Who is allocated to psychoanalytic psychotherapy in a Tier 3 CAMHS setting?

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Abstract

At a time when Child and Adolescent Mental Health services are seeing unprecedented demand (Look Ahead, 2023), the question of which patient needs which intervention has becoming increasingly important to understand. Linked to this is whether the clinicians responsible for making these decisions are consistent across the different disciplines that work together. This qualitative study aimed to explore the clinicians' understanding of 'Who is allocated to psychoanalytic psychotherapy' in a Tier 3 CAMHS service, and whether a patient profile could be developed for patients deemed appropriate for psychotherapy. Data was collected through 5 semi-structure interviews with clinicians from various health care backgrounds, all working in the same multi-disciplinary team (MDT). Thematic analysis was used to identify common themes in the data. Six main themes emerged: (1) Preliminary patient characteristics, (2) Going deep, (3) One size does not fit all, (4) Team process, (5) Clinical intuition versus guidelines, (6) Issues of disagreement. The findings highlighted some consistent characteristics of those allocated to psychotherapy, including internalizing patients, who had suffered complex forms of relational trauma and were understood to need a new kind of relationship with the therapist to work these through. Despite these, several clinicians stated they were unsure what treatment with psychotherapy was and would like to know more. The findings also identified factors beyond the patient themselves including team dynamics and, notably, the influence of resource pressures on the decision-making process. These findings have implications for understanding how the MDT functions in the current economic climate of CAMHS, and the need for a more coherent narrative on what psychotherapy is to enhance clinician confidence on allocating to this intervention.

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Introduction to research project

What is psychoanalytic psychotherapy? If one were asking five clinicians, we might get five quite different answers, with each perhaps focusing on a different but relevant aspect of the discipline. The different understandings of psychoanalytic psychotherapy, and by extension who should receive it as an intervention, became increasingly striking to me as I progressed through the child and adolescent psychotherapy training at my clinic between 2019-2023. During this time, I began to develop a more cohesive idea of what psychoanalytic psychotherapy *is* in my own mind, which further reinforced the perception that others' views differed quite significantly. What psychoanalytic psychotherapy *is,* and who it is *for* did not appear to be something that was necessarily agreed upon between clinicians who had worked within my Child and Adolescent Mental Health Service (CAMHS) for several years or more, suggesting that understanding was not necessarily something that improved the longer one worked in CAMHS services. The relative understanding of psychoanalytic psychotherapy and who it is appropriate for not only has clear implications for the service in which I work, but is also relevant to the wider understanding of the discipline and its contribution to child and adolescent mental health, particularly at a time where demand is ever increasing, (Health and Social Care Committee, 2021) and thus the question of who needs what is of particular importance. This is why I have chosen to explore the question, 'Who is allocated to psychoanalytic psychotherapy in a Tier 3 CAMHS setting' and whether a 'patient profile' can be developed for psychotherapy patients.

Literature review

This section will explore the relevant literature on psychotherapy allocation, aiming to provide both a background to the topic and justification for the research itself. First the review methodology will be outlined, including databases searched, terms used, and techniques employed. A brief clarification of a working understanding of *psychoanalytic psychotherapy* treatment for the purposes of this study is then necessary before reviewing the current empirical research on which patients *are* allocated to psychotherapy in contemporary Child and Adolescent Mental Heath Services (CAMHS). This section will look at both the clinicians' perspectives, but also consider the research on the demographics and characteristics of patients being offered psychotherapy. This section will conclude by stating how the proposed research can be understood and justified in the context of the literature explored and linked together in this review, whilst also remembering that a literature review aims to "provide an argument, not a library" (Rudestam & Newton, 1992, p.49). The review will then aim to provide an in-depth background to psychotherapy. This will include a brief section on the origins and developments of Psychoanalysis (the forerunner of psychoanalytic psychotherapy) and who it has been able to help. Bringing the reader to the present day it will then consider what the empirical research recommends in terms of who psychotherapy works for, before moving on to reflect on whether the relevant research is fully considered in the official NHS guidelines. This will include looking at the National Institute for Health and Care Excellence (or NICE) guidelines, which recommend treatment options for National Health Service (NHS) patients. It is important to include this background as it will allow contextualisation of the research findings in relation to the factors in psychotherapy allocation, and how the current

literature and present research project can be understood in relation to both what the evidence base recommends and what NICE guidelines recommend.

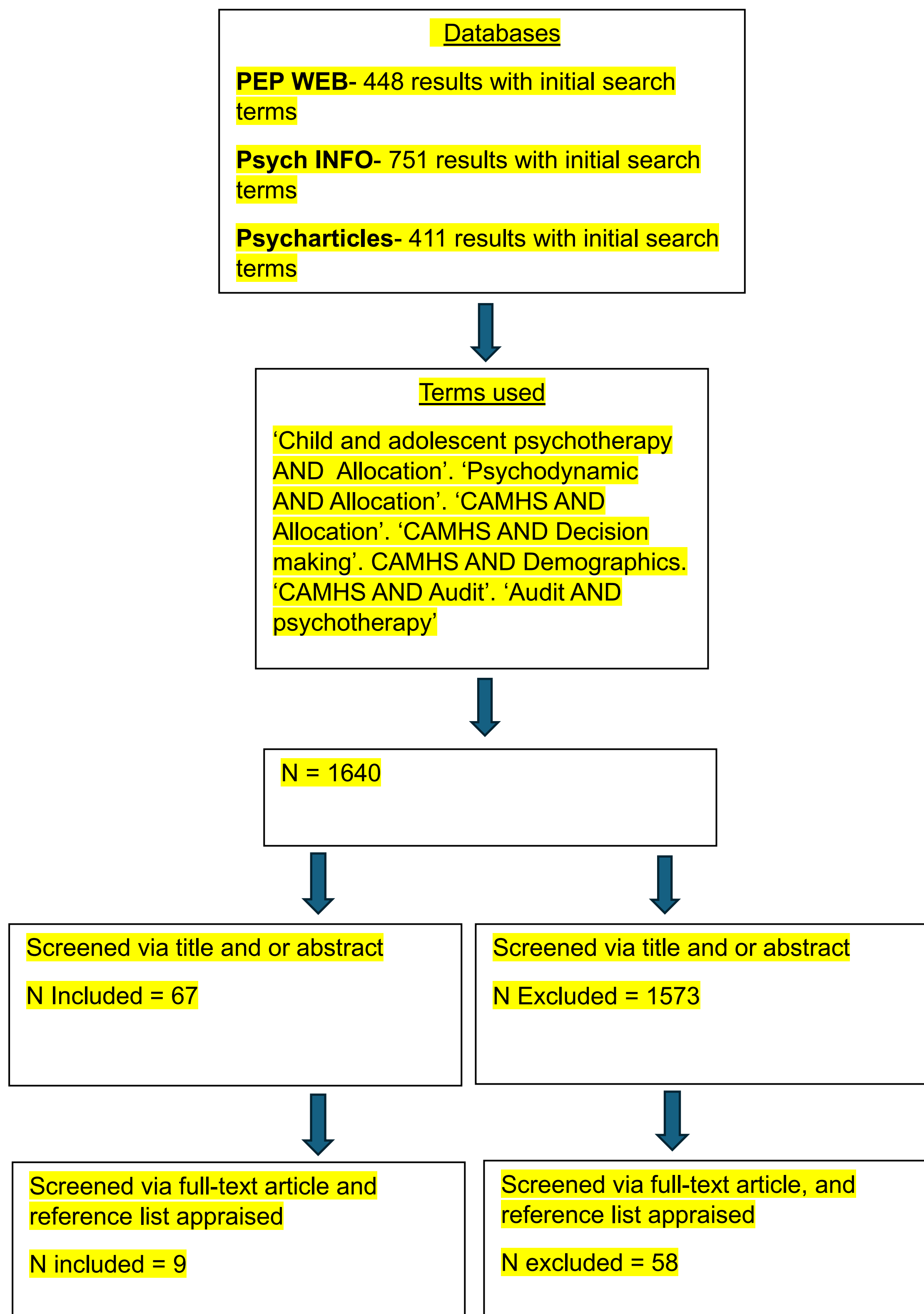
Literature review methodology

Three databases were chosen in an attempt to minimise selection bias and gain a substantive picture of the literature. The databases that were selected for the preliminary search included more general psychological databases, namely *Psych Info, PsychArticles*, in addition to a database that focused more specifically on psychoanalytic literature: *PEP-web*. Some of the initial terms used included: child and adolescent psychotherapy, CAMHS, allocation, decision-making, audit, and the search was not limited to a specific time frame. These terms were used in various iterations by utilising Boolean operators. An example of the way Boolean operators were employed includes searching for terms in the following format, 'CAMHS AND Allocation', which would ensure that citations containing both of these terms would be made available from each data-base.

The snowballing technique (Sayers, 2007) was then used to identify papers that were relevant but not picked up with the terms used on the databases, either because they were not on the databases used, or were not identified by the researcher's choice of terms. There were several studies in the preliminary stage of the literature search which were of a similar nature to the one being undertaken, (for example Curen, 2017). These were not only similar but also relatively contemporary, so their reference lists were also appraised for new sources of literature. A more detailed picture of the systematic review process is outlined below in figure 1 taking the literature on psychotherapy allocation specifically as an example:

Figure 1

Prisma for psychotherapy allocation literature search



As one can see from the Prisma diagram, there were not a significant number of articles found on allocation and psychotherapy that were relevant to this project. Considering this, articles were not excluded because of questions over the rigour of their methods. Instead, given the limited number of articles, it was possible to include those that had data on who received psychotherapy in the United Kingdom, and the strengths and limitations of their methodologies were critiqued. This will be referenced within the main body of the literature review. Articles were included where there was either some descriptive or demographic categorisation of who is seen for psychoanalytic psychotherapy, both in CAMHS and private practice, and solely within the United Kingdom, with no specific time limit in terms of publication date.

Regarding the National Institute for Health Care Excellent (NICE) guidelines which form part of the literature review, the recommendations for all mental health concerns addressed at the clinic in question were considered, including anxiety and depression. In addition, other categories which might be addressed in other levels of CAMHS, such as bi-polar disorder were included. The decision was made to include mental health issues which are not necessarily treated in the clinic that this project focus' on, because it was important to obtain a picture as full as possible about potential recommendations for who would benefit most from psychotherapy.

Finally, in reviewing the evidence base, systematic reviews were analysed to give a broad picture of who benefits from psychotherapy, as the constraints of time and space with this project did not afford the possibility of critically analysing all individual studies. The earliest and most contemporary systematic reviews were analysed in detail, as not only were their methods reliable and valid, but it also afforded a view of how the research had developed across time, to better understand which mental

health problems had a greater developing body of evidence regarding the benefits of psychotherapy, and which did not.

Understanding psychoanalytic psychotherapy

Terminology

Psychoanalysis is a term which is used to describe therapy undertaken with patients which was psychoanalytic in its theoretical approach and involved seeing patients up to five times per week and was typically open-ended time wise. The term *psychoanalytic psychotherapy* is a more contemporary concept which refers to using much of the same theory but with less frequency (typically once, but up to three times per week) in treatment that can be both open ended and time limited. The terms are sometimes used inter-changeably, but from this point onwards, the term *psychoanalytic psychotherapy* (often shortened to *psychotherapy*) will be used as this is what is the form most commonly offered in present day CAMHS. When referring to psychoanalytic psychotherapy the working definition will be a therapeutic intervention which: “focuses on the psychological roots of emotional suffering. Its hallmarks are self-reflection and self-examination, and the use of the relationship between therapist and patient as a window into problematic relationship patterns in the patient’s life” (Shedler, 2010, p.98). Often, particularly in the empirical literature, ‘psychodynamic psychotherapy’ is used to reference *psychoanalytic psychotherapy* and other interventions that have a similar focus on self-reflection, the roots of suffering, and the relationship between the therapist and patient. So whilst the term *psychoanalytic psychotherapy* will be used in this project, this review will also search and review research literature which has used the term *psychodynamic*

psychotherapy, as the findings from this slightly broader category of approaches are also pertinent.

Training as a Child and adolescent psychoanalytic psychotherapist

To work as a Child and adolescent psychoanalytic psychotherapist within the NHS one must completed a two-year pre-clinical course, followed by a four-year doctoral level clinical training. The latter part involves a four-year NHS placement funded by Health Education England (Association of Child Psychotherapists, 2023a). This training is the only specialist mental health training that focuses exclusively on work with the patients aged 0-25 years old and their families. Within the public sector, child psychotherapist work in a multi-disciplinary team within the NHS and other publics services, and are considered one of the twelve psychological professions within the NHS (Association of Child Psychotherapists, 2023a).

Who is allocated psychoanalytic psychotherapy in CAMHS?

The research into who is referred to psychoanalytic psychotherapy in CAMHS is limited at present, but the research that does exist can be broadly divided into three categories. The first is audits of the profession, often taking the form of surveys which ask members of the Association of Child Psychotherapy (ACP) about their perceptions and experience. The second is audits which focus on one service specifically. Often the original purpose of the audit is of the psychotherapy provision itself rather than specifically of patient allocation, but the research is still helpful in attempting to establish if there are some consistent characteristics of children and young people receiving psychotherapy. The third form of research is that which aims to explore patient allocation to psychotherapy in a deliberate and focused way. This often uses a combined approach, supplementing an audit of patient demographics

with semi-structured interviews designed to gain a deeper, richer, and more nuanced insight into which patients are receiving psychotherapy. This research often considers more than just the psychotherapists' views, including the different clinical disciplines who are typically part of the multidisciplinary CAMHS team. This review will now turn to first consider each group of audits and what it can contribute to an overall picture of psychotherapy patients.

National Audits

The question of who is referred to psychotherapy was first addressed by Beedell and Payne (1987). Citing a gap in the literature regarding who Child psychotherapists saw in the NHS, Beedell, and Payne (1987) conducted a survey in 'Making a case for psychotherapy'. This survey was focused on ACP accredited child and adolescent psychotherapists, the majority of whom were working in NHS settings. Out of 875 eligible members, 215 responded to the survey. The findings include that 75% of children worked with were considered to be either 'severely or very severely ill', and that a high proportion of cases were perceived to be referred to psychotherapy because of prior un-responsiveness to other treatments. Nearly sixteen years later Rance's (2003) survey with ACP member had 4365 responses and found that over a third of children and adolescents seen had the involvement of social care, in addition to finding that the number of looked after children seen had risen since the Beedell and Payne audit (by 2003 15.6% lived with foster carers, 9% with adoptive parents in 2003, compared to 4% and 1% respectively in 1987). Both these studies represent the broadest brush stroke of auditing where members of the ACP are canvassed for their views, but they start to build a picture of quite a complex

patient demographic for psychotherapy cases, at least in the views of those seeing them for psychotherapy. However, there are few of these wide scale audits and none found in the literature search that are from the last five years. Those that there are increasingly focus on specific populations, such as Robinson, Luyten and Midgley (2017), which focuses on psychotherapist activities with looked after children (LAC). An additional consideration is that these surveys relied on the reports of psychotherapists themselves, for example with the Beedell and Payne audit (1987), the respondents' views of what constitutes 'severely, or 'very severely Ill' is not deconstructed. The terms are not only vague, but also subjective to the responding psychotherapists and their perceptions of the patient population in 1987 and 2003 respectively, which may differ significantly to the patient population in 2022.

Service specific audits

Since 1987 the audits that are service specific have steadily increased and are often used as part of an initiative to understand and improve the service provision. Within these audits, demographic data of those who are allocated to psychotherapy is included to help contextualise the main research question. For example' Baruch & Vrouva (2010) studied data on routine outcome measures at the Brandon Centre, a referral and self-referral community psychoanalytic psychotherapy service in innerLondon for ages 12-25 (this changed to 12-21 whilst the study was being carried out). Within this study they recorded the demographics of young people who attended psychotherapy between 1993-2008 (1608 patients). Of those that attended psychotherapy, the mean age was 18.5, 71.6 % were female, 26 % were from ethnic minority backgrounds (slightly higher than national average, but not necessarily higher for the locality area). Regarding diagnosis, 52.8 % were diagnosed with

depressive disorders, 25.4 % neurotic, stress-related or somatoform disorders, the next two highest percentages were for hyperkinetic disorder or personality disorders, both of which were 6.2 %. The other patients were made up of small percentages of different disorders, with those who had psychosis / a developmental disorder (which were grouped together in their analysis) only representing 1.2 % of the patients seen. In terms of the family situation the majority lived with biological parents and 41.2% had an 'intact family structure' compared to just 2.7 % who were in residential, fostered or adoptive care. This is significantly lower than the average found by Rance (2003) when surveying ACP members nationally. In this audit the female population, depressed / neurotic patients are heavily represented suggesting a potential preference for these groups to be seen for psychotherapy at least within this service. Whilst these audits are a helpful tool to begin to understand who might be allocated to psychotherapy, they are limited to categorisation by diagnosis alone, and so reveal less about the nuance of decision making in the MDT allocation, for instance why one depressed patient might be offered psychotherapy, whilst another could be offered cognitive behavioural therapy (CBT).

Combined audit and interviews

In comparison to research solely utilising audits, there are studies which have combined both an audit *and* semi-structured interview approach, to provide a deeper, richer picture of the patients allocated to psychotherapy. Again, much of this research has tended to focus on the implementation and outcomes of psychotherapy, rather than which patients are allocated to it, though the data is still helpful in trying to understand who is allocated. One such study was carried out at the Fulham and

Hammersmith CAMHS service in 2012 (Pretorius & Karni-Sharon, 2012), and repeated in 2018, (Pretorius et al., 2018). This review will focus on the 2018 audit as the most up to date and therefore most relevant to the present day CAMHS context. This research was an audit of the CAMHS service provided at Randolph Beresford Early years centre, established in 2008. The aim of the research was to evaluate parents' and caregivers' perceptions of progress made towards treatment goals as well as the perceptions of the psychotherapists delivering the treatment. This was achieved using Goal Based Outcome Measures, alongside 8 semi-structured interviews with care givers, and 10 with child and adolescent psychotherapists. Thematic analysis was used to systematically analyse and summarise these views. The pertinent aspect for this review is that the various characteristics of patients referred for psychotherapy were recorded over a 20-month period from September 2011 to April 2013. In total, 10 diagnoses / risk factors were identified and developed by the psychotherapist and consultant child psychotherapist at Hammersmith and Fulham CAMHS. Pretorius et al. (2018) found that of those referred to psychotherapy during this time 58 were boys and 35 were girls. In terms of their characteristics, 34.6 % had experienced a personal frightening experience in childhood, 31.8 % suffered from emotional neglect, 19.3 % experienced disruption from family separation or divorce, and 33 % had a parent involved with domestic violence. Additionally, 33.1 % were under a Child in Need or Child Protection Plan. A theme that emerges in this research, is the prevalence of a complicated and damaging family experience from a young age (taking into account that this is an early year's unit) in those who received psychotherapy. However, the audit does not make it clear how many young people were in multiple categories, so it is hard to

know for example if the majority of the children who suffered from emotional neglect were *also* those with a personal frightening experience in childhood.

Overall, this audit suggests that those referred for psychotherapy in this setting, were likely to have suffered some form of trauma related to the family environment. In addition to this the non-white population was also significantly overrepresented: 53.8 were either mixed race, Black-African or Black Caribbean, compared to 17.2 % being white British. This shows a significantly higher referral rate for the non-white British population. Without statistics on referrals by race to other interventions it is hard to draw conclusions in relation to race and psychotherapy specifically within this service. However, it does raise questions about the possible influence of race on this and perhaps other services regarding the factor it plays in influencing rate of referral, and which groups may be over or under-represented in different trusts and clinics.

Pretorius et al. (2018) acknowledge that the particular setting of inner London, with a specific local population, and only one psychotherapist interviewed make it hard to generalise the results with confidence. It is also worth noting that being an early years unit, the population was limited primarily to these under the age of 5, meaning that the findings are also *age* specific.

If one compares this audit to Baruch and Vrouva, (2010) they can see that some of the findings are quite different. In Baruch and Vrouva (2010) it was girls who are significantly over-represented rather than boys, as is the case in Pretorius et al. (2018). Equally, ethnic minorities were over-represented in the Pretorius et al. audit (2018), but not to nearly the same extent in Baruch and Vrouva's (2010) study. However, in trying to compare the two audits a problem becomes apparent, namely that the audits frame the mental health problems and contexts with different criteria.

Where Baruch and Vrouva (2010) are explicit about the diagnosis, Pretorius et al. (2018) focuses more on broader descriptions of 'experiences of emotional neglect'. In addition, the audits pertain to very different age groups, further complicating a comparison between them. Ultimately it would be helpful to have the diagnoses *and* the broader descriptions of the family environment within the same study, but the differing focus and terminology used in each audit makes it hard to synthesise. Combined audits such as Pretorius et al. (2018) do raise the issue of terminology when describing a patient's needs and context, and whether the more diagnostic terminology is employed or more descriptive detail is used, this will be something to re-visit when carrying out the present research project, and needs further consideration in the discussion section.

