yale University Press.

Shapiro, E.R. & Carr, A.W. (2012) An Introduction to Tavistock-Style Group Relations Conference Learning *Organisational and Social Dynamics* 12(1), 127-128.

Shapiro, G. K., Cusi, A., Kirst, M., O'Campo, P., Nakhost, A., & Stergiopoulos, V. (2015). Co-responding police-mental health programs: a review. *Administration and Policy in Mental Health and Mental Health Services Research*, *42*(5), 606-620. DOI: 10.1007/s10488-014-0594-9

Shields, L. (2015) What is family centred care? *European Journal for Person Centered Healthcare*, *3*(2), 139-144.

Shonkoff, J. P., Garner, A. S., Siegel, B. S., Dobbins, M. I., Earls, M. F., McGuinn, L., ... & Wood, D. L. (2012). The lifelong effects of early childhood adversity and toxic stress. *Pediatrics*, *129*(1), e232-e246.

Shortell, S. M., Waters, T. M., Clarke, K. W., & Budetti, P. P. (1998). Physicians as double agents: maintaining trust in an era of multiple accountabilities. *Jama*, *280*(12), 1102-1108. DOI:10.1001/jama.280.12.1102

Sigerist, H. E. (1987). *A history of medicine: Early Greek, Hindu, and Persian medicine* (No. 27). New York: Oxford University Press.

Silove, D., Austin, P., & Steel, Z. (2007). No refuge from terror: the impact of detention on the mental health of trauma-affected refugees seeking asylum in Australia. *Transcultural psychiatry*, *44*(3), 359-393. DOI:10.1177/1363461507081637

Silvio, J. R. (2007). Psychodynamic Diagnostic Manual, By PDM Task Force, Alliance of Psychoanalytic Associations, Silver Spring, MD, 857 pp., 2006, $. *Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry*, *35*(4), 681-685.

Simon, R. I. (1992). Treatment boundary violations: Clinical, ethical, and legal considerations. *Bulletin of the American Academy of Psychiatry and the Law, 20(1),* 269-288.

Simons, R. (1995b). Control in an age of empowerment. *Harvard Business Review* (March/April), 80-88.

Sinason, V. (2015). Social defences against anxiety: explorations in a paradigm*. Journal of Child Psychoterapy* 41(3) 321-323. DOI:10.1080/0075417X.2015.1090705

Sivan, E (1986) Motivation in Social Constructivist Theory, *Educational Psychologist,* 21(3) 209-233

Slade, M. (2009) *Personal recovery and mental illness: A guide for mental health professionals*. Cambridge University Press.

Smajdor, A. (2013). Reification and compassion in medicine: A tale of two systems. *Clinical Ethics*, 1477750913502620. DOI:10.1177/1477750913502620

Smith, D., & Fitzpatrick, M. (1995). Patient-therapist boundary issues: An integrative review of theory and research. *Professional Psychology: Research and Practice, 26*(5), 499-506 DOI:10.1037/0735-7028.26.5.499

Smith, J., Swallow, V., & Coyne, I. (2015). Involving Parents in Managing Their Child's Long-Term Condition—A Concept Synthesis of Family-Centered Care and Partnership-in-Care. *Journal of Pediatric Nursing*, *30*(1), 143-159. DOI: 10.1016/j.pedn.2014.10.014

Smith, M., Carroll, D., & Education, K. (2015). Residential child care and mental health practitioners working together. *Scottish Journal of Residential Child Care*, *14*(3).

Smith, P.C (2005) Performance Measurement in Health Care: History, Challenges and Prospects, *Public Money & Management*, 25(4), 213-220

Smith, P.C.; Anell, A.; Busse, R. ; Crivelli, J.; Healy, J.; Lindahl A.K.; Gert Westert, G.; Kene, T. (2012) Leadership and governance in seven developed health systems *Health Policy* 106(1), 37–49 DOI:10.1016/j.healthpol.2011.12.009

Sorenson, J.E.; Zelman, W.; Hanbery, G.W.; Kucic, A.R. (1987). Managing mental health organizations with twenty-five key performance indicators. *Evaluation and Program Planning* 10(3) 239–247 DOI:10.1016/0149-7189(87)90035-8

Spielberger, C. D. (Ed.). (2013). *Anxiety: Current trends in theory and research*. Elsevier.

