

**Exploring the Contribution of Safe Uncertainty in  
Facilitating Change**

**This thesis is submitted in fulfilment for the requirement of a**

**Degree of Doctorate of Philosophy 2014**

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## **Abstract**

### Background

This PhD study was an examination of the mechanism adopted by a change agent during an organisational change in healthcare. The context for the study was the secondary analysis of action research in a Child and Adolescent Mental Health Service (CAMHS) that had developed practice at an organisational level to address the excessive waiting list impacting upon that service.

### Aims and Objectives

The research question addressed in the thesis was

How does a change agent facilitate organisational change in a health setting?

The objectives of this study were to

- i. explore the current literature available discussing the role of the change agent, thus identifying what is already known about this mechanism
- ii. through a secondary analysis of the data generated through the aforementioned action research in CAMHS examine the relationship between the change agent and the change participants
- iii. formulate an understanding of the mechanism of the change agent during organisational change.
- iv. use these findings to make recommendations for practice and further research.

### Methods

The impact of the change agent during this organisational change was investigated using a triangulation of three methods: interviews with change participants, observations in the field and a reflexive diary.

## Findings

The data were thematically analysed looking at the interaction between the change agent and participants. The way that the change agent used anxiety through the change process was presented in three themes: introducing anxiety into the system to initiate change; tolerating anxiety through the change process; sustaining the change. Analysis of the data generated through this study illustrated the change agent acknowledged the anxiety expressed by change participants and used this in a functional way to lever, maintain momentum and sustain the change process in the field.

## Conclusion

This builds on the available literature that discusses how change agents might hold or contain anxiety during change processes. This thesis presents evidence that the change agent introduces and then uses anxiety functionally to initiate organisational change in a way similar to that described by Mason (1993) in his safe uncertainty theory. Mason had developed that theory to explain the work a family therapist does with families. Mason suggested that a family therapist invites a family into a position of 'safe uncertainty' in order to facilitate behavioural change within that family. From this study, there is evidence to suggest that a change agent working with health organisations works in a similar way, by inviting participants in an organisation to move into a position of safe uncertainty in order for change to be effected.

# Thesis Summary and Declaration

## DECLARATION

This work has not previously been accepted in substance for any degree and is not concurrently submitted in candidature for any degree.

Signed ..... (candidate)      Date

.....

## STATEMENT 1

This thesis is being submitted in partial fulfilment of the requirements for the degree of PhD

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.....

## STATEMENT 2

This thesis is the result of my own independent work/investigation, except where otherwise stated.

Other sources are acknowledged by explicit references.

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## STATEMENT 3

I hereby give consent for my thesis, if accepted, to be available for photocopying and for inter-library loan, and for the title and summary to be made available to outside organisations.

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committed to the possibilities of change to improve services for children and young people accessing mental health services.

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## **Chapter One: Introduction to the Thesis**

This chapter provides the context for the thesis. Organisational change was effected in a Child and Adolescent Mental Health Service (CAMHS) through action research designed to address the excessive waiting list for children to have an initial assessment. Children and young people referred to the service waited over 12 months for a first appointment during the period 2003-5. Attending to the mental health of children and young people is critically important. Statistics suggest that 10% of 5-15 year olds currently have a diagnosable mental disorder (Green et al 2005). Left untreated, the impact for children and young people could have long lasting effects, such as disturbance to their educational attainment, difficult family relationships as well as the potential for developing long term mental health conditions (Moss, 2008). Acknowledging the significance of this the Department of Health set targets for children and young people with mental health concerns to be seen by appropriate services within a timely manner (Department of Health 2008, Department of Health 2009). A project was therefore developed to address the long waiting time between referral to CAMHS by primary care for an initial mental health assessment of children and young people with mental health concerns.

The thesis was an examination of aspects of the change process.

The research question being addressed in the thesis was

How does a change agent facilitate organisational change in a health setting?

The objectives of this study were to

- i. explore the current literature available discussing the role of the change agent, thus identifying what is already known about this mechanism

- ii. through a secondary analysis of the data generated through the  
aforementioned action research in CAMHS examine the relationship between  
the change agent and the change participants
- iii. formulate an understanding of the mechanism of the change agent during  
organisational change.
- iv. use these findings to make recommendations for practice and further research.

### **Presentational Style**

Throughout the thesis I have used the acronym CAMHS to represent children and young people's mental health services. I have also used the term 'child' or 'family' to represent any child or young person and their carers, family or care setting as a convenient term, but acknowledge the breadth of family and care setting for children and young people.

### **Organisation of the Thesis**

In **chapter one**, the context for the study is set through the discursive account of the action research conducted within a Child and Adolescent Mental Health Service (CAMHS). It was a secondary analysis of this data that was used to investigate the change agent's influence that formed the basis for this thesis. A systematic review of the literature on the role and effect of a change agent that informed this thesis is found in **chapter two**. **Chapter three** provides a detailed description of the methods used to investigate the change agent role in this study. The findings in relation to

participant anxiety and the mechanism a change agent used are presented in **chapter four**. A discussion of significance of these findings in relation to the body of existing knowledge can be found in **chapter five**.

This thesis offer new thinking in relation to how a change agent initiates organisational change in an NHS team.

## **Setting the Clinical Context**

### The Importance of Child and Adolescent Mental Health

The most recently available statistics on the mental health of children and young people indicate that 10% of 5-15 year olds currently have a diagnosable mental disorder (Green et al 2005). The NHS has acknowledged the significance of this, emphasising that the mental health needs of children and young people should be accurately identified and met by appropriately located services in timely fashion (Department of Health 2008, Department of Health 2009) as this reduces the likelihood of chronic mental health conditions developing (Moss 2008). Evidence linking childhood emotional and psychological difficulties with adult mental health problems (Fombonne, Wostear, Cooper, Harrington and Rutter, 2001) suggests it is imperative that timely effective interventions are targeted at children and young people (Hewson, Chennells and Worrall-Davies, 2003). Fergusson and Norwood (2001) note that towards the later end of childhood, the rate of mental disorder shoots up between the ages of 15-18. At age 15 in their study of a cohort of 1265 children, 25% had diagnosable mental disorder (anxiety, mood, conduct, substance dependence), which by aged 18, had increased to 40%.

Health interventions aimed at early input for children and young people help prevent secondary stigmatisation from long term unmet needs (National Assembly for Wales, 2001). Interruptions to children's normal psychological development can have a number of sequelae. Children may become disconnected from their peers and thus

lose the benefits that social relationships bring to emotional health. Periods of psychological ill-health can affect school performance and attainment which can have a long lasting impact upon a child's academic, social and emotional development. Some groups of children are at particular risk of mental health problems. For example, children looked after by local authorities are five times more likely to have a mental health problem than children in private households (Meltzer, Corbin, Gatward, Goodman, Ford, 2005). Current health policy emphasises that that all agencies have a responsibility for contributing to children's emotional health, (National Assembly for Wales, 2001).

### **Policy Context in Wales**

The intervention was undertaken in a policy context shaped by both Wales and UK wide initiatives. Williams and Kerfoot (2005) offer a potted history of CAMHS in the UK. An increasing understanding of children's emotional states and psychological development throughout 1950s and 1960s led to the creation of a CAMHS in-patient building programme that lasted for the next decade following concern in the House of Commons about children being admitted into adult psychiatric beds. Increased service demand led to the commissioning of the Health Advisory Service (HAS) review of CAMHS across England and Wales resulting in the publication of the report Together We Stand (1995). The HAS review found in England and Wales an absence of strategy for the development of CAMHS services, ineffective commissioning resulting in a 'patchy service provision that was unrelated to need' and 'problems in the availability and accessibility of services'. HAS found that

‘specialist CAMHS at all levels and in all sectors are in danger of being swamped by rising levels of demand and increasing yet competing expectations; with many services [having] long waiting lists and times’. HAS recommended that Wales should become a centre for practical research in CAMHS and that pilot projects should be conducted in all sectors by all relevant disciplines. The proviso for this was that projects were to be selected so that they produce benefits across Wales.

The key document Everybody’s Business (National Assembly for Wales, 2001) provided a strategic plan for CAMHS development in Wales and had at its core the belief that CAMHS services should offer relief from current suffering and problems with the intention of improving, as soon as possible, the mental health of children, adolescents and their families and that services should be offered ‘in a timely and coordinated manner’. It stressed multiagency, multi-disciplinary working and an approach built on partnership with young people and families and organised in a tiered system of provision. The expectation was that the strategy would be implemented across Wales over a period of ten years. Particular issues in Wales included a lower number of adolescent inpatient beds per head of population compared to the rest of the UK, the absence of children’s specialist CAMHS inpatient beds, a lack of beds for young people who have eating disorders, virtually no service for children with a learning disability and no emergency adolescent beds in Wales. As in the rest of the UK there were significant issues regarding recruitment and training of the CAMHS workforce.

HAS also declared their intention of ensuring that services were both competent and accountable for the quality and breadth of service they offer. Importantly for the design of this piece of research, the Welsh Assembly committed itself in principle to ‘strive to learn from the opinions of service users, their families, carers’ (p10).

In 2005, The Welsh Assembly Government published the National Service Framework (NSF) for Children in Wales. Its aims were to improve quality and equity of service delivery through the setting of national standards for health and social care. Chapter four is dedicated specifically to children and young people with mental health problems, although the NSF clearly states all standards apply for all children across Wales. The NSF makes reference to the earlier published circular WHC 2004 (083)32 that all children and young people referred to Specialist CAMHS are seen within six months, and feedback is given to their referrers within three weeks of that appointment. This clearly indicates the importance of redirecting or signposting a child to another service when they were incorrectly referred to CAMHS in the first instance.

### **Significant Policy Development across the UK**

York and Lamb (2005) were commissioned by the Royal College of Psychiatrists, Child and Adolescent Faculty to review the capacity in CAMHS services. Their stated aim was to generate a ‘rule of thumb’ tool that could be applied across the UK to provide a degree of consistency in defining the core business of CAMHS (see appendix seven).

Several areas of research are recommended by this review. Of note, York and Lamb (2005) identified the need for research that looked at the relationship between demand and waiting times, and the effectiveness of different models of service delivery within all tiers.

One of the most debilitating aspects of a child or young person developing a mental disorder is that they fail to maintain the progress of their psychological development alongside their peers and thus are disadvantaged both by the distress of the disorder and impaired psychological development (National Assembly for Wales, 2001). It is this compounding impact on a child's life that highlights why children, above everyone, need to have their mental health needs met. Evidence suggests childhood emotional and psychological difficulties are highly linked with on-going mental health problems in adult life (Fombonne, Wostear, Cooper, Harrington and Rutter, 2001). It therefore makes sense on both a humanitarian and an economic basis that timely effective interventions are targeted at children and young people who present with mental disorder (Hewson, Chennells and Worrall-Davies 2003, Children's Commissioner for Wales, 2005) and for many of the common mental disorders good evidence exists to support the efficacy of early interventions (Fonagy 2002, Carr 2000).

### **The Research Setting**

The research was located in a CAMHS team serving a population of approximately 120,000. The team was part of a larger Managed Clinical Network crossing three NHS Trusts, six unitary authorities and serving a population in excess of 800 000.

The managed clinical network as a concept is defined by the Welsh Assembly Government (WHC [2005]076) as a strategy for enabling providers or commissioners of specialist health services to join in a way that significantly improves services across organisational boundaries. The research site was a tier 2/3 CAMHS service (Health Advisory Service, 1995) providing outpatient assessment and intervention to children and young people up to the age of 16 or 18 (if they were in full time education) and their families. Services were offered by this team to children who presented with mental illness, mental disorder and mental health problems.

### **The Research Locality**

The CAMHS team served a small market town and its surrounding area, which has within its boundary sections of the community with marked deprivation in contrast to areas of affluence. The majority population was white Caucasian. Movement away from the areas was uncommon, with many people remaining in the area throughout their life.

### **The Research Collaborators**

At the start of the project the team consisted of one consultant child and adolescent psychiatrist, one social work therapist (full time), two social work therapists (part time), one of whom was on extended leave, one part time clinical psychologist, one full time nurse therapist, one training psychiatrist (senior house officer). A health visitor was attached to the team on a developmental secondment for a year. Two nurse therapists linked with the team in a less direct way. Their primary functions were with the substance misuse and youth offending teams.

Through the course of the field work, six of the above personnel left their positions, and two new (psychiatry) posts were developed. There were periods when student practitioners from both nursing and social work joined the team. The overall picture was therefore one of a reasonably static structure, but with changing personnel occupying those positions. This had implications for the way the project evolved.

### **Planning Stage of the Study**

Excessive waiting lists are acknowledged to be a problem for CAMHS throughout the UK and securing access to care can be difficult (Foreman and Hanna, 2000). The initial stage of this project involved an exploration of both the research and professional literature to identify existing protocols for the brief assessment and prioritisation of mental health services for children. The aim was to establish whether there were any models in existence which could be adapted to meet the specific needs of this CAMHS team. No suitable models were identified which were directly transferable, but the literature did provide some helpful ideas which informed the development of the triage intervention. The preliminary planning for this action research project started in June 2004.

### **Stages in the Original System**

#### **The Referral Process**

Prior to the implementation of the intervention, referrals were made in writing to the consultant psychiatrist in the team. Referrals could come from as range of health

providers in primary care, education and social care, such as GPs, health visitors, educational psychologists and social workers. Occasionally when they thought there was a particularly urgent case referrers would make telephone referrals and supplement this with a written referral later. A standardised referral form had previously been circulated to referrers but this was rarely used as a template. Referrers would generally prefer to write letters, which ranged from one sentence to a few pages of detailed history. The practice of ‘scatter-gun’ referrals was common. This was a colloquial term for children being referred to multiple agencies simultaneously in the hope that one of the agencies would accept responsibility for the child. This practice was often used for children with complex or chronic needs.

On receipt of any referral, a memo would be made in the ‘referrals book’ by the team administrator recording demographic details and key words indicating the nature of the child’s problem.

#### How Decisions Were Made on Receipt of Referrals

On a weekly basis the consultant would scrutinise referrals received and decide what action needed to be taken. As there was a significant waiting list pre-dating this project, only urgent cases would be allocated for immediate appointments and others would be allocated on the basis of next in line on the list. Those referrals identified as urgent during the interim period would be scrutinised by the consultant and dealt with accordingly.

The possible options the consultant might consider would be to not accept the referred child, accept immediately, accept and place on a waiting list or ask the referrer for more information. There was a general understanding of the criteria on which these decisions were made, but there was no forum during which such decisions could be explicitly discussed. The decision making process was therefore unilateral and consultant led. The extent of this practice became highlighted at periods when the consultant was on leave as only children at immediate risk of harm would be allocated to the team. Other referred children would wait until the consultant returned from leave before a decision was made about their disposal.

#### Original Initial Assessment

The original initial assessment consisted of a clinical interview that lasted over an hour. All family members were invited for this assessment. Within this, questions were asked of the referred child's developmental history the composition of the family in which the child lived, including extended family, step or half siblings and foster siblings, the child's full educational and medical history. In addition to detail about the child's development to date, information was sought about the child's current functioning in relation to siblings, peers, teachers, parents, play, going out of the home, eating, sleeping and toilet habits. Contemporaneous notes were made throughout the clinical interview. This was using a tried and tested assessment form that had been used across the CAMHS Network for over twenty years.

Due to the high volume, most referrals were placed on a waiting list for the initial appointment. During 2003-4, this waiting list was approximately 15 months. This was improved to 12 months through administrative processes and by checking whether the original reason for the child's referral was still problematic. It has been found that attendance is connected to the length of wait for a health appointment, so the longer people are waiting for an appointment, the less likely they are to attend and thus the non-attendance rate increases, reducing service efficiency. A number of authors have commented upon the critical time between referral and first appointment (Rawlinson and Williams, 2000) but there is no consensus between them about how long this period should be. Within this service the protocol after a non-attendance (DNA) was that the family would be sent a card asking them to indicate whether they would like a further appointment. If they responded positively, they would be sent an appointment. If there was no response after an unspecified number of weeks, they would be discharged without being seen. So there were a number of referrals conflating the waiting list but who would not actually attend the service through non-attendance but who were being given appointments of one and a half hours duration that were being wasted.

#### The Difficulties with the Original System

The system had a number of junctures when decisions were made about the child's suitability for the CAMHS service. Determining whether a child met criteria for CAMHS was based upon the referrer's assessment and their articulation of the child's mental health needs in the referral letter. Referrers came from a range of professional

backgrounds. They included GPs, school nurses, teachers, social workers, care workers from the voluntary sector, all with different experience and understanding of mental health in the context of child development, mental health services and perceptions of risk posed to children. They therefore also had different ideas about which children they thought required routine or emergency appointments from CAMHS. The quality of information provided in referral letters was variable and the content reflected the referrer's professional orientation which has been found not to be a valid mechanism for making a decision about the appropriateness of the child's referral (Potter, Langley and Sakhuja 2005).

### **Research Strategy**

Action research is the methodology of choice for initiating and exploring a change in clinical practice. It is a 'clinically reflexive model of research' (Morton-Cooper, 2000) aimed at generating knowledge about a social system whilst simultaneously trying to change it (Hart and Bond, 1995). It is founded on a research relationship in which those involved are participants in the change, and involves a cyclical process in which research, action and evaluation are interlinked (Waterman, Tillen, Dickson, de Koning, 2001). Greenwood and Levin (2007) describe the professional action researcher and members of either an organisation or network (stakeholder group) as coming together specifically to improve an aspect of the stakeholders' situation.

### **Action Research Methodology**

There have been a number of reviews of the methodological literature on action research and these were drawn upon during the fieldwork to guide the evolution and

progression of the project (Waterman et al, 2001, Welsh Assembly Government, 2000). Cassell and Johnson (2006) suggest that the broad range of action research methods are drawn from the breadth of ontological and epistemological philosophies of types of action research that fall within this research paradigm. Therefore different research methods within the approaches are consistent with the respective philosophy. What is distinctive about action research as an overall research strategy is the iterative cycle of identifying a problem, planning to address the problem, intervention and review in order to plan subsequent intervention (Cassell and Johnson, 2006).

Hart and Bond (1995) noted the absence of a definitive text that described and distinguished action research from other research methodologies so they created a typology based on their examination of available literature on action research, containing four broad 'traditions' alongside seven criteria that distinguish different types of action research. There have since been further typologies that aim to characterise features of action research (Chandler and Torbert 2003, Heller 2004). Hart and Bond's typology illustrated that action research has a distinct identity that originates from a range of ontological philosophies from experimental to social constructionist. The typology aims to capture the features of the range of action research approaches from the experimental approach (seen on the left of the typology) to the emancipatory (on the right) with two incremental approaches in between, organisational and professionalising. Hart and Bond have suggested that

each of these approaches has defining characteristics within seven criteria which are summarised in the table below (figure one).

This typology has been useful in understanding the breadth of action research approaches and seeing how, despite their differences, can be understood within one paradigm. Hart and Bond suggest that studies which take significant time may adapt their approaches and 'move' across the spectrum.

**Figure one: Features of the continuum of action research (Taken from Hart and Bond's Typology, 1995)**

	Consensus model of society			Conflict model of society
	<b>Experimental</b>	<b>Organisational</b>	<b>Professionalising</b>	<b>Empowering</b>
<b>Educative base</b>	Researcher focus.	Training. Organisational change towards consensus.	Reflective practice. Patient advocacy. Enhancing practitioner's ability to control work situation	Consciousness raising. Empowering oppressed groups
<b>Individuals in groups</b>	Closed group, participants selected by researcher	Existing work groups	Professional groups, membership negotiated	Fluid, open groups
<b>Cyclic processes</b>	Research dominates action. Time constrained.	Tension between action and research with action dominating. Discrete cycles of action and research.	Tension between action and research with research dominating. Dynamic spirals of action and research cycles	Action dominates. Study is open-ended, not constrained by time.
<b>Research relationship &amp; degree of collaboration</b>	Outside researcher as expert. Clearly differentiate roles.	Client pays an outside consultant. Differentiated roles	Could be either researcher or practitioner with merged roles.	Strong collaborative, or co-researcher roles.
<b>Change intervention</b>	Experimental intervention to test theory and/or generate theory	Problem to be solved in terms of management aims	Problem to be resolved in the interests of research-based practice	Problem to be explored as part of process of change, developing an understanding of meanings of issues.
<b>Improvement and involvement</b>	Towards controlled outcome and consensual definition of improvement	Towards tangible outcome and consensual definition of improvement	Towards improvement in practice defined by professionals and on behalf of users	Towards negotiated outcomes and pluralist definitions of improvement: account taken of vested interests

<b>Problem focus</b>	Problem emerges from the interaction of social science theory and evident social problems.	Problem defined by most powerful group.	Problem defined by professional group or emerges from professional practice.	Problem emerges from members' practice / experience.
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### **Features of Action Research**

In action research, multiple methods of data gathering may be employed in a systematically evolving process that becomes evident through the life of the project. Action research is a multi-disciplinary, multi-method, contextual and holistic approach to social research that respects the complexity of problems people (stakeholders) face in their everyday lives (Greenwood and Levin, 2007). By enrolling those affected by the intervention in the process, and by linking research with practice development, the aim of action research is to promote sustainability for the change. Its strength lies in its focus on generating solutions to practical problems and its ability to empower practitioners - getting them to engage with research and subsequent development or implementation activities (Meyer, 2000). Nichols and colleagues argue that the evolution of action research as a methodology directly addressed the 'persistent failure of research in the social sciences to make a difference in terms of bringing about actual improvements in practice' by rejecting the concept of a two-stage process of researcher first then application by practitioners to a more integrated one-step approach (Nichols, Meyer, Batehup, Waterman, 1997). In action research therefore there need be no gap between theory, research and practice as the three can be integrated.

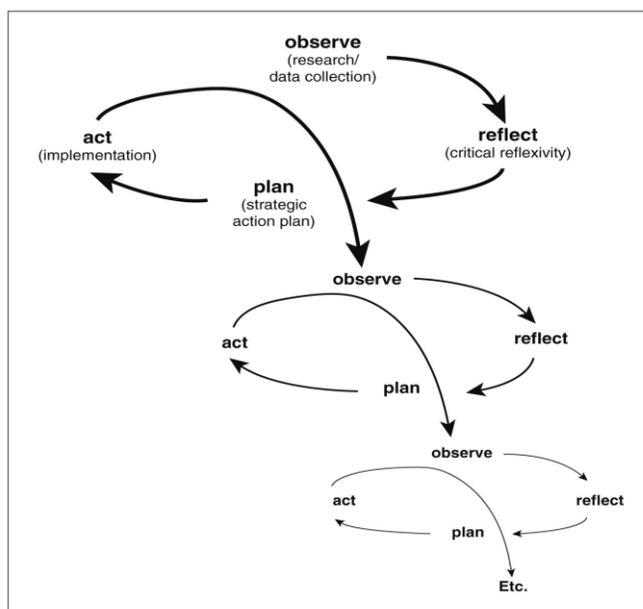
Action research promotes a greater partnership between academics and clinicians thus breaking down the barriers between acquiring or generating knowledge through research and its application in the field. Therefore, participants involved in the research benefit from their involvement at the time of their involvement and are also able to participate as part of their normal work activities (Dick, 2008). It is also a defining feature of action research that data generation begins as soon as the problem becomes apparent and a decision is made to conduct an action research study (Streubert Speziale, Rinaldi Carpenter, 2003). It is this degree of responsiveness that Dick (2008) considered to be the most compelling reason for selecting action research as a methodology. The fundamental tenets of action research methodology are inclusiveness, a focus on effecting change, timeliness and a contemporaneous integration of practice, research and theory around an area of interest.

### The Action Research Spiral or Cycle

The origins of action research are attributed to Kurt Lewin having used the phrase 'action research spiral' (Lewin, 1946). Lewin introduced the idea of a continual spiral of activity of reviewing and acting to effect change in an organisation. The cyclical nature of action research involves what Winter (1989) referred to as four stages of planning, acting, observing and reflecting not as discrete, single entities but more an overlapping process of which these may be components, or 'moments' in a spiral, (Kemmis and McTaggart, 1988) (see figure two). Where these functions occur in a spiral way and are embedded within practice, the result is that changes which occur

through this process are more likely to be sustained (Argyris, 1985). One of the difficulties with this particular aspect of action research is representing this three dimensional activity within a linear report such that reflects its complexity but is easily understood.

**Figure two: Cycles in action research**



**FIGURE 10.2** CYCLES IN ACTION RESEARCH

### Spirals of action, observing, reflecting and planning in this study

In reading through reports of action research studies and hearing action research studies presented at conference, I have been fascinated by the way these studies had been apparently organised into discrete phases: for example, cycle 1-planning, cycle 2-implementation, cycle 3-evaluation. Cook (2009) suggested that authors choose not to report their ‘messy sections’ in papers for fear of this detail being considered as ‘inappropriate’. I can appreciate the difficulty in articulating messy inter-related

spirals of action research activity but when constructing a discursive section on the process of the cycles, it has been appealing to try to neatly section them similarly.

Having completed this study, I am able to retrospectively impose this structure of discrete cycles of plan, act, observe and reflect but at the time the field work of the study was on-going, there were multiple cycles occurring such that it was difficult to distinguish the categories contemporaneously. In this study, rather than there being a series of sequential longitudinal waves forming a spiral of logically ordered work, there appeared to be a collection of overlapping and interconnected cycles of planning, action, observation and reflection, which have different sizes and timescales that have created a forward trajectory. This continued well after the field work was completed. The idea of action research being a messy methodology (Coghlan and Brannick, 2005) was a useful contrast to the ordered sequencing of a typical experimental design study, but conceptually, it is difficult to represent in

### **Securing Access to the Field to Conduct the Study: Engaging the Research Participants**

I met with the Consultant Psychiatrist of the CAMHS team in June 2004 to establish the need for and viability of my proposed project. The consultant in the CAMHS team was interested from the outset and between us we brainstormed to identify the key parties with whom we needed to consult for the project to move forward. The CAMHS team in which the study was located was part of a larger Managed Clinical Network that covered three NHS Trusts. The Clinical Director of the Clinical

Network was a critical stakeholder. He had the authority to either permit or block the project, so before any further work was done I arranged an early meeting. This allowed the frank discussion of my aims for the project, whilst inviting his response and clarifying what he would want from such a project.

### **Engaging Stakeholders**

Negotiating access and engaging stakeholders was not the linear process I had expected it to be. Identifying key stakeholders is acknowledged in the literature on change management as a critical activity to secure success and reduce resistance to the proposed process (Bryson, 2004). There are a number of methods of identifying stakeholders for a given project, but the principles of the Basic Stakeholder Analysis Technique (Bryson, 2004) were adapted in this case to ensure there was a systematic method to their identification. The process of identifying stakeholders and their relative hierarchy was complex and dynamic.

At the outset of the study, I had no real sense of who the critical stakeholders might be, but creating a metaphorical map at an early stage helped to identify those individuals with whom initial conversations were required. This is better conceptualised as a series of spiral activities rather than a linear one. The stakeholders initially identified were the Clinical Director of the Managed Clinical Network, the lead clinician for research whose support I needed for permission for the study to be obtained, the respective Heads of Nursing, Social Work and Psychology who had staff members in the potential study site and whose working practices were being invited to change during the course of this study. It was necessary to modify the

stakeholder map in the light of new information gained from initial negotiations, as new stakeholders were identified.

A strategy similar to the snowball sampling technique was used to widen my access to the next layer of stakeholders. It was useful to think about stakeholders in terms of their functionality and how each stakeholder potentially would influence the project to determine what preparation each category needed (Martin and Tate, 2001).

Emergent critical stakeholders included personnel from the wider CAMHS network who were influential, the newly appointed lead for Research and Development and other consultant psychiatrists in the CAMHS Managed Network who were highly influential in deciding whether to support clinical initiatives. There was a fine balance in achieving the right degree of collaboration with different stakeholders, acknowledging their hierarchical status in relation to both their roles in the organisation and their roles in relation to this project in order to keep the momentum of the project going.

### **The Role of the Researcher in Action Research**

The role of the researcher using action research methodology is complex and appears to require a combination of the scientific rigour of a researcher with the motivating leadership of an instigator of change. Greenwood and Levin (2007) in their discussion of pragmatic action research distinguish themselves as ‘reformers not revolutionaries’ (p9) within their roles as change agents. They acknowledge the contribution that every member of the team makes, accepting themselves as having

no more solutions than anyone else in the team and adhering to their principles of democratic decision making as a tool for effective change. Their definition of democratic decision-making includes the necessity for healthy debate and the possibility that decision need not always be based on majority rule but taking into account the contribution made by the diverse group members.

Stringer (1999) described the role of researcher as a catalyst, who 'stimulate(s) people to change, things they can do now' and enables people to develop their own analysis. It is an approach that requires researchers to work in close collaboration with stakeholders and form flat organisational structures that put decision-making power in stakeholder's plans (p26). Other descriptions of research role include: change agent (Waterman et al 2001), harem manager (Williams, St Quintin and Hoadley 2006), skilled facilitator (Argyris, 1985), holder of the duality of position between insider and outsider (Titchen and Binnie, 1993), and 'planner, leader, catalyser, facilitator, teacher, designer, listener, observer, synthesizer, reporter' (O'Brien, 1998). Whereas the literature provides numerous descriptions of what roles the researcher holds, with the exception of Titchen and Binnie's exploration of the balance between insider and outsider position in relation to the research project itself, no literature examined *how* the researcher roles was enacted. In this study, the way I positioned myself in the field is similar to that described Greenwood and Levin (2007) of their pragmatic action research approach. Greenwood and Levin describe the researcher as a having an external perspective of the study issues, by adopting a role of Socratic teacher in order to open up broader thinking and discussions about the identified problem and

thus create potential solution(s). As the researcher, I occupied a position that was definitely outside of the organisation in terms of my paid employment and contract but inside, or sympathetic to, of the organisation in terms of culture, behaviour towards service users and operational knowledge.

I found that it was unavoidable for me to be either only a researcher or only a practitioner. My two roles were interwoven in my thinking, my approach to families, to practitioner colleagues and to the tasks before me. This is not a new idea that there are difficulties keeping the boundary between researcher and practitioner in health research (Williams et al, 2006). In Waterman et al's review of action research studies (2001), they noted that one of the distinguishing factors of the action researcher took either an insider or outsider position in relation to the study. They helpfully define the difference between the two as whether the researcher has a formal contract (of employment) with the study site as an insider and a lack of formalised contract as an outsider. I think this differentiation can be helpful when looking at patterns of research programs, but certainly with this study, the allocation to either the insider or outsider camp is more complex.

Another description of what seems to be based upon similar defining criteria is the emic (participants) and etic (researcher) perspectives, where emic perspectives are considered to be more influential as they have to live with the change once the researcher has left the field. This of course is an artificial delineation between those who are insiders and those who are outsiders. Young (2005) suggests that in fact one

must have a degree of insider knowledge to determine who the key stakeholders are. Titchen and Binnie (1993) recommend moving the researcher into the practice site to prevent potential problems of the practitioners not liking either the direction of the study or the findings. This very structured intervention suggested that intervention could possibly have implications in terms of ownership of the study and long term sustainability of the change.

In this project, however my experience has been that although I have felt that I understood much of the politics of the organisation, the structure of the organisation and the way it works, I was viewed by the research collaborators as an outsider as I could walk away at the end of the day when they are left holding cases.

### **A summary of the Literature review that Informed the Development of the Intervention**

This literature contains a mixture of reports on empirical research, discussion papers and reports on innovations in practice. There was no assessment of quality for these papers as this review was contemporaneously conducted to generate ideas for us as a collaborating team to create a useful clinical intervention. For each paper, I offer a summary and note what aspects from that paper were useful in the development of the intervention. The three categories I have used to group the literature are: waiting list initiatives in CAMHS specifically, the use of brief assessment tools, screening protocols or triage assessments for CAMHS and the use of psychometric measures in CAMHS.

### **Waiting List Initiatives in CAMHS specifically**

The literature offered a number of models of care provision that have been introduced to try and address the waiting list problem specifically in CAMHS, (Jones, Lucey and Wadland, 2000, Parkin, Frake and Davison, 2003). None of these had demonstrated a universally effective strategy that met the needs of the research site. What was being sought was a waiting list initiative that used a shortened assessment process so that a high volume of referred children could be assessed by CAMHS within a short timeframe. Several studies reported waiting list initiatives, but none had used this precise approach. There were, however, elements of practice that were reported upon in either the research or professional literature related to CAMHS and other specialities that influenced the development of the triage clinic in this research study.

Jones, Lucey and Wadland (2000) report on a study conducted to evaluate a pilot project of a 'triage style' clinic in CAMHS. A sample of a mixture of families recently referred to CAMHS and those on the waiting list were invited to attend the triage clinic. They were sent a letter explaining the purpose of the clinic and a well-validated questionnaire (the Strengths and Difficulties questionnaire, discussed later in this chapter) for completion in advance of the appointment. In this paper, the team had looked at the completed questionnaire in advance of seeing the families to aid the assessment process. This triage clinic was held on two days per month. Before seeing the families in triage the CAMHS team met to explore ideas about each family. Each CAMHS practitioner saw one family per half day allowing the practitioner to

continue with their other work as well. Each triage appointment lasted one hour. The detail of the clinical interview was not included in the paper apart from stating that it was to gain an overview of the presenting problem. At the end of the day a CAMHS practitioner meeting was held with the consultant psychiatrist to review assessments made and make treatment plans. This process was evaluated by looking at the records of attendances and appointment patterns for families seen in triage compared with those seen in the usual way. The results reported on this evaluation were that of 155 cases allocated to triage, 43 (27.7%) were closed as a result and the waiting list was reduced from 56 to 13 weeks. The authors also noted a reduction in the non-attendance rates of the families seen in triage compared with usual practice which they attributed to the additional effort afforded by the administrative staff who telephoned these families to remind them of their appointments.

The interesting feature of this paper was that the idea of a specific clinic was introduced to address the waiting list in CAMHS. It was a whole team initiative that involved preparatory work, a meeting and sending questionnaires to the family, followed by a post assessment team discussion. This paper did not offer the option of a brief assessment at all. The system they described did not appear to be any more time efficient than the existing assessment in the study site so was not considered a suitable model to adopt. The use of questionnaires was noted.

One of the issues mentioned repeatedly in the literature was that of families not attending scheduled clinic appointments. High rates of non attendance (DNAs) block

appointment slots, inflate the waiting list and waste clinical time. Excessive waiting for an initial appointment correlates highly with non-attendance at first appointment and thus potential ineffective use of practitioner time (Parkin, Frake and Davison, 2003, Foreman and Hanna, 2000) so there are clinical as well as organisational reasons for tackling the wait for first appointment.

Parkin et al (2003) report on the effectiveness of a service development designed to improve the waiting list and non-attendance rates. They introduced what they referred to as a triage clinic for the initial assessment of non-urgent referrals. Similar to Jones et al (2000), their triage clinic was set up in order to address the waiting list and the high rate of non-attendance for first appointments. All CAMHS practitioners in the team took part with each family being seen by two practitioners. The rationale offered for two practitioners seeing each family was to offer a 'broader professional perspective'. At the start of the clinic, the CAMHS team met to discuss referred cases in advance, they then conducted a clinical interview lasting one and a half hours, and the team met afterwards to review the decision making.

The evaluation of this triage project was conducted over a ten month period. There were two aspects of the evaluation. The first was a two part survey with two strands in the first section: families referred during the study period and the respective CAMHS practitioners who conducted these assessments. The aim of this survey was to determine satisfaction with the new clinic but there was no detail of the content of the questionnaire in the paper apart from that it was a specifically designed Likert

style questionnaire. Families seen were given the questionnaire after attendance at the triage assessment but before a decision had been reached about the follow-up care. The second aspect of the evaluation was a survey of all the GPs in the catchment area and a specifically designed postal questionnaire was used to determine their satisfaction with the clinic. During the study period 92 referrals were appointed, of whom 78 attended. This study found that the introduction of this triage clinic reduced the nonattendance rates by one third to 15% and 21% of children assessed were discharged after their triage appointment. Of the 143 questionnaires returned by practitioners within the CAMHS team, 90% were satisfied with the new way of working. There was a 30% response rate from children indicating their satisfaction, but of course the respondents may have been the families who were satisfied rather than those who were not. There is no indication whether these were families accepted by CAMHS and offered follow-up appointments or whether they were discharged. The GP survey was less encouraging as although 34% of GPs surveyed responded, only half were satisfied with the new triage service.

