An Interpretative Phenomenological Analysis study exploring the experience of Support Workers working in Child and Adolescent Mental Health Services teams.

A thesis submitted for the degree of Professional Doctorate in Child and Adolescent Psychotherapy.

The Tavistock and Portman. University of Essex.

Date of submission for examination September 2025

Marie Nicholson

ABSTRACT

This thesis explores the experiences and sense making, of support workers employed in Child and Adolescent Mental Health Services (CAMHS). Support workers play a vital role in delivering frontline mental health care, yet their voices are often underrepresented in research and workforce planning. The study aims to understand how these staff make sense of their professional role, challenges, and contributions within multidisciplinary teams.

Using an Interpretative Phenomenological Analysis (IPA) approach, semi-structured interviews were conducted with five support workers across four CAMHS settings. Data were analysed ideographically and thematically to capture participants' meaning-making processes. A psychoanalytic perspective underpins this research providing the lens through which data were analysed and interpreted. Organisational dynamics within CAMHS teams are considered from a psychoanalytic perspective in relation to the research questions and findings.

The findings highlight three overarching themes: (1) The challenges of establishing a professional identity and sense of belonging within a clinical hierarchy, (2) the tension between the dual senses of feeling valued and lacking worth, and (3) the emotional labour of working with high-risk and vulnerable young people.

This study contributes to the limited literature on unregistered clinical support staff in CAMHS, offering insights for workforce and role development, enhanced role support and utilisation, and the integration of support worker perspectives into service planning and policy.

ACKNOWLEDGEMENTS

This project would not have happened without the inspiration and support of a large number of people. Firstly, I give thanks to the support workers, past and present, who I have had the privilege of working alongside. Your commitment, energy, compassion and care have not gone unnoticed and if nothing else comes from this project, I hope you recognise how much you are valued and appreciated.

I offer huge thanks to my Research Supervisor Dr. Felicitas Rost, for her relentless wisdom, curiosity and patience during this process and to colleagues – both M80 and CAMHS, who have endured countless hours of me wittering on and being distracted and confused. Thanks for all the cups of coffee.

I want to thank my friends who have supported me in the right way at the right time. Your encouragement and belief have kept me afloat during times when I would have undoubtedly sunk without you. Thanks for keeping me motivated.

Finally, I owe an enormous debt of gratitude to my ever-steady partner, who has offered soothing words in stressful times, righteous indignation at just the right moments and a constant and unceasing level of practical and emotional support throughout this journey. I would not have managed this without you.

CONTENTS

CHAPTER ONE – INTRODUCTION **7**
1.1 – THE PERSONAL REASONS BEHIND THIS PROJECT 8
1.2 – THE PROFESSIONAL REASONS BEHIND THIS PROJECT 10
1.3 – THE RATIONALE FOR THIS PROJECT 10
CHAPTER TWO - LITERATURE REVIEW **12**
2.1 - INTRODUCTION TO THE LITERATURE REVIEW 12
2.2 – A REVIEW OF THE THEORETICAL AND CONCEPTUAL LITERATURE 13
2.2.1 - Introduction 13
2.2.2 - Method 13
2.2.3 - Results 17
2.2.4 – Conclusions Drawn from Reviewing the Theoretical and Conceptual Literature 22
2.3 - A REVIEW OF THE RESEARCH 22
2.3.1 - Introduction 22
2.3.2 – Method 23
2.3.3 - Results 25
2.3.4 – Conclusions Drawn from Reviewing the Qualitative Research 29
2.4 – A REVIEW OF THE CONTEXTUAL LITERATURE 31
2.4.1 - Introduction 31
2.4.2 - Method 31
2.4.3 - Results 33
2.4.5 – Conclusions Drawn from Reviewing the Contextual Literature 39
2.5 – CONCLUSION OF THE LITERATURE REVIEW 40
CHAPTER THREE - METHODOLOGY **42**
3.1 - INTRODUCTION 42
3.2 – DESIGN 42
3.2.1 - Why IPA was selected 42
3.2.2 - Reflexivity in IPA 43
3.2.3 - Private Theories 44
3.3 – THE SETTING 45

3.4 - PARTICIPANTS 46
3.4.1 - Participant Summary 47
3.4.2 - Inclusion and Exclusion Criteria 47
3.4.3 - Consideration and management of boundaries, power dynamics and issues of bias in pre-existing relationships with participants. 48
3.5 - DATA COLLECTION METHOD 51
3.5.1 - Recruitment 51
3.5.2 - The Interview Process 51
3.6 – DATA ANALYSIS 52
3.6.1 – Transcription and Data Storage 52
3.6.3 - Beginning the Data Analysis 53
3.6.4 - Developing Personal Experiential Themes (PET's) 53
3.6.5 - Developing Group Experiential Themes (GET's) 54
3.7 – ETHICAL CONSIDERATIONS 55
CHAPTER FOUR - FINDINGS 57
4.1 - INTRODUCTION 57
4.2 - SUPERORDINATE THEME 1: ISSUES OF IDENTITY AND BELONGING ... 57
4.2.1 – Subordinate Theme 1: A Search for Identity 58
4.1.2 – Subordinate Theme 2: A Sense of Belonging 60
4.3 – SUPERORDINATE THEME 2: A QUESTION OF VALUE AND WORTH 64
4.2.1 – Subordinate Theme 1 - Feeling Valued 65
4.3.2 – Subordinate Theme 2 - Questioning Worth 67
4.3.3 - The Intersection Between Value and Worth 71
4.4 – SUPERORDINATE THEME 3: THE WEIGHT OF RESPONSIBILITY 71
4.4.1 – Subordinate Theme 1 - "You feel so responsible for their life" 72
4.4.2 – Subordinate Theme 2 - "I don't know what I'm doing." 74
CHAPTER FIVE - DISCUSSION 78
5.1 - INTRODUCTION 78
5.2 – ISSUES OF IDENTITY AND BELONGING 79
5.2.1 - A Search for Identity 79
5.2.2 - A Sense of Belonging 84
5.3 – A QUESTION OF VALUE AND WORTH 88
5.3.1 – Feeling Valued 88

5.3.2 – Questioning Worth 91
5.4 – THE WEIGHT OF RESPONSIBILITY 95
5.4.1 – “You Feel So Responsible for Their Life.” 96
5.4.2 - “I Don’t Know What I’m Doing.” 98
5.5 – DISCUSSION - LINKING THE FINDINGS WITH THE AIMS AND OBJECTIVES 100
5.5.1 – Who Are the People Who Take Up This Role? 101
5.5.2 – What Can We Learn About the Role? 102
5.5.3 – What Can We Learn About Working in CAMHS? 105
5.6 - LIMITATIONS OF THE CURRENT STUDY 111
5.6.1 - Reflexivity Explored: Considerations of my own position as researcher, including potential bias. 116
5.7 – CONCLUSION 118
REFERENCES 120
APPENDICES 126
APPENDIX A – ACRONYMS AND LITERATURE SEARCH INFORMATION 128
APPENDIX B – ETHICAL APPROVAL AND TRUST PERMISSION 141
APPENDIX C – PUBLIC FACING DOCUMENTS 172
APPENDIX D – DATA ANALYSIS 182

CHAPTER ONE – INTRODUCTION

This research study has come about for a number of reasons, both personal and professional. I shall begin by explaining my personal reasons before discussing the professional reasons. I will then offer a rationale for undertaking this project and outline the research aims and objectives.

I have held the title of 'support worker' a number of times in settings which include housing, residential childcare, offender management, care leavers, education and youth justice. The scope of the support worker role is vast and extends far beyond these few examples. While there is clearly immense variety and difference across the various sectors in which support workers might be found, surely there must also be something which unites this group and something that is fundamentally consistent to the role or to the people who choose to take it up?

Health Education England (2021, p.10), reported that as of March 2021, CAMHS had a total of 15,486 whole-time equivalent staff across NHS services in England, with a 54% increase in unregistered support worker staff compared to 2019. The authors of this report suggest that this is perhaps partly a response to increased funding from CCG's and creative attempts to manage gaps in the recruitment and retention of the workforce.

The make-up of the children's mental health workforce has undergone a number of changes over the years, some radical, some seemingly circular. The emergence of the support worker role in CAMHS is perhaps just one small thread of the fabric of health service changes but one that I believe deserves further exploration and

attention. Support workers do not only provide support to patients and families, they provide support to CAMHS colleagues and it is time that their voices are heard.

1.1 – THE PERSONAL REASONS BEHIND THIS PROJECT

Prior to embarking upon the child psychotherapy training, I worked in a CAMHS team as a Mental Health Practitioner (MHP). At that time, the title of MHP was not being used within the Trust, but *Senior* Mental Health Practitioner (SMHP) was. I had not intended to be a MHP or to work in CAMHS. I had been employed for the two years prior in the role of Primary Mental Health Worker (PMHW), working for the Local Authority's tier two targeted mental health service. When I applied for the role, I met the recruitment criteria with my Diploma in Therapeutic Counselling. The role at that time was paid at the equivalent of a NHS Band 6 role.

My previous working experience had centred around various types of support work and working with children and young people. Events in my personal life had brought me closer to wanting to better understand mental health and I began to forge a career in the discipline. When an opportunity arose to take on a PMHW role, I seized it.

I learned a lot in the two years I held the role and then things changed. The service was suddenly up for tender and a not so nearby NHS Trust was interested in acquiring it. Inevitably, they were successful and the process of TUPE'ing (Transfer of Undertaking (Protection of Employment)) the small team of PMHW's into CAMHS began.

I was now employed by the NHS. The Trust who took over did not recognise my counselling qualification and as such, lengthy discussions took place around pay and NHS banding. I was no longer 'qualified' to do the job I was employed to do and the process was exceedingly painful, stressful and frustrating.

I settled into my new team who were kind and understanding and we were allocated 2 desks and associated equipment to share between the three of us. My two former colleagues found other jobs and moved on within 6 months. I was alone, but at least I had my own desk now.

We were an anomaly when it came to what to call us and how to categorise us. There were also challenges associated with which aspects of the role we could take on. SMHP's are expected to carry out regular Duty tasks and to take part in an on-call rota. While I was initially paid at a Band 6 salary, I was deemed 'unqualified' and so was not able to perform these functions within the team. I was frequently told (not unkindly), that I was 'unqualified' or 'unregistered' and so unable to do a particular thing. Furthermore, I didn't belong anywhere, I didn't have a professional group or lead.

I continued in my role and gained a lot of experience and knowledge. The service underwent changes guided by national and local policy shifts, and new teams and roles emerged. Roles in specialist eating disorder and in crisis and outreach teams were appealing to me but I was unable to apply for them as they were Band 6 roles. I began to feel increasingly stuck. Other Band 5 roles were rolled out, but I couldn't apply for them as I was 'unqualified'. My experience, skills and qualities didn't count.

At the end of my first year in CAMHS, a new colleague arrived, recalled from a secondment. The role was 'support worker' and they were gainfully employed on a Band 3 salary. They told me that they had been working in this role in one form or another for almost 40 years. They were and still are, the most skilled, thoughtful, generous, kind and empathic clinician I have worked with. We excelled in being 'unqualified' together and shared the burden of being referred to by our bandings,

being called ‘the unqualified’s’, of being reminded what we *weren’t*. We remained anomalies for a long time. Eventually, and partly in response to a crisis in recruiting ‘qualified’ staff, more support worker roles were created across local CAMHS teams.

1.2 – THE PROFESSIONAL REASONS BEHIND THIS PROJECT

After 8 years in that team, I moved on to embark on child psychotherapy training. During the second year of my training, my placement in a neighbouring CAMHS team began to take on support workers. One of them, whom I shall call Jemma, was 21 years old and straight out of a psychology degree. She was enthusiastic and motivated. One day I overheard her on the phone; she was having a difficult conversation and when it was over, she burst into tears. She told me that she had called a parent to pass on a message that her daughter would be seen next week. The mother was upset and angry at the wait and shouted “If she’s still alive by then which is unlikely and it’ll be your fault!” before hanging up the phone.

Jemma was devastated and terrified. I escorted her to find a manager to explain the situation. The manager we encountered was upset on Jemma’s behalf and commented “It’s not right what these Band 3’s have to put up with.” I walked back to my office with two questions on my mind: Why *do* they put up with it? And, are they supported enough to *be able* to put up with it? This incident marked the birth of this project.

1.3 – THE RATIONALE FOR THIS PROJECT

I have been fortunate enough to encounter and work alongside some excellent support workers. I have also watched a lot of them leave their roles. Sometimes this has been to pursue further training, sometimes because the job has been too difficult in one way or another, sometimes because they felt they were worth more. Sometimes support

workers hold risky and/or complex cases. There may be another clinician involved but it is likely that the support worker has the most contact with the patient or family and often in the community, away from immediate contact with supportive colleagues. And they manage all this without the solid theoretical and practical framework that a formal professional training provides.

This project is an exploration into this emerging part of the CAMHS workforce. Who are they? What are their hopes and aspirations and can the support worker role meet them? What exactly is the role and what function does it serve in CAMHS? Do they feel valued? What can we learn from support workers about working in CAMHS?

As a psychoanalytic psychotherapy trainee, I have employed this theoretical lens throughout the project. Psychoanalytic thinking underpins the interpretation of data as evidenced in the Findings and Discussion chapters. Psychoanalytic theory has been used to understand organisational dynamics in CAMHS teams and to explore unconscious processes present for support workers in their roles.

I interviewed 5 support workers for this project, they represent a range of backgrounds and hold varying levels of experience, education, training and qualifications. They have arrived in their roles for a variety of reasons and hold both shared and very different views to each other as my qualitative analysis has highlighted.

I hope that the findings from this study can take some steps towards the role being better understood, better defined and better supported.

CHAPTER TWO - LITERATURE REVIEW

2.1 - INTRODUCTION TO THE LITERATURE REVIEW

This literature review aims to explore the published literature relating to the experience of support workers working in CAMHS teams. I am curious to explore and understand the emergence and meaning of the role in the wider NHS and in CAMHS. Within the broader context of the research question are some more focused questions:

- Who are the people who take up this role?
    - What are their hopes for themselves and the role? What do they bring to the role? Why do they choose to take up the role?
- What can we learn about the role?
    - Do support workers feel their role is valued? Is the role useful and what function does it serve in modern CAMH services?
- What can we learn from support workers about working in CAMHS?
    - How can this learning help in understanding the changing shape and purpose of CAMHS?

This review will be conducted in stages with separate literature searches to address each question. I will first explore the theoretical and conceptual framework to answer the question of who and what support workers are. To answer the second question, I will conduct a review of the existing qualitative research of the support worker role. To address the third question, I will explore the contextual literature including a review of recent and current NHS workforce planning and policy documents to build an understanding of the role and its place in CAMHS.

2.2 – A REVIEW OF THE THEORETICAL AND CONCEPTUAL LITERATURE

2.2.1 - Introduction

This part of the review aims to explore the conceptual and theoretical literature that relates to who support workers are. In starting my literature review, I soon found that there is very limited literature relating to the subject of CAMHS support workers. Therefore, the scope of the literature review was widened to explore what has been written about the 'support worker' role in other health settings. It soon became apparent that the role of support worker is vast and varied. I have tried to ensure that the included literature links to the aims of this project and that it pertains primarily to mental health settings.

2.2.2 - Method

Literature regarding the experiences of support workers in CAMHS settings in the United Kingdom was searched. All available databases were searched using EBSCO discovery. A full list of databases searched can be found in **Appendix A – Acronyms and Literature Search Information.**

Inclusion and Exclusion Criteria

The search parameters were limited to publications in English between the years 2000 and 2025. This time frame was selected to enable a focus on the current picture of support workers and the role. Only publications with a linked full text were included in the search. The search terms, the resulting number of texts and number of excluded and included texts of the search are summarised in Table 1.

Table 1 – Literature Search for Question 1

SEARCH TERMS USED INCLUDING BOOLEAN OPERATORS	NUMBER OF RESULTS	NUMBER EXCLUDED	NUMBER SELECTED	OUTCOME

			FOR SCREENING	
SEARCH 1 Experience OR perceptions OR attitudes OR views **AND** Support Workers **AND** CAMHS OR Child and Adolescent Mental Health Service	143	136	7 papers were selected for review. All of these papers contained the term 'peer support worker'	0 papers selected for review
SEARCH 2 Support + worker **NOT** peer **AND** CAMHS OR Child and Adolescent Mental Health Service	34	34	0	0 papers selected for review
SEARCH 3 CAMHS support + worker OR Healthcare Assistant OR HCA **NOT** peer **AND** Experience	906	903	3	1 paper included for review
SEARCH 4 Support + Worker **AND** Role or duties **AND** Mental + health **NOT** Peer	916	912	4	1 paper included for review
SEARCH 5 Google Scholar Search using 'experience of support workers in CAMHS'	17,000	All but 1 of the papers were excluded	1	1 paper included for review
SEARCH 6 unregistered or unqualified or support + worker or HCA or healthcare assistant **AND** CAMHS or Adolescent inpatient **AND**	153	153	0	0 papers selected for review

Experience or perception				
SEARCH 7 Snowball Technique	2	0	2	2 papers included for review

As shown, the search strategy identified five relevant papers to be reviewed. Scanning the abstracts excluded the vast majority for reasons that there was either a different and specific professional group involved, such as nurses, social workers or psychologists; or that papers had a specific focus, such as children looked after, school-based treatment and topics including 'burn-out', 'wellbeing' and 'trauma'.

Literature was found that relates to the role of 'peer support workers' but was not included. Peer support workers are employed in both paid and voluntary roles across the health and social care sector and valued for their contributions based on their lived experience (Cooper et al., 2024). While there may be some common ground, the differences in the roles outweigh the similarities and I believe that including this group in this review would not add anything other perhaps than more confusion.

After reviewing the literature about peer support workers, I made the decision to exclude it from this study for a number of reasons. Firstly, I was unable to find any literature about peer support workers working in CAMHS settings. Literature about peer support workers exclusively focused on those working in adult services.

Secondly, while both roles include the term 'support worker' I believe the remit of these roles to be quite different. As Cooper et al., (2004) outline, peer support workers are employed *because* of their own lived experiences of mental health difficulties. The rationale for the role is around support and connection through shared experience, befriending and role modelling. CAMHS support workers are employed in clinical roles requiring a different approach, different boundaries and different role

expectations. Further, the research reviewed covered peer support workers in both paid and voluntary roles, making it again, quite a different role to the role of CAMHS support worker.

The decision to exclude literature relating to peer support workers from this study perhaps raises some ideological and political implications. There has been a drive to build on and increase the number of peer support workers working across the health and social care sectors in recent years. By excluding peer support workers from this study, it is possible that I am excluding useful information that could help to make sense of the wider support worker role and experience of those in such roles.

By choosing to not include peer support workers in this study I am aware that I am potentially contributing to a divide between two similar but distinctly separate roles. As this study is comparatively small in nature and is focused on the experience of CAMHS support workers, there is no scope for incorporating literature pertaining to peer support workers working in adult services. Had I found literature relating to peer support workers in CAMHS settings, it is likely that I would have included a thorough review of it as the shared ground would have been a valuable connection to explore.

Due to the lack of information and published literature relating specifically to CAMHS support workers, I expanded my literature search (Search 3) to include health care assistants (HCA's) in inpatient CAMHS and adult community mental health services. The term 'HCA' was present in the reviewed literature and it seems that there are some similarities between the role of CAMHS support worker and mental health HCA's. For example, HCA's are employed on similar NHS bandings, are often considered 'unregistered, unqualified or unregulated' and while community and inpatient settings

are different, the work of supporting people with mental health challenges is perhaps similar.

Of the initial five papers that made the inclusion criteria, one turned out to be more relevant for question two and is reviewed in the appropriate section. The other four papers are summarised in Table 2.

Table 2 – Summary of the Reviewed Papers:

1	Saks, M., & Allsop, J. (2007). Social Policy, Professional Regulation and Health Support Work in the United Kingdom. *Social Policy & Society*, *6*(2), 165–177.
2	Tudor, K., Cowan, C., Hennessy, J., MacEwan, I., & Warriner, R. (2017). Mental health support workers: Profession and professionalization. *International Journal of Mental Health*, *47*(1), 74–89.
3	Cavendish, C. (2013). *The Cavendish review: An independent review into healthcare assistants and support workers in the NHS and social care settings*. Department of Health.
4	Griffin, R., Kessler, I., & Hall, A. (2024). *The Cavendish Review: Ten years on – Are NHS support workers still "invisible"?* King's College London & University of Exeter.

2.2.3 - Results

Who are Support Workers?

The first part of the review focused on answering the question as to who support workers are. The literature highlighted that the title 'support worker' is vague and can be found in almost all parts of health and social care, within the public and charity sectors. Some estimates indicate that there are in excess of one million support workers in the UK (Saks and Allsop, 2007; Cavendish, 2013). This means they make

up one of the largest working groups within the healthcare system. As Saks and Allsop (2007) point out:

> "Support workers are a diverse and shadowy group who work across the health/social and the formal/informal boundary." (p.165)

The idea of support workers as 'shadowy' perhaps needs exploring. While there are negative connotations to this word, I believe the authors are reflecting more on the fact that support workers *reside in the shadows* and are therefore not seen, rather than that they are 'sinister'. They define support workers as:

> "A worker who provides face-to-face care or support of a personal or confidential nature to service users in clinical or therapeutic settings, community facilities or domiciliary settings, but who do not hold qualifications accredited by a professional association and is not formally regulated by a statutory body." (p.170)

The authors describe the diverse roles and locations in which support workers can be found and highlight some important ideas around "accredited qualifications" and regulation. This description outlines something of what the role entails and where it can be located, but interestingly also describes the workers by what they aren't, or don't have. This suggests that there are likely inherent difficulties in describing such a large and diverse group.

The issue of not holding accredited qualifications raises interesting questions about the function of support workers across various health and social care areas and perhaps suggests that they are not 'qualified' to perform certain duties within their services, but this leaves an open question as to what they *are* able to do and what they are employed to do.

Secondly, the authors outline the lack of regulation of support workers. Saks and Allsop raise concerns around patient safety when 'unregulated/unqualified or unregistered' staff are deployed to work directly with (often) vulnerable patient groups and often independently.

I included a paper by Tudor et al., regarding the professionalisation and regulation of support workers in New Zealand, since their description appears to mirror the picture in the UK regarding support workers and was therefore felt relevant. The authors laid out some interesting and helpful ideas regarding the role:

> "As an occupational group with no professional reference, support workers are held responsible to the professional and ethical standards of their employers…There is no professional development, research, or ongoing education supporting standard professional practice for support workers." (p.84)

The Cavendish Review (2013)

The Cavendish Review (2013), was an independent review commissioned by the UK Department of Health to examine the role, training, and development of HCAs and support workers in the NHS and social care. Authored by Camilla Cavendish, the review was commissioned in response to serious failings in the health and care sector where 'unregistered' workers were highlighted as a concern.

This Review focused broadly on healthcare assistants (HCA's) within NHS physical health settings and support workers in social care. Cavendish (2013) clarifies in a footnote (footnote 5, p.13) that the support workers in the Review were employed within adult social care to deliver community-based care. As such, there are significant differences between the support workers and their experiences described in the review and the support workers that the current study seeks to better understand. However,

Cavendish makes some important points and so a summary of the Review is included here.

The Review paints support workers as essential but undervalued and under-supported members of the healthcare workforce and highlights the significant concern of the lack of standardised training and regulation for both support workers and HCA's, identifying how this might contribute towards inconsistent care quality and safety.

The key points raised in the Cavendish Review focus on training and career progression, and the supervision and support needs of HCA's and support workers and suggests that HCA's and support workers need to receive good, high quality and regular supervision from qualified professionals to ensure the continuation of high levels of care and support for patients. A recommendation in the Review is the need for greater recognition of the contributions of support workers and HCA's.

The lack of clear pathways for progression was noted and Cavendish makes strong recommendations for addressing this, including the development of a national set of minimum standards (around training, experience and qualifications), the development of a universal code of conduct specific to each group, and systems to allow registration of the workforce that don't present unnecessary bureaucratic, cost or access barriers.

While the review is detailed and informative, grouping support workers and HCA's together perhaps adds confusion to an already confusing picture and makes it harder to pick out the differences in these workforces. There are evident similarities across these two groups, but there are also vast differences, most notably perhaps in the function of the roles.

Cavendish suggests the implementation of 'The Certificate of Fundamental Care' but was not clear about whether this would provide a suitable training base for mental

health support workers. While I agree that standardised training is necessary for unregistered staff, it is difficult to conceive of one that meets the needs of all of these diverse work groups.

The Cavendish Review Ten Years on: Are NHS Support Workers still 'invisible'? Griffin et al (2024)

Ten years after the publication of the Cavendish Review, Griffin et al, (2024) conducted a review to assess the impact of the Cavendish Review. They looked at what changes and developments had occurred and found that core recommendations have been implemented in varying ways. For example, the Cavendish Review recommended the introduction of the 'Certificate of Fundamental Care' as a starting point for standardisation of basic training. While this was introduced, Griffin et al., found that uptake of it remains limited. There is still significant lack of clarity around role duties and scope of practice. Accessing appropriate training and role development opportunities continues to be a challenge for many support workers and HCA's.

The title of this report questioned if support workers were still 'invisible' and this was interesting as Cavendish only used this word once and almost in passing in her review (2013, p.83). However, she does convey something of this quality about the group. Perhaps part of the difficulty in being visible relates to the apparent lack of organisation. By this, I mean that there is no professional body or framework to organise, represent or advocate for this group.

This review asked the question 'who are support workers?' and answered it with demographic statistics relating to age, ethnicity and length of time in role. While it is of interest to note that the majority of support workers are female, white and aged

between 51 and 65 (p.21-22), the authors did not engage further with this information to garner additional meaning.

2.2.4 – Conclusions Drawn from Reviewing the Theoretical and Conceptual Literature

Terms such as 'unregulated, unqualified, unregistered' appear somewhat interchangeably in the literature but have helped me to clarify my own approach and thinking. I will not be using the term 'unqualified' in this study, I find it dismissive, inaccurate and somewhat demeaning. For the purposes of this study, I prefer the term 'unregistered.'

The literature included in this section is minimal as I was unable to find anything specifically regarding CAMHS support workers. Further, the literature pertaining to support workers in a more general sense is also incredibly limited. The literature reviewed in this section highlights that unregistered roles are highly heterogeneous, varying significantly across settings, job titles, and local practices.

2.3 - A REVIEW OF THE RESEARCH

2.3.1 - Introduction

The second question guiding the literature review encompassed what we can learn about the role by primarily focusing on support workers' experience. I was unable to locate any studies that explored the experience of support workers working in CAMHS teams, the search was therefore also broadened out to include physical and mental health settings. The review found some literature that explored the experience of support workers in CAMHS inpatient settings, support workers working in Older Adult Community Mental Health teams and factors that affect HCA retention. Given the very limited literature, I also included one study that focused more broadly on allied health

professionals and their experience of feeling valued at work. The search focused on qualitative research studies.

2.3.2 – Method

The same inclusion and exclusion criteria were employed as described in section 2.2.2 with the addition that the area of work of support workers was broadened out. Table 3 summarises the search terms, and number of excluded and included papers.

Table 3 – Literature Search for Question 2:

SEARCH TERMS USED INCLUDING BOOLEAN OPERATORS	NUMBER OF RESULTS	NUMBER EXCLUDED	NUMBER SELECTED FOR SCREENING	OUTCOME
SEARCH 8 Qualitative research AND CAMHS or child and adolescent mental health staff AND Support + worker AND Experience	291	291	0	0 papers found, refine search
SEARCH 9 Qualitative research AND CAMHS AND Staff or workers or clinicians	2423	2423	0	Refine search
SEARCH 10 Qualitative research AND Support + workers	10,086	10,084	2	2 papers included
SEARCH 11 Qualitative research AND Support + workers OR Healthcare Assistants Or HCA	12,571	12,569	2	2 papers included

Reasons for exclusion included papers being specific to professional groups (i.e. psychologists) or focussing on specific topics such as accessing or transitioning from CAMHS, gender diversity and the impact of COVID-19. As shown, my second review

also only identified four relevant papers (see Table 4). These papers were selected for inclusion as they referenced mental health services and support workers, both of which align with the aims of this research project.

Quality Appraisal

The five selected papers were read in full and appraised for their quality using the Critical Appraisal Skills Programme (CASP) checklist (see **Appendix A**). This approach ensured that the included papers were critically examined. In my review and appraisal of the included papers, I considered whether there was a clear statement of the research aims and whether the research design was appropriate to address the research aims. I considered the recruitment strategy and methods of data collection. I looked for evidence that the research was ethical and that data analysis was sufficiently rigorous and I considered whether the research was valuable.

Table 4: Papers Identified for Question 2:

1	Kelly, L., Livanou, M., Benn, Y. (2024). "The little ants that make everything else work": Experiences of healthcare support workers in inpatient Child and Adolescent Mental Health Services (CAMHS). *Psychology & Psychiatry Journal*, 473
2	Wilberforce, M., Abendstern, M., Tucker, S., Ahmed, S., Jasper, R., & Challis, D. (2017). Support workers in community mental health teams for older people: Roles, boundaries, supervision and training. *Journal of Advanced Nursing, 73(7), 1657-1666.*
3	Senek, M., Long, J., Ohlsen, S. *et al.* Factors affecting the retention of healthcare assistants in English mental health services: a qualitative interview study. *BMC Health Serv Res* **25**, 505 (2025).
4	Hall, A.J., Goodwin, V.A., Allchurch, L. *et al.* Feeling valued at work: a qualitative exploration of allied health profession support workers. *BMC Health Serv Res* **24**, 1511 (2024).

2.3.3 - Results

Kelly et al's study involved semi-structured interviews of nine healthcare support workers (HCSW's) working in a CAMHS in-patient setting. An exploratory qualitative descriptive approach was utilised and data were analysed using thematic analysis. The researchers identified four main themes from the interviews: (a) 'just' a HCSW, (b) the therapeutic journey, (c) lack of control and (d) in-job support.

The authors concluded that the role of an inpatient HCSW is often stressful and that the lack of control HCSW's experienced in their workplaces was a major contributing factor to stress. The authors identified a lack of clarity around HCSW contributions on the ward and limitations in their training as contributing towards a lack of professional identity within the role.

A comprehensive summary of the participants including their time in service and educational backgrounds is provided. Interestingly, they did not discuss in the report that of the nine participants, seven held graduate level qualifications and three of these held post-graduate qualifications in psychology. The authors note that all participants shared the view that the role was a 'steppingstone' to a further career, but they did not explore what careers the participants were interested in pursuing. While an account of the experience of HCSW's working on CAMHS inpatient units was given, it failed to provide a context for understanding the HCSW's intentions and motivations for working there.

It is unclear from this (or indeed other studies reviewed), whether HCSW's see the role as a steppingstone because of a lack of training and development opportunities, or if there are a lack of training and development opportunities *because* the role is seen as a steppingstone. It is therefore difficult at this stage to understand which aspect is the

cause and which is the effect and further research is urgently needed to shed some light on this.

Wilberforce et al explored support workers in adult mental health teams. While there are clear differences in the function and purpose of these teams compared to CAMHS teams, there are lines of comparison within the mental health setting and with the inclusion of support workers as part of the clinical team make-up.

