

Portfolio including Thesis

Volume 1 of 2

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Looked After Adolescents' experience of mental health services

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**Why Should Clinical Psychologists
Work With Older Adults? Give a Critical
Analysis of the Nature and Purpose of
Clinical Psychology in Services for
Older People**

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Introduction

In order to address this essay question effectively it will first be necessary to evaluate historically the services that have been provided for older adults. This will include taking into consideration the social, as well as psychological reasons that services for older adults were previously neglected. I shall then explore the nature of the mental health problems that older adults experience identifying both functional and organic mental health problems. Following on from this it will be relevant to look at the nature and purpose of clinical psychology in older adult services, evaluating the unique skills and services that clinical psychology can offer. Attention will also be paid to whether these services should be different to those provided for adult service users. I shall also consider issues of ageism and diversity and the implications these have for psychological services for older adults and their delivery. Finally I will offer a discussion of developments for the future. This essay will conclude by elucidating the nature and purpose of the work conducted by clinical psychologists, as well as highlighting the need for continued development in psychological services for older adults.

Historical and social context

Historical context

Historically the neglect of older people by psychological services has been attributed to Freud's dismissal of older people's capacity to change. This has been suggested in view of increasing cognitive rigidity as well as concerns regarding the sheer volume of life experiences to be covered (Knight, 1996, Lee et al., 2003, Woods, 2003). It is recognised that Freud's scepticism regarding the value of psychotherapy for older people influenced the delivery of psychological services for older adults. To a certain extent attitudes and the literature in this area have continued to display a pessimistic attitude. This is highlighted by the fact that The British Psychoanalytic Society, the main institution governing psychoanalysis in Great Britain, did not officially accept clients over the age of forty until 1986 (Lee et al., 2003).

Despite some pessimism it would be fair to say that since Freud's writing society has moved on and there has been change in the provision and delivery of psychological services for older adults. There are now clinical psychologists who specialise in older adult services. Furthermore, specialised research is now being conducted in this area, and policies such as the National Service Framework (NSF) have been devised to address the needs of the client group (National Service Framework for Older People, 2001).

Epidemiology and older adults

In addition the older adult population has changed considerably and will continue to change with the over 65's being the fastest growing population. Currently the number of very elderly people is increasing with more people living over the age of 75 and the fastest growing group of people in Western Countries being those over the age of 85. It is anticipated that the big growth will come after the year 2011 when the 'post war generation' reaches old age (Britton & Woods, 1999).

With the population living longer, this has serious implications for clinical psychology. The increase in those aged over 85 is significant because these people are more likely to use health and social services than those aged 65-74 (Woods, 1994). Therefore, for clinical psychologists the challenge is to develop methods not only appropriate to this age group, but also for those who care for them. However, although the population is living longer it should be noted that the majority of people in the older adult age bracket, including those aged over 85, are not confused, highly dependent or in need of psychological services (Woods, 1994).

Regarding population trends and the implications this has for clinical psychologists and recruitment it has been noted that whilst 10 per cent of clinical psychologists work with older people, 20 per cent of the population is 65+ and uses 40 per cent of the NHS budget (Lee et al., 2002). This as well as other literature would suggest that older adults are being significantly under

served (Lee et al., 2002, James et al., 1995). These figures also highlight that whilst general vacancies are widespread in clinical psychology, under recruitment in the field of older adults is a particular problem (Britton & Woods, 1999).

Nature of mental health problems experienced by older adults

Older adults experience a variety of functional and organic mental health problems although the dementias and depression are most common (Woods, 1999).

Functional mental health problems

Whilst functional mental health problems such as depression and anxiety are experienced throughout the population there are vulnerabilities that are more common to certain age groups. For older adults these include retirement, an increase in physical health problems and bereavement. It is commonly thought that this can be a time when mental health problems surface due to difficulties with adjustment. For many of the older adults receiving psychological services today there will also be generational factors. These will include the war for those in their 70's and 80's and the Blitz and evacuation for those in their 60's. These experiences will have made a significant impact on their life history as well as their psychological well-being.

There is also the issue of social context, which can be a risk factor for depression for some older people. Particularly for those who find themselves in nursing homes or those who are socially isolated. In addition it has been reported that older people are the most likely age group to successfully commit suicide. Data from a large number of countries indicates that elderly males have the highest rate of suicide in virtually every country (Cattell, 1994). Fear of falling also has a major impact on older peoples well being, often making them housebound. This has been suggested to be the biggest fear for older people (Howland et al., 1993).

In addition older adults experience the life events that other members of society go through including disappointment in love, conflict in relationships with loved ones and failure with personal goals. There are also those that have experienced depression, anxiety, psychosis and substance abuse throughout their life and are continuing to struggle with these difficulties into older adulthood (Knight, 1996).

However, although old age can be a time when mental illness surfaces the majority cope with the transition without difficulty (Woods, 1994). Peter Coleman comments on how well older people do adjust to, and cope with life as they become older. He comments how theorists who have seen old age positively seem to provide more useful models of aging, such as Erikson's ideal of the goal of integrity as the goal of life. Coming to terms with life as it has been lived, making sense of a changing society and facing the reality of death (Coleman, 1993).

Organic mental health problems

With regards to organic mental health problems it is the dementias that have particularly led to the development of psychological services. Whilst it is recognised that younger people may develop a dementia prevalence of developing a dementia increases with age (Woods 2003, 1999, Challis et al., 2002). Although the figures are presented differently in various studies the general consensus is that the prevalence doubles for each increase of 5.1 years. Widely accepted figures for the prevalence of dementia in the older adult population is that 5% of over 65's and 20% of over 80's have a dementia (Livingstone & Hinchcliffe, 1993). Although a minority of the older adult population are affected by dementia there is still a tendency to presume that all older people show some level of cognitive decline. Whilst age may have some bearing, there are other factors that may impact on the cognitive differences between a younger person and an older adult including socio-cultural factors such as health care, nutrition and sensory abilities (Britton & Woods, 2003).

Nature and purpose of clinical psychology in services for older adults

The nature and purpose of clinical psychology in older adult services has changed considerably over the past thirty years. In the early 1970's almost all psychological work was restricted to assessment. Towards the end of the 1970's there was an increase in interventions and service context work. The 1980's saw an increasing number of publications in the UK and USA for psychological work with older adults demonstrating a wider range of approaches applicable to the work with older people (Britton & Woods, 1999). This time period indicated an increase in interest and activity in psychological work with the elderly, which was complemented by an increase in attention being paid to older adults on clinical training courses. The PSIGE (Psychologists' Special Interest Group – Elderly) group was also founded in 1980, which later became a sub system of the British Psychological Society, Clinical Division (Britton & Woods, 1999). The nature and purpose of clinical psychology in services for older adults today involves a multitude of tasks including assessment, formulation, intervention, family work, consultation and research.

Assessment

This includes individual assessment of psychological needs and well being, cognitive assessment of intelligence, memory and other such areas as well as assessment of family and carers in systemic work with families. Clinical psychologists also bring skills to the team, which can prove beneficial for a comprehensive assessment to inform and guide care plans and observational methods (Woods, 1999).

In addition neuropsychological assessments are a unique type of assessment offered by clinical psychologists to assess cognitive functioning and deficits and their impact. Davies states that 'neuropsychological assessment requires the detailed, systematic testing of various important psychological functions thought to maintain a human in an adaptive state. In older people we are trying to understand the breakdown or changes that occur either through the aging

process itself or through the action of various diseases which may or may not be primarily cerebral in their origins' (Davies, 1997). Regarding the diagnosis of dementia clinical psychologists have a vital role to play via neuropsychological testing. A comprehensive, sensitive neuropsychological assessment has been described as the best tool available for assessing cognition in older people as well as forming an essential part of the diagnostic process. It can also offer guidance for treatment, rehabilitation or management. (Davies, 1997).

For clinical psychologists adopting a holistic approach when conducting psychological assessments with older people it should be part of the nature and purpose of the role to be aware of wider issues impacting upon the individual. Aging is perceived by most as a time of inevitable physical and mental decline, where cognitive impairment becomes inevitable. As part of the nature and role of the clinical psychologist it is imperative that when conducting assessment we guard against these ageist attitudes. The skill of the assessor should ensure that emotional, physical and social factors are also considered when conducting the assessment and formulating. Subsequently we need to ensure that the assessment is being carried out in the interests of the older person.

Formulation

Whilst traditionally psychometric assessment was the major task carried out with older people by clinical psychologists, this has changed and there is now a greater emphasis on treatment and management of psychological problems, based on assessment and formulation (Britton & Woods, 1999).

Formulation is a technique central to the purpose of the work carried out by clinical psychologists and involves the bringing together of information to provide an individual account of the clients world and aspects that contribute to their difficulties. This again is not only invaluable to the individual but can be a crucial tool for the team in devising a care package to meet the individuals needs.

Interventions for functional and organic mental health problems

Clinical psychologists have much to offer with reference to interventions covering a wide scope of areas including cognitive and memory deficits using reminiscence and reality orientation, behavioural modification work in residential and institutional settings, family therapy and group work as well as individual therapy from a variety of therapeutic approaches more closely resembling the work of other client groups (Woods, 1999).

With regards to Cognitive Behavioural Therapy (CBT) research carried out demonstrated that CBT could be effective in treating older adults. With particular reference to late life depression a study by Terri et al. viewed approximately 20 studies employing variations of cognitive or behavioural strategies. The results found that substantial improvement was seen in 50-75% of the patients, which compares favourably with results of studies using pharmacotherapy as the treatment modality (Terri. et al., 1994).

In addition various studies on the use of psychodynamic psychotherapy with older adults have been carried out (Thompson, et al, 1987, Sloane et al, 1985 & Gallagher & Thompson, 1982). These studies appear to suggest that psychodynamic psychotherapy is superior to no treatment and roughly equal in effectiveness to other types of treatment. This would also offer support to the notion that psychodynamic psychotherapy for older adults is effective contradictory to Freud's belief.

Life review and reminiscence therapies have also developed as a means of working psychologically with older adults. Life review has a long standing history in work with older adults. Reminiscence has been argued to be a natural and healthy psychological activity that is often used effectively in therapy with grieving clients (Knight, 1996).

In addition to therapeutic approaches for functional mental health problems clinical psychology has been at the forefront of developing therapeutic

approaches for working with people with dementia (Woods, 2003). Psychological work with people with dementia will not reverse its effects but should aim to improve the quality of life of the person and their carer. This can be done using several tools including dementia care mapping, life review and reality orientation. Kitwood has encouraged taking a person-centred approach towards working with people with dementia for improving the individual's self-esteem and quality of life (Woods, 2003, Kitwood, 1997). Reminiscence and life review work taking a life span developmental approach allows us to recognise the impact of difficult life events and life circumstances. A more recent development in care for people with dementia is being taken forward by Allen & Newby, who are developing a multimedia life review tool to guide future care in order to preserve personhood in dementia. This tool aims to allow people with dementia to make their wishes clear and ensure people are able to exercise judgement whilst they are able to do so (Allen et al., 2003).

Clinical psychology also plays a vital role in specialist services for dementia such as memory clinics. Phipps and O'Brien have highlighted that memory clinics have been established in the context of clinical governance and the drive for quality improvement, which is driven by the NSF for older people and the National Institute for Clinical Excellence (NICE) (Phipps & O'Brien, 2002).

Whilst there is literature based on the nature of the work carried out by clinical psychologists for those with dementia excluding reality orientation there has been little systematic evaluation of interventions. Although techniques have been employed to improve functioning in people with dementia such as reminiscence therapy, cognitive therapy and behaviour modification, the absence of controlled trials makes it difficult to draw conclusions about the efficacy of the treatments despite promise shown in case reports and open trials (Woods & Roth, 1996).

Family work

The nature and purpose of the clinical psychologist in services for older people also involves scope for carrying out work with the family. The impact of a diagnosis of dementia can spread from the person with dementia to the main carer and wider family. Likewise this can be the case when an older person suffers with depression or any other form of mental illness. Within systemic family therapy events that can impact on peoples relationships with each other are called 'transitional events' because they usually have an impact on the way the family organise themselves (Dixon & Curtis, 2003). There is therefore much scope for family work with older adults and their carers and family (Woods, 2003). Regarding elder abuse there is also a place for psychology to carryout psychosocial interventions with families and carers. Interventions can be helpful for residential as well as family environments for reducing elder-abuse (Kingston & Reay, 1996).

Consultation and research

Consultation is another area in which clinical psychologists flourish, disseminating their knowledge and guiding others regarding the therapeutic milieu. Staff training and consultation interventions are increasingly reported for people who reside in nursing care homes, particularly those with dementia. In addition clinical psychology has a central role to play in multidisciplinary work. Community care has become the focus for the provision of health and social care services for older people in most western societies. This has been enforced via the Community Care Act, 1990. This involves multi disciplinary work between the various disciplines in order to provide a care package for the individual. The role of the psychologist in the multidisciplinary team can involve supporting the development of flexible care strategies that consider ways of enabling older people with mental health problems to benefit from services and to ensure services are being addressed to meet their needs rather than the needs of others who insist upon care being provided. Psychologists are often drawn in when a client is presenting as difficult and a behavioural modification plan is required (Woods, 1994).

Taking into consideration the broader context clinical psychologists have much to offer in the development of our understanding of older adults and the aging process through our active interest in research. Psychology has also been useful in providing models of aging such as the life span development model advocated by Erickson (Erickson, 1995).

Possible adaptations for psychotherapy for older adults

Although effective therapeutic interventions have been highlighted above it has been suggested that whilst many of the issues affecting older adults are similar to those issues affecting adults aged 18-65 there are some key vulnerabilities unique to this age group. When carrying out psychological work with older adults it is important to consider adjustment issues, losses, separation and bereavement, social events such as war and evacuation and the implications, social and emotional support and cohort effects. In terms of presentation it is crucial to consider sensory impairments, polypharmacy and the fact that older people often present with more somatic symptoms. Due to these factors there is a debate amongst therapists working with older adults as to whether psychotherapy needs to be adapted to ensure optimal treatment outcome. It would be paramount that this should be done without substantially altering the rationale or the process of therapy. These adaptations can include therapist factors such as the therapist's own issues of treating older adults and their belief in the ability of older adults to change. Education through learning what therapy actually involves can also be crucial, particularly for those who have been socialised to think that psychologists see people who are 'crazy' and for those who are more familiar with the medical model and will expect a 'quick fix'. Sensory changes can be another crucial factor to consider when carrying out psychotherapy with older people. Many of these adjustments can be simple but are crucial such as using video/audio tapes when written tasks are difficult. Physical problems also need to be adapted for particularly if carrying out behavioural interventions that may involve physical strength such as relaxation and graded exposure (Zeiss & Lewinsohn, 1986).

Despite this summary of the nature and purpose of the clinical psychologist in services for older people it is evident that older people appear to be less likely to receive psychological treatment (Woods & Roth, 1996). It is also interesting that there are far fewer studies of effective psychological treatment for older people in comparison to younger people (Woods, 1999). Although it has been demonstrated that clinical psychology services have developed in the work with older adults it would seem that there are still issues, such as ageism that provide obstacles.

Ageism

It is important to recognise that there has been a steady expansion of interest in psychologists carrying out work with older people in addition to special interest groups such as PSIGE being set up to form support and encourage enthusiasm for the subject as well as exposing and working to combat issues such as ageism. However, ageism is a concept that is very much alive within British society and psychology today (Woods, 2003). The issue of ageism against older adults has been acknowledged in a recent paper by Woods who states 'It is widely accepted that the provision of health services, including psychological services, to older people is subject to ageism' (Woods, 2003). It has also been suggested that older people are less likely than younger people to receive psychological treatment despite a similar prevalence of psychological problems such as depression and a greatly increased prevalence of the dementias (Woods & Roth, 1996). It is often claimed that older people do not want such services. However, in the USA a survey of younger and older adults was conducted to ascertain preference for treatment of depression and older adults had a similar or more positive attitude to various aspects of the mental health services including psychodynamic therapy and CBT (Rokke & Scogin, 1995).