Spiggle, S. (1994). Analysis and interpretation of qualitative data in consumer research. *Journal of consumer research*, *21*(3), 491-503 DOI:10.1086/209413.

Sponheim, E., & Skjeldal, O. (1998). Autism and related disorders: epidemiological findings in a Norwegian study using ICD-10 diagnostic criteria. *Journal of Autism and Developmental Disorders*, *28*(3), 217-227. DOI:10.1023/A:1026017405150

Srivastava, P. & Hopwood, N. (2009) A Practical Iterative Framework for Qualitative Data Analysis *International Journal of Qualitative Methods* March 2009 8(1), 76-84 DOI:10.1177/160940690900800107

Stanley, D.E & Campos, D.G. (2013) The logic of medical diagnosis. *Perspectives in Biology and Medicine* 56(2) 300-15.

Strand, M. (2011) Where do classifications come from? The DSM-III, the transformation of American psychiatry, and the problem of origins in the sociology of knowledge *Theory and Society* 40(3) 273-313. DOI:10.1007/s11186-011-9142-8

Stevenson, S. (2012). Race and Gender Dynamics as an Organisational Defence against Anxiety within a Specialist Multi-Disciplinary Child and Family Assessment Service. *Organisational and Social Dynamics*, *12*(2), 131-144.

Stevens, R. C. (2016). Theory for Skilled Practitioners. In Stevens, R.C. (Ed) *Changing Organizations from Within: Roles, Risks and Consultancy Relationships*, (pp 165–180). London Routledge

Stone, M. H. (1997). *Healing the mind: A history of psychiatry from antiquity to the present*. WW Norton & Company.

Strauss, A., & Corbin, J. M. (1997). *Grounded theory in practice*. Sage.

Strenger, C. (2006). Freud's forgotten evolutionary project. *Psychoanalytic Psychology*, *23*(2), 420-431. DOI: 10.1037/0736-9735.23.2.420

Strike, C.; Goering, P. & Wasylenki, D. (2002) A population health framework for inner-city mental health *Journal of Urban Health* 79(1) S13-S20. DOI:10.1093/jurban/79.suppl_1.S13

Stuart, H., & Arboleda-Flórez, J. (2012). A public health perspective on the stigmatization of mental illnesses. *Public Health Reviews, 34*(2), 1-18. Retrieved from

http://search.proquest.com.ezproxy.lib.rmit.edu.au/docview/1749281045?accountid=13552

Sturmberg, J. P.; Martin, C. M.; Moes, M. M. (2010) Health at the centre of Heath Systems Reform: how philosophy can inform policy. *Perspectives in Biology and Medicine* 53(3) 341-56.

Svensson, G., & Wood, G. (2003). The dynamics of business ethics: a function of time and culture–cases and models. *Management Decision*, *41*(4), 350-361. DOI: 10.1108/00251740310468195

Summers, F. (2014) *Object relations theories and psychopathology: A comprehensive text*. Routledge.

Sundet, R. (2012). Postmodern- oriented practices and patient- focused research: possibilities and hazards. *Australian and New Zealand Journal of Family Therapy*, *33*(4), 299-308. DOI: 10.1017/aft.2012.38

Tarren-Sweeney, M., & Vetere, A. (2013). *Mental health services for vulnerable children and young people: Supporting children who are, or have been, in foster care*. Routledge. London

Taylor, M., & Hill, S. (2014). *Consumer expectations and healthcare in Australia*. Australia.

Taylor, P. (2014). Anti-Psychiatry Movement. In P. Taylor, K. Corteen, & S. Morley. (Eds.). A Companion to Criminal Justice, Mental Health and Risk. Bristol, United Kingdom: Policy Press.

Taylor, S. (2014). *Anxiety sensitivity: Theory, research, and treatment of the fear of anxiety*. Routledge.

Teague, G.B (1998) Response to Rosenheck and Ciccheti's A Mental Health Program Report Card: A Multidimensional Approach to Performance Monitoring in Public Sector Programs *Community Mental Health Journal* 34(1) 111-4.

Thoits, P. A. (2013). Self, identity, stress, and mental health. In Aneshensel, C.S.; Phelan, J.C.; Bierman, A, (Eds.) *Handbook of the sociology of mental health* (pp. 357-377). Springer Netherlands.