The study analysed data from interviews with 42 clinicians from nine different teams in England, using thematic framework analysis. The authors identified four themes: (a) roles, (b) boundaries, (c) supervision and (d) training; however, this was somewhat unclear as the table referenced in the report was not included.

The results suggested that support workers take on a wide variety of duties within their roles and while there was generally some clarity on what they should do as part of their role, what they *shouldn't do* was harder to clarify suggesting that role boundaries were often blurry. They identified that support workers' experiences of clear lines of authority were sometimes complicated and confusing but that support workers generally felt supported through open access and communication with the wider team.

The study concluded that when there is a lack of clarity around support worker duties there can be 'drift' across the boundaries of the role remit, both for support workers and registered clinicians. It would have been interesting if the authors had further explored this dynamic and how it impacts (or not) on the other findings. Four researchers were involved in the coding and analysis of the data but the authors do not detail how differences in approach and interpretation were mitigated against. The authors acknowledge that the findings are limited by the fact that only five of the 42

interviewees were actually employed as support workers, despite a pool of 21 support workers being available.

In the third paper reviewed, Senek et al., examined the factors affecting the retention of HCA's in English mental health services however it does not specifically focus on CAMHS support workers. The HCA's who participated in this study worked in adult mental health inpatient or adult community mental health settings. For this study, 31 participants took part in semi-structured interviews and data were analysed using a framework analysis.

The authors identified three themes, each with three subthemes. These themes were: (a) high workloads and unclear role boundaries creating stress and concerns for patient care; (b) good relationships with line managers and colleagues providing essential support to cope with both work and personal challenges; and (c), feeling undervalued by the wider organisation, with a lack of investment including pay, facilities, and opportunities for development.

The authors concluded that many HCA's were dissatisfied with their roles and felt undervalued by their employing organisations. They suggested that improved role boundaries, career pathways, and appreciation of the role such as reward and recognition schemes, could help retain this key staff group who provide a large proportion of essential patient care.

The authors clarified in the report that unregistered CAMHS staff were excluded from the study but they did not offer a rationale as for why they made this decision. Recruitment for the study was carried out by contacting three NHS Trusts directly with a request for participant information to be passed onto HCA's. The authors comment on difficulties with recruitment and this was noticed particularly within minority ethnic

groups, who make up a disproportionately large number of the healthcare sector. The results therefore are somewhat limited in representing the HCA workforce views.

The last research study the review identified relates to allied health professionals (AHP) experiences of feeling valued at work. Hall et al., recruited 29 allied health professional (AHP) support workers who took part in semi-structured interviews. Data were analysed using reflexive thematic analysis. The participants worked in a variety of settings though notably; they all sat within physical healthcare settings such as hospitals. Support workers working within the mental health field did not feature in this study.

Three main themes were found: (a) recognition, (b) belonging and (c) empowerment. Recognition consisted of subthemes of appreciation, trust and scope of practice. Belonging included subthemes of identity, inclusion and relationships. Empowerment included subthemes of opportunities, wellbeing and support.

This study concluded with the suggestion that (AHP) support workers are an integral part of the healthcare workforce and that when they feel valued, marked improvements are noted in patient care. The authors argue that recognising, empowering, and including support workers in teams is crucial for a supportive environment. Acknowledging their skills, providing learning opportunities, and supporting their development is essential for their well-being and fostering inclusivity in healthcare.

The researchers recruited participants for this study through two main channels, firstly through a social media post and secondly, by contacting the different AHP professional bodies with a request to disseminate the information to the ‘unregistered’ staff. The authors acknowledge that of the 14 bodies approached, participants representing only seven of these bodies agreed to take part. It is possible that there are AHP support

workers who are not recognised as being 'unregistered' staff belonging to a particular AHP group and so there may be a number of support workers who were not contacted and given the opportunity to partake in the research thus, the results of this study are not comprehensive or generalisable within the field of AHP support workers.

2.3.4 – Conclusions Drawn from Reviewing the Qualitative Research

There were a number of interesting themes in the research studies outlined above. A theme of role boundaries being unclear was present in three of the four studies and contributed towards feelings of stress, frustration and job dissatisfaction amongst the participants. A theme of feeling undervalued was present in three of the studies and this was linked with pay, job title and role expectations. Support and supervision were identified as a theme across all studies and were reported as being valued by participants, although some participants shared concerns that it was not always available or prioritised. This theme extended into relationships with colleagues and managers and was a positive and important part of the participants' experiences.

The findings reveal that while there may be a number of different job titles in operation across the health and social care sector, there are a number of shared experiences. For ease and clarity, I shall refer to these varying job titles as 'support workers.' The findings tell us that support workers need and want more clarity around their roles and duties. Furthermore, they want clearer differentiation between their duties and the duties of more senior colleagues. I share the view that clearer role boundaries and expectations would allow for support workers to feel more certain in carrying out their roles and to feel more confident in recognising their strengths and limitations as a result.

The findings suggest that while job dissatisfaction is noted amongst some participants, the people in these roles feel that they do important jobs but feel that their value and contributions are not always recognised by senior colleagues and at a wider organisational level. This is perhaps a consequence in part to hierarchical workplace structures where support workers are usually deemed to be at the bottom of the ladder. As with any structure however, it is of the utmost importance that the foundation is a solid one.

There appears to be something inherently important across all studies about the 'entry-level' nature of the roles translating into the job being regarded as easy or not important to the functioning of the wider team. Across different settings support workers comment on the emotional, physical and mental toll of the work they do and how they do not feel fairly compensated for this financially.

The findings don't offer an account of the range of experience, training and qualifications that support workers in these studies hold. Nor do the studies explore in any depth who takes up these roles or the reasons why they do. These studies do not explore the career hopes and aspirations of support workers and whether they are met by their support worker roles.

As per inclusion criteria, all studies used qualitative research approaches and employed semi-structured interviews as methods for gathering data. Overall, although some studies included a relatively large sample size for a qualitative study that enabled depth of exploring the experience of individual support workers, it is important to bear in mind that findings are not generalisable to other settings or the wider

workforce. Nonetheless, the findings from these studies are informative and not only would it be interesting to see if further qualitative research would yield similar results, but also if these could inform direct hypotheses testing in quantitative or mixed-methods design, that would allow for more generalisation.

A large-scale survey within one or two Trusts would also be an interesting follow-up for future research to see if the larger population indeed viewed their role and experience similarly. It goes without saying that four formal studies carried out about support workers' experience in the UK isn't enough. Further research into the motivations and career aspirations of support workers would also be helpful to create a better understanding of what training is needed and which career pathways need to be developed. A 'stock-take' of support worker skills, experience and qualifications would provide valuable information on who takes up the role and what they bring to it. It may also help in better clarifying role duties and expectations and to better utilise support workers. It could shed light on gaps in training, knowledge and experience that could assist in building a more consistent understanding of the role and the variations across the different employment sectors.

2.4 – A REVIEW OF THE CONTEXTUAL LITERATURE

2.4.1 - Introduction

This part of the review seeks to address the third question and to explore the context in which the support worker role sits, both within CAMH services and the wider NHS.

2.4.2 - Method

Articles and publications relating to NHS policy and workforce planning were located within open Government sites, NHS sites and through Google searches. Independent

thinktanks The Kings Fund, The Nuffield Trust and The Health Foundation websites were explored and relevant documents found are included in the review. Documents from the National CAMHS Support Service (NCSS) are also included though this service is no longer operational. A further search was undertaken using EBSCO but this did not yield any additional results.

Inclusion and Exclusion Criteria

All NHS* documents relating to CAMHS workforce development and planning in England were initially included for review. Documents published before the year 2000 were excluded to allow for a focus on the more recent picture. After an initial review of the documents, those which did not mention or reflect the support worker role were excluded.

*(*NHS documents include publications from the Department of Health, Department of Health and Social Care, Department of Education, NHS England, NHS improvement, Health Education England, Royal College of Psychiatrists, NHS Workforce Review team and NHS Health Advisory Service.)*

Tables **A1- A6**, located in **Appendix A,** detail the papers reviewed (including the excluded papers), from a number of NHS bodies, The Kings Trust, The Nuffield Trust, The Health Foundation and the National CAMHS Support Service (NCSS).

Table 5 - Documents found, Scanned, Reviewed, Included and Excluded for Question 3.

Source	**No of docs found**	**No of docs scanned**	**No of docs reviewed**	**No of docs included**	**No of docs excluded**
NHS and Government Departments*	16	16	10	5	11

The Kings Fund	6	6	4	2	4
The Nuffield Trust	3	3	3	2	1
The Health Foundation	3	3	2	0	3
Joint publications from Kings Fund, Nuffield Trust and Health Foundation	1	1	1	1	0
National CAMHS Support Service (NCSS)	2	2	2	2	0

2.4.3 - Results

The review identified 12 papers, published between 2006 and 2025. These documents are broad in their focus and content, and I shall keep my summary focused on the aims of this project; that is, in understanding the role of support workers in CAMHS, the presence and development of the role and what this can reveal about working in CAMHS.

The main themes identified within the reviewed papers were:

- The challenges and changes of the NHS workforce
- The issue of regulation
- The development of support worker roles

The Challenges and Changes of the NHS Workforce

The increase in the numbers of unregistered support staff across the NHS over the last 20 years appears to be at least in part, a practical response to workforce shortages and financial pressures. The challenges around NHS workforce recruitment and

retention are well documented and the reasons behind them are complex and multi-layered (Nixon, 2006; NHS England (Mental Health Taskforce) 2016; NHS England 2019; DoH & NHS England, 2015). A thorough examination of the historical and political framework that underpins this is beyond the scope of this review. Here, I focus on what the reviewed documents can tell us about how support workers have been recognised as one possible means of addressing some of those challenges.

In 2006, Nixon, on behalf of the NCSS, published his paper 'Delivering Workforce Capacity, Capability and Sustainability in CAMHS'. Nixon calls for a rethinking of roles and responsibilities so that tasks are matched to competencies rather than professional titles, allowing a broader sharing of clinical duties. He highlights the essential contributions of unregistered staff within CAMHS and urges for creativity and flexibility around how roles are deployed.

Nixon is clear that unregistered roles should complement, not replace registered professionals particularly in respect of the delivery of complex interventions. He warns that without adequate support, reliance on unregistered staff could lead to role drift, burnout, and inconsistent quality of care. To guard against this, he makes a number of clear recommendations including structured inductions and competency frameworks for unregistered staff along with robust supervision arrangements.

Nixon (2006), argued strongly for a greater recognition of staff qualities and competencies:

> "In assessing staffing requirements it will be increasingly important to recognise that it is the skills and knowledge that staff can bring that are important rather than simply their professional background." (p.7)

In 2008, Nixon co-authored a paper with Morris: New Ways of Working in CAMHS. This report represented a big cultural shift in the approach to delivering CAMHS

services and Nixon continued to express his views around the potential limitations of only utilising registered clinical staff in the delivery of specialist services:

> "One element of this shift is to move from a workforce defined and restricted by professional qualifications to one defined by skills, competencies and capability." (Morris & Nixon, p.22)

Several years on from Nixon's paper, the independent thinktank The Kings Fund, published their report: Mental Health Under Pressure (2015). They reviewed the national state of mental health services and the proposed NHS plans to address these challenges. The development of a more generic workforce with reductions in the number of clinical specialist staff and an increase in non-clinical roles was highlighted. This approach appears to somewhat contradict Nixon's recommendations that support staff should "complement and not replace registered professionals."

The following year (2016) saw the publication of 'The Five Year Forward View for Mental Health'. It stated that "building and maintaining a qualified workforce of committed staff is one of the greatest challenges facing the NHS." (Mental Health Taskforce, 2016 p.44). The report identified that changes to the make-up of the workforce were needed and had not been fully explored, despite recommendations outlined in previous publications.

In 2016, the Nuffield Trust published 'Reshaping the workforce to deliver the care patients need' (Imison et al.) The authors comment on the rise in the presence of clinical support staff and how their roles were changing to meet the needs of services and patients. They reflect on an interesting initiative within an adult community mental health service in Bradford, which saw an opportunity for Band 4 'associate practitioners' to take on more responsibilities within their practice. The Bradford case

study in this report highlights both the diverse range of skills and abilities of unregistered staff and their potential.

The 2017 NHS report ‘Stepping Forward to 2020/2021: The Mental Health Workforce Plan’ recognises that trusts have in recent years, developed a number of initiatives to deploy unregistered staff to deliver the competencies required in teams (Health Education England, 2017) and the authors argue that:

> “The growing proportion of support staff represents both a broadening of the talent pool as we develop new roles, but also the emergence of new service models…..which relies on a wide range of roles to work alongside qualified staff and help ensure they are making the most productive use of their time.” (Health Education England, 2017 p.4)

The position of support staff working “alongside qualified staff” is interesting and perhaps explains something of the confusion and lack of clarity around roles and role boundaries. Imison et al., (2016) concluded that support workers can help to reduce the workload of more qualified staff but that when there is a lack of role clarity and differentiation of tasks between support workers and qualified clinicians, the potential benefits can be undermined. The Kings Fund (2018) report ‘Closing the Gap’ highlighted the issue of a lack of clarity for unregistered workers in their roles and the difficulty for registered staff to know what tasks were safe to delegate to unregistered workers. They suggested the need for:

> “a structured approach to the development of the roles, setting out clear boundaries and expectations.” (p.82)

Closing the Gap focused on actions that could be taken to address the workforce challenges faced across the NHS. The authors discuss the issues around recruitment and acknowledge the changing skill mix of the workforce.

The 2021 report for Health Education England: ‘Children and Young people’s Mental Health Services Workforce Stocktake’ details with a series of graphics, the picture of the workforce and reported a significant increase in the presence of support worker roles across CAMHS settings. This was interesting as up until this point, CAMHS support workers had not been identified as a specific work group in the NHS literature. Between 2019 and 2021, an increase of support workers (including nurse associates) of 54% was noted. The authors clarified that support worker staff are more commonly found within inpatient settings than in community CAMHS and revealed that support workers make up 12% of the discipline mix across both settings - 6% in community settings and 41% in inpatient settings (p.10). These figures are perhaps one of the clearest indicators so far of the rise and prevalence of support workers in CAMHS.

More recently, the Children and Young People’s Mental Health Workforce Census (HEE, 2023) states that there were approximately 1,865 whole-time equivalent support workers employed in NHS CAMHS in England. This is a significant number in my view and so the dearth of information regarding the role is concerning and indicative that further enquiry is not only needed, but needed urgently. The NHS Long Term Workforce Plan, (NHS England, 2023) expresses an ongoing commitment to recruiting and developing healthcare support workers to help address staffing shortages but does not highlight the presence or need for CAMHS specific support workers.

The Issue of Regulation

The lack of regulation of support workers and other unregistered staff was first noted as a concern in the 2016 publication from the Nuffield Trust (Imison et al.,). Here, the authors identify that Band 1-4 NHS staff working in clinical settings are not regulated and this raises concerns about accountability and about the standard of patient care, particularly in relation to the quality, availability and requirements of training across the

Band 1-4 workforce. They argue that regulation would standardise training and reassure professionals and patients about the competence of unregistered staff. The risk of regulation is that it could reduce the potential flexibility of this workforce and, given the limits of regulation, not provide the safeguards looked for.

The NHS Interim People Plan (NHS England, 2019), acknowledges the changing picture of the NHS workforce and identifies the concerns regarding a lack of regulation for support staff performing clinical roles. The authors suggest that further investment is needed to develop these roles and that:

> "It will also require the right professional standards and systems of professional regulation to ensure clarity about the scope of new and extended roles and provide patients and the public with the assurance that staff in these roles will meet the highest standards of safety." (p.33)

This report appears to clearly acknowledge that there is a growing and shifting skill mix amongst NHS staff and it recognises a need for 'professional regulation' around new roles. Importantly, this is linked to an understanding that the public require assurance around 'unregulated' staff being able to deliver services effectively and safely. However, several years on from this report, there is still no universal or comprehensive system of regulation of support workers or other unregistered staff.

Developing Support Worker Roles.

Nixon argued for the creation of routes of progression for unregistered staff as a viable option for addressing longer term staffing issues and workforce shortages (2006). He somewhat optimistically implies that staff entering the NHS workforce in unregistered roles, can progress through training and development to registered roles but he does not offer any insight into the mechanics of how this could happen.

This thinking is echoed by The Nuffield Trust who appear equally optimistic in their suggestion that by upskilling support workers, the role can offer a 'steppingstone' to becoming a registered clinician, however, they do not provide any suggestions or evidence for how this could happen (Imison et al., 2016, p.25). They suggest that investment here could provide a cost-effective and rapid solution to mitigating some of the pressures on more senior staff.

The Interim People Plan states:

> "We will continue to enhance the skill mix of our workforce by scaling up the development and implementation of new roles and new models of advanced clinical practice – and by providing clear career pathways that enable people to continue developing and achieve their maximum potential (NHS England 2019, p.33).

While there does appear to have been some progress in the development of clear pathways to progression, (see **Box A1** in **Appendix A** for an account of the nurse associate training scheme), this is certainly not true across the board and there are still a vast number of support worker roles which do not present such opportunities.

2.4.5 – Conclusions Drawn from Reviewing the Contextual Literature

The rise of the support worker, in terms of presence, banding and level of responsibility appears to have come about, at least in part, as a response to ongoing, historic and chronic workforce shortages within the NHS and attempts to address some of the difficulties posed by funding, recruitment and retention issues. The reports reviewed reflect on how unregistered staff have been and can be, better utilised. The general feeling conveyed to me through this, however, is one of a slow and somewhat begrudging acceptance of the unregistered worker.

While support workers remain largely unnamed throughout these documents, there is increasing reference to the shift in skill mix and capabilities and a move away from a focus on the need for specific roles and professions. There are important questions to be asked around the regulation, registration and accountability of support workers and how this may or may not impact patient care and safety.

2.5 – CONCLUSION OF THE LITERATURE REVIEW

Reviewing the literature has highlighted that workforce planning in the NHS can at best be a cumbersome and slow process; at worst, it can be utterly stagnant. This is perhaps understandable given the complexity involved in NHS funding, systems and structures that provide employment for over 1.54 million people in England (NHS Digital, 2025). The NHS does not exist in a vacuum but is located within a changing political, educational and financial landscape. However, the literature has also revealed that when there *is* a focus and determination to address specific groups (i.e. nurses, doctors) and the challenges of recruitment and retention, things can and *do* happen. A detailed and comprehensive recognition and understanding of CAMHS support workers is called for.

The issue of regulation (or lack thereof) of support workers is significant and widely debated in the literature. There is no consensus on whether this should happen for unregistered staff and if it should, how it would happen. Further, it has been estimated that undertaking regulation would likely be incredibly costly and at a time when NHS bodies are already forced to make cut-backs to spending, it is unlikely that this would be a priority.

I was unable to locate any qualitative research that relates specifically to CAMHS support workers. The limited number of studies exploring the experience of support

workers in other fields, highlights the dearth of formal research and suggests that further enquiry is urgently needed.

The current study aims to address this gap by exploring the experience of support workers in CAMHS through the use of semi-structured interviews and reflexive interpretative phenomenological analysis (IPA). It aims to garner understanding and meaning of the lived experiences of CAMHS support workers to better understand the people who take up the role, and their hopes. It aims to find out more about the role of the CAMHS support worker, whether they feel their role is valued and useful and to explore the function of it within CAMHS. Finally, the current study aims to find out what can be learnt from support workers about working in CAMHS and how this learning can help in understanding the changing shape and purpose of CAMHS.

CHAPTER THREE - METHODOLOGY

3.1 - INTRODUCTION

In this chapter I explain how I went about answering the research question: 'How do support workers experience and make sense of working in CAMHS teams?'. I outline the study design and include thoughts about reflexivity in IPA research before introducing Werbarts (2005) work on Private Theories. I then describe the setting and participants before outlining the recruitment and interview processes. I then explain the data analysis method and conclude with the ethical considerations.

I give a full account of my rationale for selecting Interpretative Phenomenological Analysis (IPA) as the method for conducting the data analysis in the Discussion chapter. There, I will also describe and discuss in depth, the limitations of qualitative research, IPA and the current study.

3.2 – DESIGN

Qualitative research can be understood as "the systematic enquiry into social phenomena in natural settings" (Teherani et al., 2015, p.669). It is an approach that aims to understand how people experience the world and make sense and meaning of those experiences. Qualitative research allows for detailed and personal accounts to be acquired and can provide a depth of understanding that may not be achieved through quantitative research.

3.2.1 - Why IPA was selected

IPA was chosen for this project because I wanted to explore in depth how support workers make sense and meaning of their work experiences. I chose this approach because it is well suited to exploring how individuals experience and make sense of

significant aspects of their lives (Smith et al., 2009) and because I wanted to embrace my interpretative role in the study rather than bracket it.

'Bracketing' is the process of setting aside one's own experiences, biases and preconceptions in order to focus entirely on the participant's perspective without influence from the researcher's position. As an approach, IPA recognises that in practice it is incredibly difficult, if not impossible for researchers to fully and effectively bracket their own experience. Instead, IPA embraces this aspect of the researcher and research process. By embracing my interpretative role, I was able to explore my own thoughts, feelings and reactions to the material and be mindful of any influence and impact they might have had on understanding and interpreting the data.

3.2.2 - Reflexivity in IPA

Reflexivity relates to how findings are produced and the role the researcher has in the process (Heaton, 2004). This involves a critical self-reflection about the ways that researchers' own assumptions and perspectives impact and affect the way the data is analysed, understood and interpreted. Reflexivity can be understood as:

> "a set of continuous, collaborative, and multifaceted practices through which researchers self-consciously critique, appraise, and evaluate how their subjectivity and context influence the research processes." (Olmos-Vega et al, 2022, p.241)

Reflexivity requires that the researcher constantly and regularly reflects on their own assumptions, values and judgements as they engage with the participants, the data and the emerging findings. It also requires that the researcher remains aware of the interpretation process; that participants interpretations are then subjected to further interpretation by the researcher, this is known as 'double hermeneutics' (Smith & Osborn, 2008).

Reflexive IPA acknowledges that meaning is co-constructed through the interaction between researcher and participant, positioning the researcher's perspective and reflexivity as integral to, rather than separate from, the analytic process (Pietkiewicz & Smith, 2014). Furthermore, reflexive IPA moves away from rigid procedural 'recipes' and instead emphasises transparency, flexibility, and critical engagement with the data, making it well-aligned with contemporary qualitative research values (Finlay, 2011). This approach is therefore highly appropriate for applied health and social care research, where nuanced insights into lived experience can inform both theoretical understanding and practice.

3.2.3 - Private Theories

In psychoanalysis 'private theories' refers to the deeply personal and often unconscious frameworks through which individuals understand their internal worlds and relationships. It is through this subjective and unique lens, that a person is able to construct meaning and sense from their experience. Werbart (2005) states:

> "The notion of private theories covers the human tendency to create implicit explanatory systems about what has befallen us and whence it came." (p.1442)

Werbarts work on private theories is focussed within the realm of the analyst and analysand relationship, however, his ideas are relevant to this project.

> "It was no longer sufficient to permit the patient to recount his own story – the analyst's task was to hear something more and something else than merely the recounted story." (Werbart 2005, p.1447)

Here, Werbart is highlighting the importance of what is not said, what is communicated non-verbally, how the intention behind the verbal communication might be different to what is implied in words and perhaps most importantly, what meaning is attributed to what is spoken of.

I have included the use of Werbart's work on Private Theories as it aligns well with IPA, as both are rooted in understanding the individuals process of meaning-making. Werbart's framework allows for a focus on idiosyncratic accounts and for a move beyond a description of an experience to a systematic exploration of the personal logic the participant uses to interpret the experience. Werbarts work on private theories has been used in previous IPA research such as Radcliffe et al's., (2018) study 'Clients' experience of Non-Response to Psychological Therapy: A Qualitative Analysis'

The current study explores the views, feelings and ideas that support workers in CAMHS teams hold about their roles and their work. Their private theories are considered and included in the research process. I was alert to notions of private theories during the interviews and later during the data analysis. I tried to be aware of and recorded any reflections on my own private theories during the research process and these were considered and incorporated into the development of the themes and findings that emerged. This was important because researcher reflexivity is an essential component of IPA.

3.3 – THE SETTING

Participants were recruited from across five CAMHS teams that form a directorate providing CAMHS services for a large geographical area in the UK. Each team provides routine and generic CAMHS services to the local population of children and adolescents (0-18). Within each CAMHS team are a number of sub-teams. These include The Eating Disorder Service (TEDS), a Neurodevelopmental Clinic (NDC), Hospital Liaison and a Learning Disability service (LD) which operate within their individual teams and localities. Some clinicians work entirely within one sub-team, but more often, workers may sit within a number of sub-teams.

Further to the individual teams, there are a number of specialist services and roles that cover all five locality teams. These include teams working specifically with children looked after (CLA), children at risk of exploitation, children involved with youth justice services, Hospital at Home (HaH) and the Crisis and Home Treatment Service (CAHTS). Workers who hold roles within these teams are based within one locality but cover a wider area, potentially the entire patch.

3.4 - PARTICIPANTS

The Trust in which this research took place is a large one, however, the five locality teams are fairly small and the number of support workers employed across these teams is very small with some teams only employing support workers in specialist parts of the service e.g., CAHTS. While the locality teams are separate and operate from their distinct locations, there are regular meetings, events and conferences that bring the five locality teams together. As such, I have had to be mindful of how the participants are described and represented in this study.

Thorough consideration has been given as to how to best give a voice to individual's views, thoughts and opinions whilst protecting their identities. To enable anonymisation and protect support workers identities, I have taken the following steps:

- Participants are referred to throughout this study by their numbers – i.e., Participant One, Two, Three, Four and Five. While this is perhaps impersonal, it enables anonymisation by neutralising the genders of the participants. As such, all participants are referred to using 'they/them' pronouns.
- Identifying information regarding participants work base locations have been anonymised to Locations 1,2,3 or 4.

3.4.1 - Participant Summary

In order to protect individual identities of the support workers who took part in this project, I have chosen to give a summary of them as a group:

Table 6: Summary of Participant Demographics

DEMOGRAPHIC FACTOR	DETAIL OF PARTICIPANTS
GENDER	Four female, one male.
ETHNICITY	Four are White British, one is White European.
AVERAGE AGE	The average age of the participants is approximately 40 years old; however, it is worth noting that one participant is nearing retirement age.
LENGTH OF SERVICE	The average length of service is 15 years. The shortest term of service is 8 months.
BANDING	Four are employed at Band 4, one is employed at Band 3.
CONTRACT TYPE	Four of the participants are employed on permanent contracts, one on a fixed term contract.
ROLE IN TEAM/SUB-TEAM	Two of the five participants are employed solely in the CAHTS team. The three other participants work across Getting Help (GH), Getting More Help (GMH), The Eating Disorder Service (TEDS), Hospital Liaison and Neurodevelopmental Clinic (NDC) sub-teams within their locality teams.

3.4.2 - Inclusion and Exclusion Criteria

Participation in the study was open to anyone who held the title of support worker or senior support worker within any of the five CAMHS teams. Participants were invited from all locality teams and recruited from four of the five teams.

It is important to note at this stage that I had pre-existing relationships with three of the five participants in the study. In the interests of transparency, I will outline the nature of my relationships with the participants and how I considered and managed the boundaries, power dynamics and potential bias.

3.4.3 - Consideration and management of boundaries, power dynamics and issues of bias in pre-existing relationships with participants.

Prior to the commencement of this study, I had no prior relationship with two of the participants and pre-existing relationships, of different natures with the other three. In order to protect their anonymity, I will describe the relationships I had with participants without attributing identifying details to them, see Table 7 below.

Boundaries

Prior to the interviews, all participants received information outlining the purpose of the study, how data would be stored, used and anonymised. The information provided explained my role and what participants could do if they had any questions or concerns, including contact details for the research supervisor. These preparations contributed towards the construction of the boundaries and provided a foundation ahead of the interview. The boundaries of the interviews with all participants were managed through the use of and adherence to the interview schedule.

Table 7 – Descriptions of pre-existing relationships with participants with consideration given to power dynamics and potential bias.

RELATIONSHIP	POWER DYNAMIC	POTENTIAL BIAS
Former colleagues who worked closely together before developing friendship outside of work.	I think this participant may have engaged with the study as a favour to me based on our friendship. However, I think the participant would have taken part if they didn't know the researcher also. The existing friendship may have allowed for a more balanced power dynamic or it may have shifted the balance of	Because of our shared work history, this participant often referred to particular individuals, locations and situations informally, without having to give further details. I was aware of a significant level of assumed shared knowledge (i.e, we had previously both worked under the same Manager and the participant would refer to the Manager's views on support workers and the support worker role in a way they might not have done had we not known each other.)

	power in favour of the participant. The interview was informal whilst being sensitive to the format and information discussed.	I was mindful of my own feelings towards this participant who is someone I hold respect and positive feelings for. As such, I had to consider potential bias both during the interview and in the data analysis. An interesting observation I made during the interview process and transcription and data analysis, was how often this participant communicated non-verbally. The participant often implied things through facial expressions and voice tone in a way that I would have been less alert to had I not known them so well. It is possible that I was able to infer meanings from the participants account that I may not have been able to infer without prior knowledge of them and their communication style. I had to be mindful that I did not attribute extra, unspoken meanings to the comments made by the participant. This required close attention and I was perhaps more rigorous when reviewing this participants data as a result.
Working as colleagues in the same team at time of interview.	I think the participant agreed to take part as a favour to me and possibly would not have taken part otherwise. As such, I think the participant held more power in this dynamic as I was conscious of my own feelings of gratitude. The interview was fairly formal which was somewhat unexpected given the pre-existing relationship. I experienced the participant as holding more power in this dynamic.	I was conscious throughout the interview that the participant seemed in a hurry and this may have prevented me from asking further expanding questions such as 'can you say more about that?'. This may have resulted in less detailed and expansive responses to the questions. I was mindful that this participant and I had some shared experiences from earlier in our careers (in terms of training and job roles) and this potentially created a situation where certain things may have been assumed by me.

Known to each other outside of work as acquaintances, never worked together.	The dynamic with this participant was different to the others, perhaps because the pre-existing relationship was not work-place based or professional in nature. The interview felt informal and at times confusing. This participant was the only male participant in the study. I think there was something of gender difference present in the power dynamic, giving the participant more power than me.	This participant disclosed neurodiversity as part of their personality during the interview. I had not been aware of this prior to the interview and had to consider this once it was disclosed. As a result, more time was taken to ensure that the questions were understood. At times it was unclear to me if the participant shared the same understanding of the questions as I did and further clarification was offered more frequently with this participant. It is possible that in doing so, I attributed something of my own bias to a reframing or explanation of the question. The participant was observed to often assume I understood what they were implying and I perhaps had to check their meaning more so than with other participants. The participant and I had known each other in a social capacity for a number of years and this may have impacted how the participant responded.

It is worth noting, that some participants were open about their intentions to leave their roles and the Trust, and it is possible that these intentions allowed the participants to speak more freely, particularly about negative or difficult aspects of their roles and their experiences, than other participants. These participants may have felt that they had ‘nothing to lose’ by speaking openly. Other participants spoke about their hope to move into professional training within the Trust and this may have impacted the way that they approached the interview and responded to questions. These participants may have felt the need to maintain a polite, grateful and positive outlook regarding their role and experience.