For our study purposes, this model of triage clinic appeared too time consuming and resource intensive to be adopted by the research team and as there was no shortened assessment used, it did not offer a model for adoption. We thought the method of evaluating from multiple perspectives was useful and noted that the authors recommended using qualitative methods to elicit these views in future studies.

York and Kingsbury (2005) developed their 'seven helpful habits' framework to improve CAMHS services. They report that they were influenced by their own clinical experience as CAMHS consultant psychiatrists in outpatient services and by the Ten High Impact Changes for Service Improvement and Delivery (NHS Modernisation Agency 2004) which they applied specifically for CAMHS into their seven helpful hints. The ideas within the helpful hints focus on handling demand, extending capacity of services, letting go of families when they no longer need a service, process mapping the patient journey, flow management techniques, using care bundles and looking after staff. Each habit is meant to offer a range of ideas for local implementation with the underpinning philosophy of CAMHS teams developing a sense of curiosity about their practice and openness to change. One of the practical applications of these seven helpful hints that York and Kingsbury advocate is the use of opt-in appointments where referred families book appointment times to suit themselves. York and Kingsbury found that this increased the likelihood of families attending. York and Kingsbury used this model for two years in Richmond, UK. The waiting list for first appointment for CAMHS has been reduced from eight months to six weeks or sooner as a result.

Parker and Froese (1992) report on a series of changes in their practice adopted to reduce what they refer to as their chronic waiting list problem. They did not describe their research study in detail, apart from stating it was a review of records, and that the initiative was driven by management aims. Parker and Froese routinely collected data related to attendance at the child and adolescent outpatient clinic. They used this

to estimate the waiting list and predict the likely trend of the waiting list which they found to be on an increasing trajectory, as well as determining the rate of non-attendance for first appointments, which they found to be high, at 27%, and an inefficient use of their resources. The service employed two additional clinical staff with the intention of reducing the waiting list, but this had no impact. They report that as a strategy this was ineffective and so they concentrated on an intervention to address the non-attendance for first appointments and thus address the inefficiency aspect of these clinics. The underlying hypothesis was that by engaging parents in advance of the first appointment, they would be more motivated to attend and thus non-attendance rates for first appointments would reduce. A controlled study was undertaken whereby a brief questionnaire was sent to parents of referred children in advance of their first appointment for alternate referrals. The control was a letter sent to parents advising them there would be a wait until their first appointment. All families were telephoned within two weeks of their appointment to remind them of the appointment details. The overall non-attendance rate for first appointment in this study was 35.8% (138/385 patients). The findings of this study revealed that parents returning the completed questionnaire were more likely to attend for the initial appointment but not exclusively. This led the authors to reach the following conclusions from the study. An increase in the number of psychiatrists had no effect on the waiting list. The return of a brief questionnaire sent in advance of the first appointment did correlate with attendance at the first appointment but the authors argue that this was merely an indicator of level of motivation of the family and in fact

those families who were in greatest need may have been those who did not return the questionnaires.

It was useful to read about the impact that sending a questionnaire in advance of a clinic had on attendance, but our practitioner participants acknowledged that there were limitations to this as a strategy. The lack of impact on the waiting list of introducing additional members of staff to the clinical team suggested that a fundamental operational change was required to address excessive demand upon the CAMHS service rather than simply increasing resources. The carefully monitored non-attendance rate for the initial assessment was a useful benchmark for the study site against which to measure its own performance.

Woodhouse (2005) described how they addressed the waiting list within a CAMHS psychology service and then audited it. The intervention was very much context determined as this service was in the Highlands, Scotland where, because of the geography, travelling to visit children can take significant time. It was therefore important for this service to become more efficient in their use of time by developing a system that helped them prioritise which children to see. This service used opt-in alongside a new method of prioritizing referred children to offer initial appointments. Opt-in is a system of inviting referred patients to select a time and date of appointment that suits them rather than one be arbitrarily given. The team of three clinical psychologists examined available research evidence to determine what clinical presentations respond better with specific psychological interventions. From

this they created the Highland Prioritisation Criteria which specified that the child had a clear specific focus to their problem, that this was an acute rather than chronic presentation, that the child lived within a stable family and that the family was motivated to engage with the service. This service had no emergency component and so could exclude self-harming behaviour from their assessment of the child's priority. Further to the introduction of these two strategies, the non-attendance rate reduced from 39.1% to 13.2% - which was attributed to the introduction of the opt-in system. The average wait for an initial appointment was reduced from approximately 45 weeks to an average of 13 weeks, which was attributed to the Highland Prioritisation Criteria.

There was a clear rationale for the development of these criteria in this geographical and professional context (psychology service), but this was not transferable to a generic CAMHS outpatient clinic which had to consider the needs of all children, particular those with complex needs and those at risk of harming themselves.

### **Brief Assessment Tools, Screening Protocols or Triage Assessments for Mental Health**

In searching the literature a range of search terms were used in an attempt to include all available models of a shortened assessment. However, different practitioners and authors used the same terms to refer to a range of different concepts. So, for example 'triage', was deployed to represent a number of ideas. Conceptually similar practices were called different terms, such as screening and brief assessment, with

nomenclature used interchangeably. It was therefore important to search all terms, read the literature and then distinguish between the approaches adopted without using the title alone to select or de-select relevant literature.

In the interests of clarity, I have distinguished between brief psychological assessment and brief psychological testing. Brief psychological assessment is a comprehensive assessment that may include a clinical interview, an observation and the use of appropriate psychometric measures (the use of which discussed later in this chapter). A brief psychological test is a systematically scored validated measure. So a psychological assessment is a broader activity than a brief psychological test. My interpretation of therapeutic screening is an approach to determine the presence of a presentation within a population, and my working definition of [psychological] triage for the purpose of this study is the assessment and prioritisation of [psychological] need of individuals.

Whitworth and Ball (2004) describe the impact of the introduction of primary mental health workers (PMHWs) on the referral and attendance rates for their outpatient CAMHS service. PMHWs had been advocated as a useful addition to CAMHS services in the Health Advisory Service report (1995) to improve the link between primary care and CAMHS services and to improve the quality of CAMHS care provided within tier one (primary care). According to Whitworth and Ball, the specific role of PMHWs was to ‘develop the capacity and capability of staff in tier one’ by providing training, consultation about cases in primary care about whom

practitioners were concerned, joint working and assessment of cases referred by tier one. The impact on the introduction of this role was evaluated by Whitworth and Ball by reviewing the case notes of 100 referrals to CAMHS pre and post introduction of PMHWs. They found that non-attendance rates had fallen after introduction of PMHWs from 45% to 9% and that those referred to CAMHS post introduction of PMHWs better met the criteria for the service with an increased proportion of appropriate specialist CAMHS referrals from 36% to 75% using criteria described by Abrahams and Udwin (2002). From this data and considering the guidance provided by Gale et al (2005) who make explicit the need for PMHWs to ‘demonstrate ... triage skills, to assess and screen referrals’ as part of their core function, it would appear that the assessment provided by the PMHWs appeared to have provided a fit for purpose screening function that helped to determine the suitability of referred children to that CAMH service.

This paper encouraged us to consider that a screening process could help ensure referrals who did not meet criteria for CAMHS were directed to alternative, more suitable services. It also encouraged consideration of how we might include referrers in the development of the triage clinic and its evaluation.

Dryfoos (1994) was involved in the development and evaluation of an initiative in New York, USA to provide a health provision into four Washington junior high schools (age range 12-15 years) in an area of low socio-economic status. Initially, the project was set up in to provide a comprehensive health service providing medical,

mental health and social services at the school based clinics. To promote consistency and confidence when first doing this clinic, a policy and procedures manual was devised to assist the clinical staff. All new students had a health screen and there was a drop-in clinic available. This service became used so extensively that a triage system had to be introduced to manage the demand. Dryfoos reported in her paper the evaluation of the introduction of the triage aspect of this service. The methods used in this study were a review of the records, participant observation and interviews with practitioners. The evaluation revealed that there were a small number of young people in the school with either severe mental health problems or complex health and social needs. This led to the recommendation of a specific psycho-social triage to identify this small group of very needy young people but unfortunately the detail of this tool was not reported in the paper.

There were two issues raised in this paper that were useful for the development of our triage clinic. This study highlighted the value of using set procedures to guide the triage assessment and thus promote consistency when the clinic was in its developmental stage. This paper also supported the idea that a distinct psycho-social triage assessment tool was required to identify those young people with either severe or complex mental health needs.

Cawthorpe (2001) found that the use of a computerised package assessing the presence of depression (the Computer-based Diagnostic Inventory Schedule for Children – Revised) in a clinical sample of adolescents was more effective than

clinician diagnosis, suggesting clinicians over-diagnose. A two hour long computer-based assessment package was administered to a sample of 122 young people who were in-patients in a Canadian mental health hospital. The sample group had already been diagnosed with depression or sub-diagnostic depression, known as dysthymia. A comparison group had a range of other diagnoses. For 76% of the sample, there was agreement between a clinician diagnosis and the diagnosis identified by the computerised package. This suggested using this package was an effective assessment tool for depression in young people.

When we were reviewing this paper for our study, we considered that the use of a computerised diagnostic screening package could be efficient, but the computerised package reported in this study had used diagnostic criteria that had been revised and thus was out of date. We could not locate a similar package with an updated diagnostic criteria base. This tool had a specific diagnostic focus, and required two hours for its implementation; both factors did not meet our needs for addressing the development of a brief assessment tool that could identify features from a wide range of clinical presentations.

Maguire and Guishard-Pine (2005) were interested in looking at the referral meeting of a CAMHS outpatient service. This referral meeting discussed all referred cases and determined in which order they should be seen, based on the outcomes of the team discussion. Maguire and Guishard-Pine then conducted an evaluation of this referral system over a six month period by comparing the determination of the priority of a

particular child from the parents' perspective with that of the CAMHS practitioners. The results showed that there was no concurrence between the two perspectives. They concluded that the existing system of referral meetings were ineffective and needed reform. Following this, they advocated using an initial assessment or triage system to improve the accuracy of determining the urgency of need of a referred child. Maguire and Guishard-Pine recommended that parents should complete an appropriate psychometric measure.

In order to access Australian mental health services, patients are assessed via a triage system. The standardised information available from the Victorian Government, Department of Human Services ([www.healthvic.gov.au/mentalhealth/pmc/triage](http://www.healthvic.gov.au/mentalhealth/pmc/triage) accessed 3/3/06) clearly states the function of mental health triage is to 'conduct a preliminary assessment of whether a person is likely to have a mental illness or disorder, and the nature and urgency of the response required' indicating the triage process is twofold; detection and prioritisation. This helped in our formulation of the function of our initial assessment, to determine the presence of any mental health problem alongside making a judgment about the urgency to treat the referred child. However the context of mental health triage in Australia was very different to the context in which we were planning to introduce a brief assessment. In Australia, this was the main access point for people across the lifespan for mental health services, some of whom were trying to access the services at a point of psychological crisis. There was no dedicated child focused assessment. In the CAMHS service, we were

developing a non-urgent method of determining priority that was specifically child focused.

The professional literature did offer descriptions of the use of mental health triage in trauma situations (Kennedy, Aghababian, Gans and Lewis, 1996) and Accident and Emergency Departments (Smart, Pollard and Walpole, 1999), where an immediate assessment of life limiting conditions was required. In these situations, there was more than one stage in the determination of the patient's needs. The patient would go through a series of decision-making processes with different professionals, often using triage scoring systems, bringing together a number of criteria to determine the patient's priority at triage. The focus of such processes was on the assessment and management of risk rather than determining the patient's longer term need (Engleman, Jobes, Berman and Langbein, 1998). It was also to ensure that where there was a limited resource, those people with the best chance of responding to intervention for an immediate health need were given the effective and timely intervention.

Brief psychological assessments are found to be effective in the assessment and prioritisation of need in trauma situations in adults (National Institute for Clinical Excellence, 2005) and as screening tools for court and prison (Birmingham, Mason, Grubin, 1997). The overall function of brief psychological assessment is to effectively determine how urgent need is, what the most important needs are and to offer an indication of how quickly an intervention is required. In trauma situations,

the time frame for highlighted needs could be seconds, minutes or hours whereas the timeframe for needs being identified from children on a waiting list for CAMHS were likely to be days, weeks and months. The question that faced us was therefore what length of time is reasonable for a child with a specific clinical need to wait. As with all prioritising exercises, treatment options need to be in place to assist in the clinicians' decision-making possibilities even though Brown, Parker and Godding (2002) postulate that the process of screening itself offers a brief intervention where symptom relief is addressed.

There were two specific brief psychological assessments for CAMHS found in the research literature. The first of these was the brief child assessment for GPs (Luk, Mildred and Fisher 2000).

The brief child mental health assessment for GPs was described as a brief assessment (Luk, Mildred and Fisher 2000) that should take between 10-15 minutes to conduct and which helps GPs offer a preliminary diagnosis to a family. It had been developed with the underpinning philosophy that parents should feel listened to, understood, respected and involved. The cornerstone of this assessment was the use of a mnemonic for remembering the significant questions to ask at consultation. The mnemonic PLOTS & SPACES represented questions focused on the following areas: PLOTS - Pattern (of problem), how Long had the problem persisted, presence of Other associated problems, the existence of any Traumatic experience, what Stresses was the child experiencing. SPACES represented assessment of how School was for

the child, any Physiological issues, any issues related to Attention span, any Conduct problems, what the Emotional state of the child was and how the child functioned Socially. As this was designed for GPs to prompt their assessment and the standard appointment time per patient for GP in this paper was identified as fifteen minutes, this was categorized as a brief assessment. The use of this schedule was under evaluation at the time of the development of this study, but given the breadth of information being sought it would be a challenge to keep within a fifteen minute timeframe. The difficulty for GPs in the UK is that they allocate ten minutes for a routine appointment and so unless they had forewarning that the appointment was for a child with a mental health concern, they would feel compromised from a time perspective. The breadth of questions suggested using the PLOTS and SPACES framework seem ambitious to cover all these aspects in such a short period, particularly as the stated underpinning philosophy was to ensure patients and families felt heard: it is reasonable to assume families would feel hurried in such an interview. The mnemonic did however offer a template for organising the focus of a GP interview, guiding the direction of questioning and thinking about the child's difficulties.

It was the idea of using a designated framework to structure a time limited clinical consultation that we considered would be useful in our study.

The second brief assessment tool found in the research literature was a research measure designed in Canada to conduct a large survey. A tool specifically designed

for determining the priority of referred CAMHS cases in Canada was tested with a sample of 817 cases (Smith and Hadorn, 2002). This was part of a large study known as the Western Canada Waiting List Project that spanned three Canadian states. The child mental health panel developed and tested a set of criteria for determining the level of priority for a child to access CAMHS. These criteria included detail about the severity of the illness, family and social factors and the likely outcome from intervention. The tool was piloted with six hypothetical cases to ensure its validity. It was found to have good inter-rater agreement as well as good test-retest reliability and therefore a sound clinical tool. It relied upon information from a referrer in primary care to undertake an assessment of the urgency of a child's needs. On completion of the study, the research team advocated the use of this instrument in primary care to advise whether or not the identified child should be referred to CAMHS and met the criteria for the CAMH service. The score from this assessment tool would then also determine where on the CAMHS waiting list the child would be placed depending on the severity of their condition. The helpfulness and consistency that was created by using a validated tool was useful to us, but this one was too diagnostically oriented for our service, we were looking for a tool or framework that noted a child's degree of impairment in functioning rather than whether they met diagnostic criteria for a specific disorder.

The Canadian screening tool relied upon accurate information from the referrer from which to base an assessment of the urgency of a child's needs and as Potter et al (2005) found in their postal survey, there was no correlation between suitability of the

child for CAMHS determined from information generated at initial assessment by a CAMHS practitioner and in the information provided by this sample of referrers.

Emergency departments in UK, USA and Australasia work on the premise of making a judgement about the urgency required for the presenting patient in relation to the other patients present. These judgements have predominantly focused upon the physical health of patients but have developed to include mental health as a component in response to increasing patterns of demand and unmet mental health need (Horowitz et al, 2001, Ayliffe et al, 2005). A triage assessment matrix has been piloted in London for use by liaison psychiatry in Accident and Emergency (Hart, Colley and Harrison, 2005). This practice based paper reported the use of a service designed matrix that was being used in an Accident and Emergency unit to determine whether people, both children and adults, presenting with mental health problems were low, medium or high risk. The focus of this was to determine what were the immediate needs and risks that the patient posed rather than an assessment of their longer term needs. This assessment needed to be brief and easy to administer to detect those children at immediate risk of self-harming behaviour, but apart from this specific area of mental health, did not assess any other mental health needs.

We found the integration of risk assessment with a more general health assessment to be an important aspect of this protocol, and this focussed our thinking on how to include risk assessment within our developing triage assessment.

In the USA, the Crisis Triage Rating Scale (CTRS) was developed to screen psychiatric emergencies presenting in an emergency department (Bengelsdorf, Levy, Emerson and Barile, 1984). Assessments were carried out within five to fifteen minutes by asking questions relating to presenting risk to self and others, the existence of patient's support system and their ability to co-operate with care services. A pre-determined cut-off score on the scale determined whether a patient was admitted to in-patient services. Clearly this was a model to determine requirement for admission when patients presented in a crisis situation which was different to our context but the aspects of determining the ability or readiness of the patient to engage with the care service we thought were important factors to build into an assessment protocol.

Turner and Turner (1991) carried out a retrospective case note review of the use of the CTRS tool with a sample of 500 cases. They found the CTRS had a robust predictive validity and could be effectively used as a tool to assist in the determination of whether a patient presenting with mental health needs required admission. Although the sample contained people aged 14 and over, the scale was designed specifically for crisis assessments rather than non-emergency assessment and the identification of who needed to be considered a priority. It also had a bias towards adult patients. It was therefore a helpful tool in determining whether someone needed to be admitted to hospital but would not have been useful in helping to determine the priority of less urgent presentations. As its focus was adult

predominantly, there were limitations in its direct applicability for the purposes of this study.

Smart, Pollard and Walpole (1999) developed a triage scale to determine the severity of mental health issues for patients presenting at an Australian Accident and Emergency department that could be incorporated into the existing validated [Australian] National Triage Scale. The aim for the development of this additional component was to reduce the time that mental health patients waited to be assessed by the triage nurses in the accident and emergency department. The purpose was to ensure patients across the age range presenting with mental health problems were allocated priority according to their mental health needs thus improving the functioning of the department. The criteria used to determine priority focused on risk behaviours such as violence and self-injury and the presence of psychosis. High risk patients were seen within one hour. People with ascribed semi-urgent and long term mental health issues were seen within four hours. In order to evaluate its impact, data was collected two years after the introduction of this scale. The data collected looked at the length of time a patient waited in the accident and emergency department, the number of patients who did not wait to be seen at accident at emergency department (effectively non-attendance after initial registration in the department) and the staff satisfaction with the new process. Analysis of the data revealed that waiting times within the department were significantly reduced with the introduction of the new scale, the number of patients who failed to wait to be seen was reduced and of the nurses who responded to a satisfaction questionnaire (17/31), 15 reported they found

it useful. This triage tool was found to be useful in that context, to assess the emergency presentations of both adults and children presenting at accident and emergency departments.

The mental health triage tool itself was not directly applicable to our developing study but what was useful from this paper was the attention they paid to providing adequate and specific preparation for nurses expected to conduct time constrained assessments.

The idea of a triage interview was one of the options suggested by Salmon (2003) in her unpublished discussion paper on waiting lists and workload in one NHS Trust CAMH service in Wales. In her brief review of the literature, she concluded that triage systems are preferred by patients to the ‘traditional process of waiting both for assessment and therapy’. However, she offered no definition or description of psychological triage and as this review of the literature has shown, there was not a suitable triage type assessment accessible. Salmon’s review advocated this method as a general principle for the development of a suitable model of triage for demand management in CAMHS.

### **The Use of Psychometric Measures in CAMHS**

The Strengths & Difficulties Questionnaire (SDQ) ([www.sdinfo.com](http://www.sdinfo.com)) has been validated as a useful and brief screening measure for psychopathology in children (Goodman, 2001, Warnick, Bracken and Kasl, 2007). It is a one page questionnaire

designed to assess the psychological adjustment of children up to sixteen years old. There are versions for teachers and parents which can also be completed and used to triangulate with the child's own scores. It is available online, free and has been translated in more than 40 languages. Goodman (2001) undertook a nationwide epidemiological study of over 10, 000 children between the ages of five and fifteen. It was found that the SDQ was effective at screening for conduct or hyperactivity disorders, depression, pervasive development disorders and some anxiety disorders but poor for a small group of anxiety disorders namely specific phobias and panic disorder, and for eating disorders and seasonal affective disorder. SDQs work best when all sources of data are used; that is from parents, teachers and children who are within the correct age range to complete self-rating scales. Parents and teachers reports are equally predictive.

Given its wide ranging availability, reliability and validity and ease of use, we decided this would be a useful addition to a triage clinical interview that was being developed.

### **Aspects of the Literature that Influenced the Development of the Intervention**

There was no clear model of intervention that could be directly applied to the research site to address the waiting list problem, but there were ideas in the literature reviewed that informed the development of the intervention. While reviewing the literature, the idea of a brief assessment or triage process resonated with the team's ideas of what might work within this context. The term 'triage' however was used to

describe a range of meanings in the literature and did not also relate to a shortened assessment.

Brief assessment in psychological health was limited in the literature to trauma related situations (in the USA) and in relation to accessing adult mental health services in Australia where triage is the routine process for accessing services. Across the UK, references were made to 'triage', but on exploration, these did not prove to be shortened assessments; the term was used to convey signposting or assessment rather than within a time constraint. The brief assessments found in the literature related to emergency or crisis situations and were highly risk focussed with aims for the immediate term, and whether to hospitalise (Horowitz et al, 2001, Ayliffe et al, 2005). There was a schedule to guide GP assessments which had useful elements within it but appeared to contain too much information to function effectively as a brief assessment in the UK context and had not been evaluated (Luk et al, 2000).

The use of the SDQ psychometric measure was of particular interest to us, however. It had been subject to a large scale study and found to be valid, reliable, easily accessible and economical (Goodman, 2001) for identifying mental health needs in children and young people. It was found to be a useful aid to enabling clinical decision making and reviewing processes (Parkin et al, 2003).

The opt-in idea of enabling families to self-select a convenient appointment time for them appeared to improve attendance rates and engage families in a collaborative way so this was incorporated into the development of the intervention.

Parkin et al (2003)'s commented upon the importance of securing dedicated administrative support for their intervention to address their waiting list so this was included in the team's planning.

Due to the lack of an available assessment tool or protocol, a purpose made intervention for the initial assessment of children and young people referred to a CAMHS service was developed. It became known as the 'triage clinic'.

### **The Intervention – the Triage Clinic**

#### **Organisation and Structure of the Triage Clinic**

Most children referred to the CAMH service from primary care for an initial assessment were offered an assessment in the triage clinic. There were some exceptions to this. Children who had engaged in self-harming behaviour and were receiving in-patient care from the local paediatric ward were assessed by a CAMHS professional as part of their discharge procedure from the paediatric ward. Also, children who had moved home into the local area, and previously had a diagnosis were not assessed during triage, but were offered routine follow-up appointments consistent with their previous care.

Those children who were to be seen in the triage clinic were given appointments in order of their referral. The triage clinic ran once a fortnight and all referred children were appointed within one month of referral. The triage clinic ran on two days per month, one full day and one half day. The frequency had been determined through trial and error. The team administrator performed reception duties for this clinic, meeting families and distributing the self-report measures (questionnaires). Between two and five practitioners would be available to see families. Appointments were scheduled 45 minutes apart to give practitioners time to conduct the 20 minute interview, score the questionnaires and write brief notes. It was commonplace for families to be seen by two practitioners particularly when the triage clinic was being established and practitioners were becoming skilled in conducting brief assessments.

Decisions about the child's needs and level of priority were based on a synthesis of the two sources of information: clinical interview and psychometric measures.

The team administrator performed reception duties for this clinic by meeting families and distributing self-report measures (or questionnaires) to families for their completion on arrival at the waiting room.

The practitioner participants developed the schedule for the brief clinical interview based on their experience of what information was pivotal in the understanding of a child's needs and priority. A specific section on risk assessment was included so that this could be highlighted to both the assessing practitioner and to focus later feedback. The triage schedule can be found in appendix three.

At the end of the triage appointment, practitioners had five possible options to take in terms of responding to the family. They could:

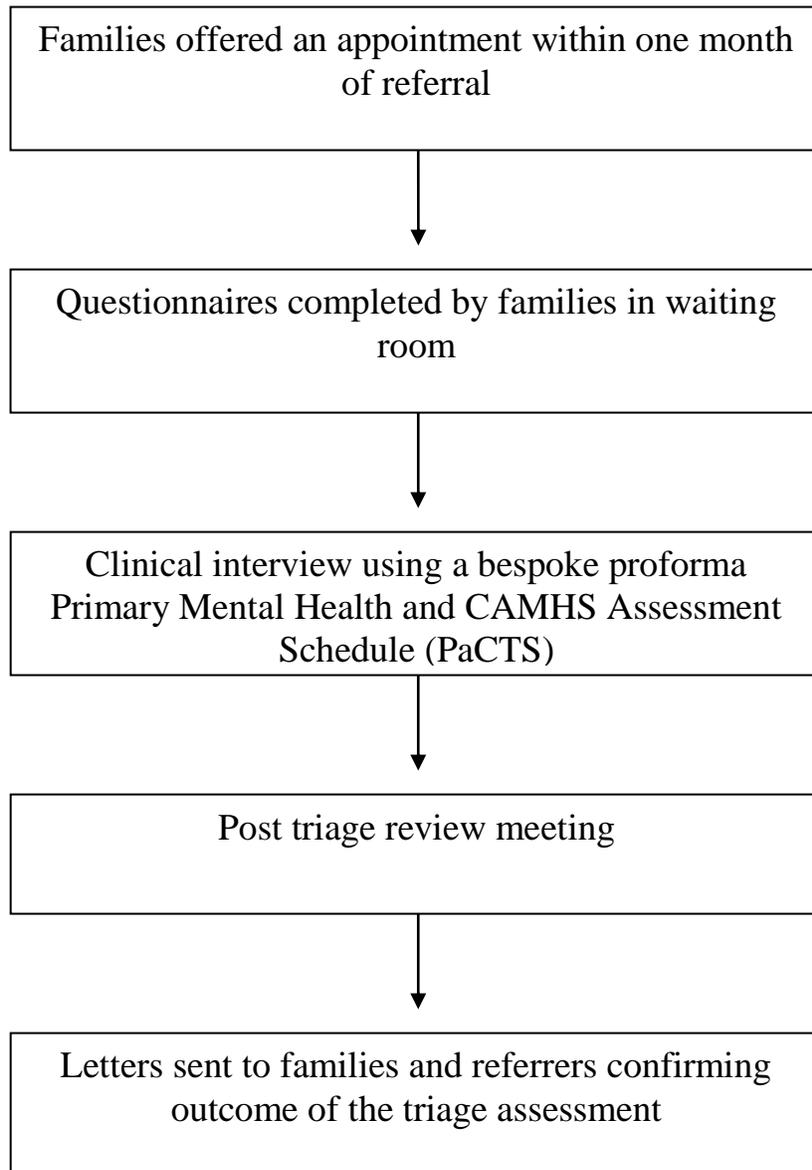
1. accept the child as meeting the criteria for CAMHS and offer an outline of an intervention for them as a routine, non-urgent case,
2. accept that the child needed either an urgent further assessment and/or intervention and appoint accordingly,
3. accept that the child would need a further specific assessment, for example there was an indication that the child had a specific diagnosis, or difficulty that required a particular and detailed assessment,
4. where the CAMHS practitioner was unable to make a decision on the available information, invite the child and their family to return for a further, more in-depth general assessment, or
5. decide that the child's needs did not fall within the CAMHS remit so discharge the family with information about a more appropriate service. For those children discharged at triage, families and referrers were reminded that if symptoms persisted, the child could be re-referred to CAMHS.

At the end of the clinic, all practitioners would meet for the 'post triage discussion' during which all children assessed would be reviewed. An hour was set aside for the post-triage discussion during which all cases seen were presented and discussed. Individual practitioners were given the opportunity to reflect upon the decision they had made about a particular child and for their colleagues to comment upon this.

After this point, letters would be sent to both the families and the referrer to confirm the decision that had been made at triage.

A flowchart of the intervention is offered below (figure three).

Figure three: **The intervention: the triage assessment process**



### **Piloting the Intervention**

The intervention was piloted during April –July 2005 using 114 referred children taken from the waiting list. The function of the pilot was to test out the brief assessment tool to establish whether it assisted practitioners conduct an accurate brief

psychological assessment of children sufficiently to identify the needs and priority of the individual child. The pilot was conducted by self-selecting CAMHS practitioners who had been heavily involved in the development of the intervention.

During the pilot 114 appointments were offered, 95 children were seen, nine did not attend (DNA), and six cancelled. Nineteen children were discharged directly from triage (20%), two were referred to different parts of the wider CAMHS service (one more intense and one less intense intervention) and for only two children was it not possible to make a clear decision about their care needs based on the triage assessment. Therefore, this pilot highlighted that the triage process (containing three component parts: the self-scoring psychometric measures completed in advance, a brief clinical interview using an interview schedule and a post triage team review) was a valid screening or initial assessment process to determine whether children should be seen by CAMHS and, if so, what type of follow-up appointment should be offered. This was determined because a decision was reached about suitability and priority for 98% of referred children within the pilot period.

### **Introducing the Intervention into Routine Practice**

From the pilot period, it was decided that the three component parts of the intervention would be retained because as a complete process, they appeared to function effectively. At the planning stage of the study, it was anticipated that a range of relevant psychometric measures (questionnaires) would be available from which the practitioner could select the couple most appropriate to that individual child.

Throughout the pilot, it became evident that that idea was too complicated and in order to streamline and standardise the triage process, two specific measures were selected because they gave the practitioners an overall measure of the child's areas of need. The Strengths and Difficulties Questionnaire (Goodman et al, 2001) and the Mood and Feelings questionnaire (Angold et al, 1995) offered the best combination of self-rate measures that could be administered in advance of the clinical interview as these gave an indication of both the child's overall functioning and their mood. This whole triage system was named by the CAMHS team as the Primary Mental Health and CAMHS Triage Schedule (PaCTS). As some practitioners were unfamiliar with using the required questionnaires, the SDQ and Mood and Feelings, practitioners practised using them to become familiar with both their application and scoring.

### **Evaluation of the Triage Intervention**

As this was a practice development to address a clinically oriented problem, it was important for there to be an evaluation of the impact of introducing the triage intervention to address the excessive waiting list in the CAMH service. For the evaluation we generated feedback from four perspectives in attempt to understand all of the stakeholder views: semi-structured interviews with children and their families assessed in triage; an examination of waiting list data; survey of referrers to CAMHS; data generated from CAMHS practitioners conducting triage assessments.

### **Interviews Conducted with Families Who Attended the Triage Clinic**

Data was generated through a number of methods. Semi-structured interviews were used to elicit from a sample of families their view on the triage process. Although the first interviews followed the interview schedule (found in appendix four), the interviews with families developed in an iterative way. Feedback from previous family interviews and hypotheses generated through observational data in the field influenced the issues I raised with families. These were tape-recorded and transcribed. They were thematically analysed and fed back into the project.

A fundamental principle of this project was to engage with those people who use the service provided by CAMHS, children and young people and their families. Thus interviewing patients and their families was a critical part of the evaluation of the intervention. The design of the patient interview schedule was created following consultation with a representative from YoungMinds, a mental health advocacy and information charity for children, young people and their families. Alternative methods of generating feedback from children were explored with YoungMinds such as using storyboards and other visual representations. I therefore tried to make available drawing material during the family interviews to help children express themselves through this medium if they wished.

The interview schedule for families I had developed provided an outline for the first two interviews. As issues arose within the triage clinic itself, these became integrated into the interviews I held with families thereafter. Some families would raise issues

that were fed back into the practitioner team which prompted further searching about the said topic. Such issues raised were then included in subsequent family interviews.

All families were sent a flyer advertising the research project, which was a replica of a poster displayed in the CAMHS service waiting room. A full information pack, contact sheet and consent form was sent to those families interested in taking part. In addition, I was available in the waiting room on triage clinic days to discuss the project with any interested families and to meet families to reduce any possible anxieties they might have about taking part in a research project.

Using this combination of strategies a total of eighteen families agreed to be interviewed. I visited a further family but established that the child was not living with the parents. The child was being cared for by the local authority so I excluded this family from the project because of the difficulty of getting consent. Children under the care of the Local Authority would have unique parental responsibility issues. If children are under a Care Order, the parental responsibility is shared between the parent and the Local Authority. Therefore consent would need to be secured from both parties for that child to have been included in the study. This is a clear weakness of the study because Looked After Children have an increased risk of mental health problems (Meltzer, Gatward, Corbin, Goodman and Ford, 2005) and were likely to be a significant percentage of the children seen through the intervention.

Seventeen families were therefore interviewed (see appendix four).

### Conducting Interviews with Families

All families were seen in their own home at their convenience. The length of the interviews ranged from 40 minutes to 1½ hours. Mothers were present at 15 interviews, fathers at two. In one family, the child lived with grandparents and both were present; the child referred to their grandparents as mother and father. With each family I sought the consent of the child or young person whilst I was there in addition to the parent where appropriate and recorded all interviews. The interviews were later transcribed and analysed for emergent themes. All children who took part in the interviews were given a certificate thanking them for their contribution.

There were examples of parents asking specific queries about appointment times and similar detail. I forwarded these messages onto the CAMHS administrative department. There were three children for whom I provided details of relevant web addresses and voluntary organisation contact details because they were asking for further information about their condition. As I previously discussed, one child I interviewed had clear evidence of a diagnosable mental disorder that, with the parent's permission I followed up with a discussion with the CAMHS service who offered a follow-up appointment with the family.

### **Key Issues Raised by Families**

#### Experience of the Waiting List

Of the seventeen families interviewed, sixteen only had experience of the triage clinic and so had not previously been on the CAMHS waiting list, therefore could not

compare with the former system. The range of time that these families reported waiting being seen by referrer and their first CAMHS appointment in the triage clinic was between four and eight weeks and most were pleased with this time interval. One family, however, found this was a distressing length of time and had anticipated being seen by CAMHS much sooner.

Families interviewed expressed the importance they attached on receiving a timely response from mental health services and valued this new approach that CAMHS had taken to first appointments.

But when you've got a child with problems, well they need to be sorted straight away because that issue will affect that child for the rest of their life and you'll always have problems then.

[F13 family interview, mother of 12 year old girl]

### Brief Assessment

The majority of respondents found the practitioner gained sufficient information through the combination of clinical interview and questionnaires to understand the nature of the child's difficulties. One parent queried whether there was sufficient information gained at triage to enable practitioners to make a reasoned decision about the referred child. Those offering comparative perspectives preferred the triage to the previous lengthier detailed assessment.

I had [a questionnaire] to fill in initially while we were waiting to be seen ...the initial referral ... was querying Asperger's syndrome, but during the triage appointment, the therapist picked up on [child's] lowness of mood and she explained that ...depression was assessed as being present and quite significant ...and in fact then, the outcome of that was that the therapist felt that, that the depression actually took priority.

[F8 family interview, mother of teenage girl]

I thought it was fine, I thought it was very good actually from start to finish...the initial appointment was to see whether he was suitable and the kind of service they could offer...It was decided during that interview actually that certain sessions would be offered... followed up with an appointment fairly quickly.