Thomas, D. (2006) A General Inductive Approach for Analyzing Qualitative Evaluation Data *American Journal of Evaluation 27*(2), 237-246. DOI:10.1177/1098214005283748

Thomas, J. C. (2013). Citizen, customer, partner: Rethinking the place of the public in public management. *Public Administration Review*, *73*(6), 786-796. DOI: 10.1111/puar.12109

Thompson, A. E., Nadkarni, A., Nazir, S. A., Sorour, W., Owen, V., & Buggineni, S. K. (2013). Professional life in child and adolescent mental health services may be getting more complicated, but cases are not. *The Psychiatrist Online*, *37*(10), 326-330. DOI: 10.1192/pb.bp.112.040857

Thorne S. (1997) The art (and science) of critiquing qualitative research. In: Morse J.M (Editor). *Completing a qualitative project: details and dialogue*. (pp 117-32) Thousand Oaks, CA: Sage

Thornicroft, G., & Slade, M. (2014). New trends in assessing the outcomes of mental health interventions. *World Psychiatry*, *13*(2), 118-124. DOI:10.1002/wps.20114

Timimi, S. (2014). *Pathological child psychiatry and the medicalization of childhood*. Routledge. London

Timimi, S., & Maitra, B. (Eds.). (2006) *Critical voices in child and adolescent mental health*. Free Assn Books. London

Ting, L., Jacobson, J. M., & Sanders, S. (2011). Current levels of perceived stress among mental health social workers who work with suicidal clients. *Social Work, 56*(4), 327-36. DOI: 10.1093/sw/56.4.327

Tintinalli, J. E., Peacock, F. W., & Wright, M. A. (1994). Emergency medical evaluation of psychiatric patients. *Annals of Emergency Medicine, 23*(4), 859-862. DOI:10.1016/S0196-0644(94)70326-4

Trist, E., and Bamforth, W. (1951), Some Social and Psychological Consequences of the Long Wall Method of Coal-Getting, *Human Relations,* 4(1) 3-38. DOI:10.1177/001872675100400101

Trist, E and Emery, F. (2000) *Social Ecology*. London Tavistock

Trist, E. and Murray, H. (eds) (1990) *The Social Engagement of Social Science: A Tavistock Anthology*. London Free Association Books.

Trist, E., and Sofer, C., (1959) *Exploration in Group Relations,* Leicester, Leicester University Press.

Tritter, J.Q. (2009) Revolution or evolution: the challenges of conceptualizing patient and public involvement in a consumerist world. *Health Expectations 12*(3), 275-287. DOI:10.1111/j.1369-7625.2009.00564.x

Tsai, T. C., Jha, A. K., Gawande, A. A., Huckman, R. S., Bloom, N., & Sadun, R. (2015). Hospital board and management practices are strongly related to hospital performance on clinical quality metrics. *Health Affairs*, *34*(8), 1304-1311. DOI:10.1377/hlthaff.2014.1282

Tseng, W., and J. Streltzer. (2004). Quoted in Rahimi, S. (2014) Power, change, and 'the culture of psychiatry', *Anthropology & Medicine*, 21(3), 312-324, DOI:10.1080/13648470.2014.931096

Tyson, T. (1998) *Working with Groups* South Yarra. MacMillan

US Department of Health and Human Services. (2014). The health consequences of smoking—50 years of progress: a report of the Surgeon General. *Atlanta, GA: US Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health*, *17*.

Upadhaya, B. & Munir, R. (2014) Association between performance measurement systems and organisational effectiveness. *International Journal of Operations & Production Management* 34(7) 875-853 DOI:10.1108/IJOPM-02-2013-0091

Vaill, P. B (1998) *Spirited leader and Learning. Process wisdom for a new age*. Jossey-Bass. California.

Valentine, N., de Silva, A., Kawabata, K., Darby, C., Murray, C., & Evans, D. (2003). Health system responsiveness: Concepts, domains and operationalization. In C. J. L. Murray, & D. B. Evans (Eds.), *Health system performance, debates, methods and empiricism* (pp. 574–596). Geneva: World Health Organization.