There are concerns that clinical psychologists as well as other health professionals and the general public have ageist attitudes, perhaps believing that therapeutic change in older people is not attainable or even worthwhile. It is

interesting that psychological services for adults are divided into those for adults, being those aged 18–65, and those who are over 65 implying that there is some arbitrary cut off when services cease to be relevant, or that the nature of psychological problems suddenly change (Woods, 2003). This is not to minimise the fact that there are organic mental health problems that are more prominent in later life, as has been highlighted above, however many of the functional mental health problems present with the same symptoms throughout the population. There are also social issues unique to older adults such as retirement, which no doubt impact upon mental health however does that create a need for a different service? Within the adult age bracket of 18-65 it would be possible to divide this into sub groups by way of developmental stages such as becoming a parent, buying a home and reaching other milestones which all potentially pose significant life changes and have a bearing on mental health.

An article by Gilleard et al. takes a more detailed look at the concept of ageism and suggests that it seems many of the problems older people confront come not from a critical or disparaging public but from institutionalised ageism. They elucidate how the existence of age discrimination in medical and psychiatric care has been well documented. They reveal that there is evidence of age discriminatory practises within the mental health field particularly in the under treatment of depression and the over-sedation of older mentally frail patients in nursing home care. With regards to psychologists in particular they note how recent research suggests that psychologists display distinctly less enthusiasm for working with older age groups than younger or middle aged adults (Gilleard, et al., 1995).

In training for clinical psychologists a placement with older adults has been a core requirement for several years. This aims to allow exposure to positive experiences and encourages an understanding of the client group. However, with the new structure of the clinical training which will focus on gaining core competencies as opposed to focusing on training placements it will be possible that trainees are able to avoid placements with older adults, which could have

implications for recruitment in such services (Knight, 1996). In a study carried out measuring the attitudes towards psychotherapy with older people among trainee clinical psychologists they found that although a significant number of trainees held negative stereotypes about therapeutic work with older people, positive attitudes were also expressed towards the profession (Lees, et al., 2003).

Diversity

In terms of diversity in general it was evident that there is scope for research in this area with few available studies.

Regarding cultural issues old age appears to carry different connotations within various cultures. Whilst a discussion of ageism has been presented which is more associated with British Culture it is evident that these attitudes are not shared in all cultures. In a longitudinal study of the over 85's carried out in San Francisco it was found that the very old held a special status as long term survivors (Johnson & Barer, 1992; 1996). In this study the African-Americans viewed their long lives positively attributing them to religious and supernatural significance (Johnson & Barer, 1992; 1996). Culture also appears to have a bearing over how older adults are cared for with different ethnic groups holding different values about caring for older people (Lawton et al., 1992).

With regards to gender in a report based on a study carried out by ONS on psychiatric morbidity of adults aged 16-74 it was found that women were more likely to have significant levels of neurotic symptoms in comparison to men (Evans et al., 2003). It was also found that whilst the prevalence of mental disorder decreased with age this was statistically more significant only for men. It was also interesting that whilst being married was associated with lower prevalence of mental disorder for men at 7% married women had a higher prevalence of experiencing mental disorder at 12% (Evans et al., 2003).

There are also issues regarding social class and poverty for older adults with a large proportion of older adults in Britain living in poverty (Bond et al., 1993, Woods, 1999). It has been reported that the prevalence of common mental disorder increased steadily with decreasing household income. It was also found that common mental disorders were more prevalent for those from lower social classes (Evans et al., 2003). In addition social class also has implications for mental health and access to fee-paying services.

Future Development

In terms of the future and a positive way forward, the NSF emphasizes the fundamental importance of combating discrimination on the basis of age in the provision and delivery of health care (NSF for Older People, 2001). This marks recognition that ageism is an issue for health services and it will be important for psychological services that this is recognised and tackled. However is it an ageist notion in itself that we have a National Service Framework for older people (NSFOP)? Within the NSFOP there has been explicit recognition of clinical psychology as a key profession, as well as recognition of the validity and importance of psychological treatments. The opportunities for clinical psychologists in NSFOP include person-centred care: the single assessment process, 'psychological care' and information for choices, clinical psychologists being identified as core members of mental health teams, and as part of stroke teams. Further opportunities arise in relation to memory clinics and young onset dementia services. However there are also some omissions in NSFOP appertaining to clinical psychology, which include, psychologists not being mentioned as core members of teams in intermediate care, general hospital or falls services with psychological strategies not mentioned for stroke or falls. (Lee et al., 2002).

Another possibility for the future of psychological services focuses on the dementias and depression, which are the major mental health problems experienced by older adults. It has been reported that symptoms of anxiety and depression coexist with dementia. Traditionally assessment has sought to

discriminate between the two however it seems that there should be more awareness of a greater probability of a dual diagnosis (Woods, 1999). From the work carried out by Woods and Roth looking at the effectiveness of psychological interventions with older people they identified implications for the future based on their findings. They highlight the need for specialist psychotherapeutic services for older people to meet the need not only created by mental health problems in the individuals but also to support, advise and treat carers. They also suggest the use of further specialist post qualification training because of the obstacles faced in the treatment of functional disorders, the special problems presented by comorbid organic disorders and the specific difficulties faced by those involved in the care of older people. Early detection of organic problems via routine health checks could also prove useful in recognising problems. Another area for development could be work to support positive attitudes amongst care staff in which dementia sufferers will benefit. There is also scope for development with family work and research and evaluation (Woods & Roth, 1996).

Conclusions

It is evident from this essay that clinical psychologists provide a unique role in the assessment, treatment and research of older adults in services for individuals and their carers and families. However, it is also apparent that there are ageist attitudes that persist within the profession and society, which together place limits on the services being provided. Several issues have been raised that have implications for the services provided, including the growing number of older people in our society and the difficulty in recruitment within the area. It has also been interesting to consider the similarities and differences between mental health problems experienced by older adults in comparison to the general adult population and to fundamentally question whether these services do in fact need to be separate.

This essay began by presenting a historical view of the pessimism injected into psychological services for older adults by Freud. Whilst it is clear that society's

attitudes towards older adults have positively progressed, and that psychological services have developed, it is also apparent that pessimistic attitudes are still held by many, both within the profession and society at large.

References

Allen, C., Newby, G. & Kennally, M. (2003) Forthcoming research in the Oxford region: Innovations in dementia care – the benefits of multi-media profiling for older people with dementia. PSIGE Newsletter (83): 13-14.

Allender, J. A. & Rector, C. L. (1998) Readings in Gerontological Nursing Lipincott.

Baty, F., Bhutani, G., Guss, R., McDonagh, C., Shankland, M. & Stirling, E. (2002) Clinical Psychology Services for Older People in Primary care The British Psychological Society.

Bender, M. (1996) Explorations in Dementia Jessica Kingsley Publishers.

Bond, J., Coleman, P. & Peace, S. (1993) Ageing in Society: An Introduction to Social Gerontology (2nd Ed.) Sage.

Bramesfeld, A. (2003) Service provision for elderly depressed persons and political and professional awareness for this subject: A comparison of six European countries. International Journal of Geriatric Psychiatry (18): 392-401.

Britton, P. G. & Woods, R. T. (1999). Introduction. In R. T. Woods, Psychological Problems of Ageing Chichester: Wiley.

Cattell, H. (1994). Suicide behaviour. In J. R. M. Copeland, M. T. Abou-Saleh & D. G. Blazer (Eds.), Principles and Practise of Geriatric Psychiatry Chichester: Wiley.

Challis, D., Abendorff, R. V., Brown, P., Chesterman, J., & Hughes, J. (2002) Care management, dementia care and specialist mental health services: An evaluation. International Journal of Geriatric Psychiatry (17): 315-325.

Charlesworth, G. (2001) Reflections on using cognitive therapy with depressed family caregivers of people with dementia. PSIGE Newsletter (78): 26-30.

Clinical psychology services for older people in primary care (2002), The British Psychological Society Division of Clinical Psychology Occasional Paper No. 4.

Coleman, P. G. (1999). Identity management in later life. In R. T. Woods, Psychological Problems of Ageing Chichester: Wiley.

Coleman, P. (1993). Adjustment in later life. In J. Bond, P. Coleman & S. Peace Ageing in society: An introduction to social gerontology (2nd Ed.): Sage.

Davies, S. (1997) Neuropsychological assessment of the older person. In R. T. Woods, Handbook of Clinical Psychology of Ageing Wiley.

Dick, L. P., Gallagher-Thompson, D. & Thompson, L. W. (1999) Cognitive-behavioural therapy. In R. T. Woods, Psychological Problems of Ageing. Chichester: Wiley.

Dixon, M. & Curtis, L. (2003) Family work with older adults: Teaching mental health staff ideas and skills from systemic family therapy for everyday work. Signpost to Older People and Mental Health Matters (7) 3: 16-19.

Duffy, M. (1999) Handbook of Counselling and Psychotherapy with Older Adults Wiley.

Eastman, M. (1994) Old Age Abuse: A New Perspective: Nelson Thornes.

Erickson, E. H. (1995) Childhood and Society Vintage: London.

Evans, O., Singleton, N., Meltzer, H., Stewart, R. & Prince, M. (2003) The Mental Health of Older People Department of Health.

Gallagher, D. & Thompson, L. W. (1982). Treatment of major depressive disorder in older adult out patients with brief psychotherapies. Psychotherapy: Theory, Research and Practice 19: 482-489.

Gibson, H. (1999) Ageism among professionals: straight from the horse's mouth. PSIGE Newsletter (69): 3-6.

Gilleard, C., Askham, J., Biggs, S., Gibson, H.B., & Woods, R. (1995) Psychology, ageism and health care: A DCP symposium. Clinical Psychology Forum, 85, 14-15.

Gilleard, C., Lieberman, S. & Peeler, R. (1992). Family therapy for older adults: a survey of professionals' attitudes. Journal of Family Therapy 14: 413-422.

Howland, J., Peterson, E. W., Levin, W. C. & Fried, L. (1993) Fear of falling among the community dwelling elderly. Journal of Aging and Health 5: p. 229-243.

Howley, L. (1998) Influences on choice of specialism: Trainee psychologists, self-esteem, identity and experience. PSIGE Newsletter (68): 9-13.

James, I. A. (2003) Working with older people: implications for schema theory. Clinical Psychology and Psychotherapy 10 (3): 133-143.

James, J.W. & Haley, W. E. (1995) Age and health bias in practising clinical psychologists. Psychology and Aging (10) 4: 610-616.

Johnson, C. L., & Barer, B. M. (1992) Patterns of engagement and disengagement among the oldest old. Journal of Aging Studies 6: 351-364.

Johnson, C. L., & Barer, B. M. (1996) Life Beyond 85 Years: The Aura of Survivorship New York: Springer

Kingston, P., & Reay, A. (1996) Elder Abuse and Neglect. In R. T. Woods, Handbook of the Clinical Psychology of Ageing, Wiley.

Kitwood, T. (1997) Dementia Reconsidered: The Person Comes First Open University Press, Buckingham.

Knight, B. G. (1999) Psychodynamic therapy and scientific gerontology. In R. T. Woods, Psychological Problems of Ageing. Chichester: Wiley.

Knight, B. G. (1996) Psychotherapy with Older Adults, (2nd Ed.) Sage.

Laidlaw, K. (2001) An empirical review of cognitive therapy for late life depression: Does research evidence suggest adaptations are necessary for cognitive therapy with older adults? Clinical Psychology & Psychotherapy, 8: 1-14.

Lawton, M.P., Kleban, M.H., Moss, M., Rovine, M.N. & Glicksman, A. (1989) Measuring caregiving appraisal. Journal of Gerontology: Psychological Sciences, 44: 61-71.

Lawton, M.P., Rajagopal, D., Brody, E. & Kleban, M.H. (1992) The dynamics of caregiving for a demented elder among black and white families. Journal of Gerontology: Psychological Sciences, 47: 156-164.

Lee, K. M., Volans, P. J., & Gregory, N. (2003) Attitudes towards psychotherapy with older people among trainee clinical psychologists. Ageing & Mental Health (2): 133-141.

Lee, T., Critchley-Robbins, S., Smyth, C., McDonagh, C. & Dooley, C. (2002) Implementing the national service framework for older people: What can clinical psychologists do? PSIGE Newsletter (79): 17-23.

Lindesay, J., Briggs, K. & Murphy, E. (1989) The Guys age concern survey: prevalence rates of cognitive impairment, depression and anxiety in an urban elderly community. British Journal of Psychiatry 155: 317-329.

Livingston, G. & Hinchcliffe, A.C. (1993) The epidemiology of psychiatric disorders in the elderly. International Review of Psychiatry 5: 317-326.

McCarthy, G. & Davies, S. (2003) Some implications of attachment theory for understanding psychological functioning in old age: An illustration from the long-term psychological effects of world war two. Clinical Psychology and Psychotherapy; 10 (3): 144-155.

Moniz-Cook, E., Stokes, G. & Agar, S. (2003) Difficult behaviour and dementia in nursing homes: five cases of psychosocial intervention. Clinical Psychology and Psychotherapy 10 (3): 197-208.

Murray Parkes, C. (1996) Bereavement: Studies of Grief in Adult Life (3rd Ed.) Routledge.

National Service Framework for Older People (2001), Department of Health.

Phipps, A. J., & O'Brien, J.T. (2002) Memory clinics and clinical governance – a UK perspective. International Journal of Geriatric Psychiatry (17): 1128-1132.

Pusey, H. & Richards, D. (2001) A systematic review of the effectiveness of psychosocial interventions for carers of people with dementia. Aging and Mental Health 5 (2): 107-119.

Rokke, P. D. & Scogin, F. (1995) Depression treatment preferences in younger and older adults. Journal of Clinical Geropsychology 13: 243-257.

Scholey, K. A. & Woods, B. T. (2003). A series of brief cognitive therapy interventions with people experiencing both dementia and depression: a description of techniques and common themes. Clinical Psychology and Psychotherapy 10 (3): 175-185.

Scogin, K. (2001) The First Session with Seniors Wiley.

Scott, J. & Clare, L. (2003) Do people with dementia benefit from psychological interventions offered on a group basis? Clinical Psychology and Psychotherapy 10 (3): 186-196.

Sloane, R.B., Staples, F.R. & Schneider, L.S. (1985) Interpersonal therapy versus nortriptyline for depression in the elderly. In G.D. Burrows, T. R. Norman & L. Dinnerstein (Eds), Clinical and Pharmacological Studies in Psychiatric Disorders London: John Libbey and Co.

Teri, L., Curtis, J., Gallagher-Thompson, D., Thompson, L. (1994) Cognitive behavioural therapy with depressed older adults. In L. S. Schneider, C. F. Reynolds, B. D. Lebowitz & A. J. Friedhoff (Eds), Diagnosis and Treatment of Depression in Late Life: Results of the NIH Consensus Development Conference Washington DC: American Psychiatric Press.

Vernooij-Dassen, M. J. F. J., Van Hout, H. P. J., Hund, K. L. M., Hoefnagels, W. & H. L., Grol, R. P. T. M. (2003) Information for dementia patients and their caregivers: what information does a memory clinic pass on, and to whom? Aging & Mental Health 7 (1): 34-38.

Watts, G., (2001) The development of a new service for older people whose behaviour is seen as challenging. PSIGE Newsletter (78): 11-12.

Woods, B. (2003). What's so different about older people? Clinical Psychology and Psychotherapy, 10, 129-132.

Woods, R. (1999) Psychological Problems of Ageing Chichester: Wiley.

Woods, R. & Roth, A. Effectiveness of psychological interventions with older people In A. Roth, & P. Fonagy, (1996) What works for whom? The Guildford Press: New York.

