“You absorb trauma, without noticing it”: A qualitative exploration of staff experiences and subjective well-being working in CAMHS inpatient services.

L. S. Hunt

A thesis submitted for the degree of Doctorate in Clinical Psychology

School of Health and Social Care

University of Essex

26th November 2020

Acknowledgements

Firstly, I would like to thank the 11 participants who kindly gave their time to share their experiences with me. Each one of you provided interesting and meaningful contributions to the project, and without you this thesis would not have been possible. Thanks also to the wider staff teams at the participating units for welcoming me, engaging in discussions around the study, organising rooms and encouraging people to participate. I would also like to thank the staff involved in the focus group which helped build the foundations to the interviews carried out in the study.

A huge thank you to my supervisors Dr Frances Blumenfeld and Dr Kate Budge, I will forever appreciate the time and effort you put into supporting me with this thesis, your guidance and feedback has been invaluable. Kate, thank you for helping me set up this project; and for always knowing the right things to say when I was struggling.

I would like to thank my parents for their whole-hearted, endless belief in me along this journey and throughout my life. Thank you also to my friends for their patience and understanding when I've been 'off the grid'; and for always being a source of support, strength and much-needed laughter.

Lastly, thank you to my partner Andy, I cannot put into words just how much your support and encouragement throughout this process has meant to me. I am so grateful to have you by my side.

Contents

Statement of Terms

The terms ‘psychiatric’ and ‘mental health’ in reference to staff discipline and/or the relevant setting may be used interchangeably throughout this thesis in accordance with the works of other authors or participants’ accounts.

The terms ‘young person’, ‘patient’, ‘service-user’, and ‘client’ may also be used interchangeably.

Other individual terms and acronyms are explained as necessary within each chapter.

Abstract

Background

Child and Adolescent Mental Health Service (CAMHS) inpatient staff are lacking representation in the literature, particularly their subjective experiences in the context of well-being. Previous research has tended to be quantitative, with a focus upon an absence of distress or symptomology as indicative of well-being, rather than holistically exploring the felt sense of well-being. The current research aimed to gain a greater understanding of the subjective experiences of CAMHS inpatient staff, the impact of their well-being, and what can be done to support staff in meaningful ways.

Method

A qualitative research methodology was employed. Recruitment took place across two CAMHS inpatient units and a total of 11 frontline staff from various disciplines participated in the study. Semi-structured interviews were utilised for data collection, data was analysed using thematic analysis. The study was underpinned by a critical-realist position.

Findings

A total of 10 themes and 16 subthemes were developed from participants' data. Participants described CAMHS to be both rewarding and stressful, and placed emphasis on the collaborative atmosphere within the wards. Participants felt an enhanced sense of responsibility compared to other settings. The findings also indicated possible Secondary Traumatic Stress within the staff. Participants expressed a need to be held in mind, as well as trying to find ways to overcome barriers to accessing the support offered to them.

Discussion

Findings are discussed in relation to existing literature and relevant psychological theory. The strengths and limitations of the study are outlined. Consideration is given to the clinical implications, including recommendations for Trauma Risk Management training for staff,

revisions to local policies, and meaningful staff consultation during CAMHS inpatient design. Recommendations for future research are presented such as exploring the impact of staff values on subjective well-being, and well-being comparisons between psychiatric intensive care and acute CAMHS settings.

Chapter 1: Introduction

1.1 Chapter Overview

The chapter begins by exploring key definitions and conceptualisations of 'well-being' and how these relate to healthcare staff. The chapter continues with providing the background to the study, beginning with research around inpatient staff more broadly and then focussing on CAMHS staff. An overview is presented regarding the current research on well-being of mental health professionals working within inpatient settings, resulting from a systematic search of the literature. Following this, key National and Local Policies directed at addressing NHS staff well-being are outlined. The chapter concludes with a rationale for the current study and research questions to be explored.

1.2 Study background

In this section, topics relevant to the background of the current study will be discussed.

1.2.1 Well-being

The impact of working within mental health on the workforce has been a topic of inquiry for numerous years. The literature on burnout in staff dates back to the 1970s, at a time when psychiatric asylums were still in use, but community-based alternatives were becoming more common. There have since been over 3000 publications on the topic (Elliott & Daley, 2013). Pines & Maslach (1978) posed that when the stressors of working in human-service professions are not acknowledged and sufficiently dealt with, it may result in staff burnout. They described burnout as a syndrome of emotional and physical exhaustion, which involves developing a negative self-concept and job attitude, and resulting in loss of compassion for clients.

Since then, Romppanen and Laitila (2017) have highlighted that in the context of the workplace, the concept of well-being itself has different meanings within and across organisations and countries. They note that previous research reviews describe healthcare professionals' well-being at work from the perspective of burnout, as above. They highlight that research on the effectiveness of interventions for nurses' well-being at work is sporadic and in need of further exploration. Bech, Olsen, Kjoller and Rasmussen (2003) also argue that mental health is about having a relatively high level of psychological well-being and not simply a lack of depressive symptoms.

Therefore, it is important to distinguish 'well-being' as a separate concept. The term 'well-being' is used by many different disciplines and in everyday language of the general population. It has been highlighted that reaching a conclusive definition of the concept, or even a universal spelling has proven difficult (Dodge, Daly, Huyton & Sanders, 2012). Dodge, Daly, Huyton and Sanders (2012) also argue that there is a difference between describing the construct in terms of its elements and giving a definition of well-being.

The Oxford English dictionary currently defines well-being as "the state of being healthy, happy, or prosperous; physical, psychological, or moral welfare" (Oxford English Dictionary, 2014). The National Institute for Health and Care Excellence (NICE) have produced guidelines for well-being at work; describing mental well-being as: "a dynamic state in which the individual is able to develop their potential, work productively and creatively, build strong and positive relationships with others and contribute to their community" (NICE, 2009). NICE (2009) also suggest mental well-being is improved when a person is able to fulfil social and personal goals and develop a sense of purpose in society; and argue that mental well-being specifically at work is governed by the interaction between the working environment, the nature of the work, and the individual.

Well-being can also be conceptualised as a broad concept referring to people's evaluations of their lives, and to their "optimal psychological functioning and experience" (Ryan & Deci, 2001, p. 142). There are several theories that conceptualise this, and most of the empirical research on well-being draws upon two separate perspectives, underpinned by different philosophical traditions and worldviews.

The first perspective adopts a hedonic view and focuses on well-being as pleasure or happiness. This perspective is often referred to as subjective well-being within the literature and encompasses core components of the experience: positive affect, the experience of low levels of negative affect, and high levels of life satisfaction (Diener & Lucas, 2000). The second perspective holds a eudaimonic view, with well-being constructed as comprising: (a) personal growth and self-realisation, (b) authenticity and personal expressiveness, and (c) the pursuit of meaning in life (Ryff, 1995). Thus, hedonic well-being is conceptualised mainly as a subjective experience of feeling good, and eudaimonic well-being refers mainly to living a good and meaningful life. Some researchers regard intrinsic motivation as an aspect of eudaimonic well-being (Ryan & Deci, 2000), which then makes it challenging to define clear conceptual boundaries of the eudaimonic well-being concept. Intrinsic motivation also effects the evaluation of the eudaimonic concept as the motivation itself is difficult to evaluate; existing in the nexus between a person and task, its nature remains open to interpretation (Ibid).

Underpinning these stances is also what has been described as the core of the well-being concept; the subjective experience of feeling good and/or feeling authentic and meaningful in one's life. Therefore, well-being may result from perceptions of positive features in one's own self, one's working life, and one's action in the world (Ryan & Deci, 2001).

Frameworks of understanding well-being

In attempting to develop a framework for understanding well-being, there have been numerous measures created by researchers. Linton, Dieppe, and Medina-Lara (2016) identified 99 different measures developed over the past 50 years, within their systematic review. They reiterated the difficulties with defining the concept, and recommended that the most suitable measures to assess this topic depend upon the particular dimension of well-being the user is interested in, in conjunction with psychometric guidance.

Ryff (1989) argued that, within the context of successful aging, previous definitions of success lacked a clear theoretical foundation and focussed on negatives such as the absence of distress while apparently ignoring the potential for growth. This led to Ryff (1989) developing a model of personal growth and psychological well-being. She formulated six components of psychological wellness: self-acceptance, positive relationships with others, autonomy, environmental mastery, feeling purposeful in life, and personal growth.

From this model, Ryff (1989) developed the Scales of Psychological Well-being (SPWB, Ryff, 1989). The SPWB is a self-report measure encompassing the six domains, with definitions for both high scoring and low scoring across each dimension of well-being. The domains are: (1) Self-acceptance. This assesses one's attitude towards oneself, whether a positive attitude acknowledging multiple aspects of the self, or a more dissatisfied view of the self and is troubled by certain qualities. (2) Positive relations with others; which focuses on the level of warmth, trusting relationships with others, concern for others, and one's understanding of the nature of human relationships. (3) Autonomy. This domain considers self-determination and independence, and the level at which an individual can resist social pressures or if they rely on the judgment of others to make decisions. (4) Environmental mastery, which includes a sense (or not) of competency and control over external activities in relation to personal needs and values. (5) Purpose in life. This dimension looks at goals and

sense of directedness, or whether a person lacks a sense of meaning or aims in life. (6) Personal growth; encompassing a feeling of continued development and seeing one's self as growing and expanding; or a sense of personal stagnation.

The 18-item version of the SPWB (Ryff & Keyes, 1995) has been widely used, including within several large-scale surveys. The measure has been validated across several populations, although McDowell (2010) argues that despite psychometric validation, the tool may benefit from further refinement to improve its performance. Furthermore, Ryff and Keyes (1995) acknowledge within their report that the theories used to guide and underpin their research have unexpectedly provided little commentary to happiness or positive affect as a defining feature of human wellness. Moreover, it has been proposed that particular aspects of positive functioning, for example the realisation of one's goals and purposes, require effort and discipline that may actually be in conflict with short-term happiness (Waterman, 1984).

Evidence has also indicated that well-being is likely to be best explained as a multidimensional phenomenon incorporating both hedonic and eudaimonic notions of well-being. Compton et al. (1996) found that two factors which seem to reflect subjective well-being and personal growth were moderately correlated out of 18 indicators of well-being and mental health. It was consequently proposed that the hedonic and eudaimonic approaches are both overlapping and distinct. They suggest that an understanding of well-being might be enhanced by measuring the construct in differentiated ways.

McGregor and Little (1998) demonstrated in their research that pursuing personal goals, doing well and feeling happy may be disconnected from finding meaning and acting with integrity. Therefore, despite the significant overlap, the most valuable results may be those highlighting the factors leading to divergence rather than just convergence in the hedonic and eudaimonic markers of well-being.

Positive Psychology Theory

Another framework to understand well-being derives from the positive psychology movement. Martin Seligman is at the forefront of this movement, and his most recent conceptualisations of well-being are captured under what he names 'flourishing'. Seligman (2004) argues that the extent to which people are aware of, and are able to use, their 'signature strengths', such as courage, persistence, or wisdom, significantly affects quality of life and in turn well-being.

Seligman (2012) developed a theory of well-being known by its acronym "PERMA" which provides the foundations for flourishing. The elements of PERMA are: positive emotions, engagement, relationships, meaning, accomplishments. Each of these elements has three key properties: - it contributes to well-being; people pursue for their own sake not just to attain other elements; it is measured and defined independently from the other elements.

The PERMA model explains the notion of defining well-being, particularly in the context of positive psychology, and moves away from theories based purely on happiness. Seligman (2012) argues: "well-being theory denies that the topic of positive psychology is a real thing: rather the topic is a construct – well-being – which in turn has several measurable elements, each a real thing, each contributing to well-being, but none well-being" (p.20).

However, Dodge, Daly, Huyton and Sanders (2012) describe the PERMA model as disappointing, suggesting it does not achieve what it claims. Instead, it focusses on elements of well-being as the building blocks for flourishing. Dodge and her colleagues disagree with Seligman's position that well-being is a construct. They propose that well-being should be considered a state; as described by Reber (1995) "a condition of a system in which the essential qualities are relatively stable" (p. 750).

In terms of application within the field of Clinical Psychology, it has been argued that measures of positive functioning should be endorsed due to Psychiatrically-led views of well-

being being restricted to the absence of distress and reduced functioning (Joseph & Wood, 2010). It has also been suggested that adopting a positive functioning stance would naturally broaden the field (Ibid).

Recently, it has been highlighted that the current evidence-base for mental well-being is dominated by research related to medical careers (Health Education England, 2019). It is acknowledged within the Health Education England (2019) report that whilst medical Doctors will undoubtedly experience difficulties, care must be taken not to allow this narrative to dominate or obscure the issues faced by other professional groups. Therefore, it is important to include mental health staff narratives within this evidence base, such as those aiming to be captured within the current study.

Finally, given the outlined evidence-base and that the research population is healthcare staff; the definition by NICE (2009) will be adopted to underpin this project, along with the broad application of Ryff's (1989) framework of understanding well-being in terms of the six key areas (self-acceptance, positive relations with others, autonomy, environmental mastery, purpose in life, and personal growth).

1.2.2 Inpatient Staff

Over the past few years, there have been increasing discussions around the low morale of the mental health workforce, and that mental health professionals face significant challenges, particularly within the context of the economic strains the NHS is encountering (Onyett 2011; Morse et al., 2012).

In relation to these strains and to meet the growing demand for inpatient mental health services, particularly for adolescents experiencing significant distress presenting high levels of risk towards themselves or others, an increasing number of CAMHS acute inpatient units have developed Psychiatric Intensive Care (PICU) style provisions (NHS England, 2014).

PICU environments are designed to accommodate more complex and high-risk presentations within the adolescent population (Page & Parker, 2015). In general, adolescent inpatient settings have been found to create significant 'moral distress' in nursing staff (Musto & Schreiber, 2012). Jameton (1993) explains this as situations where nurses make moral judgments but are unable to act upon them due to external factors. The term 'moral distress' encompasses a range of subjective experiences within this context.

Extensive research within adult services suggests that exposure to violence and aggression within inpatient settings not only jeopardises staff safety, but can impact upon professional functioning (Nijman, Bowers, Oud & Jansen, 2005). Evidence suggests that staff working within psychiatric units experience some of the highest levels of burnout and job dissatisfaction across the healthcare workforce (Gilbody et al., 2006). Gilbody et al. (2006) investigated the effectiveness of interventions targeted at improving staff morale within this population. They concluded that there is significant opportunity to create and implement interventions to improve the experience of the workforce within psychiatric units, but there is a need to focus upon long term impact, and prospective evaluation. Gilbody et al. further highlighted that approaches to enhance social support networks and managerial support, including supervision, could affect staff well-being but that approaches were often impeded by staffing levels, and attendance was not always easily facilitated even for interested staff.

Regarding inpatient staff morale, Cahill et al. (2004) highlighted that research exploring the morale of the inpatient mental health workforce in England was limited. Their systematic review identified studies related to staff working within adult acute, forensic and long stay wards, but findings in relation to staff morale were varied and limited. A methodological limitation of this study was the lack of established definition of morale. As mentioned previously, indicators such as burnout, job satisfaction and overall psychological

well-being were most frequently used and often alongside indicators of vacancies and sickness rates.

Johnston et al. (2011) argue that none of these factors provide a satisfactory indicator of well-being at work or particularly engagement with work. Their study responds to this concern with a large-scale, mixed-methods investigation into mental health staff morale. Johnston et al. found that average reported morale differed between types of inpatient settings and community services. Staff working within the community mental health team (CMHT) were found to experience high levels of stress and emotional exhaustion, and were the only team found to experience higher anxiety than contentment. Staff working within acute wards were found to show high levels of burnout in relation to emotional exhaustion. Both staff from the CMHTs and the acute wards, including CAMHS, were found to possess high levels of personal accomplishment.

From this study, it was noted that NHS strategies to reduce stress within the workforce, often focus upon peer or managerial support, such as: supervision, appraisals, peer support groups or additional training. Johnson et al. (2011) demonstrate these approaches could increase morale, but only if they are experienced as supportive. Furthermore, initiatives within inpatient settings particularly, for example protected engagement time, concentrate on improving the quality of staff–patient interaction and reducing the amount of time staff spend in clinical offices. However, opportunities for staff to have more time together and more high-quality interactions with one another could be imperative for enhancing staff morale, and consequently performance (Johnson et al., 2011).

There is further evidence that differentiates between the experience of staff in community and inpatient settings, particularly in terms of supervisory support. Interestingly, it has been suggested that formal supervisory support is most beneficial to staff in community settings and co-worker support is more helpful within inpatient services (Halsey, 2014). This

is explained by the idea that community staff operate within autonomous roles that are likely to benefit from supervisors accepting a level of responsibility and offering protection for staff. Within inpatient services, it is argued that co-workers can share the workload demands between them and this reduces emotional exhaustion (Rousseau & Aube, 2010).

Additionally, Sørgaard, Ryan, Hill, and Dawson (2007) found that community teams experienced more organisational problems, higher work demands, less contact with colleagues, but also better social relations and more control over their work. Conversely, inpatient staff were found to be more satisfied with organisational structures and had easier access to colleagues during shift but described a worse social environment, and sense of a lack of control. Although a useful comparison, this study had methodological weaknesses which may have adversely influenced reported findings. Characteristics of the client base varied between the sites of investigation, meaning the differences in reported stress and other measures may have actually reflected the various levels of 'difficulty' in the client populations (for example, acute inpatient setting, rehabilitation, community teams, early intervention services). This is acknowledged but not explained within the paper; it could be possible that the client population itself influences staff well-being and stress levels. For example, within the Ryff (1989) well-being model described earlier in the chapter, staff sense of purpose and meaningful achievement and therefore overall well-being may be impacted working in older adult services where the majority of literature suggests a reduced sense of 'professional hope' (Koenig & Spano, 2006).

In relation to inpatient staff, Zarea, Fereidooni-Moghadam, Baraz and Tahery (2018) propose that the physical and mental well-being of nurses is vital, and in the context of moral and professional responsibilities of organisations to protect their health, inpatient staff experiences need to be examined. It is suggested that understanding these experiences, particularly through qualitative methods, could help enhance staff work-life and in turn aid

the recruitment and retention of inpatient nursing staff. Furthermore, evidence demonstrates that improving staff well-being also benefits patient experience and outcomes. Workforce factors including staff experience, well-being, fewer nurses and use of temporary staff have been associated with quality, safety and patient outcomes across care settings (Sizmur & Raleigh, 2018).

1.2.3 CAMHS Staff

It has been highlighted that the well-being of CAMHS staff has generally been neglected within the research literature (Lizano & Barak, 2012). There are a number of studies which explore burnout (e.g. Barford & Whelton, 2010), morale, and staff attitudes towards self-harm in adolescents (e.g. Crawford, Geraghty, Street, & Simonoff, 2003) but there is a dearth of research focusing upon CAMHS staff well-being.

Barford and Whelton (2010) highlight that whilst child and youth care workers possess similarities with other professionals, such as social workers, they also possess unique characteristics. Barford and Whelton argue that this uniqueness relates to the extent of direct contact with clients for extended periods of time daily. Child and youth care workers appear to experience aspects of burnout in a distinctive manner compared to other human service occupations. Arguably, the psychological and emotional demands of working in care with young people make it an exceptionally demanding profession, contributing to significant staff turnover within the profession.

Halsey (2014) examined the prevalence and predictors of burnout and secondary traumatic stress (STS) within CAMHS staff across Tier two, three and four services. Consistent with previous studies conducted within CMHTs, emotional exhaustion levels were found to be at the higher end of average and significantly higher than the normative data of mental health professionals within these groups. Sickness absence was not associated with burnout, although it was positively correlated with STS. Emotional exhaustion was predicted

by high levels of perceived stress and low levels of perceived organisational support. Education around symptoms of burnout and STS, and Acceptance and Commitment Therapy (ACT) based interventions were suggested as potentially beneficial for increasing personal accomplishment and improving staff well-being.

There is evidence to indicate that a large proportion of psychiatric nurses, as high as 85% in some studies, are exposed to aggression within their professional roles (e.g. Inoue et al., 2006). The literature has historically focused upon the impact of aggression within nursing staff in adult or older adult services. However, episodes of aggression are also common within CAMHS wards (Dean et al., 2007). Due to significant developmental and clinical differences across populations, findings from adult mental health studies are unlikely to translate to staff working within child and adolescent settings (Dean et al., 2010).

Dean et al. (2010) examined the impact of patient aggression upon CAMHS staff. They found aggression affected staff therapeutic or professional capacity, which could lead to staff avoiding patients or developing beliefs that their relationship with the involved patient is impaired. However, it remains unclear whether these staff views change the care young people receive on the ward, or how these views may affect clinical outcomes. Furthermore, contrary to what was expected, it was found that one third of participants expressed a view that levels of aggression were either acceptable, or dependent upon context. This perspective is incongruous with the, albeit small, evidence base within other mental health settings, where staff tend to view violence and aggression as unacceptable.

It is important to note that ‘acceptable’ in this context is not synonymous with ‘condoning’ aggression. Dean et al. posited that participants who expressed acceptance or understanding about aggression may have been more likely to view this behaviour as occurring within the developmental context of adolescence, compared to staff working within adult or older adult services. Additionally, the behaviour itself, although undesirable, could

be seen as a symptom of emotional dysregulation and therefore used as a focus for therapeutic intervention. Arguably, this is not unique to CAMHS settings; emotional dysregulation has been associated with 'self-destructive', impulsive and aggressive behaviours within adult mental health populations (Scott, Stepp & Pilkonis, 2014). It is unclear from the available research, what impact accepting violence and aggression from clients may have upon staff within inpatient CAMHS. Perhaps this may lead to more permissive attitudes and approaches to risk management and prevention, and in turn, become a hindrance to change, and ultimately service improvement (Dean et al. 2010).

An interesting development in relation to researching the experiences of CAMHS staff has been exploring the impact of ward design upon staff, as well as patients. Trzpuc et al. (2016) investigated how design elements and spaces affected behaviour and well-being for patients, staff, and families within a CAMHS inpatient unit. Trzpuc et al. found that unit design impacted upon emotional reactions, perceptions of safety, and pride in the work environment. Participants were particularly positively influenced by colours and artwork throughout the unit, along with upgraded security and safety features. The authors highlighted the tentative nature of conclusions drawn, suggesting that each CAMHS unit is unique due to patient populations, organisational structures, and procedural strategies. They did however suggest that organisations should carefully consider these complex variables when exploring design strategies during renovations of a unit, or constructions of new provisions.

As outlined, a lack of empirical research exists concerning the CAMHS staff population, particularly studies focusing upon subjective experiences. Staff working within inpatient settings with young people commonly encounter complex issues related to: risk of assault, exposure to traumatic material, complex presentations, individual and organisational defensive processes, and challenging countertransference (Lynch, Ryan & Plant, 2005).

Clark (2013) explored the experiences of staff in a forensic CAMHS setting, within an Interpretative Phenomenological Analysis (IPA) paradigm. Themes developed from staff accounts highlighted that staff felt they were isolated from the outside world both from other professionals and the general public. Meaningful contact was discussed, staff explained the unit aims to make the environment and belief system more holistic and systemic. Staff felt that understanding patients' presentations in this way was imperative to their professional development and enhancing relationships with the young people and their families; this was believed by staff to be the basis for satisfaction. Another theme was openness; its role alongside honesty was felt important particularly in the context of therapeutic processes. It was also reported that safety was a key theme, as well as structure and control. Staff described an 'ambivalent attitude' towards control. Some spoke about the difficulty with balancing positive risk taking and therapeutic needs in the structured nature of the ward. Staff felt that the structure and controlled environment was beneficial for both staff and patients, but also noted a multiplicity of rules and boundaries that were believed to be arbitrary and inconsistent at times.

Furthermore, team dynamics came up as a theme within the study, and the importance of relationships with colleagues. Staff found each other as a source of support, both practically and personally. Finally, 'complex task' was highlighted; the work required in the unit was found to be a source of stimulation and satisfaction as well as frustration. These findings may translate to other CAMHS inpatient settings, although there is an additional layer with the custodial element to admissions.

Clark (2013) argued that there is a risk the team could develop an idealised view of itself and become introspective when managing external systems and colleagues. This could hinder the team from exhibiting a functional and reflective approach to practice and become further isolated from the wider systems. In terms of staff needs, Clark proposed that including

nursing staff in therapeutic work with patients would increase their sense of professional identity and value. The importance of group supervision, specifically with an independent, external facilitator is emphasised. The evidence suggests that this would allow problematic relationships to be explored and resolved in a safe space. Also, to reflect on other issues, given the individual and group level impact that patients can have (Aiyegbusi, 2004). Exploring these relationships could have a direct impact on staff well-being. Maben (2016) states that the ability to form therapeutic relationships has an emotional impact on nurses. Maben argues that nurses sought this and wished to connect with patients, and meeting these aims is crucial to nurses' wellbeing.

1.2.4 The importance of CAMHS inpatient staff

Arguably, well-being is particularly important within CAMHS staff due to the various tasks they have in terms of their professional duties, building therapeutic relationships, supporting the young people develop, and providing containment for them (Hogan, Rogers & Hemstock, 2009). In the context of child development, Case (1992) integrates Paigetian and Information Processing theories of development. Within this, emotional understanding and development play an important role. Typically, children are initially helped to regulate by their caregivers. This continues to develop until eventually children can display and manage a variety of emotions. However, this process relies on an attuned and emotionally available caregiver. Evidence demonstrates that infants who do not experience this type of caregiving are more likely to develop longer term difficulties such as cognitive or behavioural issues (Gupta & Frake, 2009).

The young people admitted to CAMHS wards often struggle with emotional regulation (Dean et al., 2010). CAMHS inpatient units are environments which provide the opportunity for young people to begin working towards resolving some of their difficulties.

In order to support this development, staff can arguably adopt dual roles of both professional and 'parent' figure. Within both roles comes the function of containment. This provides a sense of safety to the young people while allowing them to explore their emotions and independence, particularly if this experience was inconsistent in early childhood (Hogan, Rogers & Hemstock, 2009).

Leighton (2009) suggests that for CAMHS staff, it is imperative to have mental space both individually and as a team. This allows practitioners to think about and makes sense of situations. It is also suggested that locating a space in the mind when considering feelings allows the containment of a young person's distress. Furthermore, for young people, being held in mind is key in order to for them to develop their own mental space. Bowley and Bratley (2005) argue that if there is space in someone else's mind, it is possible to have the concept of space in one's own mind. Therefore, the understanding and promotion of well-being in CAMHS staff may help to develop their capacity to find this space, or reflect on how the space itself is developed. Evidence suggests that poor well-being and emotional distress shuts down the capacity to hold someone else in mind and think about the mental states of another (Fonagy & Bateman, 2008), something that CAMHS staff are arguably required to do on a daily basis. Therefore, staff well-being within CAMHS inpatient services appears likely to directly impact upon their ability to provide attuned, appropriate and sensitive care to meet the needs of adolescent patients.