Van Buskirk, W., & McGrath, D. (1999). Organizational cultures as holding environments: A psychodynamic look at organizational symbolism. *Human Relations*, *52*(6), 805-832. DOI:10.1177/001872679905200606

Van den Berg, R. (2014). Providing a containing space for unbearable feelings. *Psycho-analytic Psychotherapy in South Africa*, *22*(2), 1-19.http://hdl.handle.net/10520/EJC164492

Van de Walle, S. & Cornelissen, F. (2016), Performance Reporting in Bovens, M., Goodin, Robert E. & Schillemans, T. (Eds). *The Oxford Handbook on Public Accountability. (*pp. 441-455.) Oxford: Oxford University Press,

Van Belle, S., & Mayhew, S. H. (2016). What can we learn on public accountability from non-health disciplines: a meta-narrative review. *BMJ open*, *6*(7), e010425. DOI:10.1136/bmjopen-2015-010425

Van Dooren, W., Bouckaert, G., & Halligan, J. (2015). *Performance management in the public sector*. London Routledge.

Van Nieuwenhuizen, A., Henderson, C., Kassam, A., Graham, T., Murray, J., Howard, L. M., & Thornicroft, G. (2013). Emergency department staff views and experiences on diagnostic overshadowing related to people with mental illness. *Epidemiology and Psychiatric Sciences, 22*(3), 255-62. DOI:10.1017/S2045796012000571

Varese, F., Smeets, F., Drukker, M., Lieverse, R., Lataster, T., Viechtbauer, W., ... & Bentall, R. P. (2012). Childhood adversities increase the risk of psychosis: a meta-analysis of patient-control, prospective-and cross-sectional cohort studies. *Schizophrenia bulletin*, *38*(4), 661-671. DOI:10.1093/schbul/sbs050

Vaz, S., Cordier, R., Boyes, M., Parsons, R., Joosten, A., Ciccarelli, M., . . . Falkmer, T. (2016). Is using the strengths and difficulties questionnaire in a community sample the optimal way to assess mental health functioning? *PLoS One, 11*(1) DOI:10.1371/journal.pone.0144039

Veatch, R. M. (1981*) A theory of medical ethics. http://www.popline.org/node/425908*

Vince, R., & Broussine, M. (1996). Paradox, defense and attachment: Accessing and working with emotions and relations underlying organizational change. *Organization Studies*, *17*(1), 1-21. DOI:10.1177/017084069601700101

Vermeiren, R. M., & van der Meer, J. (2016). Child psychiatry: limited research, evidence for cost-effectiveness of treatment. *Tijdschrift voor psychiatrie*, *58*(10), 728-732. http://www.tijdschriftvoorpsychiatrie.nl/en/issues/506/articles/10949

Veronesi, G; Harley, K.; Dugdale, P & Short, S., (2014). Governance, transparency and alignment in the council of australian governments (COAG) 2011 national health reform agreement. *Australian Health Review, 38*(3), 288-94. DOI:10.1071/AH13078

Victorian Government DHS (Department of Human Services) 2008. *Consultation feedback – Because Mental Health Matters* https://www2.health.vic.gov.au/about/publications/researchandreports/BecauseMentalHealthMatters

Victorian Government Department of Human Services. (2006). *CAMHS in communities : working together to provide mental health care for Victoria's children and young people.* Melbourne: Dept of Human Services

http://www.health.vic.gov.au/mentalhealth/camhs/camhsrep0906.pdf

Victorian Government DHHS - Department of Health and Human Services (2016) *About Mental Health Services in Victoria* https://www2.health.vic.gov.au/mental-health/mental-health-services http://www.health.vic.gov.au/mentalhealthservices/child/

Victorian Government DHHS - Department of Health and Human Services (2016) *Victorian Health Performance Framework https://www2.health.vic.gov.au/hospitals-and-health-services/funding-performance-accountability/performance-monitoring*

Victorian Government DHHS - Department of Health and Human Services (2016) *Definitions of KPIs* http://performance.health.vic.gov.au/Home/Resources/Definitions.aspx Accessed 4.11.16

Victorian Government DHHS - Department of Health and Human Services (2016) *National Mental Health Strategy* https://www2.health.vic.gov.au/mental-health/priorities-and-transformation/national-mental-health-reform