3.5 - DATA COLLECTION METHOD

3.5.1 - Recruitment

Permission was sought from the service manager for the directorate. This happened initially through a face-to-face conversation and then formally through email (**Appendix C – Public Facing Documents**). Once granted, the five clinical team managers (CTM's) of the locality teams were contacted to explain the study and to seek their consent and permission to approach and interview support workers in their teams. Emails containing a 'Recruitment call' were sent to all support worker email addresses (**Appendix C**).

Participants who initially expressed an interest were emailed the full pack of documents including the participation information sheet and consent form (**Appendix C**). Participants then responded with their agreement to continue and interviews were arranged.

3.5.2 - The Interview Process

Interviews were arranged over email and suitable times and settings were agreed. Interviews adhered to the interview schedule (**Appendix C**) and followed the prescribed order of the questions, which were divided into sections:

- About you
- About your role
- About training and development
- About supervision and support
- About how your role fits into CAMHS

By starting with questions relating to the participant, the hope was that as well as giving the participant an opportunity to introduce themselves and locate themselves within their role, there would be an opportunity to build some initial rapport as a basis to then move onto more detailed questions.

In addition to the prescribed interview questions, further exploratory questions were asked (i.e, can you say more about that? Is there anything else you want to say about that?). The interview categories and subsequent questions were designed to illicit responses that would provide information pertaining to the overall focus of this study.

3.6 – DATA ANALYSIS

3.6.1 – Transcription and Data Storage

I chose to transcribe the interviews without the use of software or transcription services in order initially to be re-acquainted with the participants and the data provided, particularly as most of the interviews had taken place a number of months prior. Interviews were typed into word documents. This process was time consuming but enabled familiarisation with the data in a manner which was helpful.

Once transcriptions were completed, I listened again to the recordings while reading along with the electronic transcript. This provided an opportunity to spot and rectify any errors in the transcriptions and to ensure they were accurate. The transcripts were printed out single-sided, and a piece of lined paper was taped to the side of the pages to provide space for notes. Non-verbal communications including pauses, hesitations and laughter were noted in the transcriptions.

Interviews were recorded using a Homder Digital Voice Recorder and then uploaded to a password protected personal laptop and saved in an encrypted file. Interviews

were transcribed verbatim and typed into password protected documents, over a two-week period in August 2024.

3.6.3 - Beginning the Data Analysis

Data analysis began using the audio recording and transcript from Participant One's interview following the approach suggested by Smith et al., (2009). Listening to the recording allowed for a focus on the verbal communications including tone of voice, intonation and incongruencies between speech content and delivery. Notes were made at this stage to reflect comments that were interesting to me and my own thoughts as they emerged.

Following an initial review of the transcript and recording, I undertook two further rounds of listening to the audio recording and reading along with the transcript. The transcript was then revisited without the audio recording to allow the material and data to be experienced differently. Different colour pens were used to take notes each time the data was revisited to allow comments and thoughts to stand out and to track the development of thoughts. (**Appendix D – Data Analysis Process**).

The next stage involved reviewing the exploratory notes and creating a list of experiential statements on a word document. This document was then printed out and the experiential statements were cut into separate statements. These statements were scattered in a random manner on a large piece of paper allowing for an opportunity to review them all together and to begin to see links and arrange them into groups of emerging themes.

3.6.4 - Developing Personal Experiential Themes (PET's)

Following a close review of the experiential statement groupings of Participant One's data, it was possible to begin to extrapolate PET's, which were recorded in tables

(**Appendix D**). Once completed, it was repeated for the data from the other four participants. A detailed account with accompanying images can be found in **Appendix D**.

3.6.5 - Developing Group Experiential Themes (GET's)

The PET's from all participants were then scattered randomly across a large piece of paper so that they could be reviewed together. This process allowed for similarities and links to emerge. The PET's were sorted into groups and notes and thoughts explaining the links were added to the paper. Grouping the PET's allowed for GET's to emerge. Table 8 below shows the common themes amongst the PET's and how they formed the GET's.

Table 8 – PET's, GET's, Subordinate and Superordinate Themes:

Themes of PET's	Group Experiential Themes	Subordinate Themes	Superordinate Themes
• Training is available but limited in scope/depth • Progression is not available to higher band/other roles	Training and progression are problematic	A Search for Identity	**Issues of Identity and Belonging**
• Pay doesn't reflect skills • Pay doesn't reflect experience some SW have • Role is not sustainable long term for some SW (because of pay and progression limits)	Pay is a problem	Questioning Worth	**A Question of Value and Worth**
• Working with risk can be emotionally challenging • Working with risk carries a risk of overwhelm, stress, burn-out • Working with risk can feel scary, worrying, sad • Desensitisation is a risk	Working with risk is hard	"You feel so responsible for their life"	**The Weight of Responsibility**

• Role is valued by team • Role is valued by SW • Role seen as important	Role is valued	A sense of belonging	**Issues of Identity and Belonging**
• Hard to know what job is • Hard to know how to do job • Easier to know what not to do than what to do	Role is Unclear	"I don't know what I'm doing"	**Issues of Identity and Belonging**
• SW value formal and informal learning opportunities within MDT	Learning from MDT is valued	A sense of Belonging	**Issues of Identity and Belonging**
• Can feel stressed, sad and worried by work	Role is emotionally demanding	"You feel so responsible for their life"	**The Weight of Responsibility**

3.7 – ETHICAL CONSIDERATIONS

Ethical approval was sought and granted through the Tavistock Research and Ethics Committee (TREC), (See **Appendix B** – **Ethical Approval and Trust Permission** for relevant documents).

While the interview process and questions were not deemed to be emotionally loaded or likely to cause emotional or mental harm, consideration was given to any risk of harm that may be caused by the interview process and information was provided with contact details for the research supervisor, the researcher, TREC, the Trusts Pastoral and Spiritual support services and Trust Occupational health services. Advice was given that CTM's and clinical supervisors could and should be contacted for support if needed.

Participants gave informed consent when they agreed to take part in the study and this was reviewed at the beginning of the interview. Participants were informed that they could pause the interview if needed and that if they experienced any distress that

the interview would be paused and that advice and support could and would be sought if necessary. The interview questions were designed to focus on the participants experience of their work. The interview questions did not seek to gather or explore any patient related information. If references to patients were made which provided identifying information the information would be anonymised and redacted from the transcript.

Participants were informed of their right to withdraw from the interview at any time ahead of or during it. They were informed of how their data would be stored and used and they were informed of their right to withdraw data from the study at any time.

CHAPTER FOUR - FINDINGS

4.1 - INTRODUCTION

This chapter presents the findings of the IPA and private theories data analysis. In line with the idiographic commitment of IPA, each transcript was analysed in depth before identifying convergences across cases to generate a set of superordinate and subordinate themes (Smith et al., 2009). The analysis revealed three overarching themes that capture how participants made sense of their experiences, Table 9 below summaries the main findings.

Table 9 – Superordinate and Subordinate Themes

SUPERORDINATE THEME	SUBORDINATE THEMES
1. Issues of Identity and Belonging	1. A Search for Identity 2. A Sense of Belonging
2. A Question of Value and Worth	1. Feeling Valued 2. Questioning Worth
3. The Weight of Responsibility	1. “You feel so responsible for their life” 2. “I don’t know what I’m doing”

I will introduce each superordinate theme and then explore the subthemes in detail in the sections that follow, supported by verbatim extracts to illustrate participants’ voices and situated within interpretative commentary that connects individual accounts to broader conceptual understandings.

4.2 - SUPERORDINATE THEME 1: ISSUES OF IDENTITY AND BELONGING

This superordinate theme is represented by distinct but interrelating subthemes. ‘A search for identity’, which highlights the participants sense of a professional identity in combination with an exploration of their views of their skills and qualities. The second

subtheme 'A Sense of Belonging' highlights how participants view their roles and themselves in the context of the wider CAMHS team.

4.2.1 – Subordinate Theme 1: A Search for Identity

Participant One describes their decision to apply for the role of support worker:

> *"I applied for it because it was a support worker role, it was band 4, which felt better than band 3, which meant I could afford my house, umm, and yeah, I didn't need any… I was qualified to do it. Or unqualified to do it." Page 4, Lines 16-18*

The comment about being "unqualified to do it" was profound and I felt that it highlighted a potential focus on what support workers don't have, rather than what they do. I noticed during the data analysis that the role of support worker was often described in this manner, with a focus on what it *wasn't* and how it differed from other more clearly defined CAMHS roles.

> *"I would say that I would be interested to take part in umm, more advanced varieties of these trainings. Umm, but of course there is going to be a limit because I am unqualified workforce." Page 9, Lines 7-9*

Participant Two's categorisation of themself as 'unqualified workforce' was interesting. The term seemed incredibly broad and vague and seemed to reflect something of how the role can feel and how there may be a challenge to establishing a professional identity within it. The language again focuses on what is not there, the lack of a qualification. This term seems perhaps inaccurate as many support workers do hold qualifications, and some at high levels, but they are not the 'right' qualifications to allow inclusion in the 'qualified workforce' category. For example, one participant is a qualified Teacher with several years of experience. They referenced their previous role a number of times during the interview and it seemed that they had a clear sense

of their professional identity while in that role and that they were perhaps still holding onto it.

All participants were able to vocalise their qualities when directly asked about them, often listing qualities like ‘patient, reliable, organised’. All five participants described themselves as people who ‘wanted to help’ and saw the role of support worker as potentially being an opportunity to be able to fulfil this desire.

Participants also shared some of their doubts and worries about their abilities to fulfil the role:

> *“What if I can’t do this on my own and that means I’m not as good at my job as I thought I was?” Participant One, Page 14, Lines 24-25*

This worry echoed those expressed by others in the study. Participant Four, for example, spoke about the difficulties they experienced in asking for help and support at times:

> *“Probably my own pride: “I should be able to do this” so… yeah, why am I worrying or…. Yeah, probably that. Probably not wanting to seem like I don’t know what I am doing, even though sometimes I don’t know what I’m doing.” Page 9, Lines 4-6*

Participant Five spoke of the different job titles they have held:

> *“I mean I was proud, my most proud… obviously OT assistant but when I was a ‘practitioner’, when I worked for Early Intervention, I was a practitioner I felt…. that made me feel, you know I’m still proud to be a support worker, cos I still do, you know that cog like again, but you’re still doing valuable, great work so yeah.” Page 16, Lines 7-10*

In this excerpt the participant reflected on the different roles they have held during their career and the impact of the role title. The written word doesn’t fully capture the level of emotion that was expressed with this comment. Their ‘pride’ at holding the title

‘practitioner’ was palpable listening to them. They quickly explained that they are also proud of being a support worker and I had a strong sense of the importance the title ‘practitioner’ held in terms of their professional identity. They added:

> *“I’m just a good support worker, you know rather than made it up to be qualified, to have that title or whatever, but I’m a senior support worker now so, you know, stepping up.” Page 16, Lines 29-31*

I noted mixed feelings expressed in this statement. The professional identity of the participant seems strongly rooted in the identity of support worker but there appeared to be something sad in the reference to not having “made it up to be qualified”.

Participant Five had spoken earlier in the interview about their skills and qualities which included ‘patience, reliability, ability to engage people and to build therapeutic relationships’ and later reflected on how you cannot learn those things, they are part of who you are.

4.1.2 – Subordinate Theme 2: A Sense of Belonging

This subtheme captured participants ideas of where they felt their roles sat and were seen within their teams and this appeared to provide a basis for a sense of belonging. Being able to locate the role and its functions allowed participants to have a sense that they, and their roles, belonged in CAMHS teams.

Three of the five participants spoke explicitly of how much they value the opportunity to be part of a multi-disciplinary team (MDT), and reflected on the learning, both formal and informal, that is available to them as part of it. Much of the training that support workers can access is delivered by members of the MDT and this was valued by the participants. They also valued ad-hoc conversations and support that can be accessed from MDT members. For example, as Participant One explains:

> *"I value the expertise of the team around me, the help and how helpful they are….I value that you can speak to someone who's a social worker and they've maybe got a lot of information about the legal framework and thinking systemically … and then you can speak to a family therapist and they might have really helpful idea's….Psychologists might be like 'oh, you should do this standardised test with them', …. learning a lot and feeling supported from lots of different angles, that's something I really value in this role, that it's okay to ask, like, we all have our strengths and areas and it helps with a feeling of belonging that we can access so many different people and approaches." Page 8, Lines 14-29*

The ability to access support, advice and thinking from MDT members contributed towards a sense of belonging for support workers. While some participants reflected on how it can feel difficult to ask for help at times, they acknowledged that this was more to do with matters of pride and a feeling that they should know what to do, rather than help not being available from the MDT.

The issue of belonging was perhaps more complicated for the support workers from the crisis service who had a sense of belonging to the crisis team, but felt that the experience of belonging to the wider CAMHS team was at times harder to locate and could change depending on how they felt utilised by the wider CAMHS team. I was given the impression that Participant One's sense of belonging was somewhat confused:

> *"We're not always seen as in CAMHS because if you've got someone who comes in for an initial assessment and you're like 'oh it would be great to have a support worker do some outreach with them', we can't do that because that's not our job, so in that sense we're not useful to the Getting More Help (GMH) and Getting Help (GH) kind of work of CAMHS." Page 13, Lines 21-24*

Participant One's statement here is somewhat in contradiction to the previous statement made. While they felt able to access support from across the wider CAMHS

team and this enhanced their sense of belonging, it seemed that it might feel like a one-way street in that the participant was less sure that they were *seen* as belonging in CAMHS.

The support worker role within the crisis team appears to be experienced by support workers as being perhaps more defined and clearer in terms of what they do and don't do as part of their role. I observed a tension here however and ideas of 'being left out/excluded' were present.

Participant Three who had been in their role for decades, reflected on the changes within the service and to their role and commented that:

> *"It's really changed over the years and I'd like to say I know exactly where I sit now but I don't, not really, if I'm absolutely honest." Page 4, Line 21*

They were evidently unclear about exactly where in the service their role would be located but despite this, they conveyed a sense of belonging. They went on to say:

> *"The people that have known me the longest, know what to give me, if that makes sense." Page 4, Lines 32-33*

In this, Participant Three raised the issue of their individuality as a support worker and the relationships they have in their team and how these connections can dictate how they are utilised by co-workers. This suggested that there is awareness within their team of the sort of cases they work effectively and the kind of work they do.

Participant Two gave an account of some of the functions of their role and how it sits in the wider picture of the crisis team and wider team:

> *"I think within my role I can provide useful observations, feedback, to help formulate. I'm able to offer a space to hold the young people and their families who sometimes just need a little bit more, umm, before admission, after admission or during their treatment." Page 11, Lines 23-26*

In response to a question about how they feel their role fits into CAMHS, Participant Two gave the following answer:

> *"I think my role is a great addition to what CAMHS already provides." Page 11, Line 20*

This comment appeared to place the role of CAHTS support worker outside the remit of CAMHS and as an addition to what CAMHS provides. While the role appeared located slightly beyond CAMHS, there was still a sense of belonging conveyed.

Participant Five reflected on their role as being an important "cog in the machine":

> *"Oh, they're all important, aren't they? I think, yeah, every person there is doing a bit, I'm like a cog in a machine. You know, in my eyes it's important, you know cos if you can't get them engaged, you can't get them to therapy, well … good luck, you know, what's the craic, you aren't going to, it isn't going to work for them you know, so yeah, it's got its place." Page 14, Lines 27-31*

This comment suggested that Participant Five had a strong sense of belonging and saw themselves as fulfilling an integral and important function within the wider team.

Participant Four expressed a different view of their sense of belonging:

> *"It just feels like a temporary job. Umm, there doesn't really seem to be any specific training, any specific roles as in 'this is a support worker role and this is the SMHP role'. There doesn't actually seem to be any differentiation, because support workers aren't really supposed to be here as there is no budget for them." Page 6, Lines 1-5*

Participant Four appeared to have a complicated relationship to their sense of belonging. They expressed in the interview that they certainly felt a part of the team, recognised that their role was important and valued, though also had this idea that the role was 'temporary' and this appeared to contribute to their fragile sense of belonging.

Understandably, it might be challenging as an individual to feel a sense of belonging when the role itself, feels like it doesn't belong.

Participants Three and Five both seemed to have a better relationship to their professional identity of support worker although this could also feel undefined to them at times. It is possible that their length of service means that they have experienced a number of changes to their roles and while colleagues, team structures and locations can change, what remains consistent is the support worker. This suggests to me that aspects of the support worker identity have been internalised and integrated within the personality of the individual.

4.3 – SUPERORDINATE THEME 2: A QUESTION OF VALUE AND WORTH

This superordinate theme combines concepts of value and worth and explores them through the subthemes of Feeling Valued and Questioning Worth. The theme captures both participants' experiences of external recognition ("feeling valued") and their internal struggles with self-perception ("questioning worth"). This echoes Crocker and Wolfe's (2001) distinction between externally conferred value and internally held self-worth. I understand 'value' to be subjective and built on personal beliefs, private theories and preferences and it can often contain ideas of 'usefulness'. We value things, people and experiences and we do so from an internal position. 'Worth' is externally imposed and objective and often refers to the material or monetary cost of something.

The concepts of 'value' and 'worth' intersect and when these moments occurred during the interviews, I often encountered some powerful and complex feelings. Further thought will be given to the intersectionality of value and worth below.

4.2.1 – Subordinate Theme 1 - Feeling Valued

All participants spoke about feeling that their roles were valued within their teams. They all agreed that they valued their roles, and they all spoke of valuing being part of a MDT. I noted a trend across the participants who spoke about feeling valued and often connected this to the experience of receiving some form of external validation. For example, Participant Five spoke about their experiences of feeling valued by the patients they work with:

> *"I got a nice email the other day because I did some really good work with a patient and they obviously sent one in to I Want Great Care, and I had a nice email and that made me feel nice and valued." Page 15, Lines 15-17*

Participant Two spoke positively of their experience of feeling valued:

> *"it's such an experience when a clinician walks up to you and as an equal will ask your opinion, will ask for the support in their work so I think it is recognised in my workplace how important my job is and seen as equals" Page 12, Lines 14-16*

And Participant One commented:

> *"I do feel valued….I feel trusted to do my role, I don't feel micromanaged, umm, I feel like I've received like positive feedback from managers or from families so that makes me feel valued as well. That stuff is super important right? Being told that you've done a good job, that's always nice to hear, whatever you do, umm, so that's helped me feel valued." Page 15, Lines 10-14*

Participant Four appeared to make the slight distinction between feeling valued as an individual and feeling that the role is valued:

> *"Umm, I feel that the wider team appreciates our role and…..Probably what I said earlier, it doesn't really feel like a specific role but that doesn't mean that I don't feel appreciated because I do, but yeah." Page 8, Lines 19-22*

Participant Four made a couple of statements regarding the role of support worker in their team and suggested that there is no budget for support workers and that the role can feel like a temporary one as a result:

> *"I don't know if it's the commissioners or whoever sets the budgets but there aren't actually any budgets for support workers in the team, so it's almost like … 'they'll do' while we're trying to get Band 5's and upwards." Page 5, Lines 34-36*

They also clarified that they recognised that the support worker role within CAHTS was more defined and that there was a clearer remit and understanding of that particular role:

> *"Possibly different in crisis because that's a job made for support workers." Page 6, Lines 15-16*

Participant Four holds support worker roles across two smaller CAMHS sub-teams, the hospital liaison service and the eating disorder service (TEDS):

> *"Liaison - I feel really valued just because it's a hard job and I know how much easier it makes the other clinicians' jobs, when there's a support worker. TEDS, I don't know, TEDS has changed, it's more …. I don't really feel like …. I don't know whether it's just because the cases are much more complex, umm, there doesn't really seem to be a role in TEDS for support workers anymore, and I don't know why that is." Page 10, Lines 9-13*

All participants spoke about their access to training and supervision and commented that they valued what was on offer and knew that they could access extra support and supervision if and when needed. There was a consistently positive attitude towards support and help being readily available from team members and management and this was something participants valued about their role and appeared to support ideas of 'feeling valued'.

There was however a shared frustration with the limitations of the role, specifically in terms of career progression. Most participants shared the view that an ability to progress through the banding system was problematic for them and would mean that their futures within the support worker role, were time-limited:

> *“That would be the thing that pushed me out of CAMHS I think, it would be like purely a financial decision if I didn’t get onto the clinical training within the next year or two. I think I’d probably be like ‘I can’t really afford to stay on Band 4 for much longer or indefinitely you know?’ So, it would be like, it would be….I don’t know how it would happen but it would be nice in this role if there were more pathways to progress.” Page 9, Lines 31-36*

This comment from Participant One raises the idea of ‘pathways to progress’ and the idea emerges again in a slightly different manner from Participant Two:

> *“On the other hand, I think if we could have workers in this role that could advance within it and build up experiences in years, that would be really so beneficial but the question is how would you be compensated for that, that you worked 10 years as a senior support worker, versus if you went on and did, for example, a clinical psychology course, or you moved on in other ways?” Page 8, Lines 3-7*

There was a strong sense from three of the participants (One, Two and Four) of a desire and ambition to advance in their careers and a frustration that this was not available as part of the support worker role. I felt that these participants were caught in a struggle between their commitment to the role and their ambitions to progress and that they recognised, with some disappointment, that these two ideas were not compatible; if they wanted to progress, they would need to leave the role.

4.3.2 – Subordinate Theme 2 - Questioning Worth

For the participants, ideas of ‘worth’ often reflected and referenced the hierarchy and rigidity of the NHS banding and pay system. A theme of ‘us and them’ was apparent

when some participants discussed differences in pay across the bandings. A tension was highlighted between how their roles and duties differed or were perceived to be the same and what this meant when there was a difference in pay.

Participant One gave this account:

> *"Like when I started I remember trying to work out how CAMHS worked, how the bands worked because it was all quite new to me and sort of talking to people who were on Band 6 or Band 7 and they're kind of doing the same things as me and at first, I was sort of like 'why are they getting paid more than me when they do pretty much the same thing as me?' and then I was like, you kind of work your way through and you're like 'okay, they actually do these other little bits some of the time and they do have a lot more knowledge than me in certain aspects, you know, because of their experience and so on." Page 7, Lines 17-23*

Participant One appears to be trying to make sense of the differences in job role and pay. Their language caught my attention in that initially they are clear in stating their confusion and claiming that they and the Band 6 and 7 staff are "*doing the same things*". They then appear to acknowledge that there are differences, however their phrasing "*little bits some of the time*" felt dismissive and reductive. They acknowledge that Band 6 and 7 clinicians have more knowledge and link this to "*their experience and so on*" but do not mention anything about their formal training or qualifications. They conclude by conceding that these mental health professionals do have more knowledge than them "*in certain aspects*."

Participant 4, who has held both Band 3 and 4 roles commented:

> *"I could really think that Band 3's could really say "I'm doing exactly the same as (Participant 4), why are they paid at Band 4?" There's not really much difference. If any." Page 3, Lines 14-15*

While Participant Four could reflect on Bands 3 and 4 doing the same job for different pay and appeared to be at ease with this, they appeared more frustrated when they stated:

> *"When we did have SMHP's it was almost like there wasn't a difference between what they were doing and what support workers were doing. And then, you're kind of like 'okay, apart from being able to sign off a care plan, how is that worth an extra … however much money?'" Page 5, Lines 30-32*

Again, there is a sense of dissatisfaction and unhappiness from the participant who appears to diminish the role and responsibilities of the SMHP. I wondered if both participants might have some painful feelings of envy and the potential role of defensive feelings of omnipotence.

Further to the tensions between the bandings in respect of pay, there was a tension observed when participants thought about the pay they receive for the work they do. Participants generally expressed varying levels of dissatisfaction regarding their pay, apart from Participant Two:

> *"Well for me, in comparing how well or not so well I was paid to do my job back in (home country), just doing, being in this amazing role and doing this work and being compensated as I am compensated now is just an amazing jump." Page 8, Lines 19-21*

Participant Two has a different frame of reference than the other participants in that they are a European citizen who has chosen to move to the UK to work. They have had some higher-level training and had worked clinically prior to taking up this role.

Participant Three raised an objection that related to the difference between the salaries of support workers and senior support workers, (Bands 3 and 4 respectively) and expressed some dissatisfaction and frustration:

> *"I feel a bit of a bug when new people come in and they're employed as senior support workers and I don't mind if they're skilled when they come in, but when they, they've not done anything and they're coming in in those roles, I do feel a little bit like, why did you take my banding away?" Page 8, Lines 24-27*

I enquired with Participant Three as to what they believed to be the reason someone would be employed at Band 4 rather than Band 3 and they answered assertively that "they have a degree or educational qualification." I found this interesting as this does not actually appear to be the case. Participant Five (Band 4) mentioned in their interview that they do not hold a degree or other educational qualifications.

As with Participant Three, there was a sense with Participant Five of acceptance regarding salary although they were able to acknowledge some difficult feelings in relation to pay:

> *"But yeah, I've obviously got to look at the future about progression and earning a better wage because it's not, yeah it's good, but it's not great. You know, I could probably go and work in Morrisons and get the same pay with less stress because it is a very, very demanding job." Page 9, Lines 19-22*

Participant Five raised an important issue here, that the role can be demanding and stressful and that they could probably earn the same salary doing what they perceive to be a much less demanding and stressful job, i.e., "work in Morrisons". During the interview, I was struck by this comment and responded to the participant that had they worked at Morrisons for as many years, they would probably be on significantly more pay as pay scales in the private and commercial sector, often have a culture of rewarding longevity of service and experience and a clear promotional system. This led to a brief conversation about the rigidity and structure of the NHS Agenda for Change pay system. They reflected on how once you reach the top of your banding, there is nowhere else to go financially, no pay progression and no bonus system.

4.3.3 - The Intersection Between Value and Worth

Participant Four appeared to strongly equate their pay with how they believed 'they' valued their role and by extension, the participant themselves. They were not explicit at this time as to who 'they' were. Participant Four appeared to imply that the level of pay reflected something of the quality of staff and that it neglected to account for the skills and qualities that support workers have and bring to the role:

> *"It almost feels like anyone could do my job. Or they feel… I don't know whether they feel …. but almost like, because of what we get for pay, I just kind of feel like, it almost equates to the same as what anyone could do really, so …. Yeah, it's not really very important, so, I don't feel appreciated that way." Page 9, Lines 32-35*

Participant Three made a direct link between the tasks they undertake as a part of their role and the pay they receive not being of equal value:

> *"I'd rather not be doing risk assessments and care plans, I don't get paid enough to be doing risk assessments and care plans, apart from anything else." Page 7, Lines 23-24*

4.4 – SUPERORDINATE THEME 3: THE WEIGHT OF RESPONSIBILITY

This superordinate theme appeared to emerge from two distinct subthemes, both of which took their titles from participant quotes. The first subtheme: "You feel so responsible for their life" captures participants feelings and experiences related to the exposure to young people presenting with high levels of risk and the feelings of responsibility that get stirred up.

The second subtheme: "I don't know what I am doing" highlights how participants understand their roles and how they fulfil them. I noticed that participants appeared to have a 'bigger picture' idea of knowing what they do and how they do it, but when

this was further enquired into, the 'smaller picture' revealed uncertainty, unclear role boundaries and often a lack of confidence.

4.4.1 – Subordinate Theme 1 - "You feel so responsible for their life"

This subtheme explores the impact on support workers of working with high-risk young people and the effects this can have. Participants spoke explicitly and implicitly about the emotional demands placed on them by the role and the work that they do. For example, Participant One, says:

> *"I hadn't fully considered before I started, what it means to work in a crisis team with kids who are in the eye of the storm, in that crisis." Page 5, Lines 16-18*

The metaphor of being in the eye of the storm implies impending danger, chaos and destruction. It perhaps also suggests a temporary state of calmness and stillness amidst a sense of inevitable change. I was intrigued that the participant hadn't considered what it would mean to work in a crisis service and wondered about their private theories of the role and their ideas of themself in regards to the role. They go on to talk about the weight of responsibility that they can feel in their role:

> *"Another thing that's hard I guess sometimes is the sense of responsibility that all of your actions can have…and that's quite hard as well knowing that… or feeling that with some young people, it almost robs you of your right to make an autonomous decision because you feel so responsible for their life. That's quite hard as well." Page 6, Lines 21-36*

This comment spoke to the weight of responsibility that support workers can feel in their roles, particularly when exposed to risk. Participant Two highlighted the importance of emotional regulation for clinicians and the impact the work with young people in crisis can have:

> *"I think in the crisis team we are just meeting so many risky people who are in really sometimes a dire situation and you have to be able to manage your own emotions as well, umm and modelling for them, but of course it can get overwhelming, and all these people live in your head while you are supporting them." Page 5, Lines 15-19*

Participant Two's description of 'people living in their head' while working with them gives an insight into the emotional impact of the role and the worry and concern that can be experienced by support workers.

Issues and concerns around risks and responsibilities were present for all participants, regardless of specific role or level of experience. Participant Three, with decades of experience in CAMHS, commented:

> *"I enjoy the work I do. Sometimes it's hard, isn't it? It's hard to, when I've taken the ones on that have been a bit more risky, that's been a bit more scary I think." Page 7, Lines 39-40*

Feelings of fear and uncertainty around how to manage risk issues emerged for other participants, as Participant One states:

> *"So that can be quite difficult you know, holding that risk, when you're not in base and you can't just knock on someone's door and share that with them. You are kind of on your own." Page 6, Lines 15-17*

In response to the question about how they manage the emotional impact of the work, Participant Four said:

> *"I'd probably say 95% of the time I am able to, there's just those odd ones where you kind of think about it, but then I kind of … yeah, maybe give myself a little bit of time to think about it and then be like 'there's nothing I can do about it here, so ….'" Page 5, Lines 24-27*

Participant Four appeared to be expressing a level of powerlessness around their ability to manage the emotional impact of the work at times. There was also an

implication that issues that bothered them, could after some thought, be parked. They later comment on their ability to 'compartmentalise' things and credit this with being part of the reason that they can do their job.

Participant Five, with 2 decades of experience across a range of mental health settings spoke about risk:

> *"It's sad really but you get acclimatised to certain behaviours, you know on the wards with people ligaturing, biting, cutting themselves, I've seen a lot of horrific stuff you know, and being a dirty nurse when they put the stitches in and all that sort of thing, so I've seen a lot of distressing things but you get sort of used to it, do you know what I mean?" Page 5, Lines 17-21*

I wondered about the participants comments about 'getting used to it' and the interesting choice of the word 'acclimatised' and wondered if they were expressing something about feeling desensitised to the work at times.

When discussing risk management, Participant One said:

> *"I've sort of reflected that I've found myself sometimes sort of talking about risk in sort of a tick-boxy way which I don't think is actually what either of my supervisors would do but that's the way that I interpreted some of those conversations, alongside me feeling anxious and nervous maybe to ask them about self-harm or about suicide." Page 12, Lines 13-14*

This comment implies something of desensitisation and it is interesting that the participant links this with their own emotional state, implying perhaps that one means of managing the difficult feelings aroused by subjects like self-harm and suicide, is to resort to "tick-boxy" methods of communicating.

4.4.2 – Subordinate Theme 2 - "I don't know what I'm doing."

The second subtheme which emerged was around the participants ideas on how they carried out their roles and their private theories about their own qualities and skills.