1.2.5 Trauma-informed Care

Many of the children and young people open to social services, mental health, special education, and youth justice settings have been exposed to trauma in their early years. The literature defines acute trauma as the result of exposure to a single overwhelming event; and complex or developmental trauma as the result of extended exposure to traumatising situations. Van der Kolk (2005) describes complex trauma as "the experience of multiple,

chronic and prolonged, developmentally adverse traumatic events, most often of an interpersonal nature...and early life onset" (p. 402). Kinniburgh et al. (2005) state that, in terms of both experience and effect, complex interpersonal trauma is qualitatively different to acute trauma.

Perry (2006) describes that traumatised children are in a constant state of alarm, even when no external threats are present. They have 'reset' their normal level of arousal. These children can also perceive adults as potential sources of threat rather than sources of support and comfort.

Mental health systems, Bloom and Farragher (2010) argue, can re-traumatise survivors through their fundamental operating principles of coercion and control. For example, restraining and forcibly medicating a rape victim, or, less obvious re-traumatisation, such as the pressure to accept medication mirroring prior experiences of powerlessness. This can also have a detrimental impact on the staff. The policies and practices that staff may be required to perform in such "trauma-organised systems" (Bloom and Farragher, 2010) can conflict with personal and ethical codes of conduct.

In recognition of this, trauma-informed approaches to treatment of mental health difficulties have been developed. These are models of system development underpinned by a clear understanding of the impact that exposure to trauma has on service user's neurological, biological, psychological and social development (Paterson, 2014). Trauma-informed approaches utilise neuroscience as well as attachment and trauma theories. At the centre of the approach is the acknowledgment of the complex and pervasive impact trauma has on a person's worldview and interrelationships.

Sweeney, Clement, Filson and Kennedy (2016) explain that in a trauma-informed mental health service within the UK context, it is assumed that most service users have experienced trauma and may consequently find it difficult to develop trusting relationships

with staff and feel safe within services. Therefore, services are structured, organised and delivered through ways that engender safety and trust; and consequently do not re-traumatise. The 'three pillars' of trauma-informed care are: safety, connections and managing emotions (Bath, 2008). These elements of treatment are applied by anyone in that service who has a role in caring for, teaching, or mentoring the children and constitute the essential features of healing environments.

Hanson and Lang (2016) suggest fifteen components for implementing trauma informed care. These include; staff training in the impact of trauma, processes to prevent and help with staff secondary trauma, collaboration and information sharing *within* the agency e.g. between care and education, input from children and purchasers in service planning and development of a trauma informed system, provide services that are strength-based and promote positive development, provide a positive, safe physical environment, and presence of a defined leadership position or job function specifically related to trauma-informed care.

An important note is that trauma-informed services are distinguishable from trauma-specific services which aim to treat the impacts of trauma using specific therapies and different approaches. Predominantly trauma-informed care is a person-centred response focused on improving an individuals' overall wellness rather than solely treating symptoms of mental illness.

Trauma-informed services are developed on the understanding that most of the service-users have been affected by trauma; therefore, adequate training, supervision and support for staff are viewed as essential. This focus on staff support has been argued to have the potential to decrease burnout and reduce staff turnover (Sweeney, Clement, Filson & Kennedy, 2016). Research has demonstrated that supervisors who feel that their organisation values them and cares about their well-being are more likely to be supportive towards the people they are responsible for (Shanock and Eisenberger, 2006). Furthermore, Hales et al.

(2017) found that the assimilation of trauma-informed care within organisational settings increased the overall levels of staff satisfaction and decrease the risk of traumatising staff.

1.3 Systematic Review

A systematic literature review was conducted for the current study. The purpose of the review was to use a precise question to identify and evaluate relevant research, which would provide evidence to underpin the study (Robinson & Lowe, 2015).

In order to explore the experiences and well-being of CAMHS inpatient staff, the experiences of CAMHS staff more broadly were first investigated. This was due to the lack of research within the CAMHS inpatient staff population. The following section provides a description of the literature review undertaken on this topic specifically to consider the following question:

"What are staff experiences of working in CAMHS in relation to well-being, burnout and satisfaction?"

1.3.1 Search strategy

An adaptation of the SPIDER format was employed (Methley et al., 2014) to conduct a systematic search of the literature. Four electronic databases; CINAHL Complete, Medline with full text, psychINFO, psychARTICLES were included, all available years of publication from 1900 to 2019 were included within the electronic search. The search was conducted between October 2019 and December 2019, using the following key words and search terms, truncated where appropriate:

"CAMHS" or "child and adolescent mental health" or "CAMH"

AND

Staff or work* or professional or practitioner or clinician or nurse or "healthcare assistant"

AND

wellbeing or well-being or “well being” or stress or burnout or satisfaction

Identified literature was filtered by the following limiters: empirical studies of humans, and written in English language. The following inclusion and exclusion criteria were applied during the screening of articles;

Inclusion criteria:

- The research undertaken was specific to mental health professionals’ experiences
- Participants included those working within CAMHS services
- Full text was available

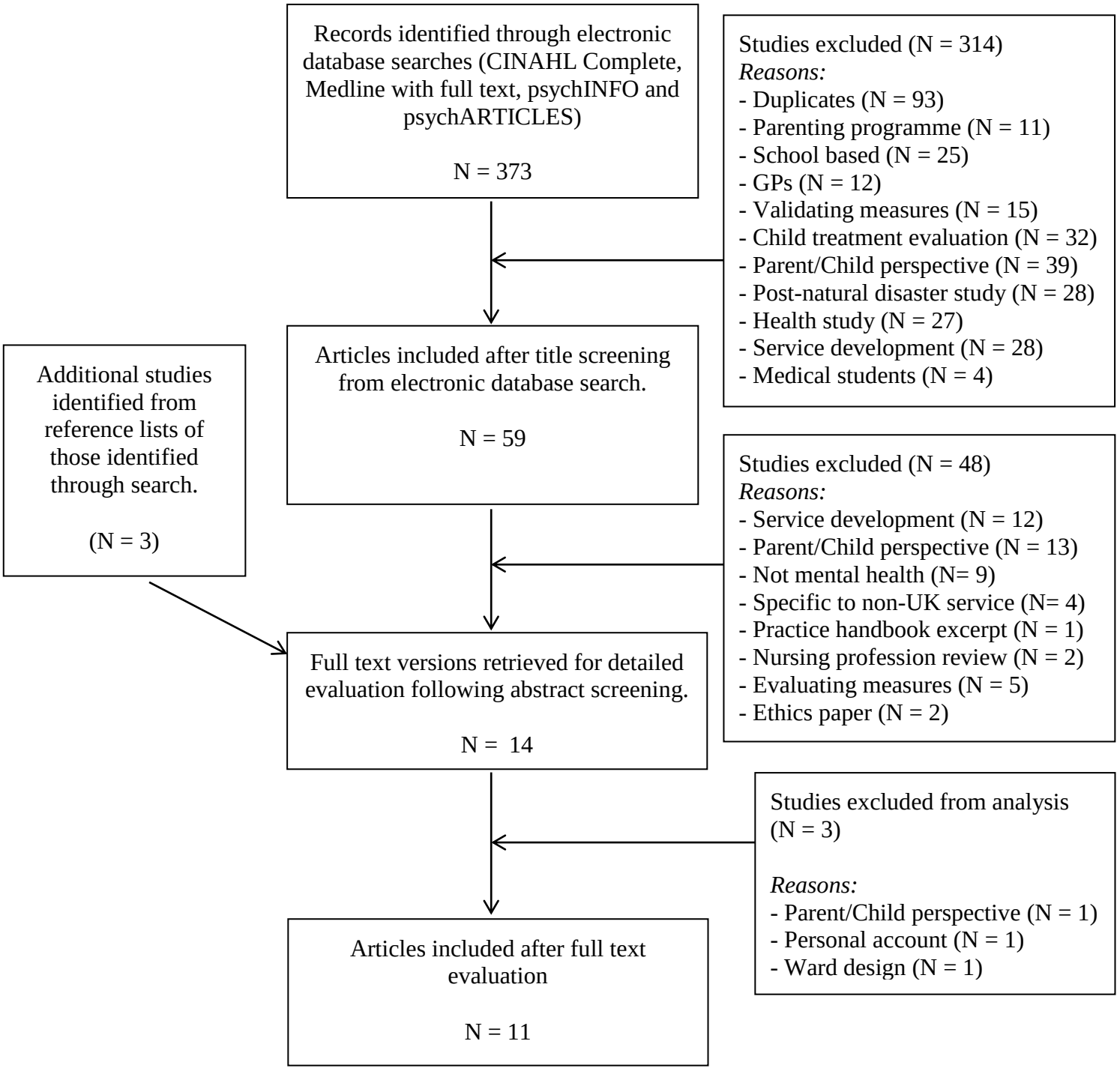
Exclusion criteria:

- Research focused on general health practitioners (such as GPs, general Nurses)
- Research which did not focus upon healthcare professionals (such as teachers)
- Studies not written in the English language, due to time constraints and the obstacle of translation

Application of the inclusion and exclusion criteria for title screening resulted in the identification of 59 relevant publications. Abstracts were then screened, and 11 appropriate articles were identified. References of the 11 studies were checked for further papers, which identified three further publications. Given the nature of the review question, a hand search of journals International Journal of Wellbeing, Clinical Psychology Forum and British Journal of Mental Health Nursing from dates January 2014 to December 2019 was also completed; no further studies were identified which met inclusion criteria. During the full text reviews,

three papers went on to be excluded due to factors including the study being from the child or parent perspective, a personal account, and a ward design study; which only became apparent through full text examination. In total, 11 articles were consequently eligible for review. See figure 1 for search procedure and outcomes.

1.3.2 Figure 1: Flow chart of Search Procedure and Outcomes



1.3.3 Data Extraction

Individual study data was extracted into pre-defined tables (see appendix I for example). A number of study characteristics were extracted, including aims of study, demographics (age, gender, role, length of time in role), sample details (total *N*, recruitment and attrition), method (design and procedure), data analysis used, findings and any study limitations that were reported. If any data were not available in the study, authors of the reports were contacted. For most studies, the above data were obtainable. An attempt was made to contact Jennifer Oates to obtain information regarding the work settings of participants her 2018 paper; but this was unsuccessful.

1.3.4 Literature Review

Given the heterogeneity of the studies, formal analysis of synthesised data was not feasible. For the purposes of the current thesis, the studies will be evaluated according to their methodological profile in addition to a synthesis of research findings and implications. Sandelowski, Docherty and Emden (1997) highlighted the inconsistencies in the literature regarding what constitutes "good" research, as such, studies were not excluded based on quality. Instead, the final 11 articles were subjected to an appraisal process using the Critical Appraisal Skills Programme (CASP) to help make sense of the studies and their methodological strengths and weaknesses. Table 1 provides an overview of the reviewed including the sample size, population, methods used and main findings from the study. It also includes a rating on the overall quality of the research based on the findings of the CASP evaluation.

1.3.5. Table 1. Overview of reviewed literature.

Author(s)	Sample (N)	Population	Methodology	Main findings	Quality
Foster & Smedley (2019)	26 data sets	CAMHS PICU staff	Qualitative – conceptual analysis of work discussion group.	There is significant emotional labour generated from the detailed and intense relationally-focused work with young people. This is responsible for both a sense of value and job satisfaction, and corrosion of staff capacity to sustain these interventions over the longer term. It was also found that projective identification has a central role in both enabling nursing staff receptiveness to young people's needs and in engendering distress in staff.	High
Matthews & Williamson (2016)	10	Inpatient CAMHS staff (private organisation)	Qualitative – IPA of diary entries and interviews.	Findings illustrated that inpatient mental healthcare is a distinctive area of nursing, where disturbing behaviour is often normalised and detached from the outside world. Staff experience tension between their personal moral code, orientated towards empathy and support, and the emotional detachment and control expected by the organisation. This contributes to burnout and moral distress.	High
Littlewood, Case, Gater & Lindsey (2003)	333	CAMHS Psychiatrists across settings	Quantitative – postal questionnaire	Lower satisfaction rates among females compared to males. Staffing numbers were fewer than recommended child psychiatry guidance. The majority of respondents felt the service they are in is inadequately resourced. Rates of psychological distress and	Moderate

				burnout were high. Adequate services and the presence of a close, supportive colleague were associated with higher rates of satisfaction and lower rates of distress and emotional exhaustion.	
Foster (2018)	17	Mental health nurses and Healthcare Assistants in an adolescent PICU	Quantitative – repeated measures, longitudinal design, questionnaires	Compared to benchmark data, participants showed significantly higher than expected levels of compassion satisfaction, and lower than expected levels of burnout and STS for staff in an adolescent PICU. There were no significant differences between qualified nurses and HCAs.	High
Oates (2018)	237 survey, 27 interviews	Mental health nurses	Mixed Methods – survey and interviews	Nurses' subjective well-being is reasonably low, some use strategies to support their well-being inside and outside the workplace. Well-being was associated with clear boundaries between home and work life, regular clinical supervision and translating learning from work with patients to nurses' own lives.	High
Totman, Hundt, Wearn, Paul & Johnson (2011)	71	Across disciplines, qualified & unqualified. Seven inpatient wards.	Qualitative – thematic analysis of individual and group interviews.	For frontline staff, the strongest positive influence on morale was peer support within a close-knit team. Despite feeling 'embattled' and often neglected by senior management, morale was maintained through camaraderie, mutual loyalty and collaboration. Supervision and training can be experienced as highly supportive in the context of the right working relationships and organisational support, but frontline	High

				experiences of formal support mechanism varied widely.	
Mendenhall, Grube & Jung (2019)	41	Case managers – community mental health centre (children & families)	Quantitative – repeated measures, longitudinal design, questionnaires	After 6 months of implementing the Strengths Model for Youth (SM-Y) significant increase in compassion satisfaction, significant decrease in burnout levels and a decrease (non-significant) in secondary trauma. Findings suggest that having high levels of secondary trauma may lead to higher levels of burnout at a later time if left unaddressed.	High
Clark (2012)	13	Inpatient forensic CAMHS	Qualitative – IPA of semi structured interviews	Staff reported the work is valuable but challenging. Challenges include negotiating relationships with management, other staff & young people while in a complex work environment. Team dynamics were a key finding, staff reported experiencing enjoyment and a close, supportive team. However, feelings of isolation were emphasised due to experiencing a lack of support and sometimes hostile attitude towards the unit by external staff.	High
McLean & Wade (2003)	116	Mental health staff working with traumatised clients	Quantitative, postal questionnaires	Therapist beliefs were found to predict vulnerability to vicarious trauma and burnout, supporting a cognitive model of therapist distress. Therapist beliefs tended to be the sole or most important contributor to both burnout and vicarious trauma, rather than situational variables external to the therapist, such as	Moderate

				predominant client type. Overall levels of distress on all measures were sub-clinical, representing mild impairment.	
Newman, Maggott & Alexander (2015)	17	Multiple disciplinary staff in a CAMHS Unit	Qualitative - retrospective open-ended questionnaire	Participating in the staff drumming group encouraged emotional expression, represented a distraction from vicarious trauma, helped to level hierarchical structures, increased energy and productivity, improved mood states, created feelings of accomplishment, and fostered a sense of belonging.	High
Green, Albanese, Shapiro & Aarons (2015)	256	Multiple disciplinary staff in community mental health programs for children & families	Quantitative, surveys (face-to-face sessions)	Gender and caseload size were not significantly correlated with burnout variables. Age was positively related to personal accomplishment, and years at agency was negatively related to emotional exhaustion. No significant differences found in emotional exhaustion, depersonalisation and personal accomplishment by professional discipline. Significant difference found in depersonalisation between 'Wraparound' providers and traditional case managers.	High

1.3.6 Description of included studies

The 11 included articles reported findings from research carried out across varied settings. Taken together, the studies represent the views of 848 CAMHS professionals. Based on the information that was provided in the articles, this included 35 healthcare assistants, 105 psychologists, 336 psychiatrists, 27 mental health nurses, 41 case managers (various backgrounds), 150 social workers, two occupational therapists, one administrator, 102 family therapists, 49 identified as mental health professionals (nurses, occupational therapists, education staff). Seven of the studies were conducted in the UK, two in the USA, one in Australia and one in South Africa.

1.3.7 Methodological profile and evaluation of studies

Definitions and measures

Within the quantitative studies, the main measures utilised were the Maslach Burnout Inventory (MBI: Maslach, Jakcons & Leiter, 1996). This was employed directly in one study (McLean & Wade, 2003), whereas two studies (Green et al., 2004; Littlewood et al., 2003) used specific subscales from the MBI and additional measures which map directly on to these such the Organizational Social Context scale which measures the cultures and climates of child welfare and mental health organisations.

The Professional Quality of Life Scale V (ProQoL V, Stamm, 2010) was used in the quantitative studies. Additionally, within the two studies that employ it (Foster, 2018; Mendenhall, Grube & Yung, 2019), both discuss the reliability and validity of this measure and found that it had high internal reliability and scale validity. The MBI studies do not

explicitly do this. Oates (2018) used the Edinburgh Mental Well-being Scale (Tennant et al., 2007) although the rationale for using this compared to other measures is unclear.

There were also some specific job-related questionnaires employed in studies such as the Multifactor Leadership Questionnaire, the Recruitment and Retention questionnaire, and job satisfaction and job stress questionnaire (Littlewood et al., 2003) .

Two studies developed their own measures; McLean and Wade (2003) constructed a therapist belief scale which was then rigorously evaluated. Newman, Maggott and Alexander (2015) uses a qualitative questionnaire containing six open-opened questions requiring written response, however, they do not explicitly state how this was developed nor underpin it with any specific construct or definition.

A number of the studies do discuss definitions to add to the study context such as 'burnout' and 'well-being', but do not always critically examine these concepts. Only one study (Foster, 2018) discusses in depth the difficulty of definitions, and particularly with defining compassion satisfaction and compassion fatigue.

Clarity of research process

The majority of studies provided a clear description of the research process but there were some issues highlighted by the current review. As mentioned, Newman, Maggott and Alexander (2015) use a qualitative questionnaire but do not describe how they developed this, or if it was a standardised measure used in previous research. Furthermore, most studies did not fully describe the recruitment process in terms of inclusion and exclusion criteria of participants, nor attrition rates.

Acknowledging potential bias

Within the qualitative studies, the majority did not include explicit statements from the researchers about their own perspectives. Given that the studies may or may not have been driven by the beliefs of the researchers, it is noteworthy that their own perspectives have not clearly been outlined. Only two studies (Newman, Maggott & Alexander, 2015; Matthews & Williamson, 2015) discussed the epistemological position within the methodological context of their research, both were qualitative studies. They were also the only two studies to include a clear consideration of the relationship between the researcher and the participants.

Three out of the six qualitative studies used quotations to ground in examples of their data coding (Newman, Maggott & Alexander, 2015; Clark, 2012; Totman et al., 2011). Five qualitative articles made clear attempts to increase the validity of their findings through data checks with independent researchers, consensus within the research team, or member checks with participants. All of the qualitative studies used post-hoc tests where appropriate.

Ethical Considerations

Three of the reviewed studies did not include a statement about ethical considerations or approval (Mendenhall, Grube & Jung, 2019; Littlewood et al., 2003; McLean & Wade, 2003; Green et al., 2015). Five of the studies state they had been granted ethical approval by a governing research body (Foster & Smedley, 2019; Newman, Maggot & Alexander, 2015; Totman et al., 2011; Clark, 2012). Three of the studies included a detailed statement of the ethical considerations made and steps to reduce the impact on staff, such as offering a debrief or support channels (Foster, 2018; Matthews & Williamson, 2015; Oates, 2018).

Considering the consensus that mental health staff are often exposed to trauma, it is pertinent for researchers to engage with ethics and demonstrate this within the development

and implementation of their studies. They should give particular consideration to the nature of their questions/measures and having clear rationale for these within the research aims.

1.3.8 Implications for practice.

The findings from the current literature review have a number of implications for clinical practice as well as management applications.

For those working in ward environments, there should be an increase in constructive and open-dialogue with external colleagues. Furthermore, management should attend the ward occasionally, this is to reduce frustration caused by a possible lack of action after difficulties have been raised; and reduce possible difficulties at all levels. Encouraging ward team cohesion, mutual support and trust appears crucial to staff's ability to sustain and gain satisfaction from their roles in potentially stressful environment. Although consideration needs to be given if very close-knit teams are created as evidence shows these can be hazardous. For example, bullying can occur between the main cohesive group and any staff perceived as outsiders to this.

More generally, good quality, regular clinical supervision is paramount, as well as staff having "self-care plans", particularly for newly qualified staff. It may also be helpful to make temporary adjustments to caseloads in terms of type or quantity, at times of direct therapist exposure to traumatic stress in times of personal stress/crisis for the therapist. Furthermore, well-being monitoring should be included as part of staff surveys and evaluation of well-being initiatives, and encouraging nurses with high well-being to share 'what works for them'. Well-being activities should be part of, rather than additional to, the working day. For example, end-of-shift debriefs, offer 'short burst' well-being activities

during shift breaks, and promote ‘walk and talk’ or outdoor meetings. Well-being skills training should be open to both patients and nurses.

Leadership should also be an area targeted for intervention. Structured training programmes could be offered that teach transformational leadership behaviours. Leadership should be clear, sympathetic and flexible, and attend to clarity of staff roles while allowing some autonomy within carrying them out. It is also important to provide clear and concise goals/objectives to providers. In addition, leaders should provide systematic ways to manage increasing demands on providers’ time.

1.3.9 Strengths and limitations.

Whilst some of the studies included small sample sizes, taken together, the review represents the views of a wide range of professionals working within various CAMHS settings. However, given that several of the studies are from specific regional settings, some outside of the UK, each will have their own philosophy, therapeutic approach and treatment programmes. This will inevitably shape the experiences of the staff, and therefore limits the generalisability of findings. If conclusions are to be drawn about this, they should at least be made with this explicitly in mind.

Methodologically, the synthesis was completed by one researcher due to time and resource constraints. Due to the limited literature available in this area, both qualitative and quantitative studies were included which used a range of analyses. This made it difficult to synthesise findings using a formal synthesis method such as a meta-analysis. In addition, applying the specific inclusion and exclusion criteria to the literature meant that both exploratory studies and intervention studies were included for review. This adds complexity to the synthesis, but adds broad, rich data to the review.

Within the studies that used participants from a mix of adult and child settings, comparisons of the data were not drawn out between the groups, making it more difficult to draw specific conclusions around CAMHS workers within the review (e.g Totman et al., 2011; Foster, 2018). Furthermore, the quality assessment highlighted inadequate contextual information in some included literature, such as the recruitment strategy and data collection processes and methodological weaknesses were identified. However, these studies were felt to contain significant data relevant to the review aims.

1.3.10 Literature review summary

The aim of the literature review was to summarise previous research findings in relation to CAMHS staff experiences of well-being, burnout and satisfaction. Most studies identified included a range of multi-disciplinary CAMHS staff, with some studies incorporating workers in both CAMHS and adult services from one profession. The included studies used predominantly self-report measures to assess the aims, rather than exploring the subjective experience of staff more broadly. Studies included investigating symptomology within the context of well-being as well as more positive psychology-led notions such as professional quality of life and job satisfaction. Two studies included evaluating interventions for CAMHS staff to address or prevent burnout, and the majority of articles gave clinical implications from their results, appropriately limited to their particular setting. The review highlights a dearth of studies focussed on the well-being experiences of CAMHS staff, particularly inpatient staff. It has been previously been noted that methods of supporting staff within the inpatient environment are in their early stages (Clark, 2013), and this seems to remain the case. Despite the limited research on this topic, the importance of staff well-being has been noted by NHS managers and various policies have been written to address this.

1.4 Current Policies

There are numerous policies and guidance both nationally and within local Trusts focusing upon NHS staff well-being. This section will outline the key policies which contextualise the current study.

1.4.1 National Policies and Strategies

West (as cited in NHS Employers, 2018) argues that poor staff health and well-being has a significant impact on the performance of NHS organisations. Public Health England (2019) estimates the cost to the NHS of staff absence due to poor health at £2.4bn a year (accounting for approximately £1 in every £40 of the total budget); it is argued that investing in staff health and well-being can therefore deliver benefits for NHS organisations, staff and ultimately patients.

The Health and Wellbeing Framework (NHS Employers, 2018) collates best practice, research and insights to advise NHS organisations in relation to improving staff health and well-being. Within this, it is advocated that every healthcare setting should have an NHS Workforce Well-being Guardian responsible for the mental well-being of staff. This would ideally be at board-level. It is also recommended that all NHS organisations appoint a Workplace Well-being Leader to work with and report to the Well-being Guardian.

NHS Health Education England (2019) has outlined recommendations for all NHS staff which support the recently published NHS Long Term Plan. The plan sets the challenge of establishing a new deal for staff, envisioning a culture wherein all staff feel supported and respected for the valuable work they do. This is relevant given the reviewed literature that highlighted the impact of social support upon psychiatric staff well-being.

NHS Health Education England (2019) identify the needs of NHS staff. Within the recommendations, emphasis is placed upon establishing workplace cultures which encourage

self-compassion and normalise the practice of self-care. The report also captures the need to be ‘human beings’ and not adopt a ‘superhero complex’ to help ease pressures associated with professional roles. Furthermore, the importance of taking a break is emphasised. It is suggested that staff can feel under pressure from colleagues or the accepted workplace culture to work long shifts without breaks, come to work when ill, and even skip annual leave, particularly where staffing is under-resourced.

Overall, NHS Health Education England (2019) assert that well-being at work needs to be addressed strategically across the NHS, but actually the “simple things” can make a real difference, such as staff lockers, showers, a quiet room, the availability of nutritious food, a good coffee, a psychologically safe space to get together with others to talk and debrief, or a colleague taking time to say ‘thank you.’

NICE (2009) have developed guidance on well-being at work. Within this they recommend: a strategic and coordinated approach to promoting employees' mental well-being by employers in all organisations, assessing opportunities for promoting employees' mental well-being and managing risks, flexible working, and strengthening the role of line managers in promoting the mental well-being of employees through supportive leadership style and management practices. Whilst these are still currently being implemented, NICE reviewed this guidance in 2018 and are in the process of updating this. This guidance is designed to capture staff in all organisations and can therefore be applied in the context of CAMHS services within the current project.

As part of the development of the aforementioned guidance, NICE found that there was very limited UK-based evidence that met the inclusion criteria for organisation-wide approaches which aim to improve the mental well-being of employees within different sectors, occupations and organisations of varying sizes. The current study aims to address this

by exploring UK-based, multi-disciplinary staff within a setting yet to be included in the evidence-base for staff well-being experiences.

Finally, NHS England (2009) developed the system 'CQUIN' (Commissioning for Quality and Innovation). This was designed to make a proportion of healthcare providers' income conditional upon demonstrating improvements in quality and innovation within specific areas of care. In the most recent implementation report (NHS staff health & wellbeing: CQUIN 2017-19) the need for action to address the health and well-being of NHS staff is emphasised. The report also provides tools and resources (for example; signposting, healthy eating advice, ways to reduce stress) to aid the implementation of the CQUIN indicators.