[F12 Family interview, mother of teenage boy]

The two extracts demonstrate that the mothers in these cases found the triage assessments useful in moving forward the care planning for their children. There was no issue about brevity of clinical interview. This possibly was because the families interviewed (apart from one) had no prior knowledge of the extensive clinical interview that was fundamental to the former system of initial assessment. This had been an issue raised at the clinical network seminar so I was mindful of specifically

seeking families' views about this issue. I found myself explaining the former system so that families could differentiate between the two and thus offer their comments.

### Use of Psychometric Measures

One of the three component parts of the triage process was the use of self-report validated measures, familiarly referred to by practitioners and families as questionnaires. The two measures that were used for the intervention were the Strengths and Difficulties Questionnaire (Goodman 2001) which had a parent version and version for child over 11 years. The Mood and Feelings questionnaire (Angold et al, 1995) had a child version only. Families found that being given psychometric measures (or familiarly known as questionnaires) to complete was a useful way to begin the process of assessment. Some families described difficulties completing the questionnaire when in the waiting room as the parent and child did not agree on answers to the questions posed whereas other families noticed an increase in their own sense of curiosity about what each other had written.

When we'd finished them ... we swapped over to have a look and, I mean it didn't matter what [child] had put in because she felt that she was answering this honestly and there was only about two or three questions that she'd put down different to how I had answered them.

[F7 Family interview, mother of middle school age girl]

It was difficult because ...I'm obviously going to disagree with [child] about some of the things,...[child] wanted me to change them and also it had already set up antagonism between us before we even got into the room. So I think it would have been better to have done that privately if they wanted us to.

[F11 family interview, mother of 16 year old boy]

Despite a few families feeling rushed to complete the measures prior to the clinical interview, parents valued the importance of using questionnaires to give the child a voice in the assessment process. Children themselves enjoyed having something to do rather than speaking. Those children who were reticent about talking in clinic did comply and complete the questionnaires. Parents respected their child's ability to disclose their own feelings although as can be seen in the extract above, in some cases this resulted in tension being aired about the differing perspectives of the child's perceived problem.

### **Information from Examining the Routinely Kept Waiting List Data**

The CAMH service routinely collected information and when and by whom a child was referred, when and by whom a child was seen for their first appointment and when they were discharged. This allowed an easy calculation of the length of wait per child between referral and their first CAMHS appointment. The non-attendance rates (DNA) of children given either a first appointment or a follow-up appointment were also collected within this process.

### The Difference in the Waiting List before and after Intervention

Prior to the start of the study: the number of referred cases on the waiting list for this CAMHS service was 176 [data extracted on 1 March 04] of whom 83 had waited less than three months, 68 had waited between three and five months, 14 had waited between six and nine months and 11 had waited between nine and twelve months. In the year before the introduction of the intervention, between the period April 2004 to March 2005, the DNA rate for first appointments was 18.7%.

The triage was piloted between April to July 2005. Data was collected during the period September 2005 and August 2006.

Within the intervention period between September 2005 and July 2006, there were 17 triage clinics, in which 211 families were seen. Within this period, all children were seen in the triage clinic within one month of referral. There was no waiting list at all for initial assessment at the end of this period as it had been eliminated. An analysis of the appointment data held by the NHS trust for a comparable period of April 2005 to March 2006 showed the DNA for first appointments to have reduced to 0.08%, during the time the triage was operating (see table one).

**Table one: Referral statistics from study site**

	April 04 - March05 Pre-intervention	April 05 - March 06 Post-intervention period
<b>New first appointments seen</b>	<b>262</b>	<b>470</b>
<b>New appointments DNA</b>	<b>76 (18.7%)</b>	<b>46 (0.08%)</b>
New appointments cancelled	67 (16.5%)	40 (0.07%)
Total new appointments offered	405	556
Follow up appointments seen	1453	1876
Follow up appointments DNA	257 (13.2%)	242 (10%)
Follow up appointments cancelled	234 (12%)	275 (11.5%)
Total follow up appointments offered	1944	2393
Total appointments offered	2349	2949

The absolute reason for the reduction in the DNA rate at the same time as this new initial assessment clinic was running has not been fully explained by the data generated through this study, but a possible conclusion that might be drawn is that families were offered a timely intervention and thus the family were motivated to engage with the CAMHS service. In addition, whilst families had been waiting for such a long time to be seen, they may have sought help from other agencies for the problem, the problem may have resolved itself or the family may have become disenfranchised with CAMHS.

## **Feedback Generated from Referrers to CAMHS through a Survey**

This was the third element of generating feedback for the intervention. The majority of referrals came from primary care, with GPs being the group who referred most frequently. Therefore it was important to determine whether the introduction of a triage process improved the accessibility at all from the referrers' perspective.

Thinking in a systems framework, the impact of the intervention may have been felt at any point in the wider system so inclusion of referrers in the evaluation attempted to establish the impact on that part of the system.

## **Sampling strategy**

All referrals made during the period 1 September 2005 to 31 December 2005 were examined and a database created of professionals who had referred to CAMHS during this period. The total population of referrers was a difficult group to describe as it was constantly changing. Therefore, in order to create parameters around this body, a timeframe of one year circumscribed the period within which a referral had to be made for that referrer to be included in the study population.

## **Findings from the Referrer Survey**

The referrers identified a number of factors that were of interest to them. They commented upon their satisfaction with the triage intervention, their perception of the benefits of the intervention and there was opportunity for them to suggest how this idea might be further developed. In this section I also comment on the remarkably low response rate from referrers.

### Satisfaction with triage

The respondents were asked to indicate whether they had accessed the triage clinic. At the six month survey all 22 respondents, commented, of whom 11 did not realise the child they had referred had been seen in the triage clinic. This had not changed by the 12 month survey with 10 of the 23 respondents who commented, stating they did not know they had accessed the triage clinic.

Combining the results of the surveys at both time points, the majority of respondents who commented were satisfied with the intervention. Of the total responses to the Likert scale asking respondents to rate whether the intervention was very unsatisfactory, quite unsatisfactory, neutral, quite satisfactory or very satisfactory, only three out of the 22 responses gave an unfavourable opinion. Whether this offers a true representation of referrer opinion is uncertain given the low response rate. An explanation for this might have been that those who chose not to respond did not have any knowledge of the intervention and consequently felt unable to comment.

### Perceived benefits of triage

Most referrers were satisfied with the time between the referrer and the child's first appointment. The time between referral and being seen by CAMHS had been one of the initial driving forces behind the creation of the intervention as this was construed by the CAMHS service as the waiting list. The main advantages cited by the referrers were the speed at which the initial assessment was conducted from point of referral,

in terms of both need and risk, and the process of prioritisation by the specialist service for those children who needed a more immediate intervention.

#### How Referrers Would Like Triage to Develop

The more frequently suggested improvement by the referrers for the intervention was the introduction of a telephone advice line, some suggested on a 24 hour basis that would be available to either professionals or parents. This was a commentary about the whole CAMHS service rather than the specific triage/brief assessment clinic and was not therefore integrated within the on-going development of this initiative but was fed back to the wider organisation.

#### **Feedback Generated from In-depth Interviews with CAMHS Practitioners**

Generating data from the CAMHS practitioners was the fourth part of the evaluation of the intervention. I collected data from practitioners through three methods: participant observation, attendance at team meetings and individual interviews that were held pre and post intervention. The plan had been to interview the CAMHS practitioners at two intervals but because some staff left the service during the intervention, only five CAMHS practitioners were actually interviewed at two points.

#### Impact on the Waiting List

The team administrator was key in identifying the full impact that the intervention had not only on the waiting list itself but upon the wide issue of managing demand for the service. She observed the fundamental organisational difference in managing

new referrals through the triage process both for its value in reducing the existing waiting list and in proactively managing future excessive demand.

Researcher: Would there be any value in doing triage where there was no waiting list?

Practitioner A9: I don't know. There has always been a waiting list here... We would have a waiting list soon enough if we didn't have triage... The therapists couldn't possibly see 21 kids in a week, with their own workload. We had... 14 referrals were being done on that day. That apart they should never have been allowed to build up. They were hanging around. But they'd built up since last Thursday. So you can see Thursday to the Tuesday, 14 referrals in half a week. So you imagine that building up, we would be back to square one.

[A9 Practitioner, Post intervention interview]

Practitioners valued the reduction in the waiting list and here has made the connection between the introduction of the triage clinic and the waiting list process.

### Good Administrative Support

This was a very important aspect of the project that made its development successful as expressed by the practitioners in the CAMHS team. The team administrator performed many critical roles that allowed the practitioners to concentrate solely on their clinical task; she organised appropriate files, rooms, and ensured there were

sufficient practitioners for the families expected. She welcomed families, offered guidance for them to complete questionnaires and generally managed the waiting area. For a new service setting up, without administrative support, one of the practitioners would need to take this role initially until the routine were established.

An idiosyncrasy of this service was that the CAMHS clinic was 20 miles away from the administrative offices that supported the service in the CAMHS Network. It was seen by the Network as quite a deviation from the normal working practices for the administrative support to be in clinical centre for the intervention. All practitioners who were interviewed acknowledged this to be a major asset to the intervention because of the administrator's versatility and willingness to help, acute attention to detail in preparing and organising the files and attending to the needs of the waiting children illustrated in the data extract below.

She's the one who is in control of it all really. She is aware of appointments sent out and who is coming and who is not coming. She physically sets up, in terms of the waiting room and families and questionnaires and who's due next and who is seeing who. She just organises it basically. You notice the difference when [administrator] isn't here, put it that way I think!

[Practitioner A1, post intervention interview]

The data extract shows the breadth and detail of the contribution made by the team administrator to the triage clinic. It is of concern actually that so much is reliant on one person and needs to be considered as a risk of the triage clinic.

The intervention provided an opportunity to try a new way of working for that CAMHS team. During the period of the field work, the administrative support increasingly attended the clinical area for a range of set clinics. There is now permanent administrative support in that clinic that is indirectly related to the development of the intervention.

### **Key Messages from Generating Feedback about the Intervention**

This intervention appeared to eliminate the waiting list for children referred to CAMHS by primary care for an initial assessment. This concurred with the literature looking at gateway assessments to secondary mental health services (Ryan et al, 2007) which found that gateway assessments helped to manage excessive demand upon mental health services at the juncture between primary and secondary care.

What was also unexpected and noticeable was that the DNA rate for first appointments was considerably reduced was from 18.7% to 0.08% after the introduction of the intervention.

Generating feedback about the triage clinic was important to feed into action research as an evaluative cycle. This process included generating data from people who used the service: families seen in triage and professionals who referred to CAMHS and

thus inadvertently used triage. Families seen in the intervention were pleased with the speed of their first appointment and appreciated being offered early advice and an indication of whether they needed to be seen again by CAMHS. At the end of the study period, children referred to CAMHS were assessed within one month of their referral which was a significant reduction in waiting time. Engagement of referrers in this evaluative process was not wholly successful but the comments they did offer suggest that they found the improved time to access CAMHS to be beneficial for children and their families.

CAMHS practitioners became accustomed to the new way of working and valued the structure they had created within the triage process. The schedule for the brief assessment helped to guide their clinical interview and the post triage review meeting was an opportunity for practitioners to revisit clinical decisions made.

### **Chapter Summary**

The context for this study was the organisational change in a CAMHS outpatient clinic. Children referred to the service waited an excessive amount of time for their initial assessment. Action research was used to create an intervention and implement it within the service to address the waiting list. A bespoke triage intervention was developed through action research. The triage clinic consisted of three stages, administration and scoring of two standardised questionnaires, a brief clinical interview conducted by a CAMHS practitioner using an interview proforma followed by an opportunity to review decision making at the end of the clinical day in a post

triage review meeting. As a result of the intervention the waiting time for referred children was reduced from 12 months to them being seen within a maximum of one month from referral. This was viewed by the CAMHS practitioners as a successful intervention that improved the quality and efficiency of their service. Despite only a small number of referrers responding to an invitation to feedback on the new process, their comments were that this model improved the throughput and was welcomed. Families reported that the style of conducting assessments through this triage approach was acceptable to them and despite the clinical interview being brief, families reported that they were able to impart sufficient information during that time to enable an assessment to be completed.

In order to understand the role of the change agent during this successful and sustained change process, a systematic review of the literature was conducted to establish what is already known about this mechanism for this critical role and is found in the next chapter.

## **Chapter Two: Exploring the Role and Function of a Change Agent**

### **Introduction**

Within this chapter, I will be exploring what is already known about the role of a change agent in facilitating organisational change in health settings.

There is significant writing on change management processes across disciplines (management, education and organisational development). This material comprises theoretical perspectives examining the change processes involved, proposing models for understanding how change occurs effectively in organisations, includes empirical studies examining aspects of the change processes and draws on a range of organisational contexts. In this thesis, I am interested in examining one aspect of the change process and that is how the facilitator of change initiates, leads or influences the change process. Although there is commonality across disciplines and thus potential for transferability of theoretical understandings, the focus of this review will be in the context of the health settings.

### **Review Protocol**

#### **Aim**

The aim of this review of the literature was to investigate what is already known about the role and function of a change agent during a process of organisational change. The literature to be examined therefore was located in both research literature and theoretical, professional or discussion literature contained in journal articles, reports and textbooks. The challenge with this review was to capture as wide a scope

as possible to ensure no significant bodies of knowledge were overlooked but retrieve a manageable volume of material to examine.

The principles of conducting a systematic review advocated by the Centre for Reviews and Dissemination, University of York (2008) informed the development of this search, but what was required was a scoping of the available literature rather than a systematic review of research evidence. This review of the literature was therefore a systematic scoping of research and professional literature to inform the study.

### **Review Question**

How do change agents initiate and sustain organisational change within health?

There are many different definitions of change agents, that have been developed from Lewin's original work on change processes (1952) but for the purposes of this study, I am using the description of a change agent offered by Rogers (2003) as an 'individual who influences clients' innovation-decisions...and who seeks to obtain the adoption of new ideas and who is heterophilous (external) from their client' (p27-8).

### **Inclusion and Exclusion Criteria**

The inclusion criteria were published papers (research, opinion and discussion) with an explicit focus on the change agent in organisations. Initially the search was limited to publications from 1990 onward and that had been written in the English language.

Further to the discovery of a significant review paper from 2002 by Harvey et al, the limits to the search were altered to identify papers published between 1 January 2002 and 12 December 2012. Material was included if it contained an explicit focus on change agent role or methods of facilitation of change. Exclusions included descriptions of general barriers and facilitators to change, mechanical, biochemical or structural change agents (as found in physical science literature).

## **Search Strategy**

### Scoping to Determine Search Terms

The Cardiff University 'Library Search' function was used to conduct an initial scoping to determine the terminology used in the literature to explore the above question. The Library Search function enables a search of books and journals (both electronic and print versions) provided by Cardiff University and NHS Wales libraries and ORCA (Online Research @ Cardiff). The search focused on published papers. An initial scope of the textbooks in the fields identified a high volume of text that would have been unmanageable to include in this review. Therefore it was anticipated that key theorists in the field would feature in the papers, and references to their work sought via backchaining. Through the initial scoping process the following search terms were identified: change agent, change anxiety, leadership, change management, organisational change, action researcher, action researcher role, and facilitator.

After identification of key search terms to be used, a search was conducted using the following databases: ASSIA, CINAHL, British Nursing Index, EMBASE (containing

PsychInfo and Medline) and Scopus, using the following terms creating three strands of hits as follows:

Strand one: change agent\$ OR facilitator\$ OR leader\$,

Strand two: health OR healthcare OR health service

Strand three: behaviour change\$ OR organisational change.

A second search was conducted using the term ‘action research\$’ as strand one from the above in conjunction with strands two and three.

In their review on practice development, McCormack et al (2007) found that to search using ‘practice’ and ‘development’ as key words resulted in a large number of papers which had to be scrutinized and a large number rejected. This was because the databases searched used the words practice and development separately and together resulting in such a high volume of hits. A similar situation arose as I used the terms ‘change process’ hence, I restricted the search to the use of ‘agent’ and used the combining functions of the Boolean operator AND to limit the results to health specifically. A summary of the search is found overleaf (table two).

Table two: Review of the literature on change agents

<b>Database</b>	<b>Search terms</b>	<b>Hits</b>	<b>Limits: English language, 2002-2012</b>	<b>Papers selected through sifting abstracts to check relevance to search question</b>
EMBASE (containing Medline & PsychInfo)	Change agent\$ OR facilitator\$ OR leader\$	100,647		
	Health OR healthcare OR health service	5,232,159		
	Behaviour change\$ OR organisational change	5551		
	Change agent\$ OR facilitator\$ OR leader\$ AND Health OR healthcare OR health service AND Behaviour change\$ OR organisational change	148	126	2
EMBASE Second search	Action research\$	401		
	Action research\$ AND Health OR healthcare OR health service AND Behaviour change\$ OR organisational change	2		0
CINAHL	Change agent\$ OR facilitator\$ OR leader\$	15,300		
	Health OR healthcare OR health service	899,468		
	Behaviour change\$ OR organisational change	8,193		
	(Change agent\$ OR facilitator\$ OR	90	74	6

	leader\$) AND (Health OR healthcare OR health service) AND (Behaviour change\$ OR organisational change)			
CINAHL second search	Action research\$	4060		
	Action research\$ AND Health OR healthcare OR health service AND Behaviour change\$ OR organisational change	11		1
British Nursing Index	Change agent\$ OR facilitator\$ OR leader\$	2,175		
	Health OR healthcare OR health service	92,832		
	Behaviour change\$ OR organisational change	5,372		
	Change agent\$ OR facilitator\$ OR leader\$ AND Health OR healthcare OR health service AND Behaviour change\$ OR organisational change	46	46	7
British Nursing Index second search	Action research\$	1195		
	Action research\$ AND Health OR healthcare OR health service AND Behaviour change\$ OR organisational change	33	28	6
Scopus	Change agent\$ OR	417,283		

	facilitator\$ OR leader\$			
	Health OR healthcare OR health service	2,819,400		
	Behaviour change\$ OR organisational change	411,605		
	Change agent\$ OR facilitator\$ OR leader\$ AND Health OR healthcare OR health service AND Behaviour change\$ OR organisational change	7,267	6788* - 215	11
Scopus second search	Action research\$	102995		
	Action research\$ AND Health OR healthcare OR health service AND Behaviour change\$ OR organisational change	605	348*- 188	
ASSIA	Change agent\$ OR facilitator\$ OR leader\$	10,303		
	Health OR healthcare OR health service	177,349		
	Behaviour change\$ OR organisational change	76,729		
	Change agent\$ OR facilitator\$ OR leader\$ AND Health OR healthcare OR health service AND Behaviour change\$ OR organisational change	670	608	11
ASSIA Second search	Action research\$	6845		

	Action research\$ AND Health OR healthcare OR health service AND Behaviour change\$ OR organisational change	616	553	27
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\* A further limit was used for this database to identify ‘health professional’, ‘nursing’ or ‘social science’ papers and excluding accounting, engineering and biological science because the hit rate was so high.

### **Funnelling of Results**

A large number of papers were identified (n = 9,862,761) from the each of the broad keyword terms. The search terms were then combined (n = 1680) and after data and language limits were applied 1069 potential papers were identified for sifting through examination of the abstract. The inclusion criteria for the abstract sifting process were that the papers *discussed features of leadership* through organisational change. From this process, a final set of 37 papers were selected for review. It is noted that there were no randomized controlled trials identified that had investigated the impact of change agent during organisational change in healthcare. Further papers were identified from backchaining and searching specific journals as detailed above.

Backchaining of references was used as a strategy to identify sources from retrieved articles where potential relevant papers were cited. Handsearching of specific journals, the Journal of Change Management, Educational Action Research and Implementation Science reduced the likelihood of relevant papers being overlooked. Handsearching of key authors in the field, such as McCormack, was also conducted to identify their previous work or collaborations.

### **Quality of the Material Selected**

The material was drawn from a range of types of literature, from research reporting on empirical findings, discussion papers, theoretical papers and case studies.

Research protocols and debates were excluded. The literature on organisational change crosses a number of disciplines, with different traditions of knowledge dissemination. An appraisal of the quality of individual papers was not undertaken as the focus of the review of the literature was on the concept of change agent (and other terms cited earlier) and how it was used. Thirty seven papers were identified for appraisal through the database search. These were reviewed to determine their suitability and relevance to the aim of the review, so whether they discussed the detail of the role and/or function of a change agent in healthcare.

### **Limitations of Literature Review**

In selecting key word terms for this review, I failed to accommodate American spelling particularly of organisation and behaviour. Their inclusion may have increased the number of hits in the initial search before funnelling. The scope of the search was so wide that decisions had to be made to restrict the results to manageable volume, so this process necessarily will have eliminated some relevant text, particularly if they were solo papers, not part of a series of papers or reporting findings sequentially over time. The focus of this review was on health, but there may possibly be interesting work in the fields of social science such as education, organisational development, criminology and similar.

## **Findings of the Literature Review: The Role, Functions and Skills of the Leader of Organisational Change**

I found the following three key papers had key relevance in the discussion of the role of ‘facilitation’ in the NHS. McCormack et al (2007a, b, c, d) in their realist evaluation of practice development looked at the role of facilitation within that. Dogherty et al’s (2010, 2012) work particularly relates to the uptake and application of research evidence into nursing practice, but the principles of facilitation are discussed in detail in this paper. Harvey et al (2002) conducted a useful review of literature related to facilitation in the NHS. As they had conducted a systematic review of the literature to that point, I decided to use the date for that paper as a date limit for my review.

### **Levels of Influence**

In order to articulate my thinking around aspects of change agency, I have considered the literature within three conceptual levels of influence: macro, meso and micro levels described below.

The first section is a summary of key approaches from a ‘grand theory’ perspective and offered by way of an introduction to aspects of leadership approaches through change. I refer to this as a macro level of influencing change. This section brings together overarching approaches to change agency, style of leadership, organisational approach including the overall strategies adopted by change agents in facilitating organisational change.

The next section of literature discussed in this review refers to what I have categorised as the meso level of influence that a change agent has in relation to change. This section generally discusses the roles that change agent adopt during change processes. I consider the meso level of influence to represent the roles that a change agent might take in order to influence organisational change. The finer detail of the mechanism a change agent might use I describe as micro level of influence. This draws particularly on the existing literature of how a change agent operates their role in order to effect organisational change.

### Use of Terminology

In searching the literature it quickly became apparent that there was no agreed nomenclature for the 'person' who holds the position for facilitating a change in an organisation. There is a range of terminology used including change agent, 'master of change...problem owner, facilitator, project manager' (Burnes 2009, p54). It is also apparent that even where the same words are used between sources, the attribution of meaning for the term may be different. So for the purposes of this literature review, I shall use the term 'change agent' throughout to name the person who enables or facilitates change within an organisation. The idea of a 'change agent' originated from Lewin (1946, 1939) following his study on classroom management. Following decades of developing the thinking, he created the notion of a 'planned approach to change management' with its template of the required skills and attributes of a change agent as a clear strength of the approach, (Burnes 2009, p389).

There is however a difficulty with this convention as Harvey et al (2002) suggested subtle differences between facilitator and opinion leader as a result of their concept analysis of available literature on change processes, '[Facilitator] is an appointed role as opposed to that of, for example, an opinion leader who through their own personal reputation and influence acts as a change agent'. Dogherty et al (2012) attempted to differentiate between aspects of this terminology in their mixed methods study of what constitutes facilitation. They found in their review of the literature that 'facilitators use group dynamics and skills to promote change while opinion leaders and other change agents rely on their level of expertise and knowledge' (Thompson et al 2006), whilst others suggest change agent roles and facilitators likely integrate other implementation strategies while facilitating such as providing education and using audit and feedback data (Stetler et al, 2006). McCormack et al (2007a) in their realist synthesis of practice development found although a number of studies had been published clarifying the term facilitation (of research utilisation in nursing), they suggested this topic required a full critical in-depth review of facilitation in relation to practice development.

**Macro Levels of Influence: what approaches to leadership do change agents employ?**

There are three broad areas of leadership approaches that are important to consider in change agency. These are the overall style, the relationship between the leader and their employees, or followers, and the status of the environment for the proposed

change. It was suggested that it is the fit between the organisational readiness and the leadership approach that determines viability for change (Weiner, 2009).

### **Overall approach**

Burnes (2009) offers a review of the development of the literature relating to the roles of manager and leader in an organisation their similarities, differences and the dilemma of conceptualising both (p486-502). Burnes acknowledges Fayol as the first writer who tried to describe the features of a manager in his book *General and Industrial Management* published in 1949. This first attempt portrayed managers as people who systematically plan control and direct the functioning of an organisation but it was much later that Drucker in 1985 acknowledged the added value that a manager gives to an organisation. He drew on systems theory to suggest that a manager is the ingredient that creates a larger whole from the sum of the individual component parts (or employees) within an organisation. Two other key influential writers that have shaped the developing body of knowledge about management theory are Handy (1986) who proposed managers identify, diagnose and intervene where problems arise in an organisation and Mintzberg. Mintzberg reported in his text 'Nature of Managerial Work' (1973) the findings from his observational study of managers. He found that although managers in this study had reported that they would plan, think reflectively and consider carefully before acting, his observations found that their actual work was *reactive* to organisational problems rather than proactive. They continually responded to pressures on the job as they emerged. Their work routine was varied, unpredictably and lacked continuity. Mintzberg's work was

therefore challenging the rhetoric about managerial work, finding that observed behaviour was contradictory to the managers' perception of their own work.

Both Nahavandi (2006) and Yukl (2002) noted that there are differences between managers and leaders. Nahavandi suggested that leaders are future focused, create change and have an emotional link with followers whereas he thought managers are present focus, maintain the status quo and attempt to retain an objective stance or distance from their followers. This might therefore suggest that both roles cannot exist in one person. Hayes (2010) thought that the type of leadership was the key aspect in an effective change process. He differentiated between leadership and management, but unlike Nahavandi, suggested that the manager would intermittently have to take the role as leader, thus holding a flexible position within an organisation.

### **Attributes**

In their comprehensive review of the skills and of facilitators, Dogherty et al 2010 found facilitators to be innovative and resourceful, able to maintain momentum and direction and to allocate roles and delegate responsibilities, and to give support and encouragement, to have an understanding of the practice context (Ellis et al., 2005), to be authentic (Wallin et al., 2005), credible (Stetler et al., 2006) adaptable, committed and experienced. Emotional intelligence was described by Salovey and Mayar (1990) as the social and interpersonal aspects of intelligence. Within their description they include emotionally literate people have a high degree of self-awareness, are able to self-regulate their emotional responses, have a high degree of

self-motivation, feel genuine empathy for others and have good interpersonal and social skills (Goleman 2004). Nahavandi (2006) believes it is this emotional intelligence that differentiates between people with good ideas, inventors, or mavericks and effective leaders who can steer groups of people through periods of change.

### **Relationship between leader and ‘followers’**

Mintzberg (1973) in his study of seven male managers coined the following managerial roles: figurehead, leader, liaison, monitor, disseminator, spokesperson, entrepreneur, disturbance handler, resource allocator, negotiator. They manage a wide variety of tasks, have frequent interruptions and take little time to reflect, whereas he suggested a leader would need to pay attention to the emotional state of their followers, particularly in what he called ‘uncertain and ambiguous situations’ (p122). The reason he suggested for this was that employees take their cues from the emotional responses of their leaders, but this suggests that employees, or followers are not influenced by other persons, such as colleagues or social contacts, nor influenced by their own appraisal of the existing work situation and the influence of the leader is significant.

Brown and McCormack (2011) in their study looking at adoption of evidence based practice in nursing found that although how the change agent worked with the context was an important factor in the change process, the mechanism of this interaction was not fully understood. They did find that nursing practice is affected by numerous

factors within the context of health delivery, including organisational structures and hierarchies, relationships between staff and consequently the change agent is connected and interwoven within all of these variables.

Cummings et al (2008) systematically reviewed the multi-disciplinary literature to look at the factors contributing to nursing leadership. They examined peer reviewed studies but excluded qualitative studies and grey literature with a resultant 24 studies to analyse. They noted that the findings from these studies could be organised into four main themes: traits and characteristics of leaders, the context in which the leaders work, the leaders' engagement with educational activities and the behaviour and practices of individual leaders. As this was a review paper, the detail of the findings from individual studies was limited but Cummings et al noted that 'relationship based competencies' were important behaviours and that there was a connection between leader effectiveness and the amount of contact between the leader and staff, highlighting the influence of 'social emotional' leadership. Their review suggested that the more time a leader is with the staff, the more open they are to be influenced by that leader. In conclusion, Cummings et al suggest that organisational climate predicts leadership behaviour.

### **Organisational readiness for change**

Readiness for change refers to the acceptance of the people within an organisation to implement a change (change commitment) alongside their belief that they are actually able to effect that change (change efficacy) (Weiner, 2009). It is this readiness for

change at multiple levels of individual, group, unit and whole organisation that Weiner found to be a critical point in leveraging the proposed change. In his discussion paper in which he aimed to conceptually define organisational readiness, Weiner draws on social cognitive theory to suggest change efficacy is a function of organisational members' appraisal of their ability to effect the desired change and so confidence for a proposed change is high when change efficacy is high.

Hofstede's Five Cultural Dimensions (cited in Nahavandi, p11) includes the concept 'uncertainty avoidance'. Hofstede defines this as the extent to which the organisational culture is able or prepared to tolerate ambiguity and uncertainty. Hofstede then goes on to suggest that in an organisation where high uncertainty avoidance is present, this leads to low tolerance for uncertainty and thus a low tolerance or openness for change within that organisation. It therefore follows that in order for change to be possible, the culture of tolerating uncertainty or potential for change needs to be addressed in order for change to be achieved. It is not clear whether Hofstede discussed this to be a situational response or a more permanent trait within an organisation but for both interpretations, there is an assumption that an organisation is behaving as is one person, in unity, without acknowledging the potential dissonance that may be present in the organisation.

One of the most cited theorists about change process is Lewin. In his study on classroom management, Lewin (1939) found that a democratic style of leadership more effective than an autocratic approach in managing the behaviour and learning of children. He proposed a model of change (Lewin, 1946) in which he suggested the

importance of using various strategies to 'unfreeze' the existing practices of people within an organisation in order to enable the organisation to embrace the possibility of change. This simplistic approach to change does not consider the concept of self-determinism that individuals themselves can decide whether they would wish to engage in the change processes proposed.

Killbride et al (2005) found in their action research study examining the change processes in a stroke unit considered the coming together as a specific stroke team as a trigger to evoke 'a situation of disequilibria' – the coming together as a new team was a challenging process in itself. Team members had to learn how to interact effectively with one another, drawing on complexity theory with this team as a complex adaptive system. This suggests that defining a team's function as that for instigating change might be a sufficient enough trigger to promote change behaviour for the organisation driven by the identified team.

In summary, the literature looking at the macro level of influence of change agents draws our attention to traits and attributes of change agents, or leaders overall approaches to leadership and the relational aspects of the fit between change agent and the organisation. This relational aspects also includes the change agent's role in getting an organisation ready for change.

## **Meso Levels of Influence: what role does a change agent take to influence change?**

This section considers the roles adopted or bestowed upon change agents and then the skills and attributes within the change agent themselves that have been found to be influential in facilitating change. There are *seven* key research groups that have investigated the roles of change agents, or facilitation in healthcare and they form the cornerstone of this section (Harvey et al, 2002, McCormack et al, 2007, Thompson et al, 2006, Pearson et al, 2007, Dogherty et al, 2010, 2012, Simmons 2004 and Rycroft-Malone et al 2012).

Despite the body of literature about the role of change agents being considerable Harvey et al (2002) found few explicit descriptions or evaluations of the concept of facilitation. Harvey et al (2002) found that there was insufficient clarity about the role and function of a facilitator in general and also in particular in relation to promoting the application of research evidence by nursing into practice. This prompted them to conduct a concept analysis of facilitation by mapping and analysing relevant literature. They reviewed a range of health care literature published between 1985 and 1998. Their findings show that facilitation involves helping others change practice with facilitation ‘ranging from a discrete task-focused activity to a more holistic process of enabling individuals, teams and organisations to change’, (p578) which was then used this as the basis for a continuum of facilitation commenting on role skills and attributes of facilitators.

This prompted further work by McCormack et al (2007) on their realistic evaluation of practice development including the role of facilitator within it. McCormack et al (2007a, b, c, d) produced a series of four papers from their realist synthesis of evidence relating to practice development. Their papers report (a) methods and methodology, (b) analysis of the literature, (c) telephone interviews and synthesis of the data and (d) recommendations. In their concluding paper McCormack et al (2007d) suggested that there is a need for further investigation into the role of practice developer, clarifying the skills, knowledge and expertise needed in order to effectively carry out that activity. This is because they found people holding formal practice development roles experience isolation and role ambiguity. They found that there were only a few examples where organisations had a strategic infrastructure to support them. They found data showing that practice developers felt there was confusion over their role and that they were caught between clinical and managerial roles. McCormack et al (2007d) found 'the expertise required by practice developers to undertake particular roles is largely unknown and unrecognized' (p78) or elusive (Simmons, 2004).

Thompson, Estabrooks and Degner (2006) conducted a literature review to distinguish and clarify the concepts of opinion leaders, facilitators, champions, linking agents and change agents within the health education and management literature. Their rationale for conducting the review was that they had found difficulty in reviewing intervention studies because such terms had been used differently and so

made comparison between studies difficult. In their review they summarised their analysis of the roles from the literature in terms of the contexts and characteristics of each of these roles. They noted that both facilitators and change agents were boundary spanning across disciplines or contexts, and that all but facilitators used social interaction as the mode for working whereas facilitators were more focused on problem-solving and thus task-oriented. Despite discrete differences between each of these five descriptions of roles, Thompson et al found that all were essentially a 'form of change agent' (p691).

Although Pearson et al's (2007) systematic review focused on developing and sustaining nursing leadership to create a healthy work environment, there were aspects of it that were relevant to this review of the literature. They search for qualitative and quantitative studies and discussion papers that addressed feasibility, meaningfulness and effectiveness in developing and sustaining nursing leadership to foster a healthy work environment in healthcare. They reviewed 44 papers and noted that the use of local opinion leaders was inconclusive. Their description of opinion leaders was of people in the organisation who were influential in making change happen, but not in a designated role.

Effective change agents (or facilitators the actual term used) need to be flexible and possess a range of both task-focused and enabling skills, which are employed according to the needs of the context or environment in which they are working.' (Harvey et al 2002). Their method of working Hayes (2010) suggests is by

identifying and breaking cycles or patterns of behaviour that are unhelpful to the organisation. Hayes suggests that change agents often have pre-existing role that give them 'boundary-spanning rites' across aspects of an organisation. They are often aware of the natural communication flow within an organisation and use this to positively affect their sphere of influence by 'align[ing] people, communicat[ing] new direction and creat[ing] useful coalitions' for change to be effected (p160). Hayes does not elaborate on the mechanism any further, however.

Dogherty et al (2010) used a similar approach to Harvey et al' (2002) to examine recent literature for descriptions of the meaning of facilitation, strategies involved, characteristics and skills of facilitators, and effectiveness of facilitation interventions on using research in nursing. Their aim was to describe what facilitation is in order to develop a taxonomy of facilitation interventions. Dogherty et al (2010) found the following five areas of functioning were common to facilitators of change: increasing awareness of a need for change, leadership and project management, relationship-building and communication, importance of the local context and ongoing monitoring and evaluation. In concluding this piece of work they suggested there is a need for a greater understanding in the literature of 'how' facilitation occurs, so the mechanism the facilitator employs to effect a change in practice – in their case increase of research application in practice

Dogherty et al (2012) conducted a mixed methods study using case audit (of notes made during the change process) and focus group interview of facilitators in three

case studies where implementation of new guidelines about practice was being introduced. This study was conducted to gain further understanding of the role of facilitation activities that were occurring within the Canadian Partnership against Cancer in an initiative to improve the uptake of evidence in clinical practice. They found that facilitators engaged in a wide range of activities: increasing awareness, developing a plan, knowledge and data management, recognizing importance of context, administrative support, project management, fostering team building, problem-solving, ensuring group remains on task, providing regular communication via email and phone-calls, consensus building, leading meetings, providing reassurance, networking, maintaining momentum. These tasks were completed by both external and local facilitators and 'to a large extent, facilitators were helping the group develop the capacity to do it for themselves' (p10). An important finding of their study was that they considered facilitation to both be carried out by individuals and by groups as a process. They suggested further research is needed to fully understand *how* facilitation is used to change nursing practice.