Woods, R. T. (1994) Problems in the elderly: Investigation. In S. J. E. Lindsay & G. E. Powell The Handbook of Clinical Adult Psychology (2nd Ed) Routledge.

Zarit, S. H. & Edwards, A. B. (1999) Family caregiving: research and clinical intervention. In R. T. Woods Psychological Problems of Ageing Chichester: Wiley.

Zeiss, A. M. & Lewinsohn, P. M. (1986) Adapting behavioral treatment for depression to meet the needs of the elderly. Clinical Psychologist: 98-100.

**Explain how an Understanding of the
Different Causes of, and Characteristics
of People with, Learning Disability
Should Inform the Clinical Psychologist
in His or Her Work.**

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Introduction

In order to address this essay question it will initially be necessary to define what will be referred to as learning disability throughout this essay. This will then proceed into a description of the different causes of learning disability focusing on both biological and environmental factors. This will be followed by a discussion highlighting the various characteristics of individuals with learning disability which will concentrate on cognitive systems, mental health problems, challenging behaviour, communication difficulties and social skills and adaptive behaviours. This essay will then divulge into a discussion concerning how an understanding of these factors should inform clinical psychologists in their work, which will focus on assessment, formulation, intervention and consultation. In addition there will be discussion of the biopsychosocial model and its relevance to clinical psychologists and their practise as well as a critical analysis. There will be case examples presented throughout this essay to highlight the points discussed. A conclusion will then be presented to finish this essay which will extract the main points from within the body of the essay.

What do we mean by learning disability?

The term learning disability has been described as a socially constructed concept and therefore what it means, how it is measured and who counts as being part of this group of people has inevitably changed over time (Wright & Digby, 1996). Definitions of learning disability also vary across countries according to a whole host of ideological, political, economic and cultural factors (Fryers, 1993).

For the purpose of this essay the definition proposed by the 2001 Department of Health white paper 'Valuing People' will be utilised which defines learning disability as including the presence of a significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence), with, a reduced ability to cope independently (impaired social functioning) and which started before adulthood, with a lasting effect on development. This definition encompasses people with a broad range of

disabilities without restricting the presence of a low Intelligence Quotient (IQ), for example an IQ below 70, as being the predominant reason for deciding whether an individual should be provided with additional health and social care support. In addition Valuing People advocates that an assessment of social functioning and communication skills should also be taken into account when determining need as many people with learning disabilities also have physical and/or sensory impairments (Department of Health, 2001).

With regards to prevalence rates Valuing People highlights the fact that producing precise information on the number of people with learning disabilities in the population is difficult. They estimated that in 2001 there were around 210,000 people with a severe and profound learning disability which consisted of around 65,000 children and young people, 120,000 adults of working age and 25,000 older people. Whilst in the case of people with a mild/moderate learning disability, lower estimates suggest a prevalence rate of around 25 per 1000 population, which equates to 1.2 million people in England.

What are the causes of learning disability?

Identifying the causes of learning disabilities has been described as a complex process, particularly for people with a mild learning disability as the aetiology is largely unknown (Matilainen et al., 1995)

Studies estimate that for people with severe learning disabilities aetiology is unknown for between 20 and 40% of cases (McLaren & Bryson, 1987) although more recent studies are at the lower end of this range (Matilainen et al., 1995). However for people with a mild learning disability aetiology is said to be unknown for a somewhat higher proportion of 45-62% of cases (McLaren & Bryson, 1987; Matilainen et al. 1995; Wellesley, Hockey & Stanley, 1991).

It has been hypothesised that for the majority of people, the cause of their learning disability probably involves a complex interaction between biological,

social, behavioural and educational factors, which could influence the individual at the prenatal, perinatal, or postnatal stage of their life (Luckasson et al., 1992).

Prenatal Causes

Overall, studies estimate that between 2-40% of those cases of severe learning disability can be accounted for by chromosomal disorders, and that a further 20-30% of cases accounted for by other prenatal biological factors, such as single gene disorders, multi-factorial/polygenetic causes and environmental effects (McLaren & Bryson, 1987; Matilainen et al. 1995 Wellesley, Hockey & Stanley, 1991). However for people with a mild learning disability it is claimed that only 4-10% of cases are generally accounted for by a chromosomal disorder (McLaren & Bryson, 1987; Matilainen et al. 1995). With regards to chromosomal disorders by far the most common disorder associated with learning disability is Down's syndrome of which there are an estimated 1 in every 700 live births. Other genetic disorders associated with learning disability include Prader-Willi syndrome where there is an estimated 1 in 10,000 birth prevalence and Williams syndrome for which there is an estimated 1 in 25,000 birth prevalence (Emerson et al., 1998).

With regards to single gene disorders Fragile X-syndrome has attracted much interest in recent years with prevalence estimates of 1 in 1,100-2,500 for males and 1 in 1,700-5,000 for females. This has been claimed to be the most common hereditary cause of intellectual disability, although not all males and only one third of females with fragile-X syndrome have a learning disability to any degree (Hagerman & Cronister, 1991).

There are a wide range of other relatively rare biological syndromes that may have a prenatal causal effect on later learning disabilities. These often have a genetic basis. However there are other learning disabilities that may be the result of disorders of brain formation at the prenatal stage.

In addition to biological factors environmental factors have also been recognised as possibly having a contributory role to the development of a learning disability. Prenatal environmental factors that could be contributory to learning disabilities include maternal malnutrition and ingestion of drugs and toxins during pregnancy, maternal diseases during pregnancy and irradiation during pregnancy (Emerson et al., 1998).

Perinatal Causes

Studies estimate that approximately 10% of cases of severe learning disability are due to perinatal causes. Figures for mild learning disability are more variable, ranging from 1-19% of cases (McLaren & Bryson, 1987; Matilainen et al. 1995; Wellesley, Hockey & Stanley, 1991).

Intra-uterine infections are the most common biological perinatal cause of learning disability, accounting for between 2-6% of people with a severe learning disability and only 1% of people with a mild learning disability (Emerson et al., In Emerson et al., 1998).

Interestingly the most common perinatal cause of severe learning disability is asphyxia with 4-8% of people with a severe learning disability and a varying 5-19% of people with a mild learning disability suffering asphyxia during birth. Another environmental factor that has commonly been described as the cause of learning disability is premature birth (Emerson, 1998).

Postnatal Causes

Very little is known about the relative impact of postnatal factors on the development of learning disabilities. There are a wide range of biological factors that may impact upon the development of a learning disability such as infections including meningitis, diseases affecting the central nervous system, degenerative disorders such as Rett syndrome and epilepsy and related disorders. There are also a range of environmental factors, which probably in a multi-factorial fashion can influence the development of a learning disability

including head injuries, toxic disorders and malnutrition. Environmental deprivation such as psychosocial disadvantage, child abuse and neglect and chronic social/sensory deprivation have also been hypothesised to influence the development of a learning disability (Emerson et al., 1998).

What are the characteristics of people with learning disability?

A fundamental statement in the Government white paper Valuing People, 2001 captures the essence of the life of many of those with learning disabilities by succinctly summarising some of the key characteristics of their life. It highlights that people with learning disabilities are amongst the most socially excluded and vulnerable groups in Britain today. Very few have jobs, live in their own homes or have real choice over who cares for them. Many have few friends outside their families and those paid to care for them. Whilst this statement draws attention to some of the social factors that differentiate many of those with a learning disability from the general population there are a vast array of other common characteristics found in individuals with learning disabilities. However for the purpose of this essay the focus will be upon some of those characterising areas that I perceive to be most striking.

Cognitive systems

Cognitive systems are one of the key areas that differentiate people with learning disabilities. It has already been mentioned that the cut off IQ score for the diagnosis of a learning disability is 70 however it is more meaningful to look at some of the cognitive systems paying particular attention to the characteristics of those with a learning disability.

With regards to the language system people with a learning disability are vulnerable to a wide range of specific language and communication disorders. Even of those who do not show specific communication disorders many show slower development of verbal skills compared to development of other areas (Clements, 1998). Another cognitive system that can be characteristic of those with a learning disability is executive functioning which is the system that is

important for many areas of problem solving. Key processes involved are strategic planning; working memory, selection of task-relevant information, inhibition of task-irrelevant information and inhibition of previously emitted but inappropriate responding. Those with executive functioning difficulties can find it hard to tackle problems in an organised way, perseverate on irrelevant or incorrect responses and find it hard to organise information in time (sequential processing). These difficulties will be more evident in problem solving situations as opposed to when carrying out familiar tasks or routines (Clements, 1998). In addition individuals with a learning disability can experience information-processing problems in a wide range of specific domains such as reading, mathematics and spelling. Many people with a learning disability also experience difficulties with motor skills. Interestingly it has been reported that this can mask cognitive difficulties and also correlate with the presence of a learning disability such as in Cerebral Palsy (Clements, 1998)

With Regards to social cognition there has been research conducted focusing on the relevance of theory of mind and autism. Research has demonstrated that the capacity to 'mind-read' is precisely the ability that autistic people lack seeming unable to grasp the idea that others have different beliefs and knowledge to their own (Happe, 1994). Social cognition problems will interfere radically with the acquisition of social relating skills and raise the likelihood of behaving in ways that others find unacceptable. This is certainly something that has been described as characteristic of those with autism. Happe and Frith (1995) suggest that in terms of cognitive processes and mechanisms, autistic people may be qualitatively different from non-autistic people.

Social skills and adaptive behaviours

As well as having cognitive difficulties those with learning disabilities also experience more difficulties with social skills and adaptive behaviours. Adaptive behaviours, or the skills to cope successfully with the daily tasks of living, is linked to what skills would be appropriate for a person's age and includes skills such as self-care, community use and home living skills. It has been reported

that more accurate prevalence rates can be determined by assessing adaptive behaviours in conjunction with IQ testing as opposed to assessing IQ alone (Caine & Hatton, 1998). In addition research suggests that among the most important determinants of levels of meaningful activity by people living in community residential services is adaptive behaviour, so that the more disabled the residents, the lower their activity level (Mansell et al., 2003).

Mental health problems

Until recently mental health problems in people with learning disabilities has been largely neglected by both professionals and researchers (Caine & Hatton, 1998). Classifying mental health problems in people with a learning disability is complex and therefore a wide variety of prevalence rates are reported ranging from between 10-80% depending on the definition used (Borthwick-Duffy & Eyman, 1990). Nevertheless it should not be seen as surprising that those with learning disabilities demonstrate higher levels of psychiatric disorder given the likely life experiences they may go through such as birth trauma, institutionalisation, stigmatisation, unemployment, lack of friendships and intimate relationships (Caine & Hatton, 1998). In addition they are more likely to experience separation anxiety, a lack of control within their care environment, bullying and abuse from peers and have a lack of skill in managing stress and social demands which inevitably must lead to an increased vulnerability.

Interestingly those with learning disabilities experience different levels of psychiatric disturbance to the general population showing higher prevalence for autism and psychosis whilst lower rates are shown for affective disorders such as depression and neurotic disorders such as phobias, panic and obsessive compulsive disorder. It has also been reported that those with mild as opposed to severe learning disability are also reported to experience higher prevalence rates for mental health problems (Bouras & Drummond, 1992).

As life expectancy rates are becoming higher for those with learning disabilities dementia is also becoming more prevalent in the learning disability population. Prevalence rates for those with learning disabilities experiencing dementia are reported to be at least twice as likely compared to the general population (Turner & Moss, 1996). People with Downs Syndrome are at particular risk of developing dementia with almost all those aged over 40 displaying the neuropathological signs of Alzheimers disease (Caine & Hatton, 1998).

It has also been reported that medication is used too frequently despite difficulties with diagnosis. Major tranquillisers are often used and people with learning disabilities may be unable to report their side effects (Harper & Wadsworth, 1993).

Challenging behaviour

Challenging behaviours are shown by a number of those with a learning disability and come in a variety of forms. Prevalence rates for challenging behaviour are more difficult to accurately estimate. This is due to the fact that a reported incident of challenging behaviour largely depends on the values of the person who witnesses the behaviour which is inevitably influenced by social and cultural factors. Therefore what one person may deem as a challenging behaviour may not be perceived by another in the same way. Challenging behaviours can largely be grouped into self-injurious behaviours, aggressive behaviours and disruptive behaviours. It has been reported that challenging behaviours are more common among boys and men, people between the ages of 15 and 35, people with more severe intellectual disabilities, people with additional sensory impairments, reduced mobility or specific impairment of communication and people with some specific syndromes, such as autism (Emerson, 2001).

Communication difficulties

Many people with a learning disability have extreme difficulties with communication. This is most difficult because the quality of our cultural and

social lives largely depends on our ability to influence or be influenced by others through the use of language, spoken or written (Remington, 1998). McLean et al. 1996 in their study which focused on communicative function found that care givers of those with a severe or profound learning disability reported that 59% of the people they worked with showed limited evidence of symbolic communication and a further 19% showed evidence of non-symbolic communicative intent. However 21% showed no evidence of intentional communication. When measuring symbolic communication McLean et al. were referring to not only speech but also communication using manual signs, such as those used by the deaf and iconic symbols both of which are now in common use for people with learning disability. The symbolic communication system is profound in terms of both intellectual and social functioning and has implications for working with people with learning disabilities.

How should this understanding inform the clinical psychologist in their work?

Understanding the causes of a person's intellectual disability can have a potentially crucial impact on prevention, treatment and management programmes for that individual (Emerson et al., 1998). Having a good understanding of the different causes and characteristics of learning disabilities should inform the psychologist in many ways.

Assessment

Assessment will usually be the first stage in the psychologists work with the client. Having an understanding of the different causes and characteristics of learning disabilities at this stage will allow the psychologist to consider a whole variety of biological, psychological and social factors that may be contributing to the clients difficulties. In many cases referrals will come in to the psychologist and having an understanding of the complex social and psychological characteristics may help them develop initial hypotheses with regards to fundamental issues such as 'whose problem is this'.

Psychometric assessment is one of the assessments often asked to be conducted by the psychologist in order to assess cognitive functioning and adaptive behaviours. Having a good understanding of the causes and characteristics of people with learning disabilities, such as the individual having possible communication difficulties, will allow the psychologist to select the most appropriate tool which may need to be interpreted with caution as many psychometric tools are not standardised for those with severe learning disabilities. With regards to informant-based measures having knowledge of the characteristics of those with learning disabilities such as their social and living situation and the fact that the informant may be a staff member who works part time with the client will allow the psychologist to be mindful of the reliability and validity of the information they are collecting. In order to overcome this issue the psychologist may need to use several informants or several approaches.

With regards to assessing cognitive abilities, which is one type of assessment carried out by psychologists there are several factors that the psychologist will be mindful of based on their understanding of those with learning disabilities. The tests assume that the person is performing to the best of their ability, this is an assumption that may be called into question when assessing those with learning disabilities. Evans (1991) suggests that those with learning disabilities may show greater 'interest variability' and lower motivation to perform 'correctly' in formal testing situations. This was an issue that I needed to be mindful of when carrying out a cognitive assessment of a client with a severe learning disability. This can be a difficult issue to uncover and it can be valuable to check whether the scores obtained match the level of functioning witnessed by the staff. Working closely with a clients care team when carrying out a cognitive assessment can be most helpful. It was also useful for me to have an understanding of the cause of the client's learning disability. In addition it was essential to have an understanding of their communication difficulties to allow me to ensure the tests to be administered would be suitable. The cognitive assessment was part of a dementia screening assessment and this client had Down's syndrome, it was therefore useful that I knew the prevalence rates for

dementia for those with Down's syndrome. In addition carrying out an assessment of the clients social and adaptive behaviours with care staff where they live allowed me to gain a more accurate picture of their functioning. This was an evident case whereby an understanding of the different causes and characteristics of those with a learning disability allowed me to complete a valid assessment that will have implications for the clients care package.