1.4.2 Local Policies

Whilst upholding the anonymity of the NHS Trust within the current project, it is important to contextualise the research by acknowledging the unit-specific approach to managing staff well-being. Employee well-being, in the context of promoting mental and physical health, is captured alongside the management of sickness and absence policy. The document sets out a framework for the approach to 'achieve and maintain employee well-being in the workplace'. It also delineates the management of sickness and absence processes for managers, staff and recognised accredited Trade Union representatives. The policy appears to synonymise poor well-being with sickness, and managing this through various support structures. This is somewhat contrary to the literature on well-being outlined in this chapter which argues that well-being is not solely the absence of symptoms or distress (e.g Ryff, 1989).

Furthermore, within this policy document, available services designed to support the well-being of staff are identified. The Trust states that it aims to make the workplace safe by

ensuring managers promote a working environment which supports the health and well-being of their staff, and to encourage them to take responsibility for their own health and well-being. The policy also asserts that managers will put measures in place to minimise risks, which includes identifying stress as a risk to well-being. The Trust also states that they promote good working practices, and ensure that the health of the workforce is not compromised through work itself or the working environment. This includes identifying, assessing and reducing organisational factors potentially affecting the health and well-being of staff.

1.5 Rationale for current study

The literature review in the previous section summarised the findings from research on well-being within the inpatient mental health staff population. Since there were only six papers identified in this area, it highlights the need for additional exploration of the topic. Furthermore, the studies predominantly involved nursing staff working within adult services, with the exception of one study which explicitly investigated the experiences of staff working within adolescent settings. Therefore, there is a need for further investigation with this specific population; particularly given the potential impact staff well-being may have upon the ability to provide emotional and psychological containment for young people in crisis, a critical concept within the child development literature.

CAMHS staff needs are also relevant in the context of the increasing demand for CAMHS inpatient settings, and growing demands placed upon the professionals working within them (NHS England, 2014). Additionally, Public Health England (2016) identified that whilst previous literature has focussed upon stress-reduction within the health workplace, there remains a gap within the literature where further investigation is needed. Particularly as

research within the domain of staff well-being has predominantly relied upon quantitative methodologies, using predetermined measures (e.g. Paris & Hoge, 2010). Such research has also tended to focus upon an absence of distress or symptomology as indicative of well-being, rather than looking more holistically at the positive felt sense of well-being and functioning (Joseph & Wood, 2010).

In conclusion, given the challenges and pressures commonly experienced by clinicians working within CAMHS contexts (e.g. aggression, exposure to traumatic material, complex presentations; Lynch, Ryan & Plant, 2005), there is a need for further exploratory research in order to better understand the experiences and perceptions of staff working within this area. This is also important given the review findings in this chapter that the subjective experiences of staff are lacking representation within the literature.

1.6 Study aims and research questions

The present study aims to gain a greater understanding of the subjective experiences of CAMHS inpatient staff, the impact of their role upon well-being, and their opinion on what can be done to support staff in meaningful and relevant ways. This will be explored through two primary research questions; "What are the experiences of staff working within inpatient CAMHS?" and, "How does working within a CAMHS inpatient setting affect staff well-being?".

Chapter 2: Methodology

2.1 Chapter Overview

The research design outlined in this chapter has been developed to address the primary research questions identified in section 1.6. The remaining chapters, including the current chapter, are written in first person narrative. This recognises, as highlighted by Reid (1991), the impact of my own values and beliefs on the analysis and interpretation of the data collected. I outline some of these beliefs within this chapter in relation to the current study. I also outline within the chapter the philosophical and epistemological underpinnings of the research, in addition to describing the procedures that took place for the recruitment, data collection, and data analysis phases of the research. I also discuss ethical considerations along with plans for review and dissemination of the findings.

2.2 Reflexivity

Reflexivity enhances understanding and acknowledges that the researcher influences and shapes the research process, both as a person (personal reflexivity) and as a theorist/thinker (epistemological reflexivity) (Willig, 2013). This goes beyond acknowledging personal biases, by asking us to think about how our own reactions to the research context and the data actually make possible certain insights and understandings. Willig (2013) also draws commonalities between reflexivity and the concepts around countertransference.

2.2.1 Self-Reflexive Statement

I am a 30 year old, white, British female. I have one older brother and two older step-brothers. I left home at the age of 19 years old to study Psychology and Early Childhood

Studies at University; I subsequently graduated with upper second-class honours. I then went on to work for four and half years within NHS Mental Health Services before commencing the Clinical Psychology Doctorate Training aged 26 years old.

My previous clinical experiences have largely been within Child and Adolescent Mental Health Services. I worked for three years on a Psychiatric Intensive Care ward in a CAMHS unit and undertook additional shifts on the acute ward. I also worked for 18 months in a CAMHS community team. During this time before training I had an additional NHS contract to do bank shifts across the Trust. In order to gain as much experience as possible I undertook additional shifts on two adult acute inpatient wards, and a mother and baby unit.

Clinically, I value integrative approaches, and have an interest in systemic, cognitive analytic and third-wave cognitive behavioural ways of working.

I became interested in research within the area of well-being in staff, particularly in CAMHS prior to training whilst working in the NHS. I noticed that there seemed to be something quite particular about the CAMHS inpatient setting; and I was struck by the intensity and levels of care given to the young people on the unit. It seemed different in some way, perhaps more intense, than the other settings I had worked in. I found it difficult to leave work at the door when I left, even though I knew the patients were being looked after there. This was surprising to me as I thought I would experience those feelings more within the community team. I subsequently became curious about how the staff care for themselves, there appeared to be high levels of stress and sickness rates, and sometimes dominant narratives in staff interactions around feelings of stress, exhaustion and trauma. I had noticed that staff support groups were on offer but there were a mix of attitudes surrounding the helpfulness of these groups and often noted that attendance rates were poor. I felt a sense of sadness that staff were feeling burnt out but they perhaps did not feel the right support was

there. I started to look into this from a more academic perspective and found that there were studies involving well-being in healthcare staff but was surprised to find very few studies with staff in inpatient CAMHS.

My exposure to, and my passion for, the experiences of frontline staff working in CAMHS has inevitably formed assumptions about CAMHS services and the staff that work within them. Throughout this study, I took a reflexive perspective about the impact of my experiences, knowledge and beliefs (personal reflexivity) and the contextual factors (functional reflexivity) on the research process (Malterud, 2001). I recorded my reflections on the impact of these factors in a reflective journal (see Appendix H for example of this), along with a record of my analytic decisions following the recommendations outlined by Lincoln and Guba (1985). It was important to also upholding the reflexive stance when establishing and negotiating relationships with the study participants (Maxwell, 2012). I acknowledge that whilst I have tried to hold my assumptions in mind in a non-biased manner during data analysis, my experiences and assumptions will have influenced my interpretation of participants' data.

2.3 Philosophical Framework

To ensure transparency and increase the credibility of the current study, it is necessary to discuss the philosophical assumptions I have chosen to underpin the research, and the justification of these decisions.

2.3.1 Ontology

Ontology refers to the nature of reality, and the researcher's assumption of what constitutes reality. It determines whether or not we believe that reality exists separately from human practices and understandings. The knowledge gained from research will therefore be

reflective of our standpoint on this (Willig, 2013). It has been argued that ontology is the starting point of all research, and epistemological and methodological positions will logically follow from this (Creswell, 2013).

One can conceptualise the different ontological positions as forming a continuum. At one end is a realist ontological position, which assumes that there is a knowable world, an objective reality, which can be understood through research. It also asserts that there is only one 'truth' that can be accessed by the appropriate application of rigorous research methodology (Giddens, 1974). It is argued that, when taking up this position, one can give an objective and unbiased presentation of findings (Lyons & Coyle, 2016). Due to these assumptions, a realist position rarely informs qualitative research, but is often associated with quantitative studies that aim to generate replicable results (Carson, Gilmore, Perry, & Gronhaug, 2001).

At the other end is a relativist position, which assumes that knowledge is inter-subjective and constructed through social meanings and understandings. Relativism argues that there are multiple constructed realities and that rather than being universal, what is 'real' and 'true' fluctuates across times and contexts. Therefore, what we can know reflects where and how knowledge is generated (Nightingale & Cromby, 1999).

Critical relativism lies between these two stances and asserts that 'truth' exists but a researcher's presence impacts upon what is measured (Guba, 1990). I assumed this ontological position within the current study. I do not believe there is an objective 'truth' to be discovered, however I acknowledge that I am using an, arguably, measurable construct by using the term "well-being" and defining it within my research. I do believe that individuals perceive different realities. I would argue that people's experiences, and gaining knowledge of these, are influenced by the co-construction of meaning.

2.3.2 Epistemology

Epistemology is concerned with the nature of knowledge, and poses the question of *what* it is possible to know (Braun & Clarke, 2013). Epistemological positions can also be thought about as being on a continuum, from representational to more subjective stances (Cohen & Crabtree, 2008).

The more realist epistemological positions and are grounded in empiricism, they assume that there is a knowable world, and hold a more positivist stance. This assumes that there is a straightforward relationship between the world and our perception of it. Positivism also supports ideas of dualism, that researchers and participants are independent of one another, and there is an objective reality that can be discovered through logical, unbiased collection of data (Scotland, 2012). This position would also deny any influence of the researcher on the knowledge gained.

With a more subjectivist stance, social constructionism can be placed at the opposite end of the epistemological continuum. A subjectivist epistemology proposes that knowledge is constructed through social interactions, and this is influenced by the dynamic and reciprocal process between participants and researchers (Ponterotto, 2005). Consequently, this assumes that researchers are actively involved in the co-construction of meaning within a study, and the position of both the researcher and participants' positions are considered and included when presenting and contextualising the findings (Hofer & Pintrich, 1997).

In between the two stances sits a critical realist position. This assumes there is a knowable world which is underneath the subjective and socially-located knowledge which can be accessed through research (Madhill et al., 2000). This stance also attempts to integrate individual experiences and their associated meanings whilst taking in to account the broader contexts of these, and how these can impinge those meanings (Willig, 2013). The critical

realist position asserts that we need to maintain that some 'authentic' reality exists to produce knowledge that 'make a difference' (Stainton Rogers & Stainton Rogers, 1997). In this position, external reality provides a foundation for knowledge.

Given this, I adopted a critical realist epistemology throughout this study. Bhaskar (1978) proposes that knowledge and reality are inherently linked to one another, and therefore reality without the context of knowledge has little meaning. I am using the construct of 'well-being' and its associated theories throughout this study which would set the context from which the data is gathered. I believe, as described by Denermark et al. (2002), that the data generated by this study was shaped by both participants' interpretations of the phenomena and by my interpretations of participants accounts.

2.4 Research Methodology

A qualitative design was chosen to explore the experiences of staff working in a CAMHS inpatient unit rather than quantitative survey/questionnaires as the literature review undertaken in the introduction chapter highlighted the need for exploratory research with the CAMHS staff population, and qualitative research has been argued to give a greater opportunity to explore individuals' feelings and to reflect on their experiences (Henwood and Pidgeon, 1992).

2.5 Methods of qualitative data analysis

As highlighted by Braun and Clarke (2006), there are several analytic methods which aim to identify and illustrate patterns across qualitative data. This includes grounded theory (GT) and interpretative phenomenological analysis (IPA). Both GT and IPA seek to illustrate themes from the data but are theoretically constrained. IPA for example is underpinned by a

phenomenological epistemology (Smith & Osborn, 2007). GT analysis aims to generate a plausible, and useful, theory of the phenomena that is based on the data (McLeod, 2001). However, there has been criticism about the application of GT, in that some researchers use it more as a set of procedures for coding data similar to thematic analysis (TA). As such, the analyses do not seem to fully adhere to the theoretical commitments of GT which requires analysis to be directed towards theory development (Holloway & Todres, 2003). The current project does not aim to generate a theory to understand staff well-being but aims to explore and gather a greater understanding of individuals' experiences. This lends itself to a TA approach to the data.

TA is a pattern-based data analysis method for identifying, analysing and reporting themes across datasets. Unlike GT and IPA, it is not wedded to any pre-existing theoretical framework nor pinned to any particular ontological and epistemological positions. Braun and Clarke (2013) assert that it can be applied to descriptive and exploratory research, investigating semantic (descriptive, surface level) or more interpretative research to explore meaning on a more in-depth, latent level. TA also allows greater transparency and clarity by sharing the series of decisions the researchers have made, making clear their theoretical position (Braun & Clarke, 2006). Despite its advantages, TA is not always a fully recognised method of data analysis in psychology (Roulston, 2001). Furthermore, as the analysis tends to focus on the semantic level of data, language itself is not attended to. This has been a criticism of the approach, and Braun and Clarke (2006) describe language as a means of accessing participants' reports of the research phenomena, not subject to analysis itself.

2.5.1 Thematic Analysis in the present study

For the present study, a decision was made to analyse the data using TA as it allows for both social and psychological interpretations. This type of analysis has also been highlighted as beneficial when exploring an under-researched area (Braun & Clarke, 2006). Furthermore, TA can be applied within the critical realist stance I have adopted for this study. Braun and Clarke (2006) state that TA can be positioned at any point on the realist-relativist spectrum, although as researchers they do not subscribe to a naive realist view of qualitative research where the aim is to simply 'give voice' to the participants. The present study aimed to employ TA to provide an in-depth thematic description of the entire dataset, capturing the experience of the participants whilst considering broader contextual factors.

2.6 Service context

Study participants were recruited from two child and adolescent inpatient psychiatric units within one NHS Trust. The trust covers a large, semi-rural area in England, UK and draws from a mixed demographic of clients and staff. The participating units consist of two acute wards, and one psychiatric intensive care ward (PICU). The units offer assessment and treatment to young people (aged between 13 to 18 years old) with acute mental health difficulties. The units have beds for fifteen young people on each the acute wards and ten young people on the PICU. They offer a range of assessments and treatments delivered by a multi-disciplinary team of nurses, healthcare assistants, psychiatrists, occupational therapists, psychotherapists, clinical psychologists, family therapists and teachers. Both units also have Education provision on site. The frontline teams provide twenty-four-hour care to young people admitted to the units.

2.6.1 Participants

A convenience sampling strategy was employed for recruitment of participants to the study. This is a type of non-probability or sampling where members of the target population that meet certain practical criteria, such as proximity, availability at a given time, or the willingness to participate are included for the purpose of the research (Etikan, Musa & Alkassim, 2016). Etikan, Musa and Alkassim (2016) contrast purposive sampling strategies which aim towards saturation, so continuing to sample until no new substantive information is gained, with convenience sampling which places emphasis on ensuring that the knowledge gained is representative of the population from which the sample was obtained. Although a criticism of the convenience sampling method is sampling bias and the lack of predictability about how well the sample represents the population in terms of its traits or homogeneity of the entire population (Leiner, 2017). Given that the present study is aiming to draw themes across data to represent the views of CAMHS inpatient staff, convenience sampling was deemed the most appropriate recruitment strategy.

In terms of sample sizes, it has been suggested that a minimum of five participants are required for a reasonable student project (Smith & Osborn, 2003). Braun and Clarke (2013) offer the guidance that when exploring experiences of participants via interviews, the sample size should be large enough to demonstrate patterns across a dataset, but small enough to retain a focus on the experiences of individual participants. They suggest collecting sufficient data from six to ten interviews for small projects (such as an undergraduate dissertation), and ten to twenty interviews for medium projects (such as a professional doctorate thesis). Given these suggestions, the current research aimed to recruit a total of between ten and twenty participants from a range of disciplines.

For staff to meet the inclusion criteria for the study, they were required to be a full-time clinical member of staff (registered or non-registered) working in the participating Child and Adolescent inpatient wards. Additionally, they were required to have worked in at least one other healthcare setting prior to working in the participating units; this was to allow participants to draw comparisons between settings. Staff were excluded from recruitment if they were unable to read or understand the verbal/written explanation, this was due to the limited financial resources of the project and consequent lack of provision for interpreters.

2.6.2 Recruitment procedure

In order to support the sampling strategy, posters were put up in staff areas around the participating CAMHS units (Appendix C). The same advertisement was emailed as an attachment to staff by the on-site research advisor and the manager in the units. I gave brief presentations to staff during their handover meetings that outlined the aims of the study and what participation would entail. I answered questions about the project and staff that expressed interest in taking part were provided with a copy of the participant information sheet. Staff who were given the information sheet were provided with seven days to read this and decide if they wished to participate. If staff wished to take part, I then requested their written informed consent (Appendix E).

2.6.3 Data collection

Data was collected through 11 semi-structured interviews with individual participants. Interviews were chosen rather than focus groups for data collection due to practical difficulties in getting several professionals together for a period of time before, during or after their shift hours. Furthermore, individual interviews allow greater freedom for

participants to express sensitive issues without their colleagues present, who may make them feel they need to inhibit their responses (Hennink, 2007). It was hoped that this would make it more likely to gain a reliable account.

Interviews were also in keeping with my position of aiming to explore individual accounts rather than collectively constructed experiences. In-depth interviews can be used in both structured or unstructured approaches. Structured interviews are usually carried out using an interview schedule made up of closed-ended questions in a pre-determined manner. Whilst this allows for easy replication of interviews, it has been argued that participants' accounts may then lack sufficient depth and detail (McLeod, 2014). Unstructured interviews may be guided by an interview schedule of pre-determined questions, but the questions are open-ended, and can be used flexibly to allow participants to elaborate. A drawback of this approach is that interviews can take longer to complete and analyse (McLeod, 2014). I decided that semi-structured interviews using a topic guide would be most appropriate to meet the research aims.

The interviews were planned to last up to 60 minutes. The duration of the interviews was inevitably varied given individual differences in participant's level of engagement and how much information they shared. There was also a pilot interview carried out with a Mental Health Nurse from an inpatient CAMHS unit. The purpose of the pilot was to gain my confidence in completing the interviews and to refine any questions through my reflections and feedback. A decision was made not to include the pilot data as I felt I had asked some leading questions during the interview. All of the interviews carried out were digitally recorded using a Dictaphone.

2.6.4 Topic Guide Development

The topic guide for interviews was developed in consultation with research supervisors and professionals within the participating service. Arthur and Nazroo (2003) assert that using a topic guide ensures that relevant issues are covered in a systematic way, whilst allowing flexibility to pursue important details to each individual. They also emphasise that this does not mean asking all the questions in the same way to all participants, nor asking the same questions to each individual being interviewed.

I carried out a focus group with six staff (healthcare assistant, family therapist, psychologist, occupational therapist, psychotherapist, mental health nurse) from an inpatient CAMHS unit to develop the topic guide to ensure I was going to capture what was important to staff to tap into for the research. I used a thematic approach to draw out salient themes arising from the focus group, and incorporated the well-being theories discussed in the literature review. For example, the focus group participants felt presenting a specific definition of well-being would not be helpful during the interviews:

> Suzanne: "Mmm, avoid giving an academic definition, make it more about them."
>
> Phil: **"**Yeah, because I guess you're interested in their experience of it, rather than their knowledge of it."
>
> Suzanne: "Maybe also how they see it modelled by others because I think it's really important for psychologists to model self-compassion and self-care, not just for psychologists, but as supervisors to model it, so it's permitted."

There was also a theme around looking after oneself; how you look after yourself in the context of caring for others:

> Suzanne: "I wonder whether when we ask about how people care for themselves, how much of that will then be actually caring for others, but in a different context."

> Alice: “I think a related question could be, I don't know whether this leads too far. ‘What tops you back up? What gives you energy back?’…… What tops up our, our resources? That can be self-care, like making sure I get enough sleep or doing kind of decompression with a colleague after a really bad day. All those are forms of self-care. I don't know whether that's too leading, that's what I'm thinking just now.”

Another theme was around exploring staff members’ sense of responsibility.

> Ahmed: “…….I think there's probably loads- I think there's something about, erm, working with young people. Of course, that affects people very much emotionally, people invest a lot of themselves into that work. Particularly, I would say more because they're younger. Because there's a hope that we can actually make a real lasting change for them. People do go the extra mile in CAMHS, I think, compared with in other services.”

> Carol**:** “I was thinking about what you said, Ahmed, about responsibility. That we feel more responsible for creating change-- That isn't quite how you framed it. I think responsibility is a huge key to burnout or whatever you want to call it. There is a sense, ‘Well, if we can't create change here, will that lead to years in adult mental health services?’……...I think the dilemma that leads to, is if you don't create that change, where does that leave your sense of responsibility and failure? I think that leads to, erm, burnout and things like that.”

Furthermore, focus group participants felt that asking questions around the impact on relationships that working in inpatient CAMHS should be included:

> Leila: “….. I'd be curious as well, particularly for the people who are parents and the influence of working here on the parent-child relationship. Because, interesting, I heard some of the [staff] last week, talking about what it was like, when they had their children. Listening to everything everybody says in ward reviews and how anxious that made them feel about what they were doing with their own kids. I guess, yeah, I’d be interested to see how it affects parenting.”

Phil: **“**Where people are getting that support outside in their personal relationships which isn’t ideal, and can create problems.”

There were also discussions around how questions might be perceived in the interview, with some honing of potential wording to ensure they allow participants to answer freely and honestly as possible.

Alice: Actually, that's interesting because the things that you've asked about are more positive in terms of- it's almost like you're asking, "Are you looking after yourself okay?" You're asking, "Are you eating well or getting enough sleep?" You're not asking, "How is your sleep?"

Suzanne: "Are you getting exercises?"

Alice: “’Do you feel you get enough sleep?’ ‘Are you eating well?’ Maybe you should rephrase that so that you’re not-“ [crosstalk]

Suzanne: "Is your eating pattern affected by your-"

Alice: “By your work, or-?”

Phil: “How does it affect your lifestyle?”

Alice: “Yeah, maybe, ‘How does work impact upon your lifestyle?’"

Four broad areas to be covered were subsequently developed with some prompts to illicit further information in each topic. To minimise the influence of the researcher (Kvale, 1996), I also used open-ended, neutral prompts (E.g. “Can you tell me more about that?”)

during the interviews. See Appendix F for full topic guide, below are the main areas and example prompts that emerged from the development process.

Area 1. Experience of CAMHS

- E.g. “Can you tell me what it is like to work in a CAMHS unit?”

Prompts

- Positives and difficulties of CAMHS working
- Comparison to other settings
- Impacts on relationships
- Organisational change

Area 2. Well-being

- E.g. “How are you at the moment, in terms of your well-being?”

Prompts

- Things to unwind/switch off
- What impacts well-being
- Effect on lifestyle - diet/sleep pattern/alcohol
- Working relationships/relatedness

Area 3. Views on support

- E.g. “Do you feel supported?”

Prompts

- Feeling valued and/or appreciated
- Support availability

- Access/attending support in and/or out of work

Area 4. Intervention

- E.g. “What do you think would be helpful to staff in managing stress and improving well-being?”

Prompts

- Unit/Organisation/Individuals
- Work environment
- Any other support

2.8 Data Analysis

To meet the study objectives, a thematic analysis was conducted on the interview data as it allows for both social and psychological interpretations and can highlight similarities and differences across a data set whilst summarising key features (Braun & Clarke, 2006). The analysis process used a theoretically informed but inductive approach, as outlined by Elo and Kyngäs (2007). This was chosen as CAMHS inpatient staff well-being is a developing area of interest for research, although the study is underpinned by well-being theories. Inductive approaches are more data driven and use open-coding as part of the initial analysis as described below. Deductive approaches are often used in studies where the researcher wishes to retest existing data in a new context. In deductive content analysis, a categorisation matrix is used to code the data according to the categories (Elo and Kyngäs (2007).

The transcripts were analysed using the six phase guidelines set out in Braun and Clarke (2006). The analysis firstly uses a technique of repeatedly reading the transcripts to become familiarised with the data, actively engaging with the transcripts and noting any

initial patterns. The second phase involves creating initial codes through open coding, a code can be any feature (semantic or latent) that is interesting to the analyst. Next, the codes were examined, grouped together and theme categories created. A 'theme' in this context denotes something important about the data relative to the research question, and demonstrates some level of patterned response or meaning within the data set. Furthermore, the significance of a theme is not dependent on quantifiable measures, but whether it captures something key in relation to the research question (Braun & Clarke, 2006). The themes generated were reviewed and refined, then given definitions and named. The final phase of TA is writing up the analysis.

As TA can be used within a variety of theoretical and epistemological frameworks, it is important to discuss how my stance has underpinned the approach. With data analysis in this context, a realist approach would take interview data at face value and the analysis would specifically seek to identify patterns in the behaviours and reactions as described in participants' account. As previously described, I adopted a critical realist position for this research. Therefore, interpretation of the data would not assume there is a clear-cut relationship between the account and what 'actually happened' (Willig, 2013). From this stance, the researcher makes inferences about the underlying mechanisms which have produced the account given by the participant. It is hoped that the data will express something about the social and/or psychological processes that take place in particular circumstances. These processes then allow the researcher to make sense of the data by providing an explanatory account of what has been described by participants (Willig, 2013).

The findings of this thematic analysis were then taken to a further focus group. The focus group consisted of five multidisciplinary staff from CAMHS inpatient services. Participants were not part of the original individual interviews for data collection. The aim of

this focus group was to discuss the themes identified from the individual interviews and develop them further, specifically to put the focus on child and adolescent staff perspectives.

2.8.1 Data Preparation

An orthographic transcription style was used when I was transferring the audio data to written data. This was chosen due to the focus of the study being the content of what was said about participants experiences, and not for example on the interaction itself or non-verbal communication. This style was employed to ensure consistency and a high quality of transcription of audio data to written language (Braun & Clarke, 2014). Although, Emerson, Fretz and Shaw (1995) propose that it is impossible to produce verbatim transcripts.

In keeping with this style, during transcription I omitted non-linguistic information, such as body language and facial expressions, as well as tone of voice. I did include pauses, and all verbal communication such as sighs, coughs, laughter and any utterances. This was to ensure the context of a particular segment of speech was being conveyed. Any new utterances were recorded in a new line.

All interviews were transcribed in the order that they were carried out, after each interview. They were manually transcribed, using Microsoft Word Software with aid of a transcription pedal. I checked the accuracy of the transcriptions against the audio recording and checked each transcript twice.

2.9 Ethical Considerations

I ensured that I complied with the professional guidance for conducting ethical human research published by the British Psychology Society (2014). To maintain a high standard of ethical conduct, I took the following actions.

2.9.1 Ethical approval

Ethical approval was gained from the Research and Development (R&D) service within the participating NHS Trust on 16th April 2018 (Appendix A), this was obtained through the Integrated Research Application System (IRAS). The research project was also granted approval by the University of Essex on 3rd May 2018 (Appendix B). An amendment to the ethical approval was also submitted through IRAS at a later date, approval for this amendment was granted on 27th January 2020 (Appendix J).

2.9.2 Informed consent

I ensured that potential participants were given the opportunity to discuss participation and ask any questions prior to consenting into the study. After participants had read the information sheet (Appendix D) and had any questions addressed, I asked them to outline the research aims and potential harm and benefits of them participating. I asked them to clarify their understanding of the levels of anonymity they would be given, and their reason for participating.

2.9.3 Anonymity

Following the interview, the digital recordings were stored on a password protected computer in encrypted electronic files. Each recording was transcribed after each interview and identified by a numerical code. All names and contextual identifiers were either anonymised, removed, or modified, within the quotations presented in the thesis. Minimal demographic data was reported.

It was explained to participants that although transcripts and data would be anonymised for the research, due to the nature of their responses and the use of verbatim

quotes during the write up, they may be recognisable from their responses. For the write-up of the thesis project, pseudonyms were used to describe participants and their interview data.