In their cluster trial specifically investigating the role of facilitation in using research evidence in neonatal care in Vietnam, Wallin et al (2011) used the PARHIS model of facilitation of research findings (Rycroft-Malone et al 2002) they found this 'bottom-up' approach to change agency was effective alongside what they described as the 'vital role of the local community' to effect the change in practice and improve outcomes for neonates. As a secondary outcome Wallin et al noted the importance of

gender in the effectiveness of change agency, but they provided insufficient detail to understand fully the precise nature of the influence of gender on the process.

*QUERI* is an improvement initiative in the USA to improve health outcomes for veterans whilst studying the process of health improvement strategies used. Stetler et al (2006) report on an evaluation of the nature of facilitation, including the use of external change agents from a series of health improvement programs under the *QUERI* portfolio. The study was a reflective exploration of participants during the improvement programs and data were generated through semi-structured telephone interviews. From this retrospective reflective Stetler et al found that the role of facilitators was a distinct intervention comprising of multiple functions. These included the facilitator problem solving with the organisation, provided ad-hoc education that arose from discussion within the organisation, so iteratively created learning opportunities rather than planned teaching sessions and an evaluation was conducted with each participant.

Simmons (2004) in her concept analysis paper of facilitation, summed up with a series of attributes, tasks and behaviours that she considered indicative of facilitation or change agency including sharing decision making, making tasks easier, enabling critical thinking in others, managing group dynamics, identifying barriers to change, recognizing enthusiastic individuals and understanding organisational politics. Interestingly Simmons talked about the 'hidden' work that change agents may undertake between group meetings. This could involve supporting and encouraging

individuals and troubleshooting. Simmons thought it was this hidden work that might be pivotal for the successful implementation of an initiative in clinical practice.

Rycroft-Malone et al (2012) conducted a controlled study testing out the impact of adding facilitation to the utilisation of evidence based clinical guidelines in relation to fluid fasting prior to anaesthesia. Sites were randomised to one of three interventions: one - standard dissemination (SD) of a guideline package, two - SD plus a web-based resource championed by an opinion leader, and three - SD plus plan-do-study-act (PDSA). Facilitators had a one-day training session, but it was found that in cohort two and three, the style and approach of facilitation varied considerably. The outcome of the study showed no difference in the primary outcome (fluid fasting times) with the three implementation leaving questions over whether facilitation added any value. Rycroft-Malone et al suggested that effective facilitation requires change agents to ‘work collaboratively, handle difficult situations... understand where people are coming from’.

In summary, at a meso level, there are suggestions about how a change agent might influence change but there is also a degree of acknowledgement that this work is not yet fully understood, that it contains hidden aspects which perhaps are the critical parts of the function, the ‘how’ of change agency has not yet been fully explored and there is ambiguity or confusion about the change agent role. Accepting that however, in the literature there are suggestions that at a meso level, the change agent operates through the following three approaches. They span boundaries within organisations

and thus by aligning people within the organisation, enable people to meet and talk with other significant people. Change agents enable others' increased knowledge and understanding. They do this by either facilitating a problem solving processes or by offering impromptu teaching in the field, to respond to emergent needs. Change agents also manage the process of change, keep projects on task, take responsibility for managing the project and finally they offer reassurance to participants in change and can themselves create a buffering function between dissonant parts of an organisation.

**Micro Level of Influence: how does a change agent operate their role in order to create organisational change?**

**1. Communicating: breadth and strategy**

Galvin et al. (1999) highlighted the lessons learned regarding the need to keep participants and stakeholders 'in the loop' and of ensuring greater clarity around roles, expectations and responsibilities. Similarly, while Bates (2000) identified positive leadership strategies being used in the practice development work being undertaken, ways in which these strategies could be embellished or capitalized upon did not seem to be addressed.

If organisations want to reduce uncertainty and anxiety (Wanberg and Banas, 2000) adequate change-related information must be shared to shape employees' expectations about change. Portoghese et al (2012) reported on a study in which they hypothesise that the relationship between the change agent and the employers, or

followers influences the expectations about the change from the employees and therefore their commitment to the proposed change. They were interested in aspects of leader-member exchange theory. In their study, they surveyed 703 nurses involved in a national change programme in Italy. They found that change agents (or leaders) critically used communication strategies to reduce uncertainty. By reducing uncertainty, this reduced negative expectations about the change, which resulted in a higher level of participants' commitment to the on-going change process. Portoghese et al continue to suggest that in order for change agents to effectively influence change, their first task is to 'encourage positive expectations of change...creating workplace environments in which nurses develop relationships of high reciprocity with their co-ordinators and receive appropriate information regarding change programs (high quality of change-related communication),' (p589).

Allen et al (2007) argued that the reason organisations experience resistance to change is that the uncertainty felt by members of an organisation about the proposed change is not reduced sufficiently, often due to using top-down communication strategies. The focus of Allen et al's paper was on using communication strategies effectively to manage uncertainty in people during change processes. Allen et al suggested that facing change, individuals experience an inability to predict with much confidence what the likely outcome or trajectory of a change might be. It is this inability to predict that Allen et al suggest causes the uncertainty. Hayes (2010) agreed with the idea that the mode of communication selected by the organisation can have big impact on process of change and/or resistance to that change. He suggested that

interpersonal communication strategies such as face to face meetings are more likely to reduce participants' feelings of uncertainty about the proposed change than by using less personal communication methods such as email.

## **2. Coaching**

Stefancyk et al (2013) in their discussion paper on the role of nurse manager as change agent defined in behavioural terms how they believed a nurse manager actually enabled change in clinical practice. They thought the role as change agent was both to effect a change in practice as well as to increase the capacity for change in others. Their paper does not report on the findings of an empirical study; it is more of a discussion on observations in practice, but they do highlight the following tangible ways of working that change agents use. Stefancyk et al suggest change agents promote the 'exploration of creative solutions' (p15) by acknowledging contributions in a meaningful way without necessarily accepting or implementing them. Stefancyk et al consider this is an example of how the change agent inspires others, by instilling confidence in others' ideas and abilities and recognising the value of their contributions. They discuss a model of leadership that they have implemented in practice. One of the components of this model is the coaching function performed by change agents. Their view on coaching is that it is the clarification of others' expectations by giving feedback on their actions.

### **3. Monitoring and Responding to Emotions in the Organisation**

Stefancyk et al (2013) also found that change agents also monitor the atmosphere generally in the organisation to determine whether people are ready for change or whether they are experiencing ‘change fatigue – initiative overload’ (p16). Where there is evidence that the organisation is going through a period of change fatigue, Stefancyk et al suggest that an effective change agent responds to this feedback by delaying the proposed change to protect the staff from continuing to experience change fatigue.

At the core of thinking about the emotional life of an organisation is the underpinning assumption, according to Barrett (2003), that people have a low tolerance for anxiety, and will naturally engage in behaviour that reduces the feeling of being anxious. So when an organisation is about to go through a change process, it can be reasonably predicted that most people belonging to that organisation will feel anxious about the change. Change anxiety is an acknowledged phenomenon frequently discussed in the change management literature (Stacey 2007). As a consequence, people will engage in behaviours to avoid the anxious feelings, such as not supporting the change, and thus avoiding feeling anxious, or expediting the change so the anxious feeling is extinguished quickly (Bion, 1961).

Both Baruch and Lambert (2007) and Hyde and Thomas (2003) suggest that effective change agents, or leaders absorb the anxiety experienced by the organisation as part of their function. Baruch and Lambert (2007) in their conceptual paper looking at

organisational anxiety commented that when organisations go through a process of change, the 'sharp transitions...chaos and inevitable by-products of the process ... cause uncertainty, stress and anxiety' (p85). They considered that it is the *appraisal* of the threat that would be caused which is pivotal in determining participants' responses to suggested organisational change. Baruch and Lambert continue to suggest that the appraisal of the threat (from proposed change) is influenced by the organisational style of communication - how anxieties are aired and managed within the organisation according to the organisational beliefs and rules. The complex interaction between these processes from appraisal to coping behaviours determines the degree of either debilitation or progress with the change that the organisation is then able to make. This in turn is connected to the level of individual and organisational anxiety that is experienced as a result. Baruch and Lambert conclude that excessive anxiety felt by an organisation could result in impaired performance and decision making in general functioning and during proposed change processes.

Health services are organised in such a way that leader is required for each subsection or team within the service. By the very nature of providing healthcare, there are opportunities for employees to become anxious about the work they do. Hyde and Thomas (2003) suggest therefore that it is common for employees within NHS teams to project decision making responsibilities onto their immediate leader as a way of reducing their own anxiety.

Certain staff members within an organisation require particular attention when facing organisation change according to Bovey and Hede (2001). They highlighted the need to attend to any individual staff who also have personal life transitions on-going, as they will find going through an organisational change at work additionally stressful because of the compounded effect of both work and home life (James and Clarke, 2002). Strategies suggested in the literature to address this change anxiety include introducing counselling at work to help 'constructively [balance] the human needs with those of the organisation' (Bovey and Hede, 2001) but they do not suggest that this is the direct work of the change agent, more that the change agent should facilitate such an intervention,. James and Clarke (2002) suggested change anxiety needs to be contained for the organisation to function, particularly given that individuals' anxiety levels rise in tandem with any increased uncertainty within an organisation. Stacey (2007) recommended the following actions to reduce destructive effects on group functioning work when the group is facing uncertainty, increased anxiety, or change in practices: to establish clarity of the task ahead, to clearly define roles within the group, to ensure adequate leadership and to establish procedures that will help the group defend against anxiety. The establishment of these four features by the change agent Stacey argued would reduce the potential impact of the change anxiety and lower the risk of basic assumption behaviour affecting the organisation. This resonates with Paton and McCalman (2008)'s view, in their book on organisational change, that the 'core task of a change agent...reduce uncertainty associate with the change situation and then encourage positive action' (p54).

In their discussion paper on resistance to change, Curtis and White (2002) in their discussion paper looking at resistance to change considered that the feeling of uncertainty is a fundamental feature of change, is directly linked to resistance to change and both are connected 'to a sense of loss of control'. Curtis and White do not continue to suggest strategies to address this specifically, but it might be argued that part of the role of effective change agency would be to enable participants to have a degree of control of the proposed change and possibly work collaboratively with them.

In all of the above the suggestion has been that change agents need to notice and pay attention to the emotion, often anxiety and uncertainty of participants in an organisation facing change, and then manage or contain this anxiety. However Davidson (2002) takes a different approach that it is possible to use this discomfort experienced by participants as a lever into change. He suggested that the anticipatory fear experienced by an organisation can be 'harnessed by change managers to great effect' (p54). 'It's not as if they brought the situation but they can make use of it'. So anxiety, uncertainty, discomfort Davidson suggested could be useful in the initiation of change processes but this observation was not based on empirical data, rather drawn from a theoretical proposition based on learning through experience.

#### **4. Creating an Opportunity for Reflection**

Cook (2009) wrote about her experiences of being an action researcher over the previous 12 years, facilitating change in a number of community based child services

and from reflecting upon this experience drew conclusions about the specific role an action researcher takes in relation to helping the research participants reconsider their thinking and actions. Cook suggested that the pivotal aspect of action research projects was the ‘messy turn’; a process or point where participants were able to appreciate their existing thoughts and beliefs about their current situation and tolerate the possibility of an alternative, but in that moment when articulating the alternative was not quite possible. This position Cook described as a ‘messy turn’ and it is her suggestion that the role of facilitator of change was to support participants ‘disruption in their thinking’ alongside maintaining their ‘confidence in themselves as practitioners’. The facilitator role as she saw it was to both hold practitioners in an uncomfortable place and enable them to continue thinking creatively in this messiness. It is important to mention here the noteworthy work of Menzies (1960) who conducted an observational study on nursing behaviour. She noticed that nurses failed to develop close relationships with patients as a way of protecting themselves against emotional pain (or anxiety) by focusing on tasks rather than emotional work. In this way nurses were thus staff split off from too much emotional contact with patients.

In bringing together the literature examining the micro level of influence at which a change agent engages, there is evidence to suggest that the change agent interacts with the emotional state of participants in change processes. This may be directly linked to the change anxiety experienced by the organisation or by identifying individuals more at risk of being emotionally compromised by the proposed change. In the literature are suggestions that change agents use strategies to instill confidence

in others, by acknowledging their unique contribution, by encouraging positive expectations of change to reduce anticipatory anxiety and by ‘containing’ or managing anxiety where present.

### **Chapter Summary**

The literature was examined to establish what is already known about the role a change agent has in facilitating change in health. In this chapter I have thematically presented my findings from the available literature since 2002. The literature has been organised into three categories of thinking about the influential level of a change agent: macro level, meso level and micro level. Macro level refers to the broad approaches that are suggested in the literature, change agents reported adopt to influence change in organisations and are based around traits, contexts and relational aspects of the change agent. Meso level factors include the contested roles that change agents adopt in relation to facilitating change within micro levels of influence. There is evidence that change agents’ work is often attending to and connecting with the emotional atmosphere of participants, at both an organisational and an individual level.

Apart from the well acknowledged body of literature around ‘containment’ of anxiety by leaders (Menzies 1960, Baruch and Lambert 2007, Hyde and Thomas 2003) suggesting containment of anxiety can be useful in organisation’s functioning. There does appear to be a gap in the literature that discusses how exactly a change agent

might work with anxiety during a change process. It is this area that I discuss in the following chapter in relation to the data generated through this study.

## **Chapter Three: Methods**

### **Summary of Study**

This was the secondary analysis of an action research study in CAMHS to specifically investigate the role of the change agent during this organisational change process. Triangulation of methods was intended to create a broad perspective of the change process. The methods selected were observations in the field captured in field notes, observations of team meetings recorded and transcribed, interviews with key informants pre and post intervention, recorded and transcribed and a log of my thoughts and ideas through a reflexive diary. By using these methods and triangulating the findings, it enabled a rich picture of the interaction between the change agent and participants in the field to be understood. A summary of the amount of data generated is offered below.

Observations in the field that had been captured as field notes amounted to 72 records (n= 72). There were 13 clinical team meetings observed and recorded (n=13) I conducted a total of 14 in-depth interviews with participants, seven pre –intervention and seven post-intervention (n=14). My reflexive research diary was contained as one document of 8920 words (n=1). Each of these records were considered to be an individual document. On completion of data generation, the total dataset comprised 100 ‘primary documents’ of which were 14 semi-structured tape-recorded interviews (seven pre-intervention and seven post-intervention), generating 89340 words of text. There were 13 tape-recorded clinical team meetings generating 40696 words of text. Field notes were used to record the observations I made during observations in team meetings, clinical sessions and being in the field (n=72) generating 28,000 words.

## **Research Methods**

The focus of this study was to examine the inter-relationship between change participants and change agent. As I was both the change agent and researcher, the account of the change process is understandably reflexive, and attempts have been made throughout to draw out my pre-understandings and how they have influenced the focus of my investigation, how I then generated and analysed the data. I have also attempted to be transparent about the impact or effect that I as researcher was having on the field.

I elected to triangulate four methods to create an understanding of the change process from a multiple perspectives. I selected to conduct participant observations in the field, to record a series of team meetings throughout the study and to conduct semi-structured interviews with key informants at two stages in the change process; pre and post intervention. I also kept a log of my thoughts and ideas through the process. I refer to this reflexive record as my research diary.

### **Generating observational data**

Observational methods were used as a means of investigating the processes involved in the development and implementation of the intervention. Observational methods are a critical tool for studying a 'constantly changing social phenomena' (May 2001, p47) and their value in generating data are attributed to the Chicago School (May 2001) in their ethnography of social divisions of the city of Chicago. In order to effectively notice and thence record transformations of a social context or

organisation, there are advantages to the researcher being part of the organisation's life to fully understand how it changes. The advantage of using observational methods was that it gave me an opportunity to gather firsthand information about the clinical team's social process in a naturally occurring situation (Silverman, 2000), while they went about the change process in their usual clinic and with their usual colleagues.

I generated observational data in the form of field notes between July 2004 and November 2006 (number of entries = 72). Brief notes were jotted contemporaneously in the field in my 'purple book' that served both as my aide memoire and as a reminder signal of my role in the field. These jottings were written up as field notes of my observations, paying attention to the recording of interactive detail about decision making, alongside my accompanying thoughts (Emerson, Fretz, Shaw, 1995). These were made as soon as possible after leaving the field each day. I attempted to keep a consistent style of field notes and distinguished in them between comments recorded verbatim and paraphrased material (May, 2001).

The observational data were generated in the natural setting of the CAMH service through participant observations of team meetings during which the development of the triage was discussed, multi-disciplinary team meetings held on the triage clinics where clinical decisions were reviewed, stakeholder presentations and triage clinics. The clinical team meetings were also recorded (n=13). The style of keeping field notes developed over the course of the study informed by reflective conversations in

supervision from trying to distinguish and declare my perceptions and pre-understandings from the observations I was making (Emerson et al, 1995) and from discovering through the analytic process what data was useful to me. There were challenges in deciding what notes to generate from the team meetings. Initially, as we (the research collaborators and I) were focussed on the development of the triage process itself, I kept notes that revolved around technical aspects of offering this intervention as can be seen below.

In our discussion today, we considered who goes on a waiting list, who is seen immediately and who is to be discharged with advice – so thus determining who the priority should be afforded to and on what basis.

Ideas that were suggested about the duration of the ‘intervention clinic’ were all day or half day, weekly, monthly, fortnightly and whether all new referrals attend or would there be a selection process in advance?

[Field notes, 30 September 2004]

Field notes I generated later in the change process concentrated more on the team dynamics and how people were approaching the change task.

We discussed the relationship between the CAMHS team itself and primary mental health. There seemed to be some friction between these two parts of seemingly the same service with professional competence between one another being questioned.

This seemed to resonate with the activity I was concentrating on at that moment but the limitations of this are that I possibly failed to capture key data at the early stage of the change process that was focused on team dynamics and inter-relationships as my focus was clearly on the intervention itself.

There were other difficulties with attempting to generate this data. It became quite a dilemma when participants wanted to say things to me 'off-record' and what I would then do with that information. A difficult situation arose for me when one participant expressed that they felt they were being bullied by their line manager. I had expected to be faced with child protection type disclosures and dilemmas given the field of practice but had not anticipated this. They disclosed this at the point of leaving the service, but I was aware that my future observations of this particular interactional dynamic and indeed any interaction between the alleged bully and other team members would be influenced by my concern and wonder whether bullying behaviour was present. I suspect this did actually influence some of the feedback I gave to the participants during the spiral of action and review whilst developing the intervention. I included in my feedback to the team my queries about allocation of workload to raise into the group's consciousness that equality of work was an issue raised, but I did so in a very broad sense in an attempt not to expose any vulnerable individuals.

### My relationship with the field

Gold (1958) described four ways of conceptualising the interplay of a researcher as participant and observer in the field; from complete observer, to participant-observer, observer-participant to complete participant. Mindful of Gold's role suggestions (1958) of the participant/observer stance in the field, and of action research as the methodological approach, the function of observation in the field was as practitioner and observer. The *emphasis*, however, shifted during different parts of the study. This was dependent upon the nature of action spirals at the time and how much participation was required from me for that task or series of tasks. As an example, when the intervention was being introduced into practice, I found I was drawn more into participant/practitioner, modeling the intervention, contributing to clinical decision making despite my attempts at trying to hold back from that practice. I wrote an entry in my diary and later discussed with my critical friend the dilemma I felt in being so involved as an apparent participant. The data extracts below show the events that triggered my discomfort.

Practitioner A5: What else do we need to do apart from see the girl on her own?

Researcher: It's very tricky because I'm trying not to contribute to the clinical stuff but it's really hard not to. What's going through my head is that this sounds like a typical [Community Intensive Therapy Team] case.

[Post triage discussion, 10 October 2005]

This was the entry I had put in my diary when I was trying to make sense of how I ought to position myself in relation to the field and the conversation I previously had with an advisor to the study.

I had a phone conversation today with [A Person from YoungMinds]. They had previously worked as clinician in CAMHS before taking a role as a researcher and consultant with this organisation. They found so many difficulties researching where you practice with families that you know clinically and advised wherever possible to become 'removed a little'. I was reminded of my supervisor's comments to use my notebook for the collection of field notes very visibly as a visual reminder or prompt to the practitioner team of the purpose of my being there.

[Research diary, 16 September 05]

I came to the resolution that the development part of the study required my 'hands-on' involvement at that stage of the study. At a later stage when the intervention was more established, I was however able to stand back and observe more, concentrate on watching others and resist engaging in the clinical decision making processes. My engagement with the field was dynamic, changing over the course of the field work.

As May (2001) suggests there is an effect on the observer of the observed being present and this may lead them to behave differently than they normally would in that situation. However this idea of second order cybernetics (von Foerster, 1984), or the researcher being part and thus altering the nature of the field interactions was

accepted as an underlying assumption of the study. Immersion in the field over a protracted period of time encourages a reversion to the behavioural norms within that organisation but can be costly in both terms of financial costs to the study itself and time constraints for both the researcher organisation and the study site.

May also noted the difficulty when conducting unstructured observations of being able to sufficiently examine multiple aspects within the same phenomenon which occur at the same time. This was one of the difficulties I encountered. As I was contributing significantly to team discussions, trying to capture any notes simultaneously was difficult. After I started using a digital recorder this did allow conversations to be recorded, but nuances, what people did and mechanistic issues could not be captured this way, so I attempted to also keep field notes as well. There were naturally the common mishaps with using a digital recorder: batteries ran out, switched off instead of on, in the wrong location in a room so the quality of recording was poor.

Although my data generation in team meetings was an observation of the natural setting rather than a constructed group interview, May (2001) notes that when groups are interacting their behaviour is 'modified according to the social situation', noting the difference in the dynamic as I had joined the group but this nevertheless could offer 'a valuable insight into...examination of processes and social dynamics in particular (May 2001, p126). In the data extract below, the participant comments in a

humorous way about the meeting being recorded but it is a reminder that they were aware of the impact of my presence.

Yes I sought of have in my mind when we've had a period of restricting all our referrals, what we're taking on sufficiently and getting rid of the waiting list then there might be time, therapeutic time, to be saying we're going to allocate a certain amount of time and make it more targeted for this group and not taking them on an ad hoc basis. We have a bit of a sense that [the organisation] won't allow us to do that, not that they've ever prevented us before from doing what we want to do, but we think there are political games going on. We'd better scrape that bit off the tape...

[Practitioner A5, post triage meeting 10 October 2005]

### **Conducting in-depth interviews with key informants**

The interview is an accepted method of generating data for both qualitative and quantitative purposes (May 2001). There are strengths and weaknesses of the three approaches to conducting interviews (structure, unstructured and semi-structured) but for all three approaches the relationship between the researcher and interviewee is acknowledged as influential in forming the content of material generated through the interview process. As Silverman (2000) comments interviews cannot be non-contaminated because of the introduction of the interviewer. Denzin and Lincoln (1998) emphasise the 'socially constructed nature of reality, the intimate relationship between the researcher and what is studied [therefore] shape inquiry' (p8). Therefore a constructionist approach was taken to the generation of interview data. As

Silverman (2005) suggests, constructionists focus on the ‘sense’ (p97) that people, researchers and respondents make in situations such as interviews, rather than respondents’ views be accepted as ‘reality...delivered from a fixed repository’ (Holstein and Gubrium, 1997).

Before conducting any of the research interviews I had already established relationships with these practitioner participants, some prior to commencing the study, others during the early stages of the study when the intervention was collaboratively being developed. Therefore the focus and tone for each individual interview was already influenced by the relationship that had been established before as Silverman suggested (2000). Despite having prepared an interview schedule to guide the direction of the interviews, it quickly became evident that this was restrictive because participants had much more to say than I had scheduled (appendix one). The process of interviewing became iterative with each individual interview informing issues to be touched upon in the next. As these interviews included content related to the development of the intervention, I collated thematic feedback to give the practitioner group as part of an action research spiral.

In order to explore the practitioners’ experiences of the change process, I intended to conduct sequential interviews: pre intervention to get a baseline understanding of what they were anticipating both from the triage clinic and its operation and from the process of change; then twelve months after the intervention had been introduced to elicit their reflections on the process. However, this was applied real world research.

The launch of the intervention triage, under its own momentum, started with a pilot before ethical approval had been given for me to interview practitioners in a fashion articulated by Meyer (1995) as ‘democratic impulse’. My ‘pre’ data were therefore collected by conducting semi-structured interviews in the period between pilot and the twelve month intervention stage (n=7) so depending on when I interviewed the individual they had a little or no exposure to actually trying out the intervention.

The second confounding factor was that there was not a static group of CAMHS practitioners throughout the study as Meyer found was typical of action research studies (Meyer, 1993). A number of practitioners changed roles and where possible I interviewed them even though they had moved to other roles. New practitioners joined the team, and thus were exposed to the intervention as a developing practice mid project. They were interviewed and their data stored with the ‘post’ intervention category (n=7). There were a total of nine practitioners interviewed but therefore only five were interviewed both pre and post intervention (see table three).

Respondent code	Interviewed pre-intervention	Interviewed post-intervention
A1	yes	yes
A2	yes	yes
A3	yes	yes
A4	yes	yes
A5	yes	yes

A6	yes	
A7	yes	
A8		yes
A9		yes

**Table one: Table of CAMHS Practitioner Interview Participants**

I was aware that the interview respondents may shape the nature of their responses because of my role as change agent in this project and their wanting to support me. They had invested time in the developing project and had worked alongside me during this time and so had views about me and the relationship between us. I earlier mentioned the dilemmas posed to me when generating observational data, and my responses to such disclosures must have affected the content that practitioner participants offered during the interview process.

**Using a research diary**

A research diary or journaling in action research was used for multiple purposes (Coghlan and Brannick, 2005): record events in an audit trail of decision making (Lincoln and Guba, 1985); to consider influences from reading and to gain insights from my pre-understandings (Coghlan and Brannick, 2005). In this study I created a single document (8920 words) in which I captured thoughts I had about the study, decisions I made and what influenced those decisions and extracts of conversations from my PhD supervision to promote my reflexivity of the process, in a similar dynamic to that of ‘critical friend’ described by Whitehead and McNiff, (2006, p103).

The idea of a ‘critical friend’ was first recommended by Stenhouse (1975) as a partner who can give advice and is working with the teacher–researcher in the action research. In the context of my study for a PhD, my supervision offered a close proximity to this opportunity for dialogue with a critical friend and as such elements of supervision were therefore captured in my diary. An example is offered below.

We discussed the researcher role in the field and blurring of boundaries. My supervisor was concerned at the amount of blurring in researcher’s role at present and so I need to reconsider my role in the field in light of completion of project and sustainability of project. One option might be to feedback to the service side management the role that I am now taking, to encourage service side to address the gap. This is a real dilemma working out how much or little to facilitate team processes at present, and how widely to assist in the development of the triage throughout the network.

[Supervision notes, 24 April 2006]

The diary was used to record events and tasks, to ensure an audit trail of the unfolding process and to capture my thoughts on such processes to later reflect upon. I also used my research diary to capture ideas that had been generated when, for instance, reviewing relevant literature that made a particular connection with the field.

The data extract below from my research diary demonstrates how I used the diary to bring together evidence from the field, and have a conversation with myself before deciding upon a resultant action. So thus, it helped me articulate my work through the action research cycle: move into a further ‘action’ section of an action research cycle, having ‘observed’ and ‘reflected’ from a previous cycle of planning and action.

I have now completed four interviews with practitioners who are actually doing the triage clinic...It is becoming apparent that it is significant to individuals to have their ‘new cases’ counted. If they *are* doing triage, they have lots of new cases. If they *are not* doing triage, they do not have new cases. The concept of ‘new cases’ seems to indicate to the service how hard an individual is working, so it appears to be an important measure of their worth in the team and maybe in the wider service. I remember when I worked in the team how much we used to playfully cheer when someone saw more than four new cases in a week. So for those practitioners not in triage, who have no new cases, I wonder what this feels like. I wonder if there are repercussions for them and whether this now feels like an unfair system of acknowledging workload.

I shall present this dilemma back to the team: we can explore the meaning behind ‘new cases’.

[Research diary, 3 October 2005]

Thinking about this issue of ‘new cases’ was important for the CAMHS practitioners because of the meaning attributed to seeing referred children for their initial assessment. Capturing these thoughts and my recollections of earlier experiences with the team prompted me to consider with the team how this ought to be addressed. It resulted in an administrative change to the way statistics were collected by the CAMHS Network for their initial assessments.

One of the strengths of using a research diary is that data can be collected close to the time of the event. Wheeler and Reis (1991) suggested that research diaries can be classified as interval-contingent or event-contingent based on the triggers that prompts the recording of the diary. I used the diary following a triggering event, but this approach has the potential to be an erratic method of generating data as the significance of an event may not be realised until time has lapsed and thus the recording could be significantly retrospective and contain less fine detail as a consequence.

A summary of the research methods used is provided below (figure four).

Observations	Research diary	Semi-structured interviews with practitioners
<ul style="list-style-type: none"> <li>• Team meetings: audio-recorded and transcribed, n=13</li> <li>• Field notes of observations, n=72</li> </ul>	<ul style="list-style-type: none"> <li>• Thoughts, ideas, reading, discussions with critical friend, n=1 document of 8920 words</li> </ul>	<ul style="list-style-type: none"> <li>• Pre-intervention interviews, n=7</li> <li>• Post-intervention interviews, n=7</li> </ul>

Figure four: Summary of research methods

### **My Approach to Data Management and Analysis**

It is acknowledged that the process of analysing data begins even before data are generated as the decision what data to generate, and of them which to record was influenced by a researcher's orientation and pre-suppositions (Miles and Huberman 1994). It was for these reasons that I employed the use of my own reflexive diary to capture my thoughts and ideas as I moved through the study, wanting to keep these musings separate from my field notes. For this diary, I created one document of 8920 words. Keeping this as one document proved to be difficult to manipulate during the analysis stage.

The assembling of data was described as the first of three stages of data analysis as data reduction (Miles and Huberman 1994). This was the identification and isolation of the detail and events that I considered to be relevant and important to address the

research aims. On completion of data generation, the total dataset for this study comprised 100 'primary documents' of which were 14 semi-structured tape-recorded interviews (seven pre-intervention and seven post-intervention). These were recorded and transcribed and edited generating 89340 words of text. There were 13 tape-recorded clinical team meetings (of which six were post-triage discussions). During the transcription process, I decided to omit the clinical details of specific children and transcribed detail regarding process and decision making. On some occasions there were technological difficulties recording, sound quality was poor and batteries ran out. On these occasions, I resorted to field notes only. This process generated 40696 words of text. Field notes were used to record the observations I made during observations in team meetings, clinical sessions and being in the field (n=72) generating 28,000 words. There was also the research diary as one document mentioned in the paragraph above.

Information contained in each 'primary document' which identified individuals and locations was given a code word (for example, Practitioner A1, or Neighbouring CAMHS) to reduce the risk of identification of that person or location. All audio-recorded interviews in this study were transcribed. In Miles and Huberman's three step process to analysing data, the second step advocated is that of effective data display. The challenge for a researcher, according to Miles and Huberman is to display the large volume of data in a meaningful way for the researcher to see it in its whole in order to make sense of it. For this purpose of practically managing such large volumes of data, the computer assisted qualitative data analysis software Atlas-

ti version 5.2 (Scientific Software Development Scholari, 1997) was used and a single hermeneutic unit for collating the data related to the change process in this study was created. After sorting and sifting the data, assigning codes to sets of field notes in paper copy, I created ‘families’ within Atlas-ti to allow me to find and group patterns and then isolate these to examine further.

For the first step in my analysis of the data, I read through the documents looking for data that was related to the change process per se. This was the initial look at the data to notice what issues were being raised and to highlight them offering broad categories. An example can be found below (figure five).

**Figure five: Coding of data**

<p><b>A5</b> That was the original idea, or does that put too much pressure to actually see people. Should we develop a waiting list again</p> <p><b>A2</b> What about [A10] because she’s going to be the only medic then though isn’t she</p> <p><b>Researcher</b> say that again [A5]</p> <p><b>A5</b> At the moment we’ve got rid of the waiting list, we have no waiting list at all for the first time in about 5 years and we’ve been taking people on from triage fairly immediately but with the staff changes, as people leave, its obviously not just that you have less staff doing the work, you also have to accommodate all their work by the existing people. Because I’m going, I haven’t really been able to take on any of the others so you’ve effectively got 2½ members of staff leaving and people not picking up...there are staff grade interviews on Monday but even so it’ll be a while before. A staff grade is likely to come with minimal experience of child psychiatry, they may not but, so really it’s about thinking ahead, rather than running triage up to the end of March which we should do if we’re going to carry on afterwards but if what’s going to happen, what you’d rather do is create a waiting list</p> <p><b>A2</b> How will it affect your research</p> <p><b>Researcher</b> Different ways really. Whatever happens it doesn’t matter from a research point of view because I think what we’re looking at is what the factors are, what are the variables, what happens to the process when someone leaves so you’d be</p>	<p>Anxiety about reducing capacity</p> <p>Competence of incoming staff</p> <p>Commitment/anxiety about the continuation of the research project</p>
--	---

<p>investigating what happens. The other thing that's happening, well its critical really, is that [consultant] is leaving the team but any project like this when you set it up, you know people are going to come and go so I was thinking more in terms of what needs to be in place in order to help it tick over, what planning needs to happen now for the longer term</p> <p><b>A5</b> In terms of the project its addressing, but not answering, its addressing an important question about whether you actually need a consultant to run a triage, to what extent you do, whether it makes any difference really, whether you need a consultant at the beginning or later on because, when we were talking about it earlier on it started, we had a lot of debate about who does the triage and we've sort of muddled through that by everyone doing it really</p> <p><b>A2</b> I know I would like to keep it going because the alternative for me is this idea of a waiting list and then it's the same people who take the people off the waiting list anyway</p> <p><b>A10</b> yes but it depends upon how many spaces we have in our diaries. If we have a triage day, what are we going to do with those clients after we have seen them. Is there space to see them now or should we fit them in a little while</p>	<p>Role within triage over time Leadership responsibility</p> <p>Medics position in the team</p> <p>Experience of trial and error – non-scientific</p> <p>Moral arguments about waiting list</p>
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This early broad analysis of the data allowed me to consider what possible themes I could interrogate within the data. I then input the individual documents into Atlas-ti, thus eventually creating 100 primary documents with unique identifiers and created a code list. I grouped this into broad categories or families, and annotated these sections of data with initial thoughts of what I thought was important.

For example, on the initial examination of the data, I identified sections of 'quotations' (in Atlas-ti language) that related to change process, resistance to change, role of researcher and so on. Please see below for a screenshot of an early coding of the data. In Atlas-ti, all primary documents were given an identifier and in the example given below, it can be seen this document was identified as P2 in the left hand drop-down box. The code list that had been created and added to this hermeneutic unit in Atlas-ti is given below in the screenshot (figure six).