Victorian Government (2009-10) *Budget Paper 3*

Victorian Government (2013) *Chief Psychiatrist Annual Report.*

Victorian Government (2014) M*ental Health Act 2014*https://www2.health.vic.gov.au/mental-health/practice-and-service-quality/mental-health-act-2014 Accessed 6.11.16

Victorian Government (2014) *Safety of Women* http://www.health.vic.gov.au/healthvictoria/feb14/safety.htm Accessed 6.11.16

Victorian Government (2015) *High performing health services: Victorian performance monitoring framework 2015-16* Accessed 6.11.16

Victorian Government (2016) https://www.budget.vic.gov.au/budget-papers

Victorian Government (2015) *Victoria's Mental Health Services Annual Report*https://www2.health.vic.gov.au/mental-health/priorities-and-transformation/mental-health-annual-report

Victorian Government ; Victoria's Public Sector Commission (2016) People Matter Survey http://vpsc.vic.gov.au/data-and-research/people-matter-survey/

Victorian Government Victoria's Roadmap to Reform (2016) Strong Families, Safe Children http://www.dhs.vic.gov.au/__data/assets/pdf_file/0006/964455/Roadmap-for-Reform--strong-families,-safe-children-3.pdf

Vine, R., Turner, S., Pirkis, J., Judd, F., & Spittal, M. J. (2016). Mental health service utilisation after a Community Treatment Order: A comparison between three modes of termination. *Australian & New Zealand Journal of Psychiatry*, *50*(4), 363-370. DOI:10.1177/0004867415599847

Visser, M. (2016), Management Control, Accountability, and Learning in Public Sector Organizations: A Critical Analysis, in Hinna, A.; Gnan. L. and Monteduro, F. (Ed.) *Governance and Performance in Public and Non-Profit Organizations (Studies in Public and Non-Profit Governance, Volume 5)* pp.75 – 93 Emerald Group Publishing Limited

Vostanis, P. (2005), National Service Framework: Its principles are relevant to all countries. *Child and Adolescent Mental Health,* 10(3) 131–132 DOI:10.1111/j.1475-3588.2005.00363.x

Waddell, C., Mcewan, K., Shepherd, C. A., Offord, D. R., & Hua, J. M. (2005). A Public health strategy to improve the mental health of Canadian children. *Canadian Journal of Psychiatry,* 50(4), 226–233. DOI:10.1177/070674370505000406

Wahlin, Tim J. (2007), *Parents' and adolescents' perceived influences and barriers to mental health services*, Doctor of Psychology thesis, School of Psychology, University of Wollongong. http://ro.uow.edu.au/theses/2136/

Walsh, F. (2003), Family Resilience: A Framework for Clinical Practice. *Family Process,* 42(1), 1–18. DOI:10.1111/j.1545-5300.2003.00001.x

Walsh, K., Campbell, S., Ashby, M., & Procter, S. (2016). Public anxiety and health policy: A psychodynamic perspective. *Social Theory & Health*, *14*(4), 493-509. DOI: 10.1057/sth.2016.5

Walter, H. J., & Bukstein, O. G. (2007). Clinical practice guidelines. *Journal of the American Academy of Child & Adolescent Psychiatry*, *46*(8), 940-942.

Watt, B. D., Dadds, M. R., Best, D., & Daviess, C. (2012). Enhancing treatment participation in CAMHS among families of conduct problem children: effectiveness study of a clinician training programme. *Child and Adolescent Mental Health*, *17*(3), 179-186. DOI:10.1111/j.1475-3588.2011.00634.x

Worrall‐Davies, A. & Cottrell, D. (2009) Outcome research and interagency work with children: what does it tell us about what the CAMHS contribution should look like? *Children & Society* 23(5) 336-346. DOI:10.1111/j.1099-0860.2009.00241.x

Wear, A. (1992). *Medicine in society: historical essays*. Cambridge. Cambridge University Press.

Webster, L., & Mertova, P. (2007). *Using narrative inquiry as a research method: An introduction to using critical event narrative analysis in research on learning and teaching.* pp 89-118 London, UK, Routledge.

Wehowsky, A. (2000): Diagnosis as care--diagnosis as politics. *International Journal of Psychotherapy* 5(3) 241-255. DOI:10.1080/13569080020012499

Wells, L. (1980). The group-as-a-whole: A systemic socio-analytical perspective on interpersonal and group relations. In: Alderfer, C. P. & Cooper, C.L. (Eds) *Advances in Experiential Social Processes*, pp.165-198. (Vol. 2). John Wiley & Sons.