Research focusing specifically on psychotherapy allocation

The literature that focuses' specifically on who is allocated to psychotherapy is quite limited. The few studies that exist take the forms already outlined above, either being audits of patient demographics, including their histories within the CAMHS service, or a combination of this kind of audit, supplemented by semi-structured interviews with clinicians. This said, those that do exist, are both in-depth and robust in their methods, and they will now be reviewed. Kam (2004) carried out an audit of an inner London service with the specific aim of finding out 'Who is referred for Child psychotherapy and why?'. Kam (2004) found that out of the 220 children who were referred for psychotherapy (*and* started receiving it) they had on average, been seen by 3.7 clinicians, and been held under CAMHS for three years prior to being seen by a psychotherapist. This may suggest that psychotherapy was offered to young people for whom several other interventions had been tried with different clinicians

over a succession of years, and that psychotherapy may be considered to be effective for treatment resistant cases (Lanyado & Horne, 2009). Whilst one needs to balance the 'three years under CAMHS' statistic with the knowledge that wait lists for treatment can be long (Look Ahead, 2023), this figure still seems to support the idea that psychotherapy is for those for whom other treatments have not proved sufficient. Further to this, the most common issues were: school problems (especially behavioural), persistent fears/anxiety, and aggression. Additionally, many of the young people in psychotherapy had highly complex family background issues, with incidence of parental mental illness, suicide, and family breakdown relatively high. This is in line with the Pretorius et al. (2018) audit, and with the findings of the Beedell and Payne survey (1987). Taken together the limited research thus far can enable one to tentatively build a picture which matches the often-cited anecdotal evidence from psychotherapists themselves, that they see those who are severely disturbed, often as a result of trauma relating to the family environment. However, it must also be acknowledged that this could also be a trend experienced in other disciplines owing to the increasing complexity of cases seen in CAMHS settings (Child Outcomes Research Consortium, 2014).

Beyond the characteristics of the patients themselves, Kam (2004) found that there were factors within the team which could also influence referral independent of the patient's needs. For example, certain clinicians tended to refer to psychotherapy frequently (social workers), whilst other individuals, (Asian counsellors who were part of the Asian counselling service within this team) almost never referred children for psychotherapy. This suggests that there are two factors that could influence which young people are referred for psychotherapy. The first is the aforementioned patient characteristics - the nature and severity of the mental health struggles they

experience - the second is factors within the team, which clinicians might refer more than others, or how might the presence of some clinicians in the decision-making process influence the likelihood of a child being offered psychotherapy.

Curen (2017) conducted further research addressing the specific question of who is referred for psychotherapy, but this study focused on the adolescent population in CAMHS who had been referred for *intensive* psychotherapy (most commonly 3 times per week). The research was comprised of an audit of those who had intensive psychotherapy from January 2009-December-2012. The second part of the study involved observations of the multi-disciplinary team process when considering patients for intensive psychotherapy, and interviews with clinicians responsible for making these decisions, although the interviews were only undertaken with psychotherapists. There were thirteen young women and four young men identified in this audit with an average age of 18.47 (the service was offered up to the age of 25). There was a slightly lower percentage of 24 % from ethnic minority backgrounds compared to the 34 % average in the local area. The most common presenting problems were depression, anxiety and relationship problems (14/17 patients), and suicidal ideation (9/17 patients). By contrast only three were reported to have problems with violence. Overall, the patients averaged 6.5 presenting problems. Only one patient had had no previous treatment, and thirteen had some psychiatric input. Beyond general diagnosis, clinicians recommended the young people for intensive psychotherapy who had a combination of severe, long-standing concerns around areas such as “considerable personality difficulties…a high degree of isolation, somatisation, poor self-image… previously recommended intensive treatment…(risk of) psychiatric breakdown, refusal to enter inpatient treatment…acting out (sexual

acting out, self-harm and suicidal ideation)” (Curen, 2017, p.60). In addition, it was noted that there was often considerable disturbance within the family and 60 % had parents with poor mental health. The results of the audit present a picture that is becoming familiar within the literature, of a patient with complex, severe, long standing mental health problems including internalizing disorders such as depression, anxiety, suicidality, and a high level of comorbidity often linked to early experiences within challenging family environments. A key insight In Curen’s (2017) summary of the audit was the contrast between a high degree of outward stability (such as consistency in living arrangements, and school attendance) which contrasted with an inward complexity in the patient. Perhaps this was particularly important for Intensive work as attendance is so frequent there usually needs to be a high level of family support to maintain it.

The second part of Curen’s study found that clinicians referred young people to intensive psychotherapy when there was a developmental trauma or impasse in the young adult, meaning that something was stopping them from being able to move into adulthood. Decisions were also made based on whether the young person showed that they could develop an interest in their predicament during the assessment process and whether they would be adequately supported to attend sessions. This shows how consideration of the patient’s mental health challenges might interact with the treatment was a core factor in decision making about whether psychotherapy was the right match on this basis. There were also considerations particularly specific to offering intensive work, including whether a higher frequency of sessions was needed to either provide more containment, or to address deeply rooted resistances in the patient. Analogous to the Kam (2004) study, analysis of interviews also revealed that team dynamics played a decisive role. In Curen’s study

(2017) this included how different professions respond to working in a group to begin with, as well as more practical concerns like service capacity, and the latter had not been found in previous studies. The limitation of this study is the focus on an intervention very rarely offered within the NHS nationally, and therefore the findings are only relevant to a very small minority of patients. In addition, data is collected from the psychotherapists only, and so again a limited view of the allocation process is captured, by those who could be viewed as having a vested interest in the reflecting on the process in a positive way.

Despite being chronologically earlier, Kam & Midgley's study 'Exploring Clinical Judgement' (2006) is included at the closing stages of this literature review as it most closely resembles the present research project. This study focused on how the decision is made to allocate a young patient to once weekly psychotherapy in an inner-London multi-disciplinary CAMHS team. Five participants were interviewed across multiple disciplines and levels of seniority using semi-structured interviews. The participants included: psychiatrist / manager of service, psychologist, family therapist, social worker, Asian service counsellor (part of the Asian counselling service). The interviews were analysed using Interpretative Phenomenological Analysis. Efforts to assure reliability and validity included triangulation in the analysis process, peer review, audit trail and the use of rich examples to evidence the themes presented.

The first main theme focused on the perceptions of psychotherapy as 'precious'. For some this meant that it was a luxury resource that was able to go deeper than other interventions. Psychotherapy was perceived to slowly help to add meaning to seemingly meaningless behaviour. Others felt that there was a sort of rigidity and

mystery to psychotherapeutic methods and that at times psychotherapists could present interpretations as truth rather than hypothesis. It was reported that both views had implications for how likely clinicians would be to refer based on these perceptions of the modality approach rather than just the patient's needs. The role of team dynamics echoes the findings of Kam (2004) and Curen (2017). The second theme focused on what the clinicians would recognize as a psychotherapy case. Clinicians asserted that the psychotherapy patients tended not to fit into diagnostic categories, but in describing these patients' reference was made to those who are "beyond the norm", or "don't fit in the same boat as other children" (Kam & Midgley, 2006, p. 36). Clinicians' feelings were key here and it was often patients who made clinicians feel uncomfortable as well as those who showed age-inappropriate behaviour, had suffered extensive trauma, or needed help verbalizing, but who also were very invested in their internal fantasy lives, who were considered appropriate for psychotherapy. The final theme centred on the young person's journey and timeline in CAMHS. There was an idea that the patient needed to be ready for psychotherapy, to be somewhat in control. This often necessitated that they had received other interventions first which might include some stabilisation work around the family. Often it was those who were re-referred who would be considered for psychotherapy. Again, the feelings of the clinicians were key. When thinking about referring there was an idea that their own feelings of being stuck or confused in their work with a patient could mean that it might be the right time for psychotherapy. Overall, the study appeared to find that when considering a referral for psychotherapy the factors that were pertinent were not fixed diagnostic criteria, but were more transient and one can imagine that these factors would be likely to differ from clinic to clinic. The study explored how the clinicians' perceptions of

psychotherapy could interact with the presentation of the child, and their CAMHS history in deciding whether they were ready for psychotherapy, and that their personal feelings about the case could play a decisive role.

What does become clear when reviewing clinicians' decision-making processes, is that in reality the factors considered were far subtler than simply patient diagnoses. These factors include both the finer detail of patient presentation, where phrases like *internalizing and externalizing*, *persistent fears* and *complex family history* are frequently used by clinicians. There are also what Kam & Midgley termed "local, context specific factors" (2006, p.41) such as team dynamics within a service, and patterns of allocation based on clinician discipline and perceptions of psychotherapy were also seen as important, a factor which has not been highlighted in the other existing literature.

In summary, the current research indicates some tentative conclusions drawn about who is offered psychotherapy. There is a pattern across the literature that it tends to be those who have been through other interventions first, are likely to have challenging family circumstances, multiple diagnoses, and be presenting in a way that is confusing, disturbing and cannot be wholly explained by the diagnosis-led criteria. The fact that children and young people recommended for psychotherapy do not fit neatly into guideline categories could perhaps in part be explained by the emphasis in approach in some of the research, which clearly values the use of clinical judgement, evidenced in research designs that are based on working alongside psychotherapists to investigate their clinical practice and build knowledge about making appropriate referrals. The use of the clinicians' feelings was referred to by more than one study and as Kam & Midgley (2006) highlighted, it is possible that

guidelines are out of sync with locally based contextual factors, such as perceptions of psychotherapy. This use by clinicians of their feelings is likely to vary between services and is not a factor that can be easily defined or quantified; this factor also suggests that the answer to the question of ‘Who is allocated to psychoanalytic psychotherapy’ is more complex than a simple set of stipulations about evidence based effectiveness that all clinicians and services can adhere to.

Rationale for this research project

Though there are a significant number of audits which record demographics, these do not do justice to the depth and complexity of the patient, particularly because as Kam & Midgley (2006) note, clinicians do not tend to refer to diagnostic criteria when making their decisions about allocation to treatment. Furthermore, the literature that does address the specific question of ‘who is allocated to psychotherapy’, is either focused on the rarely used intensive work, or is from a period during which resourcing and the structure of CAMHS looked considerably different to the contemporary context. Additionally, the literature has tended to focus on specific age groups, most frequently, adolescents, meaning the findings are agegroup specific. Whilst some tentative conclusions have been drawn about characteristics that might indicate a young person is ready or appropriate for psychotherapy, the literature has also shown that those offered psychotherapy can differ from service to service. Taking this into consideration, more research is needed both on a national level and from individual services, so that these tentative conclusions can be reinforced or disapproved. Therefore, the present research project will focus on a Tier three CAMHS service outside of London in the South East of the UK, which offers interventions to a broad age group from 5-18. It will use semistructured interviews to

explore ‘Who is allocated to psychoanalytic psychotherapy’, and whether a patient profile can be built. This is with the aim of both expanding the literature that already exists on the topic, and to help develop and improve the service within which the research is taking place. Before exploring the methodological process undertaken to achieve this aim, this literature review will briefly outline: the origins of psychoanalytic psychotherapy, the current evidence base, and the NICE Guidelines, all of which are integral to provide a context in which one can make sense of who is allocated and why.

Background

Origins and development of psychoanalysis

Psychoanalysis is generally understood to have begun with the publishing of ‘Studies of Hysteria’ in which Sigmund Freud reflected on Joseph Breuer’s treatment of Bertha Pappenheim (S. Freud & Breuer, 1957). In this reference is made to how what was dubbed the ‘talking cure’ (including multiple sessions per week with a patient) could relieve hysterical symptoms, which Freud contended at the time were related to repressed memories of a sexual nature. His theories developed to consider more broadly how intra-psychic conflict caused anxiety which in turn could lead to the inhibition of mental functions such as speech and intellect. Perhaps the most fundamental of Freud’s developments in the theory of psychoanalysis, and one still in wide-spread use today, is the concept of transference. Freud came to understand that patients *transferred* feelings and relational dynamics from their past onto their therapist, and it was through the therapist’s understanding and bringing of these to the patient’s conscious awareness that progress could be made in relation to whatever the patient may be suffering from in the present (S.Freud, 1920).

Furthering Freud’s work with adults, Anna Freud and Melanie Klein developed psychoanalysis for children beginning in the 1920’s and 1930’s. Klein developed what she called ‘the play technique’ for helping to understand the unconscious of children through interpreting their play (Klein, 1955). This was also something pioneered by Anna Freud and elaborated in ‘An Introduction to the Technique of Child Analysis’ (A. Freud, 1974). From this point on, during the 1960’s, there was what could be considered a proliferation in psychoanalysis, both its theory and practitioners, and importantly, also a proliferation of those for whom it was reported to be effective. The psychoanalytic technique was also shown to be helpful in treating those with psychosis by several psychoanalysts including Bion (Bion, 1962). Other psychoanalytic pioneers practiced and wrote about the effectiveness for those who had come from families in which they had been deprived of adequate parenting (Winnicott, 2018) and to help patients with Autism (Tustin, 1966). This trend continued whereby the use to which psychoanalysis could be put was continually expanded for different patient populations. By the time one reaches the 21st Century, there are few mental health issues that have not been shown to be responsive to Psychoanalysis, including such complex mental health issues as dissociative identity disorder (Kluft, 2000). Indeed, when the ACP describes who psychoanalytic psychotherapy might work for, the range of difficulties includes concerns around the following: sleeping, feeding, aggressive outbursts, problems with peer relationships, oppositional behaviour, eating disorders, depression, anxiety, lack of confidence, look after or adopted children, learning difficulties, disabilities, long-term or chronic illness, those that have suffered neglect or abuse (Association of Child

Psychotherapists, 2023b). The point to be made, is that psychoanalytic thinking had, by the 21st century, been designated by the psychoanalysts and psychotherapists using it, as both helpful and appropriate for a vast range of mental health difficulties.

It is important to note however, that these accounts of effectiveness with patients were generally single case studies and from the Psychoanalysts themselves, focusing on very long-term work with a handful of patients, rather than the outcomes focused Randomised Controlled Trials (often seen as the gold standard in research). What needs to be addressed therefore, is not just a description of this diverse and expansive group with whom those who have historically practiced psychoanalysis consider to be appropriate for treatment, but whether there is empirical evidence to support its use with these patient populations.

Empirical Evidence for the efficacy of psychoanalytic psychotherapy with children and adolescents.

It is important for this review to include a brief section on the evidence base because it will enable the findings to be placed within this context. It will then be one of the tasks in the discussion to analyse the relationship between the evidence base, the NICE guidelines and the research findings regarding psychotherapy allocation.

In comparison to the vast theoretical literature, the empirical evidence begins to hone in on those who are more and those who are less likely to benefit from psychotherapy. Whilst the research regarding psychotherapy has been slow to develop (Midgley, 2009), the quantity and quality have increased particularly in the past twenty years, and are beginning to form a substantive evidence for the efficacy of psychotherapy (Midgley et al., 2021). During the literature search there were four key systematic reviews that were found to address this specific question: these

began with Kennedy, (2004), then Midgley & Kennedy (2011), followed by Abbass et al. (2013), and Palmer et al. (2013). The Midgley and Kennedy review (2011) was then updated to include the newly available research both in 2017, and again in 2021. A brief summary of the Abbass et al. (2013) and Palmer et al. (2013) reviews will be provided before focusing more in-depth on the Kennedy systematic review (2004), and the most recent and in-depth systemic review, that of Midgley et al. (2021). The decision to focus on these two reviews was made to provide a view of how the evidence base has progressed during this period, and with an acknowledgment of the limits of time and space within this review.

Although referred to as a systematic review, the Abbass et al. (2013) research could more accurately be described as a meta-analysis employing statistical methods to calculate an overall effect in quantitative terms. The study focused on shorter-term psychotherapy cases (40 sessions or fewer) with patients who were no older than 18. It included eleven studies with patients that suffered from a range of mental health problems including: borderline personality disorder, depression, anxiety, eating disorder, internalizing disorders, and mixed dis-orders. They found that for Short-term Psychodynamic Psychotherapy a 28 session treatment model (STPP) had positive comparable outcomes with other therapeutic modalities, but that in addition, a ‘sleeper effect’ could be discerned, meaning that change enabled through STPP was persistent after the intervention had ended. The study acknowledged the limitations in that heterogeneity was high across most analyses and that eleven studies is a small sample. As with the Abbass et al. (2013) meta-analysis, the Palmer et al. (2013) systematic review was also tentative in its findings, concluding some support for a finding that psychodynamic psychotherapy is effective with those who have both internalizing and externalizing problems. It also found

evidence for the ‘sleeper effect’, and found that behavioural problems (particularly externalizing) tended to be more resistant to the insight-orientated psychodynamic approach.

In 2004, Kennedy conducted a systematic review into the entire evidence base for child and adolescent psychotherapy up to this date. Their systematic review can be seen as demonstrating strong validity on the following basis: all thirteen bibliographic databases used were cited and searched from the entire life span of said bases; the data bases chosen were relevant to the field, and supplementary hand-searching was used for relevant journals, websites, as well as contacting key researchers. Clear inclusion and exclusion criteria were cited and justifications given for these choices making the review reproducible (Kennedy, 2004). In total this systematic review found 32 different studies, which included five randomised control trials, quasi randomized controlled trials, controlled observational studies and observation studies with no control. The proportion of randomized and quasi-randomized control studies was high (33.0%). The focus for this systematic review seemed to be more on the types of research and their quality than the more specific mental health issues that psychotherapy could effectively address. Despite this, there was evidence that psychotherapy could help with a range of difficulties. Again, it was found to be particularly effective for internalizing behaviour disorders and emotional disorders as compared to disruptive and externalizing disorders. Benefits were also seen with those suffering from depression, OCD and personalities disorders; learning difficulties and the associated emotional disturbance; Autism; those who were severely deprived and or within the care system; Anorexia Nervosa and sexually abused girls. At the time this systematic review was carried out, an important limiting issue was that a significant proportion of the evidence was from ongoing studies that

were not yet concluded, making their findings tentative. It did include examples of robust and large-scale studies such as the retrospective, naturalistic evaluation study carried out at the Anna Freud Centre (Fonagy & Target 1996). In this study 85% of the 299 children included had positive outcomes and some firm conclusions were drawn that those with emotional disorders showed more improvement that those with behavioural disorders (Target & Fonagy, 1994) . However, the evidence for other mental health issues such as depression, relied on just one ongoing study (Trowell et al., 2003). What the review does unequivocally show is that in the years 20022004, research into the effectiveness of psychotherapy was beginning to increase (Kennedy, 2004).

By 2021 the Midgley et al. systematic review (2021) found 82 distinct studies which met its inclusion criteria. Much like the Kennedy study (2004), this review was transparent in detailing the appropriate databases it searched, had clearly stated and justified inclusion criteria and, importantly, also involved multiple reviewers, and of these 82 studies, 22 were randomized controlled trials. All these factors enhanced the review's reliability and validity. The findings also supported those of the Kennedy 2004 systematic review in showing the effectiveness of psychotherapy for a vast range of mental health concerns: notably, internalizing disorders (including depression and anxiety), emerging personality disorders, and children who have experienced adversity (i.e. trauma, domestic violence, abuse). However, the quantity and quality of evidence has significantly approved by this review. To take depression as one example, there were now four multi-centred randomized control trials (Trowell, et al., 2003, ,2007,2009, 2010) which found that psychotherapy reduced depressive symptoms. To take one of the studies as illustrative, in the Trowell et al. study (2007), 75 % of participants were no longer classified as clinically depressed.

Regarding anxiety, the evidence base has also improved although the review acknowledges that of the four studies assessing the effectiveness of psychotherapy with this population only one was an RCT (Salzer et al., 2018). Although Salzer et al. (2018) did find that psychotherapy not only had comparable efficacy with CBT, but at 6 and 12 month follows ups there were lower rates of remission. Evidence was also found for psychotherapy being of help for those with eating and feeding disorders, neuro-developmental disorders, and behavioural disorders. However, the evidence for psychotherapy helping ameliorate these mental health issues , was less substantial, both in terms of the quantity of studies and the quality of methods in those studies pertaining to these groups.

Overall, there is a significant emerging evidence base for the effectiveness of child and adolescent psychotherapy with certain mental health issues. The main mental health issues which the evidence base supports are: emotional disorders including depression and anxiety, internalizing disorders, personality disorders, trauma relating to attachment difficulties with moderate support for bulimia nervosa, and anorexia nervosa. Evidence for the efficacy of psychotherapy in ameliorating externalizing and behavioural disorders is more tentative and needs further exploration. The aim of this section was not to provide an in-depth assessment of the evidence base for psychotherapy, but to provide a context in which the evidence for whom it most benefits can be contrasted with who the guidelines recommend psychotherapy for. This also sets the context for the findings of this study concerning how clinicians understand and think about who is allocated to psychotherapy treatment in contemporary CAMHS context.