Figure six: Extract from Atlas-ti

The screenshot displays the ATLAS.ti software interface. The main window shows a transcript of a meeting with line numbers 131 to 164. The transcript includes the following text segments:

- 131 interm and its nice to share that then.
- 132 A5 yes and looking at the referrals, deciding what happens to them is something that has to be done without fail, no matter how we do it. It has to be done.
- 133 Researcher So the option is that everyone takes a collective responsibility for it or one person or two people who are
- 134
- 135
- 136 A3 I think what A10 says it would be an exercise in people familiarising themselves with the way that A5 has prioritised so that for all of us it would be a useful exercise.
- 137
- 138 A5 There are relatively few now that are allocated to specific therapists from referral letters. So its not as much of an issue as previously, when you would get fifteen referrals in a week and have to give them all out at that point and then and then when it comes back to triage of course whoever is doing this isn't doing it on their own, the traditional way, the traditional NHS way of doing it if the consultant were not there, the SPR does it.
- 139
- 140 Researcher But in community mental health teams, its often not the consultant at all who does it
- 141
- 142 A5 They might not even be there
- 143
- 144 Researcher It's often the team manager who's either a social worker or a nurse so consultants are usually outside of that process.
- 145
- 146 Pat Just thinking about my last job, that's exactly what I did, half my role
- 147
- 148 OP That's useful
- 149
- 150 Researcher that's very useful
- 151
- 152 Clare thanks for volunteering
- 153
- 154 A5 I'll stick my oar in about it now. I would say from A10's point of view, A10 needs to be very central to that process, whatever happens.
- 155 Apart from anything else, it's about nominal medical responsibility within the system and there are different ways you can do it aren't there. You could do it with somebody, you could be the one who actually brings them to the meeting, you could be the one, with the straight forward ones, where it's clear what's going to happen, and each week bring two or three to the team meeting of ones you're not sure about. That sort of thing.
- 156
- 157 A10 But I'm still in training and this needs to be supervised by somebody, when I'm in doubt
- 158
- 159 A5 yes, absolutely, that's the bit we started talking about last week.
- 160
- 161 Clare is been doing our heads in for weeks.
- 162
- 163 A5 whatever happens, you have to have your hour a week with a supervisor and you don't want to spend all that discussing how you allocate referrals. It's not such a complicated process. In a way you learn the rules then you apply them. The ones that don't fit into those rules are sometimes problematic but there aren't that many of them.
- 164

On the right side of the interface, several codes are applied to the text segments:

- change process, options
- delegation, authority
- clarifying roles
- delegation, authority
- change process, anxiety
- team roles, teaching

The bottom status bar shows: P:2: 12 Jan 06.doc -> h:\My Documents\team meeting data\12 Jan 06.doc, Size: 100 %, ANSI, CP: 0

**(Figure seven: Coding frame)**

**Code-Filter: All**

---

HU: change process 12 aug 08 office  
File: [h:\My Documents\Scientific Software\ATLAsTi\TextBank\change process 12 aug 08 office.hpr5]  
Edited by: Super  
Date/Time: 08/05/13 09:52:04

---

**change process, anxiety**  
**change process, authority**  
**change process, miscellaneous**  
**change process, options**  
**change process, planning**  
**change process, skill acquisition**  
**change process, sustaining change**  
**change processes, feedback into system**  
**change processes, fine tuning**  
**change processes, problem solving**  
**change processes, unexpected events**  
**clarifying roles**  
**clinical**  
**decision making, miscellaneous**  
**delegation**  
**delegation, authority**  
**organisation of team meetings**  
**other service involvement**  
**research experience, anxiety**  
**researcher role facilitated reflection**  
**researcher role, clinical commentary**  
**researcher role, empowering ownership**  
**researcher role, feedback**  
**researcher role, holding anxiety**  
**researcher role, keeping focus**  
**researcher role, miscellaneous**  
**researcher role, moving change forward**  
**resistance**  
**service parameters**  
**supplementing other services**  
**system, effect upon**  
**team roles, teaching**  
**tension, differences of opinion**

Connections between codes were visually represented using the software and this enabled me to further refine the codes to capture specific areas of interest. This allowed connections to be made between different primary documents that had data related to specific codes. This helped in the synthesising of data across data sources

to provide a rich picture of evidence across perspectives. It was this third aspect of interrogating the data that Miles and Huberman describe as the conclusion drawing and verification stage.

### **Strategies Taken to Address Quality in this Study**

Action research has been criticised as being unscientific and practice development rather than research, (Waterman, Tillen, Jackson, de Koning, 2001). According to Waterman et al, the criticisms focus around the inherently integrated position of the action researcher in relation to the study site and its participants. As these criticisms originate from the positivist approach, there is an understandable questioning over the apparent bias of the researcher and the inability to generate objective data using this methodology. Connected to this are the questions raised about validity of findings generated through action research. Attempts have been made to strengthen validity within action research studies by the creation of standards to be achieved to promote validity. Lincoln and Guba (1985) have identified criteria that help to ensure attention is paid to the validity of findings in qualitative studies. Lincoln and Guba's categories of credibility, dependability, transferability and confirmability are discussed incorporating Waterman's specific categories related to action research of dialectical, critical analysis of change and attention to reflexivity. In their helpful review of action research (Waterman et al, 1998) also argue that action research needs to be judged on its degree of participation, its change focus and the interaction between reflection, action and evaluation.

Winter and Munn-Giddings (2001) advocate the notion of dialectical thinking in relation to action research by considering the context in which the study was conducted, the changes and decisions how the changes evolved and differences or contradictions found throughout the data. These processes are labour intensive and require effective communication opportunities and capabilities between researcher and participants so there is a risk that rigorous attention to these functions may be overlooked. In this study, the regular team meetings enabled frequent discourse between me as researcher and the practitioner participants about emerging aspects of the study. Even though I organised less frequent opportunities to liaise with the wider stakeholder network by occasionally presenting at their regular seminar programme, this did create the possibility for meaningful discussion and debate about the practice research interface.

### **Reflexivity**

Action researchers also reject the notion of researcher neutrality, understanding that the most active researcher is often one who has most at stake in resolving a problematic situation (Lather 1986, Morley 1991). One of the integral parts of action research methodology is therefore the reflexive component. It is important to differentiate between reflexivity and reflection as both are important concepts in this methodology and I am mindful of Allen's (2004) observation about the misunderstanding between the two that is apparent in some literature. Allen's own description of reflexivity provides a basis for understanding, for the setting the scene of the study, encouraging the researcher to declare their professional orientation, bias and perspective on the topic matter under study.

‘How the field of study is filtered through the very particular interpretative lens of the researcher...reflects their individual history and biography as well as their theoretical perspective’ (Allen, 2004).

This enables the reader to appreciate the stance taken with the study and thus contextualise the generated data. This transparency about the conceptualisation and development of the study becomes of particular relevance when considering the replicability of the study. Within the action research approach, as with other qualitative research designs the contribution the researcher brings to the study impacts upon all aspects of its theoretical approach and operationalisation. Emerson, Fretz and Shaw (1995) in their text on writing ethnography field notes explicitly state they believe how the ethnographer writes, and what they choose to write about are informed by their ‘assumptions, interests and theoretical commitments’. It is for these reasons that I have articulated my biography in relation to working within CAMHS, my theoretical perspectives from a therapeutic and thus academic perspective so that ‘pre-understandings’ (Ashworth 1987) in relation to the study are transparent. I have been using reflection-in and reflection-on action as an integral phase of the action research spiral but acknowledge its difference from taking a reflexive stance in relation to the study in its entirety.

Throughout the design, data generation and analysis of this study, I have been mindful of how my own beliefs informed the construction of the research problem.

My approach to the whole research project resembles that described by Johnson and Duberley (2000) as epistemic reflexivity. Johnson and Duberley (2000) describe the process of reflexivity as an objective one, a meta-approach, of ‘thinking about our own thinking’ as researchers. Epistemic reflexivity is therefore thinking about the initial conceptualisation of the research approach, the assumptions held about the nature of knowledge and how knowledge discovery is understood, and thus how this informs decisions about the design and analysis of the study in the context of the researcher’s experience and knowledge base.

### **Credibility**

Denzin and Lincoln (1998) describe credibility as being parallel to internal validity found in positivist tradition of research, so an assessment of whether the data can be believed. Guba and Lincoln (1989) suggest that credibility can be promoted by prolonged engagement in the field. The fieldwork for this study spanned two phases: the development of the intervention which took approximately 12 months and the implementation and evaluation which took a further 15 months. During this extensive period, I was immersed in the field with increasingly regular contact: initially monthly meetings for the development stage and weekly contact for full clinical days during the implementation and evaluation phases. The familiarity with the field and research participants increased the opportunity for honesty from them as can be seen from the following data extract in which one practitioner is complaining about their workload and relationships in the team.

When I started the job the job was pleasant and bearable and now the workload I've got is unbearable...decisions are made in an autocratic manner...I don't want to go into anything personal... but we could leave it as this team is different...I'm not naïve, there's usually splitting and factions and different tendencies...

[Pre-intervention interview, Practitioner A6]

This data extract shows the practitioner clearly uncomfortable with the interactions within the team, but was free to discuss this with me in the context of a research interview. The volume of data generated through the 15 months of fieldwork also adds to its credibility. Data extracted through tape-recording team meetings, interviewing practitioners individually and fieldnotes of my observations all contribute to understanding the whole picture of the field. The extent of this data over a sustained period of time give the data depth and substance.

### **Dependability, or trustworthiness**

Dependability is similar to the idea of reliability in quantitative research and is concerned with the stability of the data over time and whether the study could be repeated eliciting the same findings. In order to satisfy the dependability of the study an in-depth description of the methodology has been offered that allows the study to be repeated. Whilst multiple methods of data generation have been used in this study no claims are made here that triangulation has been employed to promote validity,

rather than all sets of data have value in their own right adding to the complex picture of the research context (Silverman, 2001).

In this study the approach and methods have been described in detail thus the study could be repeated but no assurances can be given that the same findings will be reached. This is due to the interactionist approach informing the design, methods and analysis of this study. The relationship between researcher and researcher collaborators has informed the way in which the study was conducted, the focus of the data generation and the inferences drawn. By including my biographical detail, this allows a degree of transparency about my theoretical underpinnings and orientation to the study prior to engagement. Reflexive commentary adds to an understanding of how I have engaged with the field and interpreted data.

### **Transferability**

The advantage of using case studies is that they allow the 'examination of behaviours embedded in particular patterns of social organisation' (Silverman 2000, p83). A common critique of qualitative methods enquiry is that its products cannot be generalised from the context in which data were generated. However, the lack of statistical tests in qualitative enquiry does not mean that findings generated in one context will necessarily be of little or no value in another.

In this case the research setting was a typical NHS CAMHS outpatient clinic. It was similar in nature to many other CAMHS outpatient clinics across the UK and indeed with similar working practices to many NHS outpatient clinics where referrals

originate from primary care and intervention is offered on a consultative outpatient basis. The research context was described in detail such that contextual comparisons can be made and the value of the study's findings for other contexts can be determined. So this demonstrates the context similarity and this direct applicability to other similar services. However, in a broader sense, this was a secondary analysis of an organisational change process, involving a small practice focussed team, who were change participants with an external change agent facilitating the process. This conceptualisation has wider transferability and could have resonance with other small teams in health, social care and possibly aspects of education where delivery of a service to clients is the focus of the work and where demand for service challenges the way that service is provided. By detailing the context, the participants and illuminating the relational aspects between change agent and participants, the value to other agencies and settings can be determined.

### **Confirmability**

Confirmability is similar to objectivity from quantitative research. It is the need to show that data, interpretations and the outcome of the study were from the research context itself and 'not simply figments of the [researcher's] imagination' (Guba and Lincoln, 1989, p 243). So therefore all data is supported by processes identified in the audit trail of decisions made in the study for transparency. The biographical detail about the researcher was included to allow for a critical consideration of how data were identified, collated and analysed. By presenting sufficiently large segments of data in this thesis, a reader can draw their own conclusions about what the data say.

Silverman (2000) suggests this strategy attempts to address the potential problem of anecdotalism that could arise from reporting data without discussion of its representativeness nor with discussion of contradictory data. As I was both the researcher and the change agent, the use of a reflexive diary as a data source was critically important in illustrating how my thoughts and actions linked with my beliefs about what was happening. This allowed for transparency about decisions made in the field and assumptions made during the analytical process. An example of this can be seen below, during which I reflect upon two interviews I had conducted.

I think I made a good connection with practitioner A1 when I interviewed them. I find myself very sympathetic to their position in the team, more so since I interviewed her. This was quite different to my interview with practitioner A2 as I found my interview with them difficult, stifled and awkward. Perhaps this was because I suspected them of bullying others and because of the higher hierarchical position she is held in the team. Listening to the tape again, it sounds quite balanced. In the second interview, Practitioner A2 is thoughtful, considered and spontaneous, contrasting with my recollections of the interview. That surprised me.

[Diary 2 October 2005]

By recalling my thoughts and feelings as I was conducting the fieldwork, this allowed me to consider how I was feeling, and the assumptions I was making was impacting upon the data I was generating.

## **Ethical Considerations**

Research ethics are a set of principles about how researchers conduct themselves when conducting research projects (May 2001). These principles ensure research participants enter into studies knowing the parameters of the study, how their data will be generated used stored and disseminated, the degree of anonymity that the study affords thus allowing them to make an informed decision about whether to take part. It is also critical to ensure that people taking part in a study are not harmed consequential to their involvement. Inherent within my practice as a researcher is that as a registered nurse, I am bound by an ethical code of practice. This informs all of my work including as a researcher. Therefore when ethical dilemmas presented themselves during this study, the decisions I made how to address these dilemmas were based on my principles of professional practice.

One dilemma I was faced with during the field work was clinical presentation of a child with serious mental health issues who was not in receipt of mental health care at that time. When researching vulnerable groups as a mental health practitioner, I found I needed to prioritise the clinical need of the child over my investigation as a researcher. This challenging relationship between practitioner and researcher is referred to frequently in the literature (Bate, 2000, Hart and Bond 1995).

Action research as an approach fundamentally requires the involvement of people within a context in order to involve them in a change in practices whilst evaluating the impact of those changes. This therefore throws challenges to the researcher as to how to offer and then enable the option for people within the context of not taking part in the study. In this case, the people working within the context were a changing

group so the process of recruiting people into the study was continual. Some people were in the context in training positions, for example student nurses and social workers. Others were on temporary secondments for set days a week or a set period. Both of these groups of people were excluded from the data generation aspect of the study but by the very nature of working within the context where the study was located, they were involved in the development and implementation of change. As discussed earlier, the direction and pace of action research studies can be unpredictable so it is important that participants understand that potential when consenting to take part. With any study where professional practice is illuminated, the activity of professionals comes ‘under the microscope’ (Denscombe, 2007) this where poor or bad practice is uncovered, there is an ethical requirement for the researcher to address this.

### **Seeking Ethical Approval**

There were two levels of anxiety raised about the proposed intervention: one was from the Local Research Ethics Committee (LREC), the other from the CAMHS practitioners themselves. Interestingly, it was a paediatrician on the LREC, and therefore a potential referrer to CAMHS, who expressed concern that the introduction of a triage system might result in a child with a mental health problem being overlooked by the CAMHS service. Of course, this potentially could have happened with the pre-existing system if the pertinent questions had not been asked by the practitioner, or the child and family declined to respond openly to questions posed.

This possibility had been raised during the CAMHS practitioner team meetings during the preparatory stage of the project and it had been acknowledged that a safety mechanism for retrieving any missed 'caseness' would be the inclusion in the feedback to all families discharged at the point of triage to return to their referrer if the child's symptoms persisted or worsened. The inclusion of this safety mechanism appeared to reassure that paediatrician and LREC.

One of the factors that appeared to satisfy the ethics panel was clarification that in the existing system of conducting initial assessments, individual practitioners already had the authority to accept or decline referred children into CAMHS, a fact about which they appeared unaware. The main difference between the former system and proposed new triage process was the amount of time practitioners had to conduct a clinical interview with a child and their family and the volume of information generated on which to base their decision about suitability of the service, need and priority for that child. At the point of going to LREC, the actual process had not been fully developed, and had not been tested at all. The inclusion of the possibility for fuller assessment where the practitioner was unsure what action to take helped reassure the ethics panel.

There is a degree of unpredictability with action research methodology that makes it difficult to identify at the outset of the study key individuals might later become important as the study evolved. This certainly happened with this particular study. At the outset I had failed to appreciate the value that the administrative support would be

in generating and thus feeding back into the action research spirals. I sought approval to use all the CAMHS practitioners in the team through research governance procedures but when I made what I thought to be courteous enquiries to use data from the team Administrator, I was advised to resubmit my study to the Local Research Ethics Committee as this was a deviation from my original protocol. This process took a further two months.

### **Chapter Summary**

In this chapter I have discussed the methods used that to generate data for the change process during the action research study conducted in a CAMH service. The four methods chosen were participant observations in the field generating field notes (n=72), team meetings that were recorded and transcribed (n=13), semi-structured interviews with key informants pre and post intervention (n=14) and a reflexive research diary (8920 words). These data were managed using a computerised software package Atlas-ti. Examples of initial coding of the data are found in the chapter as is an example of creating 'families' using the software to manipulate the data.

Throughout the study my practice was informed by my professional code of ethics and in this chapter I give examples of the dilemmas posed during the study.

## **Chapter Four: Findings**

In this chapter I present my analysis of the data to answer the question ‘what did I do as change agent to facilitate the team’s change from the old system to the new system?’ In the previous chapter, I described how the data were generated and analysed using Atlas-ti predominantly as a tool for managing and manipulating the high volume of data.

Throughout the field work in the action research, I was mindful of the experience of repeated confirming answers to ‘what if’ questions and noticing that as a collaborating team, we appeared to revisit some aspects of the development several times. On reflection of this, and from looking at the data at a later date, triangulation of the data allowed me to see that the most dominant discourse that pervaded the change process appeared to be centred on the change participants’ expressed feelings of anxiety and my response as change agent to that expressed anxiety. I have presented the data therefore around the three significant aspects of the change process, where the interaction of myself as agent, the participants and the process of change are illuminating. Saturation of data was achieved across all three themes. The three themes are initiating change, tolerating the change process and sustaining the organisational change. I present the data thus, to demonstrate the interaction between the change agent and the levels of the change organisation, from the practitioner participants to the wider CAMHS organisation. The focus of the data presented here is how anxiety was expressed and its relation to the change agent’s role during the process.

## **Theme one : Introducing Anxiety into the System**

### **Perceived Consequences of the Intervention**

When this new idea of conducting brief clinical interviews in place of the established long, thorough clinical interviews with referred children was suggested, some practitioners expressed their worries about what this new process would be like. The idea of a *brief* assessment model was floated early in the discussions (September 2004). It was the specific idea of brevity that appeared to concern practitioners about their practice and whether they were sufficiently prepared to conduct such an assessment. In the extract below, the practitioner expressed their concern about being too inexperienced in CAMHS to conduct a shortened assessment.

I had met with the CAMHS team to explore the possibility of developing with them a ‘triage’ model of assessment...One of the team (a trainee psychiatrist) expressed their unhappiness about using a brief assessment particularly if they did not have direct supervision in the room. They felt they were too inexperienced to make decisions about a child’s needs on the basis of less information than would be gathered in a standardised full length assessment.

[Field notes, 20 September 2004]

This practitioner described their feelings about conducting a brief assessment. They expressed feeling too inexperienced and unsure whether they would be sufficiently competent to conduct the assessment in this way. They appeared to feel anxious about the prospect of doing something new, an assessment that was quite different from the

style of the assessment for which they had originally trained. They believed that more time was needed to conduct an assessment of a child's needs and that they would need supervision during this process because of their limited experience in the field. I later learned that although they had been qualified for five years, they were new to CAMHS as a speciality, so the newness was associated with the CAMHS speciality in particular.

### Feeling uncertainty

In this section, I present data that suggests practitioners were unsure about making a transition from a well-established way of working to a new untested approach for which they had not been trained. Different disciplines had been formally trained in a range of systematic ways through their original professional training and the suggestion of a brief assessment was a departure for all disciplines. Conducting brief focussed assessments seemed to be a challenging and new way of working for some of the practitioners in the CAMHS team. Some of these practitioners had been trained in a particularly formal way. Practitioners from both psychology and psychiatry backgrounds described their standardised assessments taking at least an hour to complete and so the invitation to conduct a condensed clinical interview from which to make a similar decision was challenging. Other practitioners had worked over twenty years in this organisation and as the pre-existing assessment had been well established prior to their arrival, they felt it had been embedded into their practice. Inviting team practitioners to do a much shorter assessment felt uncomfortable for them and they reported feeling unsure how successful or achievable it would be for

them. It was interesting that the fear appeared to be associated with the brevity of the assessment interview particularly.

Practitioner A7: [Doing triage] feels very new and unfamiliar at the moment.

It's the first time in my life I've had to do an assessment in half an hour and that feels really weird after always having an hour to an hour and a half

assessments, that's a bit of a shock... I do have this anxiety that you'll miss something in such a short assessment, but I'm not used to being that concise.

[Practitioner A7, Pre-intervention interview]

In this extract the practitioner described that they felt anxious at the prospect of engaging in such a different way of practising, particularly as it was quite a deviation from the way they had learned to conduct assessments in their initial professional training. The new brief assessments seemed to be such a big change from two aspects of their existing practice. The original assessment practice in CAMHS was very well established, known across the CAMHS network. It formed the cornerstone of the induction package for new practitioners into the service. The uniformity of all practitioners using this method to conduct initial assessments possibly provided reassurance that people were 'doing it right'. So this was the organisation norm, the tried and tested unilateral assessment process for new referrals. In addition, all disciplines had been trained and socialised into their own approach to assessments depending on the orientation of their discipline. So for psychiatrists, they would have had a diagnostic lens influencing their assessments and social workers may have had

a family functioning lens influencing theirs. These established approaches were not time constrained, but it seemed to be the thought of gaining sufficient information to inform an assessment within a short timeframe that was resulting in the practitioners feeling uncertain or unsure of they could do it.

The comment about the brevity was repeated by the CAMHS practitioner team at several junctures. The fact that it was raised repeatedly suggested to me that it was a continuing anxiety felt by practitioners and it seemed to be associated with no previous experience of this approach. For one CAMHS practitioner, there was a real sense of uncertainty about whether their triage decisions would be supported by their line manager, particularly given their lack of confidence in being able to conduct a thorough enough assessment within the required brief timeframe.

Practitioner A6: I feel that practice has to change, but when practice changes then everybody feels a little bit unsteady ... if someone says to me triage, then fine you can do your assessments in 20 minutes and if that is going to be supported by your consultant, then no problem.

[Practitioner A6, Pre-intervention interview]

In this extract there is a suggestion that the practitioner is prepared to try out the new style of assessment noting that feeling anxious or 'a little bit unsteady' is a common feeling when changing practice. Their anxiety is heightened by the uncertainty with whether they would be supported presumably by their line manager, or consultant in

the team, in the event of making a wrong clinical decision about a child through the proposed triage process.

The invitation to do something different in relation to conducting initial assessments of referred children was sufficient to cause a general feel of uneasiness or anxiety within the clinical team. This was expressed openly as well as displayed in behaviour such as asking 'what if things go wrong' questions which I interpreted as signs of feeling anxious. There seemed to be a number of aspects that contributed to this uneasiness. Making clinical decisions within time constraints was a completely new way of working for these practitioners so how to do that was a new skill to be acquired. They were also concerned about what the consequences of getting these new type of assessments wrong would be for them as practitioners and for the children assessed in terms of their needs not accurately determined and thus met.

### **Potential Consequences and Repercussions**

There were three areas of consequences and repercussions about which the practitioners expressed concern. They worried if they would make a wrong clinical decision during this new assessment process and what the consequences of that might be. They worried about the extra workloads that would be involved in doing the new assessment seeing more children and the stress associated with that. They also expressed concern about how they might manage high risk cases in the proposed new assessment process.

### Anxiety about making the wrong clinical decision

Frequently within the team planning meetings, questions were raised about the consequences should an incorrect clinical decision be made for a child assessed in the proposed new system. From this practitioners wanted to know what the repercussions might be then for both the assessed child and they themselves as practitioner conducting the assessment should a mistake be made. A frequently expressed concern for these wrong or incomplete assessments in such a brief timeframe was is any potential risk areas for the child were overlooked. The most worrying risk for practitioners was if they overlooked if the child was intending harming themselves. Another key area was if the child was experiencing harm from someone and did not have the opportunity to disclose this in such a short assessment opportunity. Practitioners expressed their concern of how significant the consequences of missing a risk issue could be for the child.

This was the first team meeting in the study site after my meeting with the Clinical Director and getting permission to move forward with the study. There were five practitioners present, but this was not the whole team. One team member stated that they were unhappy with conducting a brief assessment rather than a full assessment without direct supervision. They queried who would be responsible for the outcome decision made given they themselves felt too inexperienced to do this in case the risk issues were missed (I presumed this meant suicidal risk that a child might pose). I asked

what specific areas of risk were the team worried about? Suicide was the main one, but also child protection was mentioned several times.

[Field notes, 29 September 2004]

A commonly held worry discussed at team meetings was whether practitioners would glean sufficient detail from the brief assessment to identify any issues of potential harm or risk to the child. The over-riding philosophy of care within the team was the child's needs and safety were paramount and their role as CAMHS practitioners was to ensure this was maintained. This topic was raised repeatedly at both team meetings, in individual conversations and during seminar presentations with the wider CAMHS network. It was useful for practitioners to raise their individual concerns about getting the risk assessment incomplete or inaccurate whilst the consultant was there in the room and could respond. As several weeks of iterations about this issue and from consulting widely with the literature, two strategies were introduced to address the potential issue of incomplete risk assessments. The first of these was specifically to introduce a section in the proforma (see appendices for complete clinical interview proforma) for the clinical interview which asked about risk. The second was to introduce a review meeting directly post triage clinic as an opportunity for CAMHS practitioners to review clinical decisions they had made.

#### Concerns about high risk cases

A number of the team practitioners expressed their fears about the impact of the new brief assessment would have on their workload. This practitioner, data extract below,

explained that one of the scenarios that they were more apprehensive about was coping with completing a thorough assessment and the corresponding paperwork when there is a child protection issue raised during the initial assessment.

In the future we will be seeing clients in a very short period of time that may require a lot of work. That is one of my worries...

When there is a more severe problem...one I can think of, someone came in query ADHD... because he'd been trying to throw his one year old brother out of the window and she had to physically restrain him on three occasions. This is a problem, first it's a social problem will leads and generates a lot of work I don't think you can deal with it in triage 20 minutes...so if there is a risk area you need to create an environment of safety, you may need to ring Social Services, fill up a referral form, explain to the relatives that you're not taking the child away...I think when you start to do that ...20 minutes is not enough time.

[Practitioner A6, Pre-intervention interview]

Facing child protection issues generally appeared to cause discomfort and sometimes distress for the CAMHS practitioners. It was a situation they said they preferred not to encounter but given it was part of the territory, they accepted they would inevitably encounter such presentations. This concern was shared amongst others on the CAMHS team, and although it was agreed that the disclosure of information requiring referral to Social Services was an *occasional* rather than common event, it

was agreed a reasonable precaution to include some 'slippage' room within a triage clinic to accommodate such instances. It was interesting that the team seemed to be worried about how they would cope with the occasional high risk or challenging case rather than how they would cope with the more common routine cases. The fear of the high risk case seemed to distort the thinking about the overall new approach to assessments. Interestingly of course, they already had to deal with high risk or challenging cases that arrived or disclosed unexpectedly so they were already accommodating that into their work and accepting there were times when this would add an additional dimension to their workload.

#### Concerns about Additional Volume of Work and the Associated Stress

There was the suggestion however that introducing the new system did in fact create an additional workload as is evident from a discussion at the end of a busy triage day. The following filed notes demonstrate what different people in the team had been saying at the end of the working day.

It was absolute chaos today. There was a gas leak in the street so families couldn't get to the hospital. Five practitioners were here but they all seemed to be running late, I thought we'd be here until 6pm at this rate...

We definitely need to have a planning meeting before the next triage, I can't cope...

It's always chaos, no matter what we do...

It's all too pressured...

[Field notes 18 July 2005]

The team appeared to be quite uncomfortable with the way the triage had run that day. There was the suggestion that a more definite arrangement needs to be in place before the next clinic, perhaps to reduce the anxiety some practitioners felt about a repeat of today's experience. A date was agreed for a triage operational planning meeting a fortnight later as an attempt to plan in advance for some of the difficulties that were experienced today.

## **Features and Impact of Anxiety**

### Reluctance to Change

At the beginning of the negotiations about developing a new assessment process, this practitioner was supportive about the new assessment process. She offered encouraging remarks and listened carefully to discussions. However this engagement remained at a distance and I understood this to mean she did not want to object to the proposed new practice but gently resisted to it by expressing her preference for the former established system.

When I had interviewed this practitioner before introducing the triage clinic, they gave a clear example of when they thought the previous system (which they refer to as the 'real format') had worked well.

Practitioner A3: I do feel quite happy using the real format simply because I've used it for a long time. It's easy. I find actually it can be quite therapeutic in itself and ... sometimes you can actually find you don't need to go any more because it can be quite cathartic...the one that really comes to mind was a family who it was so obvious and blatant actually I mean that they had a lot of life events that had been stressful and they overwhelmed by it and the lad's behaviour was going haywire, but when they sat down and looked, [the father] had been made redundant and [the mother]'s been ill with ME... it was very much about communication, dynamics in the family and I said do you think you'd like me to refer you to [family therapy] and ...they articulated it 'no

you've given us what you need'.. and they went yes ... people don't usually spell it out.

[Practitioner A3, pre-intervention interview]

The practitioner explained that they had experienced the former assessment process as reliable as they had used it for over ten years, with apparent success and no apparent complications. For them, this was tried and tested method that the organisation was familiar with and in which she had familiarity and confidence. Therefore the rationale for any suggested change in this process was not clear to her. She considered the first appointment with a child to be the initial stages of an engagement in treatment process, a therapeutically important task from her perspective. This overlapping of conducting an assessment and engaging in therapeutic work appeared to be a feature of the original system. Usually, the person conducting the initial assessment would be the person who offered an intervention for the child. In the new system, one of the proposals was that these two functions were separated, so practitioners conducting the initial assessment would often not be the practitioner who offered an intervention for the child. The sense of interrupted engagement that Practitioner A3 described in the extract above was an unexpected consequence of the new intervention.

This case appeared to confirm to this practitioner that moving to a triage process would eliminate the opportunity for similar successful outcomes after an initial longer discursive initial assessment. For this practitioner, this would be a serious limitation

of offering a briefer assessment. This practitioner also wanted to be helpful to me so I wondered they had used the clinical cases to illustrate their argument as a less confrontational approach.

A reluctance to change from the familiar way of conducting initial assessments was evident from a number of practitioners in the team as can be seen from the data extract below. The following practitioner liked the original assessment process. She was very familiar with it and could not see any limitations using that approach.

Practitioner A3 said she is happy with the original method of conducting initial assessments as it is a tried and tested, and for her marks the beginning of a therapeutic process. I questioned whether there was any evidence base to the existing initial assessment, but there does not appear to have been any research or evaluation of its effectiveness.

[Field notes, 5 May 2005]

Even practitioners who had expressed keenness on the proposed project, the anticipation of the extra workload required to prepare for the new clinic was causing some concern.

Another practitioner mentioned that they had read that people conducting triage assessments become burned out quickly so would introducing triage be such a good thing?

[Field notes, 29 September 2004]

Practitioner A4: The one thing that's been on my mind ever since we started it is really is the preparation side of it everything really...preparing the packs, what we said initially was about being a bit one step ahead of the game which I feel like chasing it a little bit.

[A4 Practitioner, Pre-intervention interview]

There had been no time set aside for any preparation of new paperwork, information packs or template letters to support the triage project at this stage. This practitioner was involved in a number of specialist clinics that happened throughout the working week each with their own processes, and the thought of the workload involved in setting up a new specialised clinic was clearly worrying this practitioner. I addressed this by developing some of the material myself and circulating for feedback and by negotiating set days for this admin activity.

### **Engaging the Whole Organisation in the Change Process**

#### **Seeing the Whole Picture**

At the outset of the study, I had no real sense of who the critical stakeholders might be, but creating a metaphorical map at an early stage helped to identify those individuals with whom initial conversations were required. This is better conceptualised as a series of spiral activities rather than a linear one. The CAMHS team in which the study was located was part of a larger Managed Clinical Network that covered three NHS Trusts. The Clinical Director of the Clinical Network was a critical stakeholder. He had the authority to either permit or block the project, so

before any further work was done I arranged an early meeting. This allowed the frank discussion of my aims for the project, whilst inviting his response and clarifying what he would want from such a project.

I had a brief meeting with the Clinical Director. He explained the CAMHS Network is taking forward the partial booking idea, which means that families will be asked to confirm their appointment before attendance otherwise that appointment will be given to someone else. He explained that the practitioners had not yet been consulted about this approach. He was very interested in the idea of a triage system that could be rolled out across the Network but agreed it should be trialled in one team first. He suggested I read a report compiled by a research psychiatrist in the Network on the management of waiting lists (Salmon 2003).

[Field notes, 22 July 2004]

The clinical director appeared to be considering how this proposed project would fit into the overall strategy for the network's development. It seemed to link with the partial booking system: driven by improving service user satisfaction and service efficiency.

### **Provoking Discomfort in the CAMHS Network**

As part of the training and development schedule for the CAMHS Clinical Network, regular seminars were held which a high proportion of staff attended. I had used one

of these as an opportunity to engage the stakeholders in hearing, thinking and contributing to the development of the intervention after LREC permission had been given to proceed with the study.

I also used the seminars as an opportunity further into the study to invite stimulating discussion and feedback about the developing project. I therefore arranged to present a further two follow-up seminars.

The following clinical scenario was one that I used in the network seminar to illustrate a clear deficit in the existing system of managing referrals and conducting initial assessments. By using a real example of a child I had assessed, I hoped it would provide a connection for the audience particularly given the gravity of the mental disorder the child was experiencing.

I presented the following story about a girl I had seen when I worked in the Clinic. There was quite a response from the practitioners in the audience, mostly about severity of the child's presentation, what the next intervention was and how she was now. I was asked how quickly into my assessment of that child I thought she was experiencing psychosis and specifically what the symptoms were that led me to that conclusion.

'One 14 year old girl had waited for approximately ten months for an initial assessment. She had been referred because she was experiencing bullying at school. Within ten minutes of starting my assessment, she displayed symptoms highly suggestive of psychosis that had been present for some time

according to her mother. This girl needed an immediate CAMHS intervention because of the severity of her symptoms but had inappropriately waited on the waiting list for a long time. Her parents were shocked and relieved to hear that something could be done to help her.’

[Field notes, presentation at CAMHS Network Seminar, 19 July 2005]

This case example proved universally suitable possibly because of the emotional connection the audience appeared to make with the child. They asked questions specifically about the child’s welfare, treatment plan and her progress to date and it linked with their beliefs about the prominence of addressing children’s needs. It led to interesting questions predominantly about the child discussed, but it also led to discussions about the potential new way of working – a triage clinic. What was evident was the unequivocal stance that children with such mental distress should never have to wait for an appropriate clinical response. This story provoked both emotional responses from practitioners and comments about inefficiencies about practice, service delivery and organisational procedures.

There were a lot of comments and questions from the practitioners in the audience, mostly about severity of the child’s presentation, what the next intervention was and how she was now. I was asked how quickly into my assessment of that child I thought she was experiencing psychosis and specifically what the symptoms were that led me to that conclusion. I was also asked specifically about the risks this child posed to herself and others. The

presentation of the case appeared to make it 'real' for practitioners. They used the actual detail of this child's circumstances to consider their own practices. People were clearly uncomfortable that this child had been left 'undiscovered' on the waiting list for such a long time.

I recorded the questions asked by the audience. What if the referral rates increase? How will you manage? Might you use too many resources to run the triage? What about the rest of the team who are not doing triage, do they feel excluded? Do families know in advance it will be a brief assessment instead of a 'proper' one?