Wells, P. (2007) New Labour and Evidence-Based Policy-Making: 1997–2007, *People, Place and Policy Online*, *1*(1), 22-29. DOI:10.3351/ppp.0001.0001.0004

Westra, H.A.; Aviram, A.; Barnes, M. & Angus, L. (2010) Therapy was not what I expected: A preliminary qualitative analysis of concordance between client expectations and experience of cognitive–behavioural therapy. *Psychotherapy Research* *20*(4), 436-446. DOI:10.1080/10503301003657395

Werry, J. (2013). Fifty years in child and adolescent psychiatry. *Reclaiming Children and Youth*, *22*(2), 25-30.

Werthamer-Larsson, L. (1994). Methodological issues in school-based services research. Journal of Clinical Child Psychology, 23 pp. 121-132 quoted in Repie, M. S. (2005). A school mental health issues survey from the perspective of regular and special education teachers, school counselors, and school psychologists. *Education & Treatment of Children, 28*(3), 279-298. http://www.jstor.org/stable/42899850

Wahl, O. F. (1999). Mental health consumers' experience of stigma. *Schizophrenia bulletin*, *25*(3), 467-478. DOI:10.1093/oxfordjournals.schbul.a033394

Wheaton, B. (2001) The role of sociology in the study of mental health...and the role of mental health in the study of sociology *Journal of Health and Social Behavior* 42(3) 221-234. DOI: http://www.jstor.org/stable/3090212

White, S., & Featherstone, B. (2005). Communicating misunderstandings: multi‐agency work as social practice. *Child & Family Social Work*, *10*(3), 207-216. DOI:10.1111/j.1365-2206.2005.00372.x

Whiteford, H.A., Buckingham, W.J.; Harris, M.; Burgess, P. M., Pirkis, J.E.;

Barendregt, J.J. & Hall, W. (2014). Estimating treatment rates for mental disorders in Australia. *Australian Health Review, 38*(1), 1-5. DOI:10.1071/AH13142

Whittaker, A. (2011). Social defences and organisational culture in a local authority child protection setting: challenges for the Munro Review? *Journal of Social Work Practice*, *25*(4), 481-495. DOI:10.1080/02650533.2011.626654

Widmark, C., Sandahl, C., Piuva, K., & Bergman, D. (2016). What do we think about them and what do they think about us? Social representations of interprofessional and interorganizational collaboration in the welfare sector. *Journal of interprofessional care*, *30*(1), 50-55. DOI:10.3109/13561820.2015.1055716

Willcox, S. (2014). Chronic diseases in Australia: The case for changing course, Australian Health Policy Collaboration Issues paper No. 2014-02. Melbourne: Australian Health Policy Collaboration.

Wilkin, P. (1999). Chomsky and Foucault on human nature and politics: an essential difference? *Social Theory and Practice, 25*(2), 177-210. DOI:10.5840/soctheorpract199925217

Williams, F. (2000) *New principles for welfare*. Cambridge: Polity Press,

Williams, R. & Kerfoot, M. (2005) *Child and Adolescent Mental Health Services: Strategy, Planning, Delivery and Evaluation* London. Oxford University Press

Williams, T. M., & Smith, G. P. (2014). Can the National Disability Insurance Scheme work for mental health? *Australian and New Zealand Journal of Psychiatry*, *48*(5), 391-394. DOI:10.1177/0004867414530007

Williamson, G. R., & Prosser, S. (2002). Action research: politics, ethics and participation. *Journal of advanced nursing*, *40*(5), 587-593. DOI:10.1046/j.1365-2648.2002.02416.x

Willshire, L. (1999) Psychiatric services: organizing impossibility. *Human Relations 52*(6), 775-804. DOI: 10.1177/001872679905200605

Wilson, A. M. (2001). Understanding organisational culture and the implications for corporate marketing. *European Journal of Marketing,* 35 (3/4), 353-367. DOI:10.1108/03090560110382066

Wilson, M. (1993). DSM-III and the transformation of American psychiatry: a history. *American Journal of Psychiatry*, *150(3)*, 399-410. DOI:10.1176/ajp.150.3.399

Winick, B. J. (1998). Sex offender law in the 1990s: A therapeutic jurisprudence analysis. *Psychology, Public Policy, and Law, 4*(1-2), 505-570.