2.9.4 Confidentiality

Potential participants were informed of the limits of confidentiality. It was explicitly explained to participants that if any safeguarding concerns were raised during the interviews, I would discuss these with the onsite research supervisor who would then follow up with the necessary channels including the staff involved and Trust safeguarding lead if required. It was anticipated that concerns of this nature might include information indicating: they or others were at risk of imminent harm, the security of the participating unit was threatened, or a crime had been committed (The British Psychological Society, 2014).

Furthermore, if there were any concerns about participants' capabilities or well-being that may impact upon the quality of care they provide to the young people; I would discuss this with the participant including possible referrals to occupational health and informing their line manager, in accordance with relevant NHS trust policies. Participants were asked to acknowledge my duty to share such information as part of the consent process. I emphasised to participants that I would discuss with them any need to break confidentiality prior to me doing so.

2.9.5 Right to withdraw

As part of the informed consent process, participants were informed of their right to withdraw from the research at any time during the process (The British Psychological Society, 2014). Participants were informed that any data that had been collected up to this point would still be used for the write-up of the thesis.

2.9.6 Data storage

Interview data was digitally audio-recorded, transcribed and stored on a password protected computer system at the University of Essex. Following the transcription, which took place in a private room I had booked at the University, all the digital recordings were destroyed. Only I had access to the identifiable participant data, and data was not transferred outside of the United Kingdom. The data will not be used in future research projects. Participant data that was in paper form was stored in a locked cabinet at the University of Essex, with the key available to only myself, the doctoral administer and my supervisor. Participants were informed of the data storage procedures and consented to their data being managed in accordance with the General Data Protection Regulations (GDPR, EU/679, 2016).

2.9.7 Risk

It was acknowledged that participants could become distressed during interviews due to the nature of the content being discussed. Therefore, appropriate channels of support for participants were identified, if these were needed, such as providing a debrief or advising of further avenues of support, such as clinical psychologists in the teams, occupational health departments, and the Samaritans.

I was also mindful that as the researcher, I may have been exposed to details of a graphic and/or distressing nature during the interviews. A plan was made that I would seek support via the supervision process if I experienced any symptoms or had concerns with vicarious trauma. Furthermore, although I was alone when I was carrying out the interviews, they took place in a clinical setting with other staff available in the building.

2.9.8 Prize draw

Participants were offered a free entry into a prize draw to win one of three high street vouchers of £20 value each. This was deemed an appropriate and proportionate amount to encourage participation, but not to coerce. Within the Code of Human Research Ethics (British Psychology Society, 2014) it is deemed vital that participation in a research study is not coerced as this infringes the human right to autonomy, for example, through offering disproportionate rewards or indicating disincentives for not participating. Participants who opted to be entered for the prize draw provided their email address at the end of the interview which was kept separately to the interview data on a password protected computer using an encrypted file. There was no way of linking the email addresses to any of the participant's interview responses. Once all of the data was collected, the three winning participants were emailed to inform them of their prize winnings. It has been suggested that financial remuneration can serve as a token of appreciation for the contributions and time given by research participants, it can also aid the timely recruitment and subsequent participation of numbers and types of participants (Permuth-Wey & Borenstein, 2009).

2.10 Quality assurance

I outline below the essential qualities proposed for evaluating qualitative research by Yardley (2000) and the application of those criteria to the current project.

Sensitivity to Context

Yardley (2000) suggests that searching for contradictory data to the generated themes and by grounding themes firmly within the theoretical framework of the study, sensitivity can be attained. Throughout the analysis, the data was examined for unexpected findings and the differences between them and the other themes were explored. During the data collection

interviews, I used techniques of summarising and clarifying statements to check whether my understanding of what was being described matched the intended meaning of the participant. Henwood and Pidgeon (1992) labelled this as respondent validity (Henwood & Pidgeon, 1992). Yardley (2000) also emphasises the social context of the relationship between the researchers and the participants. She argues that the dialogic context of each utterance is crucial to interpreting its meaning and function and the design of the study should consider the effects of the researchers' actions and characteristics. I used a reflective diary to note any effects that I had noticed, and outlined my own characteristics in the reflexive statement at the start of this chapter.

Commitment and Rigour

The appraisal of commitment to the research and rigour in both the collection and analysis of data are imperative in assessing qualitative research (Yardley, 2000). I demonstrated my commitment though attempting to immerse myself within the data, by transcribing all interview recordings myself, listening to the recordings and reading the transcripts multiple times. I also spent as much time as possible as a researcher engaging in the field.

Lincoln and Guba (1985) argue that 'member checks' are a vital technique to help minimise data misinterpretation. This process is where data, themes and findings are checked for accuracy and perceptions by participants or individuals from the research population. However, this is based on the realist assumption that there is one 'truth'; one fixed reality. Given that I have taken a critical realist epistemological position for this project which takes the stance that we all experience different aspects of reality, the decision was made not to

include formal member checks. I also acknowledge that participants may change their perspective on a narrative about their experiences which they shared during interview.

It has been argued that all interpretations contain an implicit claim of authority (Denzin & Lincoln, 2008); they suggest that it does not make sense to engage in a process of analysis and then deny that it has any validity.

Transparency and Coherence

Within qualitative research, it is important that there is Transparency throughout to ensure decisions made are clear and that the research is consequently accessible and auditable (Baxter & Eyles, 1997). The current study uses TA which grounds conclusions with the data. It also follows a systematic, and therefore transparent, process (Braun & Clarke, 2006). To ensure I was being transparent in decision making, I evidenced all of my analytic decisions taken in a research journal and in annotations throughout the research process. Appendix G contains an example of a coded transcript.

The topics that were covered during interviews were developed from the existing literature on well-being in healthcare workers, and from CAMHS staff themselves. This was to ensure my own agenda was not dominating the data collection, but also that I was covering the topics important to the research population.

I also have been explicit about my background as a clinician working in CAMHS inpatient settings, the inevitable assumptions I have developed about the experiences of staff working in those environments and the measures I have taken to reduce the influence of these on the research.

Impact and Importance

Yardley (2000) asserts that assessing the usefulness of research is essential to determining the quality of it. This study hopes to better inform support provision to manage well-being in CAMHS inpatient staff; through consideration of participants' responses, and refining/introducing support mechanisms to improve emotional well-being and reduce burnout. It will also contribute to the developing body of research into the well-being of healthcare staff, specifically those working within CAMHS settings.

Chapter 3: Findings

3.1 Chapter Overview

Within this chapter, I present the themes and subthemes developed from participants' data. The data included is taken from both the 11 individual interviews and follow-up focus group. The themes and subthemes are supplemented with verbatim interview extracts to explain my interpretations, convey participants' experiences, and allow the reader to draw their own interpretations of the data. To protect participants' anonymity, specific contextual information and identifiable demographics are not included.

The findings are derived from the research questions, "What are the experiences of staff working within inpatient CAMHS?" and, "How does working within a CAMHS inpatient setting affect staff well-being?".

3.2 Study Sample

Although information about participants' job roles was initially gathered, I made the decision to include generic roles rather than the job titles within the write up as some participants had specific roles that could increase the likelihood of them becoming identifiable. In keeping with the inclusion criteria, all participants were frontline clinical staff having worked in at least one other setting prior to working in a CAMHS inpatient unit. Participants' ages ranged from 27-44 years with a mean age of 36.73 years. A total of 11 participants were interviewed for the study, there were 6 males and 5 females. The length of time staff had worked in the CAMHS inpatient setting ranged from 1.2 – 9 years, with an average of 4.94 years. The duration of interviews ranged from (minutes:seconds) 28:03 to 61:14, with an average of 39:51. Table 2 presents the order in which research interviews were completed, along with participant's assigned pseudonym and demographic information.

Table 2.

Interview order and participant demographics (N=11)

Interview order	Participant (Pseudonym)	Age	Job Role	Length of time in inpatient CAMHS
1	David	44	Qualified	9 years
2	Neil	33	Unqualified	5.6 years
3	Jenny	27	Unqualified	5 years
4	Simon	52	Qualified	6.3 years
5	Harriet	39	Qualified	8 years
6	Glenn	42	Qualified	2.5 years
7	Sharon	41	Qualified	4 years
8	Jasmine	27	Qualified	4 years
9	Katie	29	Qualified	1.7 years
10	Raymond	40	Qualified	7 years
11	Dominic	30	Unqualified	1.2 years

Participant pseudonyms for the follow-up focus group were: Gemma, Andy, Rebecca, Ian and Hayley. Four participants were qualified and one was unqualified. The follow-up focus group lasted 64 minutes.

3.3 Analysis

Themes were developed using thematic analysis (Braun & Clark, 2006). A total of 10 themes and 16 subthemes were constructed from the data. Table 3 provides an overview of constructed themes and subthemes.

Table 3

Themes and subthemes constructed from participants' data (n=11)

Theme	Subtheme(s)
Absorption	Absorbing Trauma In a bubble Saturation
A double-edged sword	
Dynamic	On edge Relentless
Self-awareness	On an even keel Mechanisms
A balancing act	Prioritising Managing expectations
Collaboration	Containment The importance of networks
Agents of change?	Responsibility for their lives
Held in mind	Environment Needing to feel seen
Barriers	
Tolerating uncertainty	The future Power

3.3.1 Theme One: Absorption

Most participants' accounts described experiences that fit with conceptualisations of absorption. That could be staff absorbing trauma or distressing incidents, becoming absorbed by the ward as though it is all consuming, or becoming saturated; and the possible effects of that.

Absorbing trauma. Working on a CAMHS ward comes with witnessing potentially distressing events, and hearing or reading about trauma histories in young people.

Participants conveyed themselves to be almost sponge-like in this process. David explicitly talks about this:

> "Erm, and actually [pause] one thing I've learnt is that w- we are working with trauma all day, you absorb trauma, without noticing it."

In the context of staff being exposed to trauma on a daily basis, in her interview Sharon wondered about the opportunities staff get to discuss this:

> "Certainly, I don't think we probably do that enough. Certainly with, as like a bigger group of staff, been thinking about support workers, and some of the people that suck that up every single day, and every time that they're on shift."

In a bubble. Some participants described having a sense of being absorbed by the ward, and not being able to get their mind off it. David described:

> "Yeah, all my focus was here and when I wasn't here I was thinking about here."

In the focus group, Ian explained that he has shared a similar experience, which ultimately impacted his health. He only realised when it was pointed out to him:

> "I mean, for me, actually, for my own my health. I was staying until one or two in the morning every day and coming back at 7 [am]. It's not very good for you. And I had- I had friends, I had colleagues and other people telling me 'look you've really got to slow down'.

The majority of participants also spoke about the ward as if they are on the 'inside' and others are on the 'outside'. Glenn explains in his interview how it may feel for someone on the outside to witness what the staff inside the ward do:

> "It's where if somebody come out from the outside, they would- they would probably faint and pass out and cry, you know, it would just be horrendous, but you're just- it- it's just the normal."

Harriet also depicts this notion, drawing upon an analogy of being inside a bubble working on the CAMHS wards:

> "Yeah, it's like a bubble we are in, that this stuff is all kind of like normal but to bring your average sort of 15, 16-year-old here they would just be, 'What? They did *what* with leggings around their necks?'"

Saturation. If staff are continually absorbing trauma and distress, they too, like a sponge, will eventually become saturated. Neil describes this process:

> "You can become kind of- absorb later on and then it can, kind of, emerge sort of unbeknown to us sometimes and take us off-guard which can affect our ability to then take on those situations and support people properly."

Glenn also wonders about what might happen in the future if the distress continues to be taken in by staff without addressing it.

> Glenn: "Well, I suppose if you don't- if you don't talk about it, it all gets locked away, doesn't it? It'll come out at some point … So where do all them images go and lock away? I suppose it's- I don't know. In the future, I don't know. It could all, you know-"
>
> LH: "Do you feel like that's what happens? People just sort of lock it away?"
>
> Glenn: "Yeah, definitely, definitely because, like I say, you know, you don't think of your mental health."

Perhaps an indicator of, or a means to protect one's self from the saturation is a process of desensitisation. Through the impact of witnessing distress and trauma in various forms, staff can become desensitised. Harriet draws comparison between her personal and professional lives which highlights this process.

> "If I read a book out of work, that details some kind of trauma, like sexual abuse and all that, I can't get that out of my mind, so I won't- I won't watch anything like that. Or

> even things like children in need night, things like that, it upsets me too much, but it's almost like I can read it here and not take it home with me, but I don't know how I've done that. But yeah, so erm, in terms of things around kids necks, and the self-harm that we see, erm, it sounds awful, but nothing really shocks me anymore."

Jasmine also reflects upon this desensitisation within the staff team.

> "I think the staff don't even realise when something is traumatic anymore."

Gemma also described this process as a sort of detachment.

> "… I know that I personally detach a little bit. Because otherwise it would be a bit much. So I have this sli- slight little barrier of detachment, that I don't keep feeling that responsibility, but I know some other people that take it all a lot, and they get weighed down by it."

3.3.2 Theme Two: A double-edged sword.

Almost all the participants described their experiences of working within CAMHS inpatient settings in terms of a dichotomy of feelings. On one hand, the work and environment can be very stressful and people often feel criticised, while on the other hand, it can be rewarding and instil hope.

Simon compares CAMHS inpatient settings to his previous roles while reflecting on his experience.

> "Erm, it's a tough job. Probably the toughest job I ever had, I think, in sort of health and social care. Erm, you wouldn't think [that number of] youngsters would generate so much work- or whatever you want to say, input. Erm, it's tough."

Harriet describes how young people's presentations can influence staff stress.

> "I think it's, you know, it's quite stressful and you-you a lot of the behaviours displayed by the kids is quite manipulative. So you have to kinda get your head around that."

David notes the process that participants described of feeling criticised on various levels:

> "You could work as hard as you possibly can, erm, do your absolute very best, and not be able to give any more but still be criticised. That's probably, the most difficult part of the job."

He goes on to explain where he feels this criticism can come from.

> "Erm, you could be criticised by the young person, 'you're not helping me', their families, because the families actually, are more often than not the young people are here because of family problems, families often project all of their failings on to us. So, they weren't able to keep their child safe, erm, or they'd failed their child in some way so then they push it on to us *you've* failed their child, *you've* not kept their child safe……..And you could also get criticised by your own managers and by the Trust as well."

Jenny describes experiences of criticism in the context of making mistakes, rather than being supported to learn from them.

> "I don't feel that there's any, kind of, I mean, I know sometimes people do mess up, it's- you know, that's human nature. Erm, but there's no kind of constructive criticism. It's, 'Well, you've done this'."

In keeping with the dichotomy, participants described the positive side of working in CAMHS units. Simon explains how rewarding it can feel to have an impact on someone's life.

> "Really rewarding. I think you get to change some people's lives. Not as many as you think, but you do get to change some people's lives. The unit, erm, big time."

Glenn talked about the positive relational aspects of working on the ward.

> "Once we get them, kind of, erm, medically fit I suppose, erm, and then sort of chip away at the- 'cause they'll all have barriers, and once you chip away at those barriers and you start to gain a trust and gain a rapport with them, that's rewarding as well."

The majority of participants also conveyed a sense of hope when they compared working in CAMHS to other settings such as adult and older adult services. Jasmine captures this idea in her interview.

> "I feel if you work with young people they're just at the beginning, so hopefully you can make a bigger change for them that they're not- not in that revolving door, that they don't come back into service- so they don't come back and need inpatient services but can live, you know, healthier fuller lives in the community."

Katie also describes this notion within CAMHS, describing the timing as an opportunity.

> **"**Erm, and kind of address that before it-it gets worse so- it feels like there's erm- not pressure as such, but like you want to do a good job *now* to kind of prevent them from kind of ending up stuck in services. Erm, for a long, long time. So, it's more of an opportunity I think as well."

In the focus group, Andy expanded on this idea of hope, and possible explanations from where this comes from, particularly compared with other settings.

> "…...obviously in the careplans you have a put a goal down. But when you're working with older adults, what is their goal? Do you know what I mean? And you- with kids there is- you're working *towards* something, if that makes sense. That's one of the reasons why, you know, the two places are completely different."

3.3.3 Theme Three: Dynamic

The CAMHS environment is dynamic in nature. This seems to be on multiple levels. The environment, relationships, pace and ways of working are all rapidly changing. Participants

explained that the ward environment is continually changing which can make it feel unpredictable at times. Neil describes this:

> "Erm, well, from the offset, every day is very different. Erm, the dynamics of the ward change, erm, daily, but also within minutes."

He goes on to explain, as other participants also felt, that there is something about the pace of CAMHS work that feels faster than other settings:

> "You have to run as soon as you, sort of, land and go with it. Erm and, sort of, be very fluid in how your approach can be"

Relentless. There is also the sense in CAMHS inpatient settings that everything is constant and never-ending. Participant descriptions indicate that formal breaks do not often happen, most participants described not taking a lunch break, sometimes due to believing the length of the shift does not warrant a break (7.5 hours) even if they are doing back-to-back shifts, and sometimes due to high activity on the ward or prioritising patient care. Neil talked about how he gains some respite within the shift.

> **"**Erm, we sort of- sort of take our breaks, well they're not really breaks, but you get sort of respite on the ward, when you're doing paperwork or-, but you've got to utilize that time as well, so it could be a break in terms of erm, intense patient interaction, which might be quite draining at times, erm, but other times, erm, if you're playing board games or drawing or watching a film with patients, in those terms, that's a bit of a break, it's a bit of respite. Erm, so it's not specifically a break but it's a break from erm, one kind of interaction."

This constant nature means that when you leave the ward, it can be hard to give yourself a break from thinking about it. Raymond has also found work entering his subconscious recently.

> "Erm, so- and I mean it doesn't really affect family life too much, but I've-I've-, erm, I found the last two weeks or so, I've been constantly dreaming about work."

Simon also describes the persistent workload demands.

> "I mean there's- you're *never* on top of the work here. You never- so there's always a-always-always demands put on you."

In the focus group, participants conveyed an intensity within this constant environment. Gemma felt this element makes CAMHS wards particularly different to work in:

> "I think the level of intensity in CAMHS inpatient…….constantly being on the ball, but in adult, older adult and you just used to sit there, and you would not have to be like "oh, is the alarm going to go?" "oh, is that person in their bedroom?" "Oh, is this happening?" "is that person on leave?". You're thinking about so many things at one time and then risk assessments on top. I feel like it's so intense from seven [am] to half seven at night. That's why everyone is so eager to leave on time, because it is so intense, you need to get away. Erm, I think that's the biggest difference between this and adult and older adult."

On edge. Part of being dynamic as staff members means you have to always be alert and ready while you are on shift. Raymond described:

> "Where you're kind of sitting on the edge of your chair a bit. And I think you don't quite lose that sense during the day- much."

Jenny also captured this sense of being constantly poised.

> "Having to watch your back all the time, it's like being on edge all the time knowing that anything can happen. And it just makes you- it makes you feel really tense."

Ian elaborated on what this can feel like on a daily basis:

> "……you're on a roller coaster. They could be working really well with you for an hour. The next minute they're hitting you. Half an hour they're back your friend again,

> an hour later they're spitting on you. …… the environment we're in all day, every room you walk into you could see someone very seriously harmed or dead. You don't know when you're 'gonna walk in to….if you're walking around every time you walk into a bedroom, or knock on it and you don't hear an answer, you open the door, you don't know what you're going to see."

3.3.4 Theme Four: Self Awareness

The interview process itself, for some, created an opportunity for introspection. For some participants, they were already aware of their own feelings and relationship to working on the ward.

Mechanisms. As part of being self-aware, ten participants described consciously using strategies to help them manage their feelings and to feel more able to leave work at work. Glenn uses quite passive activities to enable this.

> "Music. Computer games, I suppose. Erm, watch the telly. Bit boring, really. [laughs]"

Katie describes more active mechanisms to help her in this process.

> "Yeah, I think erm, exercise is really helpful. Erm, I- I kind of go for like walks and stuff like straight after work as well so that kind of helps to sort of separate from it. And obviously just getting out, seeing like family, friends, erm, you know different events having things to look forward to erm, and having things that you're occupied in which make you switch off from work……erm, yeah just- just having things that are completely separate from work."

On an even keel. All of the participants described feeling okay in terms of their well-being currently, although all described having a constant level of stress which was attributed to the nature of the job. Interestingly, Jasmine seemed almost surprised when I asked her about her own well-being.

"*My* well-being? I don't know. I think okay."

Katie describes the feeling of being on an even keel at the minute, while acknowledging this can be changeable, much like the course of a sailing boat.

> "Yeah, I feel fine, yeah I think. I'm enjoying the job, you know obviously it has its own pressures in terms of like caseload and doing things, but in general I'm really enjoying it and erm, I don't feel that it's erm, that tough emotionally at the moment, so- but obviously it- you know it-it always fluctuates, doesn't it?"

Interestingly, participants also expressed that the well-being of staff needs targeting. This does not have to be in a prescribed form, but time and space to think reflectively would be beneficial in helping staff to process their experience and continue on.

> Simon: "I think you could always do with a bit more time just to just to pack it off and, you know, when somebody moves on, gets discharged or something, and you sort of look at the wodge of stuff you've done with them, you think, "Gah, blimey, that was heavy." and there's nowhere, you know, then next one's there."

> Glenn: "You don't actually think of your own mental health. We're looking after mental health, but you don't actually think about your own mental health … And then when I sat down and thought about it, I thought- yeah, we don't."

In order to maintain this even keel in terms of their well-being and feel valued, participants explained it can help to have self-directed goals inside and outside of work, and to feel supported in progressing towards those. Sharon described explained this in her interview.

> "So I go to two [yoga] classes now. So, I go twice a week. I've just done that this month. So, yeah, I've got to sustain that- because, erm, doing something for my self is always the first thing to go if I'm busy doing stuff with children. So, I'm trying to kind of embed that. In terms of work goals, I just finished my [additional] training last

> October. So that had been my goal as well. I've literally just done that, and now I'm busy practicing trying to grasp that. So, my kind of work goal at the minute is to become more confident with that process, and to use it as much as I can."

Katie also highlights the importance of feeling supported and having the opportunity to develop a service while developing yourself to increase your sense of motivation.

> "I'm working towards, erm, some [additional training]. Which I'm really enjoying, and they've been really supportive with supporting me in achieving that training and- erm, you know, obviously, using that to develop the service a bit here, which is quite motivating."

3.3.5 Theme Five: A balancing act

Participants described working on a CAMHS ward means staff must be flexible, and are continually having to juggle various tasks, different roles, and adapt their communication styles. David sums up this balancing act, and that it can feel more like the scales tip one or the other.

> "Erm, so something always gives. You spend loads of time with the patients your paperwork goes on the back burner, then try to catch up with paperwork, you're not seeing the patients."

Prioritising. Working on the CAMHS ward means having to prioritise. This could be tasks, interactions and both personal and professional lives. Dominic talks about how it can be a struggle to prioritise even things you enjoy outside of work:

> "Which can get in the way sometimes because it's- it's something I enjoy and it's something that really helps. But, at the same time, a lot of that- a lot of the stuff in work takes priority at the moment over that. Sometimes, I don't think it should, but I

end up prioritising work anyway over doing cycling and everything that I enjoy, just because of the pressure that I feel sometimes."

Neil explains the need to very deliberately make a choice to prioritise, although this can still be swayed by feeling you are particularly needed at work, despite being off-duty.

"I make sure that I meet up with friends and go for meals out and erm, get them sort of booked in and if shifts do come up erm, and I know I've got a social commitment more than not, the social commitment has to come first, unless-unless they're really desperate, you have to weigh up those odds because you can't keep cancelling your own time for work"

Ian reiterated some of these ideas during the focus group, and the impact it has on staff:

"…… So I think that's one of the things that annoys staff the most actually. You've worked really, really hard all day and given 100%, kept a load of kids safe, and then you've got someone moaning at you because you haven't sent them, I don't know, some stats or something. Or a care plan has not been updated. Or a risk assessment has not being updated. It is all important stuff that needs to be done. But we can- you can get to that, you've got to take care of the kids first."

Managing expectations. Part of the balancing act is managing your own and other people's expectations. Simon illustrates this.

"I think in the community you manage your own bit, but here everybody's trying to manage the same people,-every patient is everyone's patient. Whereas in the community they're largely yours."

He elaborates on this, including the process itself.

"Are they doing what they are supposed to be doing? Are they doing *more* than they are supposed to be doing? Are they contradicting what we were saying? Are they-- So yeah, I think there's a lot more, yeah, a lot more, you know potential for, yeah miscommunications, all those sorts of things, irritations, and benefit as well."

During the focus group, participants felt trying to manage expectations within the context of feeling scrutinised was a key feature of working in inpatient CAMHS. Ian explains this:

> "……there's a lot of expectations, actually, when you're looking after children. Erm, so many people are looking in on you. To make sure that you're doing it properly. There's so much pressure. And I know all wards are inspected by the CQC, for example, but they seem to have a particular interest in looking after young people, erm there's lots of safeguarding stuff around young people as well. Erm, and you seem to be scrutinized a bit more as well."

Rebecca shares this view, comparing inpatient to community settings:

> "…… Because it almost feels a bit more, I suppose, exposed for the work that you're doing. So, people externally might call in to meetings and then you could- can almost sort of start feeling criticized about either decisions you've had to make or things, because I guess people are looking at it from a different perspective. Whereas that wouldn't really happen in other, you know, community settings"

3.3.6 Theme Six: Collaboration

There seems to be an innately collaborative approach to working in CAMHS inpatient services, as described by participants. This comes with its own pros and cons. Working in CAMHS inpatient settings feels more like a team process compared to other settings, particularly community services. Sharon talks about how the high-level risk is shared between the team, meaning staff members do not hold risk on their own, which reduces the sense of responsibility felt by staff when they go home.

> "Erm, although we carry a high level of risk, we work for some really risky individuals, erm, it feels like we *really* manage that as a broad team."

There is also something about the staff mix itself on the ward. In terms of team dynamics, strengths and weaknesses, the ratio of agency to regular staff. This all seems to impact upon

the rates of incidents, and how the staff qualitatively experience that shift. Glenn has noticed this:

> "I would say if you've got substantive team on with you that know the ward, I would say that there's probably less incidents."

Dominic illustrates how the mix is not always easy to balance, even in the context of a unified team:

> "I think in CAMHS units it can be quite a close-knit team and if things are off slightly and it doesn't get addressed, it can really fester sometimes and make a big difference to the work environment."

Containment. Another part of the collaborative process is staff supporting each other. This support provides a sense of containment. Participants described a clear picture of what this feels like when it is happening, to when it is not. Staff described the positive impact of feeling supported, and the subsequent support they feel able to offer colleagues and in-turn the patients. Sharon highlights this, particularly in the context of having the foundations of these relationships built so they can be relied upon in times of greater need.

> "Erm, on a more, kind of, informal level, I think the, erm, staff group here really warm and nurturing towards each other, so, erm, in more difficult times I feel like I can turn to my colleagues, erm, and feel supported by them."

David also describes a similar experience of the informal support staff offer one another.

> "I- I think we're very good at looking after each other. Erm, not in an official capacity. But, yeah just on the ward day-to-day. Checking that each of us are okay, and seeing each other outside of work, and all of that, messaging each other and all that sort of thing."