Functional assessment is another key tool used by psychologists for assessment of those with learning disabilities. The basic aim of which is to identify specific skills or adaptations which will enable the person to function more independently in the real world. Therefore having knowledge of the characteristics displayed by those with learning disabilities with regards to adaptive behaviours and social skills allows the psychologist to carryout the functional assessment efficiently tailoring it to meet the individuals needs. Functional analysis also allows the psychologist to identify and understand the processes underlying challenging behaviour.

It has been recognised more recently that there can be much benefit in interviewing people with learning disabilities (Prosser & Bromley, 1998). However it is important for the psychologist to be aware that people with learning disability often experience difficulty in describing subjective feelings and internal emotional states. Being aware of their limited communication skills can be beneficial for the psychologist when conducting an assessment interview as they can make adaptations to their use of language, use visual aids or prompts and use other assessment strategies in order to fully assess the client. Whilst information from a key informant is essential, talking to both an informant and the person with learning disabilities can give a greater insight into the person's behaviour. This was certainly an issue I became aware of when carrying out a piece of work based on a referral for challenging behaviour. In addition to carrying out a functional analysis of the behaviour and an interview with the deputy manager at the home where the client lived I also interviewed the client to gain her perspective on her difficulties. This proved to be insightful and

allowed me to develop a more dynamic formulation of the problems taking into consideration the way the client perceived the situation.

Formulation

Having an understanding of the different causes and characteristics of those with learning disabilities can be imperative for the psychologist when formulating. The causes and characteristics identified previously in this essay will allow the psychologist to work using a biopsychosocial model if that is relevant to the clients difficulties. They will be able to formulate based on their assessment which could include assessing biological, psychological and social factors. Having a good understanding of the biological factors that can predispose an individual to a learning disability coupled with some of the psychological factors, such as mental health issues, and social factors such as their living situation can allow the psychologist to produce an in-depth accurate formulation of the client's difficulties. In addition a psychologist may be working using different models most of which will benefit from having knowledge of the relevant causes and characteristics. When carrying out a piece of work with a client having information based on a thorough assessment allowed me to formulate more comprehensively. I was able to consider the effects of the client's physical conditions, cognitive difficulties and autistic spectrum disorder in addition to the psychological factors which included experiencing symptoms of PTSD, anxiety and anger management coupled with the pertinent social factors such as the fact that she was very socially isolated and experienced difficulties in her living environment. Having knowledge of these characteristics allowed me to formulate more effectively.

Intervention

Historically interventions for those with learning disabilities have been largely restricted to psychopharmacy for the purpose of social control (Caine & Hatton, 1998). This has changed somewhat more recently and a range of treatments, including behavioural therapy and psychotherapy are more readily used. Stenfert Kroese, Dagnan & Lonmidis, 1997, suggest that the influence of

normalisation and the development of non-aversive behavioural approaches have made professionals more inclined to listen, even to non-verbal communication in order to extract personal meaning and to create a collaborative relationship as opposed to an authoritarian one.

Having earlier identified that one of the characteristics of those with a learning disability is that they are more likely to be exposed to the experiences that can lead to mental health problems. It would therefore seem that those with learning disabilities can develop mental health problems in the same way as the general population and therefore the same models and interventions can be applied with adaption where necessary. Psychological interventions have been extensively and effectively applied to the management of challenging behaviours in people with learning disabilities (Emerson, 2001) and having a good formulation based on assessment and knowledge of the different causes and characteristics of learning disabilities should enable the psychologist to select the most appropriate intervention and adapt it if it needs to be accordingly.

With regards to challenging behaviour the psychologists understanding of the different contributory causes and characteristics will also be paramount for successful intervention. This intervention will be largely based on the findings from the functional analysis as well as detailed assessment of environmental characteristics such as the persons living situation and the receptiveness of the family or carers. The possible components of the intervention package will be to take account of the person's preferences, change the context in which challenging behaviour takes place and teach or support alternatives to challenging behaviour. This may involve direct work with the client and/or an indirect intervention with the carers. Carrying out a direct intervention with the client and an indirect intervention with the carers proved useful in a piece of work I carried out whereby as result of a functional analysis I was able to devise behavioural guidelines for the staff team and carryout individual sessions with the client addressing their anger management.

Consultation

In addition the psychologist's knowledge of the causes and particularly the characteristics of those with learning disabilities may be helpful when carrying out consultation work with families and carers. Having a good understanding of epidemiology and prevalence rates for mental health problems and challenging behaviour, an understanding of communication difficulties coupled with an understanding of cognitive, adaptive and social skills and limitations for those with learning disabilities may allow the psychologist to work more effectively with carers and organisations. In addition having a vast knowledge base will make work with families more effective as the psychologist will be able to draw upon different models and theories in their work.

Critical analysis

Despite the vast array of evidence presented implying that having an understanding of the causes and characteristics of those with learning disabilities is essential to the clinical psychologist in their work, arguments to the contrary have been presented over the past four decades particularly by those adopting a social constructionist perspective. Socio-cultural theorists believe that although it is necessary to be aware of the causes and characteristics of learning disabilities this also may inform the way that clinical psychologists perceive them in that it can pathologise and objectify them and as a consequence can deny them their status as human beings (Klotz, 2004).

Edgerton in 1963 began this work by attempting to understand and analyse the experience of people with intellectual disabilities from their own perspective (Klotz, 2004). Edgerton also carried out much work looking into the effects of labelling arguing that "the stigma of mental retardation is expanded to subsume all possible competencies such that mentally retarded people become, by definition, incompetent to manage any of their affairs and are forever doomed to their condition... There is no cure, no hope, no future" (Edgerton, In Koltz, 2004). This statement could imply that labelling such a subgroup of people and having

a definition determined by causes and characteristics is actually more harmful than useful to the individual. Following on from Edgerton's work Bogdan & Taylor have stated that "the label mentally retarded creates a barrier to our understanding people on their own terms. It prevents us from seeing and treating people so defined as human beings with feelings, understandings and needs. They have also suggested that in addition to being stigmatised by their low intelligence those with learning disabilities are often perceived as 'dangerous, irrational, undependable and threatening' and as a consequence people rarely respect, listen to or attempt to understand what it is that such people are actually saying and doing (Koltz, 2004). This work was further developed by Goode (1980) and Gleason (1989) who looked at the effects of labelling on those with severe and profound learning disabilities. Within all these studies the concept of labelling has been addressed and this undoubtedly challenges the notion that having an understanding of causes and characteristics is imperative to the work of the clinical psychologist highlighting the fact that understanding the cause of the learning disability may be informative but the individuals current needs should be the focus in the formulation of the person with learning disabilities.

Conclusion

In conclusion it has been identified within this essay that there are a number of biological and environmental factors that contribute to the cause of learning disabilities at prenatal, perinatal and postnatal stages of development.

There are also a number of characteristics unique to those with a learning disability. Some of which have been described in this essay such as cognitive systems, social skills and adaptive behaviours, the types of mental health problems, challenging behaviour and communication difficulties.

This essay has highlighted how having an understanding of the different causes of and characteristics of people with a learning disability should inform the clinical psychologist in their work. This has largely been emphasised through

the aid of the biopsychosocial model and the use of clinical examples focusing on each stage of the clinical psychologists work. However these ideas have also been challenged by looking at the negative effects of labelling adopting a social constructionist perspective. It would therefore seem that whilst this understanding can be useful it is more effective to recognise individual needs.

References

Bogdan, R., & Taylor, S. (1982). Inside out: the social meaning of mental retardation. University of Toronto Press.

Borthwick-Duffy S.A., Eyman, R.K., & White, J.F. (1987). Client characteristics and residential placement patterns. American Journal of Mental Deficiency, 92, 24-30.

Bouras, N., & Drummond, C. (1992). Behaviour and psychiatric disorders of people with mental handicaps living in the community. Journal of Intellectual Disability Research, 36, 349-357.

Caine, A., & Hatton, C. (1998). Working with people with mental health problems. In E. Emerson, C. Hatton, J. Bromley & A. Caine, (Eds.), Clinical psychology and people with intellectual disabilities (pp. 210-230). Chichester: Wiley.

Clements, J. (1998). Development, cognition and performance. In E. Emerson, C. Hatton, J. Bromley, & A. Caine, (Eds.), Clinical psychology and people with intellectual disabilities (pp. 39-53). Chichester: Wiley.

Department of Health. (2001) Valuing People: A new strategy for learning disability for the 21st century. Department of Health: London.

Emerson, E., & Bromley, J. (1995). The form and function of challenging behaviours. Journal of Intellectual Disability Research, 39, 388-398.

Emerson, E., Forrest, J., Cambridge, P., & Mansell, J. (1996). Community support teams for people with learning disabilities and challenging behaviour: results of a national survey. Journal of Mental Health, 5, 395-406.

Emerson E., Hatton, C., Bromley, J., & Caine, A. (1998). Introduction. In E. Emerson, C. Hatton, J. Bromley, & A. Caine, (Eds), Clinical psychology and people with intellectual disabilities (pp. 3-19). Chichester: Wiley.

Emerson E. (2001). Challenging behaviour: Analysis and intervention in people with severe intellectual disabilities (2nd edition). Cambridge University press.

Evans, I.M. (1991) Testing and diagnosis: a review and evaluation. In L.H. Meyer C.A. Peck & L. Brown, (Eds), Critical issues in the lives of people with severe disabilities. P.H. Brookes.

Felce, D., & Perry, J. (1996). Adaptive behaviour gains in ordinary housing for people with intellectual disabilities. Journal of Applied Research in Intellectual Disabilities, 9(2), 101-114.

Fryers, T. (1993). Epidemiological thinking in mental retardation: issues in taxonomy and population frequency. In N.W. Bray (Eds.) International Review of Research in Mental Retardation, Academic Press, San Diego.

Gleason, J.J. (1989). Special education in context: an ethnographic study of persons with developmental disabilities. Cambridge University press.

Goode, D.A. (1980). Behavioural sculpting: parent-child interactions in families with retarded children. In J. Jacobs (Ed) Mental retardation: a phenomenological approach. Springfield.

Goode, D.A. (1980). The world of the congenitally deaf-blind: towards the grounds for achieving human understanding. In J. Jacobs (Ed), Mental retardation: a phenomenological approach. Springfield.

Happe, F.G. (2004). Annotation: current psychological theories of autism: the "theory of mind" account and rival theories. Journal of Child Psychology and Psychiatry, 35(2), 215-229.

Happe, F., & Frith U. (1995). Theory of mind in autism. In E. Schopler & G.B. Mesibov (Eds.), Learning and cognition in autism. Plenum Press: New York.

Happe, F.G. (1994). An advanced test of theory of mind: understanding of story characters thoughts and feelings by able autistic, mentally handicapped, and normal children and adults. Journal of Autism and developmental Disorders, 24(2), 129-154.

Harper, D.C., & Wadsworth, J.S. (1993). Behavioural problems and medication utilization. Mental Retardation, 31(2), 97-103.

Hatton C., & Emerson, E. (1996). Services for adults with learning disabilities and sensory impairments: results of a national survey of local authorities. British Journal of Learning Disabilities, 23, 11-17.

Klotz, J. (2004). Sociocultural study of intellectual disability: moving beyond labelling and social constructionist perspectives. British Journal of Learning Disabilities, 32, 93-104.

LaVigna, G.W. & Donnellan, A.M. (1986). Alternatives to punishment: solving behaviour problems with non-aversive strategies. Irvington: New York.

Luckasson, R., Coulter, D.L., Followay, E.A., Reiss, S., Schalock, R.L., Snell, M.E., Spitalnik, D.M., & Stark, J.A. (1992). Mental Retardation: Definition, classification, and systems of supports (9th Ed.), American Association on Mental Retardation: Washington.

Mansell, J., Beadle-Brown, J., Macdonald, S., & Ashman, B. (2003). Resident involvement in activity in small community homes for people with learning disabilities. Journal of Applied Research in Intellectual Disabilities, 16(1), 63-74.

Mansell, J., Elliott, T., Beadle-Brown, J., Ashman, B. & Macdonald, S. (2002). Engagement in meaningful activity and "active support" of people with intellectual disabilities in residential care. Research in Developmental Disabilities, 23(5), 342-352.

Matilainen, R., Airaksinen, E., Mononen, T., Launiala, K. & Kaariainen, R. (1995). A population based study on the causes of mild and severe mental retardation. Acta Paediatrica, 84, 261-266.

McLaren, J., & Bryson, S.E. (1987). Review of recent epidemiological studies of mental retardation: prevalence, associated disorders, and etiology. American Journal of Mental Retardation, 92, 243-254.

McLean, L.K., Brady, N.C., & McLean, J.E. (1996). Reported communication abilities of individuals with severe mental retardation. American Journal on Mental Retardation, 100, 580-591.

Pennington, B.F., & Ozonoff, S. (1996). Executive functions and developmental psychopathology. Journal of Child Psychology and Psychiatry, 37, 51-88.

Prosser, H., & Bromley, J. (1998). Interviewing people with intellectual disabilities. In E. Emerson, C. Hatton, J. Bromley, & A. Caine, (Eds.), Clinical psychology and people with intellectual disabilities (pp. 99-113). Chichester: Wiley.

Remington, B. (1998). Working with people with communication difficulties. In E. Emerson, C. Hatton, J. Bromley, & A. Caine, (Eds.), Clinical psychology and people with intellectual disabilities (pp. 231-243). Chichester: Wiley.

Explain how an understanding of the different causes of, and characteristics of people with, learning disability should inform the clinical psychologist in his or her work.

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Stenfert Kroese, B., Dagnan, D., & Loumidis, K. (1997). Cognitive behavioural therapy for people with learning disabilities. London: Routledge.

Turner, S., & Moss, S. (1996). The health needs of people with learning disabilities and the health of the nation strategy. Journal of Intellectual Disability Research, 40, 438-450.

Wellesley, D., Hockey, A. & Stanley, F., (1991). The aetiology of intellectual disability in Western Australia: a community-based study. Developmental medicine and Child Neurology, 33, 963-973.

Wright, D., & Digby, A. (1996). From idiocy to mental deficiency: Historical perspectives on people with learning disabilities. Routledge.

**An Audit of the Clinical Supervision
Received by Those Working in Mental
Health Services**

Small Scale Service Related Project

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ABSTRACT

This audit evaluated the degree to which the supervision carried out amongst individuals in a psychology service adhered to the DCP supervision guidelines. It also aimed to uncover the extent to which supervisees are satisfied with the supervision they receive. A postal questionnaire was distributed in order to collect data and a response rate of 87% was achieved. Results showed that, for the most part, the supervision carried out does adhere to the DCP guidelines with the majority of responses indicating that supervision is a positive experience for them. It was also discovered that a large proportion of supervisees rate the quality of their supervision highly indicating a good degree of satisfaction with the supervision they receive. Nevertheless there is scope for improvement which would have implications for service development and the continuing professional development of individuals. It is suggested that it could be beneficial to individuals and the service to carryout some training with reference to supervision and the guidelines. This would provide opportunity for the sharing of good practice as well as offering a forum for the dissemination of knowledge regarding the DCP guidelines and the principles of supervision. It is also suggested that improving aspects of supervision will have implications for clinical as well as other aspects of the psychologist's role and may improve the service provided to clients. In addition this audit offers the service an understanding of the standard to which an area of their work is being carried out when measured against an influential document.

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INTRODUCTION

The role of the clinical psychologist encompasses a variety of skills. As well as carrying out duties of a clinical, research, managerial and educational nature, current government guidelines require that the practice of clinical psychologists incorporates and adheres to government legislation. This legislation includes Clinical Governance and National Service Frameworks. Supervision is part of the dynamic role of the clinical psychologist and is considered by many to be a crucial aspect for ensuring both personal and professional development throughout their career.

Practise of supervision

It is clear, from an examination of the literature base, that there is a vast amount of information that focuses on clinical supervision. Within this literature base there is an incorporation of both supervision for those in the psychology field and also for other professionals who perform therapeutic services; such as nurses (Cutcliffe et al., 2001), psychotherapists (Wiener et al., 2003) and family therapists (Barnes et al., 2000). It is evident that there is a general consensus across each discipline with regards to the notion of supervision yet each still maintains its own unique philosophy.