[Field notes, 19 July 2005]

This showed the interest mixed with scepticism in what a solution might look like as a response to the care the child described above had received. Practitioners quickly began to question the practical aspects of introducing a triage clinic, possibly considering how they themselves would cope with the impact of working within a triage clinic. It was interesting that the question was raised about doing a 'proper' assessment in lieu of a triage assessment, giving me the sense that the correct practice was the original and fuller initial assessment that the CAMHS network had historically been using. The questions about increased referrals and families' perception hint at the practitioners' concerns about increased workload and answering difficult questions that families might raise about the new system. I was also interested in the question about whether practitioners were included or excluded from

taking part in the triage clinic and the meaning attributed to that decision. One of the comments offered by the network audience was that:

It is better to use two very experienced practitioners rather than five less experienced in the new venture to ensure success.

[Field notes, 19 July 2005]

I wondered if this was to ensure that clinical decision making would be more robust under these circumstances and there would be a reduced chance of mistakes being made.

Engaging with the stakeholders in this way enabled them to verbalise their anxieties in an open forum. These were either directly responded to, or fed back into the triage planning meetings to inform further developments.

There was interesting feedback from the team practitioners about this seminar. One of the practitioners commented that:

Practitioner A2: There were more questions raised than answers...

Practitioner A4: We really need a planning meeting before we go rushing ahead now...

Practitioner A2: I am so excited and full of enthusiasm...we need to balance that...stop and think before we move ahead.

[Field notes, 19 July 2005]

By engaging with the wider CAMHS network in this way, it seemed that the anxiety was again raised about this significant departure from the established practice. This increased sense of feeling unsure, invited the team to ‘stop and think’ and to plan further about some of the detail raised during the seminar.

## **Theme two: Tolerating Anxiety**

### **Working with the Team on Tolerating and Managing Anxiety**

I was aware from reading about change processes and from my pre-understandings about anxiety in clinical presentations that reassurance had limited impact on reducing anxiety. I believed that feeling anxious about conducting new practice was a normal feature but I also wanted to offer some kind of support to the team. In an attempt to create a longer lasting solution for the practitioners who felt anxious, I wanted to help them discover their own solutions to feeling anxious with this new way of working.

### **Offering Reassurance**

In the extract below, I discussed with the team the similarities between the previous system and the new triage in terms of their level of responsibility and process of decision making with the aim of helping practitioners find their own rationale for maintaining the proposed change.

Practitioner A2: When we started [doing triage] in the beginning it was very difficult, we would check decisions on all of them...it's the security blanket though even if we make those decisions, even if we see people, at the end of the day, you know that you were there to go and discuss it with if you felt unsure

Researcher: ... But the other thing I began thinking about was, you know when you saw a new case on your own, and you do a full assessment for an hour, then ultimately those decisions would be yours anyway. So you are already making those independent decisions coming to the team the next week saying I saw this kid and this is what I thought. So the thing that's changed is the amount of time you've got with a family.

Practitioner A3: Discharging yes, but you're doing it on the basis of a full assessment.

[Team meeting, 12 January 2006]

This reassured some but not all practitioners, as can be seen by Practitioner A3's comment who appeared to prefer the surety of the longer clinical assessment interview. In the post triage review meeting, mentioned above, there was to be the opportunity to think together as a team about decisions made when conducting a clinical interview with a family. This had been identified as a strategy in some literature for reviewing decision making and collaboratively planning a suitable intervention for a child but again, it was another process unfamiliar to the team and consequently the suggestion met with a little apprehension.

## **Reflection on Risk**

At the introductory stages of using triage, the post-triage discussion had a very clear clinical focus, with an opportunity for the consultant to indirectly review cases that had been assessed that day. This seemed to have had a complementary effect of both allaying the consultant's anxiety about whether this brief assessment would be adequate and individual's anxiety about whether they had made the right [safe] clinical decision. This data extract shows one of the practitioners reflecting upon the risk issue after the introduction of the triage intervention.

Despite people's concern about the risk, it was, I felt it was actually a well-managed risk because if there was any doubt about risks and uncertainty after assessment, [the patient] just came back for a full assessment. After a bit of reassuring about that to [practitioners] I think people felt that much easier about it.

[Practitioner A5, post intervention interview]

They were concluding that on reflection that there were risks present about making clinical decisions within time constraints but these were managed effectively enough for them. Other practitioners recalled the difference over time in the way clinical information was discussed.

In the beginning, ...everybody was very anxious about making the decisions at the end [of triage] so there was a lot of time at the meeting talking through cases in detail cases to help people decide what shall we do about this case.

[Clinical team meeting, 12 January 2006]

Within this discussion at team meeting, it was remarked how important was the time spent talking through detail of cases. In the original system there was opportunity to reflect on cases in supervision or within the standard clinical team meetings if a practitioner wishes to raise any issues. This opportunity to discuss cases was immediately after seeing the families so their recall of detail was sharper and the feelings associated with seeing that particular family were more likely to be remembered or even still felt. So, where there were uncertainties in the practitioners mind about details of a case, they could explain those at the time to help them process their decision or even get advice about the decision to be made. Therefore the team review promoted decision making where practitioners were unclear what to do. This review opportunity with the team also helped to reduce any anxieties about their response to the child assessed where they were concerned about any issues or not sure what next to do. Initially practitioners found the experience of discussing the detail of their assessments uncomfortable but they became accustomed to this and found it useful to both allay anxiety and to help with the decision making process.

I'd probably started off with reservations about how short the schedule was going to be and really whether it was going to allow enough information to be

gathered that was really pertinent and a bit crucial. But so far, I find it has been okay... To see triage in that sort of context as well I think, because what is it we... are doing assessments that give us enough information to be able to decide. I think my view of it has become more positive, because ...one is more focused...and I was concerned to start with that yes we've done the long history model for so long we can slip into it ... It's not watertight but you know...nothing is. Making a decision with a brief, triage assessment, is no more fallible than doing a full assessment.

[Practitioner A3, post intervention interview]

This transpired as the need for someone with sufficient experience and confidence in decision making to offer guidance in the more complicated cases where a decision was not straight-forward.

Do you need a consultant present? I think you probably don't. But you do need somebody there with sufficient experience, training and authority to both make decisions but also relieve other people's anxiety about making those decisions...I think it's easier if it was a psychiatrist because actually psychiatrists don't have to work so hard to prove themselves in that position, it's sort of accepted that they take that position by not just the team but people outside the team as well, GPs and paediatricians.

[Practitioner A5, post intervention interview]

Practitioners discussed that introducing a new way of conducting initial assessment was potentially a risk because the new approach was new, untested and such a deviation from the practices with which they were accustomed and comfortable. Despite this, they commented that strategies, such as the post triage review, were useful in helping them manage their anxieties in relation to the new way of working.

### **Testing out the new idea to reduce anxiety**

Part of the talk during team meetings included the ‘what if’ discussions about potential events that could happen should the new system of triage be introduced.

[A Practitioner] was not happy at all at the prospect of conducting any brief assessment with out direct supervision from a consultant. They are a training psychiatrist and are becoming used to the standard psychiatric assessment in readiness for their exams. They feel too inexperienced to conduct a triage assessment and worry about who would take responsibility if something were to go wrong with a decision about a child. The main issue raised in the debate between full and brief assessment was how risk would be sufficiently assessed for the child.

[Field notes, 30 September 2004]

This practitioner moved on to another post before the triage actually started running, but the concerns they expressed exemplified the general uncertainty practitioners felt about the consequences of getting their decision wrong. In order to help alleviate some of this anxiety and test out how team members could make decisions through a

shortened assessment, trials of this process were conducted during the team meeting as the following data extract shows.

We conducted an experiment in the team meeting today. We reviewed eleven referrals from the files, took two each to see what decision we might make if we were conducting a triage assessment with them. Of the eleven cases we decided the following:

- two of them ought to be managed in tier one and referred to appropriate agencies.
- six would have been typically dealt with via triage, three appeared to require specialist tier three intervention and
- two of the cases required an immediate intervention as they were high risk and urgent.

In the triage category, there were children who had identified needs and whose treatment options needed to be considered. There were others who had previous engagement with CAMHS. There was one with a query about the presence of a mental disorder. Other issues that were evident in the sample of children selected were a physically ill parent, offending behaviour by the child, drug/alcohol use by the child and in some the presence of other agencies already working with the child.

[Field notes, 21 October 2004]

The exercise was conducted during a team meeting and everyone agreed that it was a useful exercise to do. The draft triage criteria that had been developed were used to see whether it would be possible to sort and prioritise today's new cases using those criteria. For those unsure about criteria application, this exercise opened up the decision making process so each practitioner to explore one another's rationale for their choice. Conducting this exercise in itself was a new experience for the team practitioners. Their decision making processes were on show and available for critique by their peers. There had been no advance notice that this was going to happen in this team meeting as it evolved as an idea during discussions about the triage project. Although there was no pressure on individuals to say the 'right answer' as these cases had already been dealt with, under the former system, and as such they were simply paper cases, suggestions about cases were offered tentatively. I wondered if this was because practitioners were unsure how others would view their suggestions, or even if they were worried about being criticised and getting it 'wrong'.

One of the cases discussed was a child whose parent had mental health issues. Practitioner A3 suggested they would need a series of appointments to help them cope with their parent's ill-health. Practitioner A5 insisted they should go to primary care as they had no symptomology themselves. Practitioner A3 then asked if they 'had got it wrong all these years?' It became clear that for some referred children, the outcome was not absolute and so practitioners talked about the safest option for this child. Primary mental health or further

CAMHS appointments would allow investigation of any specific mental health issues for that child.

[Field notes, 21 October 2004]

The outcome of the exercise appeared to leave the team with a sense that such a system might work as there were options to take when unsure about the extent of a child's needs at first examination. These were paper cases, children previously assessed and the information was drawn from referral letters only so the practitioners had been making their suggestions based on this small amount of information. It appeared to reassure the team that on balance, decisions were straightforward for most of the children and where unsure, there were options for them.

### **Supporting the Team through Anxiety**

As practitioners became more familiar with the triage process I noticed and fed back into the team my observations that practitioners appeared to be expressing less anxiety after conducting triage assessments.

Researcher: When we first started piloting [triage], everybody was very anxious about making the decisions at the end so there was a lot of time talking through cases in detail, to help people decide what we should do about this case. As time has gone on there has been less time required to talk about cases so people have been able to say I know what I'm doing with this one or

I'm discharging this or referring back and there's just a few cases where it's very difficult to make a decision.

Practitioner A2: The other thing is that I think individual therapists are making the decisions there and then in the room so the decisions are made before we get to the de-brief.

Practitioner A5: For most of them

Practitioner A2: I think that for me...it's the security blanket though even if we make those decisions, even if we see people, at the end of the day, you know that we could discuss it if we felt unsure.

[Team meeting, 12 January 2006]

There was a suggestion that practitioners felt more confident in making on-the-spot decisions about a referred child's needs 'making decisions then and there in the room' and that even when they were anxious about a child they felt supported by the opportunity to review their cases afterwards in the team meeting.

It appeared that the team wanted to test out my competence in the field and offered opportunities to do this. I attempted to respond by immersing myself in the work of the team, and thus sharing the experience of feeling uncertain about triage decisions. I was involved in the post triage discussions in which clinical cases were reviewed. I was often drawn into clinical decision making to offer an opinion on the way forward for a child. The following extract shows the extent of my clinical involvement from

my having assessed a referred girl with one of the CAMHS practitioners and we were discussing the case in the post triage team meeting.

Researcher: This is the second girl we saw.

Practitioner A3: 14 year old.

Researcher ...the mother said the main problem was she won't go to school and the girl was saying that she is frightened that her father, who was the alleged abuser, is going to turn up somewhere and snatch her.

Some of her behaviours are mildly suggestive of her trying to avoid some things in case she might meet the father...

Practitioner A5: Her mother isn't a safe relationship is she?

Researcher: Her mother's not warm, her mother's critical

Practitioner A3: parenting issues, the previous practitioner has written...

Researcher: So her main thing is her fear of bumping into Dad. So I did some problem solving with her about what she going to do should that happen. She has the strategies but she doesn't have the confidence to employ them.

[Post triage meeting, 31 January 2006]

This extract shows the discussion around one of the cases I assessed in triage. There were no particular anxieties about this child and the decision making seemed clear, but the fact that I was taking part in the actual clinical assessments and as such immersing myself in the field may have added to my credibility as a competent practitioner in the field. I had been inviting this team to radically change their method

of working and so by modelling the process I was demonstrating my confidence in the approach and my competence in the field.

#### Reflecting back on the former standard practice

In order to move the project forward, a strategy I employed was to invite an evaluation from each of the practitioners about the existing system for conducting the initial assessment. I did this to identify those aspects of the former system that were unsatisfactory for practitioners so they could be changed and equally to identify useful aspects that could have been adapted and incorporated into the triage clinic.

#### The Role of Administrative Staff

It became apparent that a degree of decision making about the priority of referred children was being made by administrative staff within the CAMHS service. They were the ones who opened the post or took the phone calls from referrers. There were occasions when the administrative staff would seek a clinical opinion from whichever practitioner was available but often they would allocate where on the waiting list a child would go from the information they themselves gleaned from the referrer as indicated in the data extract below.

Researcher: What happens with referred cases?

Practitioner A7: I would think they go by what's written on the referral...sometimes it would be categorically urgent, there's no other way of looking at it, its blatantly urgent from the referral, other ones would be that

the admin staff would come and ask one of us, and I have been asked in the past, this has come in and says urgent, what do you think...

Researcher: So there's some kind of screening going on by the admin people?

Respondent A7: They're just looking for the word urgent I think, I don't think its that technical...it's a big role for them actually, what if it said something like they're hearing voices or ...I'm not sure. I think the grasp is pretty good about what sort of cases by now, having done so much paper work for the consultant the sort of things that are highlighted as the top concerns, you hope but you couldn't guarantee that, they're not trained to, are they?

[A7 Practitioner, Pre-intervention interview]

As referred children often had to wait for an initial appointment, this caused both a build-up of workload for each practitioner as cases waiting in their 'in-tray' which either caused stress with that practitioner feeling burdened or an additional task of negotiating handing back these cases.

Practitioner A7: The old system used to be with that new cases they were put in your tray... if you were choc-a-block and another six appeared in your tray, you were too busy to see them for the next four months you'd think go back to the consultant and say sorry I'm overloaded at the moment, can these wait three or four months or do you want to think about giving them to someone else? I've never had a problem doing that. It was always implicit that [the consultant] would keep giving until you said no.

[A7 Practitioner, Pre-intervention interview]

Practitioner A6: Definitely, the system has potential for abuse. Case allocation could be used to give certain types of cases to certain individuals leading to super-specialisation, meaning that you get all the same geezers all the time  
Researcher: ADHD cases all the time?

Practitioner A6: That could be one possibility or...you could be thinking this one's working harder so therefore lets feed him on [expletive]. If you're seeing that there's more productivity in one of your members then you may be inclined to use that member...I am not saying that's the consultant's way but just say you're working in a team and you're not getting on with your consultant , well you could be thinking tit for tat isn't it.

[A6 Practitioner, Pre-intervention interview]

These two data extracts show the different attributions and approaches that were taken by different members of the CAMHS team with the former method of allocating new assessment cases. The second of these was a junior medic, the first was another discipline. It would be difficult to attribute the difference in response to feeling over-burdened to the professional background but there did appear to be an expectation for subservience by junior medics in this team. With both cases, in the former system of dealing with new referrals, working through the volume of cases created a high volume of work for the individual practitioner and was unsatisfactory.

In a similar way to my discomfort at knowing children with potential mental health issues were waiting for assessment and treatment, another practitioner identified this as an unhelpful aspect of the former system.

Researcher: What didn't you like about the old system?

Practitioner A2: Everybody was flat by the time they got here.

Researcher: What, you mean families?

Practitioner A2: Yes, because they were pretty exhausted, having to tell the story and it wouldn't have been the first time and so when you see them very much fresher, the story feels different and they feel different and they're much more workable so for me you're seeing people when its fresh...So for me it was the fact that people were pretty tired when they got here, tired of fighting the system, tired of everything. I didn't like that bit at all...

I was sitting doing some paperwork and my door was open. This lady came in with this young girl and it's a shame that we didn't video her actually, this child was catatonic...Mum just said I'm desperate, please help me.

[A2 Practitioner, Pre-intervention interview]

This highlighted a fundamental belief that a CAMHS service should be responding as soon as possible to the needs of unwell children and at a time when the family are motivated and enabled to change. This practitioner connected with the exhaustion that a family coping unaided might feel when they had been waiting to access an appropriate service.

## **Engaging the CAMHS practitioners**

Over time my contact with the CAMHS practitioner team evolved such that I attended the clinical team meeting on a monthly basis with the ‘waiting list/triage clinic’ as a standing item on the agenda. Getting the frequency of my attendance right was important in establishing momentum within the participating team for the project without them feeling that this would be dominating their time and resources and prevent them attending to their regular work. One of the practitioners revealed their association with seeing me and the triage project although they did not necessarily see this in a positive way, particularly when I arrived during a busy clinical team meeting.

Practitioner A2: It was the days when we were still doing the referrals in the room, doing the time sheets in the room. So in a small team meeting space of time we were fitting everything in, everything possible. And it was a cramped room wasn't it, it was hot and a lot of people. People were practically swinging off desks practically, there weren't enough seats in the room. I remember thinking, oh Nicola is coming now and she's going to take up our time, but once you got in the room, it didn't matter really, you just got into it. But that wasn't about you, it was about how much more can we fit into a team meeting sort of thing?

[Practitioner A2, Post-intervention interview]

This practitioner expressed that they were keen on being part of the evolving project but was feeling overwhelmed by their existing workload. They said it felt to them that there was going to be an additional aspect of their daily work involving learning new skills, new ways of organising their practice as well as planning and developing the work, but despite this, this practitioner continued to express enthusiasm and commitment. The worry appeared to be connected in part with the requirement to alter the pattern of working and to incorporate new administrative processes, on top of the new clinical skill of conducting time constrained clinical interviews.

At first, my presence at the team meetings tended to interrupt business as can be seen from the following data extracts but over the course of this year, there was more of an overlap or integration between their work and mine.

‘I had forgotten you were coming today’ said one of the practitioners as I arrived after tea break for the team meeting.

[Field notes, 21 October 2004]

‘You’re here a lot’, ‘You again, I thought today’s meeting would be quick’, were two comments passed by team members and left me with the feeling that triage was certainly not on their agenda today.

[Field notes, 17 November 2005]

These comments left me wondering if some practitioners were trying to avoid thinking and talking about triage. I wondered if this was because it was anxiety provoking to change their practice so dramatically, and in fact required an investment of effort on their part especially as one practitioner reminded me of their training to date.

I have spent years learning how to do the full assessment properly whereas this triage is completely contradictory to that.

[Field notes, 18 July 2005]

This felt to me like a plea to revert back to the old system. Perhaps this practitioner had just began to feel competent and confident in conducting initial assessments of children referred to CAMHS and through the introduction of triage, they were being asked to suspend their existing knowledge and potentially start again with the learning process.

I instantly think your role was holding it together to start with, because we sometimes drifted a bit and you'd pull us back. Or we'd say you can't do that and you'd say yes you can, pull it back in... there were times when I felt quite jittery when you weren't there... Yes and also what if it had gone wrong and no-one was telling us it was going to go wrong sort of thing, I felt a bit of security there... I felt that if I got jittery about things that you would come and save me. When you weren't there, I wasn't sure.

[Respondent A2, post intervention interview]

The team appeared to be testing out my clinical credibility throughout the change process and perhaps this was part of my process of engagement with them. They watched me doing the triage assessments several times as well as questioned me intently during post triage discussions as can be seen from my field notes. I wondered if part of the function of my modelling the triage assessment may have been to demonstrate my clinical skills, approach and orientation, so that my clinical credibility was proven.

Today I had been subject to testing questions during team meetings and post triage discussions, such as what my view was on a particular issue. Here was the visible evidence, how I would manage a real triage assessment.

[Field notes, 20 May 2005]

The practitioner team both observed my conducting assessments and questioned me about specific cases which appeared to be checking how robust my own clinical decision making was and what approach I might take with particular presentations.

### Collaborative solution finding

Collaboration began by developing from the outset a shared understanding and clarification of what the problem was and what a solution might look like. The following extract is taken from my field notes of a triage planning meeting that I had with the CAMHS practitioner team.

We agreed it [the solution] needs to acknowledge referrers' priorities, which includes working with children who have been abused, it needs to use the principles of the CAMHS Core Business. We also need to consider the child's functioning, and degree of impairment with a focus on the child's symptoms.

[Field notes, 21 October 2004]

In this team meeting, we had reached a broad agreement about the criteria for prioritisation of children seen in a potential triage clinic. This felt an important stage as there was some shared clarity about how to make difficult clinical decisions, who to accept into CAMHS and who to refer back to primary care. The use of the recently introduced Royal College of Psychiatrists' guidelines defining CAMHS Core Business provided an external reference point. Its contents did invite debate, but allowed for convergence around specific clinical presentations.

#### Using Spirals of Feedback to Inform On-going Project Development

We generated feedback from the stakeholders group to evaluate their perception of the triage clinic and refine it accordingly. I brought data from a survey conducted of referrers to the team meeting for discussion.

Researcher: The feedback from the questionnaires from referrers suggests that holding the triage clinic one and half days a month is not enough? We know it's enough but the referrers have the impression it's not.

Practitioner A12: What they mean is they need to be seen sooner...they have that feeling if they miss the day they'll have to wait for a month

Practitioner A1: When they have a family coming in, in distress, for a GP that's an emergency isn't it?

Practitioner A12: For the GP it's an emergency...perhaps what we should do is have fortnightly half days?

Practitioner A9: Because you can tell people...they wouldn't have to wait any longer than a fortnight. In fact that would be the maximum wait, a fortnight, when you think that people used to be waiting 18 months and now they can wait two weeks.

[Clinical team meeting, 8 June 2006]

In this extract, we see that the practitioners interpreted the data presented to them as the referrers not understanding the benefits that the triage had brought. This suggested to us that further information sharing was needed with referrers to help them understand the new system and how it compared to the previous one. The practitioners were trying to use the feedback to consider the timing and frequency of the triage, and whether in fact it needed changing or whether because of the experience the referrers had when faced with a family under distress in front of them, that emphasised the need for a speedier response from CAMHS.

### **Theme three: sustaining change**

#### **Embedding the new triage clinic in the wider system**

The team had a real sense of the triage being part of their day-to-day business. This led to their interest in better understanding its impact across the system in their locality and discussed how to generate feedback from referrers locally.

There was some discussion within the team meeting in determining whether the new system has worked. This could be by surveying all referrers, by looking at whether the waiting list has reduced at all... We decided to try to engage the referrers in thinking in advance about the new system and what their prospective views were.

[Field notes, 16 December 2004]

There was further discussion how to better engage with referrers and primary care including the Primary Mental Health Workers who sit on the boundary between primary care and CAMHS. The practitioner in the extract below identifies how this aspect was of adequate interaction with primary care, in this case the GP, was important to them for the triage clinic.

Researcher: How does the triage clinic in CAMHS need to adapt in order for it to fit in better, for there to be the best fit possible between the primary mental health role and the CAMHS role?...

Practitioner A4: I mean I think referrers need to get feedback as to, because if in future a referral comes into us and we see it as more a business triage, CAMHS business, then that GP needs to get some feedback somehow as to why was it CAMHS core business

Researcher: So the letter back needs to be something about the clinical problem with the child but also about how the decision was made between primary mental health and CAMHS?

Practitioner A4: Yes...I would prefer it that that GP gets some feedback about, because in your letter you describe the symptoms of such and such and this could be indicative of a clinical problem, this is why we've put it into triage.

[Practitioner A4, Post-intervention interview]

This practitioner highlighted the on-going dialogue that CAMHS has with primary care and the potential benefits of improving communication within this channel. The practitioners here suggested that there should be more clarity in the letters back to the GP about the child's presenting problem and whether or not it meets the criteria for CAMHS. I wondered whether this was indicating that practitioners were worried whether referrers would accept decisions based on the triage assessment and if they would consequentially seek justification for decisions made. This process would be clear not only for this child, but hopefully inform the referrer for future cases.

The primary mental health workers were positioned on the boundary between CAMHS and primary care. They contributed in part to the development of the triage

clinic initially but due to their own workload this involvement reduced over the course of the project. It became clear that communication between these two components of CAMHS had become tense. I had brokered a meeting between CAMHS and the primary care team to discuss the evolving triage clinic with them feeling that I was stepping outside of my remit.

I feel like I am leading the team in relation to triage at the moment. It's not even my CAMHS team, but I am inviting them to a meeting on behalf of the triage project I suppose.

[Field notes, 14 April 2006]

The tension between the two teams became more evident during the meeting.

I felt I was doing a relationship repair job between the two teams. One of the people at the meeting stated 'some psychiatrists don't understand the role of primary mental health workers...there's some advantages to them leaving the service...this is an opportunity to further develop and integrate the two systems'. This suggested to me that in part the difficulties were the relationships between key players in both teams as well as the introduction of the new process that had impact for both teams.

[Field notes, 14 April 2006]

So in order for the triage project to continue to develop, I needed to explore with the primary mental health team their concerns about the triage clinic as it stood, how they would like to influence its on-going development and to create an opportunity for on-going dialogue between the teams.

Spreading the innovation across the CAMHS network was also of interest to the CAMHS practitioners. This helped to embed the practice and because of its success in reducing the problematic waiting list was considered a helpful strategy by the team. We worked with a neighbouring CAMHS team who were interested in adopting the triage model that we had developed.

Meeting with [Neighbouring CAMHS]

I had sent in advance two presentations that I had given at the CAMHS seminar programme launching the triage and summarising results of the pilot. I explained the process of setting up the triage and shared with them key findings from my literature review. They asked for pitfalls as they need to do something with their waiting list, being heavily criticised for it. I emphasised the importance of good admin support and suggested that our admin speaks directly to their admin to ensure similar systems could be used.

They were interested in pilot results, low DNA less than 10% from pilot. Of 95 cases seen, we were able to make a decision on next step required for 93 of the referred children. They seemed very impressed with this. I was invited to come back to talk with the team again. The practitioners asked if they could observe a triage clinic, so were invited to attend the next mutually convenient triage clinic.

[Field notes, 10 April 2006]

After setting up and running the clinic for some time they reported back their impressions of the triage in the email extract below.

First I am glad you have not patented the idea because we have found it very useful. We have reduced the waiting list by two months over the last three months and fantasies of catastrophe have not happened (yet)...It is consistent with the HAS tiered approach and sorts wheat from chaff quite effectively...

The triage system as set up with us shares that, does not overwhelm individuals and stops problems of transition, whereby a teenager who is an eligible referral becomes ineligible by the time they come to the top of the list, has to be referred on to an adult list or is inappropriately seen for a while by chastened CAMHS staff.

[Field notes, 31 July 2006]

It is interesting to think about the words used in this email ‘fantasies of a catastrophe’, which to me is very suggestive of their anxieties of importing this method of conducting initial assessments. They suggest their fears were connected with practitioners being ‘overwhelmed’ with the volume of work and also getting clinical decisions wrong in furthering the email. This acted as a peer review of the triage system and was reassuring for the CAMHS practitioner team that the CAMHS triage was useful, safe and fit for purpose elsewhere.

### **Unexpected Consequences**

There were a number of aspects of my work with the team that seemed to be relevant to the development of this project. They include the role I had in affecting the dynamics within the team, increasing their sense of team belonging, specifically how decisions were made in relation to this project and creating clarity about delineation between team members’ roles.

### Coming together more as a team – sense of belonging

The process of change invited an increased opportunity for practitioners to work together more whilst actually assessing families. It was commonplace for families to be seen by two practitioners in the triage clinic initially particularly when the intervention was being established and practitioners were becoming skilled in conducting brief assessments. The practitioners commented on this new process of joint working in the interview conducted post intervention.

It's funny isn't it because in the beginning there was a lot of sharing, doubling up you know and people checking out with one another.

[Practitioner A3, post intervention interview]

This practitioner further described how they enjoyed that aspect of the new clinic, having the opportunity to work more closely with some colleagues for the first time. This enabled individual practitioners to watch one another work, to increase their understanding of their colleague's approach to therapeutic working and to enhance their own skills and knowledge.

Practitioner A1: I think its something that hasn't changed particularly...I think there's been a definite attempt if you like to encourage co-working...it makes people feel they belong to a team rather than they're working individually. I think that there's been a conscious effort to include everybody in triage... he's changed the Tuesday so [another practitioner] and I can do it.

[Practitioner A1, pre-intervention interview]

Practitioner A4: I enjoyed the triage because you are working as a team I think aren't you... You're learning from each other and I just think it's a pulling together thing so I think its valuable in that way. Doing things together because sitting in these rooms can be quite isolating can't it.

[Practitioner A4, post-intervention interview]

Both practitioners here reported an increase in the opportunity to work together and by doing so increasing their perception of being within a team. The triage clinic became synonymous with genuine team-working where practitioners had the opportunity to work alongside colleagues with whom they would not usually work. The shared lunch on triage days, although brief and busy became an important opportunity to socialise with one another and enhance working relationships.

Practitioner A2: I think that you get to know people in the triage in the de-briefing...you get to know people very differently...the other big thing of course was the lunch...very sociable...a number of people said, it was the only thing the team did as a team, and that was one of the things that [new consultant] has picked up....on a Friday we all have lunch together. It's quite nice actually.

[Practitioner A2, post intervention interview]

This increase in social connection between team members was an unintended but welcome outcome of the new practice and a benefit they frequently mentioned. This increased familiarity and ease with one another may have contributed to a reduction in the general anxiety about presenting cases or working within a new intervention. In the above extract, the practitioner acknowledges the increased breadth of understanding they had about their colleagues' work and although not stated explicitly the inference was that there was increased respect for one another's knowledge and skill base.

An unexpected opportunity that arose from the depth of discussion around clinical decisions following triage assessments was that this became a rich source of sharing knowledge about different treatment modalities. There was opportunity and time for practitioners to ask one another about specific approaches, medication or to arrange specific training and supervision in a therapeutic approach as can be seen in this clinical discussion about a child who had been assessed.

Practitioner A10: I saw a 9 year old child who has been seen here before...the main concern was the vocal tics. She has throat clearing and whistling and mum was worried. She still doesn't want her child to be on any medication.

Practitioner A2: Is there a Tourette's support group or anything?

Practitioner A5: It might be worth sending them a [sic Royal College of Psychiatrists] College factsheet...

Practitioner A2: How does the child cope with it though?

Practitioner A10: When the tics are not that bad she's ok. The only problems she has in school she finds it hard to concentrate...

Practitioner A4: What's the treatment for that? What would you go for?

Practitioner A10: There are different forms of treatment. Medication is one option if they're really bad and if it's distressing and not functioning, anti-psychotic medication such as haloperidol or risperidone...or you could use clonidine that has less side effects but is less effective

Practitioner A5: Well it depends who you ask actually, some people say it has more side effects and is less effective

Practitioner A10: Relaxation techniques?

Practitioner A5: You can. A lot to do with tics is about coping with your life with tics. There is some evidence about CBT for tics.

Practitioner A4: Are there specific exercises for vocal tics?

Practitioner A5: The evidence isn't great actually, in fact its getting the kids to practise. What's it called when you do the opposite to the tic? That's supposed to be reasonably effective and the CBT stuff uses that...the danger is therapy can focus anxiety on the tic and that makes the tics worse.

[Post triage meeting, 18 October 2005].

This extract offers an example of when an unusual clinical presentation had been seen in triage and it offered the opportunity for discussion about this particular type of presentation. There were a number of disciplines present in this team meeting so the information sharing went across professional boundaries but was in a relaxed manner.

This was informal and unpressured and this type of discussion about types of clinical presentations and therapeutic options happened frequently throughout the fieldwork. Other practitioners, perhaps previously not wishing to expose their lack of knowledge about particular therapeutic approaches would not previously have openly asked about the detail of an intervention unfamiliar to them, but the post triage discussion meeting inadvertently lent itself to this knowledge and skill sharing as well as creating the opportunity for further structured coaching and supervision in a clinical skill. The following extract sums up for one practitioner their overall impression of one of the benefits of the multi-disciplinary team discussion that happened post triage.

In the de-briefing you have to say something, you have to speak, because you had that case to present and so it, you get to know people very differently. I saw people and illnesses and different things, that perhaps I wouldn't have chosen to see...and so I looked it up afterwards to find out, or ask questions, or I learnt from the debriefings sort of thing about that illness, therapy or whatever...I felt a bit like a sponge in it...either I didn't know about it and I had to go and look it up or you know we did learn about it from other people...I took it with me to other therapy sessions with other people you know.

[Practitioner A2, post intervention interview]

This practitioner is suggesting that part of the value of the post triage review meeting was hearing about different formulations of clinical problems and alternative treatment options of which they had little prior knowledge. The exposure to the opportunity for new learning was an unexpected consequence for this practitioner in engaging in the triage project. They recognised the benefit of being able to share learning with one another in an informal environment.

### **Decision Making**

One of the key tasks of this new approach to assessments was an invitation to make clinical decisions differently. There were also decision making processes occurring within the team and wider network about the development of the new way of working. This involved decisions about who would be involved in the triage clinic, how workload would therefore be measured and attributed and what happened during transitional points during the evolving project.

### **How Decisions Were Made about the Organisation of the Triage Clinic**

I attempted to include all team members in the decision making about the triage and how it would or could operate. I realised there was interpersonal conflict between some team members and tried to make decisions and lead discussions with that knowledge in mind. Below is an example of one of the difficult dilemmas that presented itself. There appeared to be interpersonal conflict within the team and I was given information that I had been asked not to discuss in the team. The dilemma for

me was how to both respect the disclosure of this information and continue to make decisions in a transparent way with the team.

A practitioner approached me in the corridor. They told me they could not work with A.N. Other practitioner because they 'hate' each other. Therefore they told me they would not be volunteering for the triage project even though they would love to take part because this working combination just wouldn't work and would thus jeopardise the success of the project.

[Field work notes, 13 January 2005]

I decided not to raise this overtly in team discussions but keep on the agenda how we determine who actually contributes to the triage clinic from the outset in an open way as I could. This particular situation resolved itself shortly afterwards when there was a natural change in staffing within the team, but this did bring home the realities of team working, the effect of team dynamics and hierarchies and how they impact upon negotiations within the team. Interestingly, team dynamics was a topic also raised by another practitioner in the interviews I conducted during the evaluation of the triage clinic. For them one of the most problematic aspects of being in this team was the team dynamic. The disclosure of this during the interview was unexpected as I had not observed anything during my field work suggestive of this particular interactional challenge between the practitioner interviewed and the person with whom they felt conflict.

Researcher: Is there anything I haven't asked you that you thought I might ask

Practitioner A6: Team dynamics

Researcher: What do you want to say about team dynamics?...

Practitioner A6: [long pause]...my view could be biased. I don't want to go into anything personal and anyway I'm leaving so I don't want to be like that. I'm very grateful for the opportunity that I've had here and I'm very grateful to the team but we could leave it as this team is different...I'm not naïve, there's usually splitting and factions and different tendencies...whereas decisions here are autocratic that's one of them... there's a lot of autocratic decisions.

[Practitioner A6, Pre-intervention interview]

This was interesting because here, the practitioner remarked that there was an issue about interactions between team members but then declined to elaborate on the detail. I had made an assumption about the person they were referring to and was mindful of the career pathway this practitioner was on. CAMHS is a small field of practice and particularly in this geographical area there are limited opportunities for career development for individuals. I therefore wondered whether they thought too much disclosure might affect their career opportunities locally.

Given there were tensions in the team, I wanted to ensure there were alternative methods of facilitating involvement in decision making other than by direct discussion. I created a memo which I circulated to all team members for their

consideration. They were invited to either respond openly in the team meeting or feedback to me directly outside of the meeting any thoughts they had. This memo (see below) summarised the project development at that point, and included a mixture of data already generated but synthesised in a way that the team could not determine its sources: a synopsis of views from practitioners I had already interviewed, families I had interviewed and my observational data from the field.

Stock-take: Where Triage is Now and What is Left to Do

New cases: Which ones do not go to triage (overdoses, deliberate self harming behaviour referred from paediatric ward, known diagnosis eg ADHD re-referral, transfer from other CAMHS team after their assessment & formulation). Any others?