Participant One was open about beginning their role in CAMHS without any clinical experience or training:

> *"I came in with no knowledge really of any therapeutic interventions so I often use like, the coping skills from DBT because we've all been sent on that training." Page 7, Lines 37-39*

For some of the participants there appeared to be confusion and uncertainty about what the role is and how to carry it out, as Participant One commented:

> *"I think I sometimes lack a bit of confidence in what my role can be" Page 15, Line 19*

All of the participants spoke with confidence about different therapeutic approaches that they employ in their roles. They also shared feelings of uncertainty and a lack of confidence in themselves or in their ability to carry out their roles effectively.

Participant Two explained:

> *"And it's really interesting how, I think usually support workers are like non-qualified clinicians but on the other hand we are doing so much and we are using so many skills that of course a qualified professional uses as well." Page 5, Lines 32-34*

Participant Three described their therapeutic approach as:

> *"So…..well, umm, I really like solution focussed so I do that. I would say a bit of, I dabble a bit with CBT which isn't good is it? To be dabbling with anything?" Page 8, Lines 9-10*

Participant Three seemed to almost be suggesting that they were doing something they shouldn't be doing, that 'dabbling' was a bad thing. I wondered what the alternative to 'dabbling' was for support workers who do not have and cannot access formal training that provide frameworks and evidence-based trainings for working therapeutically.

Participant Four spoke openly about their anxieties and uncertainties around performing the role:

> *"Sometimes I sit and think actually, like do I actually know what I'm doing? And I probably do, but a lot of the time I'm a bit like …. 'I'm just making it up on the spot' (laughs)." Page 4, Lines 26-28*

They continued and clarified aspects of their approach to their work:

> *"Depends, it's different with each individual person, sometimes I might use a little bit of motivational interviewing. Most of the time it's just, kind of, the skills I got from my counselling training, so active listening, empathising, umm….. yeah." Page 4, Lines 31-33*

Counsellors are not employed within the Trust and it is not recognised as a relevant training for working in CAMHS teams. The impact of this is somewhat confusing; the skills gained from counselling training were not recognised, sought or valued, yet were certainly employed in the course of work – particularly considering the absence of other training. There was a sense among some of the participants that despite their lack of formal training, they should still know exactly what to do all of the time.

Participant Five reflected on the impact of 'burnout' in a previous support worker role and this appeared to link closely to their experience of being one of two support workers who for a time, were responsible for supporting some very unwell and risky young people who were on hospital wards:

> *"I've spoken to my manager and I've said because of burnout with going up to (names two hospitals) once every, well we shared it out as a team and it was more manageable but when it was just me and N (another support worker), it was quite intense, you were going up there on a daily basis and these ones were very tricky and they weren't eating and it did have a little bit of an effect on yourself, you know and you're doing the best as you can and all the skills*

> *that you've got to get these young people to eat and err, yeah, so … I'm not doing that at the moment" Page 3, Lines 23-29*

They explained that they had had a significant time away from work due to the impact of burn-out alongside challenges in their personal life. They expressed that they have been very clear with their current manager around what they feel they can and currently cannot cope with in terms of risk and responsibility. Experience in the role appears to have enabled this participant to feel able to voice these concerns.

CHAPTER FIVE - DISCUSSION

5.1 - INTRODUCTION

In this chapter I will briefly summarise the main findings and then discuss them in relation to the existing literature reviewed in Chapter Two. Each superordinate theme produced further thoughts and questions which I outline here and will explore in the discussion. In the first theme: 'Issues of Identity and Belonging', I was interested to hear the participants' different ideas relating to their professional identities and sense of belonging. This raised questions for me around understanding what professional identities are and how they come to be formed. Questions were also noted around the importance of the personal qualities of support workers. These questions will be explored in this chapter.

The second superordinate theme: 'A Question of Value and Worth', raised questions around understanding the role of envy in hierarchical workplace systems and how teams' function when roles are not perceived as clearly defined. The issue of pay was important for all participants and raised a question for me around whether CAMHS staff get paid fairly for what they do.

The third superordinate theme: 'The Weight of Responsibility', raised questions around burnout, desensitisation and how clinicians manage the impact of exposure to risk. I wondered again about the effect of not having a professional training and framework to refer to when it comes to matters of risk management and awareness of personal responsibility within the role, which is often experienced by support workers as 'unclear'.

The discussion of each theme will incorporate my recommendations for policy and service changes as well as further research that is indicated. I will conclude the

chapter with a general discussion including the strengths and limitations of this study and direction for future research.

Tables concisely outlining the recommendations and potential impacts of them can be found at the end of this chapter.

The analysis revealed three superordinate themes, each comprised of two subordinate themes:

1.) ISSUES OF IDENITITY AND BELONGING: A Search for Identity *and* A Sense of Belonging
2.) A QUESTION OF VALUE AND WORTH: Feeling Valued *and* Questioning Worth
3.) THE WEIGHT OF RESPONSIBILITY: “You feel so responsible for their life” *and* “I don’t know what I’m doing.”

5.2 – ISSUES OF IDENTITY AND BELONGING

This section reports on and explores the issues that emerged as part of the superordinate theme including what it means to lack role clarity, the importance of personal qualities and how the role is often considered as a steppingstone to further training for some support workers; and for others, a career in itself.

5.2.1 - A Search for Identity

A Lack of Role Clarity

The issue of a lack of role clarity emerged powerfully from the findings and was reflected in different ways in the current study: Firstly, the role could feel like it was ever evolving. This was commented upon by Participant Three who explained that their role had changed over time and that this had resulted in them feeling unsure

about where the role now sat and that the duties of the role had also changed. The participant spoke of having to undertake risk assessments and care planning where these had not previously been requirements of the role. Wilberforce et al., (2017) report on role evolution over time which suggests that this might be symptomatic of unregistered roles. When there is no overseeing body to define role duties and scope of practice, there is little to prevent roles evolving and changing to meet service needs.

Secondly, the role was often understood by support workers in terms of what it wasn't (not long term, not a role delivering a specific treatment). Interestingly, Participant Two stated that their understanding was that the 'support' part of their title reflected the capacity of the role to support the team. I had always imagined that the 'support' part of the title referred to the work undertaken with patients. It is likely that both understandings are relevant but the fact that there is a discrepancy here further highlights the issue of a lack of clarity in the role. This finding strongly mirrors what the literature review has highlighted. In some, the support workforce is described as supporting qualified clinicians (NHS England 2019), in others, as supporting patients (Nixon, 2006; Senek, 2025; Kings Fund, 2018) and in others, the term is used interchangeably (Cavendish, 2013).

Support workers in the study often referred to themselves as 'unqualified'. This could be understood as a *deficit* approach to nomenclature where not only the qualifications of the workforce are ignored but perhaps also the complex patient-centred tasks it performs (Griffin et al, 2004). Perhaps the use of these terms (unqualified, unregistered) is a response to the undefined term 'support worker' rather than a reductive and demeaning form of identification. Interestingly, while this topic came up in the current study's interviews, it was often that these terms were used by support workers describing themselves, more so than their experiences of being described by

colleagues. This somewhat contradicts the findings from Hall et al., (2024) who found that support workers described being referred to as ‘unqualified’ by colleagues.

The third concern arising from a lack of role clarity relates to the support worker scope of practice, also identified by the Nuffield Trust (Imison et al., 2016). The Kings Fund (2019) argue that this links to the fact that the role lacks regulation and state that without regulation, it is inherently difficult to define role duties and boundaries. Cavendish (2013), found in her review that the blurring of role boundaries between HCA’s and registered nurses contributed to a feeling of uncertainty around what tasks could and should be delegated to HCA’s. The findings from the current study revealed that participants experienced a blurring of role boundaries, as exemplified by Participants One and Four who spoke of not understanding the differences between the duties of support workers and those of SMHP’s.

All participants in the present study expressed a desire for more clarity around their roles, including what they should and could do as well as what they shouldn’t, underscoring the need for clarification of role expectations and boundaries that has been recommended by a number of researchers and policy makers (Senek, 2025; The Kings Fund, 2019; Kelly et al., 2024) and is a recommendation of the current study also.

Bion (1962b) and Menzies Lyth (1988) argue that prolonged exposure to role uncertainty can lead to significant internal anxiety and individuals who experience a lack of containment can end up managing complicated feelings of confusion and stress. This theory is corroborated by Senek (2025) who found in her study, that role uncertainty was a contributing factor in the development of workplace stress. In order to effectively tolerate ambiguous feelings and uncertainty, staff need to possess a high

degree of emotional maturity and reflective capacity (Bion, 1962b; Menzies Lyth, 1988). This was apparent for Participant Two who spoke about the need for support workers to be able to emotionally regulate in order to manage the emotional load of the work. Without these skills, staff may become rigid, defensive, or disengaged as a way of defending against uncertainty (Bion, 1962b; Menzies Lyth, 1988). Participant Four expressed a sentiment of feeling disengaged from the role when they spoke about the lack of role clarity and purpose, particularly in response to feeling that there was no longer a role for them within the TEDS team.

The final concern that emerged from the issue of role unclarity relates to ideas of professional identity. Diamond (1988) argues that role ambiguity in organisations can activate powerful unconscious dynamics, particularly in high-anxiety environments like healthcare. He argues that when individuals lack clarity about their roles, they often struggle to form stable professional identities. This can lead to unconscious projections of internal conflicts which can distort and negatively affect workplace function and relationships. Aspects of this theory were noted amongst participants who compared their roles to other CAMHS roles, particularly the SMHP role. I was aware of feelings of resentment and envy present for Participants One and Four and I shall explore this further in relation to the second superordinate theme – a Question of Value and Worth.

Understanding role duties and responsibilities, aligning with the established values and ethical code of the role, and gaining and maintaining the relevant skills and competencies required in order to fulfil role requirements, are some of the key elements required for the establishment of a professional identity (Trede at al., 2012). For support workers who had come into the role from previous roles with established professional identities (psychologist, teacher, counsellor), this appeared to be more

challenging and there was a sense that support workers sometimes felt a bit lost and unsure as to what they did in their roles and how they did it.

The Importance of Personal Qualities

All participants in the current study reflected on their personal qualities and attributes and the importance of them within their role. Common shared values included qualities such as patience, kindness, resilience and a desire to help. These findings lend support to The National Institute for Health and Care Research (NIHR, 2014) review that highlighted that young people value staff who are empathetic, non-judgemental, approachable, and good listeners. It emphasized that the quality of the therapeutic relationship often outweighs the specific type of treatment. Consistency, trustworthiness, and being treated with respect were seen as essential for engagement. Similarly, Cavendish (2013) recommends that managers need to recruit support workers with the right values. This sentiment is echoed in other publications which relate specifically to CAMHS:

> "staff who are positive, have a young outlook, are relaxed, open-minded, unprejudiced and trustworthy." (Department of Health & NHS England, 2015 p.63)

CAMHS support workers require a rich blend of interpersonal warmth, professionalism, flexibility, communication, and relationship-building qualities. These are as critical, if not more so, than technical knowledge in ensuring effective therapeutic support for children and adolescents (Bradley et al., 2009; Cooper et al., 2009). This view was certainly shared by Participant Five who clearly stated an awareness of their own qualities and attributes that they felt enabled them to work successfully at engaging and supporting young people.

5.2.2 - A Sense of Belonging

Belonging emerged also as a main theme in the Hall et al., (2024) study which focused on support workers' experience of feeling valued. In the current study, a sense of belonging was intrinsically tied not only to the support workers experience of feeling valued within their team, but in *their* valuing of the wider team.

Freud (1921) argues that belonging is more than a social arrangement and is actually a fundamental process of identification. Identification begins in childhood and Freud understood this as an unconscious process where aspects of the other are taken in and incorporated into the ego. Klein (1946) developed some of this thinking further and argues that these internalised aspects form the basis of the templates through which we understand and experience relationships. When early caregiving has been 'good enough' and relationships have provided a sense of safety, we develop an experience of feeling worthy and this in turn allows for an experience of belonging. Winnicott (1960) describes the necessity for a 'holding environment' in order for a child to be able to develop a sense of belonging. Within this environment, a child can gradually develop a 'true self', characterised by an authenticity which enables genuine connections with others (Winnicott, 1965).

Group bonds form between individuals through the mutual identification of shared emotional attachments to a leader or ideal. Freud (1921) argues that this allows for a sense of cohesion within groups and the creation of a sense of equality. In order to maintain a sense of unity, difficult aspects of group bonds such as feelings of aggression and rivalry, have to be displaced or repressed. Powerful feelings need to be displaced on outsiders or they threaten to disrupt or destroy the group and it's functioning.

Participants spoke of the containing function of belonging to a MDT. This was particularly apparent for the two CAHTS support workers. They reflected on their roles primarily being lone-working, community-based roles. They spoke of how they appreciate being able to call a manager or colleague to discuss concerns that arise in their work. While the primary function appeared to be about risk management, it was evident that a secondary function was about managing the anxiety and stress caused by exposure to risk issues whilst lone-working in the community. This sentiment was echoed by other participants who expressed their appreciation of the support that is available to them from the wider team when it comes to exposure to and management of risk. No other study revealed such a theme and whilst further research is needed to verify current findings, it could be speculated that it might have such weight because CAMHS teams could be seen as 'communities of practice' (Wenger, 1998). Communities of practice are characterised by mutual engagement among multidisciplinary professionals, a shared commitment to improving young people's mental health, and the use of common tools, language, and ethical frameworks.

For support workers, Wenger's concept of *legitimate peripheral participation* is particularly relevant. Wenger (1998) argues that individuals begin on the margins of practice but gradually move toward fuller participation as they acquire knowledge, experience, and confidence. This process fosters a growing sense of professional identity and belonging.

Wenger's model highlights the need for inclusive and supportive environments in which all team members are enabled to engage meaningfully, reinforcing the idea that identity is shaped not only by what one knows, but by *how one participates* in professional life. All participants spoke of the value that they place on accessing learning opportunities from the MDT. Access to colleagues from different professional

disciplines appeared to contribute towards a sense of belonging and inclusion. Three participants were explicit in talking about how much they valued the opportunity to work alongside colleagues from different disciplines and how this enabled them to learn and develop.

In the context of Wenger's (1998) *Communities of Practice* framework, learning is not solely the result of formal instruction or clinical training, but emerges through active participation in shared practices such as team meetings, case discussions, risk assessments, and direct therapeutic work.

While support workers in the current study reflected on their appreciation of being able to access supervision and support from qualified colleagues, they also shared that it can feel difficult to ask for support sometimes. Whilst some studies highlight the need for robust supervision arrangements (Nixon, 2006; NHS England 2019), I have been unable to locate other reports that identify the benefits of ad-hoc supervision and support for support workers. Support workers in the current study spoke passionately about how much they value the opportunity to learn from more senior or more experienced colleagues. As well as providing opportunities for learning new skills and approaches, there is an opportunity for MDT colleagues to be supported by the presence of a support worker.

Steppingstone or Career?

There appeared to be a clear split between the participants in the current study when it came to thinking about their career aspirations for themselves in relation to the role. The two longest serving participants appeared committed to the role as demonstrated through their time in service. The other three participants were explicit in saying that they saw the role as an opportunity to 'try out' CAMHS work and a 'steppingstone' to

further training. All three expressed a clear ambition to leave the support worker role to undertake formal training and advance their careers. The idea of the support worker role as a steppingstone is present in the literature (Nixon, 2006; NHS Employers, 2016; Kelly et al., 2024.)

The current study has highlighted that there is a distinction amongst support workers. Some are happy to stay in their role and do so for a long time and others see their role as an opportunity to gain experience of CAMHS work. Three of the Five participants spoke of clear career development plans that included further training as a psychologist, embarking on RMN training and training as a child psychotherapist. Present findings recommend that support workers with clear career development goals have opportunities to work closely with colleagues of their intended future discipline to gain more focussed experience that could further enhance their development, e.g. support workers could take up a role as a ‘psychotherapy support worker.’

Reflecting on their loss of professional identity, one of the participants suggested that support workers could become ‘specialists’ in some trainings and clinical approaches such as Motivational Interviewing, DBT skills and emotional regulation skills. The participant felt that having a speciality would enhance not only their knowledge but sense of belonging within the team. Building from this recommendation I would add another, which is that support workers could become specialists in working with particular mental health presentations such as depression, eating disorders, emotional dysregulation and self-harm.

5.3 – A QUESTION OF VALUE AND WORTH

This section reports on and explores the issues that emerged as part of the superordinate theme including training opportunities and limitations, problematic pay and the role of envy in hierarchical workplace systems. This superordinate theme came through powerfully and was often expressed with high emotion. The feeling of being valued in their roles was often overshadowed by the lesser sense of worth that the participants experienced.

5.3.1 – Feeling Valued

All participants expressed a sense of feeling valued which contributed to their sense of belonging in the team. Participant Four described a complex relationship with their role and discussed a strong sense of feeling appreciated and valued by their team. However, they felt that to the wider Trust and more senior management levels, their role was not seen the same way and this led to feelings of resentment. Participant Four reflected on how the temporary contract they had underlined the feeling that they 'would do' until qualified staff could be recruited. This compounded feelings of not being valued by the wider Trust, a sentiment echoed in Senek's (2025) findings.

Participant Two spoke openly about their experience of being approached by more senior colleagues who were seeking advice or the opportunity to discuss cases with them. They described this as providing them with a sense of equality in the workplace and said that it helped affirm that they, and their role are seen as important and valued by MDT colleagues. Hall et al, (2024) found the same thing:

> "being asked for advice by registered staff was something that afforded support workers great pride." (p.5)

For the participants in the current study, feeling valued was often linked to receiving external recognition and reward. Freud (1921) argues that work relationships engage unconscious needs for recognition and identity. When these needs are met through recognition from authority figures, the sense of self-worth within the individual is reinforced. Winnicott (1965) argues that in order for individuals to feel valued, there needs to be a "good enough" 'holding' environment where individuals experience their contributions as seen and responded to. Perhaps one of the strongest indicators for participants in feeling valued, came from their reflections regarding training, both the opportunities open to them and the limitations they perceived.

Training – Opportunities and Limitations

Training and development and the opportunities and limitations around both, presented regularly across interviews. The topic of 'training' was particularly interesting because it is a broad term and for participants, the meaning and specificity of 'training' often shifted. Participants used the term interchangeably in the interviews to refer to: (1) Training available to support workers to build their skills and effectively carry out their roles and: (2) Training not available to support workers, i.e. Formal trainings or specialist in-house, higher level trainings. I shall discuss the informal training first, that is, training that support workers can access which allows them to build skills and knowledge suitable for the role.

Cavendish (2013), highlights a concern with in-house trainings recognising that these trainings are often not accredited, leaving support workers without evidence of their training and development to take to new employers or to help them further their careers through formal training. Participant One spoke about having access to a range of trainings as a support worker but stated that they were unaccredited and often only at an 'introduction' level.

Secondly, some participants spoke of their frustrations around the limitations to access formal training. Participant Two commented on the reality of the NHS Agenda for Change (AfC) system which rigidly prevents employees progressing through the banding unless they have appropriate qualifications. They rightly observed that a support worker could be in post for a decade and have reached the top of their Band and have no further options within their role for progression. This inevitably leads to one of two outcomes: support workers stay in Band 4 roles indefinitely or they leave. Participant Two reflected on how this would mean that experienced support workers would leave the NHS and this was mirrored in Senek's (2025) study. She found that the high turnover of HCA's impacts the NHS at multiple levels, one of which was the loss of experienced staff leading to further recruitment and training costs.

Nixon (2006) called for training for support staff that would lead to progression through the banding system but it seems that almost 20 years on, this is still not available. It is my view that while the AfC banding system remains in place and while support workers are employed in line with it, there is no realistic route for support workers to progress beyond Band 4 posts.

There has been progress for certain sectors of the support workforce, namely the inception of the nurse associate programme and similar proposals in the physical health sector (i.e. physician associates), (NHS England 2019), but I was unable to find any reference in NHS workforce planning that discusses and describes a realistic plan for addressing support worker training in earnest. The focus appears to be on training at a basic level, to ensure standardisation across the role and sector and of course this is important, however it fails to account for career development.

Training is high on the agenda of all of the NHS planning documents that I reviewed, however, the focus is rarely on support workers. Discussions in the literature appear to reflect something of the experiences portrayed by the support workers in the current study, in that it often feels like a circular and frustrating topic. A number of authors (Cavendish 2013, Nixon 2006, Hall et al 2024, Kelly et al 2024) discuss the need for formal training routes for support staff. Often this is linked with other key issues including pay and regulation (NHS England, 2016). However, it appears that despite years of recommendations, the situation for support workers remains stuck.

5.3.2 – Questioning Worth

The issue of worth was more complicated than the issue of feeling valued and was often emotionally charged. There appeared to be a tension between participants' sense of feeling valued and their sense of worth. When these two issues intersected, it seemed that they impacted each other in negative ways, i.e., the sense of feeling valued was challenged or reduced when participants considered their sense of worth.

Problematic Pay

The issue of pay was present for all participants and was strongly linked to the theme of 'worth'. This area was further complicated by shifting ideas of pay that could perhaps be better understood broken down further into separate threads.

Pay is problematic:

- in relation to the role and its responsibilities. This was a cause of frustration and disillusionment for participants in this study.
- in relation to participants levels of experience and time in service. This aspect of problematic pay often lay at the root of feelings about lack of worth.

- when compared to the pay of colleagues. This appeared to underpin feelings of envy and resentment amongst participants.

Participant Three reflected on how their job duties had changed over time and commented that they were now required to complete risk assessments and care plans, something which had previously been deemed beyond the remit of a Band 3 support worker. They felt that this was a significant task and that their level of pay did not compensate them adequately for such a responsibility. Cavendish (2013) identifies a difficulty with 'status' and links this to the relatively low pay awarded to support workers but warns that this is no longer commensurate with the level of skill required and the "increasingly demanding and responsible roles that many support workers are undertaking" (2013, p.25).

Participant Five commented on their pay after more than two decades in NHS support work roles and joked that they would probably earn more working in Morrisons. Senek (2025) found that this feeling was present amongst the support workers in her study who reflected on how similar levels of pay between support workers and supermarket workers led to feelings of being undervalued. This feeling was further entrenched when support workers considered their responsibilities when compared to those of supermarket staff.

The Role of Envy in Hierarchical Workplace Systems

The NHS relies on a clear hierarchy, it is built into the fabric of the institution, from the different coloured uniforms that staff of different bandings wear in hospital settings, through to the rigid and uncompromising Agenda for Pay banding system. Hall et al., (2004) argue that titles such as 'support worker' can perpetuate a subordinate identity within the healthcare hierarchy. Participant Five spoke about the variety of titles they

have held whilst in NHS support worker roles and commented that having ‘practitioner’ as part of the title had afforded them a strong sense of pride, implying that ‘support worker’ did less so.

Menzies Lyth (1988) argues that hierarchies not only provide a structure to enable and facilitate efficiency, they also provide a means to manage staff anxiety. The structure of an organisation’s hierarchy can help to distribute anxiety and stress. Menzies Lyth’s (1988) work was grounded in the study of nursing staff working in hospital settings. She observed that rigid hierarchies not only provide a psychological buffer through the distribution of anxiety, they also provide predictability and enable organisations to keep running effectively under pressure. Hierarchical structures allow for a clear division of labour and clarity around role requirement and responsibility. However, she argues that this can lead to emotional detachment from patients and staff.

It is worth acknowledging here that the tasks of hospital nurses and CAMHS support workers are of course very different but the themes are perhaps important to further explore. The participants in the current study spoke often of the hierarchy of CAMHS and the wider NHS as being a factor which impacted their sense of worth. Questions of envy arose from the findings and I shall expand on this here. Envy was noted most prominently in relation to pay and associated status and directed towards SMHP’s more than other professionals in CAMHS teams. Two of the participants referenced SMHP’s directly when expressing frustrations around their roles and duties and how they appeared to generally mirror those of SMHP’s but with one important difference – banding, and therefore pay. This finding was not present in other studies.

One way to conceptualise this is through consideration of Freud’s ‘narcissism of minor differences’ (1930/2001). Freud describes how groups of people who are similar, may

be more hostile towards each other than to those who are obviously more different. Freud argues that small differences hold a higher threat to identity than big ones and can cause feelings of rivalry, defensiveness and envy. He suggested that the function of this hostility is to provide a defence against the threat of internal anxiety and pain. Hinshelwood (2001) argues that when unconscious processes like envy are not acknowledged within institutions, they function at the unseen level, undermining communication, cohesion, and organisational health.

Stein et al. (2000) frame envy as a destructive impulse aimed at spoiling goodness when it cannot be possessed. Envy can be emotionally destructive in hierarchical or competitive environments where good objects (e.g., authority figures, training opportunities) become targets of unconscious threats. This theme was expressed by Participant Four when they referred to the Trust and higher management as 'they', creating a nameless, faceless authority figure.

The first and perhaps most significant challenge faced when approaching the idea of managing envy in the workplace is that envy is often unconscious (Klein, 1957). The participants in this study spoke positively of their colleagues yet the theme of envy was present. Menzies Lyth (1988), wrote about envy as an unconscious anxiety which is often managed through social defence mechanisms that can distort communication and fragment teams. It is essential therefore that envy is not only acknowledged but that it can be given space and worked through. There are different methods for doing this, including regular reflective supervision spaces. If these dynamics are ignored, there is a danger of unhelpful processes such as splitting, emotional burnout and scapegoating occurring.

Klein (1957) argues that when envy is left unacknowledged, it can stir up feelings of anxiety which can in turn lead to 'splitting'. Splitting is an unconscious defence mechanism that divides people or situations into extremes of good and bad. It arises as a defence against anxiety. Splitting in organisations can lead to polarised perceptions of individuals, roles and organisations and result in idealisation and scapegoating. By creating polarised extremes, complex issues appear simplified as the ability to tolerate ambiguity and the anxiety it causes, reduces. This can in turn lead to a decline in critical thinking and result in teams behaving in reactive and not reflective manners.

There was evidence in the current study of the potential for splitting and burnout, and since Child and Adolescent Psychotherapists within CAMHS are well positioned and suitably trained to be able to offer access to regular supervision, this could indeed be easily implemented.

5.4 – THE WEIGHT OF RESPONSIBILITY

This section reports on and explores the issues that emerged as part of the superordinate theme including burnout and desensitisation. All participants spoke about and reflected heavily on the weight of responsibility that they can feel in their roles. Most often, this related to matters of risk management and the impact of working with high levels of risk. Two participants reflected on how they can be left feeling worried and uncertain about the safety of young people and whether they have 'done enough' to reduce immediate risk concerns. No other study appeared to identify or address the issue of unregistered staff working with high-risk patients or the impact of this work on them.

Further to risk related issues was a more general theme around the emotional impact of the work. Contact with patients' trauma, distress, difficult life circumstances and emotional challenges all contributed towards the heavy emotional toll experienced by participants. The emotional weight of the work is perhaps further compounded for support workers who do not benefit from having a professional framework to adhere to, rely on and refer to in times of stress and difficulty (Evans, 2020).

5.4.1 – "You Feel So Responsible for Their Life."

This statement came from Participant One who identified this as being one of the more challenging aspects of their role. It is likely that at some point, most mental health professionals have had similar thoughts to the one expressed above. Working with risk can be stressful and frightening, as confirmed by all participants in this study.

Support workers generally do not have a professional training and as a consequence, they do not have a professional framework or code of conduct to refer to. As they do not belong to a professional group, they do not have the opportunity to discuss and consult with peers in the same way that other members of the MDT might. So how do support workers respond to risk in their work and how do they manage the personal impact of this? There is currently no research on this subject and therefore a need to address this gap.

Burnout

When staff cannot process their emotional experiences, they become defended, detached, or burnt-out (Menzies Lyth, 1988). Burnout can be understood within Bion's (1962b) framework as a result of a failure of the workplace environment to provide containment. Maslach and Leiter (1997) understand burnout to be comprised of three separate components. These are:

- Emotional exhaustion – when a worker feels drained of their own emotional resources;
- Depersonalisation – when a worker develops indifferent or distant feelings or attitudes towards their patients;
- A reduced sense of personal accomplishment - workers lose belief in their ability to influence positive change and doubt their own skills and effectiveness.

Participant Five spoke openly of their experience of burnout and related it to a combination of factors. They cited high levels of stress during the COVID pandemic and working primarily with very unwell young people on hospital wards. It is interesting that Participant Five was the only one to explicitly name burnout during the interviews. Participants Three and Four described aspects of burnout (emotional exhaustion and a reduced sense of accomplishment respectively), but otherwise, it was not alluded to in the current study. Burnout did not emerge as a theme in other studies that focused on support workers' experiences.

Apart from the emotional distress experienced by support workers, burnout can have a major impact on patients, teams and the wider NHS. It is estimated that 34% of NHS staff experienced burnout in 2022 (NHS England, 2022). It is pivotal for future research to discern what its prevalence is amongst CAMHS support workers.

Desensitisation

In mental health work, the term 'desensitisation' can be understood as a psychological process where clinicians become emotionally numb or less responsive to managing distressing material and exposure to high levels of stress and risk behaviours (Figley 1995). In emotionally demanding settings such as CAMHS, professionals are routinely exposed to distressing narratives and high-risk presentations. Over time, this

repeated exposure can lead to emotional desensitisation; a defensive process that diminishes the clinician's empathic engagement (Kruger 2019).

At an organisational level, desensitisation among staff can lead to a culture of emotional detachment, where care becomes increasingly task-focused and procedural, resulting in reduced empathy, depersonalisation of service users, weakened therapeutic relationships, and a decline in the overall quality and responsiveness of care. Menzies Lyth (1959) argues that institutional practices often function as social defences against anxiety, enabling staff to cope by reducing emotional involvement in their work. In this context, desensitisation may involve a blunting of emotional responsiveness, allowing practitioners to maintain functioning while avoiding overwhelming feelings.

Participant Five reflected on their experiences of desensitisation when they used the word 'acclimatised' while talking about the experience of working with patients who self-harm. Participant One referred to desensitisation when they spoke of undertaking risk assessments with young people in a "tick-boxy" way. While some desensitisation is adaptive as it can help staff to remain composed in crises, excessive desensitisation can impair empathy, ethical judgment, and therapeutic effectiveness (Kruger 2019).

Given the potential consequences and risks of desensitisation, it is surprising and somewhat unsettling that this is not referenced in the other studies reviewed and suggests a need for further research in this area.

5.4.2 - "I Don't Know What I'm Doing."

This statement, issued by Participant Four, was echoed by others in different ways. It underscored a narrative from most of the participants that they *should* know what to do, almost *all* of the time. Though not explicitly expressed, it appeared that the

participants did not question whether the 'qualified' staff might also feel this way. This assumption may perhaps collude with unspoken and unconscious ideas of difference and inferiority and further fuel the fires of envy.

Four participants spoke of the importance of receiving positive feedback from patients, managers or colleagues and felt that this was helpful in offering reassurance that they were doing a good job. I was interested in the need for external validation in order to feel confident and competent and wondered if this linked with the lack of a professional framework or formal training, (though I accept that 'qualified' staff may also doubt their capabilities at times too.) This phenomenon was noted by Hall et al., (2024):

> "Where support workers may not have felt confident in their roles, they relied on being given compliments as a way of feeing appreciated and this increased their confidence in their abilities." (p.5)

All participants discussed times where they have lacked confidence in their abilities. This either related to a lack of confidence in having the necessary skills or training to effectively carry out their roles or; a lack of confidence in their ability to 'know what to do'. Participants all felt that they could access support and advice as and when they needed it, but this often served to reinforce their doubts about their competence ("I *should* know what to do"). Kelly et al., (2024) found similar themes and reported that HCA's can lack confidence and linked this to the lack of training available for their roles.