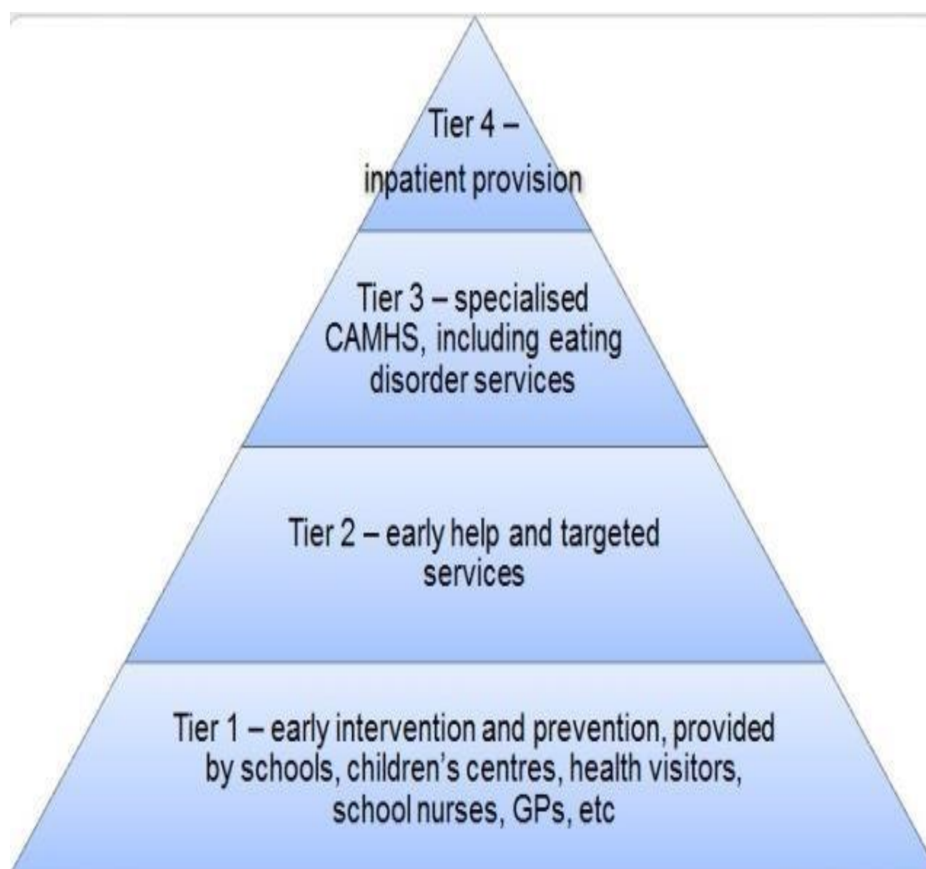
Having now considered the origins and development of Psychoanalytic psychotherapy as well as the evidence base, this review will provide some context on the present CAMHS system, and NICE guidelines which are designed to inform patient treatment decisions.

CAMHS

As it stands in 2022, Child and Adolescent Mental Health Services (CAMHS) are a branch of the National Health Service (NHS), funded from the government via commissioning groups (NHS, 2023). CAMHS follow a stepped care model which may be differently interpreted in different trusts. Some services follow a Tier model outlined in figure 2.

Figure 2

CAMHS TIER MODEL



Note. From "CAMHS Tier system". By Healthy young minds in Herts, 2023 (https://healthyyoungmindsinherts.org.uk/parents-and-carers/what-do-ifyou%E2%80%99re-worried/when-seek-professional-help/camhs-tier-systemexplained). Copyright 2023 by Healthy young minds in Herts.

However this is increasingly being replaced by the I-Thrive model first introduced in 2014 in figure 3:

Figure 3

I-THRIVE MODEL

Note. From "Child and adolescent psychotherapy & I-thrive Association of Child Psychotherapy", The Association of Child Psychotherapists, 2023. (https://childpsychotherapy.org.uk/resources-professionals/child-and-adolescentpsychotherapy-i-thrive). Copyright by 2023 The Association of Child Psychotherapists.

In the clinic for this project, which is part of the Tier 3 or ‘getting more help’ IThrive level, the presenting mental health difficulties will be moderate to severe and include

issues relating to: depressive symptoms, complex trauma, obsessive thoughts, hyperactivity, suicidal ideation and intent, severe anxiety and eating issues (CAMHS, 2018).

NICE guidelines

The National Institute for Health Care and Excellence (NICE) guidelines are designed to help make evidence-based, best practice decisions for healthcare in the UK. NICE was created in 1999 with the intention of standardising health provision across the UK and is sponsored by the Department of Health and Social Care (NICE, 2022). Its remit includes making recommendations for the appropriate mental health interventions in CAMHS for young people based on the mental health challenges they are presenting with. It is worth considering which patients the NICE guidelines recommend for children regarding psychotherapy as these guidelines are, in theory, what is used as a reference point when considering which interventions to allocate which young people to within CAMHS services.

Nice guidelines explicitly recommend Psychodynamic psychotherapy therapy as a first line treatment for 5-11 year olds suffering from moderate to severe depression (NICE, NG134, 2019). For 12-18 year olds with depression it is also recommended as a second line treatment if Cognitive Behavioural Therapy (CBT) has not been effective (NICE, NG134, 2019). ‘Adolescent Focused psychotherapy’ is recommended as a second line treatment for Anorexia Nervosa, though it is unclear whether this includes psychodynamic psychotherapy (NICE, NG69, 2017). Psychodynamic psychotherapy is not recommended regarding Anorexia bulimia or binge eating (NICE, NG69, 2017). Further, it is not recommended for Schizophrenia or Psychosis (NICE, CG155, 2013). Inter-personal therapy is one of the treatment

options for Bi-polar disorder, but psychodynamic psychotherapy is not referenced explicitly, and CBT, and family interventions are the main focus (NICE, CG185, 2014). For various forms of anxiety, psycho-education and again CBT is the recommended treatment, but there is also reference to ‘High intensity psychological therapies’ which although not particularly clear, could perhaps include psychodynamic psychotherapy (NICE, CG159, 2013). For Obsessive compulsive disorder again, CBT is the recommendation (NICE, CG31, 2005.) In terms of abuse and neglect ‘parent -infant psychotherapy’ is recommended for those under 5 (NICE, NG76, 2017), however for those aged 10-17, multi-systematic therapy is recommended with the exception of girls aged 6-14 who have been sexually abused for whom psychodynamic psychotherapy is explicitly indicated (NICE, NG76, 2017). Although those identified as having Attachment Disorders can be a group that overlap with those who have experienced abuse and neglect, parent-infant psychotherapy is recommended for under 5’s in this category, (NICE, NG26, 2015), but after this age the focus is on trauma-focused CBT, parent sensitivity training, behaviour programs and Eye Movement Desensitization Reprocessing therapy (EMDR) (NICE, NG26, 2015). Psychodynamic psychotherapy could be seen as included obliquely in relation to helping looked-after children, with the guidance that it is the local authority’s responsibility to, “Offer a range of dedicated CAMHS that are tailored to the needs of looked-after children and young people – for example, making them longer term, more trauma informed, and relationship based” (NICE, NG205, 2021, p.1). Whilst not a direct reference, the ‘trauma informed’ and especially the ‘relationship-based’ aspects of this advice could be understood that offering psychodynamic psychotherapy is indicated.

What is noticeable from these guidelines is that the focus is predominantly on CBT and pyscho-education or management strategies. Psychodynamic psychotherapy is, with a few exceptions, either a second line treatment option, not advised directly, or not included at all. This is significant in the light of the research base gathered by the systematic reviews showing efficacy across a broader range of mental health concerns than is included in NICE guidelines, for instance the internalizing emotional disorders, including issues relating to anxiety, and particularly for those who have suffered abuse, neglect and trauma from their care givers. This also contrasts somewhat with the guidance of the ACP, which cites psychoanalytic psychotherapy as being helpful for a far greater range of mental health issues than is included in the NICE Guidelines.

In summary, there are categories of mental health difficulties identified as effectively treated by psychodynamic psychotherapy by the broader research , which are different to those stipulate by the NICE guidelines. It will be pertinent to keep these in mind in the present research and during analysis, when thinking about how the different factors may influence who is allocated, and the creation of patient profile for psychoanalytic psychotherapy.

Methodology

The aim of this project was to explore psychotherapy allocation in the minds of the clinicians within one Tier 3 CAMHS clinic, and whether there was a consistent patient profile for psychotherapy patients. It is important to be clear and precise in delineating the methodology used to achieved this, and the rationale that underpins the choice of methodology. The research process will be summarised within the following sections: setting; recruitment; data collection; data analysis; reflexive considerations; ethical considerations, along with the reasons that decisions were made in each of these parts of the process.

Study Design

Setting

The present research was conducted in a Tier 3 CAMHS or 'Getting more Help' provision designed for those young people experiencing complex mental health issues. As previously outlined, these issues include depression, issues relating to food and eating, self-harm, effects of abuse, complex trauma and anxiety among other difficulties. The multi-disciplinary team within this CAMHS comprises the following clinicians: psychiatrist (1 part-time), doctor (1 part-time), psychologists (1 full-time, 1 part time), integrative psychotherapist (1 part-time), nurses (3 full-time), social workers (2 full-time, 1 part-time), assistant psychologists (2 full-time, 1 part-time) psychotherapist (1 part-time), a trainee psychotherapist (full-time, and the researcher for this project) and a family therapist (1 part-time). Focusing specifically on the psychoanalytic psychotherapy provided by the psychotherapist and trainee psychotherapist, this includes: brief work (typically less than 12 sessions), short-term

Psychotherapy (28 session model), and long-term Psychotherapy (over a year without a specific time limit).

The population of the area served by the clinic is 124,200 as of the 2021 Census (Office for national statistics, 2021a). The ethnic composition of the area is: White - 119,127 people or 95.9%, Asian - 2,107 people or 1.7%, Mixed or multiple ethnic groups - 1,719 people or 1.4%, Black - 750 people or 0.6%, Other - 507 people or 0.4%. English is 98 % of the populations first language (Varbes, 2024). The population of this area is significantly whiter than the national average which stands at 81.7 %, with 9.5 % identifying as Asian, and 4 % as Black, 2.9 % as Mixed of multiple ethnic groups and 2.1 % as Other (Office for national statistics, 2021b).

Unfortunately, it was not possible to obtain demographic information from the clinic itself. Several attempts were made across the duration of the project through contact with two team managers, and the team business manager. None of these colleagues were able to facilitate the acquisition of more information on the demographics of the clinic's patient population, waiting times, or more detail on which patients are allocated to which modalities. This does compromise the ability to further critique the findings of this project, both in relation to the patient population who access this clinic, and which treatments were offered to which patients in terms of their presenting mental health issues or diagnosis'. Having this information would have enabled this project to compare the perspectives of the clinician's, with which patients are actually allocated to which treatments, based on their mental health issues / diagnosis and demographic statistics.

Recruitment

The decision was made to recruit five participants as this was considered large enough to allow a broad spectrum of disciplines to be interviewed and to reach an acceptable point of data saturation, whilst also being small enough to allow the necessary time to conduct an in-depth thematic analysis. There is also support within qualitative research literature for this number, which suggests that, for a small-scale qualitative research project such as the one being undertaken, 4-6 interviews are appropriate (Smith, 2015).

The process involved circulating an email with a brief explanation of the project and the expectations of involvement to gauge interest, with a participant information sheet attached (Appendix A). Those clinicians that responded first with an expression of interest were then sent the consent form to sign (Appendix B) and the offer of a time for interview. It was the intention to get as wide a range of disciplines as possible and the first five people to demonstrate an interest were all from different disciplines and were representative of the main disciplines working within the CAMHS team with the exception of psychiatry, which was not represented.

Participants

The participants included: psychotherapist, social worker / team leader, nurse, integrative psychotherapist and psychologist, and these clinicians ranged from NHS pay bands 6-8b, which includes varying levels of seniority. All the participants had four or more years working in CAMHS giving them sufficient time to have experienced how the referral system works and to have seen multiple patients allocated to psychotherapy and other interventions. The minimum number of years'

experience was four and the maximum was twenty. As with the predominant population of the area itself, the ethnicity of all participants was White-British.

Interview schedule

A semi-structured interview was indicated as it permitted the interviewer the flexibility to explore the thoughts, beliefs, and experiences of the clinicians as they arose, a key advantage of this type of interview and a clear aim of the research. It is also recognised in the qualitative methodological literature that semi-structured interviews are advantageous in health care research for the aforementioned purposes above (DeJonckheere & Vaughn, 2019). The Interview schedule consisted of 12 questions with prompts designed to help the interviewees to think about psychotherapy allocation. The questions were devised between the primary researcher (psychotherapy trainee), and the project supervisor (consultant child and adolescent psychotherapist) (Appendix C) with the rationale that these were the clinicians with the closest experience of treating children in psychotherapy who were involved in the project. The questions were designed to explore the key factors investigated in generic CAMHS assessment, including some specifics such as neurodevelopmental disorders and levels of risk in relation to consideration of allocation to psychotherapy. They also included open-ended questions which allowed the respondent to bring up topics that felt pertinent to them. The number of questions was designed to be sufficient to facilitate an interview of approximately one hour which was considered long enough to allow the depth of exploration desired within the limits of the time constraints that existed.

Data collection

Both face to face and zoom interviews were offered, as at the time of interviewing (February-March 2022) the clinic was still operating a hybrid model of face to face and online working due to COVID social distancing measures. The choice was given to the participants as to which they preferred, in acknowledgement of the time they were offering and contribution they were making in agreeing to be interviewed. Out of five clinicians, four chose to be interviewed online and one in person. The interviews were recorded with the zoom recording function as well as a separate digital recording device.

The interviews ranged from 35-68 minutes and were stored initially as audio files on an NHS Trust owned work-based computer which was password protected. The audio files were transcribed using an online transcription software called ‘Happy scribe’. The resulting transcripts were checked by the researcher against the audio files for accuracy. These transcripts were stored on the same password protected computer.

Data Analysis

The steps for thematic analysis delineated by Clarke, Braun and Hayfield (2015) were followed to provide a clear form and rigour to the analytic process. This aids the reliability and validity of the research conducted, allowing others to replicate the study, and adds transparency to its findings. The steps were as follows:

Step 1 – Familiarization

This began when the transcripts were checked for accuracy against the audio files. The transcripts were then read a further time allowing general impressions to

begin to form before formal coding began. NVIVO software (a software designed to help organise data sets) was used to organise the data in a manageable way, in one place that could be stored securely, and clearly visualise which pieces of text have been attached to which categories. This is not dissimilar to the way in which one might use a spread sheet, though this software has been purposely designed to assist with qualitative data analysis.

Step 2- Coding

This step involved going through the transcripts line by line, grouping phrases, or multiple sentences under a caption that summed up something about a potential idea they might represent that was of relevant interest to the research question. This led to the creation of initial codes.

Step 3- Constructing themes

The codes created in step two were then combined into what could be termed 'umbrella themes' which began to organise ideas that were beginning to recur throughout the data set. The latter part of this step included merging some of these themes together to begin to give the analysis some shape and cohesion, and most accurately represent the data as interpreted by the researcher. It is important to clearly demarcate *codes* and *themes*. Whilst codes are basic meaning units, typically short in length, themes represent an overarching idea that may have several sub-ideas or sub-themes which combined to represent something significant in the data, which could contribute to answering the research question. For clarity an example is included here:

The theme - *'Going deep'*, referenced *the need of a psychotherapy patient to access an intervention that could go beneath surface issues and delve into a*

complicated past and put words to these experiences was identified. This theme was made up of the sub-themes *'Complex traumas that need articulating', and 'The need to redress and re-work'.*

This theme was arrived at by combining the following codes, which were all understood to act as building blocks of meaning in the final categorisation of *'Going deep'*. An example of this process is included in the table below.

Table 1.

Construction of a theme example.

Theme	Sub-theme	Code	Example

Going deep	Complex traumas that need articulating	Needing some exploration Staying with the pain of the past Something doesn’t make sense Chronic issues	just really needing to explore identity Understanding how the past manifests in the present they're hiding away, a bit withdrawn, tearful, but not able to say why, or behaviour doesn't make sense I think those young people are almost like in a chronic state of that…it's kind of like always at this place, but these ones sort of almost like stay at a kind of almost stay at Amber almost with like a hint of red every now and again

		Developmental trauma	I think the big headline that comes up for me is developmental trauma. I'm seeing things through that lens very much.
		Intergenerational trauma	So in fact, a systemic look at things is worth it in order to resolve sort of parental issues from the past, in one case something quite powerful came across about mom and abandonment by a mother, and how that might play out
	The need to redress and re-work	Need for a different adult experience	definitely think they need an opportunity to explore or see what they bring that relates to the past and some support in understanding or experiencing a different kind of relationship with somebody in the room
		Freeing what's stuck	something that would help unpick or illuminate, or set something free that's stuck inside
		Making a connection	But I guess I'm thinking about the

			higher end of the spectrum where

			there can be a real flattening out of feelings, connections, and it can be very hard but important to reach the child.
		Needing something relational	I think I would probably say that's the key to psychotherapy. It's probably more relational, it's about relationship, isn't it? The in-depth of it, the raw side of it
		Working things through slowly	I think the wonderful thing about psychotherapy is it unlocks something for young people because it has the time to do it
		Uncovering the past	with delving backwards to a certain degree. Is it to the core of what's going on? Is it something about making sense of the past and what's happened?

		Accepting the past	of understanding where something's coming from

			becomes like a level of acceptance or okay with or I can move on from it rather than it being this happened, you now have a skill.

Step 4- Reviewing themes.

In this step the researcher paused to reflect on whether the way the codes and themes had been constructed was working, and whether some codes might fit into different themes rather than their current ones. Other codes or themes that initially seemed to have potential, but did not develop any further were discarded, for example, the code '*Envious motivations'* was initially created. However, on reflection this interpretation of the data was not sufficiently supported by the whole data sample, and perhaps could be understood as the researcher trying to fit the data into a category that relates to some of the prior findings in this field, as already explored in the literature. Finally, some sets of codes that were initially labelled as themes, were on reflection deemed to be too small to justify a theme in and of themselves, and were either absorbed into other themes or discarded if not relevant. This whole process was influenced by the academic judgement of the researcher, though themes were reviewed at this stage with the project supervisor to add some degree of triangulation.

Step 5-Defining themes.

Penultimately the themes were reviewed for clarity and accuracy, ensuring that they were named in a way that was consistent, relevant, and facilitated explanation in relation to each other. At this point the naming of themes were reviewed to best

capture the essence of each and further processes of merging and discarding as appropriate were undertaken.

Step 6- Writing a Thematic Analysis.

This stage drew the various aspects of the thematic analysis together to present a coherent picture of the data with brief explanations of each theme, sub-themes, and evocative examples used not just to evidence the findings, but also to bring the data to life. The themes were reviewed by the project supervisor at this stage in addition to stage 4 to further enhance the triangulation of the data.

Although the steps outlined above were followed in this research, Braun, Clarke and Hayfield (2022) are clear that these are more guidelines than prescriptions. It is important to acknowledge that the beliefs and biases of the researcher will influence the interpretation of the themes. As referenced in the steps, these themes were reviewed at stages 4 and 6 by the project supervisor to improve the objectivity of the analytic process. However, this still meant that the themes were only reviewed by two individuals, and both of whom were from the psychotherapy discipline, necessarily influencing their preconceptions and expectations of the findings. This will have influenced what themes were developed and will need consideration in the discussion section when reviewing the project in its entirety.

Reflexive considerations

It is important to acknowledge at this point that the prime researcher's views and beliefs, both on the way the interviews will be developed, and then the way in which the resulting data will be analysed are significant. The primary factor is that the researcher is completing a training in the psychoanalytic psychotherapy discipline, and so will have already developed a degree of understanding and their own beliefs

about how it is perceived and understood, both in this clinic and more widely. Additionally, the prime researcher was known to the respondents, and this may also have had an impact on what ideas and perceptions the respondents may have felt able to bring to the interviews in the content of already established working relationships. These two points have been kept purposely brief, as they will be taken up in more detail when they can be considered in the context of the findings of the data analysis and how they may further develop understanding of the respondents' answers.

Ethics

Ethical approval was sought from Tavistock's Research Ethics Committee (TREC) panel using their detailed form covering aims, rationale and methodology of the project (Appendix D). It now remains to present the findings of the thematic analysis the following section.

Findings

Introduction

In this section the results of the thematic analysis of the five interviews will be presented. The analysis allowed the development of six themes from the five semistructured interviews with the following respondents: psychotherapist, integrative therapist, nurse, psychologist, team manager / social worker. The themes are as follows: '*Preliminary patient characteristics', 'Going deep', 'One size does not fit all', 'Team process', 'Clinical intuition versus guidelines',* and '*Issues of disagreement*'. The majority are also divided into sub-themes. The themes will be presented in an order that facilitates an understanding of their relationships to each other, and illustrative examples will be included to support and give an insight into how the data collected led to the themes which have been developed. The points of agreement and disagreement between respondents will be highlighted where these occurred, and indeed the last theme focuses solely on significant points of disagreement. Links will be made between the sub-themes to show how they work together to form the theme to which they belong. Links will also be made as this section progresses to demonstrate the relationships between the different themes and how well they enable one to try and understand the primary question driving this research, namely 'Who is allocated psychoanalytic psychotherapy in a Tier 3 CAMHS setting?'.

Key

Each respondent is represented by a series of letters which are included next to cited example from the analysis and follows the key below:

Ips-integrative psychotherapist

M- team manager / social worker.

N-nurse

Pc-psychologist

Ps- psychotherapist

Theme: Preliminary patient characteristics

Respondents were united on some easily discernible patient characteristics to either consider or not consider in thinking of whether to refer a child for psychotherapy. The majority of these characteristics are consistent with current generic CAMHS terms that are used to categorise patients and the first two would likely appear on the patient's notes system itself. These can be grouped into four sub-theme's which are: 'Stable enough', 'Neurological diversity is not a barrier', 'For internalising patients' and 'CBT versus psychotherapy patients'. A detailed account of each sub-theme and illustrative examples follows.