Triage Assessment Schedule

Relationship with primary mental health team: please see flow chart attached. Rule of thumb – if child referred by PMH team after they have complete an assessment, straight to allocation

Relevance of the post triage meeting. What is its function? Is it permissible for practitioners to not attend this part? How long should be set aside?

Development of the triage outside of this team – how should we accommodate this, if at all? Visitors, students, new staff, succession planning, Network seminar presentation

Frequency seems to be 1½ days per month. Referrers who have responded all think this is too infrequent, but demand upon service now seems to be matched by provision. Should we avoid school holidays or not?

[Field notes, 8 June 2006]

As I was engaged in trying to maintain a spiral of continual action, feedback, and review, this was one of the strategies used to generate feedback from the CAMHS team itself. It did offer structure to the feedback session and ensured all practitioners present had the opportunity to comment on these specific points but the limitation of this approach to generating feedback was that it only focussed on the points raised. I suspect it restricted time and focus such that there was insufficient opportunity for people to raise other ideas.

### **Decision Making and Roles in the Team**

In the beginning stages of developing the triage clinic, great care had been taken over deciding who would take part in the early runs of the triage clinic and how to decide that. There was discussion over availability and whether or not part time staff would have sufficient time to take part. There was discussion over length of experience in the team, with a suggestion that those more experienced would have the knowledge and experience to draw on to inform their decisions. Here I try to raise the topic of how we maintain a philosophy of inclusion in the project but there appears to be tension in the relationship between this practitioner and the other mentioned by me.

Researcher: I worry about [a practitioner] not having been involved enough.

Practitioner A2: Do you know what worries me, was everyone worrying about [the practitioner]. Everybody worries about [them]...Do you know my answer is that people choose to dip in and out. I choose to dip in and out of this network, it is incredibly selfish.

[Practitioner A2, post-intervention interview]

There was also discussion on a practitioner's role in the team, with some people specifically employed in a training capacity and therefore requiring exposure to innovative approaches.

I mean you'd expect medics because of their training, to be able to pick out what was relevant in what a patient is presenting you and decide whether this was an appropriate case or not. Perhaps it was because the medics coming through, you know, didn't have such a long experience of child psychiatry although the staff grades would have had a few years.

[Practitioner A5, post intervention interview]

I mean for social work it doesn't fit with our background and training because we're much more into family dynamics, relationships, stuff that is as long as it takes sometimes... Well I must admit I feel if it is purely a medical illness

model it's impoverished because I think, but then I would think that, not having a medical background, because I see it as much wider and broader really than that. I think a lot of, psychiatric problems you know, can be social or emotional in origin and they're not, to categorise them isn't very helpful you know. It's looking at what can you actually do about it.

[Practitioner A3, post intervention interview]

So practitioners from both psychiatry and social work identified reasons for their non-compliance with the triage approach yet both practitioners were willing to engage in the process. However, the reality was that all practitioners within the team took part in triage at some point or other and it was the acknowledgement by others as a triage practitioner that seemed to carry a degree of kudos.

### **Identifying and Responding to Anxiety in Relation to Roles**

There was an issue that emerged during the introduction of the triage in relation to counting cases and workload. Historically within the CAMHS Network, new cases seen for assessment were counted and recorded as 'new cases seen'. The association seemed to be that the more cases seen by a practitioner, the more industrious and hardworking was the practitioner. With the introduction of triage, this process inadvertently changed. Thus, those practitioners doing triage saw many new cases for assessment. Those practitioners not conducting triage assessment had *no new* cases. The practitioners described their anxiety about what this might mean to the managers of the service and how this would be interpreted in terms of their work ethic.

The issue raised today was how cases are counted, ie whether new or not and to whom they should be attributed. For those people not doing triage, they will never see new cases. For those doing triage they have a high volume of new cases and that split between practitioners will cause problems in the Network. We talked about the creation of a 'nearly new cases' category and how that might be represented on the statistics sheets for the Network. The 'nearly new' would be cases accepted through triage but they are counted as nearly new by the practitioner who then sees them for therapeutic work. The consultant agreed to raise this issue at management level, how triage cases could be better captured and differentiated in the statistical records from the previous system still operating in other CAMHS teams in the Network.

[Team meeting, 31 November 2005]

The team recognised the importance the Network placed on the throughput of new referrals and were anxious how their contribution, or indeed lack of it would be reflected in the overall statistical records. It was known that for each practitioner it was recorded the volume of cases seen. This caused anxiety for practitioners who thought their perceived work rate particularly in relation to new cases, would be seen to be reducing.

There did seem to be a degree of kudos attached to being part of the triage team, but interestingly some practitioners struggled to decide whether they were in or out.

Researcher: Do you know if you're an active part [of triage] or a spectator now?

Practitioner A6: I haven't got a clue... I think I'm not the only one.

[Practitioner A6, Pre-intervention interview]

As my rationale had been to try to make the decisions about involvement transparent, I was alerted to noting whether practitioners were actually involved in triage, how they felt about that and how this decision was reviewed.

This was a CAMHS weekly team meeting in which most team members were present.

There was much talk about how the first triage had gone, how chaotic and busy it was, where the pitfalls were. There was a general buzz of excitement about the triage, but I was aware that not all team members had taken part. I noted the rest of the team were disengaged in the conversation. Did they feel out of the loop? What was their investment in the project? I made my thoughts explicit to the team... I expressed my concern that the excluded half might feel fed up with the triage, so the question is how do we keep them involved?

[Field notes, 5 May 2005]

This question to the team invited individual practitioners to declare where they wanted to be in relation to triage. Those who worked part time found it practically difficult to commit as this would be a large proportion of their working week. Junior staff stated they needed to be told by their supervisor or senior what work they needed to do, so despite my thinking it could be a democratic self-selecting process, other contextual factors influenced these decisions.

In the semi-structured interviews I conducted with the research participants, I was interested in understanding how the individual practitioners' roles had developed through the change in practice and differing perceptions of these role changes. In this extract, I had already generated data about the significance of the role of the team administrator in helping the new clinic run smoothly and was curious how their role was perceived.

Researcher: What do you think she's done in terms of the organisation of the triage clinic?

Practitioner A2: Basic things like practical things like photocopying all the questionnaires...All the practical things really, kept us on task, definitely she says c'mon you're slacking behind you got three people waiting...yes she keeps us on task really, you have done this, you haven't done that or get on with it sort of thing so that's really, so sometimes when you're going through it you tend to slack a bit or you not realise that there is someone out there or whatever, but she certainly keeps you on task on the day. She's pretty good at

organising and taking the telephone calls and reassuring people from that end that you know it's ok at the triage you know... When [families] ring back to say they want an appointment, she does do a bit of reassurance for people.

[Practitioner A2, Pre-intervention interview]

It became evident that the role of the administrator had become pivotal in keeping the triage running smoothly. This was most evident when they were on annual leave and gaps in the organisation became evident.

### **Responding to Critical Events: Allaying Anxiety**

Before commencing any of the fieldwork or indeed planning for this project, I had not anticipated the inclusion of what I refer to here as critical events. The first of these was the consultant in the CAMHS practitioner team leaving their post during the fieldwork. They were a key gatekeeper, their permission for the project was an absolute necessity. They were a keen stakeholder because they were also involved in changing their own practice and working with the team to enable the whole team approach to change. They were also very supportive of the project and committed significant time and energy in the planning and implementation of the triage project.

### Taking the Lead – Organisational Planning

The consultant in the team announced they would be leaving their post midway through the change in practice project. This was met with surprise by a number of practitioners although it was evident that others had been given prior warning, me as

researcher included. Given that the secret was now in the public domain, it was possible for me to introduce this topic openly in team discussions, to both raise any concerns that the team had and also to begin preparation for the consequential change in the team routine. The following data extract illustrates conversations held in the weekly clinical team meeting about the consultant leaving.

Researcher: I suppose I'm thinking what would need to be in place both between now and when the [consultant] leaves and what needs to happen after he's gone to make the triage clinic still viable?

Practitioner A3: The one thing I think about [Practitioner A1] and I doing it, I think they have done it twice, and I've been once but it didn't sort of happen because other things happened that day, a family was brought along by a social worker, I ended up seeing them instead of doing the triage, so I need another intro on the next one really. So that's in the early stages of, well A1's done two and I've not done one yet, but by the end of the month...

OP It needs to be prioritised who's going to manage, because what I think the consultants are very good at is gate-keeping, so you're gate-keeping the referrals...

Researcher: So perhaps the question is who's going to manage the referrals in three months' time? Is there something that needs to happen now to prepare the team to manage the referrals in?

Practitioner A10: How do we decide which patients come onto the triage and who sees whom...we might be making some decisions beforehand.

[Team meeting, 12 January 2006]

Members of the team are asking questions about specific decision making tasks in relation to the organisation of both the triage clinic and the CAMHS team in general. At this early stage, just two weeks after the consultant had announced his intention to leave, there were more questions and anxieties raised than solutions found. There was a period of five months when there was no consultant at all in the team. Within these conversations, anxieties were expressed about who might take over and their anticipated style of clinical leadership, with particular worries expressed about the CAMHS Clinical Director potentially holding this role.

Researcher: When you've left your post, what do you think is the best way of doing the post triage discussion? Is it just for the people in the team, or do you think you're going to need the Clinical Director or another consultant to step in?

Consultant: He's saying that he's going to be there

Researcher: He's going to join for the post triage discussion?

Consultant: He's going to spend two days a week doing clinical work here.

The trouble is, well I don't believe it, I don't think anybody believes it, that's the trouble. That'll cause more problems because if we're assuming he's there, we'll book people in and then he's not there

Researcher: So what's the thinking about how to plan for this possibility in the team?

Practitioner A2: I don't think he's going to turn up so it's easier to work without them and then it's a bonus if they turn up, perhaps not. I've never worked with them so I don't know. It's always a plus then isn't it but if you wait for people and they let you down, we can't really can we because we've got patients coming in whether we like it or not. You can't really cancel people at the last minute can you?

[Team meeting, 2 March 2006]

There was clear uncertainty about how the Clinical Director might respond to the consultant's departure. There were obvious tensions between the consultant and the clinical director. This influenced how the Clinical Director's influence might impact on the team's work. Knowing this tension was present and appreciating the pivotal position the Clinical Director had in relation to the continuation of the triage clinic, I arranged to meet them directly.

I had prearranged this meeting after some thought about what would happen to the triage clinic after the consultant's departure from the service. From discussion with the consultant, it was clear that none of the team knew who would be taking consultant responsibility after his departure and this uncertainty was affecting the ability of the team in my view to make decisions about how they could commit to the on-going triage project.

I had discussed earlier in the team meeting that I would be seeing the Clinical Director to which there were a range of responses. I was aware of engaging

the Clinical Director as a critical stakeholder but two team practitioners viewed his involvement as suspicious... 'don't involve them' [Respondent A5].

The Clinical Director said they were 'very interested in the triage' and asked whether I recommend triage for all CAMHS services and invited me to present the project across the CAMHS Network. They suggested that in the absence of a consultant for the team, the triage, everything was to carry on as normal, inviting me to let them know how they could help. They agreed with my suggestion that we need to incorporate the triage clinic within the normal routine of the CAMHS clinic.

[Field notes, 21 January 2006]

During the five months in between the consultant leaving and the new appointment starting, the Clinical Director did in fact hold responsibility for the team.

Unexpectedly for the team, the Clinical Director rarely did any clinical work with them, but was very supportive from a distance and encouraging of the new practice, the triage clinic.

#### Taking the Lead in Clinical Decisions during Transition

In a clinical team meeting, we were discussing a case that had been referred by a Primary Mental Health Worker. The presenting practitioner did not know how to deal with the case as it was difficult to determine if the child's problems were severe

enough to warrant specialist CAMHS intervention or whether they were best served by the primary mental health service. .

Researcher: I'm wondering if a case comes from primary mental health and they say there's enough evidence to suggest its CAMHS, its allocated to one of the team and maybe the thing then to do is send out for those assessments and write to the family and say the appointment will be in three weeks' time, when we have the feedback from the school but without coming into triage?...

Practitioner A10: If they're thinking along the lines of [ADHD diagnosis] ...the forms come back not suggestive [of ADHD]

Practitioner A2: What do we do with them?

Researcher: Discharge them then don't you?

[Post triage discussion team meeting, 12 April 2006]

In this extract we see suggestions that practitioners were reluctant to make decisions and were looking for definitive guidance whether to discharge children who did not meet the criteria for the CAMHS service. My direction to discharge the child in question was accepted without question.

During the triage project, a primary mental health service had coincidentally been set up attached to this CAMHS service. Negotiating the boundaries between the two services was on-going but with the absence of the consultant, this dialogue between the two aspects of the CAMHS service had stopped. This interface was critical to the

successful continuation of triage, so that clear boundaries were evident between the two parts of the system, such that assessing practitioners could effectively make decisions about appropriate placement of referred children. This section of data is a discussion held in the CAMHS team meeting. It shows how having noticed the gap in communication between the two aspects of CAMHS, I attempt to negotiate between them in order to clarify boundaries and working practices.

Researcher: Primary mental health were talking about it today. There's no pre-existing groups or services or the resource packs with self-help material for them to say I can see [to a family] what the problem is, here's the information. So maybe the triage is just highlighting that gap. Should we do anything different with primary mental health?

Practitioner A2: I'm a bit sticky fingers with it really because I got my fingers burnt recently. So I feel a bit like I don't give a damn. I did get bitten a bit so I feel a bit sensitive really.

Practitioner A8: Maybe with primary mental health on board, we should be seeing less referrals? If it is supposed to be like that, we're going in the right direction.

Practitioner A2: What will the team leader of primary mental health be looking for? Can we know that?

Researcher: Well I suppose I've been trying to meet with them for a little while, do you remember three months ago, we were talking about what might be useful for primary mental health is if they do consultation within the triage

clinic and all of a sudden that [meeting] was pulled. So this is me trying to get an appointment with them to talk about it. I wanted to join their team meeting but the team leader didn't want me joining the team meeting at this stage. He wants me to talk to him first.

[Post triage discussion team meeting, 12 April 2006]

In the absence of the consultant I appeared to be the only one placed to move between the two teams, primary mental health and CAMHS team.

### **Chapter Summary**

The data generated in this study were thematically analysed. In interrogating the data for evidence of the inter-relationship between the change agent and change participants, there was evidence that anxiety was a prominent factor. The chapter is organised around three clear themes. There was saturation of data in each of these themes. In the first theme, from interrogating the data, I have suggested that the role of the change agent was to use anxiety to lever change in the organisation, thus by introducing anxiety into the clinical team this created the space and opportunity for different practice to emerge. The second theme presented demonstrates that the change agent enabled the change participants to tolerate anxiety during the change process. Anxiety felt by individuals in the immediate team and the wider network was expressed verbally in both open forums and during individual interviews. Avoidant behaviours suggestive of anxiety were also displayed by individuals throughout the organisation. It was evident that one of the required functions of the change agent

was to help the practitioners tolerate or cope with that anxiety during this change process. The third theme that has been drawn from an examination of the data is how the change agent worked collaboratively with the change participants on developing strategies to manage anxiety in the longer term thus promoting sustainability of the organisational change. In the following chapter, the significance of these findings are discussed in relation to the existing literature of change agency and what this thesis adds to the body of knowledge.

## **Chapter five: Discussion of the Findings and Contribution to New Knowledge**

The research question being addressed in the thesis was

How does a change agent facilitate organisational change in a health setting?

The objectives of this study were to

- i. explore the current literature available discussing the role of the change agent, thus identifying what is already known about this mechanism
- ii. through a secondary analysis of the data generated through the aforementioned action research in CAMHS examine the relationship between the change agent and the change participants
- iii. formulate an understanding of the mechanism of the change agent during organisational change
- iv. use these findings to make recommendations for practice and further research.

### **Summary of findings**

In this study I investigated the nature of the work of the change agent, in particular how the change agent initiated behavioural change by a team in a clinical setting.

The anxiety expressed by participants during the change process was significant and thus drew my attention to its relationship with the change process and how I as a researcher/change agent was connected to it. By interrogating the data generated in this study, three themes were created that summarised what the data illuminated in relation to the change agent role of using anxiety in a functional way. The first of

these themes was that the change agent generated anxiety in the field, to generate momentum for change. The second theme was that part of the role of the change agent was to facilitate participants to tolerate a level of anxiety during the change process. The third theme was that in recognition of the impact that anxiety had played during the change process, that the change agent's role was to create a structure to manage the on-going anxiety in the new practice for the organisational change to be sustainable.

### **What is Already Known from the an Examination of the Literature**

#### **Initiating Change**

There are two main bodies of literature to consider here. The first of these relates to 'how' a change agent operates. There is evidence that discusses the range of roles a change agent might take to effect organisational change, but the detail of the actual behaviours in which the change agent engages is not fully described. There was acknowledgement that the mechanism a change agent uses to effect organisational change may not yet be fully understood (McCormack et al 2007, Simmons 2004). It contains hidden aspects which might be the critical parts of this function. What is available in the literature however is an exploration at three levels of influence of the change agent: macro, meso and micro. At a macro level, the need for the leader to pay attention to the emotional state of the participants was identified (Mintzberg, 1973). There was also an acknowledgement in the literature that there is a pivotal time during the initial stages of a change process during which leverage occurs from inaction to action, and that change theorists note the role of the change agent in

facilitating that process, (Weiner, 2009). From reporting a significant study in 1946, Lewin had suggested that ‘unfreezing’ the existing practice in an organisational was needed for an organization to embrace the possibility of change. If we accept that to be valid, the change agent’s role is to do something to disturb or interrupt the established practice of the usual organisational behaviour. Interestingly, in Kilbride et al’s study (2005), they considered that the act of bringing together a team to address the organisational problem was sufficient to trigger the change readiness in the team. In the literature on the meso level of influence, there are suggestions that the change agent operates by spanning boundaries within organisations (Thompson, Estabrooks and Degner, 2006) and thus by aligning people within the organization or by enabling people to meet and talk with other significant people, (Hayes, 2010). Neither of these however, explain how a change agent can initially lever an organization to change its practices.

### **The Change Agent’s Role in Using Anxiety to Lever Change**

In this study, I would like to propose from a thorough examination of the data that the change agent might use anxiety as a lever for change to become possible. Davidson (2002) suggested that change anxiety could be ‘harnessed’ to promote the change process but did not expand upon this idea in a detailed way. In this study, I have identified data that demonstrates how the practitioner team particularly and also the wider stakeholder group were invited by the change agent to feel a degree of discomfort with their existing practice in relation to initial assessments in order to consider the possibility of an alternative process and thus embark on a change process. Stacey (2003) created a term ‘bounded instability’ to describe when there is

just enough instability within an organisation to prompt people to change, to look for innovative solutions even though this might be uncomfortable for them.

It is useful now to consider systems thinking to understand organisations and organisational behaviour (von Bertalanffy, 1968). An underpinning assumption of this theory is that organisations (systems) strive to maintain homeostasis through their boundaries, structures and processes when faced with an external stimulus (Flood 2006). If we accept the idea that organisations seek to achieve homeostasis, then we also accept that reverberations or external stimuli are required to initiate a change in structure or behaviour in an organisation as the organisation accommodates the new information to create a new stability or homeostasis (Maturana and Varela, 1992).

It is this introduction of a reverberation to a system or organisation that I propose a change agent brings during the process of organisation change in the NHS. In this study the reverberation brought into the organisation was the increased anxiety experienced by participants in the change process triggered by the change agent's actions.

I have earlier discussed how a case study was presented to the stakeholder group to illustrate the inefficiencies in the existing practices. The case presented demonstrated inefficiencies in the existing process for conducting assessments. The presentation of this case resulted in the audience (the wider network of change participants) voicing enthusiastic responses about the prospect of creating a new process (see page 170).

This was tempered by the expressed anxiety felt by practitioners on radically changing their well-honed process for conducting initial assessments and testing out a new method. Throughout the change process, inviting the practitioner team to

experience the discomfort of a new practice appeared to enable the change process (pages 156, 177).

So integral to the initiation of the change in practice was the creation of sufficient discomfort for people in the organisation to consider altering their practice. This suggests that one aspect of the change agent role is to generate anxiety to promote the possibility of change within an organisation. This builds on the existing literature about change agents, noting the work of Lewin (1946) about unfreezing the status quo of the organisation, Weiner (2009)'s work on the pivotal leverage time helping the organisation move from inaction to action and adding to Davidson's (2002) idea of harnessing anxiety for change to be effected.

### **Tolerating Anxiety during the Change Process**

Buffering or protecting participants from change anxiety was identified in the literature as one approach taken by change agents (Stefancyk et al 2013, Hyde and Thomas 2003, Baruch and Lambert 2007). Portoghese et al (2012) reported on a study in which they hypothesised that it was the *relationship* between the change agent and participants that influenced the change process; they suggested that by reducing uncertainty about the anticipated change, this reduced the participants' negative expectations about the change, which resulted in a higher level of participants' commitment to the on-going change process. Both Baruch and Lambert (2007) and Hyde and Thomas (2003) suggest that effective change agents, or leaders absorb the anxiety experienced by the organisation as part of their function.

There is also a well-established body of work suggesting that effective 'leaders' (the literature does not discuss change agents specifically) 'hold' or 'contain' anxiety experienced by people in an organisation.

### Object Relations Developmental Theory

Klein (1975) was a pioneer of contemporary object relations theory which describes the unconscious processes that involve the psychological splitting of the ego that Klein believed originated in infancy as a defence against persecutory anxieties. Splitting of the ego meant that whole objects (others) became part objects dividing and discriminating oneself and object (or other people) into good or bad, all or nothing, nurturing or rejecting, loving or hating. People experience anxiety about change and the uncertainty associated with it. These psychodynamics often provoke regression (adults in child-like roles) and psychological splitting (us against them mentality). Klein (1975) described the role of parenting at this developmental stage as holding the paradoxes of good and bad for the infant so that the infant would grow to learn, understand and tolerate these paradoxes themselves. The Tavistock model of organisational dynamics is based on the assumptions of the object relations developmental theory. This, using the Tavistock model, it is considered that when a group of people in an organisation face challenges, people become anxious and when anxious, people may revert to infantile protective behaviours classified by Bion (1961) as basic assumption behaviours. People are more likely to revert to basic assumption behaviour when they face uncertainty, or are under increased anxiety such as when they are facing organisational change. This basic assumption behaviour

can lead to destructive group behaviour if unchannelled as it can interfere with the primary function of the group, which means the group may not be able to complete the task(s) for which it was set up.

It is important to also mention here the noteworthy work of Menzies (1960) who conducted an observational on nursing behaviour. In her study, she noticed that nurses failed to develop close relationships with patients but rather focused on tasks to be completed as a way of protecting themselves against emotional pain (or anxiety). So in order to avoid feeling anxious and distressed, in this study, nurses created distance from their patients, to protect themselves from feeling anxious. It is from combined body of work, that the idea of ‘containment of anxiety’ as a leadership strategy has evolved.

Barnett (2010) reflected upon the impact of Menzies Lyth’s work on an action research study carried out between 1975-1979. The material for the analysis was an observational study in a nursery where they looked at the interactions of the caregivers to the children, of note some of the children had had 20 caregivers during their five year stay at the nursery and the research team linked this to earlier formulations avoidance of emotional involvement in nursing work. They did find however, that introducing an opportunity for reflection for the care-giving staff in this nursery, that anxiety experienced by both the organisation as a whole and by individual caregivers was managed better. Their conclusion was that increasing self-awareness and encouraging staff to become more observant were successful strategies

to manage anxiety. 'It is often maintained that this kind of research increases anxiety but in fact it makes existing anxiety conscious, which leads to finding ways of dealing with it. This increases the emotional involvement of staff and leads to greater job satisfaction and stability, all of which was found in this single case study of one nursery' (p150). Thus, a reasonable consideration of a leader or indeed change agent might be to use reflective processes in organisations facing anxiety, such as facing the prospect of change, for people to express the anxiety they are feeling. Holding or containing anxiety experienced by staff appears to be a valuable strategy that a leader might take in an organisation.

The reason that holding or containing anxiety has been suggested as a useful approach during organisational change might be to prevent the reversion to basic assumption behaviours described above (Barrett 2003, James and Clarke 2002). If we were to accept this theoretical basis for anxiety during change, and its expression, then we can accept and understand the value of a change agent in containing that anxiety to increase the opportunities for functional behaviour by the team facing change (Baruch and Lambert 2007) and reduce the risk of Bion's basic assumption behaviours (Stacey 2007).

So the body of literature currently available suggests that the change agent either holds, manages or reduces the anxiety felt by participants during the change process. The experience of feeling anxious was reported throughout the study by a number of the practitioners. The role of the change agent was to help the team of practitioners

*tolerate* feeling anxious, rather than remove their anxious feelings (see pages 190, 174, 182).

This suggests that integral within the role of the change agent was the task of enabling the team to tolerate their anxiety and simultaneously continue with the planned practice under these uncomfortable conditions. This builds on the expansive work written about the function of containing anxiety during group processes but offers a tangential addition to this work. By suggesting that part of the change agent's role is to enable participants to tolerate anxiety, this implies the participants themselves continue to experience anxious feelings but are enabled to cope or tolerate them during the change process, rather than the change agent ameliorating this discomfort previously suggested (Barrett 2003, James and Clarke 2002, Ruch 2007).

### **The Development of Sustaining Structures**

Ruch (2007) explored the use of reflective practice in social work. He found that it was used as a strategy for enabling social workers to cope with 'uncertain and unpredictable contexts' in which they worked. He believed that the creation of 'safe spaces' allowed practitioners to reflect and consider the uncertainties involved in their practice. He found that where practitioners felt 'held' (using Bion's concept, 1961) by clearly defined organisational and professional frameworks, there appeared to be 'greater scope for the creation of confident, stable teams and individuals with secure professional identities, who as a consequence were able to develop as reflective, confident, autonomous and creative practitioners,' ( p670). So there is already some evidence in the literature introducing a process such as Ruch's

reflective practice could be effective in managing or holding anxiety about in this case clinical work.

In this study, there was significant evidence that there were structures put in place by the change agent to offer a long term facility for managing anxiety experienced from the new way of working.

The introduction of the post triage meeting became a fundamental feature of the triage clinic. As it was built into the structure of the clinic, it was not dependent upon the change agent's continued facilitation and thus was a sustainable feature. So the change agent created with the organisation a long term structure to help the organisation manage anxiety associated with a change in practice for the period after the withdrawal of the change agent from the field. This in effect became a strategy for participants to self-manage once they had become accustomed to and confident in the process offered by the post triage review. This was not dissimilar to Ruch's reflective practice idea (2007) that was found to be useful to help social workers manage their unpredictable and difficult work. In Ruch's paper (2007), the opportunity for reflection was facilitated but ultimately the post triage review was managed by the team themselves after it had been established by the change agent. So part of the role of the change agent in addressing anxiety expressed by participants in the change process was to establish routine processes that would continue after withdrawal of the change agent from the field to increase the possibility of sustaining the change.

In this change management project, part of the integral role of the change agent was ensuring mechanisms were built into the structure of the intervention that would have

a fundamental function in enabling the team manage any anxiety resultant from the change in practice.

### **Mason's Safe Uncertainty Paradigm**

There is a theoretical idea that brings together change processes, systems thinking and the management of anxiety in change processes. The idea of uncertainty being conceptualized as an asset in change processes was generated by Barry Mason, a family therapist, in his paper Towards a Position of Safe Uncertainty (1993).

In his work as a family therapist, Mason developed a model of helping a family move to a position of 'safe uncertainty'. The therapist in family therapy functions as an agent of change. Mason suggested that the safety-certainty paradigm is a useful framework for thinking about work with families, helping them not to think about certain or absolute solutions and helping them to cope with other possibilities not yet considered so tolerating the possibility of uncertainty about the possible solution to their difficulties. He suggests that in order for the family to be able to accept the invitation by the therapist, the therapist needs to hold an attitude of authoritative doubt so portraying confidence in the expertise of the area of practice with the humility of accepting outcomes are often unknown and unpredictable. Mason believes that:

'For change to happen, we need to become less certain of the position we hold. When we become less certain of the position we hold, we are more likely to become

receptive to other possibilities, other meanings we might put to events. If we can become more open to the possible influence of other perspectives we open up space for other views to be stated and heard', (Mason, 1993, p194).

Underpinned by this belief, he created a framework for understanding the positional state of a system in relation to change, see below.

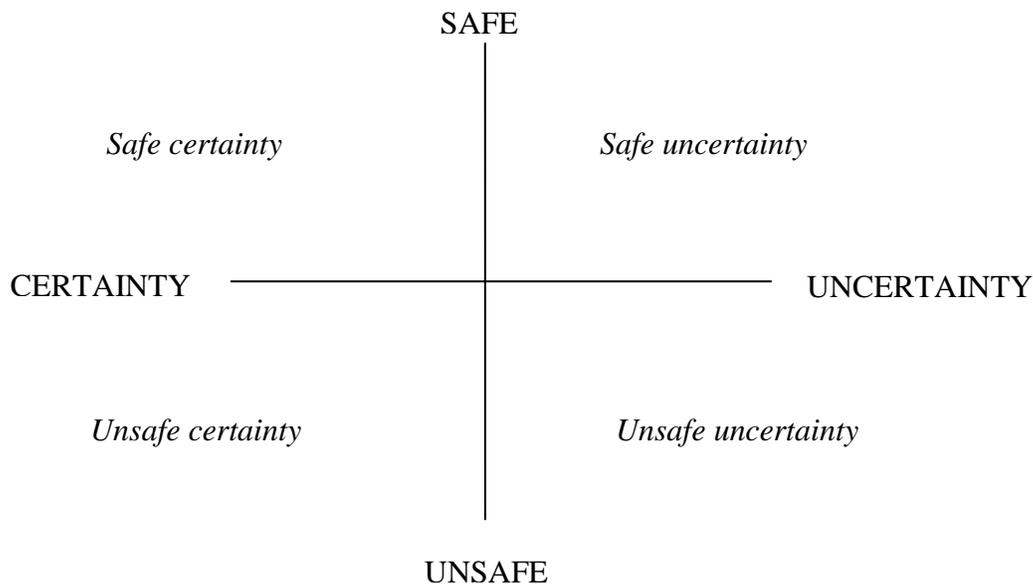


Figure eight: Positions of Safe Uncertainty (Mason, 1993)

In order for change to occur, Mason suggests that groups of people facing change need to be positioned in one of the uncertain quadrants of the above safety-certainty paradigm in order for them to be open to the possibility of change in their behaviour, when they are in a position where whatever happens next is reasonably predictable (certain) and either desired (safe) or undesired (unsafe). For organisational change,

Mason argued that the group would want to feel sufficiently safe about the proposed change otherwise fear, resentment and non-engagement in the process would result. The group would then be reluctant to take a risk with a newly proposed way of behaving if the proposed change were unpredictable (unsafe uncertainty quadrant). Therefore the role of change agent from Mason's perspective is to help a group of people move into the safe uncertainty quadrant so that they are safe enough to face unpredictability but prepared to take a risk on not knowing the outcome, other than it would be different from the existing situation.

#### Limitations of Mason's theory

The main limitation of Mason's theoretical approach is that it has not yet been empirically tested. It was an idea that Mason generated through studying a particular group, family therapists working with families seeking therapeutic involvement. My application of the ideas encompassed within it are tangential to the original source of the development of the thinking and workplace groups are quite different in nature to families, in terms of size, relationships, boundaries and membership.

Nevertheless Mason's safe uncertainty idea might be useful in helping to conceptualise the relationship a change agent has with change anxiety particularly in relation to generating anxiety for change to become possible, or as Mason describes, inviting a system (family or workplace grouping) to move into a less certain position.

### Invitation to Move into a Less Certain Position

Stacey (2007) discussed the need for participants in a change process to move outside their comfort zone for change to be initiated, but the use of a 'critical story' prompted discomfort with the status quo sufficiently to invite the participants to feel the discomfort about the existing practices such that they could consider alternative processes. This may be considered as a critical juncture (Hannigan and Evans 2013) in the trajectory of the change process, a point which alters the landscape, in this case about that area of practice, and which triggers the process into an irreversible course of action.

Mason considered the invitation to become less certain as the mechanism that enabled change to be possible, inviting a system to hold a degree of uncertainty about the future but in a contextually safe place. The data from practitioners at the outset of this change process demonstrates the uncertainty they were experiencing about the direction of travel of the project but were able to proceed.

### Use of Authoritative Doubt

Mason also discussed the need for the family therapist (or change agent) to have a degree of authoritative doubt that allowed the family (workplace group) to accept the invitation into the uncertain place.

There is significant evidence in the organisational change literature drawn from different ontological perspectives that one of the clear and accepted functions of a

change agent is to hold or contain anxiety during a change process. The containment function of a change agent (Baruch and Lambert 2007) is not under dispute, but being able to contain anxiety in an 'authoritative' way such that the group are able to try out practices which have uncertain outcomes is a new way of considering this function of a change agent. The participants initially testing out the authority of the change agent by examining competence in the field and thus clinical credibility (page 183).

It is the mechanism of containing that anxiety that can be considered in a different way. Mason talks about this aspect of the therapeutic process as the family therapist having authoritative doubt, such that the therapist is knowledgeable about the processes and potential outcomes to engender confidence in the family such that they can take a risk in the uncertain path ahead. In the CAMHS study, the potential for holding 'authoritative doubt' resulted from the participants' perception of my clinical credibility in the field which appeared to be tested intermittently throughout the change process.

In this study, the invited change was from a tried and tested method of assessment of the needs and priorities of children experiencing mental health issues to a new untested, innovative, brief assessment process about which the participants had anxieties regarding its fit for purpose, safety and their competence. The demonstration of authority therefore needed to be founded on my own competence and credibility in such a clinical skill, I would argue, rather than in facilitating change processes per se. Commanding and holding authoritative doubt was an essential

strategy used by the change agent to enable this team to take a step into the unknown and embrace the possibility of a new way of assessing children with mental health issues.

### **Limitations of this Study**

At the outset of the study my intention was to work in a collaborative way with this CAMHS team to address the excessive waiting list on the service. I became more interested in the contribution that a change agent makes as the study progressed. This meant that the data I collected at the start of the field work was more focussed on the development of the intervention rather than the specifics of the change agent and anxiety expressed by the participants. There may have been missed opportunities for data generation at that early stage or indeed attention to tangential happenings other than to what ultimately became the focus of this study.

There may have been factors that I have not uncovered during this research process that made this particular study site unique. Having previously worked clinically with some of the practitioner participants, this may have encouraged their commitment to the study or disclosed information to me because they had known me previously. Also, the converse is possible, that our previous shared clinical encounters deterred practitioners from engaging had I been a neutral researcher. Much has been written about the tensions within the practitioner research position and how this determines the methods taken, the questions asked and data generated in a study. Given that this study was driven by the need for a change in practice and that I was both the practitioner and researcher, the possibility of objectivity was a challenge. It might be argued that data generated by another researcher or by a combination of mixed methods would have allowed a more rounded and less reflexive account of the change process to have been generated.

Alternative approaches to investigate the role of a change agent in initiating change might be to use a mixed methods design, from it would be possible to synthesise data generated from multiple perspectives. It would be possible to use standardised measures, for example, to create more objective data in relation to anxiety experienced and behaviours exhibited. Interviews conducted by a researcher positioned outside of the change process itself would generate different data about that process and could observe interactions between change agent and participants from a different perspective.

Within the NHS, there is a natural culture of change so there would be lots of opportunities to study within naturally occurring experiments. As the focus of this study became an interest in the change agent specific, to have investigated that role during change in another setting would have demanded a different design and methods but would have reduced the influence that I specifically had on the progress of the change and hence findings.