Perhaps a further understanding of the participants' lack of confidence in themselves can be understood through the lens of Bion's (1962) theory of containment. Infants require help in managing their big feelings. They require a 'container' to take in their powerful projections, 'metabolise' them and return them in a more manageable form. Repeated experiences of this process allow the baby to be able to digest their

emotional experiences and they gradually internalise this process for themself. When this process fails and the baby's projections cannot be taken in, the projection remains unprocessed and this causes an escalation in feelings of anxiety for the infant. Containment is the process by which raw and unprocessed emotional experiences can become thinkable.

In organisations and groups, similar processes can be observed. The role of the container is provided by the institution in the form of its different structures, hierarchy's and leadership. Bion (1961) argues that groups can generate shared anxieties and that these need to be contained. Fears and uncertainties are projected and need to be processed. Effective containment can help to clarify roles and work purpose and difficult emotional states can be held, understood and worked through, enabling task-focused work to continue.

A failure to effectively contain the anxieties of the individual can lead to the evacuation of emotions causing conflict, blame and withdrawal. At the group level this can cause an escalation and spread of anxiety. When participants in the current study describe lacking confidence in their skills or abilities, they may be referring to an experience of a breakdown in containment.

5.5 – DISCUSSION - LINKING THE FINDINGS WITH THE AIMS AND OBJECTIVES

It seems pertinent at this point to revisit the initial aims and objectives of this study and the questions posed.

- Who are the people who take up this role?
    - ➢ What are their hopes for themselves and the role? What do they bring to the role? Why do they choose to take up the role?
- What can we learn about the role?

  - Do support workers feel their role is valued? Is the role useful and what function does it serve in modern CAMH services?
- What can we learn from support workers about working in CAMHS?
  - How can this learning help in understanding the changing shape and purpose of CAMHS?

5.5.1 – Who Are the People Who Take Up This Role?

What has emerged consistently across this study, and what appears to be backed up by wider literature and research that pertains to the role of support worker (NIHR 2014, Department of Health & NHS England 2015, Morris & Nixon 2009, Bradley et al., 2009, Cooper et al., 2009) is that there are often common shared personal qualities across the workforce. These qualities include patience, non-judgemental attitudes, kindness and caring. Cavendish (2013) highlights the importance of recruiting the right people with the right attributes to these roles and the current study supports this recommendation. In particular, she suggests that support workers are assessed on their ability to cope with stress, and based on the current findings, I would add that assessment of support workers' emotional regulation capacity and ability to seek help for themselves is included at the recruitment stage.

The participants in the current study come from a range of backgrounds and have a variety of career and development aspirations. Some appear to take up the role of CAMHS support worker to gain experience and 'try out' CAMHS work. Others see it as a career in itself. It does not appear that this distinction is currently recognised or addressed by employers at recruitment stage or beyond. A recommendation based on the current findings, would be that pathways are devised that meet the needs of both groups so that those who wish to pursue further formal training are enabled to

gain the knowledge and experience they need; and for those who see the role as a career in itself, that their interests and strengths are recognised and attended to.

When thinking with support workers about their experience of supervision, it seemed that often they were allocated a supervisor based on availability rather than clinical or developmental need. This meant that support workers had the job of having to adapt to their supervisor's approach rather than supervisors adapting to the support workers interests, needs and experience. I recommend that clinical supervision is suited to the developmental goals of support workers.

I propose that support workers are able to meet as a group for regular group peer supervision. Regular group peer supervision provided to support workers across teams and sub-teams might allow for a greater sense of belonging and further cohesion amongst the support worker staff. It may also encourage the sharing of skills and knowledge and information regarding training opportunities. A child and adolescent psychotherapist would be well placed to facilitate this.

5.5.2 – What Can We Learn About the Role?

The findings with regard to what we can learn about the role have been particularly interesting to me as they have really illuminated my own understanding of the role and its place in CAMHS and the wider NHS. Perhaps the most consistent message to emerge has been about the lack of clarity in the role in terms of scope of practice, a finding that is evident across other studies (Wilberforce et al. 2017; Hall et al., 2024; 2019; Senek, 2025; Kelly et al., 2024.) This issue is highlighted with regards to the support workforce across the health and social care sectors (Cavendish 2013) and it is my view that a significant part of the challenge relates to the issue of regulation and the associated lack of a professional body and framework.

Findings of the current study highlight that that support workers need a lead, just as every other group of CAMHS professionals has. Support workers and their roles are currently at the mercy of their managers and employers who dictate what is expected of them meaning that support workers can be used in different ways and that there can be no shared understanding of the role and its duties. The lack of clarity around the role is a significant problem that perhaps has its origins right at the beginning of the matter in that even understanding what 'support worker' means is challenging. There is no consistent definition across health and social care or even at a local level in this study which only included five participants.

Participants in the current study had different views on the role title and what it meant (support for team, support for young people). That the same title is used across two enormous employment sectors (health *and* social care) is undoubtedly part of the problem. This study is small and does not have the scope to influence wider policy (even large studies and reviews appear to have a limited impact on doing so.) However, change doesn't have to start at the macro level and it is my hope that at a local level at least, the findings of this study can be useful in informing CAMHS support workers, their colleagues and managers, of the role and the people who choose to take it up, about their needs. Based on the current finding, it is recommended that support workers are issued with clear job descriptions that not only outline what is expected of them in their role, but importantly, what is not expected of them, clarifying the boundary between their role and others'.

It might further be advisable to standardise these across the Trust in terms of role duties and expectations to include role specific job descriptions (i.e. support worker roles in CAHTS, in LD, in TEDS) that need to reflect the client group, the

commissioned work of that team and to detail exactly how and where the role sits and its functions within that part of the service.

Research into the patients' experience of working with CAMHS support workers is an unexplored area and it would be helpful for future research to explore children, young people and their families' experience of receiving support or interventions from support workers. This may help not only in justifying the role in CAMHS, but also in better defining it and developing it.

The current study found that support workers feel valued and feel the role is valued by their teams, colleagues and patients. The issue is complex and the question of whether support workers beyond this study feel valued does not have a straight-forward answer. Kelly et al., (2024) concluded that feeling valued was contingent on a number of factors and could change. The study by Hall et al., (2024) which focused on exploring support workers' sense of feeling valued, concluded with similar findings; that feeling valued is a complex and fluid issue dependent on a number of factors including how they were utilised (or not), the opportunities they had for training and development (or not) and their relationships with colleagues, managers and their organisations.

In some of the literature the issue of value was an externalised one and did not explore the support workers experience of feeling valued, but looked to understand if the role itself was *valuable* (Cavendish, 2013). Perhaps most disappointingly however, is the reality that there is very little literature or insight into this topic which suggests on some level, that it might not be that important.

Hall et al., (2024) found a clear link between support workers' sense of feeling valued and their commitment to staying in the role. Those who did not feel valued, left their

roles. Also, they noted that there was a likely link between feeling valued and the care that was delivered. Those who felt valued delivered a higher level of care to their patients. Participants in the current study spoke about the importance of receiving positive feedback from managers, colleagues and patients and I wonder if support workers were provided with regular opportunities to receive feedback, they would feel more valued and develop greater commitment.

The issue of pay was very present throughout this study and the dissatisfaction with levels of pay meant that for some support workers, they did not consider that the role was sustainable long term. Other studies identified the issue of pay as being present for support workers but to a lesser extent (Hall et al., 2024). Older policy documents and reviews highlight the issue of pay powerfully (Cavendish, 2013). In Cavendish's review, she found that support staff were employed on lower bandings (1-3) than the support workers in this study (four employed on Band 4, one on Band 3) so it appears that some progress in this area has been made.

The Agenda for Change (AfC) system plays a huge part in the issue of pay and while the NHS continues to operate within this structure, the reality is that it is unlikely that this situation will change, it is therefore challenging to offer any recommendations in this area. However, it might be helpful for new support workers coming into post to have a clear understanding of how the banding system works, the limitations of it and for there to be clearer pathways laid out at the start of employment for how support workers who want to progress, might be able to do so.

5.5.3 – What Can We Learn About Working in CAMHS?

The findings from this study revealed that working in CAMHS is a complicated picture. Support workers expressed that they enjoy their role, particularly the variety it allows

in approach and in their day-to-day experiences. Participants spoke overwhelmingly positively about being able to work with a range of clinical disciplines and particularly enjoyed the learning opportunities and chances for development that are afforded to them as part of the MDT culture. As no other studies relating to support workers in CAMHS were found, it is difficult to compare these findings. It is a recommendation of the current study that the opportunities for joint working in CAMHS teams should be increased and readily available to support workers.

Another important finding from this study revealed that working with high-risk young people can be stressful, worrying and upsetting. It is important to outline that exposure to high-risk situations is stressful, worrying and upsetting to other CAMHS professionals too and is not solely the burden of support workers (Walle et al., 2025). Working with high-risk presentations in CAMHS is a recognised source of stress, yet the literature highlights several mitigating factors. At an individual level, confidence is strengthened through specialist training and reflective self-care practices, while regular clinical supervision offers a vital space to process the emotional weight of risk (Walle et al., 2025). Peer support and debriefing further protect against isolation, particularly following adverse events, by promoting shared responsibility within multidisciplinary teams (McNicholas et al., 2020). It is a recommendation of this study that support workers are offered regular opportunities to debrief and that these should not have to be requested, but are available as part of the work day.

Another finding from the current study was that support workers highly value the opportunity to work alongside MDT colleagues. Participants describe valuing the opportunities to learn from more experienced colleagues and felt that this helped with their sense of belonging as well as enhancing their knowledge and skill base. This finding was echoed in other studies (Hall et al., 2024; Senek et al., 2025) however, this

seemed largely contingent on how they felt their role was valued by other disciplines. Further research is needed into MDT colleagues' experiences of working with support workers in CAMHS since it might help better illuminate the support worker role and help define role duties and boundaries. It may also highlight what it is that MDT colleagues most value about support workers, providing evidence to enable role development and clarification.

Tables 10, 11, 12 and 13 below, detail and outline the recommendations of this project focussing on: support worker development, supporting support workers in their roles, capitalising on the support worker role in CAMHS teams and recommendations for future research.

Table 10 *- Recommendations for Support Worker Development*

RECOMMENDATION	**POTENTIAL IMPACT**
Support workers with clear career development goals around formal training have opportunities to work closely with colleagues of their intended future discipline.	Work experiences that align with support workers future career goals can build experience and knowledge and enhance development.
Pathways to be devised that meet the needs of support workers who see the role as a stepping stone to further formal training and those who see the role as a career in itself.	Support workers who plan to access formal trainings are supported to do so through their roles and can access knowledge and experiences that benefit their future development. Support workers who wish to pursue a career in support work are enabled to gain the knowledge and experience they need to feel confident and capable in their roles and have their interests and strengths recognised and attended to.
Clinical supervision should be suited to the developmental goals of support workers (i.e, supervision provided by clinicians whose profession aligns with the aspirational goals of support workers.)	Support workers will be able to access high quality, relevant and developmentally aligned supervision from professionals who hold knowledge, training and skills relevant to the support workers long term career goals enabling exposure to particular disciplines, their

	approaches, ways of working and understanding the work.

Table 11 - Recommendations for Supporting Support Workers in their Roles

RECOMMENDATION	**POTENTIAL IMPACT**
Clear job descriptions should be devised and issued to support workers that clarify role duties, expectations and boundaries.	Support workers will have a clear sense of what they are and aren't expected to do as part of their roles allowing for a greater sense of certainty and confidence in carrying out their role duties. Clarity around roles is evidenced to promote professional identity confidence and sense of belonging.
Support workers should have access to regular and consistent supervision.	Regular and consistent supervision promotes clinical efficacy, job satisfaction, role development and patient safety. It also enables and builds on a sense of belonging, team cohesion and professional identity. Further, it allows for better management of stress and for thinking about the impact of difficult, painful and challenging emotions provoked through the work. Child psychotherapists are suitably trained and well placed to offer supervision that can assist in thinking about unconscious processes identified in this study, such as splitting, envy and resentment. Awareness and management of unconscious processes can contribute to preventing burnout, desensitisation and unhealthy team dynamics.
Recruitment of support workers should focus on hiring people with the right attributes. Assessment of support workers' emotional regulation capacity and ability to seek help for themselves should be included at the recruitment stage.	Evidence suggests that support staff with the 'right attributes' including personal qualities such as a young outlook and non-judgmental attitude are valued by CAMHS patients. Staff who possess a capacity for emotional regulation and help seeking, are less likely to leave their roles and more likely to experience job

	satisfaction and work effectively as well as enhance team functioning. The wider impact could include a reduction in costs associated with high turnover of staff and the recruitment and training of new staff.
Support workers are able to meet as a group for regular group peer supervision.	Regular group peer supervision provided to support workers across teams and sub-teams would allow for a greater sense of belonging and further cohesion amongst the support worker staff group. It may also encourage the sharing of skills, knowledge and information regarding training and development opportunities.
Support workers would benefit from a Professional lead, just as every other group of CAMHS professionals has.	A professional lead for support workers would allow for advocacy, greater role awareness and development and provide support workers with an additional layer of support within their role – they are currently reliant on their teams and team managers and would benefit from an additional and external perspective. It would also allow for better organisation around role duties, standardisation and clarification.
Job descriptions which are specific to different support worker roles in different parts of the CAMH service are advised (e.g. roles in TEDS, CAHTS, LD) that reflect the client group, the commissioned work of that team and detail exactly how and where the role sits and its desired functions within that part of the service.	Specific job descriptions would enhance awareness of the role specific to different parts of the service, enhancing clarity and understanding of the role expectations for support workers and CAMHS colleagues. These would also help to differentiate the tasks and standardise the team specific duties of the support worker role.
Support workers should be provided with regular opportunities to receive feedback.	This would enhance support workers' sense of feeling valued and enable them to develop a greater commitment to the role. Evidence suggest that support workers value feedback and that it can promote wellbeing and confidence.
Support workers should be offered regular opportunities to debrief, these should not have to be requested, but are available as part of the work day.	This would provide a greater sense of containment, contributing to support workers' wellbeing and ability to manage stress and the emotional toll of

	working with high levels of risk without a professional framework.

***Table 12** - Recommendations for Capitalising on the Support Worker Role in CAMHS Teams*

RECOMMENDATION	**POTENTIAL IMPACT**
Support workers could become 'specialists' in certain evidence based therapeutic approaches such as Motivational Interviewing, DBT skills and emotional regulation skills.	Support workers can hold particular skills and knowledge within teams, increasing job satisfaction, professional identity and sense of role clarity. Further, it would provide MDT colleagues with valuable resources within locality teams. This would widen and deepen the skill mix and enhance support worker efficacy and confidence.
Support workers could become 'specialists' in working with particular mental health presentations such as depression, eating disorders, emotional dysregulation and self-harm.	Support workers can hold particular skills and knowledge within teams, increasing job satisfaction, professional identity and sense of role clarity. Further, it would provide MDT colleagues with valuable resources within locality teams. This would widen and deepen the skill mix and enhance support worker efficacy and confidence.
Opportunities for joint working in CAMHS teams should be increased and readily available to support workers.	Joint working provides opportunities for building support worker knowledge and skills and is a supportive function for MDT colleagues.

***Table 13** – Recommendations for Future Research*

RECOMMENDATION	**POTENTIAL IMPACT**
Further research is needed to understand how support workers respond to and manage the personal impact and emotional toll of working with high-risk presentations.	A better understanding of the work support workers do, how they experience and manage risk and how the impact of this can be mitigated against so that support workers are less vulnerable to burnout and desensitisation, feel more confident and are less likely to leave their roles.

Further research is indicated to explore desensitisation – both risks of and impact of – within the support worker population.	A better understanding of the impact of desensitisation for support workers who generally do not have a professional framework to rely on could reduce support worker stress and positively impact patient outcomes.
Research into the patients' experience of working with CAMHS support workers is an unexplored area and it would be helpful for future research to explore children, young people and their families' experience of receiving support or interventions from support workers.	This may help not only in justifying the role in CAMHS, but also in better defining it and developing it.
Further research is needed into MDT colleagues' experiences of working with support workers in CAMHS.	This might help to better illuminate the support worker role and help define role duties and boundaries. It could also increase opportunities for support worker utilisation within teams and help the role develop.
Further research is needed that aims to not only include more support workers, but also looks into a more homogenous sample (i.e. CAHTS support workers).	This would help to refine, enhance and expand upon the findings from the current study. A more homogenous sample could allow for findings to be compared to ascertain similarities and differences that might be crucial.
Further research into the CAMHS support worker population in relation to issues of identity, worth and responsibility.	To expand upon and test the insights gained from the current study across broader contexts.

5.6 - LIMITATIONS OF THE CURRENT STUDY

As with all qualitative research, this study is bounded by limitations that shape the interpretation of its findings. While these limitations do not undermine the value of the insights generated, it is important to acknowledge how my methodological decisions, analytic processes, and contextual factors influenced the scope of the research and the applicability of the findings. A primary limitation lies in the sample size and composition. The small, purposive sample is characteristic of IPA, which prioritises depth of analysis over breadth (Smith et al., 2009). While this allowed for rich,

idiographic engagement with participants lived experiences, it inevitably restricts the diversity of perspectives captured.

IPA is a reflexive process which is heavily reliant on the researchers focus of interest and own interpretations (Heaton, 2004). This means that the researcher's subjectivity is inevitably a part of the process and while there can be steps taken to mitigate against bias and 'blind spots' it is important that this reality is held in mind when reviewing and considering any IPA study, including this one. My previous experience of working in CAMHS as an 'unregistered' worker will have shaped the way I attended to particular issues, such as professional identity or issues of responsibility, potentially foregrounding certain meanings while bracketing others (Berger, 2015). Although reflexive practices such as journaling and supervision were employed to enhance transparency, complete neutrality is neither possible nor desirable in IPA (Smith et al., 2009).

The interpretative nature of IPA means that findings are inevitably influenced by the researcher's perspectives. IPA involves a double hermeneutic that is, the researcher is attempting to make sense of how the participant attempts to make sense of a phenomenon (Smith & Osborn 2008). There is undoubtedly room here for things to be missed, misinterpreted or misunderstood.

I chose IPA for this study because my primary aim was to explore and understand the lived experiences and personal meaning-making of participants, rather than to generate a broad theory or simply identify patterns across data. Unlike Grounded Theory which seeks to develop explanatory models of social processes (Corbin & Strauss, 2015), IPA allows for an in-depth, idiographic focus, providing insights into individual perspectives. Similarly, while Thematic Analysis is flexible and useful for

identifying patterns across a dataset, it does not inherently prioritise the interpretation of subjective experience or the nuanced understanding of how participants make sense of their world (Braun & Clarke, 2013). IPA's combination of phenomenological depth, hermeneutic interpretation, and idiographic attention makes it the most suitable approach for capturing the complex, personal meanings central to this research (Smith & Osborn 2008).

The participants in this study were recruited from four CAMHS teams within the same Trust directorate and were all employed as support workers or senior support workers. The participants varied greatly in terms of their roles and which parts of the service they were located, and their time in service. This raises a question of whether the sample can be viewed as a homogenous group. Further research is needed that aims to not only include more support workers, but also looks into a more homogenous sample (i.e. CAHTS support workers). However, as the findings of this study highlight, in addition to what Cavendish (2013) emphasised, one of the problems lies in the definition of the role. As such, the finding that they are a rather heterogenous group might provide evidence that there is an urgent need for a clearer definition of the role. Thus, future research is needed that focuses on a sample that is more homogenous so that findings could subsequently be compared to ascertain similarities and differences that might be crucial.

The process of recruitment is likely to have introduced bias. Participants self-selected into the study, meaning those who chose to take part may have felt more strongly about their experiences, whether positively or negatively, than colleagues who did not volunteer. This could have skewed the findings towards individuals more reflective or motivated to articulate issues relating to their individual experiences. Those less confident, less available, or less comfortable sharing their perspectives may therefore

be underrepresented. Three of the participants had pre-existing relationships with the researcher and these may have influenced their willingness to take part also.

In terms of data collection, semi-structured interviews provided flexibility and depth but were not without limitations (Smith et al., 2009). The dynamics of the interview setting, including my role as a researcher and professional background, may have shaped the narratives participants shared. Further, my pre-existing relationships with the participants were not consistent. For example, one participant was a colleague, one a previous colleague and current friend, another a friend outside of the workplace. Two participants had no prior relationship with me but were aware that I was a colleague employed in the same Trust. It is possible that this shared connection will have influenced how support workers thought about and responded to the interview questions.

Further, the pre-existing relationships may have hindered my capacity to discern participants' private theories due to shared assumptions and knowledge. This was perhaps particularly true for Participant Three who was observed to often not complete their sentences and who used non-verbal communications such as facial expressions and sounds to convey their thoughts. During the interview, I felt that I was understanding the meaning of the communications and as such, garnering a sense of their private theories. On reflection however, I wonder if this may have presented opportunities for me to misunderstand or misinterpret what was being communicated.

It is perhaps worth commenting on the demographic make-up of the participant group. Four of the five participants were female and one was male and this reflects something of the NHS support workforce (Griffin et al,. 2024). Issues around gender differences in relation to participants views and attitudes were noted and considered but due to

the small-scale nature of this study which took place within one directorate of a Trust, it was not possible for me to explore these issues without risking a break in confidentiality. Four of the participants were of White British heritage and one of White European heritage. This is not reflective of the wider workforce and contributes to the challenge of making these findings generalisable.

Participants may have felt restricted in what they could say and while confidentiality and anonymity were assured, it is a relatively small and interconnected directorate, and it is possible that participants held back more negative or critical views through concern that they would be leaked or shared or otherwise expose them in an unhelpful way. Participants may have emphasised socially acceptable accounts or been reluctant to fully express dissatisfaction or vulnerability, particularly when discussing sensitive issues such as questioning their own worth or feeling overwhelmed by responsibility.

Whilst this is clearly a limitation, I tried to mitigate against this bias by adhering to the formality of the interview and reassuring participants about their anonymity and right to withdraw their data from the study at any time up until publication. Nonetheless, a comparison to findings from studies where there is no pre-existing relationship might be important to ascertain the degree of influence of the bias.

In summary, the findings should therefore be understood not as definitive statements about all CAMHS support workers, but as illuminating insights into the lived realities of those who took part. By recognising the boundaries of the research, the study positions itself as a meaningful contribution to understanding how identity, worth, and responsibility are constructed in clinical work, while also pointing to the need for further research that expands on and tests these insights across broader contexts.

5.6.1 - Reflexivity Explored: Considerations of my own position as researcher, including potential bias.

As a clinician I am interested in understanding an individual's perspective, thoughts and experiences and developing that understanding as fully as possible in order to help the individual also develop a deeper and more integrated understanding of themselves. The focus in clinical work is on the individual and how they make sense of their experience.

As a researcher, I was able to employ some of these skills as I sought to explore and understand the different experiences of the participants in the study. This aspect of the research perhaps came quite naturally but moving then towards being able to explore and understand the experiences of participants to discover similarities and differences and underlying themes required a different approach and set of skills. As such, I think at times it felt more comfortable to be in the position of clinician and more challenging to be the researcher.

Another challenge of being in the researcher position came in the form of initially acting as a receptacle for their information. While this is sometimes part of clinical work, in clinical work, my role is then to 'metabolise' the information I am given in order to 'feed' it back to the patient. As a researcher, the information taken in by me still had to be metabolised in order for sense and meaning to be extracted from it. Unlike the clinical position however, the 'feeding back' of the information had to be navigated in a very different way and through a very different medium. Withholding my thoughts and feelings throughout the interviews and not offering responses or thoughts to what was shared with me felt very different.

This process, from choosing a topic, to gaining ethical approval, to recruitment, interviews, data analysis and the ultimate production of this thesis has been a process rich in learning. Having never undertaken any kind of research before, there were a lot of academic and technical barriers I had to navigate. I have discovered and learned things about myself that may have stayed unknown had I not gone through this journey. I have learned that with patience, commitment and determination, I can design and conduct qualitative research that can shed light on previously unexplored areas. I have learned that if I apply myself, I can learn new skills and build on existing capabilities.

The project has revealed interesting findings in regards to the support worker role, some of which were perhaps anticipated and others which were surprising. I was surprised for example, to find that the support workers in the study valued a sense of belonging and just how important this was to them. The issues of identity that emerged in the study were also valuable learning points for me and encouraged further thinking and exploration of what it means to hold a particular identity.

I have learned that support workers not only feel valued within their roles but also strongly value their positions within MDT's, particularly in terms of the support, learning and training that they can access from colleagues with a range of professional backgrounds and trainings. I have learned that clinical teams employ and utilise their support workers in a range of ways and that the role can be very adaptable, sometimes adapting to meet the learning and development needs of the support workers, sometimes adapting to meet the needs of the team or service.

With the study now complete, I reflect with some regret that I was not able to widen the scope of the project to explore how different professionals within the multidisciplinary teams, thought about and experienced support workers.

5.7 – CONCLUSION

From the literature reviews and empirical studies reported, it can be concluded that CAMHS support workers are not universal across CAMHS teams in England. They are not even universally present across CAMHS teams within the Trust in which the qualitative study took place. But they *are* present, and the research suggests that, for now and for as long as the problems of recruitment and retention of 'qualified' staff persists, they are here to stay.

The complex problem of regulation has emerged as an important theme and appears to underpin many of the issues which have surfaced, from a lack of clarity in the role, to challenges with training and development, to how support workers are supervised and supported. That said, there are significant opportunities as outlined in the recommendations of this study, for addressing some of these issues.

A further conclusion drawn from this study, is that while some support workers are keen to develop their careers beyond the remit of the support worker role, this might not be an aspiration for everyone. Nonetheless, whether the support worker role is a 'steppingstone' or the final destination, those in the role need to be supported, contained and encouraged. They need to feel and *be* valued. They need to know that what they do matters and that there is a place for them in modern CAMHS teams.

Working with young people who present with high levels of risk is a difficult job mentally and emotionally. To face this work every day, and to do so often without a professional training or framework feels to me a bit like sending soldiers into battle armed with

nothing more than a cheery disposition. There is a risk that even the most experienced, committed and passionate support worker will fall. I believe that support workers need more protections than they currently receive and that CAMHS MDT's are already well equipped to meet this need.

It is my hope that this very first formal exploration can pave the way for much needed further research. It is my hope that the participants in this study feel that their voices have been heard and that those who have the power to make changes, who can think creatively and who can see the untapped potential, can and will step up to seize and make the most of the opportunities presented. It is not only support workers who stand to benefit, but their colleagues, their Trusts, the wider NHS and perhaps most importantly, CAMHS patients.

REFERENCES

Berger, R. (2015). Now I see it, now I don't: Researcher's position and reflexivity in qualitative research. *Qualitative Research, 15*(2), 219–234. https://doi.org/10.1177/1468794112468475

Bion, W. R. (1961). *Experiences in groups and other papers*. London, UK: Tavistock.

Bion, W. R. (1962b). *Learning from experience*. William Heinemann. [Reprinted by Karnac Books, 1984]

Bradley, S., Bower, P., Kramer, T., Sibbald, B., Garralda, E., & Harrington, R Macdonald, W. (2009). Primary mental health workers in child and adolescent mental health services. *Journal of Mental Health Training, Education and Practice*, *4*(4), 21–25.

Braun, V., & Clarke, V. (2013). *Successful qualitative research: A practical guide for beginners*. London: Sage.https://doi.org/10.1108/17556228200900029

Cavendish, C. (2013). *The Cavendish review: An independent review into healthcare assistants and support workers in the NHS and social care settings*. Department of Health. https://www.gov.uk/government/publications/review-of-healthcare-assistants-and-support-workers-in-nhs-and-social-care

Cooper, R. E., Saunders, K. R. K., Greenburgh, A., Johnson, S., McCowan, C., Kelly, C., ... & BMC Medicine Authors. (2024). *The effectiveness, implementation, and experiences of peer support approaches for mental health: A systematic umbrella review*. **BMC Medicine, 22**, 72. https://doi.org/10.1186/s12916-024-03260-y

Corbin, J., & Strauss, A. (2015). *Basics of qualitative research: Techniques and procedures for developing grounded theory* (4th ed.). Thousand Oaks, CA: Sage.

Crocker, J., & Wolfe, C. T. (2001). Contingencies of self-worth. *Psychological Review, 108*(3), 593–623. https://doi.org/10.1037/0033-295X.108.3.593

Department of Health & NHS England. (2015). *Future in mind: Promoting, protecting and improving our children and young people's mental health and wellbeing*.

https://assets.publishing.service.gov.uk/media/5a7e1c22ed915d26e639bfa1/Future_in_Mind.pdf

Diamond, M. A. (1988). Organizational identity: A psychoanalytic exploration of organizational meaning. *Organizational Behavior and Human Decision Processes, 42*(2), 179–214

Evans, M. (2020). *Making room for madness in mental health: The psychoanalytic understanding of psychotic communication*. Phoenix Publishing House.

Figley, C. R. (1995). *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized*. Brunner/Mazel.

Finlay, L. (2011). *Phenomenology for therapists: Researching the lived world*. Wiley-Blackwell.

Freud, S. (1921). *Group psychology and the analysis of the ego*. London, UK: Hogarth Press.

Freud, S. (1930/2001). *Civilization and its discontents* (J. Strachey, Trans.). W. W. Norton & Company. (Original work published 1930)

Griffin, R., Kessler, I., & Hall, A. (2024). *The Cavendish Review: Ten years on – Are NHS support workers still "invisible"?* King's College London & University of Exeter. https://www.kcl.ac.uk/business/assets/the-cavendish-review-10-years-on-kbs-report.pdf

Hall, A.J., Goodwin, V.A., Allchurch, L. *et al.* Feeling valued at work: a qualitative exploration of allied health profession support workers. *BMC Health Serv Res* **24**, 1511 (2024). https://doi.org/10.1186/s12913-024-11879-

Health Education England. (2017). *Stepping forward to 2020/21: The mental health workforce plan for England*. https://www.hee.nhs.uk/sites/default/files/documents/Stepping%20forward%20to%202020-21%20-%20The%20mental%20health%20workforce%20plan%20for%20england.pdf

Health Education England. (2021). *Children and young people's mental health services workforce stocktake* [PDF]. NHS Health Education England.

Health Education England. (2023). *Children and Young People's Mental Health Workforce Census 2022: National Report*.

Heaton, Janet. 2004. *Reworking Qualitative Data*. London: SAGE

Hinshelwood, R. D. (2001). *Thinking about institutions: Milieux and madness*. Jessica Kingsley Publishers.

Imison, C., Castle-Clarke, S., & Watson, R. (2016). *Reshaping the workforce to deliver the care patients need* (Research report). Nuffield Trust. Retrieved from Nuffield Trust website.

Kelly, L., Livanou, M., Benn, Y. (2024). "The little ants that make everything else work": Experiences of healthcare support workers in inpatient Child and Adolescent Mental Health Services (CAMHS). (2024). *Psychology & Psychiatry Journal*, 473

Klein, M. (1957). *Envy and gratitude and other works 1946–1963*. London: The Hogarth Press and the Institute of Psycho-Analysis.