Participants explained that various channels of support open for staff in response to serious incidents, but not so much on a day-to-day level. Some staff felt that support in times of

greater need is satisfactory, while others felt that more regular support in the form of debriefing would be helpful.

> Katie: “I'm quite happy with the level of support that is offered, I think people provide you with options and you're not pressured to take any particular option like there was- there was options for counselling, there was a team debrief, erm, we were supported erm, sort of signposted to more neutral organisations, erm and obviously support was offered as part of the team and everyone was checking in on each other….. and there's plenty of information everywhere about kind of healthy lifestyle and things like that.”

> Jenny: “Erm, I think that, actually, what we need is some proper debriefing. [pause] I think the only debriefing we get is when there's a serious incident. Or a near-miss. We don't get a debrief after, you know- Even if you've done like a full restraint. Technically, you're supposed to have some kind of debrief afterwards, just to make sure that everybody's okay, and we don't get that. And I actually find that quite wrong in some senses.”

The importance of networks. Working in CAMHS settings means working with a whole system around the identified patient. Participants described this comparison between adult and CAMHS wards particularly moving away from a more individual approach whilst working with adults, towards a more systemic approach when working with young people. David describes this multi-faceted way of working.

> “You’re dealing not only with the young person but you’re dealing with their families as well, *and* lots of other agencies like social care, erm, could be youth offending, drug and alcohol services. Erm, and then working within a large MDT here.”

Dominic also talks about how he realised that systems are not necessarily seen as important in adult services.

> “All of these systems are set around them and I think that is a big difference to how these young people come in and how the ward is run. Because a lot of these systems

are taken into account, whereas in the adult ward, I found a lot of those were just kind of brushed aside."

In the focus group, participants felt that the systems around the 'identified patient' are a distinctive feature of CAMHS inpatient settings. Gemma compared her experiences working in CAMHS and adult environments:

> "I think it's- because you speak to the social workers, you speak to the parents, you speak to so many people about this young person. Whereas in adult services, you just speak to that person about their care….When you look after a young person you feel like part of a network that's looking after them because when you look after an adult, more often than not it's just- your nursing team is looking after them."

3.3.7 Theme Seven: Agents of Change?

When comparing CAMHS inpatient settings to other places they have worked, participants felt that staff had more responsibility in terms of being the mechanism that creates some change. Sharon describes this, and how it is not always a helpful position to hold:

> "When you talk to adult colleagues, they talk very differently about responsibility, 'Well, I'm here to facilitate their change and they're responsible for their change, but I think we can get too invested in, "We're creating the change'."

Gemma talked about how this sense of responsibility can lead to disappointment if the intervention has not been as successful as hoped and the young person returns to the ward:

> "I think it's also disheartening for us, when they come back. And they come in and they're not- they've not really moved that much further forward. And if we're the ones who are responsible, feel responsible for that. Then we've got to carry that weight of 'let's try and do it again', pick back up and start again. With that same person"

Responsibility for their lives. Participants described not only a sense of general responsibility, but a sense that they are responsible for the young person's life and their future. Hayley describes this:

> "it's so much more- you yourself are so much more involved with the care you give….I feel you have to put a lot more into the young people here than you would, say, in adult ward etc. Purely because they- they don't have the responsibility for their lives the same as what adults do. And so it's almost as if you have to have a little bit more influence on their care and the way that they are, to be able to get them to their goal. Adults, more often than not, it's when they're ready and when they decide, you kind of don't influence them you just are there along the journey whereas in CAMHS I feel you're more sort of in the journey with them.

In addition, the young people staying on the ward are arguably in a vulnerable position, they often come with histories of abuse, or have become vulnerable due to the nature of their difficulties. Participants described this as increasing their sense of responsibility, and the pull towards 'rescuing' as fundamentally they are children that need looking after. Katie describes her sense of the young people and her position in the relationship:

> "I would say there is a difference erm, working in other settings, because you're working with children, you know they're vulnerable. You're in a position of- sort of, even more enhanced responsibility I feel than- than somebody who's an adult and has obviously the capacity to make their own choices and erm- It just feels a bit different"

3.3.8 Theme Eight: Held in mind

CAMHS staff spend the majority of their time at work holding the young people in mind. Participants described a variety of ways that they could feel held in mind, particularly by the Organisation, and how this can ultimately improve staff well-being. Harriet highlights that in

a Mental Health Trust, the mental health of staff is not always considered or actively recognised. Achieving this would make a difference to how staff feel.

> "Well I've noticed certainly when people go off on leave through stress or whatever, we don't know. So erm, and we don't know when they're coming back. We don't know how they are, unless we kind of- well we don't want to be like, 'Oh, are you alright? What's up?' Or that sort of thing. But we are a mental health Trust. So, we kind of think actually it shouldn't be such a taboo subject, but it is. It's like 'Oh, so and so is off, I think they've got stress.' 'Okay. Let's do something. Let's send some flowers or let's do something to acknowledge that actually we're all here for them.' But that doesn't really happen."

Raymond suggests that small gestures from the organisation would demonstrate that they have staff held in mind.

> "Better coffee would be nice."

The majority of participants (David, Raymond, Dominic, Neil, Jenny, Harriet, Glenn, Sharon, Jasmine) reported feeling valued at work, this largely comes from feeling appreciated by the people they see on a day-to-day basis. It is harder to feel valued by the higher management or organisation when they are somewhat removed from the frontline. Although this may not necessarily be needed. Neil offered an explanation of this.

> "you feel like, erm, if you did raise anything, it would be taken seriously, erm, and the appropriate action or, or like, solution, would be taken, there and then if it could or- or down the line. So, you do feel valued, you do feel listened to. More so by the actual team work with, erm, get less sort of feedback from higher management, erm, just because they're not on the shop floor so they don't see the elements of what potentially our good work we might be doing."

Sharon categorically states how valued she feels, and places a higher weight on the views of the people she works with. Perhaps this feels more genuine as they 'know' what she does at work.

> "I feel really appreciated here by the staff and the young people….for me getting feedback from the people that I work with is what's important, because I think actually on a day to day basis they know what I do. So, their appreciation is important to me."

Environment. The development of inpatient settings requires a great deal of consideration and planning. These developments do take account of staff but are predominantly focused upon patient safety. Whilst this is of course paramount, it can leave staff feeling somewhat overlooked. Harriet would like a more accessible refreshment room to facilitate breaks.

> "It would be quite nice to have like a-a coffee room or some kind of break room on the shop floor because if we do get 15-minute breaks it's going to take you a good 5 minutes to get upstairs anyway, and then you've got to allow sort of 5 minutes to come back down again as well. That's the only thing I probably would say, it'd be quite nice to have somewhere where we could relax and take 10 minutes out, but there's not."

Jenny also raises environmental aspects of staff support needs. She compares a previous adult setting to the CAMHS ward to highlight this.

> Jenny: "So it was a bit easier, better like that in a sense and when you walked on to the ward, you walked straight into the office, you didn't go into an open area until you'd walked into the office or at least passed the office. So you would have to divert straight away before you went on to the main ward, before you had patient contact which I think made a difference as well."
>
> LH: "Here you walk straight on to the ward?"

> Jenny**:** "On to the ward yeah. You never know what you're 'gonna come into. I mean, sometimes I'm not here for 4 or 5 days at a time. And you never know what you're opening that door to."

During the focus group, Ian explained that through staff talking about the original interviews for this research, it has highlighted the difficulties the environment itself can cause as well as the wider impact on staff.

"……We have to walk past all these kids and we can- I quite often get bombarded when I've opened the door before can speak to *anybody.* It's like, 'Ian, I want to go out they've stopped my leave' 'Ian, last night wasn't as bad as it sounds don't listen to the nursing team'. They're all round me and I've got to fight to get to the nursing office [laughs] before I find out what's happened…… you don't know what you're going to walk in to, I've opened that door and had something lobbed at my head or there's a fight going on, I've walked on and not known a patient has been saying they want to kill me all day…… Nurses should be able to meet somewhere first before walking in to God knows what."

Sharon also reflected on the design of the building in her interview, and how this can sometimes be a factor in impacting her physical health.

> "I don't think this building is particularly nice. There's not a lot of fresh air in here. And I get headaches sometimes, if I'm in all day."

Needing to feel seen. Participants expressed that taking the time to acknowledge the work staff are doing can help increase staff motivation and well-being. This also in turn can strengthen the connection between frontline staff, line management staff, and higher management. There can at times be a sense of disconnect between these levels. Neil talks

about the difficulties of the disconnect between clinical work and the perceived business-driven approach of higher management.

> "Erm, or starting to, or making some ground-breaking interactions with patients which, will get, sort of, recorded and reported but won't necessarily come up on their audits."

Raymond also talks about this sense of disconnect, and noted that the Ward Manager role can facilitate the process of staff feeling heard by the Organisation whilst also offering something in terms of protection from the more corporate demands or complaints.

> "…if you constantly have a manager who just acts as a mouth piece for Senior Managers in terms of demands and needing things to happen this way or that way. Where there's no sense of them, I guess, caring maybe is the best way to put it. For staff on the frontline, I was in situations, where I think those kinds of things don't work."

> "I think most staff here would probably feel that managers here care mostly. Beyond that level we don't know them very well, so to be honest I wouldn't know if they care or not. [pause] Erm, you know, you don't feel like you are dealing with a corporation every day, in to your manager, I guess, that helps. And I think managers who can, kind of, deal with complaints.... [Matron] and others must have *loads* of complaints and matters to deal with and so on, but we don't need to hear about it all the time, they're not helpful."

Jenny talks about the impact on staff if they do not feel acknowledged within their immediate team.

> "It makes it harder and makes it more stressful. If you feel like you're the person that's doing everything and you're not getting any recognition for it."

Andy also expressed how helpful it would be for the staff's hard work to be acknowledged:

> “Not underestimating what people- nurses do actually, well not just nurses, but you know- the team who work within CAMHS. Have some understanding about how busy it is and that people are doing their best, and they’re giving all they can. Yeah if people would be mindful of that. Would be good. External agencies like social care. Erm, parents, commissioners, other people within the trust who work in risk management. People looking for stats and care plans and all this and that. That we know it's important and we are trying to get it done. But our pri- our primary purpose is to look after the young people.”

3.3.9 Theme Nine: Barriers

Participants described the need for support to manage their well-being and process their experiences working on the ward, yet when these things are offered to them, barriers to engaging in this come up. Simon, who runs a staff group himself, describes an almost self-punishing position of staff.

> “I think the groups go okay. People always say they-they enjoy them. Erm, but, I wish people would more- well some are now on [particular days] saying ‘Simon are you coming- ?’ But, erm, yeah. They can’t quite let themselves have it”

He goes on to explain that staff struggle to prioritise themselves, even when attempts are made to help facilitate staff involvement in the groups.

> “I've moved it to a [different day] now- because … now there’s no excuse, really. Because no one’s up, and I say "come on." And I think they find it really helpful and I enjoy it, erm, but it's, you know, if there's a demand comes on the ward, they'll drop [the group].”

Internal and external barriers make it more difficult to access support when they need it. Participants convey a difference between availability and accessibility. Whilst support may

be readily available, it is not always accessible for staff. Sharon uses the interview space to think about how this applies to her team.

> Sharon: "What I am thinking of as we talk about that is the impact of erm, so for example, when our staff are caught up in a restraint, or when our staff might see somebody with a ligature around their neck…..which is really difficult to witness and to be part of. I think we try and use our peer supervision space, as a space to talk and think about that, but in reality, people are reluctant to come in unless they are on shift, so we don't capture everybody….. it is very, very unusual for any person to come in if they're not on shift, which is understandable. But it's something for us to think about as a team."

Neil highlights the importance of support groups or individual sessions which focus upon maintaining staff well-being, and wonders how these could be made accessible to a larger group of staff during work time.

> "I feel it's like *in* the shift - like guaranteed to happen, like actually *has* to happen. 'Because if it's not, it's not going to happen. …. If there was a way, a certain amount of people *have* to go and there's the extra staff to cover it or extra staff to come in. So, even if you've got one extra staff to come in on that shift, erm, and then each person had an allotted half an hour or something like that….. That's, in my opinion, the only way it could happen, and you'll get attendance. Obviously, that's an extra expense getting that extra person in. But it's whether you're looking at solely at the expense of the budget or back to well-being of the whole team."

Another barrier participants described having was limited time where they can be in a space without being disturbed or needed. David speaks about the idea of having 'real' protected time to be able to truly be present in a staff group session.

> "Yeah, I think being able to go a group like the Cognitive Analytic one. Knowing that someone's covering the ward, knowing that you're *not* going to be called out. 'Cause

> even when you're in this group you're waiting for the alarm to go off or someone to radio you or someone to come in and say they need you."

Raymond talks about the importance of having protected spaces where staff can feel safe to share their experiences with each other, and particularly having enough of them.

> "I think having *enough* reflexive spaces is sometimes the most important bit. And, kind of, having those feel relatively safe. So you don't have to deal with that and- I think if there was no sense of being able to go anywhere, to colleagues, then would probably- I could imagine that would start to probably create some sense of burnout for me personally."

Whilst participants felt like currently their teams are functioning well together, it was acknowledged that maintaining and encouraging this process could be helpful for staff, to feel like they are having a shared experienced at work. Neil recalls a day that staff had together off the ward which helped solidify this process, as well as getting to know each other on a basic level to build the foundations of relationships.

> "It kind of brought the team closer together, in terms of how well we gel and stuff, and seeing people's weaknesses in different aspects and so- yeah. That was- that was a real positive. And they made sure that staff- that the ward was covered and everything, and it was done way in advance."

> "The team changes all the time and the new members of staff might not have experienced that, erm, they might not want to, but having those options. I think looking at the team as a whole from a management perspective and keeping morale up, I think doing like a day out somewhere, erm, not to do with work really helped with our morale and well-being at the time.

3.3.10 Theme Ten: Tolerating Uncertainty

Working in CAMHS settings comes with a great deal of uncertainty. Staff are expected to tolerate the uncertainty to be able to do their jobs, but this can also evoke anxiety.

The Future. Due to the short term, acute nature of the ward, staff are often left in a position of wondering about the young person's future beyond the unit. Whether they have moved on within services, or been discharged, the future is unknown. This also leaves a predicament whereby staff would know the outcome if the young person is readmitted to the ward, but ultimately staff hope the young person does not require an additional inpatient stay. Neil talks about this uncertainty, and how being in a state of knowing influences staff motivation.

> "Erm, and we don't necessarily hear what- what happens next, which- I think, some staff feel like we'd like that, erm, because it would give us even more, positive momentum to go with. Erm, but they, sort of, go- leave the unit and we don't really hear what goes on."

Rebecca also described this uncertainty, and compared her experiences of community and inpatient settings:

> "I think in community teams, you get a little bit more follow up 'cause sometimes you might finish working with someone and then they might have a support worker working with them for a while, or they might still be in touch in some way for a while, but I think this is quite different in inpatient, erm, in terms of as soon as they go, they go really don't they."

Power. The organisation holds a lot of power. It has the power to keep you informed, or to keep you in the dark. Harriet talks about the Trust she works for undergoing some structural changes, which staff are aware of, but feel unsure about how these changes will

affect them.

> "Well, we haven't really- There's- no one's been talking to us about anything like that. So, we don't really know what's going on."

She goes on to describe what it is like to work with that uncertainty on a daily basis as frontline staff.

> "It's almost like we crack on with the day-to-day running of the ward and we don't really know what else is going on behind the scenes."

For some staff, this uncertainty around power extended to the threat of human resources (HR). David gave an example of this as staff choosing not to have days off sick. Indicating that if you have days off sick, or act in a way that is not deemed as appropriate, you will be faced with consequences from HR.

> "….obviously you've got HR will get on your case then as well. You have to have a back to work interview and your [sickness] score is affected. They would look at how many days off you've had….. that generates a score. Erm, and when your score gets over a certain point, erm, that triggers a, something within HR, triggers like a meeting with them. Right, then they monitor your score until it comes down again."

Jenny also talks about how it can feel like you are being watched by the Organisation and wonders about opportunities just to be silly or not act in a particular way through obligation.

> "I think, upon the organisation as NHS staff, where people are, you know, you're being watched. Like, you can't act in a certain way. You can't behave in a certain way outside of work, but I think, actually, we all just need to go and be really silly."

Participants felt that all this uncertainty on the ward at times can be too much to bear. So, creating some level of certainty, or to feel more in a position of 'knowing enough' can be

helpful in supporting staff well-being. Part of moving towards more certainty involves becoming more transparent in communication. This would not only help staff with feeling they have some sense of what is going on, but will also increase the trust they have in the Organisation. Jenny explains how team-building days have been packaged as one thing but turned out to be experienced as something different.

> "But the last few team-building days, I think they've actually been, erm, ''I'm going to sit and talk to you about how you can do your job better.'' And I don't see that as team-building. I see that as ''We're really annoyed with you about something, so we're gonna mask it as something else.' And then everybody just ends up getting annoyed with each other."

Neil describes a similar experience.

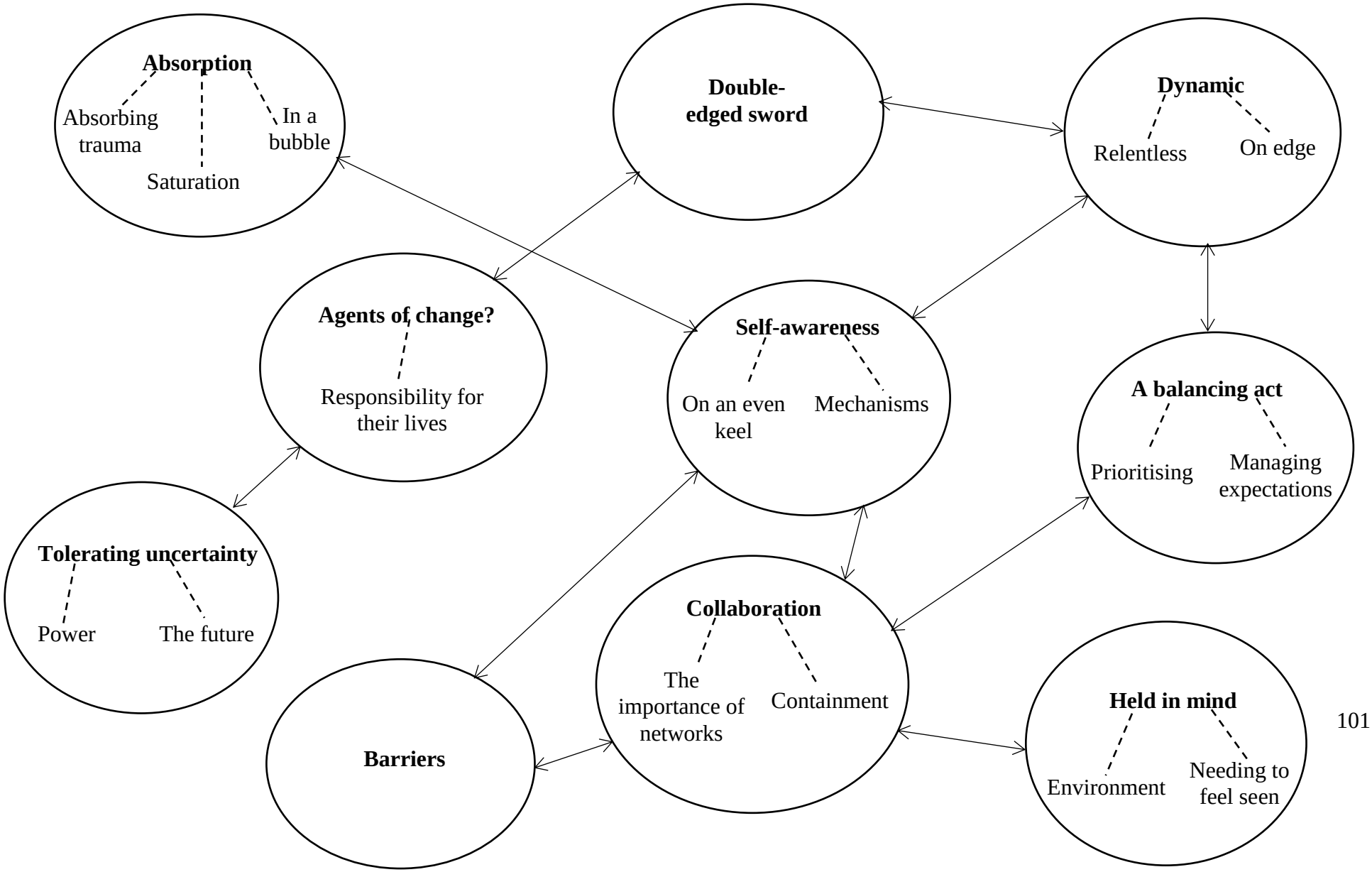
> "the last [team building day] we went to was more like a board meeting. And it was more, erm, clinical … Which was fine and everything but how it was initially marketed was it was team building, when it was more like a clinical- like a document aspect and not like just a well-being break, like a respite."

3.4 Thematic diagram

Figure 2 demonstrates the themes and subthemes along with the relationships between them. Within the circles are the overarching themes, shown in bold, and any associated sub-themes underneath joined by dotted lines. The solid lines with arrows represent the two-way relationships between the themes, which will be detailed in the following section.

Figure 2.

Dynamic map of themes and subthemes



Whilst each theme has a distant meaning represented within the data, there is a connectedness between them which fits with the experiences participants shared. The connections illustrated in the map are dynamic in nature.

For example, the process of balancing requires a degree of collaboration, which is also a separate concept in terms of wider systems and support structures. Participants spoke about the balancing act as also being constant and ever-changing. There are always new tasks, varying mix of staff and patients, changing priorities and expectations. As a consequence, the relentless nature of this can impact how 'sharp' the stressful and critical edge of the metaphorical sword feels. On the other edge of the sword, some of the hopefulness felt by staff can be driven by feeling they are predominantly the agents of change for a young person on the ward. However, as part of this, staff can also experience distress associated with the level of responsibility they feel and the uncertainty that the transient nature of the ward brings. Participants described having a sense that some of this responsibility is shared helped to moderate their distress.

The theme of collaboration seemed to become quite central within the analysis. Participants described collaboration with the team, wider systems and young people; which also invites a reciprocal process of being held in mind. This is also apparent within the theme of self-awareness, where some participants only became aware of their needs (or perhaps their saturation or that they have been on edge) through colleagues bringing this to their attention. The collaboration also feels significant in the barriers and possible solutions to these. For example, colleagues respecting 'protected time' as well as management allowing this time.

The underpinning mechanisms to the ten themes are discussed in more detail in the next chapter.

Chapter 4: Discussion

4.1 Chapter Overview

Within this chapter I begin by summarising research findings in relation to existing literature and relevant psychological theory. I then discuss the strengths and limitations of the study and consider the clinical and research implications including recommendations for future research. The chapter ends with an account of my personal reflections and plans for dissemination of the study.

4.2 Summary of Findings

Staff experiences of working within CAMHS inpatient units seem to encompass processes of absorption. Participants describe 'absorbing' the trauma that is ubiquitous across the wards. This may also have a negative impact on well-being, particularly if staff become 'saturated'. It was noted that this process also impacted participants' physical health. There also seemed to be a split described by participants between feeling replenished versus feeling depleted, or perhaps all soaked up (saturated) versus all wrung out and able to take on more.

This notion of absorbing trauma is a somewhat unique finding. It could be argued that this is a process of coping with the challenges faced on the ward. Folkman, Lazarus, Gruen and DeLongis (1986) state that coping includes any cognitive or behavioural efforts to manage, minimize, or tolerate events that individuals view as a potential threat to their well-being. However, participants who describe this process talk about not realising, as if it is an unconscious process rather than a more conscious effort to cope. Furthermore, the description appears qualitatively different to the desensitisation also described by participants which seems more of a means to shut out the trauma, rather than take it in. Although, one could argue that this desensitisation is a form of avoid coping (Folkman & Lazarus, 1988).

In addition to absorbing trauma, participants expressed a feeling of becoming absorbed by the ward, as though they were in a bubble. This fits with findings such as Clarke (2013) where staff described feeling isolated from the outside world both from other professionals and the general public. It has been suggested that this poses a risk that the team could develop an idealised view of itself and become disconnected from wider systems. This in turn could hinder the application of reflective approaches in practice and therefore well-being (Ibid). This 'bubble' may also represent social identity processes occurring, providing a sense of group bonding and possibly the notion that others do not understand the group's experience (Brown, 2000). Some participants within the current study also described a sense of this within the ward team itself, as well as the dangers of the inpatient team becoming too insular, and what it means if you are in the 'out group'.

It could be argued that some of the findings can be explained in terms of staff absorbing the pathology of the adolescents, such as 'acting out'. Participants spoke about almost rebelling against expected behaviour or wanting to act in a 'silly' way, within their professional boundaries. This could be seen as reflective of how young people can present behaviourally on the wards (Dean at el., 2010). For the young people, this behaviour can be part of their developmental trajectory; asserting individuality from what parents like or independence of what parents want. This can provoke parents' disapproval; therefore deliberately opposing the ruling norms or powers has been seen as desirable by adolescents and undesirable by adults, particularly as it creates more resistance to the parenting roles of providing structure, guidance, and supervision (Pickhardt, 2009).

The vulnerability of young people can also be absorbed and mirrored within the staff team, wherein staff members can feel they are vulnerable; at risk of harm from patients, or at risk of allegations. This is perhaps a transference reaction whereby the young people may be

projecting their feelings of vulnerability and anger into the member of staff caring for them (Ghuman & Sarles, 2003).

Within the experience of working in CAMHS inpatient settings, participants expressed a dichotomy of feelings which was captured in the research analysis as a 'double-edged sword'. This provides support for the transferability of Clark's (2013) findings that working within a CAMHS forensic unit was both a source of stimulation and satisfaction as well as frustration for staff. In the current study, working in CAMHS also brought a sense of hope to participants due to the perception that young people have their whole lives ahead of them, and therefore hold the potential for a successful future. This sense of hope and potential was felt to be a key difference when participants compared their experiences in CAMHS work to other settings such as adult and older adult services. This fits with dominant narratives within the literature around aging, as highlighted by Koenig and Spano (2006), that older adults are unable to sustain or surpass current levels of growth and development, and that there is decreased access to financial, social and other resources.

Interestingly, participants who talked about this hope for the future in CAMHS also discussed the difficult feelings an unknown future can bring to the staff. Almost all the participants described a sense of uncertainty and being in a state of not-knowing in terms of the future for themselves as well as patients, which can lead to feelings of anxiety and frustration. This level of uncertainty was felt to be particular to the inpatient environment, where stays on the ward are short term and staff may never see or hear about the young person again, especially if they are not from the local area. The feelings can be explained in terms of Mason's (1993) model of safe uncertainty. He proposed that when individuals are in a place of 'unsafe uncertainty', it can generate feelings of insecurity and as a result, people tend to seek a position of 'safe certainty', such as concrete answers and 'knowing'. These

positions, although dynamic in nature, are not sustainable long term for good overall psychological functioning. Mason suggests that moving towards a place of 'safe uncertainty' can be more conducive to psychological well-being and allows space for new meanings to emerge.