Sub-theme: Stable enough

Respondents were unanimous on psychotherapy being appropriate for those who were considered 'stable enough', which was closely connected to an idea of medium rather than high risk patients. Medium risk denoted patients who may be engaging currently in self-harm, drug and alcohol use or other risky behaviours and may have made attempts on their life in the past but were not currently *actively* suicidal. It would also not include those who posed an active risk to clinician safety. There was an idea that psychotherapy was perhaps not necessary for those who were a mild risk, but also that those who were high risk would need stabilisation work (which would include helping the young person to develop emotional coping skills, and an appropriate plan for their care involving the young person's network). One respondent painted quite a vivid picture of this risk as a long term or chronic feature, but with a level of consistency compared to the more impulsive kind of risk:

(M.) *So you're talking about kind of chronic risk that's kind of been around for a long time, maybe particularly feeling quite low, stuck, whatever, compared to some other children that maybe are quite actively suicidal, self-harming, quite considerably outward.*

There was an idea that the patients needed to be sufficiently stable to access the work in a way that was helpful and did not exacerbate the patient's difficulties to such an extent that it increased their risk:

(N.) *I mean, my understanding of psychotherapy is that it does sort of probe quite a lot. So you have to be, in a fairly stable maybe not completely stable, but you need to be stableish in being able to manage your emotions and distress before being able to do that, because otherwise it could increase the level of risk.*

This 'stable enough' also included whether a general *feeling* of safety was present about the patient in relation to their network and that measures had been put in place that would enable psychotherapy to start on a reasonably firm foundation:

(Ps.) they need to feel safe enough in themselves. So thinking about their environment, their home life, school life - has everything being put in place that can be put in place to support that, to support them to feel safe and stable, so that would be a real starting point.

This feeling of 'stable enough' was not just something that related to the young person but was also connected to the network around the child and whether the network was able to support psychotherapy sessions. This included practical considerations of getting to the clinic, particularly in the context of the length of commitment that psychotherapy involves:

(Pc.) I suppose that's a pragmatic bit of, will the parent bring them? Will the parent be committed enough to make this happen? So that's going to be stable enough at home to support psychotherapy? There's a long term, I guess, as well. It's quite a commitment.

Whilst the key was 'stable' or 'safe *enough*', it was acknowledged by respondents that they often work with patient populations where both risk and network support are fluid factors, and that sometimes respondents were having to work with and allocate children and young people living in 'less than ideal situations'.

Sub-theme: Neurological diversity, not a barrier to access

The next sub-theme of 'preliminary patient characteristics' describes strong advocation across all respondents who were clear that no patient should be denied access to psychotherapy based on neurodiversity:

(N.) I don't think we can make a broad decision about that (psychotherapy) . I think it's very much based on that individual and whether psychotherapy feels like a good fit for that individual rather than looking at the, the sort of diagnoses, really.

(M.) Personally, I don't think in this team because we're so thoughtful about our neuro-diverse young people. We've done a lot of work on that. I don't think that is a barrier to any young person accessing psychotherapy or any other intervention.

As shown above this was referenced explicitly as not being a barrier, but respondents also demonstrated careful thought as to how one might need to adapt their psychotherapy approach for someone who was neuro-diverse, suggesting this belief went beyond a general commitment to inclusivity*:*

(Pc.)I wonder, there'd have to be adjustments made to the process of psychotherapy for someone with Autism, particularly, and ADHD, I suppose ADHD, you might need a much more active form of psychotherapy, a bit more moving around the room and modelling and mirroring what they're doing to connect.

Overall the impression was of neuro-diversity as something that might promote the need to adapt, or involve different challenges than with a non-neurodiverse population of patients, but that this was seen as the responsibility of the psychotherapist:

(M.) we need to embrace it. And how do we provide the things that we do that aren't aimed at neurotypical people? That's our problem. That's not their problem. Maybe they're in a busy room that's loud outside. That's our problem to sort out. It's not theirs.

Despite these ideas of adapting for the neuro-diverse patient, there was an awareness that allocation of children and young people with neurodiverse conditions to psychotherapy may still be considered contra-indicated by some clinicians, but no respondent advanced it as an issue in direct reference to themselves:

(Pc.) But I'd hope it wouldn't prevent referrals. I think it may in some cases. I think some people might think, oh, no, psychotherapy because they've got Autism or ADHD. But for me, it doesn't stop someone having empathy and being able to talk about thoughts and feelings.

Overall, there is an acknowledgement that the perception of psychotherapy being the wrong intervention for the neuro-diverse population (or that psychotherapy is not indicated for neuro-diverse population) may still exist in the respondents' minds, but this was not something which they believed would be barrier to access in this team.

Sub-theme: For Internalising Patients

This sub-theme focuses on respondents' perceptions that psychotherapy is primarily for *internalising* patients. In this context *internalising* referred to those who were more likely to be withdrawn, quiet, keeping their problems to themselves and prone to internal rumination. It links to the earlier sub-theme of 'stable enough' in that they were not patients who were impulsively taking action to manage their feelings or the situations they were in, but were those who may be able to more readily 'sit' with their feelings:

(Ps.) And also I'd be mindful about those kids that are acting in or acting out if a child is kind of able to sit with their feelings or whether there's a sort of big inclination towards sort of something more physical.

This was judged to be important because the process of psychotherapy was seen as requiring a capacity to 'be with' or dwell on internal states long enough to try and make sense of something that had not been made sense of before:

(Pc.) Yeah. I think internalising again, I always have an image and I'm thinking of a young person just in their bedroom all day, doesn't go to school, the kind of internalised or someone who's had a lot of clearly had developmental trauma and lots of events that they could never have made sense of.

There was also an idea that these chronic problems relate to significant trauma, but that they were almost stuck somewhere inside the patient and needed elaboration through a process, which could be enabled by psychotherapy. There

seemed to be a question of whether the patient had developed a pattern of turning their problems outward to be visible to the rest of the world, (which might lend itself to psycho-education or CBT) or whether there was something harder to grasp or understand because the patient had turned their problems inward and become stuck in the process:

(Pc) So this behaviour that no one can really make sense often that would make me think, is there an underlying issue that they can't talk about or express or work through that's getting them stuck.

Sub-theme: CBT versus psychotherapy patients

Over the course of the interviews the perspective was given by four of five respondents that one their first thoughts in patient allocation, was some internal assessment of whether the patient in question was a CBT patient, *or* a psychotherapy patient. In general, this meant the former, 'CBT patients' being children or young people who were less complex, and more solution orientated and motivated, as compared to 'psychotherapy patients. There seemed to be a cleavage in people's minds as if a crossroads existed, and a patient could either be one or the other as referenced explicitly in the following examples:

(Ips.) in referring to psychotherapy and whether or not I think I about first whether a CBT type approach is going to be helpful, because Psychotherapy or CBT it's a bit black or white.

(Pc.) So I think there's a real distinction, I guess, in my head, between those that go to CBT and those that go for psychotherapy. And it's almost like a Ying and a Yang in some ways.

Whilst CBT patients seemed to be those who could manage something that focused on the problem in a conscious deliberative sense, for psychotherapy patients there was this idea that they needed something that did not focus on symptoms as much as a process of exploration:

(Pc.) we might then think, does a young person, would they benefit from something less direct? And that's an interesting word, direct, I think CBT is quite direct with feeding the problem, and needs some clear motivation, whereas maybe psychotherapy is more a process and exploration rather than so much of a direct therapy.

Further to this was the view that CBT was a short-term intervention designed to address something that could be more easily identified as 'the problem' which might be a specific symptom. Whereas for the young people who needed psychotherapy, this approach was not going to be sufficient, perhaps in part because there was not one easily identifiable 'problem', or at least not obviously so:

(M.) Now you're going to wait for CBT or something with the hope that that was enough to do the stuff. But with this group, the psychotherapy kids, I don't think, there isn't that kind of surface stuff.

Another respondent put it a little more bluntly:

(Ips.) a relationship with somebody in the room rather than a kind of CBT which is quite psycho-educational, sticking plaster rather than going deeper and having trained in CBT myself I've felt the frustrations of its limitations.

Although most respondents referenced this split between a CBT patient, versus a psychotherapy patient, the psychotherapist suggested that perhaps a child could use both but at different points in their CAMHS journey. They advocated for CBT in times when there was a specific event that a young person needed to prepare for such as exams, symptoms that needed immediate management, with psychotherapy being more appropriate further down the patient's timeline:

(Ps.) And it might be that CBT would be more appropriate in the first instance because it can address sometimes or get results in terms of managing anxiety more quickly. And then there might be a case for psychotherapy, so sort of thinking about the order of things sometimes.

It was suggested that at a later stage in the patient's journey in CAMHS there would be space for psychotherapy to work:

(Ps). *in more depth, working more relationally and understanding the past and how that manifests in the present.*

In summary, the theme ‘Preliminary patient characteristics’ links together some of the more immediately apparent factors that respondents consider pertinent to referring someone for psychotherapy. Patients needed to be suffering from something sufficiently complex and involving chronic risk to require or even justify something as specialist as psychotherapy, whilst needing to be stable enough to ensure the patient could manage an intervention with the probing nature of psychotherapy. Neurodiversity was not seen as an obstacle within this team, but a feature that might necessitated psychotherapist’s innovation when working with different populations. Despite this it was acknowledged that reservations in allocating neuro-diverse cases to psychotherapy may still exist in *others*. Respondents identified that internalising patients were more of a natural fit for the long process of exploration associated with the psychotherapeutic process. Finally, the split between those who were right for CBT and those better suited to psychotherapy seemed to centre around whether there were more surface level problems in the here and now which could be named, or more long-standing issues hinting at something which required more depth of exploration. If this first theme captures something of the initial considerations when considering referrals for psychotherapy, the next theme shows an attempt to make some sense out of what it is that might set these psychotherapy patients apart in terms of the deeper morphology of their experiences and needs.

Theme: Going deep

Beyond *‘Preliminary patient characteristics’*, the thematic analysis also identified a more far reaching and at times obscure theme in *‘Going deep’*, which was split in two sub-themes, ‘*Complex traumas that need articulating’* and *‘For those who need to redress and re-work’*. This theme was present in all respondents’ interviews and involved frequent, vivid descriptions of the depths that psychotherapy could go to in addressing past relational traumas that may not have begun to be understood and

processed emotionally by the patient. This process was understood to need time to allow the therapist and patient go over these relationally complex pasts and have the opportunity to re-dress these in the present through developing a different kind of relationship.

Sub-theme: Complex traumas that need articulating.

This sub-theme conveyed that something quite complex and even confusing had happened to patients who needed psychotherapy which the patient was not able to make sense of. This may have happened before the young person even had language available to them and in the context of damaging caring relationships. This was often first referenced as ‘complex trauma’, a phrase which every respondent used multiple times, and was often respondents’ first response to the question of who they thought should be allocated psychotherapy. This was often referenced explicitly:

(Ips.) I think that what I'm doing, I'm going to be thinking of complex trauma, as well as the presentation needing to be unpacked to consider the different forms this might take.

And then elaborated on in more detail:

(N.) umm either abuse directly to the child, either like sexual abuse, neglect, emotional abuse, that kind of thing from a parent, at least one parent, those that have experienced lots of domestic violence in that really sort of tense, hostile environment growing up.

(Ips.) I think my head is very much in looked after children, and I think a lot of kids see that really early on before maybe there's language and how do we help those children process that? I think domestic violence, relational ruptures. I think especially amongst those who are trusting, to be trusted adults in children's lives who are generally speaking unreliable and erratic and harmful sometimes as well.

As a result, the patients would behave and relate to others in a way that was not always easy to sum up, and could come across as confusing, at times defying understanding:

(Pc.) demonstrating their emotions through umm…. behaviour where they're hiding away, a bit withdrawn, tearful, but not able to say why, or behaviour doesn't make sense…maybe things like extreme soiling or um hiding things, hiding food away?

It was suggested that psychotherapy could uncover the roots of what was keeping these young people stuck and unable to move forward with their lives by getting to what was at the heart of the issue:

(M.) It's more about really understanding with that young person what is at the core of what's going on, and understanding those layers. And through that understanding, actually starting to maybe find some resolution, which doesn't necessarily need to be kind of a therapeutic skill, like an emotional coping skills group. It could be just from the realisation of understanding where something's coming from becomes like a level of acceptance.

These issues that respondents asserted were common in psychotherapy patients were seen as ones that were very deeply rooted in relational trauma and thus required something relational to re-dress what had gone wrong in their early lives in order to create new ways of relating with the therapist.

Sub-theme: For those who need to re-dress and re-work

This second sub-theme captures the premise that those patients seen as appropriate for psychotherapy needed to go over something from the past in the present. This was not as simple as talking about the past, but more about working out a new understanding of it in the present through a different kind of relationship with the psychotherapist. In short, they needed something where the relationship built with the therapist was an integral part of the treatment. Illustrative examples include:

(Ips.) the establishment of a relationship where the past and present can be explored and the parts of the self can be brought and looked at together.

(Ps.) working in more depth, working more relationally and understanding the past and how that manifests in the present.

Connected to the previous sub-theme there was also an idea that psychotherapy was for those who needed to free something which was stuck from the past that was holding them back and needed to be worked through in an environment that had grown over time to be felt as safe*:*

(Pc). Then the idea would be that psychotherapy could be something that would help unpick or illuminate. Or set something free that's stuck inside…. something is let out because it feels safe enough to do it, or something has been worked through in whatever way it can be.

To allow the therapist to go deep, uncover what is stuck and re-work it in the context of a new relationship, there was a shared understanding that having enough time was key to allow this process to unfold:

(Pc.) They're going to need a lot of time and patience and gentleness and I suppose with psychotherapy, I have this concept of you have more time to form that relationship, whereas there are some other therapies such as CBT. You need to crack on a bit.

(M.) *You know, actually when we think about helping a young person to really understand where they are and then be able to move on from that and then do something, and that's the longevity of psychotherapy…. again, I think the wonderful thing about psychotherapy is it unlocks something for young people because it has the time to do it.*

Overall, the theme *'Going deep'* identified that patients for psychotherapy not only have complex relational histories, but also might not have the words to make sense of this and the impact these histories have had on them. Their negative relational experiences require an intervention where they can gradually build a relationship that feels safe and allows them to begin to un-lock something and re-work it with their therapist. Perhaps key to these patients is that something seems 'stuck' and that this requires an intervention that delves deep to get at what this is, with the hope that something can be freed up, allowing the patient to move on from their past experiences. The first two themes have started to link some ideas together on what a psychotherapy patient might look like, but it was clear from the interviews that this

was not always easy to define in any simple way. The next theme begins to provide an answer to why this might be, and that whilst there are *some* characteristics and histories that might set psychotherapy patients aside, one cannot work only from a list of generalisations when considering referrals.

Theme: One size does not fit all.

As delineated thus far there was agreement on some patient characteristics, the nature of patient problems and the necessity of psychotherapy to address them. However, one principle which hindered the ability to gather further specificity, was that respondents believed interventions needed to be considered in relation to each individual child and their unique individual circumstances. This principle seemed to create some resistance to making generalisations about who would be appropriate to psychotherapy:

(N.) *Because I think it does depend case by case. It's really hard to I know we like to create rules and guidelines in our work, but I think it's really hard to because every child is different.*

(Pc.) It's really hard to make generalisations. It's really difficult, isn't it. Because everyone's so different, I think.

(M.)-but if we had the availability to offer the young people something that was a little bit more, maybe we would see greater change. I don't know. It's a really hard one, isn't it, because it's absolutely specific per child.

These examples illustrate a strong conviction that respondents believed patients need to be taken seriously as individuals and cannot be reduced to a set of characteristics or diagnoses. Whilst there may be some consistencies across psychotherapy patients, there are also factors that might lead a respondent to recommend one child who seems ‘stable enough’, with complex trauma and a tendency to internalize, for psychotherapy, and another with similar characteristics to a different intervention. These were not factors that could be identified upon further

investigation in the interviews, only that one needed to consider the individual circumstances of each child. There are varying, hard to identify factors that needed considering with each individual, but these could not necessarily be foreseen. Perhaps part of the answer could be in the process of allocation, something beyond the patient themselves. In next set of themes, the focus will be on precisely this, the respondent's decision-making process and the processes of the team in which the final decision to allocate someone to psychotherapy is made.

Theme: Team process

The analysis identified that the process of allocation itself could be as decisive a factor as the patients' complexities. There were more explicit issues relating to who was present at the team meeting where allocation took place, and more latent issues relating to resource related pressures and how clinical intuition might inform the decision to allocate to psychotherapy. This theme comprised two sub-themes, *'Team composition'*, and '*Dwindling Resources, quick fix is king'*.

Sub-theme: Team composition

Four out of five interviewees spoke about the presence of psychotherapists having an influence on allocation. The idea was that if psychotherapy was not represented at the multi-disciplinary team meeting, it was less likely that someone would be allocated to psychotherapy:

(N.) I think if there are no psychotherapies in, the psychotherapists in the meeting, umm very few people get added to the list.

*(M). I can't remember the last time in MDT, there was a decision for a psychotherapy case in the sense that this one sounds like psychotherapy. But I would imagine that's probably more of a conversation if *[lead psychotherapist] is there.*

There seemed to be an idea behind this that respondents did not feel confident enough in their knowledge of psychotherapy to allocate to this waitlist if a

psychotherapist were not present. There was the view that knowledge of psychotherapy did improve the longer one worked in CAMHS, however, this seemed to be contradicted by the statement from those who had worked in CAMHS longest about still not really understanding what psychotherapy was. This included the respondents who had over 10 years of experience working in CAMHS, and were quite honest and open about their lack of knowledge on what it was and what it involved:

(Pc.) I don't think I would. No, I think it might be more sometimes, we don't understand what a psychotherapist does…. I really don't know what you can and can't do in your sessions.

Whilst another respondent was clear:

(N.) To be honest, I really have no idea what it (psychotherapy) is.

Overall, the impression was given that the composition of the team could be just as important as the patient themselves, meaning that a patient who is allocated a psychotherapy referral one week, might not get referred to it the next and that this was connected to the presence or absence of clinicians who had knowledge of psychotherapy. From the perspective of the respondents this knowledge seemed to reside primarily with those who had some psychotherapy training, ie. the integrative psychotherapist and the psychoanalytic psychotherapist. This lack of knowledge about psychotherapy asserted by those not trained in the discipline, is in significant contrast with the relatively consistent patient profile that all five clinicians identified for psychotherapy, suggesting the lack of confidence in team meetings may be misplaced. These clinicians seem to believe with some confidence that they know who psychotherapy is *for* whilst simultaneously believing that they do not really know what it *is.*

Sub-theme: Dwindling resources, quick fix is king

The second sub-theme captures something of the emotional context and pressures of working in this CAMHS clinic in 2022. Respondents clearly asserted the viewpoint that over time there were less and less resources in CAMHS, and that along with an increase in demand both in the quantity and severity of cases, a more reactive treatment culture had emerged that reached for short-term solutions. The respondents seemed to imply that this drive for a short-term solution may be at odds with the longevity of psychotherapy. An idea frequently and consistently expressed in all the interviews was the lack of resources in CAMHS, with capacity for treatment diminishing further and further over the course of respondents' careers:

(Ps.) It's hard to think about it because I think it's economic as well as my career has gone on there's less and less resources. Pressure on through put, being able to offer less.

(Ips.) And it feels like, yeah, we could unravel this but actually it feels like we haven't really got psychotherapists on offer and young people are waiting so much longer, what is the right thing to do.

The increasing lack of resources was connected to the cases that were seen in CAMHS becoming the ones that were more severe, in part because those patients who may have previously gone to a higher-level service, may now be seen in a service one Tier down:

(Ps.) At the more extreme end, I think of the top end kids that might have gone into mental health, impatient units (Tier 4), are less likely to... those are missing at the top end. So sometimes there's a lot of work around keeping kids out of those units have to be deemed serious enough, risky enough. So sometimes we get them bouncing back into our CAMH's (Tier 3).

This idea of increased severity was elaborated by clinicians to explain that the primary task of the service had become managing young people who were in some sort

of crisis:

(M.) That's all we do. We only ever allocate crisis kids. We're responding to crisis constantly that we're just doing that here and now bit. We're not necessarily thinking about delving too deep into the what's it about, though, like one might in Psychotherapy.

It seems that with a lack of resources, a high level of demand and increasing case severity, the present-day context of CAMHS ran counter to the time understood by the respondents to be required by psychotherapy. The time taken in meetings to make decisions was perceived to have become almost a quick-fire process rather than a conversation to consider all potential factors and options:

(Ps.) But yeah I do think there is a mindset, a real mindset. And in team meetings it's most evident because there's such a fast pace to work all the referrals that week, initial assessments that have happened. So it's almost like an atmosphere of duelling. Who can come up with the fastest solution?

(Ips.) and being aware that actually, yes, psychotherapy could have a very long wait for, I have to say I don't feel that aware of the kind of team psychotherapy list or how fast it's being moved through. I think there's a possibility as well the young people wait so long somebody might go to a waiting list for an emotional coping skills group as a means to offer something, a means to get children and young people seen.

It was not just that the fast-paced approach to allocating might preclude thinking about long-term treatments such as psychotherapy, but also, according to some respondents, that perhaps psychotherapy does not naturally fit within modern day CAMHS anymore, which was put across strongly by the team manager.