Kruger, E. (2019, September 5). *Tackling psychologists' desensitisation*. The Psychologist. British Psychological Society. https://www.bps.org.uk/psychologist/tackling-psychologists-desensitisation

Maslach, C., & Leiter, M. P. (1997). *The truth about burnout: How organizations cause personal stress and what to do about it*. Jossey-Bass.

McNicholas, F., Sharma, S., O'Connor, C., Barrett, E., Kelleher, I., & O'Hara, L. (2020). Burnout in consultant child and adolescent psychiatrists in Ireland: A cross-sectional study. *BMJ Open, 10*(1), e030354. https://doi.org/10.1136/bmjopen-2019-030354

Menzies Lyth, I. (1988). *Containing anxiety in institutions: Selected essays* (Vol. 1). Free Association Books.

Menzies Lyth, I. (1959). The functioning of social systems as a defence against anxiety. *Human Relations, 13*(2), 95–121

Morris, T., & Nixon, B. (2008). New ways of working in CAMHS. *The Journal of Mental Health Training, Education and Practice, 3*(1), 22–27

National Institute for Health and Care Research. (2014). *Developing a model of mental health self-care support for children and young people* (HSDR 02/180). NIHR Journals Library, Health Services and Delivery Research. https://www.journalslibrary.nihr.ac.uk/hsdr/hsdr02180

NHS Digital. *NHS Workforce Statistics – January 2025*. https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics/january-2025

NHS England. (2016, February 14). *The Five Year Forward View for Mental Health*. Report of the independent Mental Health Taskforce to the NHS in England. Retrieved from NHS England website

NHS England. (2019). *Interim NHS people plan*. NHS Improvement. https://www.longtermplan.nhs.uk/publication/interim-nhs-people-plan/Psychological Professions Vision for England – 2021,

NHS England. (2019, July 23). *NHS Mental Health Implementation Plan 2019/20–2023/24*. Guidance. NHS England. NHS England

NHS England. (2022). *NHS Staff Survey 2022: Health and well-being theme*. NHS Employers. Retrieved from NHS Employers website

NHS England. (2023). *NHS Long Term Workforce Plan*. NHS England.

Nixon, B. (2006). *Delivering workforce capacity, capability and sustainability in Child and Adolescent Mental Health Services*. National CAMHS Support Service.

Olmos-Vega, F. M., Stalmeijer, R. E., Varpio, L., & Kahlke, R. (2022). A practical guide to reflexivity in qualitative research: AMEE Guide No. 149. *Medical Teacher*, *45*(3), 241–251. https://doi.org/10.1080/0142159X.2022.2057287

Pietkiewicz, I., & Smith, J. A. (2014). A practical guide to using interpretative phenomenological analysis in qualitative research psychology. *Czasopismo Psychologiczne – Psychological Journal, 20*(1), 7–14. https://doi.org/10.14691/CPPJ.20.1.7

Radcliffe, K., Latchford, G., & Beail, N. (2018). Clients' experience of non-response to psychological therapy: *A qualitative analysis. Counselling and Psychotherapy Research, 18*(1), 58-66. doi.org

Saks, M., & Allsop, J. (2007). Social Policy, Professional Regulation and Health Support Work in the United Kingdom. *Social Policy & Society*, *6*(2), 165–177. https://doi.org/10.1017/S1474746406003435

Senek, M., Long, J., Ohlsen, S. *et al.* Factors affecting the retention of healthcare assistants in English mental health services: a qualitative interview study. *BMC Health Serv Res* **25**, 505 (2025). https://doi.org/10.1186/s12913-025-12665-1

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research*. SAGE.

Smith, J.A., & Osborn, M. (2008). Interpretative phenomenological analysis. IN: J. Smith (ed.), Qualitative psychology: A practical guide to research methods (pp. 53-80). London: Sage

Stein, M. (2000a). After Eden: Envy and the defences against anxiety paradigm. *Human Relations, 53*(2), 193–211. https://doi.org/10.1177/0018726700532005

Teherani, A., Martimianakis, T., Stenfors-Hayes, T., Wadhwa, A., & Varpio, L. (2015). Choosing a Qualitative Research Approach. *Journal of Graduate Medical Education*, *7*(4), 669–670. https://doi.org/10.4300/JGME-D-15-00414.1Tudor et al (2018)

The King's Fund. (2015). *Mental health under pressure*. https://www.kingsfund.org.uk/publications/mental-health-under-pressure

The King's Fund. (2018). *Closing the gap: Key areas for action on the health and care workforce*. https://www.kingsfund.org.uk/publications/closing-gap-health-care-workforce

Trede, F., Macklin, R., & Bridges, D. (2012). Professional identity development: a review of the higher education literature. *Studies in Higher Education*, *37*(3), 365–384. https://doi.org/10.1080/03075079.2010.521237

Tudor, K., Cowan, C., Hennessy, J., MacEwan, I., & Warriner, R. (2017). Mental health support workers: Profession and professionalization. *International Journal of Mental Health*, *47*(1), 74–89. https://doi.org/10.1080/00207411.2016.1204824

Walle, M. F., Langvik, M. H., Jessen, R. S., & Stänicke, L. I. (2025). Sharing, carrying, and tolerating the pain: A meta-synthesis of clinicians' experiences from

working with adolescents who self-harm. *Psychotherapy Research*. Advance online publication. https://doi.org/10.1080/10503307.2025.2481604

Wenger, E. (1998). *Communities of practice: Learning, meaning, and identity*. Cambridge University Press.

Werbart, A. (2005). The patient's private construction of meaning and canons of science: Freud's case studies noch einmal. *International Journal of Psycho-Analysis*, *86*(5), 1441–1461

Wilberforce, M., Abendstern, M., Tucker, S., Ahmed, S., Jasper, R., & Challis, D. (2017). Support workers in community mental health teams for older people: Roles, boundaries, supervision and training. Journal of Advanced Nursing, 73(7), 1657-1666. https://doi.org/10.1111/jan.13264

Winnicott, D. W. (1960). The theory of the parent-infant relationship. *International Journal of Psychoanalysis, 41*, 585–595

Winnicott, D. W. (1965). *The maturational processes and the facilitating environment*. London, UK: Hogarth Press.

APPENDICES

APPENDIX A – Acronyms and Literature Search Information

- List of acronyms used in this paper and their meanings
- List of databases searched
- **Table A1** - Table showing all documents found and reviewed that relate to CAMHS workforce from the NHS
- **Table A2 -** Table showing all documents found and reviewed that relate to CAMHS workforce from The Kings Fund.
- **Table A3** - Table showing all documents found and reviewed that relate to CAMHS workforce from The Nuffield Trust
- **Table A4** - Table showing all documents found and reviewed that relate to CAMHS workforce from The Health Foundation
- **Table A5** - Table showing all documents found and reviewed that relate to CAMHS workforce jointly produced by The Kings Fund, The Nuffield Trust and The Health Foundation
- **Table A6** - Table showing all documents found and reviewed that relate to CAMHS workforce from National CAMHS Support Service (NCSS)
- Box **A1** – A description of nurse associate training
- CASP Quality Appraisal Tool

APPENDIX B – Ethical Approval and Trust Permission

- TREC Form
- Trust Permission

APPENDIX C – Public Facing Documents

- Recruitment Call
- Participant Information Sheet
- Consent Form
- Debrief Letter
- Interview Schedule

APPENDIX D – Data Analysis

- Images of exploratory note taking on transcript
- **Table D1** - Participant One – Personal Experiential Themes (PETs)
- **Table D2** - Participant Two – Personal Experiential Themes (PETs)
- **Table D3** - Participant Three – Personal Experiential Themes (PETs)
- **Table D4** - Participant Four – Personal Experiential Themes (PETs)
- **Table D5** - Participant Five – Personal Experiential Themes (PETs)
- **Table D6** - Table containing all participants PETs
- **Table D7 -** Occurrence of GETs gathered from PETs:
- Images of process for establishing GET's

- **Table D8 -** GETs, Superordinate and Subordinate themes:

APPENDIX E – Recommendations from the Current Study

- **Table E1** – Recommendations for Support Worker Development
- **Table E2** – Recommendations for Supporting Support Workers in their Roles
- **Table E3** – Recommendations for Capitalising on the Support Worker Role in CAMHS Teams
- **Table E4** – Recommendations for Future Research

APPENDIX A – ACRONYMS AND LITERATURE SEARCH INFORMATION

List of acronyms used in this paper and their meanings:

- PMHW – Primary Mental Health Worker
- TUPE – Transfer of Undertakings Protection of Employment
- CAMHS – Child and Adolescent Mental Health Service
- CAHTS – Crisis and Home Treatment Service
- NDC – Neurodevelopmental Clinic
- TEDS – The Eating Disorder Service
- LD – Learning Disability
- SMHP – Senior Mental Health Practitioner
- SW – Support Worker
- SSW – Senior Support Worker
- HCA – Healthcare Assistant
- MDT – Multi-disciplinary Team
- AHP – Allied Health Professionals
- AMBIT – Adaptive Mentalisation Based Integrative Treatment
- DBT – Dialectical Behaviour Therapy
- GH – Getting Help
- GMH – Getting More Help

List of databases searched for literature review:

- APA PsycInfo
- APA PsycArticles
- APA PsycBooks
- APA PsycExtra
- Psychology and Behavioral Sciences Collection
- PEP Archive
- Education Source
- ERIC
- SocINDEX with Full Text
- MEDLINE
- CINAHL
- eBook Collection (EBSCOhost)
- GreenFILE
- Library, Information Science & Technology Abstracts
- eBook Open Access (OA) Collection (EBSCOhost)

Table A1 - Table showing all documents found and reviewed that relate to CAMHS workforce from the NHS*

Year	Title	Sponsor	Summary	Included?	Reason for Exclusion
2004	National Service Framework for Children, Young People and Maternity Services – Core Standards	Department of Health	Sets system-wide child health standards that underpin early intervention and multi-agency CAMHS working.	NO	Does not address workforce or staffing issues, not CAMHS focused
2008	New Ways of working in CAMHS	The Care Services Improvement Partnership, National Institute for Mental Health in England and the Royal College of Psychiatristsp	Focuses on CAMHS and changes needed to address staff shortages	YES	
2008	Children and Young People in Mind: Final Report of the National CAMHS Review	DCSF & Department of Health	Landmark review assessing CAMHS effectiveness; recommended comprehensive system-wide improvements.	NO	Does not mention support workers, approach is broad and not specific to Tier 3 CAMHS
2011	No Health Without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages	Department of Health	Life-course strategy with specific priorities on children and young people and early intervention.	NO	Not specific to CAMHS and does not reference workforce change/ planning
2013	Building and Sustaining Specialst CAMHS to	Royal College of Psychiatry	Review of CAMHS for a psychiatric perspective	NO	Does not address workforce challenges

	Improve Outcomes (CR182)				or speak to staff skill mix
2015	Access and Waiting Time Standard for Children and Young People with an Eating Disorder (Commissioning Guide)	NHS England / NCCMH	Introduces national waiting-time standards (1 week urgent / 4 weeks routine) for CYP community eating-disorder services.	NO	This is specific to Eating Disorder provision
2015	Future in Mind: Promoting, Protecting and Improving our Children and Young People's Mental Health and Wellbeing	Department of Health & NHS England Taskforce	Defines national vision and 49 proposals for transforming CAMHS; basis for Local Transformation Plans.	NO	Does not mention support worker role
2016	Implementing the Five Year Forward View for Mental Health	NHS England	Sets out delivery milestones incl. Local Transformation Plans refresh and access increases for CYP.	NO	Does not include discussion around support workers or CAMHS workforce in detail
2016	The Five Year Forward View for Mental Health (MH Taskforce)	NHS England (MH Taskforce)	Commits to expand CYP access; basis for new investment and targets (e.g., eating disorders, crisis care).	YES	
2017	Stepping Forward to 2020/21: The Mental Health Workforce Plan for England	Health Education England (with NHS England partners)	Defines growth in the mental health workforce, including specific CYP MH staffing trajectories.	YES	
2017	Transforming Children and	Department of Health &	Introduces Mental Health	NO	Does not mention

	Young People's Mental Health Provision (Green Paper)	Social Care and Department for Education	Support Teams (MHSTs) and Senior Mental Health Leads in schools/colleges.		CAMHS or workforce development
2019	NHS Long Term Plan (Children & Young People's Mental Health commitments)	NHS England	Commits to 345,000 additional CYP accessing mental health support by 2023/24; expansion of crisis & ED services.	NO	This is an overview and does not address proposed workforce changes
2019	NHS Mental Health Implementation Plan 2019/20–2023/24	NHS England & NHS Improvement	Operationalises Long Term Plan commitments for CYP MH (access, crisis, ED, MHST rollout).	NO	Does not address workforce make-up or support workers
2019	Interim NHS People Plan			YES	
2021	Children and Young People's Mental Health Services Workforce Report for Health Education England	NHS Benchmarking network	Provides rich detail and statistics	YES	
2023	NHS Long Term Workforce Plan	NHS England	Sets growth for CYP MH workforce (e.g., EMHP training, expansion of MHSTs; wider CYP MH roles).	YES	
2024	Transforming CYP Mental Health Provision – Implementation Programme: 2024 data release	Department for Education / Department for Health and Social Care	Tracks rollout/coverage of MHSTs and Senior Mental Health Leads; progress against Green	NO	Reviews MHST, no reference to CAMHS SW or CAMHS workforce beyond MHST

			Paper commitments.		

**NHS documents include publications from the Department of Health, Department of Health and Social Care, Department of Education, NHS England, NHS improvement, Health Education England, Royal College of Psychiatrists, NHS workforce Review team and NHS Health Advisory Service.*

Table A2 - Table showing all documents found and reviewed that relate to CAMHS workforce from The Kings Fund.

Year	Title	Summary)	Included?	Reason for Exclusion
2015	Workforce Planning in the NHS	This is a broad overview of the NHS workforce picture	NO	No mention of CAMHS or plans for workforce development
2015	Mental Health Under Pressure		YES	
2019	Outcomes for Mental Health Services: What really matters? – measuring outcomes		NO	Does not address workforce planning, support workers of CAMHS
2022	The Health and Care Workforce: Planning for a Sustainable Future	An overall review considering the political landscape that has underpinned NHS planning and development	NO	No mention of CAMHS or support workers
2023	The Rise and Decline of the NHS in England 2000–20	Narrative overview of the changing picture of NHS with a focus on funding and finances	NO	Does not speak to CAMHS, MH, workforce changes or support workers
2024	Mental Health 360 – workforce and funding	A review of the current mental health workforce	Yes	

Table A3 - Table showing all documents found and reviewed that relate to CAMHS workforce from The Nuffield Trust

Year	**Title**	**Summary**	**Included?**	**Reason for Exclusion**
2016	Reshaping the workforce to deliver the care patients need	Broad overview of NHS services, Support staff are discussed and thought given to how they can be utilized more effectively. Mental health is covered but mainly this is physical health related band 4 work	YES	
2024	the NHS Workforce in numbers	Not specific to CAMHS but discusses mental health workforce including SW	YES	
2025	In the balance: Lessons for changing the mix of professions in NHS services	Commissioned by NHS Employers	NO	Is focused on physical health services, does not mention MN, CAMHS or support workers

Table A4 - Table showing all documents found and reviewed that relate to CAMHS workforce from The Health Foundation

Year	Title	Summary	Included?	Reason for Exclusion
2018	The Health care workforce in England	The paper asks important questions of the NHS long term plan but is broad	NO	Does not reference MH or CAMHS or support workers
2024	Towards a healthier workforce	Broad overview of general working population and factors that affect	No	Does not reference MH or CAMHS or support workers

2025	Action for healthier working lives	Broad overview of general working population and factors that affect	NO	Does not reference MH or CAMHS or support workers

Table A5 - Table showing all documents found and reviewed that relate to CAMHS workforce jointly produced by The Kings Fund, The Nuffield Trust and The Health Foundation

Year	Title	Summary	Included?	Reason for Exclusion
2018	Closing the Gap		YES	

Table A6 - Table showing all documents found and reviewed that relate to CAMHS workforce from National CAMHS Support Service (NCSS)

Year	Title	Summary	Included?	Reason for Exclusion
2006	Integrated Workforce Planning for Comprehensive CAMHS: A Model Plan – Barry Nixon	Focuses on one geographical area however raises some interesting points about workforce planning	NO	This report focuses on the application of a plan.
2006	Delivering Workforce Capacity, Capability and Sustainability in CAMHS – Barry Nixon	Thorough review of CAMHS workforce, provides a plan that addresses retention, demand and changing the way CAMHS works	YES	

Box A1 – A description of nurse associate training

Nursing Associates

The nursing associate role is a relatively new training route into nursing. This training and subsequent qualification, were developed in part as a response to the difficulty in recruiting and retaining enough qualified nurses across all sectors of the NHS. This route allows HCA's to advance in their career development whilst working and gaining experience.

HCA's are commonly found in physical health services such as hospital and outpatient settings. In recent times and in line with policy recommendations, the role of HCA's has been developed to now include further training and progression towards qualified nurse status through the Nursing Associate programme (Interim People Plan, 2019).

> "This role acts as a bridge between the unregulated healthcare assistant and the registered nurse." (2019, p.40)

Developed partly in response to the changes to nursing training and the requirement now for nurses to complete a degree, the nurse associate program allows for HCA's who have experience and recognised capabilities, to develop their career without the need for a degree. The implementation of the nursing degree aimed to introduce a core set of educational standards but created barriers to progression for those without academic qualifications (Cavendish, 2013).

The development of the nurse associate programme has allowed competent and committed HCA's to develop their skills and advance their careers and perhaps provides a blueprint that can be used to create a similar pathway for CAMHS support workers.

CASP
Critical Appraisal
Skills Programme

CASP Checklist Tool

CASP Checklist:

For Qualitative Research

Reviewer Name:	
Paper Title:	
Author:	
Web Link:	
Appraisal Date:	

During critical appraisal, never make assumptions about what the researchers have done. If it is not possible to tell, use the "Can't tell" response box. If you can't tell, at best it means the researchers have not been explicit or transparent, but at worst it could mean the researchers have not undertaken a particular task or process. Once you've finished the critical appraisal, if there are a large number of "Can't tell" responses, consider whether the findings of the study are trustworthy and interpret the results with caution.

Section A Are the results valid?	
1. Was there a clear statement of the aims of the research?	☒Yes ☐ No ☐ Can't Tell
CONSIDER: • *what was the goal of the research?* • *why was it thought important?* • *its relevance*	
2. Is a qualitative methodology appropriate?	☒Yes ☐ No ☐ Can't Tell
CONSIDER: • *If the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants* • *Is qualitative research the right methodology for addressing the research goal?*	
3. Was the research design appropriate to address the aims of the research?	☐Yes ☐ No ☐ Can't Tell
CONSIDER: • *if the researcher has justified the research design (e.g., have they discussed how they decided which method to use)*	
4. Was the recruitment strategy appropriate to the aims of the research?	☒Yes ☐ No ☐ Can't Tell
CONSIDER: • *If the researcher has explained how the participants were selected*	

<table>
<tr><td colspan="2">

- *If they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study*
- *If there are any discussions around recruitment (e.g. why some people chose not to take part)*

</td></tr>
<tr><td>5. Was the data collected in a way that addressed the research issue?</td><td>☒Yes ☐ No ☐ Can't Tell</td></tr>
<tr><td colspan="2">

CONSIDER:

- *If the setting for the data collection was justified*
- *If it is clear how data were collected (e.g. focus group, semi-structured interview etc.)*
- *If the researcher has justified the methods chosen*
- *If the researcher has made the methods explicit (e.g. for interview method, is there an indication of how interviews are conducted, or did they use a topic guide)*
- *If methods were modified during the study. If so, has the researcher explained how and why*
- *If the form of data is clear (e.g. tape recordings, video material, notes etc.)*
- *If the researcher has discussed saturation of data*

</td></tr>
<tr><td>6. Has the relationship between researcher and participants been adequately considered?</td><td>☐Yes ☒ No ☐ Can't Tell</td></tr>
<tr><td colspan="2">

CONSIDER:

- *If the researcher critically examined their own role, potential bias and influence during (a) formulation of the research questions (b) data collection, including sample recruitment and choice of location*
- *How the researcher responded to events during the study and whether they considered the implications of any changes in the research design*

</td></tr>
<tr><td colspan="2">Section B: What are the results?</td></tr>
<tr><td>7. Have ethical issues been taken into consideration?</td><td>☒Yes ☐ No ☐ Can't Tell</td></tr>
</table>

CONSIDER: • *If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained* • *If the researcher has discussed issues raised by the study (e.g. issues around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study)* • *If approval has been sought from the ethics committee*	
8. Was the data analysis sufficiently rigorous?	☒Yes ☐ No ☐ Can't Tell
CONSIDER: • *If there is an in-depth description of the analysis process* • *If thematic analysis is used. If so, is it clear how the categories/themes were derived from the data* • *Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process* • *If sufficient data are presented to support the findings* • *To what extent contradictory data are taken into account* • *Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation*	
9. Is there a clear statement of findings?	☒Yes ☐ No ☐ Can't Tell
CONSIDER: • *If the findings are explicit* • *If there is adequate discussion of the evidence both for and against the researcher's arguments* • *If the researcher has discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst)* • *If the findings are discussed in relation to the original research question*	
Section C: Will the results help locally?	
10. How valuable is the research?	☒Yes ☐ No ☐ Can't Tell
CONSIDER:	

- *If the researcher discusses the contribution the study makes to existing knowledge or understanding (e.g., do they consider the findings in relation to current practice or policy, or relevant research-based literature*
- *If they identify new areas where research is necessary*
- *If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used*

APPRAISAL SUMMARY: *List key points from your critical appraisal that need to be considered when assessing the validity of the results and their usefulness in decision-making.*		
Positive/Methodologically sound	Negative/Relatively poor methodology	Unknowns

Referencing recommendation:

CASP recommends using the Harvard style referencing, which is an author/date method. Sources are cited within the body of your assignment by giving the name of the author(s) followed by the date of publication. All other details about the publication are given in the list of references or bibliography at the end.

Example:

Critical Appraisal Skills Programme (2024). CASP (insert name of checklist i.e. systematic reviews with meta-analysis of randomised controlled trials (RCTs) Checklist.) [online] Available at: insert URL. Accessed: insert date accessed.

Creative Commons

©CASP this work is licensed under the Creative Commons Attribution – Non-Commercial- Share A like. To view a copy of this licence, visit https://creativecommons.org/licenses/by-nc-sa/4.0/

Need further training on evidence-based decision making? Our online training courses are helpful for healthcare educational researchers and any other learners who:

- Need to critically appraise and stay abreast of the healthcare research literature as part of their clinical duties.
- Are considering carrying out research & developing their own research projects.
- Make decisions in their role, whether that be policy making or patient facing.

Benefits of CASP Training:

⇒ Affordable – courses start from as little as £6
⇒ Professional training – leading experts in critical appraisal training
⇒ Self-directed study – complete each course in your own time
⇒ 12 months access – revisit areas you aren't sure of and revise
⇒ CPD certification- after each completed module

Scan the QR code below or visit https://casp-uk.net/critical-appraisal-online-training-courses/ for more information and to start learning more.

APPENDIX B – APPROVAL AND PERMISSION

ETHICAL TRUST

- TREC form

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

Question	Answer
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	What is the experience of support workers working within specialist CAMHS?		
Proposed project start date	September 2023	**Anticipated project end date**	September 2025
Principle Investigator (normally your Research Supervisor): Felicitas Rost			
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	Marie Nicholson
Programme of Study and Target Award	M80 Child and Adolescent psychoanalytic psychotherapy

Email address	marienicholson@rocketmail.com
Contact telephone number	07527785771

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**,
Colleagues involved in project will be fully informed of the project and requirements on them, of how data will be stored and used, anonymised, and given the choice around participation.

<table>
<tr><td>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)</td><td>YES ☐ NO ☒</td></tr>
<tr><td colspan="2">If YES, please add details here:</td></tr>
<tr><td>Will you be required to get further ethical approval after receiving TREC approval?

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):</td><td>YES ☐ NO ☒</td></tr>
<tr><td colspan="2"></td></tr>
<tr><td colspan="2">If your project is being undertaken with one or more clinical services or organisations external to the Trust, please provide details of these:</td></tr>
<tr><td colspan="2">Participants from neighbouring CAMHS teams (still within the Trust) will be invited to take part. I hope to include participants from my home team (Swindon) and other teams across the patch (Keynsham, Salisbury, Melksham and Marlborough).</td></tr>
<tr><td colspan="2">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:</td></tr>
<tr><td colspan="2"></td></tr>
<tr><td>Do you have approval from the organisations detailed above? (this includes R&D approval where relevant)</td><td>YES ☒ NO ☐ NA ☒</td></tr>
</table>

Please 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	

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)	Marie Nicholson
Signed	
Date	06/11/2023

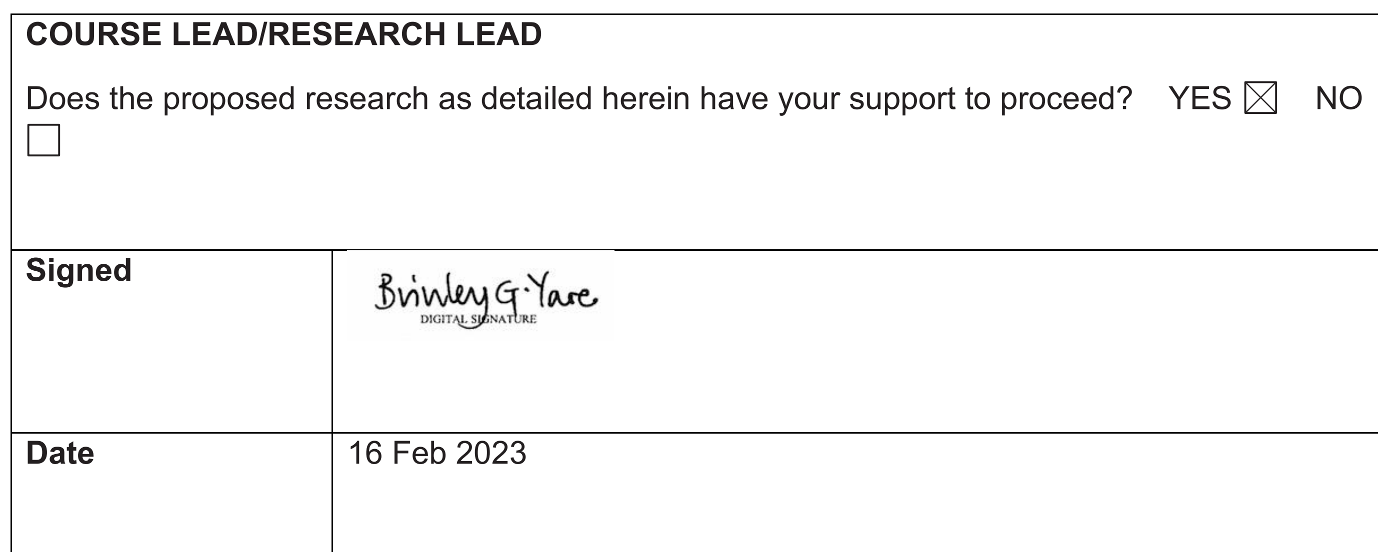
FOR RESEARCH DEGREE STUDENT APPLICANTS ONLY

Name of Supervisor/Principal Investigator	

Supervisor –

- Does the student have the necessary skills to carry out the research?
  YES ☒ **NO** ☐
- Is the participant information sheet, consent form and any other documentation appropriate?
  YES ☒ **NO** ☐
- Are the procedures for recruitment of participants and obtaining informed consent suitable and sufficient?
  YES ☒ **NO** ☐
- Where required, does the researcher have current Disclosure and Barring Service (DBS) clearance?
  YES ☒ **NO** ☐

Signed	F. Rost
Date	13.02.2024



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	16 Feb 2023

<u>SECTION E: DETAILS OF THE PROPOSED RESEARCH</u>

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 proposed research looks to explore the experience of clinicians employed in Band 3 and Band 4 roles as support workers and senior support workers respectively, within specialist CAMHS. Support workers employed within specialist CAMHS hold varied roles across a number of sub-teams: Support worker within the eating disorder service (TEDS), within Crisis and Home Treatment service (CAHTS), within Learning Disability team (LD CAMHS), within the Neurodevelopmental Clinic (NDC), within the Hospital Liaison team (HLT) and support worker within Core CAMHS. Some support workers work solely in one of these sub-teams and some support workers work across two or more sub-teams.

The study aims to investigate Support Worker conscious views and private theories (pre-conscious views) about their roles and responsibilities, how they manage the work, how they understand the support they deliver, what kind of support they receive and how they make use of this. The proposed research will seek to gain understanding of support workers' viewpoints, their experiences, and private theories about their roles, functions, and hopes and aspirations around their career development.

Specialist CAMHS Support Workers will be invited to participate in an individual semi-structured interview, which will last 60 minutes and will be audio recorded and subsequently transcribed verbatim. Interpretative Phenomenological Analysis (IPA) will be used to analyse the transcripts in order to answer the research question and objectives.

Objectives:

- To find out what draws support workers to the role and explore how expectations of the role meet the reality of the role once in post.
- To explore their experience of the role, including what they value, enjoy, struggle with and dislike about their role.
- To find out about whether support workers feel that they can influence or change aspects of their roles and if so, why and how.
- To explore the support, supervision and training that support workers receive .

- To explore the support workers sense of belonging within their sub-teams, home teams and professional identities.

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)**

This proposal has developed in response to observing a significant shift in the make-up of CAMHS team staffing. When I first took up a role in a specialist CAMHS team, support workers were rare. In the South-west where I have worked for the last 20 years, CAMHS services have traditionally been formed of clinicians from core disciplines such as Psychiatry, Clinical Psychology, Child and Adolescent Psychotherapy, and Systemic Family Therapy, providing specialist and evidence-based treatments to patients. Further to these professions, a significant proportion of local CAMHS services employ Social Workers, Mental Health Nurses and Occupational Therapists who generally work under the title of Senior Mental Health Practitioners (SMHP).

The SMHP role is demanding and complex with clinicians describing themselves as ‘a jack of all trades, master of none.’ High caseloads, complex patients, limited career progression routes, regular requirements to provide Duty and Hospital Liaison services and a requirement to be part of an out of hours on call rota are all perhaps factors in an ongoing difficulty in both the recruitment and retention of these staff members.

In response to an increasing number of unfilled SMHP posts, posts for support workers are being created and often filled quickly. To date not much systematic research has been carried out to understand this. The present study would contribute important first-person knowledge about this role and the people who choose to take it up. Moreover, it would highlight whether there is a development of a workforce of ‘unqualified’ staff that delivers complex and sometimes critical treatment, and whether this may be a viable strategy to meet the requirements and needs of modern CAMHS services and service users.

Another important area of benefit to the community of the proposed research pertains to the question of adequate support provided to support workers. First-person accounts and private theories of participants’ views as to whether they receive sufficient support will highlight whether there is a need for adjustment. Do support workers currently feel well enough equipped and supported to not only do

their jobs, but to be able to develop further skills and take on more responsibilities? The proposed study aims to shed some light on these questions.