Winnicott, D. W. (1960). The theory of the parent-infant relationship. *The International journal of psycho-analysis*, *41*, 585.

Winnicott, D.W. (1987). *Home is where we start from.* Harmondsworth: Penguin.

Wolpert, M. (2009) Organization of Services for Children and Adolescents with Mental Health Problems. In: Rutter M.; Bishop, D.; Pine, D.; Scott, S.; Stevenson, J.; Taylor, E, et al., editors. *Rutter's Child and Adolescent Psychiatry*. p. 1156-66. Malden: Blackwell Publishing Ltd.;

Wolpert, M., Deighton, J., De Francesco, D., Martin, P., Fonagy, P., & Ford, T. (2014). From 'reckless' to 'mindful' in the use of outcome data to inform service-level performance management: perspectives from child mental health. *BMJ quality & safety*, bmjqs-2013. DOI:10.1136/bmjqs-2013-002557

Wolpert M, Harris R, Jones M, Hodges S, Fuggle P, James R et al. (2014) THRIVE: The AFC-Tavistock Model for CAMHS. London: CAMHS Press. Available at: www.tavistockandportman.nhs

World Federation of Occupational Therapy (2012) Definition of Occupational Therapy http://www.wfot.org/aboutus/aboutoccupationaltherapy/definitionofoccupationaltherapy.aspx Accessed 20.11.16

World Health Organization (2015) *International Statistical Classification of Diseases and Related Health Problems* 10th Revision (ICD-10), http://www.who.int/classifications/icd/en/ Accessed November 11, 2016

World Health Organization (2015) http://www.who.int/healthinfo/paper30.pdf

World Health Organisation (2016) Definitions http://www.who.int/healthsystems/hss_glossary/en/index5.html Accessed November 11, 2016

World Health Organization (1989) *Constitution.* http://www.who.int/iris/handle/10665/36851

Wright, B., Williams, C., Smith, R., Smith, S., & Beeson, S. (2016). An Autism Spectrum Disorders Forum: A Model for the Effective Use of Multidisciplinary Assessment and Intervention Planning with Limited Clinical Resources. *Autism Open Access*, *6*(186), 2. DOI:10.4172/2165-7890.1000186

Yadav, N., & Sagar, M. (2013). Performance measurement and management

frameworks: Research trends of the last two decades. *Business Process Management Journal*, *19*(6), 947-971. DOI: 10.1108/BPMJ-01-2013-0003

Yeh, M.; Weisz, J.R (2001) Why are we here at the clinic? Parent-child (dis)agreement on referral problems at outpatient treatment entry *Journal of Consulting and Clinical Psychology* 69(6) 1018-1025.

Younis, M.; Abdul Kareem, A. O. & Al-Nuaimi, A. (2014). The workload of a psychiatric clinic at a general hospital in a post conflict area: A model from Iraq. *Journal of Public Mental Health, 13*(1), 51-58. DOI:10.1108/JPMH-12-2012-0023

Zala, C. (2012) Clinical supervision: Three frameworks for the exploration of shame and anxiety. *Psychotherapy in Australia*, 18(3) 12-21.

Zur, O. (2004) To cross or not to cross. Do boundaries in therapy protect or harm? *Psychotherapy Bulletin* 39(3) 27-32

Appendix

1. Ethics Approval
2. Participant Consent Form
3. Participant Information Form

RMIT UNIVERSITY

RMIT University
Science Engineering and Technology College
Human Research Ethics Sub-Committee
Plenty Road
Bundoora VIC 3083
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Australia
Tel. +61 3 9925 7096
Fax +61 3 9925 6506
www.rmit.edu.au

27th February 2009

Leanne Beagley
[redacted]

Dear Leanne

BSETAPP 34 – 08 BEAGLEY Public Child and Adolescent Mental Health Services (CAMHS): Perspectives in measuring organisational performance

Thank you for submitting your amended application for review.

I am pleased to inform you that the committee has approved your application for a period of **3 Years** to **February 2012** and your research may now proceed.