In relation to this, being able to tolerate feelings of uncertainty can accompany the felt sense of containment. This links back to the literature on containment and the dual roles of professionals within CAMHS units. If staff are more able to tolerate uncertainty or able to be in a state of 'safe uncertainty', this can provide feelings of security and containment for the young people in times of distress or crisis. This is akin to an integral therapeutic process provided by the therapist during systemic therapy (Mason, 1993). Furthermore, captured within the theme of 'collaboration', participants described a need to feel contained, which can be enabled by colleagues and wider networks around staff and young people.

The theme 'on an even keel' was developed from participants' descriptions of their well-being. This captures a notion of changeability within subjective well-being. This view is supported by the NICE (2009) definition of mental well-being which conceptualised this is "a dynamic state". Within this theme, some participants also described having a constant level of stress, which they attributed to the nature of the job. This may fit with findings from Dean et al. (2010) where staff found that behaviours from the young people were acceptable in the context of their development. Perhaps there is a sense of acceptance within CAMHS staff that stress is to be expected within the role given the complex nature of adolescence and the multiple demands of the job itself.

Furthermore, it may be that young people are perceived as more vulnerable and therefore are more likely than other populations (i.e. adult patients) to draw out the 'parent' role within staff. This also fits with the level of responsibility for the young people that

participants described feeling, and that they are the agents of change for the young person. This was also felt to be a key difference within inpatient CAMHS compared to other settings. Part of the role of staff is to provide a sense of safety, physically and emotionally, for the young people on the ward while allowing them to explore their feelings and independence in line with their developmental stage. This is particularly important if these experiences were inconsistent in early childhood (Hogan, Rogers & Hemstock, 2009). This may increase the pressure felt by staff members both internally put on themselves and from the systems around the young person, and further enhance their sense of responsibility.

Evidence suggests that staff working within psychiatric units experience some of the highest levels of burnout and job dissatisfaction across the healthcare workforce (Gilbody et al., 2006). This was not found in the current study. This could be explained by the desensitisation that participants described, perhaps this serves to protect staff from burnout. This could also be conceptualised as avoidance, within the context of survival responses in trauma. These responses can be filtered down the system by a traumatised organisation and increase avoidance, dissociation and retreating (Treisman, 2018). Participants did however also describe having mediators which helped maintain their well-being and sense of value. These included having self-directed goals inside and outside of work, and feeling supported in progressing towards those.

Several participants described constantly feeling ‘on edge’. This could be likened to a state of hypervigilance. This may be explained by a process of mirroring the hypervigilance experienced by the traumatised young people that staff are caring for. Although this was not explicitly spoken about by staff, symptoms such as this hypervigilance emerged through their narratives, indicating possible STS. Perhaps this is also the result of absorbing the trauma discussed previously, and the relentless nature of the environment described by participants.

This relentlessness was seen to be a distinct feature of the inpatient setting. On wider level, this may also be a symptom of a trauma-saturated system. This is described in the trauma-informed care literature as 'mission mirroring', where the system is replicating the symptoms of the problems it has been tasked to fix, and is felt internally by employees (Treisman, 2018). Some participants also spoke about difficulties with separating from work, a further indication of STS, corroborating findings from Currid (2009) that nurses on acute mental health wards were unable to stop thinking about their work after arriving at their own homes. Contrary to this, Foster (2019) found levels of STS in CAMHS PICU staff were actually lower than benchmark data.

Another potential example of mirroring young peoples' experiences is how participants described their value or particularly how they are viewed by the organisation. Participants described feeling under threat in some way as though they were constantly being watched. This impacted on the way they behaved at work, they came into work when they were unwell and felt constantly scrutinised. This level of feeling threatened could again be understood through an STS lens.

The findings related to staff well-being can be explained by Ryff's (1989) model of personal growth and psychological well-being (six components: self-acceptance, positive relationships with others, autonomy, environmental mastery, feeling purposeful in life, and personal growth). Participants described aspects of continued personal and professional growth in terms of goals and aspirations, they also spoke through a lens of self-awareness which may be accompanied by a level of self-acceptance in Ryff's terms. Furthermore, participants described mostly feeling supported by one another, consistent with previous findings (Parkes and Rabenau, 1993; Cole, Scott & Skelton-Robinson, 2000) indicating that social support is associated with increased satisfaction and well-being.

Participants described a collaborative atmosphere within CAMHS wards. This was also a key difference drawn out by participants between CAMHS and other mental health settings; there seem to be more systems around a young person that also need to be considered including carers, wider family, and education systems. Participants who had experienced working within adult or older adult settings argued that these non-CAMHS services focus more on the individual patient than within CAMHS settings. Findings suggested that adopting a greater systemic focus promoted increased collaboration, with more individuals working together to support the needs of the young people. On the other hand, participants highlighted the added pressure and feelings of scrutiny that can come from trying to manage multiple expectations and perspectives.

Ryff's model outlines the importance of positive relations and the influence of these upon well-being. This could be applied to both staff and young people. There is a particular focus on the level of warmth and trust in relationships with others. Interestingly, some participants used these words verbatim within their descriptions of staff relationships. Furthermore, within relationships, participants placed a greater significance on the views of their direct colleagues, rather than higher-level management staff, to draw conclusions about their own worth. This was also in the context of feeling somewhat disconnected from managers outside of the ward structure. Applying Organisational Support Theory, staff may have developed a general perception, through dominant discourses, about the extent to which the Organisation values their contributions and cares about their well-being (Eisenberger & Stinglhamber, 2011). It was felt that colleagues were more genuine in their feedback due to their regular contact with participants which gives a greater sense of understanding.

Mirroring previous findings (Gilbody et al. 2006), participants described needing a greater number of psychologically safe spaces to explore their feelings, but there are barriers

to accessing the formal provisions such as reflective groups or even supervision. Barriers described were external factors such staffing levels, and high 'activity' on the ward. Some participants did wonder if staff also struggled to prioritise themselves over other tasks, and described an almost self-punishing mechanism to non-attendance.

These internal and external barriers could create a maintenance cycle, such as those described in cognitive behavioural theory by Beck, Rush, Shaw & Emery (1979). It may be that staff are offered reflective spaces based on their needs, but perhaps it then feels too difficult or vulnerable to reflect at that time, so staff avoid them (consciously or unconsciously) via external barriers such as ward activity or paperwork, then the issues do not get resolved meaning staff still need reflective spaces and so on. This could also be conceptualised in terms of an ambivalent or disorganised attachment pattern within the staff team (Bowlby, 1969). The difficulty with reflection may be due to staff capacity to 'think' being undermined by the anxiety projected by the adolescents they are working with (Bowley and Bratley, 2005). Participants explained that breaking down these barriers again largely rely on external factors, rather than intrinsic motivation, discussed further in the following section.

Participants spoke about a need to break down the barriers outlined. There was a difference expressed between availability and accessibility. For example, although support may be readily available, it is not always accessible for staff. Some participants felt that staff support groups focused around maintaining well-being were important, and highlighted a need to problem solve around facilitating their accessibility. This is also raised within the literature (e.g Oates, 2018). Perhaps the peer or managerial support that is available, such as supervision, peer support groups or additional training are not experienced as supportive or meaningful to staff (Johnson et al., 2011).

In applying participant accounts to current policies, it becomes apparent that practices of self-care, even on a basic level at work such as having a break or taking sick leave when unwell, are not integrated into everyday practice as NHS Health Education England (2019) encourages. Reasons for this can be inferred from participants' accounts such as guilt, and a feeling of responsibility for colleagues, as well as the aforementioned practical barriers. Participants even spoke about altering the meaning of taking 'a break' at work, such as having a break from one task by doing a different one, while not actually having a break from the work itself.

Participants talked about needing 'away days' off the ward which included team building activities and getting to know each other outside of the work environment. This may be similar to the strive for deeper, genuine connections that can be observed within adolescents on the ward who have experienced complex trauma (Kinniburgh, Blaustein, Spinazzola & Van der Kolk, 2017). As part of underlying attachment processes, the young people can have a desire to 'know' the staff as people outside of their roles. Perhaps staff also crave this same experience within the team in order to feel more connected and therefore gain a sense of security and containment.

There is also evidence to support the need for cohesion that participants expressed. Opportunities for staff to have more high-quality interactions with one another can lead to enhanced staff morale, and consequently performance (Johnson et al., 2011), an experience the participants corroborated. Furthermore, sharing workload demands and responsibilities with co-workers within what is described by participants as a constant and ever-changing environment can reduce emotional exhaustion for staff (Rousseau & Aube, 2010).

Within participants' narratives, it was deduced that staff wish to be held in mind. Arguably, this is fundamental to feeling valued, secure and contained; all aspects that have

been associated with well-being in the literature. This may also be another illustration of a mirroring process within the staff and patients. Participants described wanting to be held in mind by others, notably the organisation, perhaps the 'parent' figure, which can lead to a sense of validation and connection (Pawl, 2006). This is in keeping with the child development literature whereby the young people on the ward have a developmental need to be held in mind and contained by staff, who often occupy parental positions.

Participants proposed a number of ways that could help develop their sense of being held in mind. An emphasis was placed on acknowledging the mental health of staff, which can feel overlooked at times. Participants seemed in a paradox whereby a mental health Trust did not consider the mental health of its staff. Participants felt there was a more reactive approach from the Organisation to staff well-being. Support structures are put in place quickly after a serious incident for example, but are time limited. Whilst this is experienced as helpful in the short term, the sense of disconnect staff can feel may increase in the longer term; perhaps akin to that of an absent parent. Ultimately, there was a sense of staff needing to feel 'seen'. However, it seemed that staff had an ambivalent relationship with this, on one hand describing a need for acknowledgement and care, while on the other hand, not wanting to be 'watched' or feeling scrutinised.

A strong feature threaded throughout the interview data was the impact of ward design on staff well-being. This is in keeping with previous literature Trzpuc et al. (2016). Suggestions included having a space easily accessible on the ward for staff to sit and have a break. Although the participating units do contain staff areas, participants explained they were not conveniently located for staff who require a short break (i.e. they are too far from the ward itself). Some participants framed physical symptoms such as headaches as a product of the environment (e.g lighting, lack of fresh air); although this arguably could also be a

result of the emotional toil and nature of the work. Furthermore, within both participating units, the nursing offices were directly within the ward space. Participants explained how this can raise their anxieties before they have even entered the ward due to the extreme uncertainty about what they will find behind the door. Participants emphasised how different office locations would allow for brief handovers and risk assessments for example before staff go on to the 'shop floor'.

Finally, staff expressed a need for some certainty to enhance their well-being experience. It is acknowledged that absolute certainty would be impossible to create, and it would likely be unhelpful to do so long term (e.g Mason, 1993). However, a level of certainty in the form of communication and transparency (even if this means being honest about not having the answers) within the organisation and teams could allow staff to feel more able to tolerate uncertainty and give rise to more flexibility in their approach. This in turn could strengthen the connection between frontline staff and management. Clark (2013) supports these findings conceptualised as openness alongside honesty. Mirroring therapeutic processes, it is important that the staff are supported to build their resilience and to maintain a position of safe uncertainty rather than purely seeking to make the uncertain certain.

4.3 Strengths of the Study

The originality of the research topic. This study makes an original contribution to the literature on CAMHS inpatient staff experiences within the context of well-being. As evidenced by the literature review in the introductory chapter, this is the first study that attempts to explore the subjective experience of CAMHS inpatient staff in relation to their well-being. Additionally, participants commented on the usefulness of the interview process,

and indicated that they intended to share some of their reflections within their clinical setting to inform professional and service development.

Methodology. To recruit frontline professionals, a convenience sampling strategy was employed within the study. This arguably allows for the generation of more representative knowledge of the wider population, from which the sample was acquired (Etikan, Musa and Alkassim, 2016). This recruitment strategy helped recruit a relatively heterogeneous sample in terms of length of time in the service and job role. Furthermore, I tried to integrate myself within the participating units by working from offices in the building, visiting the wards and attending team meetings to present the study. This aimed to increase the chances of identifying potential participants as it allowed staff to drop in or book at their convenience and facilitated informal conversations about the research. As a result, this also commenced the rapport building process before interviews were conducted. This also strengthens the credibility of the study findings due to this prolonged engagement (Lincoln & Guba, 1985).

A further strength of the chosen methodology is the use of face-to-face interviews to collect data. McCoyd and Kerson (2006) highlight the advantages of using interviews compared to non-face-to-face methods. Specifically, the value of rich, non-verbal data and facilitating researchers to interpret these alongside considering the spoken content. McCoyd and Kerson refer to face-to-face interviews as the "gold standard" of interview methods.

A topic guide was used within the semi-structured interviews. These are useful to ensure that relevant issues are covered systematically, while still allowing flexibility to elaborate on particular points salient to each participant. Moreover, the development of this topic guide was carried out in collaboration with a group of CAMHS inpatient staff. This

participatory approach increases the validity of the interviews and consequently the data gathered.

In terms of the data analysis, thematic analysis was deemed appropriate to explore the subjective experiences of CAMHS inpatient staff. Through the generation of themes, there is arguably an increased access to the more in-depth reality of the researched phenomena (Denermark, Ekstrom, Jakobsen & Karlsson, 2002). This also fits with the critical-realist stance adopted in the study, in terms of individuals having a subjective reality that can be explored through such methods.

Transparency. To ensure transparency within the study, I have been explicit about my background and the assumptions I held about the experiences of CAMHS inpatient staff. I also documented my decision-making processes at each stage of the project. This transparency is important for qualitative research to be accessible and auditable as a result which in turn increases the confirmability (Houghton, Casey, Shaw & Murphy, 2013). Furthermore, the audit trail created through outlining methodological decisions and interpretative judgments also enhances the study's scientific rigour. Koch (1994) asserts that readers may not share a researcher's interpretation, but they should be able to infer the means by which it was been made.

Reflexivity. Following on from transparency, reflexivity has been considered throughout the study. In order to understand and acknowledge my influence as the researcher on the study, I offered a statement about myself as a person, my professional background as well as detailing my epistemological position (Willig, 2013). Furthermore, I have kept a reflexive diary throughout the project, reflecting upon my thoughts and feelings before and after interviews.

I attempted to consider how my own reactions could enhance insights and understandings within the research (Willig, 2013)

Transferability. Significant attempts were made to increase the transferability of this study's findings. It provides 'thick description' of the research context (Houghton et al., 2013). This included description of the research setting, methodology, and examples of raw data through quotations. This allows the reader to then make informed decisions about the transferability of the findings to their specific contexts (Lincoln and Guba, 1985).

In terms of generalisability, this study also demonstrates internal generalisability (Maxwell, 2012). This was attained through the recruitment of staff from varied disciplines and backgrounds across two different sites. Therefore, the findings are likely to be generalisable to the wider frontline staff team within the units.

Rigour. It has been argued that 'member checks' are essential within qualitative research to minimise data misinterpretation (Lincoln & Guba, 1985). However, this is borne from the realist assumption that there is one fixed reality. Given the critical realist epistemological position adopted for this project, formal member checks were not included. Instead, as outlined, details of analytic decisions were made explicit throughout, and discussed within research supervision. In addition, the interview topic guide was developed in collaboration with CAMHS staff and the subsequent themes developed from the interview data were taken to an additional staff focus group to enhance the findings and draw out the elements they felt were specific to CAMHS in more depth. It was also acknowledged that regardless of research stance, participants may change their perspective on a narrative about their experiences which they shared during interview.

4.4 Limitations of the study

Methodological limitations. Whilst the thematic analysis approach used in the study allows flexibility and rich interpretation, it can also lead to inconsistency and reduced coherence when developing themes derived from the research data (Holloway & Todres, 2003). Furthermore, this type of analysis does not allow for interpretation around the use of language or the intricate functionality of talk (Braun & Clarke, 2006).

Sample size. Due to difficulties in recruitment, the sample size ended up at the lower end of the proposed 10 to 20 range. However, this still fell within the suggested range for medium sized projects such as this (Braun and Clarke, 2013).

Potential biases. Due to the self-selecting nature of the convenience sampling strategy employed, there could be an elective-bias within the study. For example, individuals with poor well-being may not have chosen to take part (Cole, Scott & Skelton-Robinson, 2000). It would be interesting to explore whether staff members who chose not to take part or did not make any contact with me had similar experiences to the study participants.

Furthermore, the use of self-report data and its limitations have been widely reflected in literature, particularly due to potential participants' bias on the process of data generation (Maxwell, 2012). In terms of the self-reported data generated from the interviews, there is also an assumption made about the introspective ability of participants and how this affects their responses, even if they are attempting to give honest answers (Austin et al., 1998). Whilst this limitation is often applied to quantitative data, given the introspective nature of in-depth interviews, it can be considered within the current study.

Furthermore, whilst I employed clinical skills to enhance rapport building and encourage the openness of clients to share their experiences, it is possible that levels of disclosure were influenced by a number of factors. These include assumptions around my relationship to the Organisation, and my supervisory relationship with a clinical psychologist in one of the participating units. Although these were made explicit to staff, it cannot be guaranteed that these did not influence their responses. Furthermore, in an effort to increase recruitment and to enhance the ecological validity, interviews were conducted within the participants' work environment. Whilst this may strengthen the study, it also brings limitations. Participants may have been hindered, unconsciously or consciously, from fully sharing their experiences. There was evidence of defensive strategies employed by participants declining to elaborate on comments which were associated with the Organisation in some way. Perhaps there would have been different responses or further information gained had the interviews taken place elsewhere.

Diversity. Information around ethnic and cultural background was not collected within participants' demographic information. It would be interesting to explore whether this would have influenced participants' accounts, such as those deduced by Cole, Scott and Skelton-Robinson (2000) within their findings. Such information and other 'social graces' (Burnham, 1993) inevitably shape the way we view the world, and play a role in relationships, which would include those between myself and participants, and participants to patients, colleagues and so on.

Defining well-being. A definition of well-being was not given to participants during interviews, this was decided in order to capture participants' subjective views, and not to

impose the views of myself or others; this also came out of the focus group who concurred with this stance. Furthermore, as the topic guide was broadly framed around established models of well-being (e.g. Ryff, 1989) this would have inevitably influenced the questions and responses. This is arguably a limitation in the study, given the lack of clarity around a definition, however it is keeping with the critical-realist position underpinning the research. Furthermore, the use of aggregation of experience in defining well-being may not actually reflect a unified construct, and given the inconsistent definitions in the literature, perhaps offering a more concrete definition to frame the research would have been helpful, or studying the meaning of well-being itself within CAMHS inpatient staff to generate a theory which could then be explored.

4.5 Research Implications

The current study has been successful in exploring the subject experiences of CAMHS inpatient staff within the context of their well-being, a population lacking representation in the literature. Within the literature available, few studies focus on subjective accounts, and have employed more quantitative methods based on symptomology.

A limitation in the current study was the lack of consistent definition of well-being used. It may be beneficial for future research to investigate the meaning of well-being itself with the CAMHS inpatient staff population. This could employ more data-driven methods such as grounded theory approaches to develop a framework for understanding well-being within this population.

Furthermore, thematic analysis was chosen in this study due to the exploratory nature of the research aims. In future, it may be helpful to apply more narrative approaches such as discourse analysis to explore how staff talk about and make sense of their relationships with

the young people on the wards in the context of well-being. Particularly given the developmental theories outlined in previous chapters, and the mirroring processes that have been highlighted between staff and young people in the findings. Understanding the roles that staff can adopt may have clinical implications around interventions for staff, such as attachment-based approaches to staff support.

Future research could extend the current study in a variety of ways. The sample size of the current study was relatively small. It may be beneficial to investigate well-being within a larger, more diverse sample in terms of age, gender, culture and so on. Also, drawing comparisons between PICU and acute CAMHS environments may provide useful insights into staff experiences that were not factored in to the current study.

Given that staff talk about barriers to accessing the support offered, it would be a helpful to empirically explore the psychological underpinnings to why this happens. In addition, future research could evaluate the current support structures that are in place such as supervision groups or specific staff therapeutic groups. This would allow specific developments to be made that are meaningful to staff, in turn helping them to feel heard and potentially enhance intrinsic motivation to attend.

Finally, participants noted that having goals and being supported to work towards these positively influenced their well-being. Previous findings have suggested that using an ACT approach for staff intervention may be beneficial to increase personal accomplishment and well-being (Halsey, 2014). This would emphasise the importance of values and living a life in line with one's values, rather than setting particular goals. Future research could therefore investigate whether staff values affect subjective well-being.

4.6 Clinical Implications

Firstly, in the context of feeling held in mind, participants explicitly expressed the impact of ward design on staff well-being, Therefore, Organisations should consider both service-user and staff consultations when designing CAMHS inpatient wards, and use feedback in a meaningful way. From the findings of the current study, this could include architectural differences such as the location of the office and staff break areas. This would not only help staff to feel valued and heard, but could have a positive impact on their well-being. For example, having a space to enter before going on to the ward itself may act as a transitional space, allowing staff to psychologically prepare themselves for their shift (possibly through handovers etc). This transitional space could also allow staff to psychologically separate themselves from the ward before leaving the building; not only to enhance their well-being, but to reduce the sense of being 'in a bubble' and the impact of this.

It may be beneficial for staff to be supported to think about the parallel processes that play out on the ward, as highlighted in the findings; including vulnerability, hypervigilance, and the need for containment. Through exploring these processes and better understanding the mechanisms underpinning them such as STS or attachment, it may help staff to create more space in their mind to enhance their ability to provide attuned and sensitive care to meet the needs of the young people they are caring for. Furthermore, if staff are supported to explore their own feelings and reactions to situations, young people's presentations and working on the ward in general, this may help process their feelings and let go of some of the trauma they have absorbed before they become saturated. Also, reflecting on relationships and the individual and group level impact of patients has been found to directly impact on staff well-being, and the ability to form therapeutic relationships has an emotional impact on

nurses (Maben, 2016). This process could be facilitated through group supervision with an independent, external facilitator.

Given the issues identified in terms of lack of accessibility of formal support mechanisms, the value participants placed upon relationships with fellow staff on the ward, and what appears to be high levels of STS, it may be a helpful for a number of ward based staff to be trained in a model such as Trauma Risk Management (TRiM; March on Stress, 2019), which would allow them to deliver trauma-informed peer support at times of high stress, to help manage and contain emotional reactions in a responsive and accessible way as and when staff need this.

Furthermore, given what participants had consistently described about absorbing the trauma of young people and the parallel process within the wards, it could be helpful for the organisation to move towards becoming trauma-informed in its approach. Treisman (2018) argues that using trauma-informed and trauma-responsive care as a framework to guide their purpose, principles and practices can create a sense of identity, meaning and connection. Trauma-informed care also has staff well-being at its centre, with the notion that "well-being leads to well-doing" (Treisman, 2018). Furthermore, the focus on staff support with trauma-informed services has the potential to decrease burnout and reduce staff turnover (Sweeney, Clement, Filson & Kennedy, 2016).

The parallel processes are also highlighted within the frontline staff and higher-management structures. More proactive communication from management level, alongside more frequent offers of psychologically safe spaces for staff to share their experiences, thoughts and feelings should be considered. This would help staff feel more supported by the Organisation on a day-to-day basis and strengthen connections between them.

In terms of policies, given the literature on well-being and the evidence that supports this as a construct in itself, Trust policies should be revised with the view to separate the well-being and sickness absence policies. This could lead to the creation of a well-being policy that encompasses the dynamic nature of well-being along with strategies to monitor, maintain and improve well-being. I would argue that well-being should be placed as a standard item on the agenda for supervision, framed within a subjective well-being model such as Ryff (1989), and use this meaningfully to explore the areas which staff can evaluate within themselves. This could also map on to appraisals (i.e. professional relationships, goal setting, accomplishments and so on).

Finally, participants expressed a need for cohesion. In order to encourage this process, consideration should be given to facilitating genuine protected time, perhaps with external facilitation, creating opportunities for formal and informal debriefing, and possibly team building activities which also allow time to reflect whilst out of 'the bubble', and are in keeping with previous findings on the importance of social support from co-workers. These suggestions are directly related to what participants expressed during the research interviews, it could be argued that they are therefore more meaningful to staff and more likely to succeed. Similar to the interventions offered to patients: greater engagement in the process leads to better outcomes (Swensen, Kabcenell & Shanafelt, 2016).

4.7 Reflections

I will begin by exploring my feelings about the research within a broader context, before I move on to a more focused perspective. There is a sense of uncertainty and tension within the current political climate, which inevitably impacts the NHS and its workers in terms of what the future holds. The participating NHS Organisation was also undergoing a restructuring at

the time of the study. These factors, combined with my status as a final-year trainee Clinical Psychologist with an uncertain future, initially brought up feelings of anxiety and empathy for the staff I was interviewing. Questions arose in my mind around what the NHS will look like when I qualify, what this might mean for CAMHS services, and the staff working within them.

From this, I developed a sense of wanting to truly give voice to CAMHS staff, particularly given their limited representation in the literature. I would argue that inpatient units can be 'othered' or forgotten by society as a defence mechanism, and I was motivated to ensure that this did not happen for staff within these services during strategic decision-making by management structures. It was interesting to me that staff themselves also spoke in their interviews about needing to be held in mind.

My previously roles working within CAMHS inpatient services will have undoubtedly shaped these reactions and possible assumptions I made about the research population. On reflection, this background is likely to have had a positive impact on my interactions with participants but also could have negatively impacted their ability to speak freely and openly. I also wondered about participants' views of me, and their assumptions about my relationship with the Organisation or unit management. At times, I felt positioned as perhaps a 'spy' for the Trust, I felt myself becoming defensive about my stance as independent from the Organisation, which of course I am not. This was something I continued to try and balance throughout the study.

In terms of the research methodology, I initially struggled with the more interpretative side of analysis process, and felt worried this would somehow take away from participants' voices or what they were trying to express. Through reflective discussions and familiarising myself further with TA, it became clear to me that due to the subjective nature of what is

deemed relevant to include from the analysis, that not all the views of participants would be captured. I did still feel stuck at times about which aspects of data to focus on. Braun and Clarke (2013) acknowledge that this can occur with researchers undertaking TA. I attended a qualitative data analysis course which focused on TA; this helped enhance my understanding of the approach and lessen some of my aforementioned apprehensions.

I found conducting the focus group a helpful experience in terms of this research and my own learning. The responses about what should and should not be included for the topic guide were varied; it was helpful to reflect on the decision-making process within this, and not become wedded to my own ideas. This also enhanced my understanding of the importance of participatory research, and carrying out interviews that had been developed in collaboration with members of the study population felt more a more meaningful approach to data collection. However, I do think the eclectic nature of what staff wanted to be included on the topic guide combined with the already fragmented literature on well-being did make the analysis and write up somewhat difficult in terms of putting together a coherent story, although arguably this is not a straightforward process in any research.

Throughout the interviews I tried to maintain a reflexive stance, while upholding my position as a researcher. Yanos and Ziedonis (2006) suggest researchers should ensure there is a clear differentiation between their roles as clinicians and researchers. I felt I struggled with this at times, and found myself within the initial interviews perhaps interpreting within the interaction. I found keeping a reflective diary helpful in acknowledging this and enhancing my understanding of the researcher stance. Furthermore, using this approach I was able to note an overfamiliarity in my tone during one interview, and made a conscious effort to ‘step back’ in future interviews.