The Health Education England report ‘Psychological Professions Workforce Plan 2019/20’, outlines a comprehensive plan for building and developing the current and future NHS mental health workforce. Interestingly, while the report discusses a wide range of established psychological professions including Clinical Psychologists and Child and Adolescent Psychotherapists and introduces newer roles such as Education Mental Health Practitioner (EMHP), Childrens Wellbeing Practitioner (CWP) and Clinical Associate Psychologists (CAPs), it does not mention support workers. They appear absent.

Therefore, through in-depth exploration of the experience of support workers working within specialist CAMHS settings, the proposed study aims to develop a comprehensive understanding of this role, of the people who choose to take on the role, of the support, training and development needs of support workers and ultimately, to discover if this relatively new role in CAMHS can meet the needs of, and the increasing demand from service users.

An important question remains as to whether support workers can begin to bridge the gap in CAMHS staff recruitment and retention? The proposed research might be able to identify both the developmental opportunities of this group of clinicians as well as highlight any barriers they face in their roles and outlining suggestions to maximise the potential benefits provided by this cohort.

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)**

This study proposes Interpretative Phenomenological Analysis (IPA) as a method by which to investigate how interviewees make sense of their experiences (Pietkiewicz and Smith, 2014). IPA aims to capture and analyse the views, thoughts, feelings and experiences of individuals and to draw out the meanings of

these experiences. IPA is an inductive method, meaning that the researcher begins the study with no prior assumptions or hypotheses.

IPA has been chosen for this study as it will allow the researcher an opportunity to explore the different questions outlined above by examining the views and thoughts of the people who choose to take up the role of support worker in specialist CAMHS. It is hoped that by developing a deeper understanding of support workers thoughts of their own motivations, hopes and concerns, more sense can be made of the role itself, who chooses to take it up and why, what they need in order to feel supported, invested in and valued and which directions the role can be taken in should there be a desire or requirement to further develop it.

4-6 specialist CAMHS Support Workers will be invited to participate in an individual semi-structured interview. A schedule has been developed that is informed by relevant literature and discussion with the research supervisor. It includes questions on how the participants view their role, their understanding of why they applied for it, what they hoped to gain from it, how the reality of it has met the expectations of it, what their hopes are for themselves within their role and within the wider team and service, how they view career development, support, supervision and training (see Appendix).

The semi-structured interview will be based on the Private Theories Interview (PTI, Werbart and Levander, 2006). It collects narratives, concrete examples and illustrative episodes of concerning problems, ideas and views. It requires the interviewer to refrain from her own construction of meaning and creates a space to facilitate the participant's free association. Werbart and Levander (2005) describe private theories as subjective meaning constructions or constructions of private explanatory systems of individuals. Conducting the interview in this way aims to access the individual's private theories, a notion that refers to Sandler's concept of preconscious derivatives of unconscious ideas (Sandler, 1983).

This study will follow Smith et al.'s (2009) suggestion that researchers using IPA are to explore their data, analysing each interview individually, but in the present case with a particular focus on private theories, before tracing and assessing developing themes across all interviews, thus enabling a coherent, shared narrative of private theories to emerge.

The interviews will last 60 minutes and take place within the participants work place. They will be audio-recorded and transcribed verbatim. The qualitative analysis of transcripts comes close to the hermeneutic and narrative research

tradition (Werbart and Levander, 2005). All data will be stored securely and encrypted and destroyed once the study is completed.

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)

Between 4-6 interviews are proposed for this project. Including/excluding criteria include that all participants will need be employed in the role of support worker within Specialist CAMHS. Although participants will be recruited on a voluntary basis, the researcher would aim to include support workers with a range of difference; including age, gender, ethnic background, length of time in role and previous employment experience to be as inclusive and representative of the profession as possible.

I am proposing to recruit from the 5 teams located across the south west of the Oxford Health children's mental health service. These teams are located in Swindon, Keynsham, Melksham, Marlborough and Salisbury. The service has agreed for me to approach potential participants (see letter of approval).

Initially, I intend to contact clinical team managers to explain the purpose and process of the research project. I will request that I can attend local team meetings to introduce myself and the study in order to recruit participants. Team managers will also be asked whether they could send a general email out to all staff about the study. Potential participants will be asked to get in touch with me via email. I will then respond by emailing the participant with

a brief outline of the project, its aims, and how it will be conducted. The participant information sheet and copy of the consent form will be attached to the email (see appendix).

Once the potential participant is interested in signing up to the study, I will arrange an appointment for the interview at their work place at a time of mutual convenience or online via a locked and password-protected zoom meeting if preferred. The potential participant will be encouraged to ask questions about the project and their participation, and informed, written consent will be sought after outlining and explaining the study involvement, confidentiality, and their right to withdraw.

The study proposes a small sample in order to allow for rich and in-depth meaning to be explored across all interviews. Therefore, the answers given by individual participants would not serve to identify them. However, the sample size is small and therefore this might have implications for confidentiality and anonymity in that participants might recognise their own quotes. The participant information sheet will inform participants of the possible implications and informed consent will be sought with respect to that. The consent form will clearly state that brief extracts of the interviews may be quoted, and therefore the participants may recognise them as something they have said. Participants will also be notified that all possible measures will be taken to prevent third parties from being able to identify the author of any quotations used.

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.

Ideally interviews will take place face to face in support workers work bases during usual working hours. I will aim to meet with support workers at a time that is convenient to them and the needs of their team. If face to face interviews are not possible, I will use online systems such Zoom to complete the interviews.

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, service-users, 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)

This is not applicable. Participants in this study are literate, capable of understanding verbal explanations and have a good standard of English language (as outlined in their job descriptions). If participants have communication needs, appropriate adaptations will be made (i,e a participant who is hard of hearing can receive the interview questions in writing.)

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.

N/A

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:** Where the proposed research involves students , they should be assured that accepting the offer to participate or choosing to decline will have no impact on their assessments or learning experience. Similarly, it should be made clear to participants who are patients, service-users and/or receiving any form of treatment or medication that they are not invited to participate in the belief that participation in the research will result in some relief or improvement in their condition.
The research would provide the participants with a space to reflect on their own experiences as clinicians working within specialist CAMH services. I hope this research enables participants to fully think about and explore their roles and to develop a wider understanding of how integral they are and how valued their contributions in the work place are. I also hope to highlight any areas of difficulty that emerge as potentially universal factors for support workers so that these can be thought about and addressed. Furthermore, I hope that this research can encourage participants to reflect on their motivations for applying for the role, how their expectations prior to taking up the role match the reality of the role and what this means for them. I hope that the study can help them think more about their future hopes and aspirations and can help them to feel empowered about their development and opportunities around this. I hope that the study can highlight any deficits in training, support or supervision and enable participants to feel clearer on what they need in their roles to feel competent, confident, valued and skilled. From a service perspective, my hope is that this research can go some way to developing a better understanding of the range of people who choose to take up the role and how they can be better supported and developed. I hope that through developing a more comprehensive understanding of this role, more opportunities can be created, more posts can be offered and filled and more evidence-based interventions can be successfully delivered to CAMHS service users. I hope that by better understanding this fairly new and as yet, not fully defined role, and by exploring the experiences of the current support workers in post, more support workers can be recruited and perhaps more importantly, retained. Once the research has been published, it may also be interesting for support workers and team managers to see what common themes have been found across the conducted interviews and how an external interviewer, such as the

researcher, has made sense of what support workers have shared about their work.

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)

In the event of adverse or unexpected outcomes, I will:

- Offer to pause or end the interview or stop recording
- Offer to reschedule the interview
- Offer debrief if needed
- Offer signposting to appropriate support services within the team and wider trust if indicated.
- Inform participants of support available outside of the trust.
- Offer to share any concerns raised by the participant with their team manager if this is wanted.

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.

All participants involved will be part of a service team and will have their own support structure and supervision that they could turn to if needed. It is possible that in the course of the interviews, participants may get in touch with some difficult thoughts or feelings as they revisit and explore aspects of their past including both their personal and professional lives. The interviews will encourage the participants to think about themselves within the context of the challenging work that they do as well as thinking about their future hopes and goals. It is possible that these questions and conversations could illicit emotional experiences and responses from participants. In the event that participants are emotionally affected by the interview process, opportunities to pause and/or withdraw from the study will be offered.
Participants will be encouraged to access further support from their team, line manager or supervisor in a timely and responsive manner by the researcher. If additional support is required, participants will be encouraged to access support from the wider trust including the Occupational Health Team and the Oxford Health Spiritual and Pastoral support team. Contact details for all of these services will be provided in the debrief email.

A debrief email will be sent out following the interviews, which will include contact details for the researcher, the project supervisor, and the Head of Academic Governance and Quality Assurance. Participants will also be reminded of the processes that are in place for them to receive support (Line Management and supervision) and reminded of the wider trust occupational health, support and guidance services.
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.
No external agencies to be included.
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)
N/A

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-and-procedures/

☒ 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:

Yes. The researcher, I, will be carrying out the interviews, the recordings and transcriptions. I will be responsible for secure storing and participant confidentiality will be adhered to. Interviews will be audio-recorded and after verbatim-transcription has been completed by the researcher, they will be deleted. Until transcription take place the recordings will be saved on a secure, password protected NHS server. Only I will have the password and access to the drive. All transcripts will be anonymised whereby all identifiable information will be removed. Transcripts will be given a number which will not be linked back to the participants.

Data will be anonymised by removing names and other identifying factors such as ethnic background, home team and specific length of time in role. While participants will be recruited from across 5 different teams, the information discussed in the research project and in later publication, will not clarify which team the participant sits in, thus enabling confidentiality. Direct quotes may be uses and may be identifiable by the participant.

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.

N/A

30. Please provide details on the regions and territories where research data will be electronically transferred that are external to the UK:

N/A

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)?

No

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)

33. Where it is not possible to attach the above materials, please provide an explanation below.

Permission sought and gained from Service Manager (by email):

From: Ahmad Saffia (RNU) Oxford Health <Saffia.Ahmad@oxfordhealth.nhs.uk>
Sent: Saturday, January 20, 2024 9:47 AM
To: Nicholson Marie (RNU) Oxford Health <Marie.Nicholson@oxfordhealth.nhs.uk>
Cc: Marks Susannah (RNU) Oxford Health <Susannah.Marks@oxfordhealth.nhs.uk>
Subject: Re: Request for research project approval

Hi Marie

This sounds really interesting and I am in agreement with you proceeding.

I will check whether additional approval/ agreement needs to received.

Thank you and apologies for the delayed response.

Saffia

Saffia Ahmad

Service Manager BSW CAMHS and All Age Eating Disorders Sent from Outlook for Android

---

From: Nicholson Marie (RNU) Oxford Health <Marie.Nicholson@oxfordhealth.nhs.uk>
Sent: Friday, January 19, 2024 5:17:37 PM
To: Ahmad Saffia (RNU) Oxford Health <Saffia.Ahmad@oxfordhealth.nhs.uk>
Subject: FW: Request for research project approval

Dear Saff,

Please see email below regarding my intended research project. As mentioned, I need Trust approval before I can go ahead with this. Very happy to answer any questions you may have.

Many Thanks,

Marie

From: Nicholson Marie (RNU) Oxford Health
Sent: Monday, November 6, 2023 11:12 AM
To: Ahmad Saffia (RNU) Oxford Health <Saffia.Ahmad@oxfordhealth.nhs.uk>
Subject: Request for research project approval

Dear Saffia,

As you know, I am currently training as a Child and Adolescent Psychoanalytic Psychotherapist at the Tavistock and am on placement within the Swindon CAMHS team. As part of my training, I am required to carry out a piece of original research and as such, need to seek permission and consent from the Trust around this. I am currently in the process of seeking ethical approval from the training school and will be able to provide this once it is formally granted.

The title of my project is “What is the experience of Support Workers working in CAMHS?” This research idea has come about in response to the changes I have observed in the make-up of the workforce since I first took up a role in CAMHS.

The research aims to explore and investigate the experience of Band 3 and 4 support workers to better understand their experience, how they feel about the work they do, the support they deliver, the support that they receive, training they are offered and future goals and aspirations.

I plan to contact the various team managers in BSW to introduce myself and the project and then to recruit participants from across all 5 teams for interview. Interviews will be semi-structured and confidential and will last approximately 60-90 minutes. All participants will be given information ahead of any interviews and asked to sign a consent form. Participants will have the option to withdraw from the study at any time.

I will be able to provide further information in due course but for now, I just need approval from you, on behalf of the trust and in your role as Service Manager to continue with this idea. I am happy to answer any questions you may have at this time.

Best Wishes,

Marie Nicholson

Child and Adolescent Psychotherapist in Doctoral Training

Swindon CAMHS

Swindon and Wiltshire Mental Health Directorate

Oxford Health NHS Foundation Trust

Marlborough House, Okus Road, Swindon SN1 4JS

APPENDIX C – PUBLIC FACING DOCUMENTS

- **Recruitment Call**

WHAT IS THE EXPERIENCE OF SUPPORT WORKERS WORKING IN CAMHS TEAMS?

Research Project

Are you currently employed in a Band 3 or 4 role as a support worker or senior support worker? I am conducting a research study as part of my Doctoral training in Child and Adolescent Psychoanalytic Psychotherapy which aims to explore and examine the experience of support workers working in CAMHS.

Who?

I am hoping to meet with and interview support workers from across the BSW patch to learn more about them and their experience of their roles. Support workers might work within the core CAMHS team, within GH or GMH, within LD, NDC, TEDS or CAHTS. All Band 3 and Band 4 support workers and senior support workers currently working in a BSW CAMHS team are eligible to be involved, there are no exclusion criteria.

Why?

Support workers are an integral part of our CAMHS teams. I am curious to learn more about who chooses to take up the role of support worker, the support and supervision they receive and the training and development opportunities available to them.

Where?

I would like to come and meet with you in your work place to conduct an interview lasting approximately 60 minutes. Interviews can be conducted over zoom if preferred. All information given will be anonymised and stored confidentially.

What Next?

If you are interested in being part of this research project and would like to know more, please email me at marie.nicholson@oxfordhealth.nhs.uk to discuss or to request to receive the participant information sheet.

- **Participant Information Sheet**

The Tavistock and Portman NHS
NHS Foundation Trust

NHS
Oxford Health
NHS Foundation Trust

What is the experience of Support Workers working in CAMHS teams?

Participant Information Sheet

This information sheet invites you to take part in the above-titled research project. The information below describes the project and explains what you can expect if you decide to take part.

Aim of research project

This study aims to explore and gather a wider understanding of the role of Support Worker, looking at what brought you to it, what expectations you may have held about the role prior to applying for it, what thoughts and feelings you have about the role now, what you think about the work you do, whether you feel the role is valued, what you experience in terms of training, supervision and support and what hopes you have professionally and personally around the role.

While this study is initially explorative in nature, I hope to shed light on the roles you fulfil and work you do, to bring attention to any gaps in training or support and to build a solid basis of understanding across CAMHS teams regarding your role.

Who is conducting the research project?

My name is Marie Nicholson and I am currently training as a Child and Adolescent Psychotherapist within the Swindon CAMHS team. As part of this training, I am undertaking a doctoral research study. I am interested in exploring and understanding more about the role of Support Workers within CAMHS teams. I am looking to recruit clinicians working in Band 3 support worker and Band 4 senior support worker posts to take part in this study.

What does taking part involve?

I hope to meet with support workers across the BSW patch to hear about their roles and the work they do through semi-structured interview sessions that will last around 60 minutes. Interviews will take place face to face in the support workers workplace or via Zoom if preferred. The interview will consist of some standard questions pertaining to the support worker and their role as well as offer opportunities for further thoughts and reflections.

Do I have to take part?

Participation in this study is entirely voluntary. If you agree to take part but then change your mind, you can decide to withdraw and will not be asked to give a reason. Any information or data that you have provided will be destroyed and withdrawn from the study.

You are also welcome to think through the implications of your participation with my research

supervisor, Dr Felicitas Rost, whose contact details are listed below.

What happens with the information I provide?

The Tavistock and Portman NHS Foundation Trust is the sponsor for this study, based in the United Kingdom. I will be using information from you in order to undertake this study and will act as the data controller for this study. This means that I am responsible for looking after your information and using it properly. I will keep identifiable information about you from this study for 3 years after the study has finished. The interview will be audio recorded and transcribed by myself.

Your rights to access, change, or move your information are limited, as I need to manage your information in specific ways in order for the research to be reliable and accurate. To safeguard your rights, I will use the as little personally identifiable information as possible. I will use your name and the contact details you provide only to contact you about the research study. I am the only person who will have access to information that identifies you. I may be assisted in the analysis of this information by senior colleagues, but they will not be able to identify you and will not be able to find out your name or contact details.

Quotes from the transcript will be used in the write-up of the project but these will be de-identified. However, please note, it is possible that other colleagues who know you well may recognise you in some of the quotes used, although every effort will be made

to prevent this. Any extracts from what you have said that are quoted in the research report will be entirely anonymous.

All electronic data will be stored on a password-protected computer. Any paper copies will be kept in a locked filing cabinet. All audio recordings will be destroyed after completion of the project. Other data from the study will be retained, in a secure location, for 3 years.

If you would like more information on the Tavistock and Portman and GHC privacy policies, please follow these links:

https://tavistockandportman.nhs.uk/about-us/contact-us/about-this-website/your-privacy/

https://www.ghc.nhs.uk/privacy-notice/

You can find out more about the legal framework within which your information will be processed by contacting the sponsoring Trust's Clinical Governance and Quality Manager, Simon Carrington, Head of Academic Governance and Quality Assurance (academicquality@tavi-port.nhs.uk)

There will be limitations to the confidentiality of information provided if it is deemed yourself or someone else is at risk.

What happens to the results of the project?

The results of this study will be used in my Research Dissertation Project and Doctorate qualification. They may also be used in future academic presentations and publications. If you wish, I would gladly send you a summary of the results. Please feel free to contact me with such requests, should you decide you may be interested.

What are the possible benefits of taking part?

There will be no direct benefits for you. However, the research would provide you with an opportunity to think more about yourself, your role, your hopes and aspirations. This study hopes to highlight the work you do, draw attention to any support, training or supervision needs you might have and to ultimately raise the profile and understanding of the role of support worker within BSW CAMHS.

Are there any risks?

The researcher does not envisage any direct risks to taking part in this study. However, given the nature of psychotherapy, which involves unconscious thoughts and experiences, some people may find the topic uncomfortable. Details of a confidential service you can access will be provided.

Contact details:

Researcher: Marie Nicholson – 01865 903422 – Swindon CAMHS

Marie.nicholson@oxfordhealth.nhs.uk

Research project supervisor:

Dr Felicitas Rost

FRost@tavi-port.nhs.uk

If you have any concerns about the conduct of this research, the researchers or any other aspect of this project, please contact the Head of Academic Governance and Quality Assurance: Simon Carrington, Head of Academic Governance and Quality Assurance (academicquality@tavi-port.nhs.uk)

Thank you for considering taking part in this study and taking the time to read this information. If you are willing to take part in the research or have any further questions, please contact me.

- **CONSENT FORM**

The Tavistock and Portman NHS
NHS Foundation Trust

NHS
Oxford Health
NHS Foundation Trust

Consent Form

Research project title**:** What is the experience of Support Workers working in a CAMHS team?

- I____voluntarily agree to participate in this research project. ☐
- I confirm that I have read and understood the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
- I understand that my participation in this study is voluntary and that I am free to withdraw, without giving a reason, at any time up to one week after the completion of the interview. ☐
- I understand that the interview will be digitally recorded and transcribed as described in the participant information sheet. ☐
- I understand that the information I provide will be kept confidential, unless I or someone else is deemed to be at risk. ☐
- I understand that direct quotes from the audio recording may be used in this research study but will be made anonymous to the reader and held securely by the researcher. ☐

- I understand that the results of this research will be published in the form of a Doctoral research thesis and that they may also be used in future academic presentations and publications. ☐

Contact details:

Researcher: Marie Nicholson Email: marie.nicholson@oxfordhealth.nhs.uk

Supervisor: Dr Felictias Rost Email: FRost@tavi-port.nhs.uk

Participant's Name (Printed):___________________________________

Participant's signature:____________________________ Date:____________

Thank you for agreeing to take part in this study.

Your contribution is very much appreciated.

Debrief Letter

Dear….

I am writing to thank you for your contribution to this Doctoral Research Project. I hope you found it meaningful.

If you have any questions or would like further information, please find my contact details below:

Marie Nicholson, Swindon Community CAMHS – 01865 903422

Marie.nicholson@oxfordhealth.nhs.uk

If you have any concerns about how the study has been conducted or any other aspect of this research project, please contact the research project supervisor Dr Felicitas Rost (FRost@tavi-port.nhs.uk) or the Trust's Clinical Governance and Quality Manager, Simon Carrington, Head of Academic Governance and Quality Assurance (academicquality@tavi-port.nhs.uk)

If, following taking part, there are any issues that are concerning you, please be aware that you can access the support network around you (colleagues, supervisors and line managers). In particular you could access the following:

- Spiritual and Pastoral Support - Oxfordshire, Wiltshire and Bath and North East Somerset – 01865 902760 spiritual.care@obmh.nhs.uk
- Occupational Health - occupational.health@oxfordhealth.nhs.uk

Kind regards,

Marie Nicholson

Student – Professional Doctorate in Child and Adolescent Psychoanalytic Psychotherapy (D.Ch.Pscyh.Psych.)

INTERVIEW SCHEDULE

What is the experience of Support Workers working in Specialist CAMHS teams?

Thank you for agreeing to take part in this study and this interview. There are 5 sections to this interview. These sections focus on you, your role, training and development, supervision and support and how your role fits into CAMHS.

<u>Interview Questions</u>

Job Title and Banding: ………………………………………………………………………

BSW Locality:…………………………………………………………………

About you

- Why did you want to work in CAMHS?

- Do you intend to stay in this role?

- What kind of roles did you hold before this one?

- What do you consider are your best qualities?

- What else would you like to say about yourself?

About your role

- What parts of CAMHS does your role sit in? (eg, CAHTS, TEDS, GH, GMH, NDC, LD)

- How long have you been in this role?

- Why did you choose to apply for this role?

- What were your expectations of the role when you applied?

- How does the reality of the role meet your expectations?

- What do you enjoy the most about your role?

- What do you find most challenging about your role?

- How do you feel about the work you do?

- What therapeutic approaches do you use within your role?

- What do you value about your role?

- How do you cope with the emotional challenges that come with the role?

- What else would you like to say about your role?

About training and role development

- Where do you see yourself in 2 years?

- Where do you see yourself in 5 years?

- What training have you received in your role?

- Is there any training you have not yet accessed that you feel you would benefit from?

- What else would you like to say about training and /or role development?

About Supervision and Support

- Who provides clinical supervision (what is their role/profession?)

- What impact does the profession of your supervisor have on you? (if any?)

- What impact does the profession of your supervisor have on your practice? (if any?)

- What kind of support do you receive (other than Supervision)?

- What else would you like to say about Supervision or support?

About how your role fits into CAMHS

- How do you consider your role in terms of your wider CAMHS team?

- Do you feel that you receive enough support to do your job well?

- How valued do you feel in your role?

- How do you feel your role is valued in your team?

- What else would you like to say about how your role fits into CAMHS?

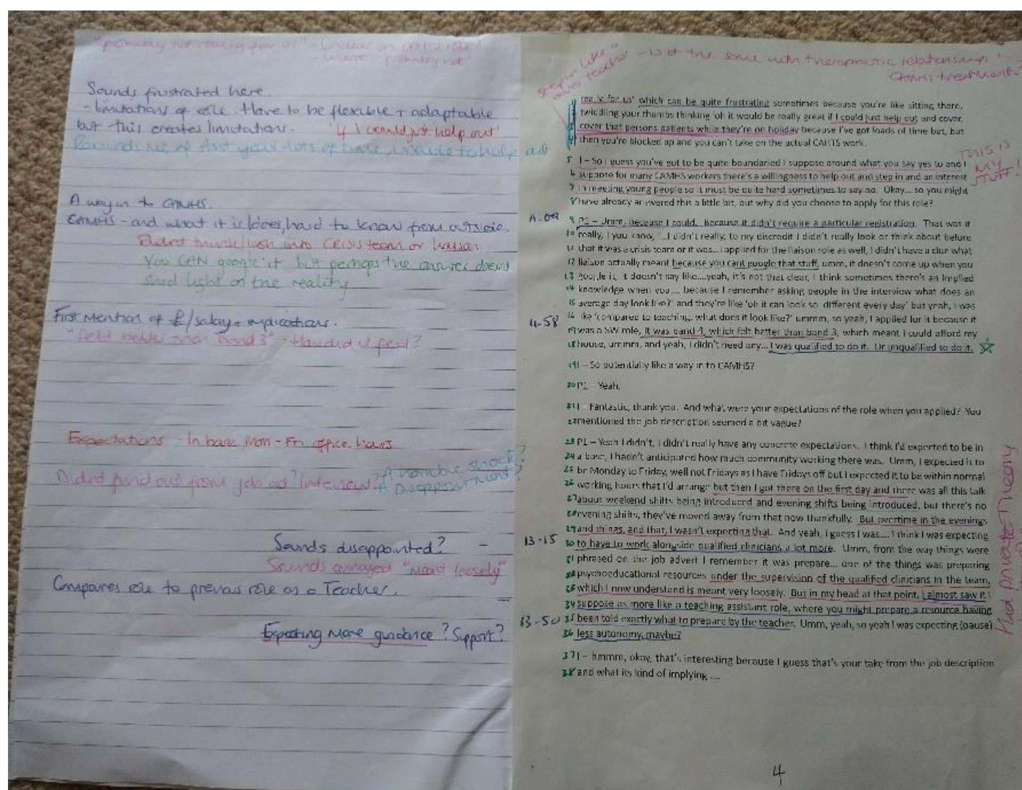
Additional to the standard questions outlined above that all participants will be asked, it is intended that where appropriate, further questions will be asked to expand and further explore the answers given. These questions may include but not be limited to:

- Can you say a bit more about that?
- Can you give me some background to that?

APPENDIX D – DATA ANALYSIS

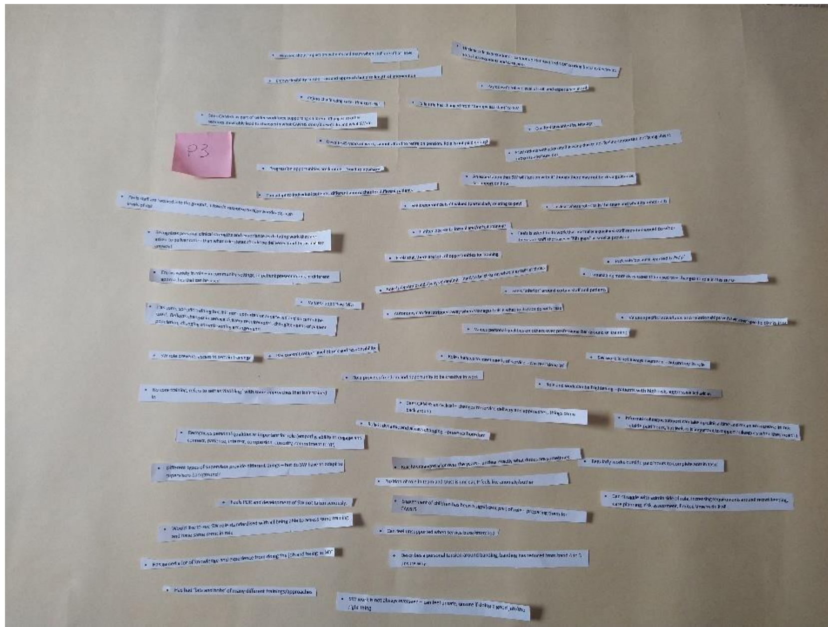
Images of initial phase of data analysis with accompanying notes - beginning of exploratory note-taking

To begin with, I listened to the audio recordings of the interviews and read along with the transcripts. I was able to begin identifying interesting comments and things which stood out to me. These comments were underlined and notes were taken reflecting my thoughts, inconsistencies and moments where the spoken work appeared inconsistent with what was being implied or suggested by participants.

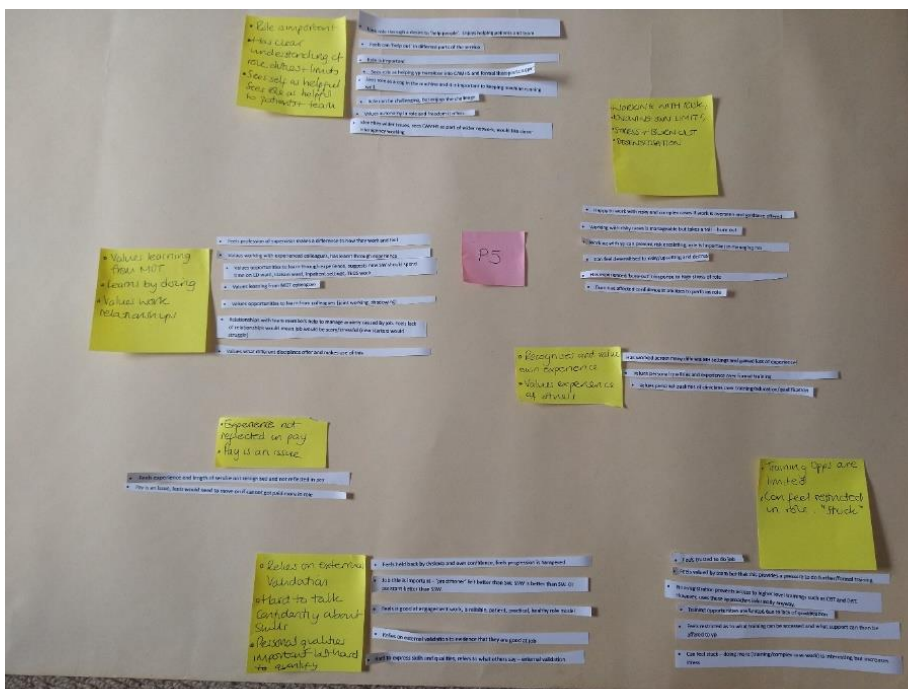


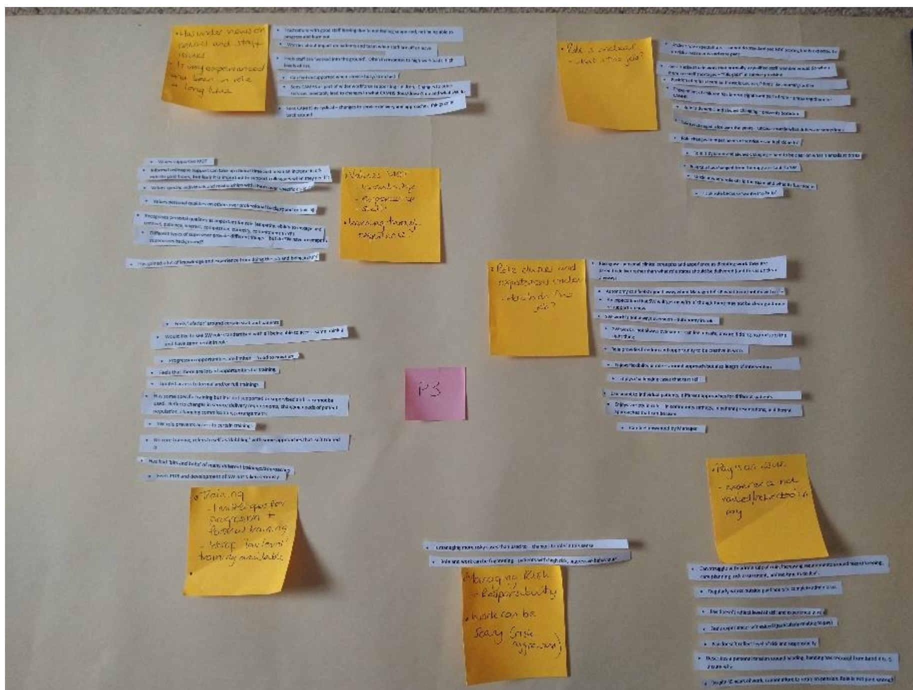
Notes were recorded in different colours each time material reviewed, key sections/quotes were underlined and highlighted.