(M.) Yeah, I would probably say it's one of those ones (psychotherapy) that doesn't necessarily fit within the new CAMHS when you think about how fast we have to work. Now, CAMHS is built on a twelve-session model.

With a lack of resources and increased demand, CAMHS was seen as needing to find solutions in as short a time frame within the MDT to manage through-put. In terms of allocating to psychotherapy, this was asserted as a factor that could negatively impact the likelihood of respondents allocating to psychotherapy because

of the driver that something needed to be offered sooner as so many cases were ‘crisis cases’; and that interventions also needed to be quick because of the volume of cases.

(Ips.) In terms of psychotherapy, I'm really aware that there’s, it's more long term. There might be a longer wait. So often a young person might get offered, say, a emotional coping skills group….to see if that works, put the sticking plaster on…or give them six sessions of CBT and whack them out.

The last phrase ‘put the sticking plaster on’ was quite evocative of what some respondents saw as a problem with CAMHS, that it existed in the context of a ‘patch it up culture’, trying to do a little and move onto the next young person. Importantly this was an idea expressed most frequently by the two respondents’ who were trained psychodynamically in interventions which were built on ideas of long-term work, far beyond the twelve-session model referenced by the manager. This could be interpreted as an emerging split between those trained in longer-term interventions such as psychotherapists and those such as nurses or psychologists.

In summary this theme highlighted the importance of factors within the team process. One can look at this as primarily the impact of a psychotherapist’s presence or absence at the meeting in which allocations to interventions were decided on. However it is unclear whether this was more to do with any given respondent’s preference for other interventions or to do with a lack of confidence in allocating to psychotherapy without a psychotherapist’s opinion on the matter. In addition, the respondents made frequent reference to the lack of resources in CAMHS and this seemed to have been at least partially responsible for developing a culture where the faster solution was often the one that was most attractive. It also resulted in a potential aversion to psychotherapy allocation, even where perhaps it could be the treatment of choice, with the fear that it might take too long for the young person to

be seen. We can see that this fear would be of enhanced significance if set alongside a view of the patient population as one that was forever in crisis.

Theme: Guidelines versus clinical intuition

Beyond the structural considerations relating to the team which have been explored so far, many respondents appeared to believe that one's own feelings could play a role in psychotherapy allocation. This was seen as something that developed with time, gaining experience working in CAMHS, so that one got a sense of which child might benefit from psychotherapy:

(N.) I think sometimes there is an intuition. And you just, yeah, like you say, you kind of get that sort of gut feeling, don't you?

(M.) I think we all have that, and that's what makes us great clinicians. We've got schooling, we've got learning, we've got skills. But actually, what generally helps us to guide decision making is the stuff around the feeling you get from a young person.
This links back to the idea of things needing to be child specific and that one could not necessarily generalise about which young people would be allocated to psychotherapy. There is a human factor and notably this was not just referenced by those that had trained in psychodynamic interventions but also by those who had said they did not understand what psychotherapy was. There also seemed to be a bit of a split emerging between the idea that one could use their gut feeling or what *felt right* as opposed to NICE guidelines. One respondent put it thus:

(M.) We can use evidence-based God knows what to make decisions, but often it's just the kind of, okay, let's have a think. I think this sounds or feels like the right thing.

The impression given was that NICE guidelines were not at the forefront of respondents' minds so much as what sounded appropriate, or felt right, and this was connected to a sense of respondents' intuition grown through experience with these young people. By contrast one respondent suggested that they 'parked' their awareness of psychotherapy as the NICE guidelines meant that psychotherapy was

fairly low down their list regardless of patient presentation, and may less readily enter their decision-making process in terms of a potential intervention because:

(Ips.) Yeah, definitely that hierarchy, I think, of what the government says. And I think I came in definitely brainwashed by, NICE guidance and IAPT guidance…. Yeah, well thinking of the hierarchy and NICE guidance coming in for me and kind of, yes. So really psychotherapy is fairly low down.

Here the perception seemed to exist that NICE guidelines work against allocating to psychotherapy, though again it is important to note that this was only expressed explicitly by one respondent. For the other four respondents the impression was given was that NICE guidelines seldom factored into their thinking, so the guidance appeared to either not be used at all, or act as some form of constraint (in the case of the Integrative Psychotherapist). Overall, this theme captured the importance that respondents placed on trusting their feelings to guide them in psychotherapy allocation. This was seen as something that could be at odds with general guidelines and could be viewed as a more human factor in the decision-making process. Whilst the use of such clinical 'intuition' does not necessarily make for a clearer picture of who is allocated to psychotherapy, it does suggest that over time and exposure to the multi-disciplinary team process, respondents from a variety of different disciplines start to develop a sense of who might be appropriate, as demonstrated in the themes *'Preliminary patient characteristics'* and *'Going deep'.* Despite this, the development of clinical intuition does not seem to result in the team feeling able to make a decision about psychotherapy allocation in the absence of someone with official psychotherapy training. Whilst the respondents agreed about the majority of issues pertaining to psychotherapy allocation, there were two issues where there was more division which will be explored now.

Theme: Issues of disagreement.

Although the factors which respondents disagreed over could perhaps also be under other thematic headings, it is pertinent to the question about who is allocated psychotherapy to consider the consistency of respondents' responses, which is why *'Issues of disagreement'* have been included as a stand-alone theme here. This theme captured the areas where respondents had more directly opposing views with each other over issues that were easier to qualify than those in themes such as *'Going deep'*. The two sub-themes within this theme are: *'Patient motivation'*, and *'Age as a variable factor'*.

Sub-theme: Patient Motivation

The level of patient motivation necessary in considering whether a referral to psychotherapy would be appropriate was a topic of dispute between the respondents. Some referenced the importance of an obvious desire and willingness to begin sessions:

(N.) Yeah, yeah, I definitely think people need to be on board and engaged and wanting to do it.

(Ps.) I think this patient felt the emotional copy skills group had been too impersonal that he hadn't been heard. He was asking for something individual he felt that hadn't been heard.

Others, however, were more ambivalent about the role motivation plays, and felt that if the patient had attended this was enough and signified they were at some level motivated enough for psychotherapy:

(M.) It's a hard one. It really is. I think there needs to be a level of motivation. Attendance feels like the starting place, whether that is even just physically to just be there in body, if not in spirit and mind.

Finally, one respondent leant towards the other end of the spectrum, noting that psychotherapy was particularly for those patients who had:

(Pc.) I've got a picture of a child in my head with someone I did refer and they had their hood up, didn't want to talk, very hunched up, didn't want to think about feelings or thoughts.

Overall respondents varied more on this subject of motivation than any other, though it is worth noting that it was the psychotherapist who most often referenced the desire of the patient for work and their wanting one-to-one work. This perhaps reflects the reality of what they feel needs to be present in a patient to make a psychotherapy case successful. It is also revealing that given this is the topic of most dispute, the disagreement was substantive but not completely polarised.

Age as a variable factor

The other factor respondents disagreed over was which age group of children or young people were most likely to be seen in psychotherapy. Though the respondents focused less on who was appropriate or most likely to benefit, and more on who actually got allocated in CAMHS for psychotherapy on a day-to-day basis. So as with the idea of being 'stable enough' (where, the desired level of stability was not always present and could fluctuate), there is an acknowledgement of some difference between what might be ideal, and the reality in this CAMHS clinic. Whilst some thought psychotherapy could be helpful across the age distribution:

(N.) A whole range of ages have been seen by psychotherapy. So just like those in single digits, sort of like seven, eight all the way up to like 17,18. So, I don't think age is a factor.

(M.) I've learned along the way that they can be all sort of ages, so they can be very little, littler than our actual age range all the way up to our top patients age range.

One of the respondents focused on younger patients:

(Pc.) Often, it's been younger children that can't always express and maybe the trauma they've had or the life event has been when they were much younger, preverbal even.

In contrast another respondent thought that because CAMHS thresholds were so high, it tended to be older patients who were more likely to be exhibiting higher levels of risk:

(Ps.) I think age, age wise actually because I think in CAMHS the threshold is so high, we're seeing less and less young kids.

As with patient motivation, in general when respondents did express different views on the issue of age, they did not assert their positions with much force, it was more a leaning one way or the other. The same can be said of level of patient motivation with some believing it was more important than others, but motivation not being identified as a definitive barrier. Perhaps what is most significant here is the absence of more factors of disagreement from the respondents. Despite different levels of exposure to psychotherapy, varying years working in CAMHS and different clinical backgrounds, the respondents were, on the majority of factors, in agreement on who should be offered psychotherapy.

Conclusion

To conclude, when asked who they were likely to refer to psychotherapy, respondents came up with a relatively consistent picture of an internalising patient, who was stable enough in their environment. They were likely to have suffered complex trauma, and not able to articulate or to make sense of this or trust that someone else could help them. Thus, they required long term work to build that trust and work through their complex pasts in an environment that felt safe enough to do so. However, there were factors that could not be accounted for with generalisations, each patient's individual circumstances needed to be attended to when considering allocation. In terms of the decision-making process, it was reflected that the presence of psychotherapists could be a significant determining factor, perhaps even more important than the patient themselves. Respondents also suggested that one may have to use 'clinical intuition', rather than hard and fast rules, which was something which developed over time spent working for CAMHS where one almost felt that

someone was the ‘right fit’ for the intervention. Finally, the contradictions between respondents’ views were few and not particularly fixed or rigid in nature. These findings and their significance will now be considered in more depth in the Discussion section.

Discussion

Introduction

This section will highlight the key findings of the thematic analysis, and consider how they could link together to provide an explanation of the different dimensions of psychotherapy allocation, in addition to placing these findings within the current literature. The latter task will consider where the literature is corroborative, where differences with the literature exist, and what might explain this. This will include both the empirical literature regarding the evidence base for psychotherapy, the published research on allocation more specifically, and how well this study fits with current NICE guidelines. Penultimately this section will consider the limitations of this research study before concluding by reflecting on the contributions the study can make, both to the clinic in question, and more broadly to the literature on psychotherapy allocation within CAMHS.

To restate the aim, this research project aimed to explore the question of *Who is allocated psychoanalytic psychotherapy in a Tier 3 CAMHS setting*. This also included investigating whether there were identifiable patterns in patients allocated to Psychotherapy, and whether any such patterns were indicative of a 'patient profile', if one existed, in the minds of the respondents interviewed.

Consistency of respondents' views

One of the key findings of the analysis was a high level of consistency amongst the respondents interviewed in the themes that emerged from their answers. There were in fact only two areas of disagreement and they were not overtly binary in nature (relative levels of patient motivation, and relative age of the patients). This consistency was found despite vastly varying knowledge of what psychotherapy is

(according to respondents themselves) and varying professional backgrounds. To take two examples as illustrative, whilst one respondent was a qualified psychotherapist with 10 years of post-qualification experience, and provided an in-depth analysis of what psychotherapy was, another (team manager and social worker) stated that they really had no idea what psychotherapy was at all. Thus, within this team the respondents did not seem to feel the need to consciously know what psychotherapy *was* in order to have a clear understanding of who it might be *for*.

The findings around a lack of clarity that several respondents brought forward (notably those without any psychodynamic training) about understanding what psychotherapy was, or even some mystery surrounding psychotherapy, was very similar to the findings in Kam and Midgley's research (2006). Whereas the analysis in this current research project related to the lack of knowledge or clarity, and the lack of knowledge seemed to be located in the respondents themselves, with Kam & Midgley's research there were different associations to this lack of understanding. For example, there were associations with the mystery of psychotherapy relating to its being a 'precious' profession, where psychotherapists could be overly rigid in their hypotheses as though these were the *absolute* truth, without it being clear to other clinicians how they had arrived at said hypotheses (Kam & Midgely, 2006). This difference could in part be explained by the relationship between the interviewer (a trainee psychotherapist) and the respondents (clinicians who the trainee psychotherapist had worked alongside for more than 2 years). As will be explored in more detail later in this section, it may be that respondents were less forthcoming with more critical views of psychotherapy, or in exploring why there was this lack of clarity, as they were aware of the impact this might have had on the interviewer.

Beyond these contrasts there is a question for this study of why there is this lack of knowledge? One explanation could be that in addition to a lack of communication between clinicians, the emphasis placed on CBT, (which in the clinic where this study was undertaken, had been offered as an introductory training to all respondents), contrasts to the minimum six years that it takes to qualify an ACP accredited child psychotherapist. There could be an assumption that because the training is long, complex and in-depth this negates the possibility of understanding what it is, a question of relative access to its theory and practices in comparison to an intervention like CBT, which is available to all within the clinic. Whilst these are both plausible explanations, one might need to undertake further research to understand why there appears to be this lack of understanding around psychotherapy, which is especially pertinent given that it is a core profession within the NHS.

Patient Profile

Regarding who is allocated to psychotherapy the research was able to develop a fairly consistent patient profile from the respondents' reports, which were consistent in describing three main characteristics they deemed related to a patient being allocated for psychotherapy. Some of these were more clearly defined characteristics, and others more richly descriptive and abstract. The first of these factors is that psychotherapy is for 'internalising patients', who tended to dwell on their problems and fantasies, rather than act them out. The second is patients who are 'stable enough' partly in themselves but particularly in their external environment which was seen as necessary to support a complex, probing and long-term intervention. Finally, *'Going deep'* referred to problems often pertaining to complex, embedded forms of trauma. The belief that internalising patients benefit most from psychotherapy has long standing support within the literature. From Fonagy and

Target (1996) to the systematic review from Midgley et al. (2021) those patients with internalising disorders were often found to benefit more than those with externalizing disorders. Whilst the reference to 'stable enough' is less prominent within the empirical evidence base, both Kam and Midgley's study (2006) in addition to Curen's research (2017) referenced the need for some stability in a psychotherapy patient and the former study makes the direct link to the impact of previous CAMHS interventions on facilitating this stability. The fact that this idea on stability is not extensively reported on in the literature could be explained by the lack of studies more generally that look in detail at who is *allocated to psychotherapy*, for which this reference to stability is relevant, rather than who *benefits from p*sychotherapy - studies which focus on more readily defined factors such as internalising versus externalising behaviours and symptoms. It is also worth acknowledging that this 'stable enough' situation is what respondents thought was ideal, but there was an acceptance, particularly from the psychotherapist themself, that this was not always the reality that manifested in present day CAMHS. There was a notable absence of reference to the allocation of mild-risk patients to psychotherapy. This could link to ideas of psychotherapy as an intervention for those with complex issues, that may in turn link to the patient presentation being one which is complex, chronic, and related to embedded traumas, since such patients are unlikely to present with mild levels of risk.

However, this absence could also be explained by the increasing severity of patient presentation in Tier 3 CAMHS, to the extent that those who are considered 'mild risk', may not reach the threshold to access services at this level (Look Ahead, 2023). Perhaps this was an area where the interviewer could have probed more on how often the ideal of 'stable enough' was met, or whether this was how a psychotherapy

case might start out, but that a patient's internal state of mind, and their external environment were both factors that could shift, regarding stability and, at times, unpredictably so.

Encapsulated in the theme *'Going deep'*, is the idea that when there were mental health problems that could be linked to early relational ruptures such as abuse from one's caregivers, the patient needed something relational, or relationship based to help. Psychotherapy appeared to be seen as the natural answer to this requirement. The thinking appeared to be that mental health problems that were the result of sustained abuses within relationships, were going to need a long-term relationship-based approach to give these young people a new experience of what it could be like to be close to and understood by an adult. The complexity and severity of the trauma experienced by those patients allocated to psychotherapy can also be identified in the wider literature as early as Beedell and Payne (1987), the systematic reviews of Kennedy (2004) and more recently Midgley et al. (2021). In the literature relating specifically to allocation, the presence of complex and severe trauma was also confirmed as a fundamental factor in the histories of those allocated to psychotherapy by Kam and Midgley (2006), which parallels the respondents in this study referring to 'extensive trauma', and those who needed help to 'verbalize their experiences'. Kam (2004) also implies this kind of complexity by noting that those in psychotherapy had gone through an average of 3.7 interventions before they were offered psychotherapy, whilst Curen (2017) noted that the patients receiving intensive psychotherapy had on average 6.5 presenting problems, these are patients that, to quote Kam and Midgley (2006) again, are "beyond the norm, or don't fit in the same the boat as other children" (p36). However, the present research goes beyond much of the literature which considers issues relating to *what* the

patient has suffered, as the respondents' narratives included some thinking about *why* psychotherapy might be the right fit for this patient population. In the thematic analysis, it appeared that a link was begging to be made by respondents between the experiences of patients who had suffered traumatic ruptures of the past with the healing capacity of psychotherapy, because it offered a *new* kind of relationship in the present where the past could be worked through.

The ideas of a new kind of relationship seemed to go beyond what might traditionally be termed the transference relationship in psychoanalytic psychotherapy. As was briefly explained in the literature review, one key aspect of psychoanalytic psychotherapy is that the patient transfers the types of relationship, and associated effects of the past onto the therapist. The ways in which the therapist understands and helps the patient understand these relational patterns and associated affects, is central to the curative capacity of the treatment. However, in the thematic analysis, respondents, most notably those trained in psychodynamic therapies, were keen to emphasize that psychotherapy was for those who might need a new experience of an adult, different from the ones the patient may have experienced in the past. In this sense, it seemed their ideas about what psychotherapy patients were needing was something resembling a 'new developmental object'. This idea was born in the Anna Freud and Winnicottian traditions, and has been developed further, including most notably by Angela Joyce (2023). The concept refers to a need for the therapist to provide functions that may have been absent for some patients, such as helping them to name affects, of which they may have had little experience before (Joyce, 2023). This is particularly relevant for those patients who may be developmentally delayed because of complex developmental traumas which have slowed or even halted normal developmental trajectories. One could see how the idea of

developmental delay could link with the respondents' ideas of something being 'stuck' and needing to be freed up and accepted within the process of psychotherapy. This did not appear to be about applying a technique or strategy, as much as it was about developing a relationship that felt safe over time, in which exploration was encouraged and that gradually this could affect some change in the patient.

Beyond the links to psychoanalytic literature, there is a complicated picture that needs linking together when considering the patient characteristics that were identified in the thematic analysis. On the one hand patients are considered appropriate for psychotherapy if there has been sustained and complex trauma often pertaining to the familial environment, but on the other hand, the patient needs to be in a relatively stable enough environment to manage the probing nature of psychotherapy. One could argue that it would be difficult to determine that a patient is both relationally *traumatised enough* to justify a lengthy and scare resource such as psychotherapy, but is also *stable enough* to access it and can be supported by their family to attend the sessions consistently, and potentially for multiple years. Perhaps 'looked after children' might be considered to fit this description, having likely been through significant traumatic experiences in order for others to remove them from their primary care givers, and then potentially being in a more stable environment, depending on the success of their current living situation. This complicated picture could be further impacted by the context of the 'crisis management' nature of CAMHS which the respondents referred to. One could begin to formulate that the combination of the quite specific criteria for psychotherapy patients, taken in the context of a culture in which 'quick fix is king' could result in a lower referral rate to psychotherapy. This is because whilst the patient profile can be seen as quite particular and needs careful thinking, the time allowed to make the decision is

increasingly short and within a context in which the primary task is seen by some as crisis management.

This issue of the role of resources was another of the significant findings in this research and has not been explored to quite the same level of depth in direct relation to psychotherapy allocation in previous research. Primarily, the issue is that a scarcity of human resources, leads to long waitlists, which can lead in turn to an escalation in mental health problems that are not treated. This can have a significant impact on patient allocation to psychotherapy as by the time young person is being considered for allocation, they may need something immediately, something 'crisis' orientated to reference the respondents, rather than being able to wait to access a long-term intervention such as Psychotherapy. The increase in demand for CAMHS services has been substantial in recent years, with a 53 % increase in referrals to CAMHS 2023 compared to 2019 (Young minds, 2023), It has also been demonstrated that this increase in demand has not been met by an adequate increase in provision (Look Ahead, 2023). Further to this, the link between an increased amount of time spent on a waitlist, and an increase in the intractable nature of the mental health problem is a relationship increasingly evidenced in the literature on the impact of waitlists (Edbrooke-Childs & Deighton 2020). In the present research, a scarcity of resources seemed to be a factor in deterring respondents from allocating child and young people to psychotherapy for two reasons: not only because in practice it meant that they would sit on a long waitlist before receiving an intervention, but also because the pervasive sense of a scarcity of resources had fostered a way of thinking within the team such that the multidisciplinary team meetings (MDTs) became almost, to quote one respondent, like "a duel to see who can come up with the quickest solution". In terms of the length

of time it takes for someone to be seen and perhaps also the slow pace of psychotherapeutic work, psychotherapy could be seen as anathema to the fastpaced environment in which decisions surrounding patient allocation were being made in this clinic. Possibly these sorts of dynamics prompted the binary notion that a patient is *either for psychotherapy or for CBT* (sub-theme: CBT versus psychotherapy patients). Whilst to some extent these interventions are seen as appropriate for different kinds of patients, perhaps it is also convenient to be able to categorise patients in a quick and somewhat absolute way, as this could facilitate more quickly arriving at a decision on patient allocation. This could also be an area where perceptions of psychotherapy, which traditionally favoured a long-term model, could need updating. This is because there are several short-term models of psychotherapy now in increasingly widespread use, including by the psychotherapist within this clinic, but these may not have been effectively conveyed to the MDT. Alternatively, the relative newness of these interventions, with Short-term Psychoanalytic Psychotherapy first being manualised in 2011 (Cregeen, 2018), compared to the long held understanding of psychoanalytic psychotherapy as an intervention that requires many months and years had been the dominant one, may still feature in respondents' minds when they are making their decisions, even if what psychotherapists can and do now routinely offer might have changed.