The committee would like to remind you that:

All data should be stored on University Network systems. These systems provide high levels of manageable security and data integrity, can provide secure remote access, are backed up on a regular basis and can provide Disaster Recover processes should a large scale incident occur. The use of portable devices such as CDs and memory sticks is valid for archiving, data transport where necessary and for some works in progress;
The authoritative copy of all current data should reside on appropriate network systems; and the Principal Investigator is responsible for the retention and storage of the original data pertaining to the project for a minimum period of five years.

Annual reports are due during December for all research projects that have been approved by the Human Research Ethics Sub-Committee.

The necessary form can be found at: http://www.rmit.edu.au/governance/committees/hrec

Yours faithfully,

Associate Professor [redacted]
Chair, Science Engineering & Technology Portfolio
Human Research Ethics Sub-Committee 'B'

Cc HRE-SC Member: [redacted] School of Medical Sciences
Supervisor/s: [redacted] School of Health Sciences

PLAIN LANGUAGE STATEMENT

I am currently undertaking a doctoral research project at RMIT. I am interested in different perspectives on measuring organisational performance of a Child and Adolescent Mental Health Service (CAMHS). As part of the project I wish to interview and discuss with both past clinicians and past service users their views and experiences as they relate to the question “what are the important considerations when measuring the performance of a CAMHS organisation?”

I am writing to request your involvement as an independent clinician/service user. Should you consent to be involved, I plan to conduct and record a semi-structured interview and discussion for up to 90 minutes with you. I will audiotape the interview (with your consent) and also write up my reflections on the themes and issues as they arise as field notes.

The interview tape and transcript and my field notes will be kept securely locked in a filing cabinet in my office. Any material or papers to be written for publication as a result of this project will in no way identify individual participants who consent to be interviewed. I am studying the themes and general issues as they arise (not specifics of people or situations).

I want to stress the voluntary nature of the participation in this project. If you wish to withdraw from the project this will be accepted without coercion to continue or later recrimination. You may also choose to withdraw any unprocessed data. If there are issues that you wish to discuss that may precipitate or contribute to your withdrawal either myself or my project adviser will be very happy to discuss these further if this is required

If you have any questions about this model of research or more information on the project I am undertaking please contact me on XXXX or my project advisor Professor XXX on XXXXXX.

If you have any ethical concerns about the project you can also contact XXXXX.

Yours sincerely

Leanne Beagley

B. App. Sc (Occ. Ther)

Grad. Dip. Family Therapy

Master Business Leadership

DATE

Appendix 3 Participant Consent Form

RMIT HUMAN RESEARCH ETHICS COMMITTEE

Prescribed Consent Form For Persons Participating In Research Projects Involving Interviews, Questionnaires or Disclosure of Personal Information

FACULTY OF **Science, Engineering and Technology**

DEPARTMENT OF **HEALTH**

Name of participant:

Project Title: ***Public Child and Adolescent Mental Health Services (CAMHS):***

Perspectives in measuring organisational performance

Name(s) of investigators: (1) **Leanne Beagley** Phone: **XXX**

1. I have received a statement explaining the process and data gathering element (interviews and discussions) involved in this project.

2. I consent to participate in the above project, the particulars of which - including details of the interview - have been explained to me.

3. I acknowledge that:

   (a) Having read Plain Language Statement, I agree to the general purpose, methods and demands of the study.
   (b) I have been informed that I am free to withdraw from the project at any time and to withdraw any unprocessed data previously supplied.
   (c) The project is for the purpose of research and/or teaching. It may not be of direct benefit to me.
   (d) The confidentiality of the information I provide will be safeguarded. However should information of a confidential nature need to be disclosed for moral, clinical or legal reasons, I will be given an opportunity to negotiate the terms of this disclosure.
   (e) The security of the research data is assured during and after completion of the study. The data collected during the study may be published, and a report of the project outcomes will be provided to RMIT for assessment purposes. Any information which will identify me will not be used.

Participant's Consent

Name: Date:

(Participant)

Name: Date:

(Witness to signature)

Participants should be given a photocopy of this consent form after it has been signed.

Any complaints about your participation in this project may be directed to the Chair, RMIT Business Human Research Ethics Committee, RMIT Business, GPO Box 2476V, Melbourne, 3001. The telephone number is (03) 9925 5594, the fax number is (03) 9925 5595 or email address is rdu@bf.rmit.edu.au.