For some time, people have shown an interest in supervision as it is viewed as a fundamental part of the work of clinical psychologists. However, relatively little is known about the process of supervision or the factors that contribute to good practice in supervision (Hirons & Velleman, 1993). Hardly any formal theory exists regarding this matter. Supervisors tend to learn on the job, drawing on their own internal supervisor which they developed through good and problematic experiences of being supervised themselves (Weiner et al., 2003).

Supervision is considered important because, amongst other possibilities, it provides supervisees with feedback regarding their performance, offers guidance, allows opportunity for alternative views and perspectives about client care and interventions, stimulates curiosity, contributes towards the process of

forming a therapist 'identity' and serves as a secure base from which supervisees can explore (Watkins, 1997).

Research has been conducted and various models have been proposed to help in the teaching of supervision highlighting the tasks, functions and process (Gilbert & Evans, 2000, Watkins, 1997). However, supervision will be an individual process dependent on the supervisory relationship, theoretical orientation and learning needs of the supervisee. (Watkins, 1997, Jacobs, 1996, Feltham & Dryden, 1994).

DCP supervision guidelines

The Division of Clinical Psychology (DCP) has maintained an unwritten philosophy regarding how "...time and space to allow for reflection, discussion and feedback on all elements of practice is a valuable way of enhancing practice and improving service quality" (DCP, 2003). Until the DCP Supervision Guidelines were produced in 2003, there was not a framework for supervision in clinical psychology which emphasised the way in which it should be conducted.

The guidelines were designed in order to be facilitative and constructive for clinical psychologists and their employers. It was anticipated that the guidelines would be beneficial to employers by enabling them to fulfil elements of their clinical governance agenda as well as allowing them to be confident that psychology practitioners are in a position whereby they can review and monitor their own practice in a non-threatening and collaborative context. In addition, it was anticipated that the guidelines would be of value to clinical psychologists as they offer a framework for helping them to make decisions regarding the best way to monitor and improve practice.

The document provides a statement of policy offering guidance for supervision. The following is an outline of the points:

1. It is expected that all clinical psychologists, at all stages of their career and in all work contexts will engage in regular supervision of their work.
2. Such supervision is regarded as a core clinical activity to ensure the delivery of effective and high quality services.
3. All aspects of a clinical psychologists work – clinical, research, educational, managerial – should be supervised, although the exact nature will vary from individual to individual and over different work contexts. There is no one model or style of supervision that will apply to all clinical psychologists in all settings and at all times in their career.
4. The DCP regards it as essential that supervision continues throughout a clinical psychologist's career.
5. As much as it is regarded as essential to be supervised, it is similarly expected that clinical psychologists provide supervision, particularly to trainees and newer members of the profession. This activity should be regarded as a core part of all clinical psychologists work and will require its own training and development.
6. All supervision should be needs lead.
7. The minimum standard is 60-90 minutes for every 20 sessions worked.
8. The supervisor must be a Chartered Clinical psychologist

Guidance on the tasks of supervision is also provided within the document. It is suggested that "the tasks the supervisor faces are to conduct an assessment of needs, to implement the appropriate supervision and to evaluate its effectiveness" (DCP, 2003).

The initial needs assessment should offer a space whereby the supervisor and supervisee can clarify the needs of those with an interest in the supervision which will include recognising the expectations of the employer and profession in addition to the supervisor and supervisee. This should lead to the production of a supervision contract which can be carried out informally through the joint setting of learning objectives and an agenda for the meeting. All contracts should take account of the context and be reviewed and updated regularly.

In order to implement the objectives and achieve the agreed outcomes a variety of methods can be used. It has been suggested that in general these will be a combination of:

1. Reflection – an opportunity for careful and detailed consideration of some aspect of recent work from the supervisee perspective.
2. Conceptualisation – when the supervisor assists the supervisee to relate his or her reflections to the perspective of others (concluding that of the supervisor) and to relevant theories and research.
3. Planning – agreeing the action implications.
4. Experiencing – carrying out actions and being aware of the accompanying affect.

With regards to the notion of evaluation, the tasks are for the supervisor to provide formative and sometimes summative feedback to the supervisee.

In addition, the document offers guidelines regarding lifelong supervision and the possibilities of this in practice. It suggests that supervision is needed in order to maintain and improve the quality of care and service delivery. It also has personal benefits. It is essential in the concept of Continuing Professional Development, as part of Clinical Governance, that all health care professionals

seek to maintain and improve the standards of all aspects of their work and services. Both supervision and CPD are mandatory activities for members of The British Psychological Society and will be statutory as part of the enactment of professional regulation (DCP, 2003).

Description of the service

This study focuses on a psychology service based in the South East of England and providing a service to a population of approximately 1 million people. The psychology service is made up of those working in adult mental health, older adult, child and family and learning disability services.

The trust was established in April 2001 as one of the first wave of integrated mental health & social care providers of working arrangements with the local County Council. It aims to develop the well-being, independence and social inclusion of people with mental health problems.

Objectives of the audit

The literature has identified that supervision has for some time been recognised as a key component of the role of the clinical psychologist across the lifespan (Watkins, 1997, Feltham & Dryden, 1994). Yet, until the publication of the DCP policy guidelines (2003) on supervision in the practice of clinical psychology there has not been a formal document outlining the way in which effective supervision should be conducted.

The study is carried out at a Trust that provides a psychological service to a large population. The service also has good links with local training courses and is made up of psychologists at a variety of grades including assistant psychologists, trainee clinical psychologists and qualified clinical psychologists of various grades.

The publication of the guidelines has made the issue topical within the profession and with exposure to such a diverse service; it would be valuable to

audit the degree to which the supervision of those who are part of the psychology service adheres to the guidelines. It was also felt that this audit could have implications for service development and the continuing professional development of individuals.

Research questions

The study aims to answer the following questions:

Primary question: To what degree does the supervision received by those in the psychology department comply with the DCP Supervision Guidelines?

Secondary question: To what extent are supervisees in the psychology department satisfied with the supervision they receive?

METHODOLOGY

Design

The research design involved distribution of a postal questionnaire to all members of the psychology service. The postal questionnaire was chosen as the methodology in this audit as it allows access to an optimal number of respondents within a target population in a time limited period (Barker et al., 2002). Whilst it was made clear that participation in the study would be voluntary, information was enclosed outlining the purpose of the audit in order to maximise response rates. Follow up letters were also distributed to increase the number of respondents.

Participants

All members of the psychology service were invited to participate in the study. This included assistant psychologists, trainee clinical psychologists and qualified clinical psychologists of all grades.

Of the 45 potential participants 39 (87%) returned their completed questionnaire. The sample was made up of 14 males and 25 females. There was a good age range with the largest proportion of participants falling within the 30-40 age group (see table 1).

Table 1: Age

Age	Number	Percentage
Under 30	8	20.5%
30-40	15	38.5%
40-50	9	23.1%
50-60	6	15.4%
60+	1	2.6%
Total	39	100%

With regards to job title the vast majority (71.8%) classified themselves as a clinical psychologist. This category was inclusive of qualified psychologists of all grades. Job titles can be viewed in table 2.

Table 2: Job Title

Job Title	Number	Percentage
Clinical Psychologist	28	71.8%
Trainee Clinical Psychologist	8	20.5%
Assistant Psychologist	2	5.1%
Other	1	2.6%
Total	39	100%

Participants were asked to describe their cultural background instead of ticking a pre-printed category. A variety of responses were recorded which have been placed into a table (see table 3).

Table 3: Cultural Background

Cultural Background	Number	Percentage
Caucasian	1	2.6%
English	1	2.6%
European White	2	5.1%
Mixed British Irish Asian	1	2.6%
Multi-heritage	1	2.6%
White UK	4	10.2%
White	1	2.6%
White African	1	2.6%
White British	15	38.5%
White English	1	2.6%
White Irish	1	2.6%
White Middle Class	1	2.6%
Missing	9	23.1%
Total	39	100%

Measures

The questionnaire was designed by the researcher as there was not an appropriate standardised tool available (See appendix I). The questionnaire was piloted amongst a clinical psychologist and five trainee clinical psychologists in order to ensure it was user friendly, valid and reliable.

Procedure

No formal approval from the ethics committee was required as this is an audit project. However, approval by the Trust Clinical Audit and Effectiveness Group was obtained. In order to be classified as an audit, there needs to be an analysis of whether an identified standard set within the team has been met. Never the less, definitions of audit vary (Firth-Cozens, 1993).

Initially, a list of the contact details for all potential participants was collated. The questionnaire was posted along with relevant information (see appendix II). Follow up letters were distributed 3 weeks after the questionnaires were posted in order to increase the response rate (see appendix III). The questionnaire data was entered into an Excel spreadsheet and subsequently transferred to an SPSS database for analysis.

RESULTS

Engagement in supervision

The questionnaire required participants to answer questions based on their experience of supervision over a four month period. The majority of the sample (87.2%) claimed that they had received regular supervision of their own work during this period.

Regarding the supervisor's chartership status there was missing data for 1 (2.6%) participant. 29 responses (74.4%) claim that they are supervised by a chartered clinical psychologist whilst 9 (23.1%) responses indicate that their supervision is carried out with a supervisor who is not a chartered clinical psychologist.

Participants engaged in a variety of types of supervision. Whilst the most common type seemed to be individual supervision, others engaged in either group, individual and group, or other types of supervision. A breakdown of the supervision that the participants engaged in can be seen in table 4.

Table 4: Types of supervision participants engaged in

Types of supervision	Number	Percentage
Individual	22	56.4%
Group	4	10.3%
Individual & Group	11	28.2%
Other	2	5.1%
Total number of reasons	39	100%

Work tasks

The type of work carried out by the sample involved a combination of clinical work, research, educational work and managerial tasks. Interestingly the most common combination of work tasks which was reported by 13 (33.3%) of the

individuals was a combination of clinical work, research, educational work and managerial tasks. Very few of the participants saw their roles as involving only one of the four components. There were 5 (12.8%) participants who saw their work as involving clinical work only; none of the participants reported that their work involved research, educational work or managerial tasks exclusively. A breakdown of the tasks carried out by participants can be seen in table 5.

Table 5: Type of work carried out by participants

Tasks	Number	Percentage
Clinical work	5	12.8%
Clinical work & research	6	15.4%
Clinical work & educational work	3	7.7%
Clinical work & managerial tasks	6	15.4%
Clinical work, research & educational work	3	7.7%
Clinical work, research & managerial tasks	1	2.6%
Clinical work, educational work & managerial tasks	2	5.1%
Clinical work, research, educational work & managerial tasks	13	33.3%
Total	39	100%

Due to the variety of work tasks, individuals can either engage in several types of supervision or single supervision which considers the individual's complex work role. The vast majority (94.9%) of those who engage in clinical work reported receiving supervision for this aspect of their work. Likewise, the majority of those who engage in research (75%) and managerial tasks (76.5%) stated that they are supervised for these aspects of their work. A lower proportion of the sample (33.3%) who carryout educational work report receiving supervision for this part of their work.

Frequency of supervision

The number of sessions worked between the two most recent supervision sessions varied greatly with a mode of 20 sessions and a range of 1-120 sessions. A breakdown can be seen in table 6.

Table 6: The number of sessions worked between the two most recent supervision sessions

Number of sessions	Number	Percentage
1	1	2.6%
2	1	2.6%
3	1	2.6%
5	4	10.3%
8	2	5.1%
9	5	12.8%
10	4	10.3%
15	1	2.6%
16	1	2.6%
18	1	2.6%
20	7	17.9%
23	1	2.6%
30	1	2.6%
38	1	2.6%
40	3	7.7%
120	2	5.1%
Missing	3	7.7%
Total	39	100%

However, whilst there seemed to be much variation amongst the number of sessions worked between the two most recent supervision sessions, for the majority (66.7%) the number of sessions worked between the two most recent supervision sessions was "about the same" when compared to the frequency of their usual supervision sessions (see table 7).

Table 7: Comparison between the frequency of the two most recent supervision sessions and the frequency of usual supervision.

	Number	Percentage
Slightly fewer	2	5.1%
The same	26	66.7%
Slightly more	7	17.9%
Much more	1	2.6%
Missing	3	7.7%
Total	39	100%

Duration of supervision

There was also variation reported regarding the length of the most recent supervision session, with a mode of 60 minutes and a range of 45-360 minutes. A breakdown of the reported duration times can be seen in table 8.

Table 8: Duration of most recent supervision session

Duration in minutes	Number	Percentage
45	1	2.6%
50	2	5.1%
60	18	46.2%
75	1	2.6%
90	10	25.6%
105	1	2.6%
120	2	5.1%
150	1	2.6%
360	1	2.6%
Missing	2	5.1%
Total	39	100%

Again the majority (76.9%) of the sample felt the duration of their most recent supervision session was “about the same” when compared with the duration of their usual supervision sessions, which would suggest continuity (see table 9).

Table 9: Comparison between the duration of the most recent supervision session and the duration of usual supervision sessions.

	Number	Percentage
Much shorter	1	2.6%
Slightly shorter	5	12.8%
The same	30	76.9%
Slightly longer	2	5.1%
Missing	1	2.6%
Total	39	100%

Supervision quality

There was a mixed response amongst the sample concerning the quality of supervision (see table 10), although most appeared to view their supervision in a positive way with the majority of individuals rating the quality of their supervision as good (46.2%).

Table 10: The quality of supervision

Quality	Number	Percentage
Poor	1	2.6%
Unsatisfactory	1	2.6%
Satisfactory	8	20.5%
Good	18	46.2%
Excellent	10	25.6%
Missing	1	2.6%
Total	39	100%

There was an opportunity for individuals to comment descriptively to indicate their opinions regarding the way in which supervision could be more useful. The general themes that seemed to be communicated included increasing the frequency of supervision and the structure including time to discuss all aspects of the individuals work such as clinical cases, managerial tasks and professional development. There also seemed to be a concern for more of an emphasis on evidence based practice and theory/practice links.

There was also an opportunity for individuals to comment on what they think makes a good supervisor. Emerging themes included the supervisor having clinical experience, clear boundaries, maintaining confidentiality, being knowledgeable of models and the evidence base, being able to help the supervisee to be reflective whilst containing their anxieties and being able to develop a relationship. A variety of interpersonal qualities were also suggested including being organised, non-judgemental, patient, a responsive listener, approachable, and having maturity, integrity and insight.

In addition the BPS specifies that supervision should be needs lead. The majority of the sample (84.6%) agreed that their supervision is needs lead. A vast proportion (87.2%) also agreed that their supervision benefits them personally. In addition most (76.9%) stated that they work within the same model as their supervisor.

Allocation of supervisor

When obtaining information regarding the way in which individuals came to be supervised by their supervisor an equal number of individuals chose their supervisor when compared to the number of individuals who were allocated (see table 11).

Table 11: The way in which individuals came to be supervised by their supervisor

	Number	Percentage
Chose supervisor	18	46.2%
Assigned to supervisor	18	46.2%
Missing	3	7.7%
Total	39	100%

Providing supervision

The BPS guidelines specify that in addition to receiving supervision individuals should provide supervision. The majority of participants (61.5%) had provided supervision in the four month time span specified (see table 12). It will be important to consider the sample with regards to these figures bearing in mind that both assistant and trainee psychologists, who make up 25.6% of the sample, will not be in a position to provide supervision.

Table 12: Whether the individual has provided supervision

	Number	Percentage
Yes	24	61.5%
No	15	38.5%
Total	39	100%

Policy Guidelines

The majority of the sample (66.6%) indicated that they had read the policy guidelines on supervision. However a significant number (11/39) stated that they had not in addition to the 2 answers that were missing (see table 13).