This desire for a quick solution and splitting patients into CBT or psychotherapy is perhaps in conflict with the theme *'One size does not fit all'*, which emphasises treating each young person separately as an individual, considering what is personal to their needs. This was put across not only very consistently, but also quite vociferously despite it not being explicitly prompted in the interview schedule. This incongruence suggests there are could be ideas or forces that pull in different

directions within the clinician's mind, one towards the quick categorisation of a patients need because of external pressures, and the other towards really trying to understand the patient as an individual, which might take more time, thought and discussion. As with the idea of 'stable enough' there seemed to be a more idealistic notion of how one might like to make the decision, which perhaps conflicted with the more practical fast pace at which decisions needed to be made in the MDT. Given that these factors are by definition 'individual' it would be difficult to ascertain what they might be, but it did support the idea that there are dynamic factors relating to patient allocation that may differ from respondent to respondent and also from service to service. Kam & Midgley (2006) refer to 'contextual factors' of the clinic in which their research took place. These undefined contextual factors could be seen as similarly elusive to the notion of treating the patient as an individual in referring to a range of diverse and individually specific issues that cannot be foreseen. Whilst they may have been hard to discern, perhaps this is an area where the primary researcher could have delved deeper in trying to explore what these individual factors might have been. Linked to this idea of the individual, is the need that respondents identified for the psychotherapist to fit around the patient rather than try to have the patient fit around the psychotherapist. This point was made particularly in reference to Neurodiversity, and the assertion that this should not be a barrier to accessing psychotherapy. It suggests that respondents may have felt a tension between answering the question on whether and what patient characteristics would prompt them to consider allocating to psychotherapy, and their awareness of their contradictory perspective that *'One size does not fit all'* and in addition that even children that were not part of this 'typical' patient profile could also be effectively treated in psychotherapy if the psychotherapist adapted their approach. Extrapolating

this idea we are left with the question that if the psychotherapist could adapt around the patient, then perhaps this suggests that, all other aspects being equal, *any* patient could be allocated? Again, this was an area that could have been further probed by the researcher or could be explored in future studies.

The idea of 'clinical intuition' was again, brought forward by the majority of respondents in the theme *'Clinical Intuition versus guidelines*. 'Clinical intuition' encapsulated the idea that, beyond the definable qualities, what the respondent *felt was right* for the patient was an important factor in whether they would be allocated to psychotherapy. The role of feelings and the idea of clinical intuition was also picked up by Kam and Midgley (2006), though this study was able to go further in identifying that it was patients who could make a respondent feel 'uncomfortable' that might motivate a psychotherapy referral. This opens a broader issue as to whether there is something more feeling based that is specific to psychotherapy allocation. This is particularly worth considering in the context of psychotherapy itself being a discipline for which one of the main tools is the use of the psychotherapist's own feelings about a patient to make sense of what they are trying to communicate through the transference dynamics (S. Freud, 1920). This could in part explain the finding from respondents that they use their feelings in relation to allocating patients for psychotherapy, as something they may have picked up from how psychotherapists work and a way to make sense of patients who do not fit neatly into diagnostic criteria. The use of feelings was not made in reference to allocating to CBT for example, where more clearly defined characteristics were identified such as the patient being more motivated and ready to do the work. This could also link to an idea of mystery surrounding psychotherapy. Perhaps if

knowledge is lacking around what psychotherapy actually *is*, then clinicians could also refer back to their feelings about patients as a way of guiding their decisions.

Kam and Midgley (2006) *also* found that people's feelings about psychotherapy itself could influence their decision regarding allocation. The term 'precious' was used both to describe psychotherapy as a valuable but scarce resource, and also in a more disparaging way by other respondents in relation to psychotherapists being overly certain in their understanding and yet mysterious in their methods. These more negative views were not found in the present research, but the idea that psychotherapy is a treatment that takes a long time, and is a scarce resource was put across by respondents. As previously mentioned, perhaps here the relationship between interviewer and interviewee could have influenced respondents' answers in the direction of avoiding offering negative associations with psychotherapy in order not to offend or upset the researcher as a psychotherapist in training.

This is an area where the interviewer could have further explored what this clinical intuition meant to the interviewees, 'Were there certain feelings that these patients evoked?', could have been a good follow-up question. Overall these ideas of considering the individual, clinical intuition, and the lack of diagnostic terminology in the respondents' answers have important implications for the diagnosis centred NICE guidelines, which, in theory, are meant to guide patient allocation in CAMHS services.

Alignment with NICE guidelines

A further key finding was that none of the respondents referred to single comorbidity depression, and yet psychotherapy is a recommendation of the NICE

guidelines when advising on an effective treatment for depression in children and adolescents. Rather the respondents repeatedly referred to complex developmental trauma as a condition or experience that would indicate allocation to psychotherapy, which is not specifically recommended by NICE guidelines except for two particular sub-sets of children. These groups are first, sexually abused girls aged 6-14 (NICE, NG76, 2017), and second, pre-age school children (under 5) for whom child-parent psychotherapy is recommended (NICE, NG76, 2017). However, the NICE guidelines do make clear that local authorities should 'offer a range of dedicated CAMHS that are tailored to the needs of looked-after children and young people – for example, making them longer term, more trauma informed and relationship based' (NICE, NG76, 2017). The suggestion of longer term and relationship-based treatments could certainly include psychotherapy, but one could question why it is not named here. One explanation is that the evidence is not as rigorous compared to other studies for mental health issues such as Depression. So, whilst there is some evidence for the efficacy of psychotherapy with the Looked after children, currently the guidance does not explicitly recommend it as an indicated intervention, and perhaps this is an area in which there need to be more RCT's before it will be explicitly referenced by NICE guidelines. A comparison that is worth making, is that psychotherapy is not at the forefront of the NICE guidelines for most mental health problems, and it was similarly not at the forefront of the minds those making the decisions in the CAMHS team where this study took place, including for the psychotherapist. In fact, the respondents seemed to be operating from a very different position to that taken by the NICE guidelines. Rather than diagnostic terminology, the respondents expressed a very different set of concepts and criteria, often using the terms *complex trauma*, or *complex developmental trauma* in their interviews, terms similar to the language used

in the Pretorius et al. (2018) audit. This idea of complex trauma is one that needs further exploration as a useful concept which is positioned somewhere between the more traditional diagnosis on which NICE guidelines are based, and the respondents' more descriptive accounts of the specific negative experiences of patients, experiences often relating to their family environments.

NICE guidelines themselves were not mentioned explicitly by all but one respondent, who when they did refer to them, did so in a negative way. Perhaps what remains as a challenge is the ever increasingly complexity of young people seen at CAMHS, so familiar to the clinicians working there, which are often hard to square with the single comorbidity diagnoses on which NICE guidelines rest. This could particularly be the case for psychotherapy patients who "don't fit the same boat as other children" (Kam & Midgley, 2006, p.36) even within the vast variety of patients which clinicians encounter in CAMHS. It may also be indicative of the environment in present day CAMHS that with increasing severity, patients' mental health issues can rarely be reduced to one or even two comorbidities.

Another part of the explanation could be that there is more of a link in the respondents' minds between cause and effect, how what has happened to *this* particular child or young person has caused them to develop mental health problems, aspects which are less of a feature in NICE guidelines. This link between cause and effect could be explained by both clinicians' training and the assessment work conducted in CAMHS settings which aims to gain a long-term view of the patient's environment, family, and inter-generational mental health problems, rather than focusing solely on one mental health concern. This disjunct could also be explained by the CAMHS model, where services such as the one in this study which are classified as Tier 3 (or 'Getting More help' in I-thrive terms) are specifically

designed to offer more extensive forms of help to address complex cases that may often require input from more than one clinician. In terms of where the emphasis is placed, what respondents seemed to have at the forefront of their minds was how the experiences that CAMHS patients had been through could connect with their presentation and so with the likelihood of them being appropriate for psychotherapy, not whether they had single-comorbidity anxiety or depression. There seems to be an emerging dichotomy between the hard, defined criteria of guidelines and the soft skills of respondents in understanding the varying nuances of each patient's situation as outlined in the theme *'Clinical intuition versus guidelines'.* Whilst these other factors are harder to account and legislate for in guidelines because they are difficult to quantify or make generalisations about between clinics, these findings still present implications for how relevant the NICE guidelines may be to the modern decision-making process within CAMHS clinics.

Team process

Further to the above, the thematic analysis suggests that the decision to allocate a patient to psychotherapy included factors beyond simply patient characteristics as conceived in the primary research question. It also included the *process* of allocation itself, namely whether a psychotherapist was present at the meeting where the patient was being discussed for allocation, and that the current context of high risk and high demand were both factors that could also influence respondents' decisions.

These findings regarding the team process could be seen to challenge the notion that a decision made by a multi-disciplinary team is always able to provide the 'best care' as it is designed to do (Transform England, 2022). From the respondents' perspectives if a psychotherapist is not present at the multidisciplinary team, the

likelihood of young person being allocated to psychotherapy decreases. One explanation might be that the self-perceived lack of knowledge there is about psychotherapy translates into a lack of confidence in allocation to this treatment without the contribution of someone trained in psychotherapy. However, the understanding of who should be allocated was demonstrated to be consistent and relatively comprehensive, so the respondents are in fact better placed than they might believe themselves to be to appropriately allocate to this intervention. Another consideration is whether in this fast-paced, high-risk, quick fix culture in which the MDT was seen to operate, without representation, psychotherapy is unlikely to be considered because other interventions are favoured for their brevity and more immediate accessibility. If the allocation process is quick in nature, *and* also searching for a quick, short-term solution as well, then waiting for the next MDT at which there is a psychotherapist may not feel possible when the level of risk that is being managed is so high. It is significant that that the pressures of waitlists and the culture this had fostered, is not referenced in the earlier studies (2004-2006), but by 2017, it is referenced by the Curen (2017) study, as one of a series of factors, and is then referred to repeatedly by respondents in the present research project. Perhaps the impact of long waitlists as a factor has increased in line with the increase in demand for CAMHS services. Indeed, the perception of respondents that there has been a rise in demand is corroborated by the national referral rate which has risen throughout the 2000's and then still further both during and after the COVID-19 Pandemic (Young Minds, 2023).

Team process was also seen to influence allocation within the existing literature. For example, Kam (2004) also found that the make-up of the team during a decision-making process could influence the outcome. This study differed from the present

research in that the project did not record the presence or absence of a psychotherapist, but did record the specific discipline of the referring respondents, finding that some disciplines (Asian counsellors) were less likely to refer than others (social workers) (Kam, 2004). In fact, with the present research when there was a question of whether a discipline was more or less likely to refer, all respondents were clear they did not think that referral to psychotherapy was linked to the discipline or training of the referring clinician.

The difference between Kam's study (2004) and the current one, could be explained by the different disciplines in each clinic, and the corresponding different perceptions of these disciplines about psychotherapy: there were no Asian counsellors in the current study for example. Again here, it is important to question whether the answers were influenced by the respondents' awareness that the researcher conducting the interviews was also a member of the team, and so respondents may have wished to avoid making potentially contentious statements about colleagues.

The finding about the relative importance of a psychotherapy presence at the allocation meeting has implications for the team in question where there is only one psychotherapist. This means that if this one clinician is on leave, or sick, or on training and so are absent from a multi-disciplinary team meeting, even if a patient being discussed is meeting the profile for psychotherapy, and clinical intuition is aligned with this, the patient is much less likely to actually be allocated to this intervention. More broadly, one could speculate about the relative referral rates to psychotherapy in relation to the psychotherapy presence within the multi-disciplinary team and wider services across the United Kingdom. Perhaps in services where there is a higher and more consistent presence of psychotherapists, patients,

regardless of their profile, may be more likely to be allocated to psychotherapy because it has greater representation in the MDT.

The findings of this study are, for the most part, very much in-step with previous research, some of which is nearly 20 years old, and because of this could be taken (with caution) to show a consistent pattern of themes over time within the limited number of studies conducted in this area. However, there are some key *new* findings in this research project. When compared to earlier research, the analysis within this study showed there was an increased presence in respondents' minds to this culture of limited resources and high demand from increasingly high-risk patients. This may in turn be contributing to a decision-making process that favours shorter-term interventions over psychotherapy. It also went further in producing and analysing themes that delved into what a psychotherapy patient was really needing with the theme *'Going deep'*, and connected this to the idea of that some patients were understood to need a new 'developmental object' in the person of a psychotherapist to help them redress through events and relationships that were traumatising and hard to make sense of. In addition, whilst previous research was London-centric, the current research project has begun to expand the geographical reach of literature on psychotherapy allocation, albeit, still within the South of England. Whilst there were some significant findings, the were also some limitations that need further consideration and by way of contextualising some of the findings.

Reflections and Limitations

The prime limitation of this study is that the researcher is a psychotherapy trainee in the clinic where the interviews were conducted. This means they have a pre-existing relationship with all interviewees that was cordial and perhaps could have

influenced respondents towards being more positive about psychotherapy and its allocation than they may otherwise have been. The researcher was well acquainted with all of the respondents and had good working relationships with them. This may have inclined the respondents to be less forthcoming in bringing any negative views of psychotherapy such as those found by Kam and Midgley (2006) regarding the potential for psychotherapy to be viewed as 'precious'. In addition to the impact it may have had on the respondents to be interviewed by a colleague, it is also worth reflecting on the impact it had in the interviewer and interview process. When interviewing colleagues, the researcher was very aware of the time the colleagues had given up to attend the interview process. In thinking about why there may have been a resistance to probe on the part of the interviewer, it may have been that there was a desire not to make the respondents feel uncomfortable, or doubt their own answers, or for the interview to take too long given that they had so much else to do in a busy clinic. Whilst there were often follow up questions asked, both as part of the schedule and as they arose in the moment, perhaps the was a desire to ensure the respondents did not regret their decision to take part in the research.

The researcher’s background in psychoanalytic psychotherapy also means there are likely to be many pre-conceptions and ideas about who gets treated via psychotherapy within CAMHS. This will inevitably have influenced the decisions about which questions to include in the semi-structured interview, and how to further probe the respondents’ answers. Whilst the questions were reviewed with the supervisor of this research project, they were not triangulated with anyone outside of the psychotherapy profession. In part answer to this, it should be noted that the respondents often brought up topics not considered or prompted by the semi-structured interview schedule, suggesting that the space allowed for the respondent

to bring their own ideas was being effectively utilised. Despite this, it does need to be acknowledged that the findings will have been influenced by the researcher's discipline in terms of the formation of the interview questions, and this extends to include the thematic analysis of the respondents' interviews as well. What was noticed, identified, and then confirmed as a relevant 'code', and how these connected to create themes were to a significant extent determined by the researcher's own academic judgement.

Further to the above, there are limitations about the location of the research. Whilst it was conducted outside of the typical inner London areas in which much of the previous relevant research has taken place, it was still in the South of England area, which has a different cultural and financial context compared to other areas of England, particularly the North (The Progressive Policy Think Tank, 2022). So whilst it could be seen as adding to a body of evidence for this area, it must be acknowledged that it has not helped to bridge the gap between research conducted in the south and other areas of the United Kingdom in relation to psychotherapy allocation in CAMHS. It was also conducted in an area with high ethnic homogeneity limiting its relevance to those from ethnic backgrounds other than White-British, but also meaning that the area of ethnicity and its potential relation to psychotherapy allocation would have been difficult to explore in any meaningful way. More specific statistics regarding ethnicity have not been included to maintain confidentiality of participants.

A further consideration is that the respondents were from *one* clinic making the findings quite specific in their scope. This clinic also had only one psychotherapist

who worked part time, which is in stark contrast to some other clinics which are more well-resourced and also to those where psychotherapy is still entirely absent.

Finally, in terms of the interview methodology, four out of five interviews were conducted over zoom. There is evidence to support the idea that this format is less natural, and can result in a less engaging interview process, which has been found to limit participants capacity for creative thinking (European Commission, 2022). The interviews themselves varied significantly in length (min 35 minutes, max 68 minutes), and perhaps a more experienced interviewer would have known to try and probe more with those respondents who gave short answers to some of the questions. It is also worth noting that the respondent who interviewed in person appeared to take more pauses when considering their answers to questions, and they asked for more clarification than some other respondents. Overall, this face to face interview process seemed more akin to a two-way discussion, compared to some respondents being interviewed online where some answers to questions were quite short and literal. Whilst this could in part be attributed to the respondent themselves, the different setting for the interview needs to be acknowledged as this may have also have an impact on the resulting transcript. Finally, as previously mentioned, the relationship between the researcher and the interviewees may account for this, the researcher may not have wanted to demand too much of the interviewees who were voluntarily taking time out of busy work schedules (as reported by respondents) to do the interviews.

Application of research

Regarding the application of this research, the findings will be delivered to the team in the clinic that this project focused on. It will be important to reflect back to

the team that the research suggests they have a more reliable and cohesive idea regarding who is appropriate for psychotherapy than they might imagine, and could have more confidence in allocating to psychotherapy even if a representative of this discipline is not present. The patient profile that has been identified can be shared with the team and used to open a discussion on whether this profile resonates with other clinicians not in the project. This could in turn lead to a more general discussion and review of who is allocated to which intervention in the clinic and whether patient profiles could also be created for these modalities. This research also builds on a growing body of evidence on the impact of resources to allocation, and the fundamental role that this plays in the decision-making process of clinicians. This could be seen to run counter to the intent of the multi-disciplinary model, which is based on combining different disciplines observations and formulations to achieve the best outcome for patients.

Further to the above, this research drew attention to how little is still understood about the process of psychotherapy, and how the idea of it as a long-term intervention remains firm in clinicians' minds. This is despite many adaptions being made to the length of treatment, including Short-term Psychoanalytic Psychotherapy, State of Mind assessments and brief work including the Tavistock consultation service which utilises a 4-session model (Carrington et al. 2012). Perhaps the adaptations within the psychoanalytic community need to be more effectively disseminated to other professions. This was also identified as a perception in other research (Kam & Midgley, 2006), that clinicians were unsure of what psychotherapy involved. This suggests that offering more understanding and insight into what psychotherapy involves as well as the different iterations within

psychotherapy could be beneficial if the MDT is to move closer to providing the 'best care' model it aspires to.

Further, whilst some preliminary conclusions have been drawn about the influence of the presence or absence of a psychotherapist on the multi-disciplinary team, perhaps more research could be helpful to explore the impact of the presence or absence of clinicians from different backgrounds. For example, what difference would it make if the family therapist was present, considering that like psychotherapy, they use a model that is not (like CBT) necessarily fully understood by all other disciplines? Perhaps there is more to be understood about the potential 'mystery' that surrounds Child and adolescent psychotherapy and where this comes from, in addition to the barriers such a sense of mystery might pose in a modern CAMHS setting to the shared decision-making processes of the MDT. In this clinic specifically, it would be interesting to conduct this study again in 1-2 years' time, as the Senior Psychotherapist is currently developing a pathway for patients aged 17+ which is centred on a 10-12 session model based around Psychoanalytic psychotherapy. One could speculate that the introduction of this model could shift perceptions of psychotherapy as a long-term intervention with a correspondingly long waitlist.

It has been referenced throughout this project that, had there been more time and resources, then different decisions may have been made. For example, it would have been beneficial to interview clinicians across multiple clinics, so that the findings could be stated with more confidence. It may be that some of the findings were as Midgley and Kam (2006) refer to it, contextual factors which were clinic specific. It would have made the research more robust and possible to generalise with more confidence, if by interviewing multiple clinicians from different clinics, one

could then look in more detail at the patterns between different clinics and between different disciplines as well. It would also have been helpful to have complemented the interviews with an audit of the psychotherapy waitlist and the waitlists for other modalities. This would have enabled the perspectives of clinicians gathered in the interview process to be compared and contrasted with the demographics and defined mental health issues of the population served by this clinic.

There was also a question surrounding NICE guidelines, highlighted in this research project, in terms of how pertinent they are to the modern CAMHS Tier 3 patient population. Whilst the NICE guidelines focused predominantly on diagnostic categories, such as 'depression, anxiety, and eating disorders', respondents tended to focus on those who had been through significant adversity in childhood, had experienced bereavement, or who may have been removed from their primary carers. As discussed previously psychotherapy is advised as a treatment of choice in relation to sexually abused girls aged 6-14, and there is a reference to trauma informed approaches for looked after children, but there remains a distinct contrast in the language used between NICE guidelines and the CAMHS clinicians within this project. Perhaps there is room for expansion within NICE guidelines, not just to be more specific on the role of psychotherapy for those who have been through adversity relating to primary care experiences, but also whether there needs to be specific guidance with some defined sub-categories relating to treatments for children and young people who have suffered complex developmental trauma. This is a category of description that was often a central part of the respondents' thinking, but not given its own place explicitly in NICE guidelines.