After the material was reviewed multiple times, the notes were used to create list of experiential themes for each participant:



Experiential themes were then cut out and arranged randomly and reviewed. This approach allowed for connections and similarities to emerge. The experiential themes were then sorted into loose groups and categories:





Once this stage was completed, I began to link the personal experiential themes with some of the comments made by participants and began to compile a document which held these quotes. Quotes were later matched to PET's to begin building evidence and a narrative.

The process which began with Participant One, was then repeated for the other four participants and eventually I was able to construct tables for each participant that showed all the PET's.

<u>Tables of PET's for all Participants</u>

<u>**Table D1** - Participant One – Personal Experiential Themes (PETs)</u>

SUBTHEMES	SUPERORDINATE THEME
• Independence and autonomy in role is valued and offers a chance to build skills and knowledge. • Role provides opportunities to gain range of experiences • Autonomy means they feel trusted to do job which helps them feel competent to do job • Taking up role is a "tactical career move". • Role is a chance to "try out" working in CAMHS • There are limitations for role development and progression	• The SW role is a 'stepping stone' in MH career, a chance to gain experience

• A strong sense of belonging to sub-team (CAHTS) – feels included, less so within core CAMHS • Strong sense of how role fits into sub-team and how sub-team fits into wider CAMHS • Values MDT knowledge and experience and grateful for opportunity to learn from MDT • Values external validation from colleagues and Managers, builds confidence	• The role has a place in CAMHS, this offers a sense of belonging
• Anxiety experienced in role generally relates to risk and responsibility • Feels the weight of responsibility – difficult and causes worry and fear • Support always available from team around risk but can feel hard to ask for it, feels should know what to do • Significant levels of risk to be managed, can feel scary, upsetting • Job is an isolated and lonely one at times, lots of community based lone working • Constant risk management can lead to desensitisation	• Managing risk is emotionally challenging
• Some freedom to pursue clinical interests but role demands can limit opportunity to shadow/try other things • Role requires flexibility and adaptability but this can make it limiting, hard to plan ahead as need t be responsive • Would prefer to work in Core CAMHS and have longer involvement with CYP • Short-term work challenging and expectations need managing, what can be achieved is limited	• Role can feel limited and limiting at times
• Lots of trainings available in trust but not all are open to SW, can feel excluded • Numerous trainings accessed but skills lost if not practiced	• Training is available but can be limited
• Confusion on distinctions between SW role and SMHP role • Can feel forgotten by Core CAMHS and feel not useful and excluded. Opposite true for sub-team	• SW role is unclear to SW and wider team
• Values autonomy but can be hard to know what to do, lacks confidence in making clinical decisions • Feels should know what to do all the time • Lacks confidence and relates this to not knowing what to do sometimes • Can feel insecure about self, skills and work they are doing.	• Can feel unsure and lack confidence in abilities and in doing the work

• Has moved from a clear professional identity, now lacks a sense of professional identity, can feel lost • Had felt competent and confident in previous role with clear professional identity, feels the loss of this certainty • SW role lacks framework that offers clear identity	• Professional Identity can feel unclear
• Would not remain in role permanently due to low pay • Resentful of SMHP being paid more for doing what P sees as the same job • Lower pay suggests lower worth, painful • Feels role is valued but this is not reflected in pay	• Feels role should be better paid

Table D2 - Participant Two – Personal Experiential Themes (PETs)

SUBTHEMES	SUPERORDINATE THEMES
• SW role lacks financial security – P feels unable to start a family due to this • Not felt to be a permanent career due to low pay • SW skills and experience not recognised or reflected in pay • Salary not sustainable longer term	• Pay limitations affect personal and professional life choices
• Lone working in community settings can feel isolating • Working with risk is a big responsibility • Risk issues pertain to patients but also staff lone working • Impact of contact with high risk CYP is significant – “they live in your head”	• Working with risk is emotionally demanding
• Feels valued clinically by colleagues • Would like to see more SW role across core CAMHS • Role can feel like an ‘addition’ to CAMHS – doesn’t feel integral, can feel external to core CAMHS	• Values the role and feels the role is valued by team (CAHTS)
• Supervision from MDT is helpful and supportive • Values access to MDT knowledge, skills and experience • Role is great to gain experience in working with CYP/CAMHS/MH settings • SW role good to get experience to take on to further training/career development	• Values learning from MDT colleagues and being part of MDT
• Role is varied – many different tasks experienced as interesting and enjoyable • Role is important • Variety in work offers opportunities for learning and gaining experience • Role is challenging but rewarding • SW is about supporting clinicians as well as patients • Parts of role can be hard to quantify – importance of engagement and containment • Enjoyable to help families and team feel better supported •	• Role is varied, challenging and enjoyable

• Role can feel emotionally overwhelming • Short-term work is hard (CAHTS) would prefer to work longer term with patients • Can doubt whether role is important	• The work is emotionally demanding
• Sees self as flexible, empathic, responsive and curious – highly values these traits as enabling them to do job • Managing own emotions is a necessary skill/quality for SW • P brings previous clinical experience and knowledge to role and relies on this to manage work and emotions	• Personal qualities expressed that help with performing role
• SW are 'non-qualified' but do a lot of the same things as qualified staff	• Role can feel unclear
• Limitations to progression feel frustrating • Role can feel limited regarding career development within role • Role feels temporary due to lack of progression opportunities • Many opportunities for lower level, broader or 'intro' trainings • Some trainings not available to lower banded staff, can feel exclusionary and frustrating	• Limitations around training and progression

Table D3 - Participant Three – Personal Experiential Themes (PETs)

SUBTHEMES	SUPERORDINATE THEMES
• Role has changed, now manages riskier cases than previously • Is now required to record and complete risk assessments, was previously a task taken on by 'qualified' staff • Position of role in team and trust is unclear, P feels like anomaly/outlier • Role has changed a lot over the years – unclear exactly what duties are sometimes • Unclear where role sits in the team and what its function is • Role title has changed from 'therapy assistant' to SW • Role is dynamic and always changing – hard to be clear on what it entails at times • Role changes to meet needs of service – can feel 'done to' • Role is dynamic and always changing – prevents boredom • Sees CAMHS as cyclical – changes to service delivery and approaches, things come back around	• Role has changed, hard to know what role is now
• Working with risk can be stressful and scary • Exposure to more self-harm and suicidality, exposure to aggressive patients is stressful	• Managing risk and responsibility can be stressful and scary

• Can feel unsupported when service busy/stretched – difficult when cases are more challenging • SW work is not always overseen – autonomy in role • SW work is not always overseen – can feel unsafe, unsure if doing a good job/the right thing • Autonomy can feel stripped away when Manager tells P what to do/not do with case	• Feels role requires more support/overseeing
• Engagement of children has been a significant part of role – preparing them for further CAMHS intervention •	• Some parts of role are clear
• Unclear role expectations – cannot do standardised NDC scoring but is expected to do risk assessments and care plans • Feels is asked to do work that normally a qualified staff member would do when there are staff shortages – "fills gaps" in service provision	• Role is unclear – Uncertainty around what role entails
• Can adapt to individual patients, different approaches for different patients • Enjoys variety in role – in community settings, in patient presentations, in different approaches that can be used • Enjoys challenging cases that test skills • Enjoys flexibility in role – around approach but also length of intervention	• Role allows for variety of approach and variety in work
• An expectation that SW will 'get on with it' though there may not be clear guidance or support on how • Recognises personal clinical strengths and experience as dictating work they are asked to deliver rather than what role states should be delivered (and this is unclear anyway) • Role provides freedom and opportunities to be creative in work with CYP – not limited to one approach	• Role duties and expectations unclear – Uncertain about how to do the job
• Despite 45 years of work, cannot afford to retire on pension. Role is not paid enough • Pay doesn't reflect level of skill and experience in role • Pay doesn't reflect level of risk and responsibility • Can struggle with admin side of role, increasing requirements around record keeping, care planning, risk assessment, limited time to do it all. Describes a personal tension around banding, banding has reduced from band 4 to 3, unsure why • Regularly works outside paid hours to complete admin tasks • Feels experience isn't valued (particularly relating to pay)	• Limited pay is problematic
• Sees CAMHS as part of wider workforce supporting children. Changes to other services inevitably lead to changes in what CAMHS does/doesn't do and what SW	• Wider views on CAMHS and staffing issues shared

• Worries about impact on patients and team when staff are off or leave • Frustrations with good staff leaving due to not feeling supported, not being able to progress and burn out • Feels staff are 'worked into the ground'. Often in response to high workloads, high levels of risk	• Recognises issues with staff retention
• Has gained a lot of knowledge and experience from doing the job and being in MDT • Values supportive MDT	• Values opportunity to learn from MDT
• Recognises personal qualities as important for role (empathy, ability to engage and connect, patience, interest, compassion, curiosity, commitment to YP)	• Values personal qualities needed for role
• Values personal qualities of others over professional background or training • Values specific individuals and relationships with them over specific disciplines • Different types of supervisor provide different things – but do SW have to adapt to supervisors background? • Informal colleague support can take up clinical time and mean an increase in work outside paid hours, but feels it is important to support colleagues when they need it •	• Values relationships with colleagues
• No core training, refers to self as 'dabbling' with some approaches that isn't trained in • Has some specific training but it is not supported or supervised and so cannot be used. Reflects changes in service delivery requirements, changing needs of patient population, changing commissioning arrangements • Feels that there are lots of opportunities for training • SW role prevents access to certain trainings • Has had 'bits and bobs' of many different trainings/approaches • Would like to see SW role standardised with all being able to access same training and have same remit in role • Feels PDR and development of SW not taken seriously. • Progression opportunities are limited – 'road to nowhere' • Limited access to full/formal trainings • Feels 'inferior' around certain staff and patients – links to lack of qualification	• Lots of different training available, yet there are limitations on what SW can access

Table D4 - Participant Four – Personal Experiential Themes (PETs)

SUBTHEMES	SUPERORDINATE THEMES
• No role specific training • Can access lots of training but it is 'watered down' not formal or full, doesn't impact salary	• Training and Development opportunities are limited
• SW role, duties and expectations are vague and unclear and changing • No standardisation of role, no standard expectation – meaning different people expect different things of SW • Feels role is unclear to wider team – can be asked, or not asked to do things that do not fit within their understanding of the role • Has worked bands 3 and 4 roles, doesn't see a difference in duties. Is now in Band 4 role • Some aspects of role have changed (TEDS) since 'qualified' staff have been recruited, now less clear what is required, fewer opportunities to be involved in TEDS work, feels pushed out?	• Role is Unclear
• Feels the pay says 'anyone could do your job' – that pay reflects a lack of skill • Pay can lead to feelings of not being valued/appreciated by wider trust/NHS • Pay isn't adequate when compared to the risk and responsibility role entails	• Pay impacts sense of worth
• Feels there is no difference in SW role compared to SMHP role – other than pay • Resentful of SMHP being paid more for doing 'same job'	• Resentment and competitiveness experienced in relation to SMHPs
• Will access ad hoc support from colleagues when struggling emotionally with the work • Can be hard to ask for additional support, feels should be able to cope/is expected to cope • Values MDT knowledge and skills	• Values MDT knowledge and support
• Can feel overwhelmed by CYP struggles and hopeless about how to help them • Feels sad sometimes at limitations of role and feels CYP needs are unmet as a result • Role sits in GMH, TEDS and Liaison – all higher levels of risk and complexity	• Managing risk and responsibility
• Role is not permanent as doesn't offer progression, will move on • Role is fixed term, lacks permanency and leads to questions/worries of whether it is really valued/wanted • Feels SW role is a stop gap until qualified clinicians can be recruited – 'they'll do'	• Role feels temporary

• Is the only SW in Core CAMHS team, feels lonely, questions if role is valued • Feels appreciated in team by individuals and wider team, but not trust	
• Values having own desk	• Feels has a place, belongs
• Values being able to help and support CYP • Enjoys seeing that their input can help CYP recover, change – rewarding part of job • Frustration at wider system, not enough service provision for CYP outside of CAMHS, feels this impacts work CAMHS can do • Lacks confidence in self sometimes, feels doesn't know what they are doing or how to do job • Relies on external validation as hard to give self this • Wants to help CYP • Values kindness and patience as personal qualities needed for role	• Parts of role enjoyable
• Can lack confidence in ability to do role • Can feel overwhelmed, unheld in team when there are staffing issues • Can feel hopeless about role and CAMHS • Frustration at wider system, not enough service provision for CYP outside of CAMHS, feels this impacts work CAMHS can do • Lacks confidence in self sometimes, feels doesn't know what they are doing or how to do job	• Role can be emotionally difficult

Table D5 - Participant Five – Personal Experiential Themes (PETs)

SUBTHEMES	**SUPERORDINATE THEMES**
• Feels can 'help out' in different parts of the service • Role is 'important' • Sees role as an 'important cog in the machine' • Role is important in managing risk and preventing escalation	• Role is an important part of CAMHS
• Feels experience and length of service not recognised and not reflected in pay • Pay is a problem – feels would consider moving on if cannot achieve higher pay in the role	• Pay is an issue and doesn't reflect experience
• Has worked across multiple MH settings, is very experienced • Values personal qualities of clinicians over training/education/qualifications • Job title matters – SSW better than SW, but not as good as OT asst, which is not as good as 'Practitioner' (has held all titles previously).	• Values own experience

• Feels happy working with high risk YP if supported and offered guidance • Working with high levels of risk can increase risk of burn-out	• Working with risk can be challenging
• Has experienced burn-out in response to stress of role • Burn-out affected confidence in ability to do job – a personal failing? • Can feel desensitised to risky/upsetting and distressing behaviours and presentations • Can feel 'stuck' – enjoys more complex case work but it comes with risk of stress/burn-out	• Role can lead to desensitisation, burn-out and stress
• Non-registration prevents access to higher level trainings such as DBT and CBT, uses these approaches anyway in a 'CBT/DBT informed way' • Training opportunities limited due to lack of formal qualifications • Feels valued by team but this can add pressure to do more formal trainings • Feels restricted by lack of formal training in terms of what support they can offer YP	• Training opportunities are limited
• Relies on external validation to evidence to Interviewer that they are good at their job • Feels held back by dyslexia and confidence affected by this, feels progression hampered by learning difficulties and related lack of confidence • Hard to express confidence in skills and qualities, refers to what others have said	• Relies on external Validation
• Values what different disciplines offer and makes use of this • Values working with experienced colleagues and has learnt through these experiences • Values opportunities to learn through experience, suggests SW should spend time on ED unit, Hospital wards, inpatient settings, TEDS work • Feels profession of supervisor makes a difference to how they work and feel about the work • Values learning from MDT colleagues – both formally and informally • Values opportunities to learn from colleagues (joint working, shadowing)	• Values learning from MDT
• Relationships with team members help to manage anxiety caused by job. Feels lack of relationships would mean that the job would be scary/stressful – new starters might struggle	• Values working relationships with colleagues
• Enjoys helping patients and team • Role can be challenging but enjoys the challenge • Values autonomy in the role and the freedom this offers • Feels is good at engagement work, is reliable, patient, practical, healthy role model	• Enjoys the role

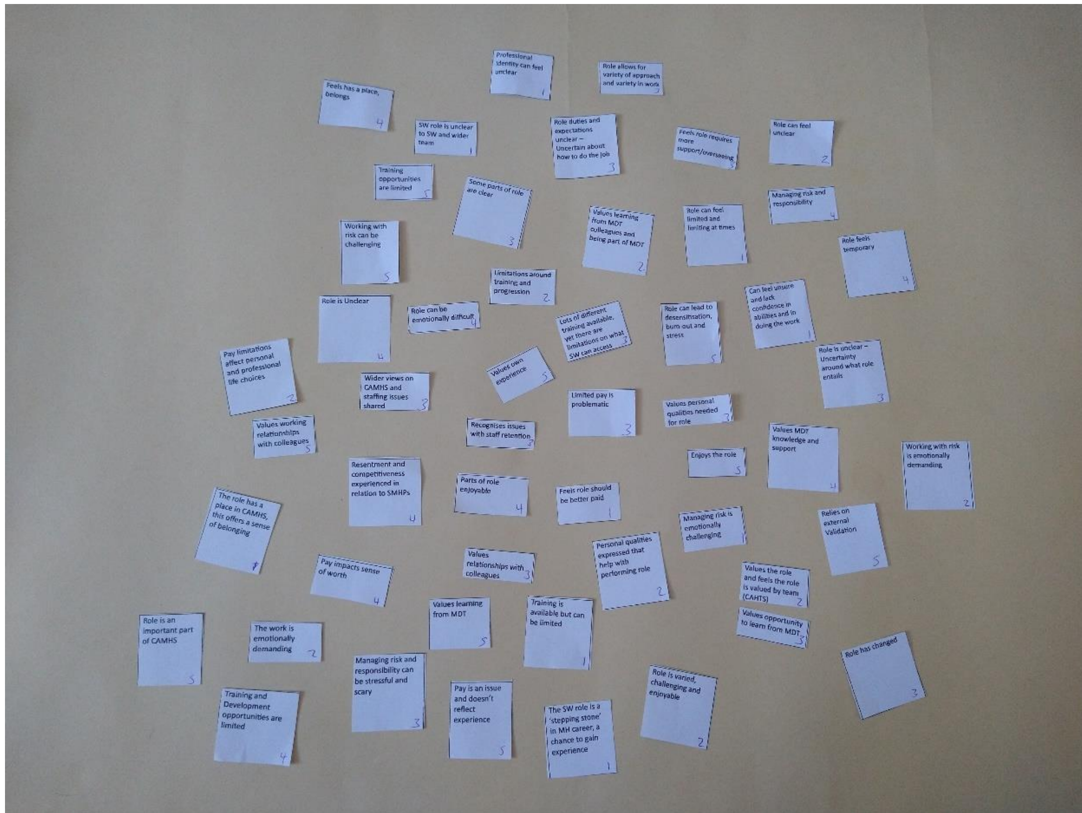
• Feels trusted to do the job, enjoys this feeling, links with autonomy	

Table D6 – PETs gathered from all participants

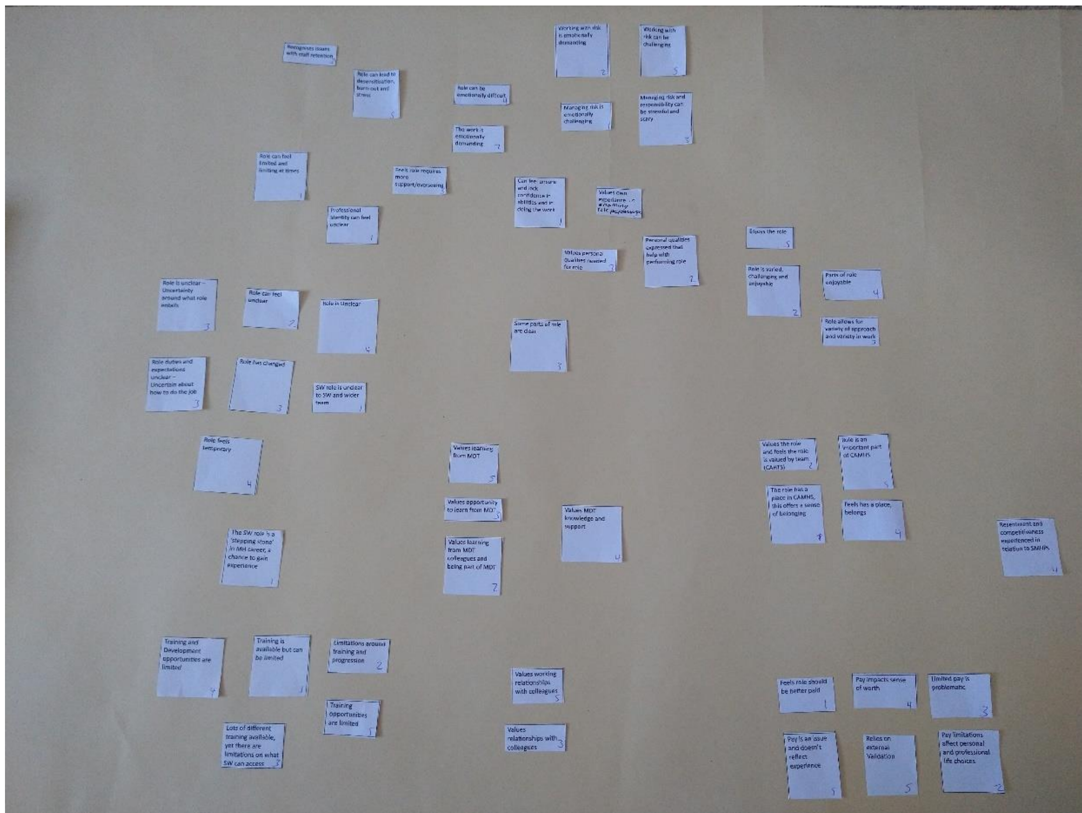
P1	P2	P3	P4	P4
The SW role is a 'stepping stone' in MH career, a chance to gain experience	Pay limitations affect personal and professional life choices	Role has changed	Training and Development opportunities are limited	Role is an important part of CAMHS
The role has a place in CAMHS, this offers a sense of belonging	Working with risk is emotionally demanding	Managing risk and responsibility can be stressful and scary	Role is Unclear	Pay is an issue and doesn't reflect experience
Managing risk is emotionally challenging	Values the role and feels the role is valued by team (CAHTS)	Feels role requires more support/overseeing	Pay impacts sense of worth	Values own experience
Role can feel limited and limiting at times	Values learning from MDT colleagues and being part of MDT	Some parts of role are clear	Resentment and competitiveness experienced in relation to SMHPs	Working with risk can be challenging
Training is available but can be limited	Role is varied, challenging and enjoyable	Role is unclear – Uncertainty around what role entails	Values MDT knowledge and support	Role can lead to desensitisation, burn-out and stress
SW role is unclear to SW and wider team	The work is emotionally demanding	Role allows for variety of approach and variety in work	Managing risk and responsibility	Training opportunities are limited
Can feel unsure and lack confidence in abilities and in doing the work	Personal qualities expressed that help with performing role	Role duties and expectations unclear – Uncertain about how to do the job	Role feels temporary	Relies on external Validation
Professional Identity can feel unclear	Role can feel unclear	Limited pay is problematic	Feels has a place, belongs	Values learning from MDT

Feels role should be better paid	Limitations around training and progression	Wider views on CAMHS and staffing issues shared	Parts of role enjoyable	Values working relationships with colleagues
		Recognises issues with staff retention	Role can be emotionally difficult	Enjoys the role
		Values opportunity to learn from MDT		
		Values personal qualities needed for role		
		Values relationships with colleagues		
		Lots of different training available, yet there are limitations on what SW can access		

The table was then printed out, the individual PETs were numbered with the participant numbers, and the PETs were cut into individual statements. These statements were then scattered across a large piece of paper and reviewed:



PETs were then gradually arranged into groupings:



Once grouped, connections and notes were added:

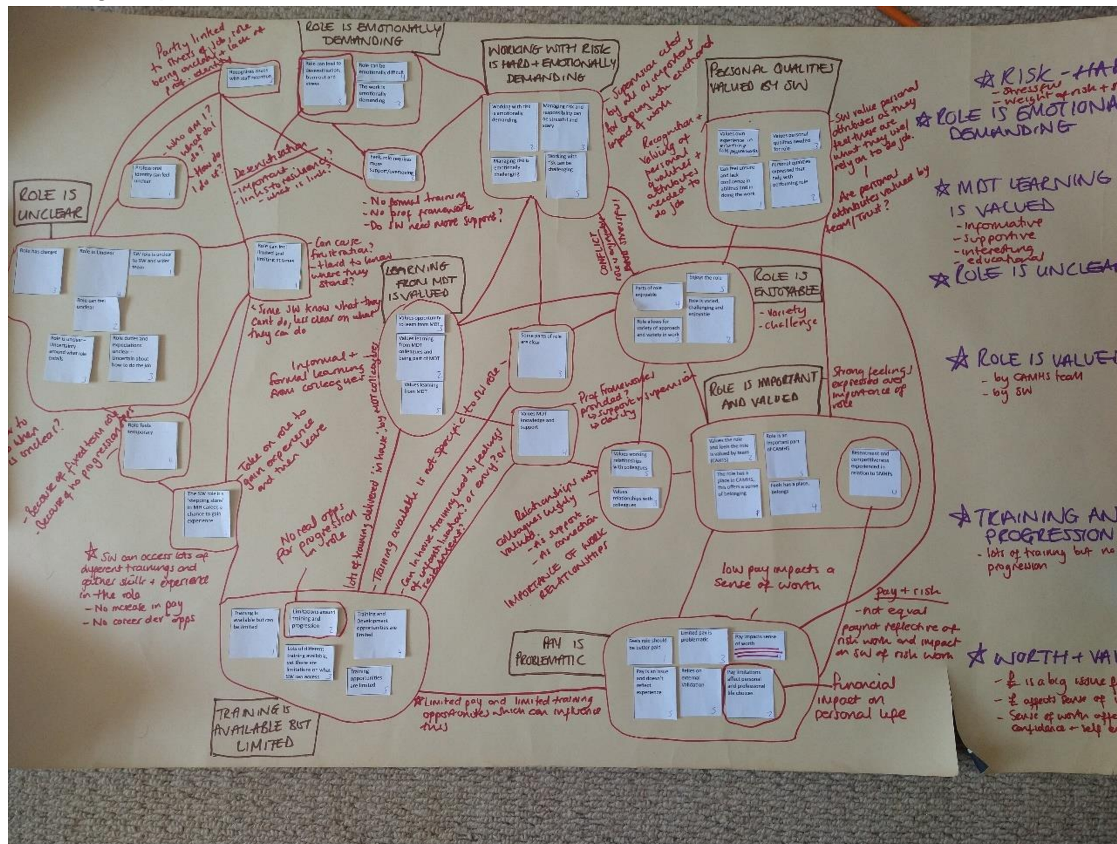


Table D7 - Occurrence of GETs gathered from PETs:

THEME AND PRESENCE OF THEME FOR EACH PARTICIPANT	1	2	3	4	5
Training and Progression • Training is available but limited	☒	☒	☒	☒	☒
Pay is a problem • Doesn't reflect skills • Doesn't reflect experience some SW have • Is not sustainable long term for some SW	☒	☒	☒	☒	☒
Working with risk is hard • Emotionally challenging • Risk of overwhelm, stress, burn-out • Feels scary, worrying, sad • Desensitisation a concern for SW	☒	☒	☒	☒	☒

Role is valued • Role is valued by team • Role is valued by SW • Role seen as important	☒	☒	☒	☒	☒
Role is Unclear • Hard to know what job is • Hard to know how to do job • Easier to know what not to do than what to do	☒	☒	☒	☒	☐
Learning from MDT is valued • SW value formal and informal learning opportunities within MDT	☐	☒	☒	☐	☒
Role is emotionally demanding • Can feel stressed, sad and worried by work	☐	☒	☐	☒	☒

Subthemes were then gathered and captured within superordinate themes.

The exploratory notes, experiential statements and themes were held in mind while the transcripts were reviewed to find quotes given by participants that would evidence the subthemes. Quotes were located, copied to a word document and were printed and cut out. They could then be arranged within their thematic groupings:

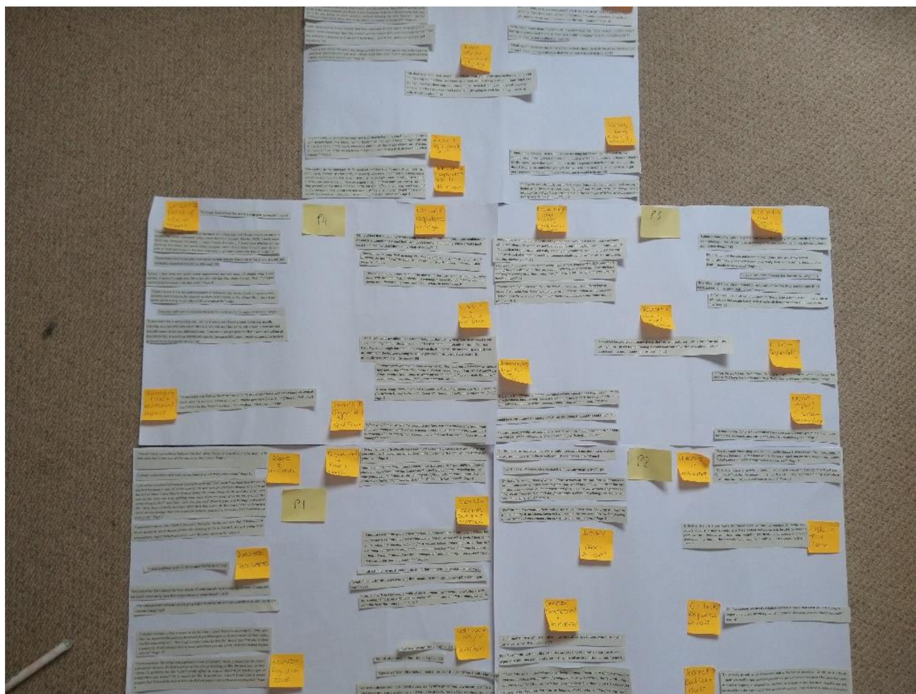


Table D8 - GETs, Superordinate and Subordinate themes:

Group experiential Themes	Sub themes	Superordinate Themes
Training and Progression • Training is available but limited • Progression is not available	A search for Identity	**Issues of Identity and Belonging**
Pay is a problem • Doesn't reflect skills • Doesn't reflect experience some SW have • Is not sustainable long term for some SW	Questioning Worth	**A question of Value Worth**
Working with risk is hard • Emotionally challenging • Risk of overwhelm, stress, burn-out • Feels scary, worrying, sad • Desensitisation a concern for SW	"You feel so responsible for their life"	**The Weight of Responsibility**
Role is valued • Role is valued by team • Role is valued by SW • Role seen as important	A sense of belonging	**Issues of Identity and Belonging**
Role is Unclear • Hard to know what job is • Hard to know how to do job • Easier to know what not to do than what to do	"I don't know what I'm doing"	**Issues of Identity and Belonging**
Learning from MDT is valued • SW value formal and informal learning opportunities within MDT	A sense of Belonging	**Issues of Identity and Belonging**
Role is emotionally demanding • Can feel stressed, sad and worried by work	Weight of responsibility	**The Weight of Responsibility**