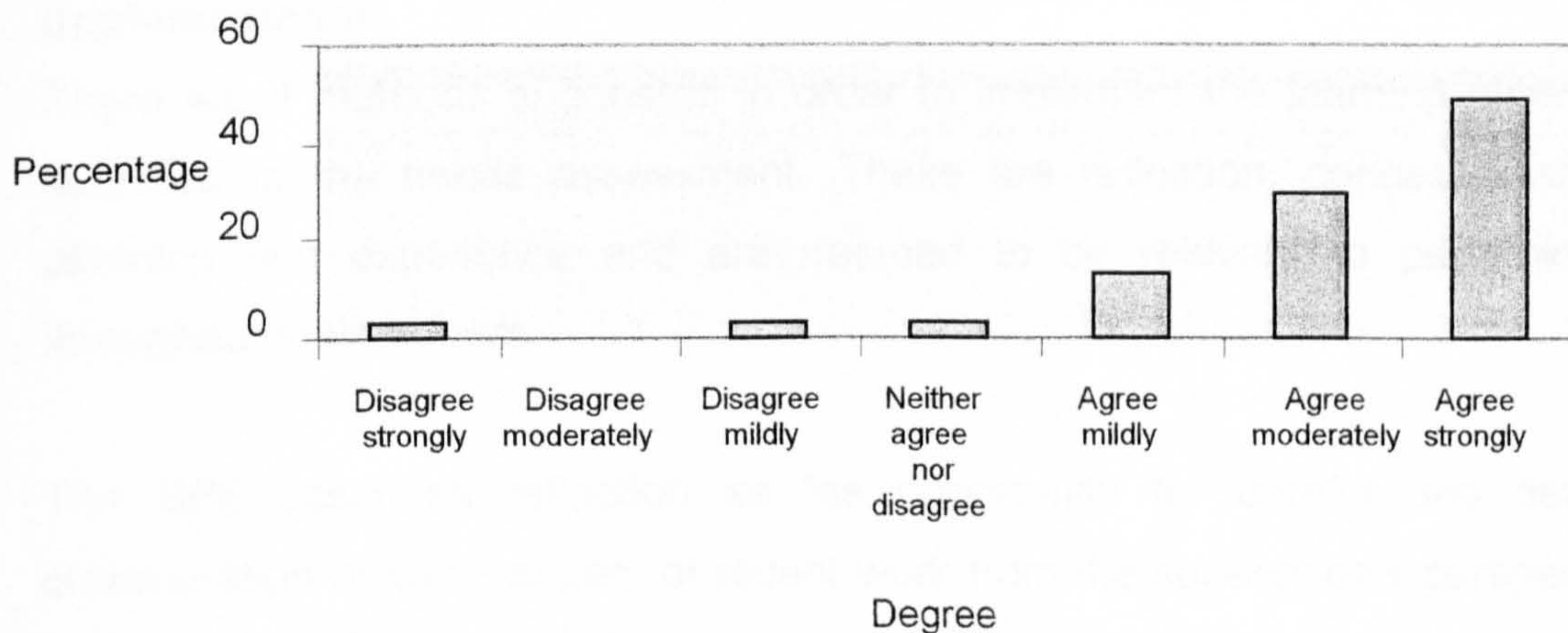
Table 13: Have the policy guidelines on supervision been read

	Number	Percentage
Yes	26	66.7%
No	11	28.2%
Missing	2	5.1%
Total	39	100%

Needs assessment

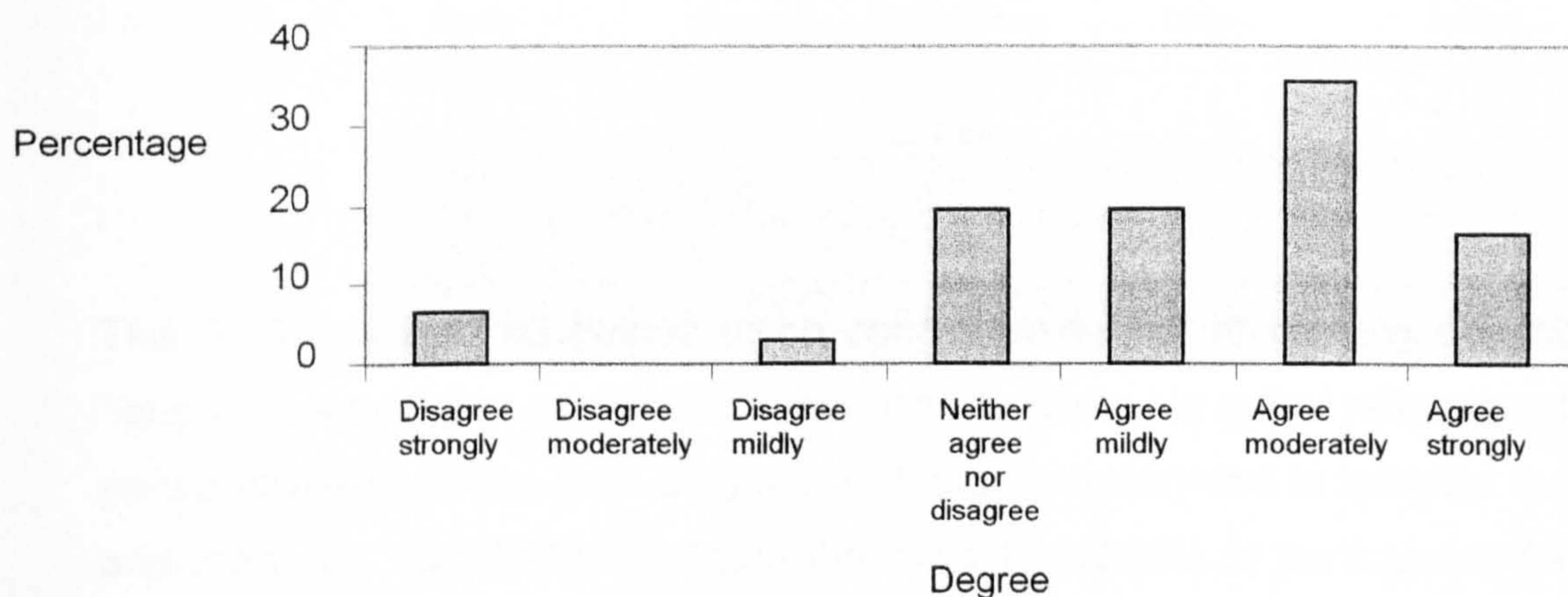
The BPS guidelines state that the initial task entails that the supervisor clarifies with the supervisee the needs of those with an interest in the supervision. The overall picture demonstrated that the participants felt the supervision they had received had taken their needs into account with the majority of the participants (48.4%) being in strong agreement (see figure 1.1).

Figure 1.1: The degree to which the supervision has taken individual needs into account



The guidelines also specify that a supervision contract should be agreed which takes both the supervisor and supervisee's interests into account. Interestingly there was more dispersion amongst the views of the sample regarding this issue with opinions ranging from neither agree nor disagree to strongly agree (see figure 1.2).

Figure 1.2: Degree to which individuals agreed that a supervision contract has been agreed which takes their needs into account

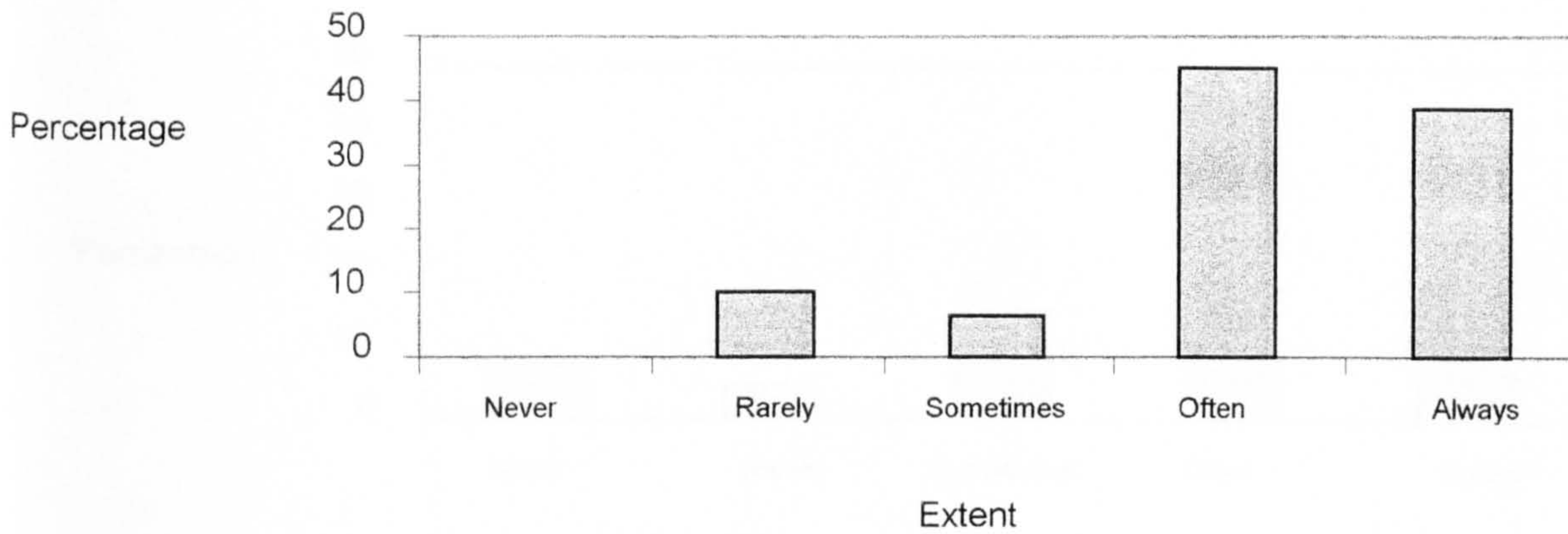


Implementation

There are 4 methods suggested in order to implement the learning objectives specified in the needs assessment. These are reflection, conceptualisation, planning and experience and are deemed to be relevant to psychologists throughout their careers.

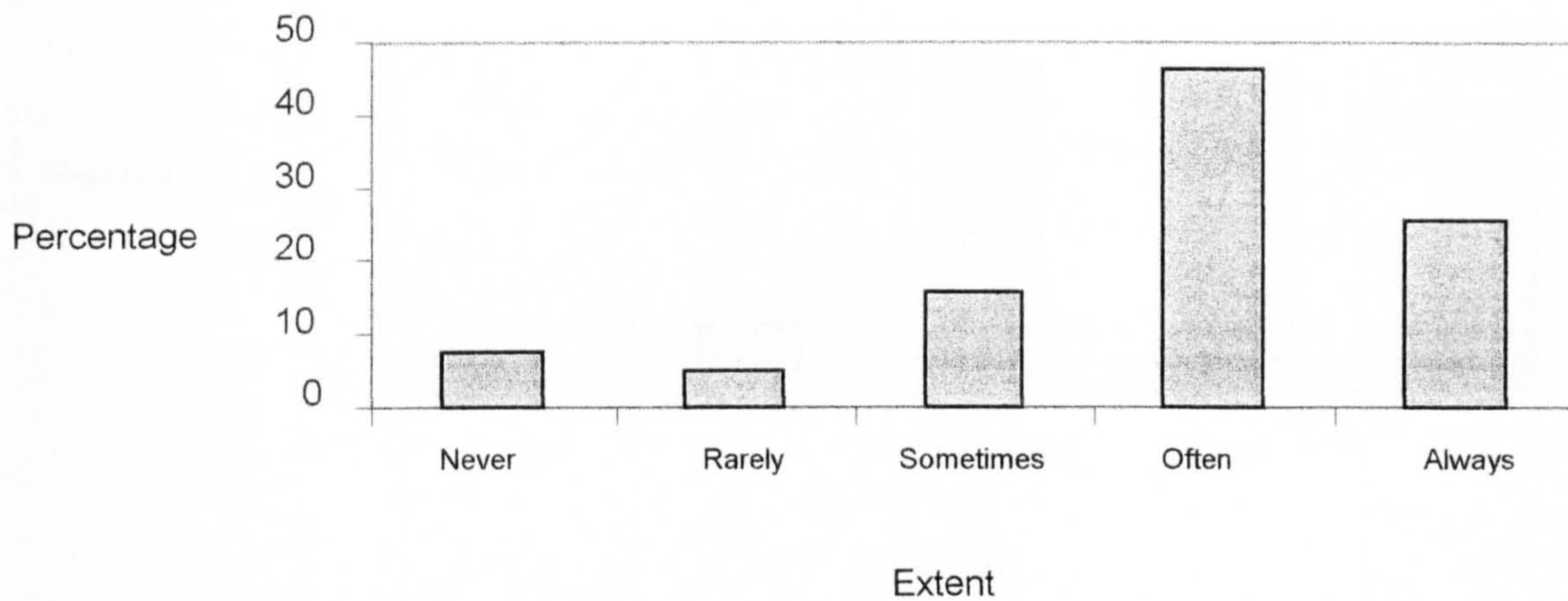
The BPS describes reflection as “an opportunity for careful and detailed consideration of some aspect of recent work from the supervisee’s perspective” (DCP, 2003). For most, reflection seemed to be used in their supervision with 45.2% of the sample stating that they use it often and 38.7% indicating that they always use reflection (see figure 1.3).

Figure 1.3: The extent to which reflection is used in supervision



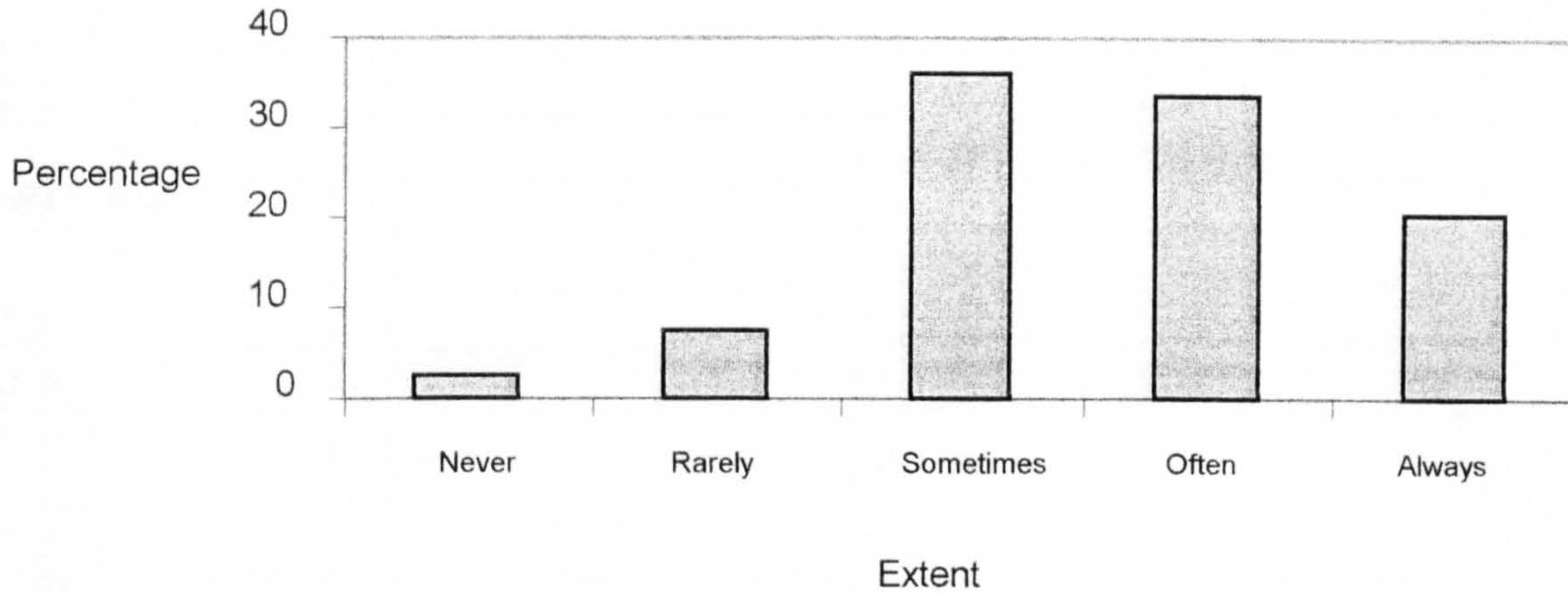
The BPS has also suggested using conceptualisation which they describe as “when the supervisor assists the supervisee to relate his or her reflections to the perspectives of others (including that of the supervisor) and to relevant theories and research” (DCP, 2003). Again the majority (46.2%) of participants felt that they do this often (see figure 1.4).