In relation to recruitment, I had some difficulty, particularly within one unit, with staff coming forward to participate. I wondered again if this was due to my position, but also if there is something about staff not being able to share their experiences, or perhaps prioritise themselves. Also, the training background of staff may also have influenced recruitment. In psychology, reflective practice is an integral part of training and subsequently practice, and I wondered how much that is true for mental health nurses, or healthcare assistants who may not have had any formal training involving this. Perhaps therefore the idea of reflecting on one's own experiences felt unusual for staff. I wondered if this was also a factor in why reflective groups are poorly attended, maybe 'fear of the unknown' or introspection feels too difficult.

In addition, staff who did participate seemed to struggle with talking about themselves and I often noted they would steer conversations back towards patients or frame their responses in terms of patient needs and well-being rather than their own. Although they did acknowledge the potential impact of staff well-being on the care provided to the young people. This compassion is valuable within the caring profession, but I also therefore wonder about staff capacity for self-compassion and reflection. Arguably this is essential in being able to sustainably deliver compassionate care to others (Neff & Germer, 2017).

In two of the interviews, participants started talking about the topic again after we had ended the interview, not with particularly new information, but almost as an extension of their responses during the interview. I was curious about why this happened, and what meant they felt unable to expand their points further during the interview. This also made me think of how patients can sometimes leave sharing important points until the very end of a session. In hindsight, perhaps I should have asked participants themselves why it happened, but I was

mindful about keeping the ending boundary we had set so did not want to restart an interview approach with them.

Finally, at times, I found it interesting that I was investigating staff well-being and the very thesis process itself was impacting on my own well-being. This also could be argued as a transference process, but I feel it is also a reflection of the overwhelming nature of doing a clinical psychology doctorate.

4.8 Summary and conclusion

This thesis presented a qualitative study exploring the subjective experiences of CAMHS inpatient staff in the context of well-being; and their views on support within this area including perspectives on enhancing staff well-being experiences.

The research data was obtained through individual semi-structured interviews. Data was then analysed using a Thematic Analysis framework. A total of 16 themes and 32 subthemes were developed from the findings within the domains of: experience of working in a CAMHS inpatient setting, staff well-being, and staff support needs.

The findings were presented and discussed alongside the relevant literature and psychological theories. The research and clinical implications of the study were then considered. It is hoped that the findings of this study can inform the development and refining of support provision to enhance well-being in CAMHS inpatient staff. It is also hoped that the findings will contribute to the developing body of research into the well-being of healthcare staff, particularly those working within CAMHS settings.

4.9 Dissemination

A copy of the study will be offered to all participants. Furthermore, it is anticipated that a presentation of the study will be carried out within the participating NHS Trust to ensure findings and recommendations are disseminated to the relevant people. Finally, submission for publication in a peer-reviewed journal will be considered.

References

Aiyegbusi, A. (2004). Thinking under fire: The challenge for forensic mental health nurses working with women in secure care. In Jeffcott N. & Watson T. (Eds.), *Working therapeutically with women in secure mental health settings.* London: Jessica Kingsley Publishers.

Arthur, S. & Nazroo, J. (2003). Designing fieldwork strategies and materials. In Ritchie, J. & Lewis, J. (Eds.), *Qualitative Research Practice: A Guide for Social Science Students and Researchers* (pp. 109-138). London: Sage Publications.

Austin, E. J., Gibson, G. J., Deary, I. J., McGregor, M. J. & Dent, J. B. (1998). Individual response spread in self-report scales: personality correlations and consequences. Personality and Individual Differences, 24 (3), 421–438.

Barford, S. W. & Whelton, W. J. (2010). Understanding burnout in child and youth care workers. In *Child & Youth Care Forum*, *39*(4), 271-287.

Bath, H. (2008). The three pillars of trauma-informed care. *Reclaiming children and youth*, *17*(3), 17-21.

Baxter, J. & Eyles, J. (1997). Evaluating qualitative research in social geography: Establishing "rigour" in interview analysis. *Transactions of the Institute of British Geographers, 22,* 505-525.

Bech, P., Olsen, L. R., Kjoller, M., & Rasmussen, N. K. (2003). Measuring well-being rather than the absence of distress symptoms: a comparison of the SF-36 Mental Health subscale and the WHO-Five well-being scale. *International journal of methods in psychiatric research*, *12*(2), 85-91.

Beck, A. T., Rush, A. J., Shaw, B. F. & Emery, G. (1979). *Cognitive Theory of Depression.* London: Guildford

Bhaskar, R. (1978). On the possibility of social scientific knowledge and the limits of naturalism. *Journal for the Theory of Social Behaviour*, *8*(1), 1-28.

Bloom, S. & Farragher, B. (2010), *Destroying Sanctuary: The Crisis in Human Service Delivery Systems,* Oxford University Press: New York

Bowlby, J. (1969). Attachment and loss: Vol. 1. Attachment. New York: Basic

Bowley, J. & Bratley, M. (2005). Making space for therapeutic work with adolescents and their families. *Journal of Social Work Practice*, *19*(3), 289-298.

Braun, V. & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research in psychology*, *3*(2), 77-101.

Braun, V. & Clarke, V. (2013). *Successful qualitative research: A practical guide for beginners*. London: Sage Publications.

British Psychological Society (2014). *Code of Ethics and Conduct.* Leicester: The British Psychological Society.

British Psychological Society. (2014). *Code of Human Research Ethics.* Leicester: The British Psychological Society.

Brown, R. (2000) *Group Processes, Dynamics within and between groups* (2nd ed.). Oxford: Blackwell Publishing.

Burnham, J. (1993). Systemic supervision: the evolution of reflexivity in the context of the supervisory relationship. *Human Systems*, *4*(19), 349-81.

Cahill, J., Gilbody, S., Barkham, M., Bee, P., Richards, D., Glanville, J., ... & Palmer, S. (2004). Systematic review of staff morale in inpatient units in mental health settings. *Report for the National Co-ordinating Centre for NHS Service Delivery and Organisation R & D (NCCSDO).*

Carr, L. T. (1994). The strengths and weaknesses of quantitative and qualitative research: what method for nursing?. *Journal of advanced nursing*, *20*(4), 716-721.

Carson, D., Gilmore, A., Perry, C., & Gronhaug, K. (2001). *Qualitative marketing research*, Sage Publications.

Case, R. (1992) *The Mind's Staircase.* Hillsdale, NJ: Erlbaum.

Clark, K. (2013). Staff Needs When Working in Secure Forensic Child and Adolescent Mental Health. *Journal of forensic nursing*, *9*(4), 217-224.

Crawford, T., Geraghty, W., Street, K., & Simonoff, E. (2003). Staff knowledge and attitudes towards deliberate self-harm in adolescents. *Journal of Adolescence*, *26*(5), 619-629.

Creswell, J. (2013). *Research design: qualitative, quantitative, and mixed method approaches* (2nd ed.). Thousand Oaks, USA: Sage Publications.

Cohen, D. J., & Crabtree, B. F. (2008). Evaluative criteria for qualitative research in health care: controversies and recommendations. *The Annals of Family Medicine*, *6*(4), 331-339.

Cole, R. P., Scott, S. & Skelton-Robinson, M. (2000). The effect of challenging behaviour, and staff support, on the psychological wellbeing of staff working with older adults. *Aging & Mental Health*, *4*(4), 359-365.

Compton, W. C., Smith, M. L., Cornish, K. A., & Qualls, D. L. (1996). Factor structure of mental health measures. *Journal of personality and social psychology*, *71*(2), 406-413.

Currid, T. (2009). Experiences of stress among nurses in acute mental health settings. *Nursing Standard*, *23*(44), 40–46.

Dean, A. J., Duke, S. G., Scott, J., Bor, W., George, M. & McDermott, B. M. (2008). Physical aggression during admission to a child and adolescent inpatient unit:

predictors and impact on clinical outcomes. *Australian and New Zealand Journal of Psychiatry, 42*(6), 536–543.

Dean, A. J., Gibbon, P., McDermott, B. M., Davidson, T., & Scott, J. (2010). Exposure to aggression and the impact on staff in a child and adolescent inpatient unit. *Archives of psychiatric nursing*, *24*(1), 15-26.

Denermark, B., Ekstrom, M., Jakobsen, L. & Karlsson, J. C. (2002). *Explaining Society. Critical Realism in the social sciences*. London: Routledge.

Denzin, N. K. & Lincoln, Y. S. (2008). *The Landscape of Qualitative Research*. UK: Sage Publications.

Diener, E. & Lucas, R. (2000) Subjective emotional well-being. In Lewis, M. & Haviland, J. (Eds.) *Handbook of Emotions* (pp. 325-27). New York: Guilford.

Dodge, R., Daly, A., Huyton, J., & Sanders, L. (2012). The challenge of defining wellbeing. *International Journal of Wellbeing*, *2*(3), 222-235.

Eisenberger, R. & Stinglhamber, F. (2011) *Perceived organizational support: Fostering enthusiastic and productive employees*. Washington, DC: American Psychological Association.

Elliott, K. A., & Daley, D. (2013). Stress, coping, and psychological well-being among forensic health care professionals. *Legal and Criminological Psychology*, *18*(2), 187-204.

Elo, S. & Kyngäs, H. (2007) The qualitative content analysis process. *Journal of Advanced Nursing*, *62*(1), 107–115. https://doi.org/10.1111/j.1365-2648.2007.04569.x

Emerson, R.M., Fretz, R.I. & Shaw, L.I. (1995). *Writing ethnographic fieldnotes.* Chicago, USA: University of Chicago Press.

Etikan, I., Musa, S. A., & Alkassim, R. S. (2016). Comparison of convenience sampling and purposive sampling. *American Journal of Theoretical and Applied Statistics, 5*(1), 1-4.

Folkman, S., Lazarus, R.S., Gruen, R.J. & DeLongis, A. (1986). Appraisal, coping, health status, & psychological symptoms. *Journal of Personality and Social Psychology, 50*(3), 571–579.

Folkman, S. & Lazarus, R. S. (1988). The relationship between coping and emotion: Implications for theory and research. *Social science & medicine*, *26*(3), 309-317.

Fonagy, P. & Bateman, A. (2008). The development of borderline personality disorder - A mentalizing model. *Journal of personality disorders*, *22*(1), 4-21.

Foster, C. (2019). Investigating professional quality of life in nursing staff working in adolescent psychiatric intensive care units (PICUs). *The Journal of Mental Health Training, Education and Practice, 14*(1), 59-71.

Ghuman, H. & Sarles, R. (2003) Indications for inpatient treatment and types of settings. In: Ghuman, H. & Sarles, R. (Eds) (2003) *Handbook of Adolescent Inpatient Psychiatric Treatment.* (pp. 3-17) UK: Brunner-Routledge.

Giddens, A. (Ed.) (1974). *Positivism and Sociology.* London: Heinemann.

Gilbody, S., Cahill, J., Barkham, M., Richards, D., Bee, P., & Glanville, J. (2006). Can we improve the morale of staff working in psychiatric units? A systematic review. *Journal of Mental Health, 15*(1), 7-17.

Green, A. E., Albanese, B. J., Shapiro, N. M., & Aarons, G. A. (2014). The roles of individual and organizational factors in burnout among community-based mental health service providers. *Psychological services, 11*(1), 41-49.

Greenhalgh, T. (1997). How to read a paper: Assessing the methodological quality of published papers. *BMJ, 315*(7103), 305–308.

Guba, E.G. (1990). *The paradigm dialog.* London: Sage Publications.

Gupta, M. D. & Frake, C. (2009) Child and family development. In Dogra, N & Leighton, S. (Eds.) (2009) *Nursing In Child And Adolescent Mental Health*. (pp. 124-133) London: Open University Press.

Hales, T. W., Nochajski, T. H., Green, S. A., Hitzel, H. K., & Woike-Ganga, E. (2017). An association between implementing trauma-informed care and staff satisfaction. *Advances in Social Work, 18*(1), 300-312.

Halsey, M. E. (2014). *Correlates and predictors of burnout and secondary traumatic stress in mental health professionals* (Doctoral dissertation, University of Southampton).

Hanson, R. F. & Lang, J. (2016). A critical look at trauma-informed care among agencies and systems serving maltreated youth and their families. *Child Maltreatment, 21*(2), 95-100.

Hennink, M. M. (2007). *International focus group research: A handbook for the health and social sciences*. UK: Cambridge University Press.

Henwood, K. & Pidgeon, N. (1992) Qualitative research and psychological Theorizing, *British Journal of Psychology, 83,* 97-11.

Hofer, B. K. & Pintrich, P. R. (1997). The development of epistemological theories: Beliefs about knowledge and knowing and their relation to learning. *Review of educational research*, *67*(1), 88-140.

Hogan, S., Rogers, G., & Hemstock, N. (2009). Inpatient CAMH nursing: two different models of care. In Dogra, N & Leighton, S. (Eds.) (2009) *Nursing In Child And Adolescent Mental Health*. (pp. 124-133) London: Open University Press.

Holloway, I. & Todres, L. (2003). The status of method: Flexibility, consistency and coherence. Qualitative Research, 3, 345–357.

Houghton, C., Casey, D., Shaw, D. & Murphy, K. (2013). Rigour in qualitative case-study research. *Nurse researcher*, *20*(4), 12-17.

Inoue, M., Tsukano, K., Muraoka, M., Kaneko, F. & Okamura, H. (2006). Psychological impact of verbal abuse and violence by patients on nurses working in psychiatric departments. *Psychiatry and Clinical Neurosciences, 60*(1), 29–36.

Jameton, A. (1993). Dilemmas of moral distress: moral responsibility and nursing practice. *AWHONN's clinical issues in perinatal and women's health nursing*, *4*(4), 542-551.

Johnson, S., Wood, S., Paul, M., Osborn, D. P., Wearn, E., Lloyd-Evans, B., ... & Hundt, G. (2011). *Inpatient mental health staff morale: a national investigation.* Final report. NIHR Service Delivery and Organisation programme.

Joseph, S. & Wood, A. (2010). Assessment of positive functioning in clinical psychology: Theoretical and practical issues. *Clinical psychology review*, *30*(7), 830-838.

Koenig, T., & Spano, R. (2006). Professional hope in working with older adults. *Journal of Sociology & Social Welfare*, *33* (2), 25-44.

Kinniburgh, K. J., Blaustein, M., Spinazzola, J. & Van der Kolk, B. A. (2017). Attachment, Self-Regulation, and Competency: A comprehensive intervention framework for children with complex trauma. *Psychiatric annals*, *35*(5), 424-430.

Koch T (1994) Establishing rigour in qualitative research: the decision trail. *Journal of Advanced Nursing. 19*(5), 976-986.

Kvale, S. (1996). Interviews: An Introduction to Qualitative Research Interviewing. Thousand Oaks, CA: Sage Publications.

Leiner, D. J. (2017). Our research's breadth lives on convenience samples. A case study of the online respondent pool "SoSci Panel". *SCM Studies in Communication and Media*, *5*(4), 367-396.

Lincoln, Y, S. & Guba, E, G. (1985). *Naturalistic Inquiry*. London: Sage Publications. DOI: 10.1111/j.1365-2648.1991.tb01689.x

Linton, M. J., Dieppe, P. & Medina-Lara, A. (2016). Review of 99 self-report measures for assessing well-being in adults: exploring dimensions of well-being and developments over time. *BMJ open*, *6*(7), e010641.

Littlewood, S., Case, P., Gater, R., & Lindsey, C. (2003). Recruitment, retention, satisfaction and stress in child and adolescent psychiatrists. *Psychiatric Bulletin*, *27*(2), 61-67.

Lizano, E. L., & Barak, M. E. M. (2012). Workplace demands and resources as antecedents of job burnout among public child welfare workers: A longitudinal study. *Children and Youth Services Review*, *34*(9), 1769-1776.

Lynch, M. F., Ryan, R. W. & Plant, R. M. (2005). Psychological needs and threat to safety: implications for staff and patients in a psychiatric hospital for youth. *Professional Psychology, Research and Practice*, *36*(4), 415–425.

Lyons, E., & Coyle, A. (Eds.). (2016). *Analysing qualitative data in psychology*. London: Sage Publications.

Maben, J. (2016) What is the impact of staff wellbeing on performance and patient experience? [Online lecture] Retrieved from: https://www.kingsfund.org.uk/audio-video/jill-maben-impact-staff-wellbeing-patient-experience

Madill, A., Jordan, A. & Shirley, C. (2000). Objectivity and reliability in qualitative analysis: Realist, contextualist and radical constructionist epistemologies. *British journal of psychology*, *91*(1), 1-20.

Malterud, K. (2001). Qualitative research: standards, challenges, and guidelines. *The lancet*, *358*(9280), 483-488.

March on Stress. (2019) *Trauma Risk Management (TriM).* Retrieved from: http://www.marchonstress.com/page/p/trim

Mason, B. (1993) Towards positions of safe uncertainty. *Human Systems: The Journal of Systemic Consultation & Management, 4,* 189-200.

Matthews, H., & Williamson, I. (2016). Caught between compassion and control: exploring the challenges associated with inpatient adolescent mental healthcare in an independent hospital. *Journal of advanced nursing*, *72*(5), 1042-1053.

Maxwell, J. A. (2012). *Qualitative Research Design. An Interactive Approach. Applied Social Research Methods Series,* (Vol. 41). London: Sage Publications.

McLean, S., Wade, T. D. & Encel, J. S. (2003). The contribution of therapist beliefs to psychological distress in therapists: An investigation of vicarious traumatization, burnout and symptoms of avoidance and intrusion. *Behavioural and Cognitive Psychotherapy*, *31*(4), 417-428.

McLeod, J. (2001) *Qualitative Research in Counselling and Psychotherapy.* London: Sage

McCoyd, J. L. M. & Kerson, T. S. (2006). Conducting Intensive Interviews Using Email: A Serendipitous Comparative Opportunity. *Qualitative Social Work, 5*(3), 389–406.

McDowell, I. (2010). Measures of self-perceived well-being. *Journal of psychosomatic research*, *69*(1), 69-79.

McGregor, I. & Little, B. R. (1998). Personal projects, happiness, and meaning: on doing well and being yourself. *Journal of personality and social psychology, 74*(2), 494-512.

Mendenhall, A. N., Grube, W., & Jung, E. (2019). Implementing strengths model for youth in community mental health: Impact on case managers' professional quality of life. *Children and Youth Services Review, 102,* 1-6.

Methley, A. M., Campbell, S., Chew-Graham, C., McNally, R., & Cheraghi-Sohi, S. (2014). PICO, PICOS and SPIDER: a comparison study of specificity and sensitivity in three search tools for qualitative systematic reviews. *BMC health services research, 14*(1), 579.

Morse, G., Salyers, M. P., Rollins, A. L., Monroe-DeVita, M., & Pfahler, C. (2012). Burnout in mental health services: A review of the problem and its remediation. *Administration and Policy in Mental Health and Mental Health Services Research, 39*(5), 341-352.

Musto L., Schreiber R. (2012) Doing the best I can do: Moral Distress in Adolescent Mental Health Nursing. *Issues in Mental Health Nursing, 33,* 137-144.

National Institute for Health and Care Excellence. (2009). *Mental wellbeing at work* (Public Health Guideline PH22). Retrieved from: www.nice.org.uk/guidance/ph22

Neff, K. D. & Germer, C. (2017). Self-Compassion and Psychological Wellbeing. In: Seppälä, E. M., Simon-Thomas, E., Brown, S. L., Worline, M. C., Cameron, C. D. & Doty, J. R. (Eds.) (2017) *Oxford Handbook of Compassion Science,* (pp. 371-386). New York: Oxford University Press.

Newman, G. F., Maggott, C., & Alexander, D. G. (2015). Group drumming as a burnout prevention initiative among staff members at a child and adolescent mental health care facility. *South African Journal of Psychology, 45*(4), 439-451.

NHS Employers. (2018) *New NHS Health and Wellbeing Framework*. Retrieved from: https://www.nhsemployers.org/-/media/Employers/Publications/Health-and-wellbeing/NHS-Workforce-HWB-Framework_updated-July-18.pdf

NHS England (2017) *NHS staff health & wellbeing: CQUIN 2017-19 Indicator 1 Implementation Support.* Retrieved from: https://www.england.nhs.uk/wp-content/uploads/2018/05/staff-health-wellbeing-cquin-2017-19-implementation-support.pdf

Nightingale, D., & Cromby, J. (1999). *Social constructionist psychology: A critical analysis of theory and practice*. Buckingham: Open University Press.

Nijman, H., Bowers, L., Oud, N., & Jansen, G. (2005). Psychiatric nurses' experiences with inpatient aggression. *Aggressive behavior*, *31*(3), 217-227.

Oates, J. (2018). What keeps nurses happy? Implications for workforce well-being strategies. *Nursing Management*, *25*(1), 35-41.

Onyett, S. (2011). Revisiting job satisfaction and burnout in community mental health teams. *Journal of Mental Health*, *20*(2), 198-209.

Page, M. & Parker, C. (2015) National Minimum Standards for Psychiatric Intensive Care Units for Young People. (1st ed.) National Association of PICU Executive.

Paris, M., & Hoge, M. A. (2010). Burnout in the mental health workforce: A review. *The journal of behavioral health services & research*, *37*(4), 519-528.

Parkes, K. R. & Von Rabenau, C. (1993). Work characteristics and well-being among psychiatric health-care staff. *Journal of Community & Applied Social Psychology*, *3*(4), 243-259.

Pawl, J. (2006). Being held in another's mind. *Concepts for Care: 20 Essays on Infant/Toddler Development and Learning*, 1-4.

Pekurinen, V., Willman, L., Virtanen, M., Kivimäki, M., Vahtera, J. & Välimäki, M. (2017). Patient aggression and the wellbeing of nurses: a cross-sectional survey study in psychiatric and non-psychiatric settings. *International journal of environmental research and public health*, *14*(10), Article 1245.

Permuth-Wey, J. & Borenstein, A. R. (2009). Financial remuneration for clinical and behavioral research participation: ethical and practical considerations. *Annals of epidemiology*, *19*(4), 280-285.

Perry, B. D. (2006). Fear and learning: Trauma-related factors in the adult education process. *New Directions for Adult and Continuing Education*, *110*, 21.

Pickhardt, C. E. (2009). Rebel with a cause: Rebellion in adolescence. *Psychology Today*. Retrieved from: https://www. psychologytoday.com/us/blog/surviving-your-childsadolescence/200912/rebel-cause-rebellion-in-adolescence.

Pines, A., & Maslach, C. (1978). Characteristics of staff burnout in mental health settings. *Psychiatric services*, *29*(4), 233-237.

Ponterotto, J.G. (2005). Qualitative research in counselling psychology: a primer on research paradigms and philosophy of science. *Journal of Counselling Psychology*, *52*, 126-136.

Public Health England. (2016) *Interventions to prevent burnout in high risk individuals: evidence review.* (PHE publications gateway number: 2015709). London: Crown.

Public Health England. (2019) *Guidance. Health matters: health and work.* Retrieved from: https://www.gov.uk/government/publications/health-matters-health-and-work/health-matters-health-and-work

Reber, A. (1995). *Dictionary of psychology* (2nd ed.). Harmonsworth: Penguin.

Reid, B. (1991). Developing and documenting a qualitative methodology. *Journal of Advanced Nursing*, *16*(5), 544-551. DOI: 10.1111/j.1365-2648.1991.tb01689.x

Robinson, P. & Lowe, J. (2015). Literature reviews vs systematic reviews. *Australian and New Zealand journal of public health*, *39*(2), 103-103.

Romppanen, J. & Laitila, A. (2017) Interventions for nurses' well-being at work: a quantitative systematic review. *Journal of Advanced Nursing, 73*(7), 1555–1569.

Roulston, K. (2001). Data analysis and 'theorizing as ideology'. *Qualitative Research, 1*(3), 279-302.

Rousseau, V. & Aubé, C. (2010). Social support at work and affective commitment to the organization: The moderating effect of job resource adequacy and ambient conditions. *The Journal of social psychology*, *150*(4), 321-340.

Ryan, R. M. & Deci, E. L. (2000). Intrinsic and extrinsic motivations: Classic definitions and new directions. *Contemporary educational psychology*, *25*(1), 54-67.

Ryan, R. M., & Deci, E. L. (2001). On happiness and human potentials: A review of research on hedonic and eudaimonic well-being. *Annual review of psychology*, *52*(1), 141-166.

Ryff, C.D. (1989) Happiness is everything, or is it? Explorations on the meaning of psychological well-being, *Journal of Personality and Social Psychology*, 57 (6), 1069-1081.

Ryff, C. D. & Keyes, C. L. M. (1995). The structure of psychological well-being revisited. *Journal of personality and social psychology*, *69*(4), 719-727.

Sacco, T. L., Ciurzynski, S. M., Harvey, M. E. & Ingersoll, G. L. (2015). Compassion satisfaction and compassion fatigue among critical care nurses. *Critical care nurse*, *35*(4), 32-42.

Sandelowski, M., Docherty, S., & Emden, C. (1997). Focus on qualitative methods Qualitative metasynthesis: issues and techniques. *Research in nursing and health*, *20*, 365-372.

Scotland, J. (2012). Exploring the philosophical underpinnings of research: relating ontology and epistemology to the methodology and methods of the scientific, interpretive, and critical research paradigms. *English Language Teaching*, *5*, 9-16.

Scott, L. N., Stepp, S. D. & Pilkonis, P. A. (2014). Prospective associations between features of borderline personality disorder, emotion dysregulation, and aggression. *Personality Disorders: Theory, Research, and Treatment*, *5*(3), 278-288.

Seligman, M. E. (2004). *Authentic happiness: Using the new positive psychology to realize your potential for lasting fulfillment*. London: Nicholas Brealey Publishing.

Seligman, M. E. (2012). *Flourish: A visionary new understanding of happiness and well-being*. New York: Simon and Schuster.

Shanock, L. R., & Eisenberger, R. (2006). When supervisors feel supported: Relationships with subordinates' perceived supervisor support, perceived organizational support, and performance. *Journal of Applied psychology*, *91*(3), 689.

Sizmur, S. & Raleigh, V. (2018). *The risks to care quality and staff wellbeing of an NHS system under pressure.* The King's Fund: Oxford.

Smith, J.A., & Osborn, M. (2007). Interpretive phenomenological analysis. In Smith, J. (Ed.), *Qualitative psychology: a practical guide to research methods* (pp. 53-80). London, UK: Sage Publications.

Sørgaard, K. W., Ryan, P., Hill, R., & Dawson, I. (2007). Sources of stress and burnout in acute psychiatric care: inpatient vs. community staff. *Social Psychiatry and Psychiatric Epidemiology*, *42*(10), 794-802.

Stainton Rogers, W. & Stainton Rogers, R (1997) Does critical psychology mean the end of the world? In: Ibanez, T. & Iniguez, L. (Eds) (1997) *Critical Social Psychology*.(pp. 67-82) London: Sage Publications.