Finally, in an increasingly crisis management, resource deprived system, further research is needed to explore what place psychotherapy has in this system

and how the skills of the psychotherapist can be best utilised when the pressures of throughput are so significant, and how it can best utilised in a system that was referred to by one clinician in this project as a '12 session model'.

Reflexivity and considerations on intersectionality

Whilst there have been multiple attempts made to triangulate the design and research process of this project, it is important to acknowledge where the researcher's personal characteristics may have shaped the decisions surrounding design, analysis and interpretation. As Charafi & Cohen-Miller (2024) highlight, the personal characteristics of the research team are fundamental to the way research is conceived, designed, and interpreted, and without reflecting on them, it can lack important contextualisation.

The researcher training as a psychoanalytic psychotherapist is likely to have meant they approached the project with a favourable view of Psychoanalysis and a potential bias. This could be viewed as influencing the literature review which focused on what psychoanalytic psychotherapy *was* helpful for with less reference made to other modalities and their potential benefits. Whilst the case for psychoanalytic psychotherapy being helpful for more comorbidities than it is recommended for by NICE guidelines was supported by the systematic reviews, one could also posit that training in this discipline is likely to lead to a bias in thinking it is a very valuable intervention that as the ACP recommends, is potentially helpful for almost all mental health issues. The researcher's discipline may also have led to interpreting the interviewee's answers in a way that was favourable to psychoanalytic psychotherapy, as well as looking for confirmations of what they already felt to be true anecdotally, and from their own experience. One could also

speculate that more attention may have been given to the two clinicians who were trained psychodynamically, whose ideas and use of language may have been closer to the ideas and language used by the researcher.

Beyond discipline, it is also worth acknowledging that the researcher is a heterosexual, White British, cis-gender male, from a middle-class background in the South of England. In addition, the research supervisor shares some similar characteristics, being a White British, middle class, cis-gender woman also from the South of England. The issue of race was not raised in relation to psychotherapy allocation owing to the high level of homogeneity in the area served by this clinic in question, as outlined in the methodology. However, the inability to assess the potential connection between race or ethnicity and psychotherapy allocation can be seen as an area which is lacking in this research. The characteristics of the researcher can be seen in what one could term the heteronormative semi-structured interview schedule, where issues relating to gender, and sexuality are not included as main questions or prompts. Some of the questions that were included could also be seen as relating directly to areas of interest of the interviewer. This includes a question on the relationship between neurodiversity and psychotherapy allocation. Whilst it is an area of contention relating to whether young people with certain neuro-diversities are more appropriate for some interventions than others, as a member of the neuro-diverse community themselves, the researcher is likely to have wanted to focus on this issue more than a neuro-typical researcher might have.

Finally, in considering how the interviews were conducted it is important to reflect on the power dynamics. All but one of the participants were female, and the historical power structures that have been predominantly and remain to this day

dominated by the male population could be seen to put the male interviewer in a position of power (Kalbfleisch & Cody, 2012). This may have influenced the female participants to give certain answers to the interview questions, which may have been different had they been interviewed by someone identifying as female or non-binary. This in addition to the power dynamic that might have existed relating to the interviewer being the one who is asking the questions, keeping the time, and who knows more about what they are exploring and the overall purpose of the interviews. This issue also comes back to the researcher's discipline, as for the nurse, social worker, and integrative psychotherapist, the researcher may have been seen as being in a privileged position by training through a fully funded NHS training programme, where they have the opportunity to conduct an extensive piece of primary research. By contrast, the aforementioned three clinicians are required to self-fund much of their training. It is important to acknowledge these latent influences on the development of the literature review, interview schedule, conduct of interviews, and the interpretation of them. Perhaps during the project itself the focus in the researcher's mind was on their position as a trainee, whilst in hindsight and with more thought given to it, the various characteristics of the researcher and interviewees will have intersected in various ways to influence this research project with a higher level of complexity than was initially appreciated.

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Appendices

Appendix A-Participant Information sheet

Children and Young Adolescent Families

The Tavistock and Portman

NHS Foundation Trust

Tavistock Centre

120 Belsize Lane

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Participant Information Sheet

Who is allocated psychotherapy in a Tier 3 CAMHS setting?

What is the purpose of the study?

To explore the CAMHS clinicians understanding of who is allocated psychotherapy. For example, are there any potential commonalties that characterise patients who are allocated to the wait list for psychotherapy.

What is the study about?

The study is about gaining a more in-depth understanding of the clinician's understanding regarding which young people are allocated to psychotherapy. Factors

to be considered include risk, age, gender, mental health presentation or service history. On what basis do these young people get allocated to psychotherapy and do clinicians have different ideas on this?

Who is undertaking the study?

The lead researcher in this study is Conor Morgan, child and adolescent psychotherapist in Doctoral Training. The study is supervised by Dr Miriam Creaser. Contact details for the research team can be found at the end of this information sheet.

What will happen if I choose to take part?

- If you decide to take part in the study, you will need to complete a consent form. This will be completed prior to the interview.
- You will be invited to participate in a face-to-face interview at time convenient for you, or online if needed due to covid 19.
- During this semi-structured interview, you will be invited to answer a series of questions designed to open up a conversation about the subject matter. Your answers will be recorded and collected as data. This data will be stored anonymously in accordance with GDPR guidelines.
- It is anticipated that the interview will take approximately one hour.

Confidentiality: how will information about me and data gathered in the study be used and stored?

If you chose to participate in the study your data will be stored anonymously. Your anonymity will be protected in the analysis of data and the report of findings. Data will initially be stored in a pass. It will then be transferred to an electronic file which will be

password protected. Data will be kept for no more than 3 years, at which point it will be destroyed. Data generated in the course of this study will be kept in accordance with the University of Essex Data Protection Policy.

Please note: **The confidentiality of the information that you provide is subject to legal limitations in data confidentiality (i.e., the data may be subject to a subpoena, a freedom of information request or mandated reporting by some professions).**

What will happen to the results of the study?

The results of the study will be written up as part of the researcher's Professional Doctorate in psychoanalytic child and adolescent psychotherapy. The study's findings may also be submitted for publication in professional journals or presented as conference papers. The study's findings may also form the basis for future research or presented in workshops or seminars.

Is there a benefit to taking part in the study?

-The findings may aid understanding in the decision-making process of assigning patients to psychotherapy within ********** CAMHS clinic.

-You may also consider your participation as contributing to the wider discussion and research base on work within Tier 3 CAMHS settings.

It will provide you with the opportunity to participate in a wider professional discussion and share your experiences with someone who is interested in learning about your clinical practice and formulations.

Are there any risks or disadvantages to participating in the study?

There are no anticipated risks or disadvantages to participating in the study. It is not expected that this study will be out of the boundaries of normal working experiences but in the unlikely event that you have any questions about the study please contact me.

Further Support and Guidance:

Should you have any queries or concerns about the conduct of the research, please contact Simon Carrington who oversees the Tavistock Centre's Academic Governance and Quality Assurance.

Further support on debriefing or advising on adverse reactions can be sought by conducting Dr Creaser, the project's Research Supervisor, or through your own professional support networks (colleagues, supervisors, analysts).

In the highly unlikely event that risk to self or other be shared during the interview; statutory reporting will need to occur. I would initially need to consult with my Research Supervisor and the Head of Safeguarding at the Tavistock Centre who would guide me in managing this highly unlikely situation.

Withdrawing:

If you have a query about withdrawing your data, please contact either myself or Dr Creaser. To preserve the study's data collection timeline, should you wish to withdraw

your data from the study please notify the Researcher within 6 weeks of the interview, after that time the data will be included as it will be too late to recruit another participant.

Thank you for taking time to read this information sheet.

If you have any questions about the study, please contact:

Researcher: Conor Morgan

Email: connor1914@live.com

Research Supervisor: Dr Miriam Creaser

Email: miriamcreaser@hotmail.com

Any concerns about the conduct of the research:

Head of Academic Governance and Quality Assurance: Simon Carrington Email: academicquality@tavi-port.nhs.uk

This project has been approved by: The Tavistock and Portman Research Ethics Committee (TREC). It is sponsored by Brian Rock on behalf of the Trust.

Appendix B -Consent form for participants

Children and Young Adolescent Families

The Tavistock and Portman

NHS Foundation Trust

Tavistock Centre

120 Belsize Lane

London NW3 5BA

Tel: +44 (0)20 7435 7111

Fax: +44 (0)20 7447 3733

www.tavi-port.org

Consent Form

	Please tick
I confirm that I have read and understood the information sheet provided for this study. I have been given the time to consider the information, ask any questions and have had these answered sufficiently.	
I understand that my participation in this study is voluntary.	

I can confirm that I have a professional network to support me in the unlikely event that I need further support following the interview.	
I understand that the interview will be digitally audio recorded and following this then transcribed.	
If I decide that I would like my data to be removed from the study, I understand that I can utilise the 6-week cooling off period after the interview by contacting Conor Morgan at the following email address: connor1914@live.com	
I understand that the information given in this interview may be used by the researcher in future publications, reports, presentations.	
I understand that any personal data that could be used to identify me will be removed from the transcript of my interview and that I will not be identified in any publications, reports or presentations.	
I understand that due to the small sample size of the study, as well as sampling of my colleagues who I worked with on the case I will talk about in the interview, it is likely that these colleagues will be able to recognize which data belongs to me. This is a limitation of the study that I am willing to accept.	
I understand there are limitations to confidentiality where disclosure of imminent harm to self-and/or others may occur.	

Participant's name:			
Participant's signature:		Date:	
Researcher's signa-ture:		Date:	

Research Identification Number:

Thank you for agreeing to participate in this study.

Appendix C-Interview schedule.

Interview-semi-structured questions

Who do you think is appropriate for psychotherapy generally? Prompt:

Ask about factor/s more specifically.

Prompt: Was there one or more stand out factors that led you Prompt:

Neuro-diversity.

Why might other interventions seem less appropriate?

What role if any might a patients risk play in considering their suitability for psychotherapy?

What role might the patient's home and school environment play in considering suitability?

Would you consider age to be a factor in suitability for psychotherapy?

Prompt, 'Why?'

In your mind, is there a particular patient presentation that most naturally fits with psychotherapy?

When would you consider another intervention other than psychotherapy?

When would it really not be appropriate?

Have you noticed any differences between clinicians from different disciplines and who they consider appropriate for psychotherapy?

Prompt, what might these be specifically?

What do you imagine psychotherapy to involve?

Has this interview highlighted anything for you concerning who gets Psychotherapy?

Are there any questions you would like to ask me?

Appendix D- Ethics form.

The Tavistock and Portman NHS
NHS Foundation Trust

Tavistock and Portman Trust Research Ethics Committee (TREC)

APPLICATION FOR ETHICAL REVIEW OF STUDENT RESEARCH PROJECTS

This application should be submitted alongside copies of any supporting documentation which will be handed to participants, including a participant information sheet, consent form, self-completion survey or questionnaire.

Where a form is submitted and sections are incomplete, the form will not be considered by TREC and will be returned to the applicant for completion.

For further guidance please contact Paru Jeram (academicquality@tavi-port.nhs.uk)

FOR ALL APPLICANTS

If you already have ethical approval from another body (including HRA/IRAS) please submit the application form and outcome letters. You need only complete sections of the TREC form which are NOT covered in your existing approval

Is your project considered as 'research' according to the HRA tool? (http://www.hra-decisiontools.org.uk/research/index.html)	No
Will your project involve participants who are under 18 or who are classed as vulnerable? (see section 7)	No
Will your project include data collection outside of the UK?	No

SECTION A: PROJECT DETAILS

Project title	Who Gets Psychotherapy? An Audit of the Psychotherapy Waitlist in a Generic CAMHS Setting.

Proposed project start date	09/2021	**Anticipated project end date**	**09/2023**
Principle Investigator (normally your Research Supervisor): Dr Miriam Creaser			
Please note: TREC approval will only be given for the length of the project as stated above up to a maximum of 6 years. Projects exceeding these timeframes will need additional ethical approval			
Has NHS or other approval been sought for this research including through submission via Research Application System (IRAS) or to the Health Research Authority (HRA)?	**YES (NRES approval)** ☐ ☐ **YES (HRA approval)** ☐ **Other** ☒ **NO**		
If you already have ethical approval from another body (including HRA/IRAS) please submit the application form and outcome letters.			

SECTION B: APPLICANT DETAILS

Name of Researcher	Conor Morgan
Programme of Study and Target Award	M80 Professional Doctorate in Child and Adolescent Psychotherapy
Email address	connor1914@live.com
Contact telephone number	07716210435

SECTION C: CONFLICTS OF INTEREST **Will any of the researchers or their institutions receive any other benefits or incentives for taking part in this research over and above their normal salary package or the costs of undertaking the research?**

YES ☐ **NO** ☒

If **YES**, please detail below:

Is there any further possibility for conflict of interest? YES ☐ **NO** ☒

Are you proposing to conduct this work in a location where you work or have a placement?

YES ☒ **NO** ☐

If **YES**, please detail below outline how you will avoid issues arising around colleagues being involved in this project:

-Colleagues will be given the choice as to whether to participate and provided with a participant information sheet and then a consent form if they decide to take part. (Both forms are attached to this application.)

-I will need to carefully consider how the findings of the project are reported back to my CAMHS team. There could potentially be some difficulties if the project had findings which indicate something different to my colleagues current understanding. If done sensitively and constructively though, any findings that highlight area's where processes or institutional understanding could be improved could actually be beneficial.

Is your project being commissioned by and/or carried out on behalf of a body external to the Trust? (for example; commissioned by a local authority, school, care home, other NHS Trust or other organisation). *Please note that 'external' is defined as an organisation which is external to the Tavistock and Portman NHS Foundation Trust (Trust)	**YES** ☐ **NO** ☒

If **YES**, please add details here:

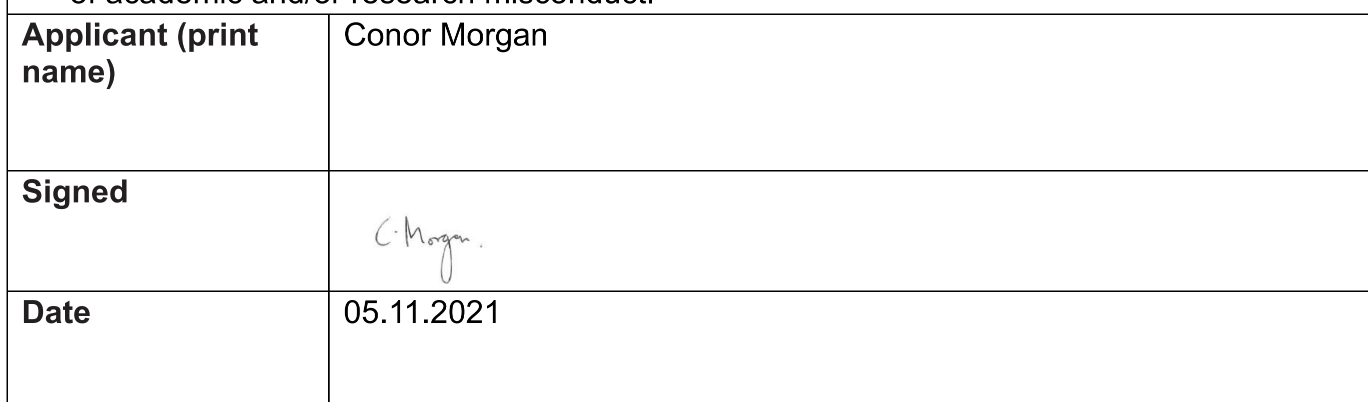
Will you be required to get further ethical approval after receiving TREC approval?	YES ☐ NO ☒
If **YES**, please supply details of the ethical approval bodies below AND include any letters of approval from the ethical approval bodies (letters received after receiving TREC approval should be submitted to complete your record):	
If your project is being undertaken with one or more clinical services or organisations external to the Trust, please provide details of these:	
**********CAMHS Address removed to maintain confidentiality.	
If you still need to agree these arrangements or if you can only approach organisations after you have ethical approval, please identify the types of organisations (eg. schools or clinical services) you wish to approach:	
Do you have approval from the organisations detailed above? (this includes R&D approval where relevant) attach approval letters to this application. Any approval letters received after TREC approval has been granted MUST be submitted to be appended to your record	**YES** ☒ **NO** ☐ **NA** ☐ -Service Manager Please Confirmation attached.

SECTION D: SIGNATURES AND DECLARATIONS

APPLICANT DECLARATION

I confirm that:

- The information contained in this application is, to the best of my knowledge, correct and up to date.
- I have attempted to identify all risks related to the research.
- I acknowledge my obligations and commitment to upholding ethical principles and to keep my supervisor updated with the progress of my research
- I am aware that for cases of proven misconduct, it may result in formal disciplinary proceedings and/or the cancellation of the proposed research.
- I understand that if my project design, methodology or method of data collection changes I must seek an amendment to my ethical approvals as failure to do so, may result in a report of academic and/or research misconduct.



Applicant (print name)	Conor Morgan
Signed	
Date	05.11.2021

FOR RESEARCH DEGREE STUDENT APPLICANTS ONLY

Name of Supervisor/Principal Investigator	

Supervisor –

• Does the student have the necessary skills to carry out the research? **YES x**
NO ☐ ☐

 Is the participant information sheet, consent form and any other documentation appropriate?
YES x ☐**NO** ☐

 Are the procedures for recruitment of participants and obtaining informed consent suitable and sufficient?
YES x☐ **NO** ☐

 Where required, does the researcher have current Disclosure and Barring Service (DBS) clearance?
YES x☐ **NO** ☐

Signed	[signature]
Date	19th October 2021

COURSE LEAD/RESEARCH LEAD Does the proposed research as detailed herein have your support to proceed? YES ☒ NO ☐	
Signed	Brinley G. Yare DIGITAL SIGNATURE
Date	10 Nov 2021

SECTION E: DETAILS OF THE PROPOSED RESEARCH

1. **Provide a brief description of the proposed research, including the requirements of participants. This must be in lay terms and free from technical or discipline specific terminology or jargon. If such terms are required, please ensure they are adequately explained (Do not exceed 500 words)**
The primary aim of this research is to explore whether there are certain commonalties that typify patients who are allocated to the wait list for psychotherapy in my training placement *********** CAMHS. For example, does it tend to be those that have being through a series of other interventions first; what

role might a patient’s level of risk play; is age a factor or is it patients who are deemed to have a capacity to reflect who are seen as appropriate for an intervention which focuses on the internal world of an individual. This research project will attempt to explore this question using qualitative and quantitative research methods.

The quantitative component will involve compiling descriptive statistics on the same patients included in the qualitative analysis. This will include but is not limited to the child’s: gender; age; length of time in CAMHS; number of previous interventions; number of risk incidents; whether the child is subject to a child protection plan and number of missed sessions and length of time from initial assessment to being allocated ot the psychtherapy waitlist. This is in an attempt to the delineate the patient’s service history.

The qualitative component will include two parts. The first is a thematic analysis of the process notes clinicians have made for those patients on the psychotherapy waitlist.

At the outset this will include:

Initial Assessments

Risk assessments

Reports for Diagnosis

End of treatment Summaries (interventions prior to Psychotherapy)

Check in phone calls /Emails where there has been a request from CAMHS for an update in the patient's current mental health presentation within the last year.

Care plans.

The second part will be a small group of semi-structured interviews with the case holders of each patient on the psychotherapy waitlist. This will act a point of comparison for the thematic analysis conducted on the clinicians process notes. The hope is this will allow some meaningful conclusions to be drawn regarding the decision making processes from the clinicians who made them rather than solely relying on the secondary analysis of the process notes.

This qualitative component will attempt to add a depth to the quantitative component in the hope of achieving a richer picture of the different patients allocated to the psychotherapy waitlist.

2. Provide a statement on the aims and significance of the proposed research, including potential impact to knowledge and understanding in the field (where appropriate, indicate the associated hypothesis which will be tested). This should be a clear justification of the proposed research, why it should proceed and a statement on any anticipated benefits to the community. (Do not exceed 700 words)

The rationale for this research is three-fold. In my experience of this CAMHS setting different clinician's have different understandings of who is appropriate for psychotherapy, this influences their decisions on who they put

forward to the team for consideration. Some clinicians appear to believe it is for the most complex cases who have exhausted all other options. Others have suggested that a patient needs to have an interest in talking to a professional and a pre-existing capacity to reflect in order to make use of what psychotherapy can offer. These different ideas are perhaps in part explained by the fact that there are no distinct criteria within ********** CAMHS regarding who is and is not appropriate for this intervention. Ultimately the case is presented at a team meeting and in liaison with the one psychotherapist, they are either agreed to be appropriate or not for a psychotherapy assessment. Thus the primary rationale is an attempt to enhance the transparency of who is being allocated to this intervention. This is with a view to potentially feeding this information back to the team.

The second aim would be to establish if there are any patterns regarding who is allocated which could lead to an increased awareness around any underlying rationales for the decisions being made and how this could potentially be improved within this service. Finally, the third aim would be for this research to make a small but important contribution to the current literature on which patients are currently perceived to be appropriate for psychotherapy. This seems particularly pertinent given the ongoing evolution of both psychotherapeutic practice and the ever increasing complexity of the patients being seen by CAMHS in 2021.