Figure 1.4: The extent to which conceptualization is used in supervision



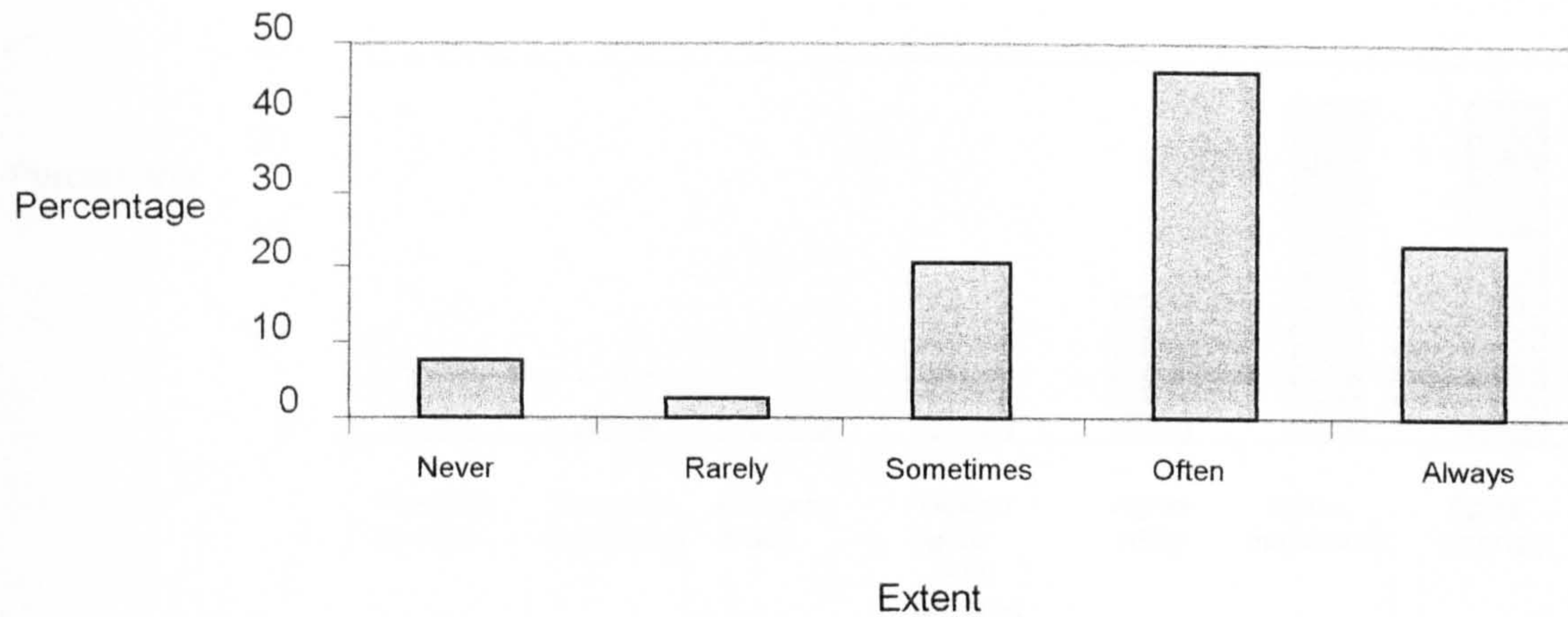
The BPS describes planning as “agreeing the action implications” (DCP, 2003). There was more of a mixed response to this question with 35.9% stating that they used this sometimes and 33.3% stating that they use this often (see figure 1.5).

Figure 1.5: The extent to which planning is used in supervision



The BPS describes experiencing as “carrying out actions and being aware of the accompanying affect” (DCP, 2003). A higher percentage (46.2%) of the sample felt that they do this often. With a sizable proportion stating that they do this sometimes (20.5%) and always (23.1%). See fig 1.6

Figure 1.6: The extent to which experiencing is used in supervision

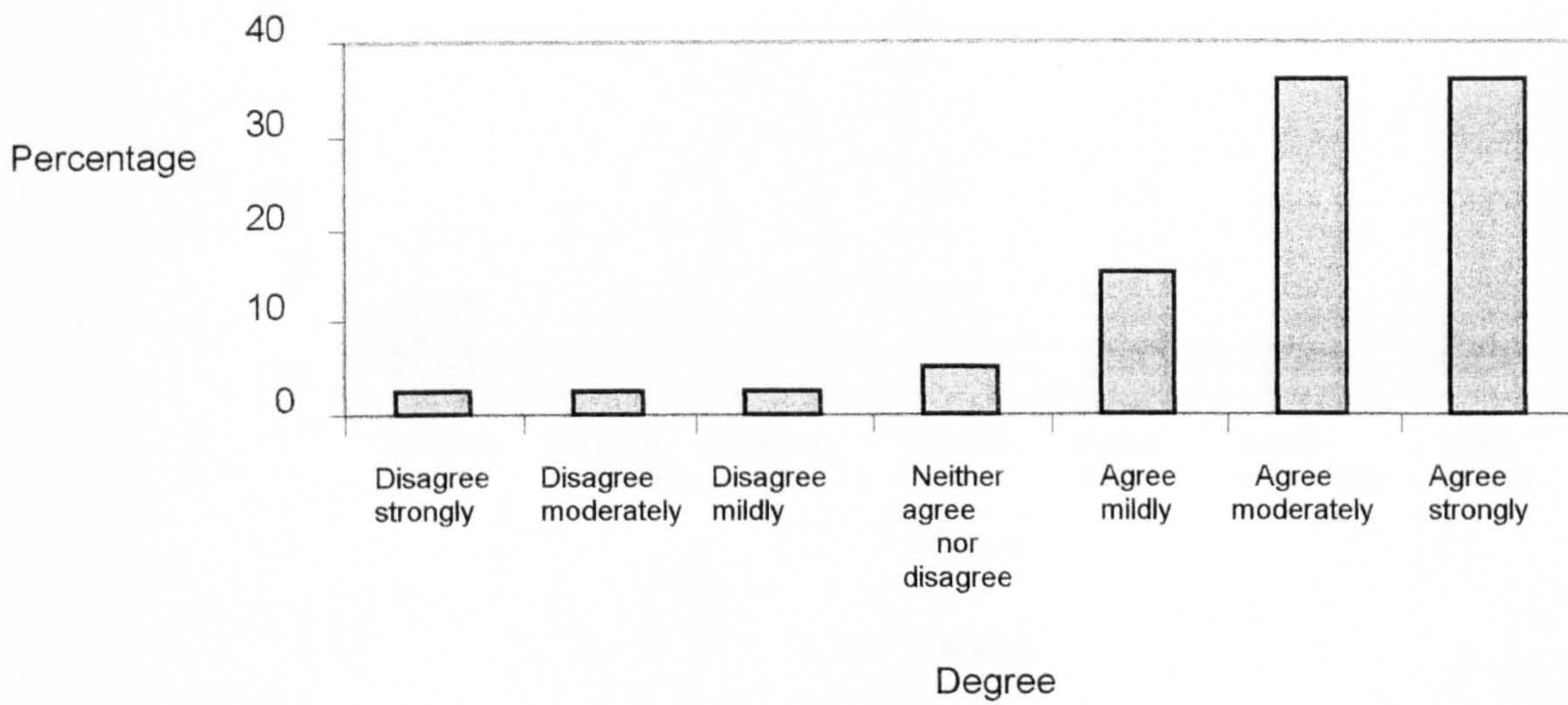


Evaluation

The BPS guidelines state that the tasks during evaluation are to provide formative and sometimes summative feedback to the supervisee.

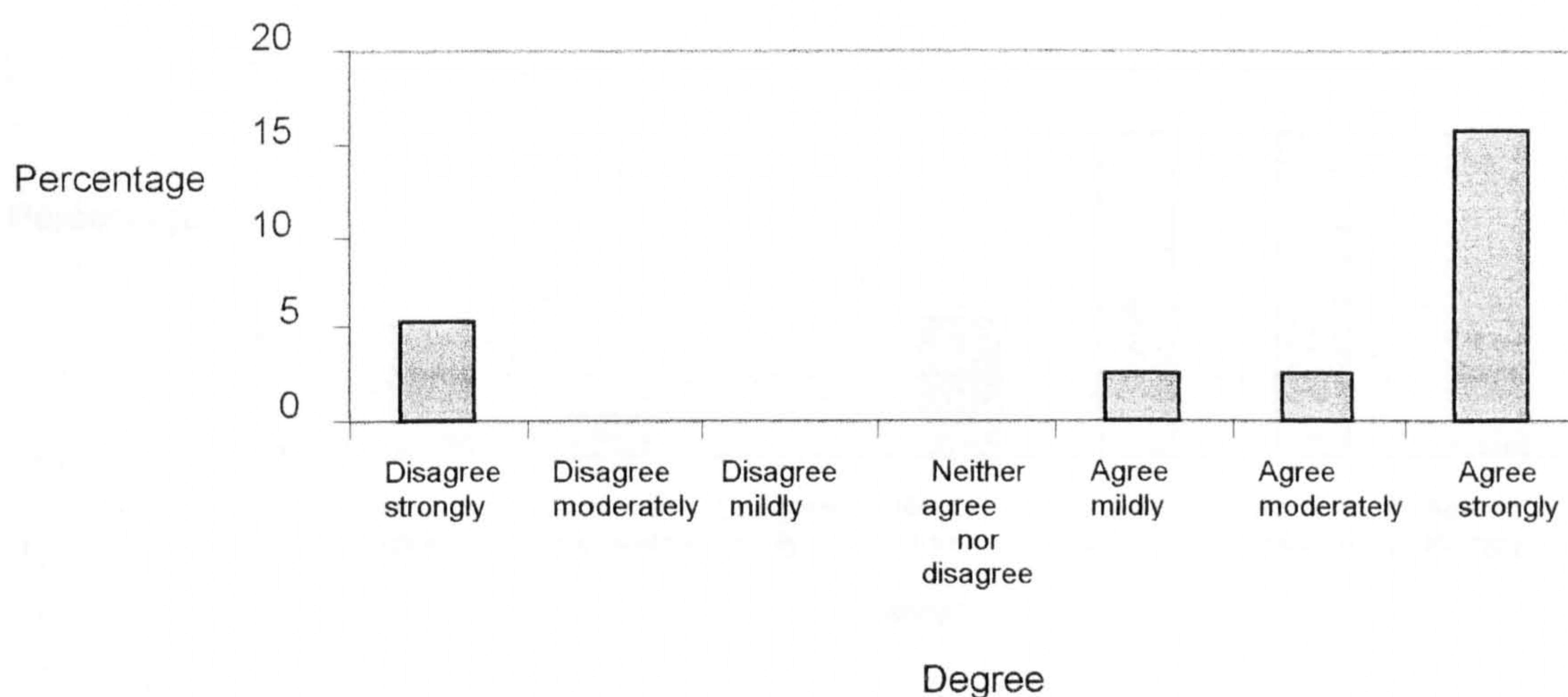
With regards to evaluation the majority of the participants felt that their supervisor had provided encouragement and corrective information with 15.4% agreeing with this statement mildly, 35.9% agreeing with the statement moderately and 35.9% agreeing with the statement strongly (see figure 1.7).

Figure 1.7: The degree to which the supervisor has provided encouragement and corrective information



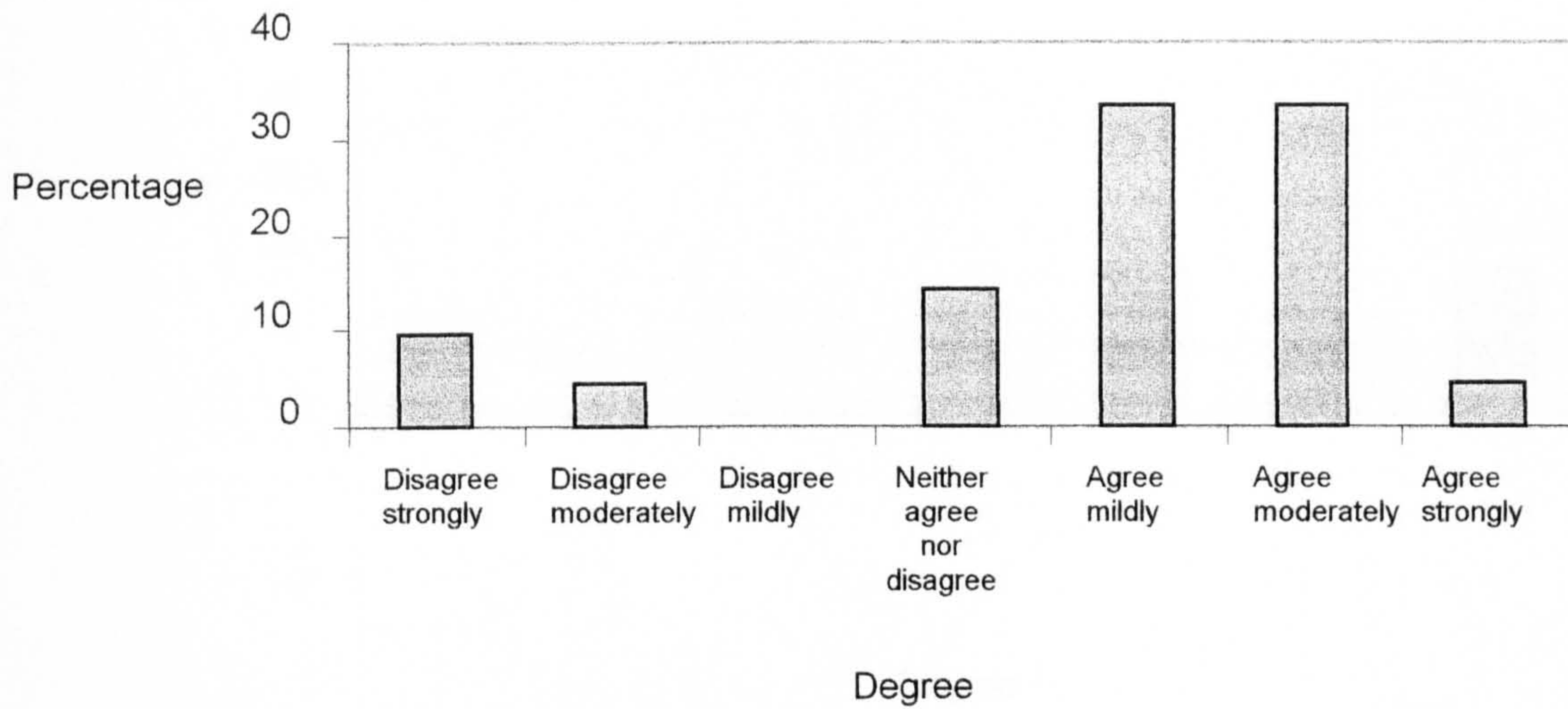
There was evaluation question, aimed specifically at trainee and assistant psychologists, regarding the degree to which their supervisor had provided information on the extent to which standards are achieved. This demonstrated that for most they agreed strongly (see figure 1.8).