Sweeney, A., Clement, S., Filson, B. & Kennedy, A. (2016). Trauma-informed mental healthcare in the UK: what is it and how can we further its development?. *Mental Health Review Journal*. *21*(3), 174-192

Swensen, S., Kabcenell, A. & Shanafelt, T. (2016). Physician-organization collaboration reduces physician burnout and promotes engagement: The Mayo Clinic experience. *Journal of Healthcare Management*, *61*(2), 105-127.

Thomsen, S., Arnetz, B., Nolan, P., Soares, J. & Dallender, J. (1999). Individual and organizational well-being in psychiatric nursing: a cross-cultural study. *Journal of Advanced Nursing*, *30*(3), 749-757.

Totman, J., Hundt, G. L., Wearn, E., Paul, M., & Johnson, S. (2011). Factors affecting staff morale on inpatient mental health wards in England: a qualitative investigation. *BMC psychiatry*, *11*(1), 1-10.

Treisman, K. (2018). *Becoming a more culturally, adversity, and trauma-informed, infused, and responsive organisation.* Winston Churchill Fellowship Report.

Trzpuc, S. J., Wendt, K. A., Heitzman, S. C., Skemp, S., Thomas, D. & Dahl, R. (2016). Does space matter? An exploratory study for a child–adolescent mental health inpatient unit. *HERD: Health Environments Research & Design Journal*, *10*(1), 23-44.

Van der Kolk, B. A., Roth, S., Pelcovitz, D., Sunday, S., & Spinazzola, J. (2005). Disorders of extreme stress: The empirical foundation of a complex adaptation to

trauma. *Journal of Traumatic Stress: Official Publication of the International Society for Traumatic Stress Studies*, *18*(5), 389-399.

Waterman, A. S. (1984). *The psychology of individualism*. New York: Praeger.

Wellbeing. (2014). In: *Oxford English Dictionary*, 3rd ed. [online] Oxford: Oxford University Press. Retrieved from: http://www.oed.com/view/Entry/227050?redirectedFrom=wellbeing&

Willig, C. (2013). *Introducing qualitative research in psychology*. (3rd Edition) Berkshire: McGraw-Hill Education, Open University Press.

Yanos, P. & Ziedonis, D. (2006). The patient-oriented clinician-researcher: advantages and challenges of being a double agent. *Psychiatric Services, 57,* 249-253.

Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology and Health, 15,* 215-228.

Zarea, K., Fereidooni-Moghadam, M., Baraz, S. & Tahery, N. (2018). Challenges encountered by nurses working in acute psychiatric wards: A qualitative study in Iran. *Issues in mental health nursing*, *39*(3), 244-250.

Appendices

Appendix A: HRA ethics approval (IRAS)

NHS
Health Research Authority

Miss Leanne Hunt
[redacted]

Email: hra.approval@nhs.net

16 April 2018

Dear Miss Hunt

Letter of HRA Approval

Study title:	**Child and Adolescent Mental Health Inpatient staff perspectives on their well-being and support needs.**
IRAS project ID:	**224021**
REC reference:	**18/HRA/2136**
Sponsor	**University of Essex**

I am pleased to confirm that **HRA Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further from the HRA.

How should I continue to work with participating NHS organisations in England?
You should now provide a copy of this letter to all participating NHS organisations in England, as well as any documentation that has been updated as a result of the assessment.

The HRA has determined that participating NHS organisations in England **will not** be required to formally confirm capacity and capability before you may commence research activity at site. As such, you may commence the research at each organisation 35 days following sponsor provision to the site of the local information pack, so long as:

- You have contacted participating NHS organisations (see below for details)
- The NHS organisation has not provided a reason as to why they cannot participate
- The NHS organisation has not requested additional time to confirm.

You may start the research prior to the above deadline if the site positively confirms that the research may proceed.

If not already done so, you should now provide the local information pack for your study to your participating NHS organisations. A current list of R&D contacts is accessible at the NHS RD Forum website and these contacts MUST be used for this purpose. After entering your IRAS ID you will be able to access a password protected document (password: **Spring24**). The password is updated on a monthly basis so please obtain the relevant contact information as soon as possible; please do not hesitate to contact me should you encounter any issues.

Appendix B: University of Essex research ethics approval

University of Essex

03 May 2018

MISS LEANNE HUNT
[redacted]

Dear Leanne,

Re: Ethical Approval Application (Ref 17034)

Further to your application for ethical approval, please find enclosed a copy of your application which has now been approved by the School Ethics Representative on behalf of the Faculty Ethics Committee.

Yours sincerely,

[redacted]
Ethics Administrator
School of Health and Social Care

cc. Research Governance and Planning Manager, REO
Supervisor

Colchester Campus
Wivenhoe Park
Colchester CO4 3SQ
United Kingdom

School of Health and Social Care
T 01206 872854
E hsc@essex.ac.uk

www.essex.ac.uk
@Uni_of_Essex /uniofessex /uniofessex

Appendix C: Recruitment Poster

Would you like to share your experiences of working in CAMHS?

…and be in with a chance to win high street vouchers worth £20!

Child and Adolescent Mental Health services (CAMHS) can often be very challenging and stressful places to work due to the complex and intensive, unique nature of this field, and the difficulties young people bring. I am carrying out some research looking at how staff in inpatient CAMHS manage their own well-being, how they look after themselves, and their views on how best the organisation can support staff well-being.

I am inviting members of staff working in CAMHS inpatient wards to be interviewed about their experiences and views, for approximately one hour.

If you might be interested in taking part, or would like more information about this project, please email **Leanne Hunt** on **lh16838@essex.ac.uk**. There is no obligation to take part in the research, even if you email.

If you might be interested in taking part, I will arrange a time to meet with you to talk about the project before the interviews take place, at a convenient time and place.

Thank you for taking the time to read this.

Appendix D: Participant Information Sheet

Participant information Sheet

Please read this information carefully before deciding to take part in this research. If you are happy to participate, you will be asked to sign a consent form.

Study Title:
Child and Adolescent Mental Health Inpatient staff perspectives on their well-being and support needs.

What is the research about?
The research will form part of a Clinical Psychology Doctoral Thesis within the University of Essex. I am interested in staff well-being and views on support whether offered or sought by staff, including what might help to encourage uptake of this support.

Why have I been chosen?
All clinical staff working in Children and Adolescent psychiatric inpatient units across Essex Partnership University NHS Foundation Trust have been given a poster presentation inviting them to take part in the study.

Do I have to take part?
There is no obligation to take part in this research.

What will happen to me if I take part?
You will be invited to attend an individual interview at a location of you choosing, either local NHS building, or the University of Essex. You will be asked a series of questions relating to the research topics. The interview will take up to 1 hour of your time and will be digitally audiotaped.

Will my results be kept confidential?
All information gathered from the interviews will be kept confidential. All information will be kept securely and your employing organisation will not have any access to your individual responses. Whilst every effort will be taken to protect your anonymity, there is a risk you may still be identifiable due to the nature of your responses. I will transcribe the audio recordings. As I transcribe, I'll anonymise any identifying details, such as your name. All digital files will be saved on a password-protected computer at University of Essex and all paper documents will be stored in a locked drawer at my office at the University of Essex, to which only the researcher and supervisor will have access. The data collected during the study may be looked at by individuals other than the research team, such as members of the university, NHS Trusts or regulatory bodies.

Are there any benefits to taking part?
If you decide to take part you have the option of being entered into a prize draw to win one of three high street vouchers of £20 each. If you wish to be entered into the draw, you will need to give your email address at the end of the study, this will be kept separately to your interview data and there will be no way of linking your email address to your answers.

Are there any risks involved?
There will be questions around your current well-being and you might talk about situations which have been traumatising or very difficult for you. You may find these distressing and if so, you are advised to contact your GP, your Occupational Health Team or a Clinical Psychologist in the team you work in. There are also services such as Samaritans whom you can contact. If you feel unable to answer a question, you may ask to skip it and move on to the next. If you make any disclosures relating to risk or safeguarding concerns, this information will be shared with the Ward Manager and Trust Safeguarding Lead.

What happens when the research study stops?
All responses will be kept anonymous, however, they will be written up by the researcher as part of a Doctorate in Clinical Psychology thesis. It may also be written up for publication in an academic journal. Whilst every effort will be taken to ensure your responses are anonymous, there is a risk you may still be identifiable through the nature of what you discuss. The data collected in the study will be kept for a maximum of 3 years, and then will be destroyed.

Can I withdraw from the study after I've been interviewed?
You can withdraw from the study at any time. If you decided to withdraw, at any point, you can contact the researcher. Anonymised data already provided will be kept and used within the study write-up. As soon as you have withdrawn, I will not contact you any further.

Will I be able to see the results of the study?
If you would like to see a summary of the results, these will be available from July 2019. You can contact Leanne Hunt (lh16838@essex.ac.uk) to obtain these. I will also be arranging to present the findings within the units at a future date. Details of this will be circulated within the team.

Concerns and complaints
If you have any concerns about any aspect of the study or you have a complaint, in the first instance please contact the principal investigator of the project (see contact details below). If are still concerned or you think your complaint has not been addressed to your satisfaction, please contact the research supervisor (see below). If you remain unhappy and wish to complain formally, you can do this by contacting Sarah Manning-Press, the Research Governance and Planning Manager, Research Office, University of Essex, Wivenhoe Park, Colchester, CO4 3SQ, by emailing: sarahm@essex.ac.uk.

Who should I contact if I want further information about the study?

Researcher:
Leanne Hunt
lh16838@essex.ac.uk

Supervisor:
Dr Frances Blumenfeld
fblume@essex.ac.uk

Appendix E: Consent form

Participant Consent Form

Title of the project: Child and Adolescent Mental Health Inpatient staff perspectives on their well-being and support needs.

Name of researcher: Leanne Hunt (Trainee Clinical Psychologist) *Please initial*:

I confirm that I have read and understood the information sheet dated [23/01/18] (Version 1) for the above research project. ☐

I have had the chance to ask questions about the above research project and these have been answered satisfactorily. ☐

I understand that my participation is voluntary and that I am free to withdraw from the research at any time without needing to provide a reason. Data already provided will be kept and used within the study write-up. ☐

I understand that participation in the prize draw is optional. If I wish to take part, my email address will be kept separately from my data so there will be no way of linking my responses to my email address. ☐

I understand that information collected about me during participation in this study will be stored on password protected computer and this information will only be used for the purpose of this study, in accordance with the Data Protection Act (1998). My interview data will be anonymised during the transcribing process, and stored for up to 3 years by the University of Essex. ☐

I understand every effort will be taken to ensure my responses are anonymous, but there is a risk I may still be identifiable through verbatim quotes within research findings. ☐

I understand that the information I provide in my interview will be treated confidentially except in instances where risk or safeguarding issues are identified. This would then be discussed with the relevant professionals as per the Trust Safeguarding and Risk Management Policies. ☐

I understand that the data collected during the study may be looked at by individuals other than the research team, such as members of the university, NHS Trusts or regulatory bodies. I give permission for these individuals to have access to my anonymised data. ☐

I agree to take part in this research project and agree for my data to be used for the purpose of this study.

Name of participant	Date	Signature
Name of person taking consent	Date	Signature

Appendix F: Interview Topic Guide

Research Interview Topic Guide

1) Interview Introduction (following consent)

a. Outline **purpose** of the interview.
b. Describe how interview **data will be stored** and what it will be used for
c. Inform study participant of how **anonymity and confidentiality** will be protected, but indicate that some responses may make them personally identifiable.
d. Check that individual is still **happy to participate**. If not, terminate interview.

2) Demographics and introduction

a. Gather information and develop rapport
i. Reasons for participating
ii. Age:
iii. Gender:
iv. Position:
v. Length of time in current role:
vi. Previous work settings and length of time in these roles:

3) Area 1. Experience of CAMHS

- E.g. "Can you tell me what it is like to work in a CAMHS unit?"

Prompts

- Positives and difficulties of CAMHS working
- Comparison to other settings
- Examples that illustrate this
- Sense of responsibility
- Impacts on relationships
- Organisational change

4) Area 2. Well-being

- E.g. "How are you at the moment, in terms of your well-being?"

Prompts

- Things to unwind/switch off
- What impacts well-being
- Content/stressed
- Any different out of work
- Examples to illustrate
- Effect on lifestyle - diet/sleep pattern/alcohol
- Lunch breaks or coming in to work unwell
- Working relationships/relatedness
- Modelled by others
- Looking after yourself/topping up your resources
- Self-endorsed goals

5) Area 3. Views on support

- E.g. "Do you feel supported?"

Prompts

- Feeling valued and/or appreciated
- Told you are doing a good job
- Support availability
- Access/attending support in and/or out of work
- Reflective group

6) Area 4. Intervention

- E.g. “What do you think would be helpful to staff in managing stress and improving well-being?”

Prompts

- Unit/Organisation/Individuals
- Work environment
- Ways to encourage staff to access/attend support e.g. reflective group
- Any other support

7) Area 5. Comments and Ending

- E.g. “Is there anything else I haven’t asked you about that you feel is important about staff well-being, self-compassion or support needs?”
- Check participant is happy with information provided
- Opportunity to ask questions about the research
- Discuss dissemination and feeding back findings

Appendix G: Example extract of coded transcript

INTERVIEW 2
"NEIL"
[56:13]

LH: So, to start with, erm, I'm just interested in your reasoning for participating. What's brought you to the interview today?

NEIL: Erm, obviously I think support at work is, erm, key to a good functioning team and providing good care. Erm, I think obviously care for the patients is important but support, erm, for staff is equally as important, potentially more so, to provide that care 'cause we go- we experience a lot of, erm, trauma and difficulties and stresses from the patient side which can then sort of, you can become kind of- absorb later on and then it can, kind of, emerge sort of unbeknown to us sometimes and take us off-guard which can affect our ability to then take on those situations and support people properly. Erm, and I think, erm [interruption -door opens and staff member requests keys off participant] staff support can be a bit overlooked at times, it's kind of left- like if the ward is busy then, erm, that's sort of pushed under the carpet 'cause obviously patient care takes priority. [unintelligible] Erm, th- that sort of standpoint and level.

LH: Okay.

NEIL: Erm, so sometimes we get sort of *left*, so I think- I thought it was quite a positive to, sort of, raise those sort of viewpoints and give some, sort of, feedback to how it is on an inpatient unit and staffing and stuff like that yeah.

LH: Yeah. Okay, thank you. And when you say prioritise do you mean, as in, patient's needs are prioritised over staff needs?

NEIL: I think potentially, at times it does sort of sway that way. I think, obviously we're- staff are there to support patients ultimately when you're on shift. But, obviously, erm, we need the support as well. But if it's a high activity level or busy, erm, or there's a lot of unfamiliar staff or staff which aren't as confident, then you might take those roles on more so, which then potentially will lead to burnout or more stresses for yourself. To then continue on to the next day and do it again. So yeah.

LH: Yeah. Okay. Can I get some, sort of, information about you. So how old are you?

NEIL: 33

LH: And what position are you in the unit?

NEIL: [redacted].

LH: How long have you been [redacted] for?

NEIL: [redacted]

LH: Okay, so about 6 months, 7 months?

NEIL: 7 months, yeah.

LH: and, before that, what were you or where were you?

NEIL: [redacted]

LH: Okay, and how long was that [crosstalk]

NEIL: For 5 years

LH: And prior to that were you in a different setting or- ?

NEIL: erm, prior to that yeah I worked [redacted] and that was- I did that for 5 years as well.

LH: and was that as like a support worker or-?

P1: Yes.

LH: Okay. And have you worked in any other settings? Sort of other mental health settings or CAMHS?

NEIL: I haven't, no.

LH: Okay. Erm, so, thinking about CAMHS inpatient unit, erm, can you tell me a bit about what it's like to work in the unit?

NEIL: Erm, well, from the offset, every day is very different. Erm, the dynamics of the ward change, erm, daily, but also within minutes, depending on, erm, different patient interactions and how well-

LH: Mm-hmm.

NEIL: - they got on with each other or-or how supportive they are of each other. Obviously, they've got their own, erm, issues to work through, with their treatments and therapies, erm, and then, you've got the different staff mix and staff balance, erm, depending on what- who's leading the shift and how experienced they are, to whether we've got student nurses leading the shift or newly qualified, or sometimes agency or bank qualified, and that goes the same with support staff as well. Erm, so a real mixed bag of, erm, how that team dynamic, in general, will work for that shift, 'cause you have to be really dynamic in, sort of, erm, gauging everyone's strengths and weaknesses- and trying to work with the best you've got.

LH: Mm-hmm.

NEIL: Erm, I think that goes with everywhere, but I think, with adolescent, it's, erm, the dynamic changes a lot more quickly. Erm, and obviously, we- the age range we have, anywhere from, sort of, 13 to 18. Erm, you might get a really mature 13-year old, but you might get a really, sort of, erm, very different 18-year old, or vice versa, and you got all that in between with, erm, their, sort of, social status, erm, their hormones, their mental health issues, their family dynamics and them trying to potentially create friendships on the unit-

LH: Hmm.

NEIL: - with staff and with their peers.

LH: Mm-hmm.

NEIL: Erm, so, it can be, it- it's- it can be a very positive place, erm, but also, obviously, we, erm, work with patients closely, and-and, sort of, erm, support them through very difficult, erm, family situations, or situations they've gone through or mental health, erm, episodes, erm, they might be really struggling with at the time. Erm, which-which does take a lot of energy. Erm, but I think, erm, a lot of staff who come to work on, erm, adolescent inpatient, sort of, erm, have that in mind.

LH: Mm-hmm.

NEIL: Erm, and, ~~are~~, sort of, you just have to go. You have to run as soon as you, sort of, land and go with it.Erm and, sort of, be very, erm, fluid in how your approach can be, because, erm, everyone can be, erm, sort of, even affected or sort of erm, offended, erm, by the way of your approach and stuff. So you have to be quite aware at all times of how you sort of come across.

LH: Yeah.

NEIL: And especially being a male member of staff a-a lot of the patients-- We do have a-a female, erm, so, erm, not saying that female staff have-have that, don't sort of, erm, think about it, but obviously, we have risk of, sort of, allegations.

LH: Mm-hmm.

NEIL: If we're working closely one-to-one with a female patient who may have had history, erm, of abuse or, erm, known, sort of, history, of allegations, erm, we just have to be extra cautious that we're not sort of leaving ourself, erm, a sort of, a route for that. Erm, but, we--It's-it's it can be a very positive place, 'cause we see, sort of, the changes of, erm, patients and them progressing and moving on, and some of them, erm, have recently come back. Now, they're adult and giving talks-

LH: Oh, okay.

NEIL: - about where they are. Erm, patients and like, erm, sort of, when we first opened, so, like, sort of, four years ago, four, five years ago-

LH: Huh.

NEIL: - they've come back and some of them are at Uni, erm, or just finishing Uni, erm, and, are sort of, erm, quite a role model too that- they can actually, although their education might be delayed while they're on the inpatient unit, that actually, there is support available outside and here.

LH: Yeah.

NEIL: And that they should really if they can, and if they feel like, they really grasp it, erm, and go with it, because they can, sort of, get a normality back, and, be successful-

LH: Yeah.

NEIL: - erm, on discharge, and to look towards the future and, sort of, obviously, they've got that- those period where they've been here, but it doesn't necessarily define them. And I think when we get patients coming back and sort of, reiterating that, that can give a lot of momentum to patients here, but also to staff, as a reminder that actually, erm, it can get better.

LH: Yeah.

NEIL: And that's kind of why we're here, and a lot of people do the job, because, erm, on an adolescent unit they've still got their future, their whole future ahead, erm, and if we can support them or give them, erm, like an element or a seed to-to, sort of, think about and go with after they leave here, erm, we've done our job.

LH: Hmm.

NEIL: Erm, and we don't necessarily hear what- what happens next, which-

LH: Yeah.

NEIL: - I think, some staff feel like we'd like that, erm, because it would give us even more, positive momentum to go with. Erm, but they, sort of, go- leave the unit and we don't really hear-

LH: Yeah.

NEIL: - what goes on. But kind of, that

s a lot of people's mindset about why we work here, erm, sometimes you can see yourself within them, like some of their attributes, or the way they're thinking about education and stuff like that, and, erm, like, we can- we can give them advice and stuff like that.

LH: Yeah.

NEIL: And with their therapy, and stuff we can hopefully, support them to a positive future.

LH: Yeah. Do you think that, erm, staff finds that uncertainty difficult, of when, erm, patients leave the unit?

NEIL: I think so because a lot- a lot of them go-- erm, a lot of patients are from out of area as well, so, they go into inpatient units that we don't necessarily have much knowledge about.

LH: Yeah.

NEIL: Erm, and some have to be transferred quite far away. We recently had one, erm who went back to [county], and, erm, another one from [county]. They're really far away. So, in terms of their family engagement, and, or even friends visiting, erm, to support them, it's really hard for them. They're very isolated while they're here.

LH: Hmm.

NEIL: Erm, but even locally, erm, the uncertainty of whether they'll get a bed or proper support when they get discharged or transferred, is very much unknown, and for us, that's quite- raises our anxiety, but for them it must be tenfold as well-

LH: Yeah.

NEIL: - because they're on their *own*. Erm, they've got to go try and make new friends, and learn a new team, erm, and that just adds even more pressure and stress to the already complicated complex-

LH: Hmm.

NEIL: - like thoughts, and, erm, therapies they're going through at the moment.

LH: Yeah. Erm, what is your sense of responsibility working here?

NEIL: So, erm, obviously, day to day care of the patients.

LH: Yeah.

NEIL: Making sure that their, erm, that their physical obs are okay.

LH: Yeah.

NEIL: Erm, if they're feeling unwell, making sure their diet and fluids are good.

LH: Yeah.

NEIL: Erm--

LH: And do you feel, like, do you have the- a feeling of responsibility for the patients or--?

NEIL: As-as a pa- as a permanent member of staff, erm, I've been here, erm, I think, about six years in total, I do feel there is some, erm, I do have some, sort of, bearing and, sort of, responsibility on making sure that they are, sort of, erm, done and patients are looked after in a-

Appendix H: Reflective diary excerpt

Interview 4

Before the interview I felt a little taken back and wondered what it would be like :- will we have enough time? - participant had said "I can spare 30 mins". Is this a reflection of the pressure the service is under, or conveying something else? I wonder what meaning is placed on my ~~presence~~ presence in the unit or research more generally. During the interview, although my confidence had been increasing from my first 3 interviews, I found this one somewhat awkward at times. It felt as though the interview was poorly timed in terms of the context of job losses/competition for jobs happening currently in the organisation. I perceived participant to be very open with responses, but at times somewhat defensive. I wondered if this was due to that context or whether the style of my questioning provoked this. I experienced myself as leading at times and remember catching this a couple of times during the interview. I do feel we developed rapport through the interview. The pace felt faster than the previous interviews, perhaps & just a result of the discussions, or perhaps I was unconsciously moving through questions or not following up as much as a reaction to the comment made about time limit to spare at the start from participant. Interesting to challenge my assumptions (possibly) that well-being would be low, as participant reported to be fine, and illustrated this with examples. Felt a helpful interview.

Things it brought up for me to consider:- What stops people accessing support when they have "no excuses"? How can this be changed/resolved? Is there disparity between the experiences of "us" & "them" → MDT + Nursing staff?

Was helpful to hear experience of a staff member who also runs groups to help other staff.

Appendix I: Example of data extraction spreadsheet

	Method	Analysis	Findings	Conclusions	Limitations	Reported	Additionally identified by me	Was there a clear statement of the aims of the research?	Is a qualitative methodology appropriate?	Was the research design appropriate to address the aims of the research?	Was the recruitment strategy appropriate to the aims of the research?	Was the data collected in a way that addressed the research issue?	Has the relationship between researcher and participants been adequately considered?	Have ethical issues been taken into consideration?	Was the data analysis sufficiently rigorous?	Is there a clear statement of findings?	How valuable is the research?
Attrition (with reasons)	Design (e.g. cross-sectional)	Method of data collection (e.g. focus															
n/a	Qualitative - semistructured interviews	Conceptual qualitative analysis	Staff experience, frustrations, learning & development	(1) presenting difficulties; (2) complexity within the clinical environment; (3) tensions; (4) nursing interventions; (5) frustrations; (6) staff experience; (7) learning and development.	There is significant emotional labour generated from the detailed and intense relationally-focused work with young people. This is responsible for both a sense of value and job satisfaction, and corrosion of staff capacity to sustain these interventions over the longer term. It was also found that projective identification has a central role in both enabling nursing staff receptiveness to young people's needs and in engendering distress in staff.	Not discussed	Is this representative? How were participants chosen for the group? Does not mention participant demographics	Yes	Yes	Yes	Doesn't detail enough	Yes	No	Only approval statement	Yes	Yes	Good - also done wider study.
n/a	Qualitative - semistructured interviews	IPA	Dominant themes - risk of isolation, meaningful contact, openness, safety, control & structure, staff relationships, and complex task.		The work is valuable but challenging. Challenges include negotiating relationships with management, other staff & YP while in a complex work environement. Suggest individual and group supervision for staff and opportunity to reflect as well as training & debriefing.	Mostly nurses recruited possibly skewed towards their perspective. Self-report problematic, although interviews have advantages. Observations and/or speaking to YP may have been useful. Defensive strategies in	Lack of diversity (at least it reports those demographics though)	Yes - and rationale outlined	Yes	Yes	Yes	Yes	No	Only approval statement	Yes	Yes	Implement locally, suggestions for future research using mixed methods
	Quantitative - survey design	Postal questionnaires (2 types)	Lower satisfaction rates among females. Staffing numbers fewer than recommended.child psychiatry guidance. Majority felt service is inadequately resourced Similar numbers said generally satisfied as said they suffer from work-related stress(65%). See Maslach burnout results too. (TABLE 2.)	Future recruitment into the speciility will not be sufficient to fill the posts. Relationship between perceived adequacy of service resources and job satisfactin, stress, psych distress and emotianoli exhaustion. Importance of close supportive colleague in the field, CCAPs withouh this more likely to be dissatisfied, time off with presssure, EE, ditress &regret career.	Self-report measures. Opportunity to determine whether those who participated differed from those who did not was sacrificed by commitment to anonymity.											
	Multi-method	Diaries & fu															

Appendix J: HRA ethics amendment approval

IRAS Project ID 224021. HRA Approval for the Amendment

hra.approval@nhs.net <noreply@harp.org.uk>
Mon 27/01/2020 10:37
To: Hunt, Leanne S <lh16838@essex.ac.uk>; Manning-Press, Sarah E L <sarahm@essex.ac.uk>

Dear Miss Hunt,

IRAS Project ID:	224021
Short Study Title:	Inpatient CAMHS staff well-being and support needs. (Version number 1)
Amendment No./Sponsor Ref:	
Amendment Date:	05 December 2019
Amendment Type:	Substantial Non-CTIMP

I am pleased to confirm **HRA and HCRW Approval** for the above referenced amendment.

You should implement this amendment at NHS organisations in England and Wales, in line with the conditions outlined in your categorisation email.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/.

Please contact [hra.amendments@nhs.net]hra.amendments@nhs.net for any queries relating to the assessment of this amendment.

Kind Regards

[redacted]

Health Research Authority
Ground Floor | Skipton House | 80 London Road | London | SE1 6LH
E.hra.amendments@nhs.net
W. www.hra.nhs.uk