### **Implications for Healthcare Practice**

This study of organisational change was conducted in an NHS outpatient team with a multi-disciplinary composition and an external change agent. There were some clear benefits to having an external change agent in the way that anxiety was introduced and then managed through the change process. Highlighting inefficiencies in the existing system by the change agent resulted in participants feeling discomfort with their existing practices. This discomfort and associated anxiety appeared to offer leverage for the participants to consider alternative ways of working. Therefore, where there is a need for organisational change in a multi-disciplinary health environment, the use of this approach by the change agent was valuable in initiating the change process. Strategies for helping practitioners to tolerate the feelings of anxiety during the change process were also found to be helpful for those practitioners during this study. Therefore, a change agent might want to develop strategies to provide sustainable measures for teams to tolerate anxiety in future health related organisational change projects.

As the NHS is a constantly evolving organisation, there are frequent occasions when services or teams need to alter their ways of working. Often managers of these services, such as lead nurses and ward managers are expected to create the motivation for change in their teams and lead a successful change process to improve practice in line with the organisation's requirement. Using Mason's (1993) safe uncertainty idea to invite such teams into a safe uncertain position in relation to that practice might create sufficient discomfort to allow change to proceed.

### **Suggestions for Healthcare Education**

This thesis might have utility in two ways for healthcare education; content specific and pedagogical approach. The first, more straight-forward use might be to include the findings of this study to inform teaching and learning material concerned with organisational change. Organisational change is frequently included within healthcare education across the academic levels. Although emotional intelligence (Goleman, 2004) often features within this content, this thesis could contribute more fine detail about the specifics that a change agent need to attend to instigate, manage and sustain changes in practice.

In the second instance, if we consider that learning is a change process, albeit on an individual basis, then the facilitation of that learning process could also be informed by the literature and proposed new thinking on the facilitator's (change agent) attention to participant's anxiety during the learning process. Using Mason's safe uncertainty idea would suggest that in order to help students learn effectively, they need to be invited into a position of safe uncertainty, thus provoked into feeling uncomfortable enough with their knowledge or skills in an area, such that they are sufficiently motivated to engage in a change process to alter them.

### **Suggestions for Further Research**

This thesis offers evidence that the role of a change agent initially is to introduce anxiety into a team to instigate organisational change, that the change agent assists the team tolerate the change anxiety and that helps develop structures to manage the on-going anxiety experienced by the participants during the change process. This study was conducted in an outpatient multi-disciplinary service that has quite a specialist remit. This interaction between change agent and participant could be investigated in other clinical settings that have quite different characteristics to the study site, such as inpatient services, or uni-disciplinary services. For inpatient settings often there is a different skill mix, and thus a different context for teams to operate, often in health having a predominance of nursing and medicine. There might be contextual influencing factors about skill or team mix, given it was a multi-disciplinary team, which have contributed to the findings in this study, but in another setting might become evident.

Taking an ethnographic approach of a change in practice would offer a different perspective than this reflexive secondary analysis of an action research study in which researcher was also change agent. A clearer focus on generating observational data by a nonparticipant observer might enable a more in-depth investigation of the nuances between participants and change agent that this study did not allow. If more detailed observational data were to be generated at the planning stages and during the development of the change idea, this might help to understand in more detail how

Mason's invitation to safe uncertainty idea has could apply within organisational change in healthcare practice.

The example of change in this study had a positive outcome in terms of clinical practice, but there are occasions in health where change in practice was intended and action taken to facilitate the change but either the change process has been unsuccessful of the intended outcome has not addressed the original problem. It would be interesting to see how the change agent works with the anxiety expressed by participants under those conditions.

In the study that informed this thesis, the change was optional. I was a PhD student working with a team that actually had the authority and freedom to decline the offer of engaging in this project. In many instances in health and social care, change is required as a result of restructuring, financial restrictions, changes in policy or evidence to guide practice and thus change in organisation of services is often not optional. It would be valuable to examine the role of the change agent in those situations, whether this thesis has resonance under those conditions and how the non-negotiable nature of the change in those instances affects the experience of change anxiety in the team.

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## **Appendices**

### **Appendix one: Practitioner Interview Schedule**

1. Warm up question how long been in team, role in team, how that fits in with team, what's it like to work here?
2. How would you explain to, eg a student on placement here, how does a child get seen by the service?
3. Elicit: how, long would they wait, what if problem was urgent, who decides if urgent (parent/GP/CAMHS)?
4. What do you particularly like about the system as it stands?...because
5. And if you could change it, what do you think you would want to change, because...
6. In what way is the way the referral list managed connected to people's workloads within the team? In what way are the stats returns related to workload, what's your understanding?
7. So everyone has an equal say on who is seen as urgent, who waits on the list and everyone's happy with that?
8. Can you think of a time when the current system has not worked out... when there has been a complaint... from a referrer...family...colleague...what happened?
9. Given that this system has existed for a long time, it has bound to have been effective in many ways. What would you say are its 3 main advantages?
10. Given that I am interested in understanding things from your point of view before the triage system is started properly, what questions have I not asked that you thought I might?
11. Sometimes, people have been preparing in their minds something to say during such interview situations, was there anything you've not yet had chance to say?

## **Appendix two: List of Codes for Analysing Change Process**

Code-Filter: All

---

HU: FINAL coding change process 14 aug 08 office  
File: [E:\FINAL coding change process 14 aug 08 office.hpr5]  
Edited by: Super  
Date/Time: 20/06/12 08:11:47

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change process, anxiety  
change process, authority  
change process, miscellaneous  
change process, options  
change process, planning  
change process, skill acquisition  
change process, sustaining change  
change processes, feedback into system  
change processes, fine tuning  
change processes, problem solving  
change processes, unexpected events  
clarifying roles  
clinical  
decision making, miscellaneous  
delegation  
delegation, authority  
organisation of team meetings  
other service involvement  
research experience, anxiety  
researcher role facilitated reflection  
researcher role, clinical commentary  
researcher role, empowering ownership  
researcher role, feedback  
researcher role, holding anxiety  
researcher role, keeping focus  
researcher role, miscellaneous  
researcher role, moving change forward  
resistance  
service parameters  
supplementing other services  
system, effect upon  
team roles, teaching  
tension, differences of opinion Appendix two

**Appendix three: Triage Brief Assessment Form**

**Assessment completed by:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Name:** \_\_\_\_\_

**Age:** \_\_\_\_\_

**DoB:** \_\_\_\_\_

**Gender:** \_\_\_\_\_

**Address:** \_\_\_\_\_

\_\_\_\_\_

**Phone:** \_\_\_\_\_

\_\_\_\_\_

**E mail:** \_\_\_\_\_

**Post Code:** \_\_\_\_\_

**GP:** \_\_\_\_\_

**Surgery:** \_\_\_\_\_

**Referrer & Profession:** \_\_\_\_\_

**Parents/Carers (relationship to child)**

**Date of Referral:** \_\_\_\_\_

**Agencies Involved:**

**School:** \_\_\_\_\_

**Head Teacher:** \_\_\_\_\_

**Class Teacher:** \_\_\_\_\_

**Names of all present**

**Symptoms/behaviour causing concern**

**Level of impairment (within family, social and school)**

**Risk to self or others**

**Brief formulation**

**Expectations of the Child and Adolescent Mental Health Services**

**Questionnaires/rating scales used**

SDQ

M & F

**Plan of action**

#### **Appendix four: Schedule for Patient Semi-Structured Interview**

Preliminary warm-up questions

How long did you wait in between getting referred and being seen at the Child and Family Clinic, (in fact did you know you were being referred)?

What was the experience like of going to the Child and Family Clinic?

If a friend was asking you what happened when you first went to the Child and Family Clinic, how would you describe it to them?

What were the best bits about your first appointment?

What were the worst bits?

If you could give the practitioners in the Child and Family Clinic some advice about how to do it better, what advice might you offer?

After your first appointment, what did you think was going to happen next? How was this discussed in that appointment? How were decisions made about having further appointments or not?

What are your thoughts on whether the relevant information was sought from you either before or during the first appointment? If there was too little or too much detail requested or required, what did you decide to do about that?

What were your thoughts on the length of time the first appointment took?

Was there anything that I haven't asked, you thought I might?

Is there anything else you think would be helpful for me to know about you referral and first appointment with the Child and Family Clinic?

### Family interview participants

<b>Code</b>	<b>Present</b>	<b>Gender</b>	<b>Age</b>
<b>F1</b>	mother	male	10
<b>F2</b>	mother	female	16
<b>F3</b>	boyfriend	female	16
<b>F4</b>	mother	female	13
<b>F5</b>	grandmother & [grand]father later	female	13
<b>F6</b>	Mother, sister joined later	female	16
<b>F7</b>	mother	female	unknown
<b>F8</b>	mother	female	unknown
<b>F9</b>	mother, father	female	13
<b>F10</b>	mother, brother	male	8
<b>F11</b>	mother	male	15
<b>F12</b>	mother	male	teen
<b>F13</b>	mother	female	12
<b>F14</b>	mother	female	7
<b>F15</b>	mother	female	unknown
<b>F16</b>	mother	male	18
<b>F17</b>	mother	female	5

**Appendix five: Referrer Survey**

Research study: **Using Action Research Methodology to Inform the Development, Implementation and Evaluation of a System of Care that Addresses the Demand on a Child and Adolescent Mental Health Team**

Q1. Role: How would you describe your main role?

GP	<input type="checkbox"/>	Paediatrician	<input type="checkbox"/>
Psychiatrist	<input type="checkbox"/>	Social worker	<input type="checkbox"/>
Health visitor	<input type="checkbox"/>	Educational Psychologist	<input type="checkbox"/>
School teacher	<input type="checkbox"/>	Police	<input type="checkbox"/>
Educational Welfare Officer	<input type="checkbox"/>	CPN	<input type="checkbox"/>

Other, please

state.....  
.....  
.....

Q2. Referrals: In last month how many CAMHS referrals have you made (approximately)?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
0	1-5	5-10	10+

Q3. Triage clinic: Have you referred a child to CAMHS who was seen in the Triage Clinic?

Yes

No

If yes continue with Q4, if no go to Q5

Q4. Triage clinic: What did you think about the following aspects of the Triage Clinic?

a) Length of time between referral & appointment:

Very unsatisfactory

Quite unsatisfactory

Neutral

Satisfactory

Very satisfactory

Additional comments

.....

.....

.....

b) Decision made about the child

Very unsatisfactory

Quite unsatisfactory

Neutral

Satisfactory

Very satisfactory

Additional comments

.....  
.....  
.....

c) Feedback mechanism about that decision

- Very unsatisfactory
- Quite unsatisfactory
- Neutral
- Satisfactory
- Very satisfactory

Additional comments

.....  
.....  
.....

d) Family's view on the process

- Very unsatisfactory
- Quite unsatisfactory
- Neutral
- Satisfactory
- Very satisfactory

Additional comments

.....  
.....  
.....

e) Difference from previous CAMHS initial assessment process

Very unsatisfactory

Quite unsatisfactory

Neutral

Satisfactory

Very satisfactory

Additional comments

.....  
.....  
.....

f) Communication between CAMHS & Referrer

Very unsatisfactory

Quite unsatisfactory

Neutral

Satisfactory

Very satisfactory

Additional comments

.....  
.....  
.....

Q5. The triage assessment is a brief assessment that lasts approximately 20mins.

Families are given questionnaires to complete in the waiting area when they arrive for

their appointment. The questionnaires and assessment interview form the basis for decision-making about the contribution that CAMHS could offer the referred child.

a) What do you think are the key benefits of a triage clinic?

.....  
.....

.....b) What do you think are the main pitfalls of a triage clinic?

.....  
.....  
.....

Q6. The triage clinic currently runs for 1½ days per month. This seems to balance the demand for appointments against the availability of follow-up appointments. Does the triage clinic run?

Too frequently

About right

Not frequently enough

Additional comments

.....  
.....  
.....

Q7. Currently the following referred cases are seen outside triage eg overdose assessment, Domiciliary visit requests by GPs, re-referrals where clear diagnosis

exists, (such as ADHD), requests for court reports. What is your view on this aspect of management of the triage clinic?

Very unsatisfactory

Quite unsatisfactory

Neutral

Satisfactory

Very satisfactory

Additional comments

.....  
.....  
.....

Q8. How would you like to see the triage clinic work in the future?

.....  
.....  
.....  
.....  
.....

Q9. If you would be prepared to comment further on your views of the triage clinic, please include your contact details below.

Name:

.....

Contact telephone number:

.....

I would like to thank you very much for taking time to complete and return this questionnaire,

Nicola Evans

## **Appendix six: Consent Forms and Information Sheets**

Family Information Letter  
[Cardiff University Headed Paper]

24 March 2006

Dear Family Member

I am working with the Child and Family Clinic as part of a research project to try to make the appointment system and waiting list for that Clinic better. We have introduced what we have called a “triage” clinic that tries to see families quite soon after they are referred.

As a nurse who previously worked within Child and Family Services, I am aware of how difficult it can be to have to wait for some months for an appointment and it was this that helped me decide to examine this for my PhD studies at Cardiff University under the supervision of Professor D Allen.

The reason I have written to you is to invite you to take part in a research project that is looking at whether the triage clinic has made anything better. I would therefore really like to talk to children, young people and their families about their experience of getting an appointment with the Child and Family Clinic. I would very much like to speak to families who were seen in both the “old” system and the new “triage clinic”.

What you tell us will help us decide what we do next, and what works best for children, young people and their families. There will be a special certificate for all children and young people who take part in the research.

Thank you very much for carefully reading the enclosed notes, and for considering whether you would like to take part in this research project.

If you would like to take part please complete the consent form and contact details enclosed and return in the envelope provided.

Yours sincerely

Nicola Evans  
Lecturer  
School of Nursing & Midwifery Studies

Tel no: 02920 917830  
Email: Evansng@cf.ac.uk

## **Patient information Sheet - Parent**

Research project: Addressing and Managing the Demand on the Child and Family Clinic

### Purpose of the study

We have been trying to improve the appointment system in the Child and Family Clinic at the Princess of Wales Hospital, Bridgend, so that children and young people do not have to wait too long for an appointment. We have started running a “triage clinic”. This is a short appointment when we can meet children, young people and their families to work out if there is any service the Child and Family Clinic can offer or if they would be better going somewhere else. The reason we set this up was because some families have waited over 6 months to be seen.

We now need to find out if the changes we have made are better or not. To do this I would like to speak to children and young people, with their family, to see what they think. I would like to talk to people who came to the Child and Family clinic before we changed things and would also like to talk to families who came to the triage clinic.

### Why Have I Been Selected to Participate?

A sample of families seen under the old appointment system and new triage clinic are being invited to participate. These families are being selected upon the basis of the time period during which they had their first appointment.

### What is Involved?

Children, young people and their families are invited to take part in an interview conducted by myself. The interview can take place at your home or another venue convenient to yourselves. The purpose of the interview is for me to hear from children, young people and their families about their experience of getting an appointment with the Child and Family Clinic. The interview will last 30-40 minutes. Children and young people can be seen with or without their parents or carers as they prefer.

This interview will be recorded. When all data has been recorded and transcribed, i.e. written down exactly as stated on the tape, the recording will be destroyed. These notes will be securely stored by myself on Cardiff University premises.

Consent to take part in the research study may be withdrawn at any time.

### Do I Have to Take Part?

Whether you take part or not is entirely your choice. If you decide to take part, you will be given this information letter to keep and you will be asked to sign a consent form. A copy of the consent form will be placed in your Child’s medical notes.

You can withdraw your consent at any time.

Your decision to take part or not with the research project or, if you withdraw from the project, will not affect the standard of care you receive from the Child and Family Clinic.

What are the Possible Risks or Disadvantages of Taking Part?

The only disadvantage to taking part in the study is that it will require you to give up a little of your time to be interviewed.

What are the Possible Benefits of Taking Part?

The main benefit to taking part in the study is that you will have the opportunity to give your opinion about the appointment system of the Child and Family Clinic. Your views will influence the way the service develops.

What if Something Goes Wrong?

If you are unhappy about the way you have been treated during the course of this research study, you are entitled to complain through the normal Pontypridd & Rhondda NHS Trust complaints route.

Will Taking Part in the Study be Confidential?

All information which is collected about you during the course of the research will be treated as confidential. Any information which leaves the clinic will have your name and address removed from it so that you cannot be identified from it. Your GP will be informed that you have consented to take part in this study, but what you say in your responses will not be given to the GP. Any information that you give as part of the research may be examined by my academic supervisors involved in the research study to ensure the study is being carried out correctly.

Any publication arising from this research will only contain detail that does not identify the source, that is there will be no names and addresses associated with directly quoted material.

What Will Happen to Results of the Study?

The initial results of the study will be reported as a poster in the Child and Family Clinic and later through publications in academic journals.

Who is Organising and Funding the Research?

Cardiff University is responsible for sponsoring the research. The Health Foundation is providing funds to support this research project.

Who has Reviewed the Study?

The study has been reviewed by Bridgend, Neath, Port Talbot and Swansea Local Research Ethics Committee.

Contact for Further Information

For further information about any aspect of this research please contact Nicola Evans, School of Nursing & Midwifery Studies, 35-43 Newport Road, Cardiff CF24 0AB or by telephone 02920 917830.

Thank you very much for carefully reading the above notes, and for considering whether you like to take part in the study.

[Cardiff University headed paper]

Respondent Number:

**Patient Consent Form - Parent**

**Title of Project:** *Addressing and Managing Demand on the Child and Adolescent Mental Health Service (CAMHS)*

**Name of Researcher:** *Nicola Evans*

Please initial box

1. I confirm that I have read and understand the information sheet dated[date]

(version 3)

for the above study and have had the opportunity to ask questions.

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected.

3. I understand that sections of any of my medical notes may be looked at by Nicola Evans or her supervisors from Cardiff University or from regulatory authorities where it is relevant to my taking part in research. I understand that any information about me will be anonymous for the purpose of this study. I give permission for these individuals to have access to my records.

4. I agree to take part in the above study.

\_\_\_\_\_  
Name of Parent or Carer  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Person taking consent  
Signature

\_\_\_\_\_  
Date

(if different from researcher)

\_\_\_\_\_  
Researcher

\_\_\_\_\_  
Date

Signature

1 for patient; 1 for researcher; 1 to be kept with hospital notes

## **Patient Information Sheet - Child**

Research project Addressing and Managing the Demand on the Child and Family Clinic

### Purpose of the study

We have been trying to improve the appointment system in the Child and Family Clinic at the Princess of Wales Hospital, Bridgend, so that children and young people like yourself do not have to wait too long for an appointment. We have started running a “triage clinic”. This is a short appointment when we can meet children, young people and their families to work out if there is any service the child and Family Clinic can offer or if they would be better going somewhere else. The reason we set this up was because some families waited a long time to be seen.

We now need to find out if the changes we have made are better or not. To do this I would like to speak to children and young people, with their family, to see what they think. I would like to talk to people who came to the Child and Family clinic before we changed things and would also like to talk to families who came to the triage clinic.

### Why Have I Been Selected to Take Part?

The children and young people and their families have been chosen because they attended their first appointment during a particular month.

### What is Involved?

All families will be asked if they would talk to me about what it was like for them coming to the Child and Family Clinic. I will tape record our talk, so that I can play it back and write it down exactly as stated on the tape. You can hear what your voice sounds like on the recorder if you want. After I have written it down, the recording will be destroyed.

I will meet with families either at their home or at a place that is convenient for families, such as the Clinic, or the school. I will see children with or without their parents whichever they prefer. The meetings will take between 30-40 minutes.

The notes I make from the recording will be safely stored in Cardiff University so that nobody else can read them.

### Do I Have to Take Part?

Whether you take part or not is your choice. If you decide to take part, you will be given this letter to keep.

You can change your mind and stop taking part at any time. This will not affect any contact you have with the Child and Family Clinic now or in the future.

### What are the Not so Good Bits of Taking Part?

I will need to take up some of your time to talk to you. This will probably be at your home or in a place that is easy for you and your family to get to.

### What are the Good Bits of Taking Part?

What you say will help us decide if we are organising the appointments properly in the Child and Family Clinic.

### Will Other People Know What I've Said in the Interview?

All information which is collected about you during the course of the project will be treated as confidential. That means I will not be able to repeat things you have said to me and say that it was you who said it. The only time I may have to say anything to anyone else is if I am very worried about the safety of someone in the family. I will have to tell someone about that

Your Family Doctor will be told that you have agreed to take part in this project. Any information that you give as part of the project may be looked at by my academic supervisors to check it is being carried out correctly.

### What Will Happen to Results of the Study?

The initial results of the study will be put on a poster in the Child and Family Clinic. After the project is complete, articles will be written for journals, or magazines that are read by doctors, nurses, social workers and other people who work in the hospital.

### Who is Organising and Funding the Research?

Cardiff University is responsible for sponsoring the research. This means Cardiff University is responsible for making sure the research is done correctly. The Health Foundation is providing money to pay for the project.

### Who has Reviewed the Study?

The study has been reviewed by Bridgend, Neath, Port Talbot and Swansea Local Research Ethics Committee. This committee makes sure that projects for people living in your area are done properly.

### Contact for Further Information

For further information about any aspect of this project please contact Nicola Evans, School of Nursing & Midwifery Studies, 35-43 Newport Road, Cardiff CF24 0AB or by telephone 02920 917830.

Thank you very much for carefully reading the above notes, and for deciding whether you would like to take part in this project.

[Cardiff University headed paper]

Respondent Number:

**Patient Consent Form - Child**

**Title of Project:** *Addressing and Managing Demand on the Child and Adolescent Mental Health Service (CAMHS)*

**Name of Researcher:** *Nicola Evans*

Please tick box

1. I have read and understand the information sheet about this research study.
  
2. I understand that I can choose whether or not to take part. I can change my mind at any time and stop taking part later if I want.
  
3. I understand that any information about me will be anonymous, that means will not have my name or address on it.
  
4. I agree to take part in the research study.

\_\_\_\_\_  
Name of Child or Young Person  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Person taking consent  
Signature  
(if different from researcher)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Researcher  
Signature

\_\_\_\_\_  
Date

1 for patient; 1 for researcher; 1 to be kept with hospital notes



# Child & Family Clinic



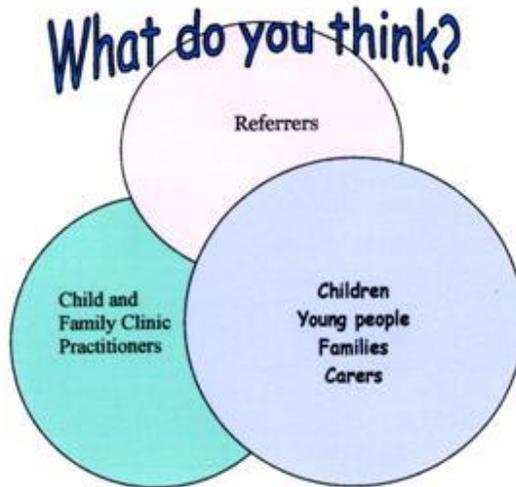
## What did you think of your first appointment here?

The Child and Family Clinic has introduced a new way of organising first appointments. You may be familiar with the 'Triage clinic' at which children and young people are now seen for the first time.

I am currently working with the Child and Family Clinic at the Princess of Wales Hospital to find out what people think about the new triage clinic and how it compares to the previous appointment system.

As well as asking practitioners in the Child and Family Clinic, and referrers like GPs, School-teachers and Social workers, **I am very interested to hear about your experience of being referred to and your first appointment here.**

### What do you think?



If you would like to offer your views in confidence, please either complete you name and address and post in the envelope below or contact

Nicola Evans

Phone: 02920 917830

Email: [EvansNG@cf.ac.uk](mailto:EvansNG@cf.ac.uk)

**Mental Health & Learning Disabilities Directorate  
School of Nursing & Midwifery Studies  
Cardiff University**

Nicola Evans  
Phone: 02920917830  
Email: [EvansNG@cf.ac.uk](mailto:EvansNG@cf.ac.uk)



**GP Letter**

[Cardiff University Headed Paper]

[GP name & address]

[Date]

Dear [GP]

Re research study: **Using Action Research Methodology to Inform the Development, Implementation and Evaluation of a System of Care that Addresses the Demand on a Child and Adolescent Mental Health Team**

I would like to inform you that [patient's name] has consented to take part in a research study that I am conducting as part of my PhD studies at Cardiff University under the supervision of Professor D Allen.

Please find enclosed a copy of the information sheet that they were given, so that you have an understanding of the project outline.

If you require further details of the project, please feel free to contact me.

Yours sincerely

Nicola Evans  
Lecturer  
School of Nursing & Midwifery Studies  
Tel no: 02920 917830  
Email: EvansNG@cf.ac.uk

## **Practitioner Consent Letter**

[Cardiff University Headed Paper]

[Name of practitioner  
Address of practitioner]

[Date]

Dear [Practitioner]

I would like to invite you to take part in a research project that I am doing for my PhD studies at Cardiff University under the supervision of Professor D Allen. I have enclosed an information letter that gives an overview of the project in addition to a description of what would be expected from you if you agree to participate. If you would like further information to aid your decision making, please feel free to contact me.

I would be very grateful if you could respond to me within 2 weeks of the date of this letter.

Thank you very much for your careful consideration and for consenting to participate with this study.

Yours sincerely

Nicola Evans  
Lecturer  
School of Nursing & Midwifery Studies  
Tel no: 02920 917830  
Email: evansng@cf.ac.uk

## **Project Information Sheet**

Project Title: Addressing and Managing the Demand on a Child and Adolescent Mental Health Service

### Purpose of the study

The aim of the project is to develop, implement and evaluate a system of care that addresses the demand placed upon a Child and Adolescent Mental Health Service (CAMHS). The current demand exceeds the service provision with the result that referred cases remain on a waiting list for assessment and treatment for approximately 6 months. This project is designed as an evaluation of practice development.

A system of triage, or brief assessment of cases referred to CAMHS is being established, with the intention of improving the system of making decisions about suitability and prioritisation of referred cases. Having introduced a new method of working, it is imperative that the impact of the new system is systematically evaluated.

The proposed evaluation will contain two strands:

1. An evaluation of the impact of the new system of working upon patients, referrers and practitioners within the team
2. An evaluation of how the practitioner team has negotiated the process of change.

### Selecting Participants

I am asking all practitioners within the Bridgend team of Pontypridd and Rhondda NHS Trust Child and Family Service to take part in the research. This will exclude people who join the team for brief periods, such as student nurses.

### What is Involved?

All practitioners will be asked to consent to be audiotaped during the team meetings on a once monthly basis. The data collection will take place over a period of 12 months. All practitioners will be asked to consent to being interviewed once pre-intervention (introduction of triage system) and once post-intervention.

For those practitioners who decide not to consent to the study, their contributions to team discussions will not be transcribed and used in analysis.

### Do You Have to Take Part?

Whether you take part or not in the research study is entirely your choice. Given that the study is evaluating a change in clinical practice, your choice to take part in the

study is limited to whether you would like to contribute to the evaluation of the change. Whether you contribute to the new clinical working practices needs to be determined between you and your line manager.

If you decide to take part in the study, you will be given this information letter to keep and you will be asked to sign a consent form. You can withdraw your consent at any time.

#### What are the Possible Risks or Disadvantages of Taking Part?

You will be required to give up a little of your time to be interviewed.

#### What are the Possible Benefits of Taking Part?

The main benefit to taking part in the study is that you will have the opportunity to give your opinion that may influence future developments within your service.

#### Will Taking Part in the Study be Confidential?

All information that is collected about you during the course of the research will be treated as confidential. Any information collected from you will have your personal details removed from it so that you cannot be identified. Any information that you give as part of the research may be examined by my research supervisor to ensure the quality of the study is satisfactory.

#### What Will Happen to Results of the Study?

The initial results of the study will be reported to the patients through the Child and Family Clinic and later through publications in academic journals.

#### Who is Organising and Funding the Research?

Cardiff University is responsible for sponsoring the research; this means Cardiff University are responsible for the monitoring and supervision of the study. As I am conducting this project for my PhD studies, I will be supervised by Professor D Allen.

An application has been made to the Health Foundation to fund the research.

#### Who has Reviewed the Study?

The study has been reviewed by Bridgend, Neath, Port Talbot and Swansea Local Research Ethics Committee.

#### Contact for Further Information

For further information about any aspect of this research or to be sent a copy of the research proposal that was submitted to the Local Research Ethics Committee, please contact Nicola Evans, School of Nursing & Midwifery Studies, 35-43 Newport Road, Cardiff CF24 0AB or by telephone 02920 917830.

Respondent Number:

**Practitioner Consent Form**

**Title of Project:** *Addressing and Managing Demand on the Child and Adolescent Mental Health Service*

**Name of Researcher:** *Nicola Evans*

Please initial box

1. I confirm that I have read and understand the information letter dated [date]

(version 1)

for the above study and have had the opportunity to ask questions.

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason.

3. I agree to take part in the above study.

\_\_\_\_\_  
Name of Practitioner  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Researcher  
Signature

\_\_\_\_\_  
Date

1 for practitioner; 1 for researcher;

## Referrer Information Letter

[Cardiff University Headed Paper]  
[Referrer Name  
Referrer Address]  
[Date]

Dear [Referrer]

### Research study: **Using Action Research Methodology to Inform the Development, Implementation and Evaluation of a System of Care that Addresses the Demand on a Child and Adolescent Mental Health Team**

I would like to invite you to take part in a research project that I am doing for my PhD study at Cardiff University under the supervision of Professor D Allen. Please find enclosed an information sheet that gives an overview of the project as well as what would be expected of participants.

You may be aware that the CAMHS Service, also known as the Child & Family Clinic, in the Princess of Wales Hospital, Bridgend has been operating a Triage Clinic on a regular basis since September 2005. Predating this was a 4 month trial period between April-July 2005.

The reason for setting up this Triage Clinic was to address the long waiting lists for the Bridgend CAMHS service. In trying to evaluate this new initiative, we very much would like your view of the triage clinic.

Thank you very much for carefully reading the enclosed notes, and for considering taking part in this study.

To take part, please complete and return the enclosed questionnaire. If you would be able to offer further information, please either complete the section on the form or leave contact details so that I can have a telephone conversation with you.

If you would like to discuss any aspect of the research project, please feel free to contact me on the details overleaf.

Yours sincerely

Nicola Evans  
Lecturer  
School of Nursing & Midwifery Studies  
Tel no: 02920 917830  
Email: [Evansng@cf.ac.uk](mailto:Evansng@cf.ac.uk)

## **Project Information Sheet Referrers**

Project Title: Addressing and Managing the Demand on a Child and Adolescent Mental Health Service

### Purpose of the study

The aim of the project is to develop, implement and evaluate a system of care that addresses the demand placed upon a Child and Adolescent Mental Health Service (CAMHS). The current demand exceeds the service provision with the result that referred cases remain on a waiting list for assessment and treatment for approximately 6 months.

A system of triage, or brief assessment of cases referred to CAMHS is being established with the intention of improving the system of making decisions about suitability and prioritisation of referred cases. The triage clinic will involve a brief assessment that lasts approximately 20mins. Families are given questionnaires to complete in the waiting area when they arrive for their appointment. The referred child or young person are then interviewed usually with their family or carers to establish the main problem areas, the degree of impairment in functioning of the child or young person and the level of risk. This information along with the information generated by the questionnaires are used as a basis for decision-making about the contribution that CAMHS could offer the referred child or young person.

The possible outcomes from a triage are for the child or young person to

- Be allocated immediately
- Be allocated for a specific intervention and be told approximately how long they will wait for that appointment
- Be referred to the primary mental health worker who can liaise with the appropriate provider in primary care
- Be referred on to a more suitable agency
- Be discharged, with or without useful information as appropriate (such as reading material, or web address).

A letter indicating the outcome of the triage is then sent back to the referrer.

Having introduced a new method of working, it is imperative that the impact of the new system is systematically evaluated.

The proposed evaluation will contain two strands:

3. An evaluation of the impact of the new system of working upon patients, referrers and practitioners within the team
4. An evaluation of how the practitioner team has negotiated the process of change.

### Selecting Participants

All practitioners who referred children and young people to Bridgend CAMHS within the 12 months preceding the project start date will be invited to participate in this study.

### What is Involved?

All practitioners will be asked to complete a questionnaire at 2 points after the new triage system has started; at 6 months and at 12 months.

### Do You Have to Take Part?

Whether you take part or not in the research study is entirely your choice. If you decide to take part, you will be given this information letter to keep and you will be asked to sign a consent form. You can withdraw your consent at any time.

### What are the Possible Risks or Disadvantages of Taking Part?

You will be required to give up a little of your time to complete the questionnaires.

### What are the Possible Benefits of Taking Part?

The main benefit to taking part in the study is that you will have the opportunity to give your opinion that may influence future developments within the CAMHS service.

### Will Taking Part in the Study be Confidential?

All information that is collected about you during the course of the research will be kept strictly confidential. Any information collected from you will have your personal details removed from it so that you cannot be identified. Any information that you give as part of the research may be examined by my research supervisor to ensure the quality of the study is satisfactory.

If you withdraw consent to take part in the study, any data you previously contributed to the study will be destroyed.

### What Will Happen to Results of the Study?

The initial results of the study will be reported to patients and referrers through the Child and Family Clinic and later through publications in academic journals.

### Who is Organising and Funding the Research?

Cardiff University is responsible for sponsoring the research; this means Cardiff University are responsible for the monitoring and supervision of the study. As I am conducting this project for my PhD studies, I will be supervised by Professor D Allen.

The research is being funded by the Health Foundation.

### Who has Reviewed the Study?

The study has been reviewed by Bridgend, Neath, Port Talbot and Swansea Local Research Ethics Committee.

Contact for Further Information

For further information about any aspect of this research or to be sent a copy of the research proposal that was submitted to the Local Research Ethics Committee, please contact Nicola Evans, School of Nursing & Midwifery Studies, 35-43 Newport Road, Cardiff CF24 0AB or by telephone 02920 917830.

Thank you very much for carefully reading the above notes, and for considering taking part in this study.

## Referrer Survey Letter

Cardiff University Headed Paper]

[Referrer Name  
Referrer Address]

[Date]

Dear [Referrer]

FINAL survey

Research study: **Using Action Research Methodology to Inform the Development, Implementation and Evaluation of a System of Care that Addresses the Demand on a Child and Adolescent Mental Health Team**

*Please* could you complete and return the enclosed questionnaire relating to the CAMHS Triage service. This has been in operation for 15months in total and we are now at the stage of the final data collection. Even if you have completed a previous questionnaire, your current views are valuable.

I have not included an information sheet this time, but should you like one, or to discuss the project, please contact me.

Yours sincerely

Nicola Evans  
Lecturer  
School of Nursing & Midwifery Studies  
Tel no: 02920 917830  
Email: [Evansng@cf.ac.uk](mailto:Evansng@cf.ac.uk)

## **Appendix Seven: Specialist CAMHS at Tiers 2 and 3**

Specialist mental health services for children and young people up to their 18th birthday, including:

- Liaison with and consultation to other agencies.
- Assessment and treatment of psychiatric and neuro-developmental disorder, including-
- Psychosis
- Depressive disorders
- Attention Deficit Hyperactivity Disorder
- Autistic spectrum disorders
- Tourette's syndrome and complex tic disorders.
- Self-harm and suicide attempts
- Eating disorders
- Obsessive compulsive disorder
- Phobias and anxiety disorders
- Mental health problems secondary to abusive experiences
- Mental health problems associated with physical health problems and somatoform disorders

The following services can also be provided exclusively by specialist CAMHS but in some areas may be provided for by other agencies and specialists such a community paediatricians, health visitors and multi-agency teams, with input by specialist CAMHS workers:

- Services for under five year olds with milder behaviour or sleep problems (e.g. provided by health visitor sleep and behaviour clinics)
- Mental health problems associated with learning disability (e.g. provided by multi-agency teams)
- Disruptive behaviour and Conduct disorders (e.g. Youth Offending Teams and local authority services)
- Adjustment disorders (e.g. voluntary sector services dealing with parental separation)
- Elective mutism (e.g. speech and language therapy services)
- Elimination problems (e.g. paediatric and health visitor services)

(York and Lamb, 2005)