3. Provide an outline of the methodology for the proposed research, including proposed method of data collection, *tasks* assigned to participants of

the research and the proposed method and duration of data analysis. If the proposed research makes use of pre-established and generally accepted techniques, please make this clear. (Do not exceed 500 words)

The Methodology consists primarily of three parts:

Quantitative

First, a decision will need to be made around what descriptive statistics need to be collected which will be partly based on academic judgment, referencing the literature review and being partly based on what has been recorded on the system where patient information is stored. The options are anticipated to be factors such as age, gender, number of risk incidents, length of time in CAMHS and whether the child is subject to a child protection plan.

At this point in the project the descriptive statistics component is considered to be the first step, however it may become apparent during the latter stage of analysis that there are certain descriptive statistics that are more pertinent than others and this will have to be reviewed ongoingly.

Second: Qualitative part 1

Process notes will be collated for:

Initial Assessments

Risk assessments

Reports for Diagnosis

End of treatment Summaries (interventions prior to Psychotherapy)

Check in phone calls /Emails where there has been a request from CAMHS for an update in the patient's current mental health presentation (within the last year)

Care plans

Third: Qualitative part 2

A series of short intervews will be completed with the case holders for the patients on the wait list to consider their understanding of why they thought these young people were appropriate for psychotherapy.

All three sets of data will be compiled on a work-based computer which is pass-word protected and kept on site. The information itself will be anonymised for any identifying details including patients and clinicians. This data for the patients on Carenotes exists as part of normal clinical practice, pre-dates this study and only patients who have not signed the op-out form will be included.

The patients included will be from the psychotherapy waitlist as it existed in November 2020. This is because having analysed wait lists at several different points in time, this wait list has the most participants who have consented to have their data used by the trust for research and service improvement. This consent is given when they attend their initial assessment by having the choice to fill in an opt-out form (attached in appendix). I have not included two patients on this list as

I am due to begin work with them and this seemed unethical, and there was a concern that my knowledge of these patients would compromise the thematic analysis. As a result the number of patients included in this research is five. At present it is expected this will allow for enough data to enable meangiful conlusions to be drawn whilst working within the time constraints that exist. The thematic analysis of the notes from the aforementioned documents will use Braun and Clarke's guidelines (2006), and utilise Nvivo software if available. The findings of both the descriptive statistics, thematic analysis and the interviews will be presented in the results section. The descriptive statistics will be presented in tables with accompanying explanation. For the thematic analysis pertinent excepts from the process notes will be used as examples to represent themes as they are briefly elaborated in the Findings section. Thematic maps will be included to provide a clear picture of what could be understood from the analysis. The interviews with clinicians will then be drawn on to inform the discussion of the results.

SECTION F: PARTICIPANT DETAILS

4. **Provide an explanation detailing how you will identify, approach and recruit the participants for the proposed research, including clarification on sample size and location. Please provide justification for the exclusion/inclusion criteria for this study (i.e. who will be allowed to / not allowed to participate) and explain briefly, in lay terms, why these criteria are in place. (Do not exceed 500 words)**

I will identify the relevant clinicians based on who their allocated case holder was at time of them being aassgined to the Psychotherapy waitlist. This information should be recorded on Care notes (clinical record system in my Trust).

The relevant clinicians will be approached with a participation information sheet to guage interest and ask if they would consider being part of the project. If they agree they will be provided with a consent form, then a time will be arranged to conduct the inteveview either face to face or through video call depending on social distancing restrictions at the time.

Inclusion / Exclusion criteria is based on whether a clinician was a case holder for one of the patient's on the psychotherapy waitlist at the time of allocation.

Sample size will be between 3-5 as some clinicians will have recommended more than one patient for Psychotherapy on the wait list. To be clear, none of the patient's on the waitlist, will be interacted with or have their treatment altered in any way as a result of the intended research.

5. **Please state the location(s) of the proposed research including the location of any interviews. Please provide a Risk Assessment if required. Consideration should be given to lone working, visiting private residences, conducting research outside working hours or any other non-standard arrangements.**

   If any data collection is to be done online, please identify the platforms to be used.

Interviews will take place either face to face at ************ Clinic or over video link depending on social distance restrictions at the time and what is more convenient for the participant.

6. Will the participants be from any of the following groups? ***(Tick as appropriate)***

- ☐ Students or Staff of the Trust or Partner delivering your programme.
- ☒ Adults (over the age of 18 years with mental capacity to give consent to participate in the research).
- ☐ Children or legal minors (anyone under the age of 16 years)[1]
- ☐ Adults who are unconscious, severely ill or have a terminal illness.
- ☐ Adults who may lose mental capacity to consent during the course of the research.
- ☐ Adults in emergency situations.
- ☐ Adults[2] with mental illness - particularly those detained under the Mental Health Act (1983 & 2007).
- ☐ Participants who may lack capacity to consent to participate in the research under the research requirements of the Mental Capacity Act (2005).
- ☐ Prisoners, where ethical approval may be required from the National Offender Management Service (NOMS).
- ☐ Young Offenders, where ethical approval may be required from the National Offender Management Service (NOMS).
- ☐ Healthy volunteers (in high risk intervention studies).
- ☒ Participants who may be considered to have a pre-existing and potentially dependent[3] relationship with the investigator (e.g. those in care homes, students, colleagues, serviceusers, patients).
- ☐ Other vulnerable groups (see Question 6).
- ☐ Adults who are in custody, custodial care, or for whom a court has assumed responsibility.
- ☐ Participants who are members of the Armed Forces.

[1] If the proposed research involves children or adults who meet the Police Act (1997) definition of vulnerability[3], any researchers who will have contact with participants must have current Disclosure and Barring Service (DBS) clearance.

[2] 'Adults with a learning or physical disability, a physical or mental illness, or a reduction in physical or mental capacity, and living in a care home or home for people with learning difficulties or receiving care in their own home, or receiving hospital or social care services.' (Police Act, 1997)

[3] Proposed research involving participants with whom the investigator or researcher(s) shares a dependent or unequal relationships (e.g. teacher/student, clinical therapist/service-user) may compromise the ability to give informed consent which is free from any form of pressure (real or implied) arising from this relationship. TREC recommends that, wherever practicable, investigators choose participants with whom they have no dependent relationship. Following due scrutiny, if the investigator is confident that the research involving participants in dependent relationships is vital and defensible, TREC will require additional information setting out the case

and detailing how risks inherent in the dependent relationship will be managed. TREC will also need to be reassured that refusal to participate will not result in any discrimination or penalty.

7. Will the study involve participants who are vulnerable? YES NO

For the purposes of research, ‘vulnerable’ participants may be adults whose ability to protect their own interests are impaired or reduced in comparison to that of the broader population. Vulnerability may arise from:

- the participant’s personal characteristics (e.g. mental or physical impairment)
- their social environment, context and/or disadvantage (e.g. socio-economic mobility, educational attainment, resources, substance dependence, displacement or homelessness).
- where prospective participants are at high risk of consenting under duress, or as a result of manipulation or coercion, they must also be considered as vulnerable
- children are automatically presumed to be vulnerable.

7.1. If YES, what special arrangements are in place to protect vulnerable participants’ interests?

If YES, a Disclosure and Barring Service (DBS) check **within the last three years** is required.
Please provide details of the “clear disclosure”:

Date of disclosure:
Type of disclosure:
Organisation that requested disclosure:
DBS certificate number:

*(NOTE: information concerning activities which require DBS checks can be found via https://www.gov.uk/government/publications/dbs-check-eligible-positions-guidance). Please **do not** include a copy of your DBS certificate with your application*

8. **Do you propose to make any form of payment or incentive available to participants of the research? YES ☐ NO ☒** If **YES**, please provide details taking into account that any payment or incentive should be representative of reasonable remuneration for participation and may not be of a value that could be coercive or exerting undue influence on potential participants' decision to take part in the research. Wherever possible, remuneration in a monetary form should be avoided and substituted with vouchers, coupons or equivalent. Any payment made to research participants may have benefit or HMRC implications and participants should be alerted to this in the participant information sheet as they may wish to choose to decline payment.
9. **What special arrangements are in place for eliciting informed consent from participants who may not adequately understand verbal explanations or written information provided in English; where participants have special communication needs; where participants have limited literacy; or where children are involved in the research? (Do not exceed 200 words)**
NA, all participants are CAMHS colleagues.

SECTION F: RISK ASSESSMENT AND RISK MANAGEMENT

10. Does the proposed research involve any of the following? *(Tick as appropriate)*

☐ use of a questionnaire, self-completion survey or data-collection instrument (attach copy) use of emails or the internet as a means

☒ of data collection use of written or computerised tests

☐ interviews (attach interview questions)

☒ diaries (attach diary record form) participant observation participant

☐ observation (in a non-public place) without their knowledge / covert

☐ research audio-recording

☐ interviewees or events

video-recording interviewees or events

☒

access to personal and/or sensitive data (i.e. student, patient, client or

☐ service-

☒ user data) without the participant's informed consent for use of these data for research purposes ☐ administration of any questions, tasks, investigations, procedures or stimuli

which may be experienced by participants as physically or mentally painful, stressful or unpleasant during or after the research process ☐ performance of any acts which might diminish the self-esteem of participants

or cause them to experience discomfiture, regret or any other adverse emotional or psychological reaction

☐ Themes around extremism or radicalisation

☐ investigation of participants involved in illegal or illicit activities (e.g. use of illegal drugs) procedures that involve the deception of participants

☐ administration of any substance or agent use of non-treatment of

☐ placebo control conditions participation in a clinical trial research

☐ undertaken at an off-campus location (risk assessment attached)

☐ research overseas (please ensure Section G is complete)

☐

☐

11. **Does the proposed research involve any specific or anticipated risks (e.g. physical, psychological, social, legal or economic) to participants that are greater than those encountered in everyday life?** **YES** ☐ **NO** ☒ If **YES**, please describe below including details of precautionary measures.
12. **Where the procedures involve potential hazards and/or discomfort or distress for participants, please state what previous experience the investigator or researcher(s) have had in conducting this type of research.**
No potential hazards identified.
13. **Provide an explanation of any potential benefits to participants. Please ensure this is framed within the overall contribution of the proposed research to knowledge or practice. (Do not exceed 400 words) NOTE:**
CAMHS colleagues may gain a deeper insight into the decision making processes of those young people who are placed on the Psychotherapy waitlist, and how close this is to their current understanding and expectations. They may also derive some satisfaction from feeling they are contributing to the development of the service.
14. **Provide an outline of any measures you have in place in the event of adverse or unexpected outcomes and the potential impact this may have on participants involved in the proposed research. (Do not exceed 300 words)**
NA.
15. **Provide an outline of your debriefing, support and feedback protocol for participants involved in the proposed research. This should include, for example, where participants may feel the need to discuss thoughts or feelings brought about following their participation in the research. This may involve referral to an external support or counseling service, where participation in the research has caused specific issues for participants.**
-Outlined in consent form attached.

16. Please provide the names and nature of any external support or counselling organisations that will be suggested to participants if participation in the research has potential to raise specific issues for participants.
-NA
17. Where medical aftercare may be necessary, this should include details of the treatment available to participants. Debriefing may involve the disclosure of further information on the aims of the research, the participant's performance and/or the results of the research. (Do not exceed 500 words)
-NA

FOR RESEARCH UNDERTAKEN OUTSIDE THE UK

18. Does the proposed research involve travel outside of the UK?
☐ **YES** ☒ **NO**

If YES, please confirm:

☐ I have consulted the Foreign and Commonwealth Office website for guidance/travel advice? http://www.fco.gov.uk/en/travel-and-living-abroad/

☐ I have completed ta RISK Assessment covering all aspects of the project including consideration of the location of the data collection and risks to participants.

All overseas project data collection will need approval from the Deputy Director of Education and Training or their nominee. Normally this will be done based on the information provided in this form. All projects approved through the TREC process will be indemnified by the Trust against claims made by third parties.

If you have any queries regarding research outside the UK, please contact academicquality@tavi-port.nhs.uk:

Students are required to arrange their own travel and medical insurance to cover project work outside of the UK. Please indicate what insurance cover you have or will have in place.
19. Please evidence how compliance with all local research ethics and research governance requirements have been assessed for the country(ies) in which the research is taking place. Please also clarify how the requirements will be met:

SECTION G: PARTICIPANT CONSENT AND WITHDRAWAL

20. Have you attached a copy of your participant information sheet (this should be in *plain English*)? Where the research involves non-English speaking participants, please include translated materials. **YES** ☒ **NO** ☐ If **NO**, please indicate what alternative arrangements are in place below:
21. Have you attached a copy of your participant consent form (this should be in *plain English*)? Where the research involves non-English speaking participants, please include translated materials. **YES** ☒ **NO** ☐ If **NO**, please indicate what alternative arrangements are in place below:
22. The following is a <u>participant information sheet</u> checklist covering the various points that should be included in this document. ☒ Clear identification of the Trust as the sponsor for the research, the project title, the Researcher and Principal Investigator (your Research Supervisor) and other researchers along with relevant contact details. ☒ Details of what involvement in the proposed research will require (e.g., participation in interviews, completion of questionnaire, audio/video-recording of events), estimated time commitment and any risks involved.

☒ A statement confirming that the research has received formal approval from TREC or other ethics body.

☒ If the sample size is small, advice to participants that this may have implications for confidentiality / anonymity.

☒ A clear statement that where participants are in a dependent relationship with any of the researchers that participation in the research will have no impact on assessment / treatment / service-use or support.

☒ Assurance that involvement in the project is voluntary and that participants are free to withdraw consent at any time, and to withdraw any unprocessed data previously supplied.

☒ Advice as to arrangements to be made to protect confidentiality of data, including that confidentiality of information provided is subject to legal limitations.

☒ A statement that the data generated in the course of the research will be retained in accordance with the Trusts 's Data Protection and handling Policies.: https://tavistockandportman.nhs.uk/about-us/governance/policies-andprocedures/

☒ Advice that if participants have any concerns about the conduct of the investigator, researcher(s) or any other aspect of this research project, they should contact Simon Carrington, Head of Academic Governance and Quality Assurance (academicquality@tavi-port.nhs.uk)

☒ Confirmation on any limitations in confidentiality where disclosure of imminent harm to self and/or others may occur.

23. The following is a consent form checklist covering the various points that should be included in this document.

☒ Trust letterhead or logo.

☒ Title of the project (with research degree projects this need not necessarily be the title of the thesis) and names of investigators.

☒ Confirmation that the research project is part of a degree

☒ Confirmation that involvement in the project is voluntary and that participants are free to withdraw at any time, or to withdraw any unprocessed data previously supplied.

☒ Confirmation of particular requirements of participants, including for example whether interviews are to be audio-/video-recorded, whether anonymised quotes will be used in publications advice of legal limitations to data confidentiality.

☒ If the sample size is small, confirmation that this may have implications for anonymity any other relevant information.

☒ The proposed method of publication or dissemination of the research findings.

☒ Details of any external contractors or partner institutions involved in the research.

☒ Details of any funding bodies or research councils supporting the research.

☒ Confirmation on any limitations in confidentiality where disclosure of imminent harm to self and/or others may occur.

SECTION H: CONFIDENTIALITY AND ANONYMITY

24. **Below is a checklist covering key points relating to the confidentiality and anonymity of participants. Please indicate where relevant to the proposed research.**

☐ Participants will be completely anonymised and their identity will not be known by the investigator or researcher(s) (i.e. the participants are part of an anonymous randomised sample and return responses with no form of personal identification)?

☐ The responses are anonymised or are an anonymised sample (i.e. a permanent process of coding has been carried out whereby direct and indirect identifiers have been removed from data and replaced by a code, with no record retained of how the code relates to the identifiers).

☒ The samples and data are de-identified (i.e. direct and indirect identifiers have been removed and replaced by a code. The investigator or researchers are able to link the code to the original identifiers and isolate the participant to whom the sample or data relates).

☐ Participants have the option of being identified in a publication that will arise from the research.

☒ Participants will be pseudo-anonymised in a publication that will arise from the research. (I.e. the researcher will endeavour to remove or alter details that would identify the participant.)

☒ The proposed research will make use of personal sensitive data.

☐ Participants consent to be identified in the study and subsequent dissemination of research findings and/or publication.

25. Participants must be made aware that the confidentiality of the information they provide is subject to legal limitations in data confidentiality (i.e. the data may be subject to a subpoena, a freedom of information request or mandated reporting by some professions). This only applies to named or de-identified data. If your participants are named or de-identified, please confirm that you will specifically state these limitations.

YES ☒ **NO** ☐

If **NO**, please indicate why this is the case below:

NOTE: WHERE THE PROPOSED RESEARCH INVOLVES A SMALL SAMPLE OR FOCUS GROUP, PARTICIPANTS SHOULD BE ADVISED THAT THERE WILL BE DISTINCT LIMITATIONS IN THE LEVEL OF ANONYMITY THEY CAN BE AFFORDED.

SECTION I: DATA ACCESS, SECURITY AND MANAGEMENT

26. Will the Researcher/Principal Investigator be responsible for the security of all data collected in connection with the proposed research? YES ☒ **NO** ☐

If **NO**, please indicate what alternative arrangements are in place below:

27. In line with the 5th principle of the Data Protection Act (1998), which states that personal data shall not be kept for longer than is necessary for that purpose or those purposes for which it was collected; please state how long data will be retained for.

☐ 1-2 years ☒ 3-5 years ☐ 6-10 years ☐ 10> years

NOTE: In line with Research Councils UK (RCUK) guidance, doctoral project data should normally be stored for 10 years and Masters level data for up to 2 years

28. Below is a checklist which relates to the management, storage and secure destruction of data for the purposes of the proposed research. Please indicate where relevant to your proposed arrangements.

☐ Research data, codes and all identifying information to be kept in separate locked filing cabinets.

☐ Research data will only be stored in the University of Essex OneDrive system and no other cloud storage location.

☒ Access to computer files to be available to research team by password only.

☐ Access to computer files to be available to individuals outside the research team by password only (See **23.1**).

☐ Research data will be encrypted and transferred electronically within the UK.

☐ Research data will be encrypted and transferred electronically outside of the UK.

NOTE: Transfer of research data via third party commercial file sharing services, such as Google Docs and YouSendIt are not necessarily secure or permanent. These systems may also be located overseas and not covered by UK law. If the system is located outside the European Economic Area (EEA) or territories deemed to have sufficient standards of data protection, transfer may also breach the Data Protection Act (1998).

Essex students also have access the ‘Box’ service for file transfer: https://www.essex.ac.uk/student/it-services/box

☐ Use of personal addresses, postcodes, faxes, e-mails or telephone numbers.

☒ Collection and storage of personal sensitive data (e.g. racial or ethnic origin, political or religious beliefs or physical or mental health or condition).

☒ Use of personal data in the form of audio or video recordings.

☐ Primary data gathered on encrypted mobile devices (i.e. laptops).

NOTE: This should be transferred to secure University of Essex OneDrive at the first opportunity.

☒ All electronic data will undergo secure disposal.

NOTE: For hard drives and magnetic storage devices (HDD or SSD), deleting files does not permanently erase the data on most systems, but only deletes the reference to the file. Files can be restored when deleted in this way. Research files must be overwritten to ensure they are completely irretrievable. Software is available for the secure erasing of files from hard drives which meet recognised standards to securely scramble sensitive data. Examples of this software are BC Wipe, Wipe File, DeleteOnClick and Eraser for Windows platforms. Mac users can use the standard 'secure empty trash' option; an alternative is Permanent eraser software. ☒ All hardcopy data will undergo secure disposal. **NOTE:** For shredding research data stored in hardcopy (i.e. paper), adopting DIN 3 ensures files are cut into 2mm strips or confetti like cross-cut particles of 4x40mm. The UK government requires a minimum standard of DIN 4 for its material, which ensures cross cut particles of at least 2x15mm.
29. Please provide details of individuals outside the research team who will be given password protected access to encrypted data for the proposed research.
None
30. Please provide details on the regions and territories where research data will be electronically transferred that are external to the UK:
None

SECTION J: PUBLICATION AND DISSEMINATION OF RESEARCH FINDINGS

30. How will the results of the research be reported and disseminated? *(Select all that apply)*

- ☒ Peer reviewed journal
- ☒ Non-peer reviewed journal
- ☐ Peer reviewed books
- ☐ Publication in media, social media or website (including Podcasts and online videos)
- ☐ Conference presentation
- ☐ Internal report
- ☐ Promotional report and materials
- ☐ Reports compiled for or on behalf of external organisations
- ☒ Dissertation/Thesis
- ☐ Other publication
- ☐ Written feedback to research participants
- ☒ Presentation to participants or relevant community groups
- ☐ Other (Please specify below)

SECTION K: OTHER ETHICAL ISSUES

31. Are there any other ethical issues that have not been addressed which you would wish to bring to the attention of Tavistock Research Ethics Committee (TREC)?

SECTION L: CHECKLIST FOR ATTACHED DOCUMENTS

32. Please check that the following documents are attached to your application.
☒ Letters of approval from any external ethical approval bodies (where relevant) ☐ Recruitment advertisement ☒ Participant information sheets (including easy-read where relevant) ☒ Consent forms (including easy-read where relevant) ☐ Assent form for children (where relevant) ☒ Letters of approval from locations for data collection ☐ Questionnaire ☒ Interview Schedule or topic guide ☐ Risk Assessment (where applicable) ☐ Overseas travel approval (where applicable)
34. Where it is not possible to attach the above materials, please provide an explanation below.