Figure 1.8: The degree to which the supervisor has provided information on the extent to which standards are achieved



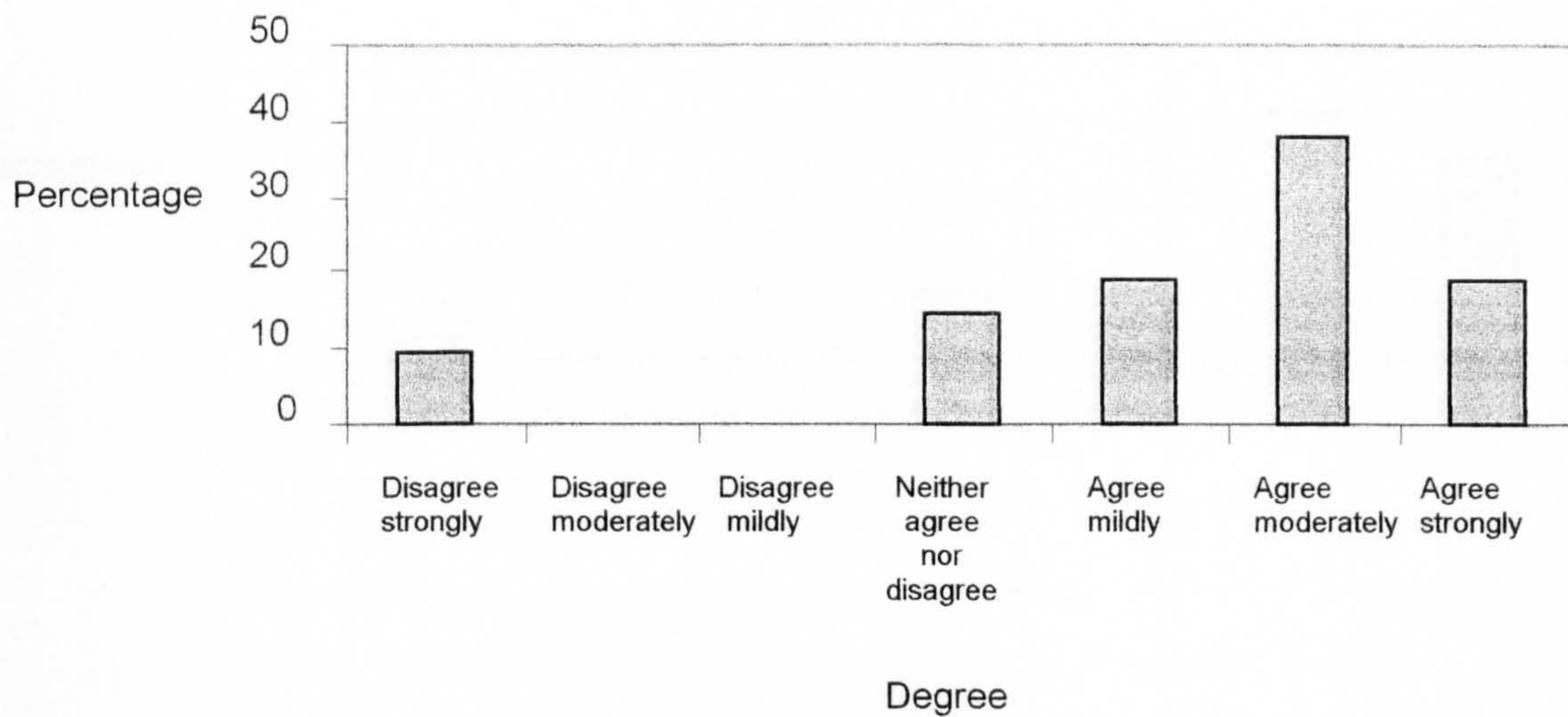
A variety of questions were asked in relation to the type of feedback received from supervisors. With regards to receiving clear feedback many agreed either mildly or moderately that they received clear feedback from their supervisor (see figure 1.9).

Figure 1.9: The degree to which individuals felt they had received clear feedback



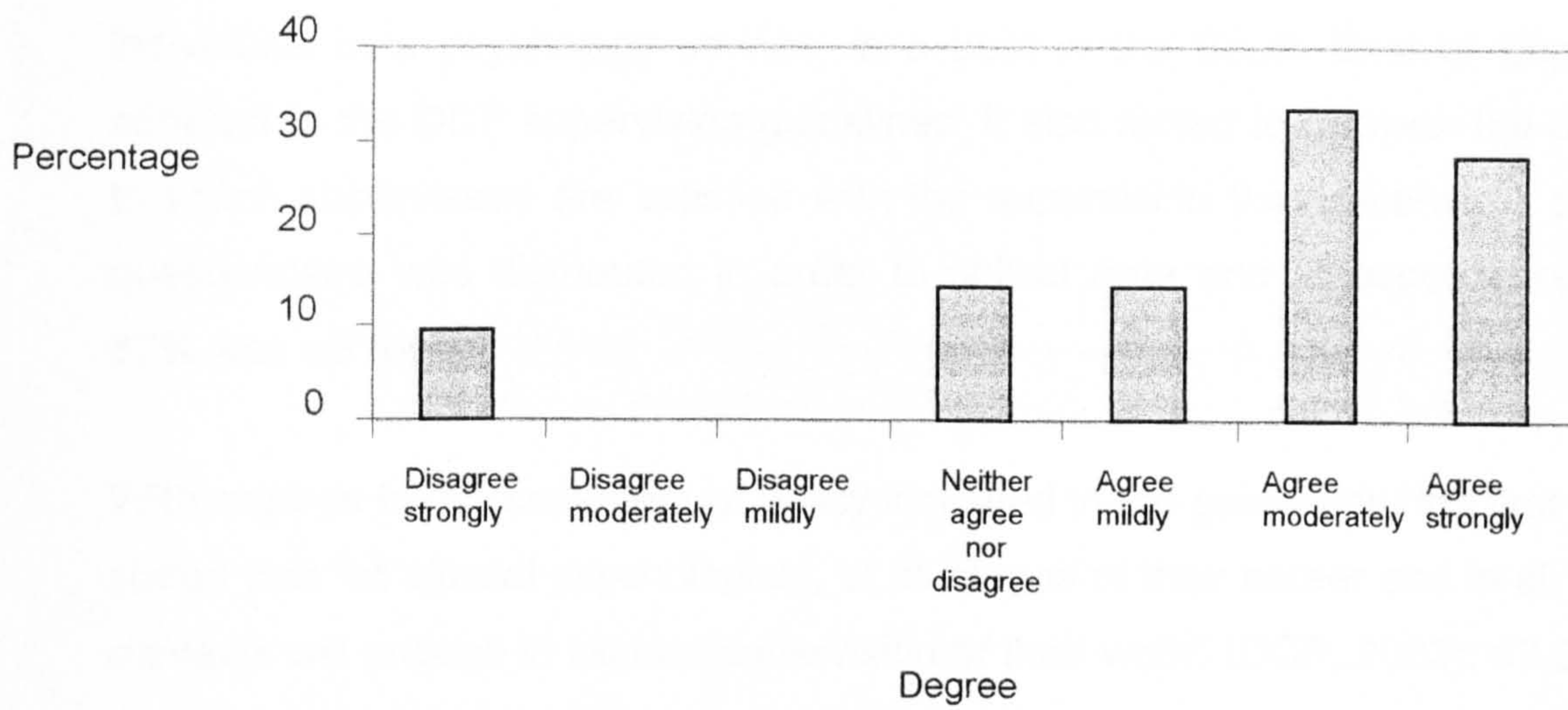
With regards to receiving honest feedback, again the responses were generally positive with many agreeing either mildly, moderately or strongly that they had received honest feedback (see figure 1.10).

Figure 1.10: The degree to which individuals felt they had received honest feedback



Responses to the constructive feedback suggested that again most agreed with this statement either mildly, moderately or strongly although there was a reasonable proportion that neither agreed nor disagreed with the statement, see (figure 1.11).

Figure 1.11: The degree to which individuals felt they had received constructive feedback



DISCUSSION

Summary of results

This audit evaluated the degree to which the supervision carried out amongst individuals in a psychology service, in a trust in the South East of England, adhered to the DCP supervision guidelines. It also aimed to uncover the extent to which supervisees are satisfied with the supervision they receive. A postal questionnaire was distributed in order to collect data and a response rate of 87% was achieved.

With regards to the statement of policy indicated in the guidelines, the first point stated that “all clinical psychologists, at all stages of their career and in all work contexts will engage in regular supervision of their work” (DCP, 2003). 87.2% of the sample indicated that they had engaged in regular supervision during the four month period stated. It is also stipulated that “all aspects of a clinical psychologists work – clinical, research, educational, managerial – should be supervised” (DCP, 2003). Whilst the majority of individuals engaging in clinical, research and managerial tasks received supervision for their work only a third of those undertaking educational tasks are supervised for this component of their work. There is, therefore, room for improvement. The guidelines also state that “as much as it is regarded as essential to be supervised, it is similarly expected that clinical psychologists provide supervision” (DCP, 2003). The majority of participants (61.5%) indicated that they had provided supervision in the time span specified. Bearing in mind that both assistant and trainee psychologists make up 25.6% of the sample and are not in a position to provide supervision. This appeared a respectable response rate. The majority of the sample (84.6%) agreed that their supervision is needs lead, which is another goal outlined in the guidelines. The minimum standard is 60-90 minutes for every 20 sessions worked. The majority (74.4%) of the sample reported that their last supervision session had lasted between 60-90 minutes, with 18% reporting that the session had lasted longer than 90 minutes. 72% of individuals had worked 20 sessions

or less between their two most recent supervision sessions. 74.4% stated that they were supervised by a Chartered Clinical psychologist, which is another point in the guidelines.

The guidelines also specify tasks relating to assessment, implementation and evaluation within supervision. Participants mostly felt the supervision they had received had taken their needs into account with 71.9% of the participants being in mild, moderate or strong agreement with the related question. There was a more mixed response that concerned the degree to which a supervision contract had been agreed. This could therefore be an area for development.

With regards to methods for implementation again they were generally viewed in a positive way. The majority of the sample reported using reflection often or always. Whilst many reported using conceptualisation, planning and experiencing often or always, there was a significant proportion who only reported using these methods sometimes. This could again be an area in which training could be useful to maximise adherence to the guidelines.

The notion of evaluation also seemed to generally be viewed in a positive way with the majority agreeing, to various degrees that their supervisor had provided encouragement and corrective information as well as information to the extent in which standards are achieved. Most of the participants also felt that their supervisor had provided clear, honest and constructive feedback to some degree. Although again the response rates suggested that improvement could be made.

Broadly, this audit shows that the supervision carried out does adhere to the DCP guidelines with the majority of responses indicating that supervision is a positive experience for them. It was also discovered that 92.3% of supervisees rate the quality of their supervision as being satisfactory, good or excellent indicating a high level of satisfaction with the supervision they receive. Nevertheless there is scope for improvement which would have implications for

service development and the continuing professional development of individuals.

Methodological issues and limitations

The design of the postal questionnaire seemed to be very effective for this audit and an excellent response rate was achieved. However, the questionnaire used in the audit was not faultless. It could have been beneficial to pilot the instrument more extensively in order to ascertain where some of the problems lie. It was clear from response rates that particular questions were less user friendly as there seemed to be specific questions which achieved high missing data rates. It may also have been useful to pilot the measure more extensively to ensure it was both reliable and valid. This could have been achieved by using test-retest reliability which would have involved re-administering the measure to the same group of individuals a week or so apart and comparing their data.

Although the questionnaire was predominantly quantitative in nature, there were some questions which elicited qualitative data. These questions produced some interesting information. It may have been useful to have used some more descriptive questions in order to achieve a deeper understanding of the sample.

More sophisticated statistical analysis may have been able to be carried out with the data, looking at group comparisons. However, given time limitation and the constraints of the project the analysis conducted was felt to be adequate to address the research questions. There were some interesting issues raised and given a more extensive remit these could have been further explored.

Ethical issues were considered very seriously with regards to data collection and presentation. Individual rights to confidentiality could have been jeopardised with the reporting of information given the small numbers in groups. The results were therefore presented in a way which would be most ethical.

Clinical and service implications

It was clear from this audit that supervision is viewed positively within the psychology service that the study was conducted. It was also clear that there is a strong adherence to the DCP guidelines. The results produced have implications for the training and development of supervision within the trust. It could be beneficial to individuals and the service to carryout some training with reference to supervision and the guidelines. This would provide opportunity for the sharing of good practice as well as offering a forum for the dissemination of knowledge regarding the DCP guidelines and the principles of supervision.

The results of this study would suggest that supervision has a positive impact on the practice of clinical psychology offering both personal and professional benefits for individuals. It could therefore be suggested that improving aspects of supervision will have implications for clinical as well as other aspects of the psychologist's role and may affect the service provided to clients

As the DCP guidelines are a relatively new document, and topical within the profession, conducting an audit will be beneficial to the service. This study offers the service an understanding of the standard to which an area of their work is being carried out when measured against an influential document.

In summary, this study has provided a detailed picture of the degree to which the supervision of psychologists, based in a psychological service, adheres to the DCP supervision guidelines, over a four month period. In addition it has uncovered the degree to which supervisees are satisfied with their supervision. The author will be disseminating the findings from this study to the Trust where the data was gathered and it is hoped that the information will be useful both in terms of providing a current picture and facilitating future development.

REFERENCES

Barker, C., Pistrang, N., & Elliott, R. (2002). Research methods in clinical psychology: An introduction for students and practitioners (2nd Ed.). John Wiley & Sons, LTD.

Barnes, G.G., Down, G., & McCann, D. (2000). Systemic supervision: A portable guide for supervision training. London: Jessica Kingsley Publishers.

Burton, J., & Launer J. (2003). Supervision and support in primary care. United Kingdom: Radcliffe Medical Press.

Carroll, M., & Holloway, E. (1999). Counselling supervision in context. London: Sage Publications.

Carroll, M., & Tholstrup, M. (2001). Integrative approaches to supervision. London: Jessica Kingsley Publishers.

Clarkson, P. (1998). Counselling psychology: Integrating theory, research and supervised practice. London: Routledge.

Cutcliffe, J.R., Butterworth, T., & Proctor, B. (2001). Fundamental themes in clinical supervision. London: Routledge.

Dryden, W., & Feltham, C. (1992). Psychotherapy and its discontents. Buckingham: Open University Press.

Feltham, C., & Dryden, W. (1994). Developing counsellor supervision. London: Sage Publications.

Firth-Cozens, J. (1993). Audit in mental health services. Hove: Lawrence Erlbaum.

Gilbert, M.C., & Evans, K. (2000). Psychotherapy supervision: an integrative relational approach to psychotherapy supervision. Buckingham: Open University Press.

Hirons, A., & Vellerman, R. (1993). Factors which might contribute to effective supervision. Clinical Psychology Forum, 57, 11-13.

Holloway, E. L. (1995). Clinical supervision: A systems approach. Thousand Oaks: Sage Publications.

Inskipp, F., Proctor, B., Scaife, J., & Walsh, S. (2001). Supervision in the mental health professions: A practitioner's guide. East Sussex: Brunner-Routledge.

Jacobs, M. (1996). In search of supervision. Buckingham: Open University press.

Kazdin, A. E. (2003). Research design in clinical psychology (4th Ed.). Allyn & Bacon.

Kolb, D. A. (1984). Experiential learning: Experience as the source of learning and development. New Jersey: Prentice Hall.

Maxwell, R.J. (1984). Quality assessment in health. British Medical Journal, 288, 1470-2.

Robson, C. (1993). Real world research: A resource for social scientists and practitioner-researchers. Oxford: Blackwell.

Rock, M.H. (1997). Psychodynamic supervision: Perspectives of the supervisor and the supervisee. New Jersey: Jason Aronson Inc.

Shipton, G. (1997). Supervision of psychotherapy and counselling: Making a place to think. Buckingham: Open University Press.

The British Psychological Society. (2003). Policy guidelines on supervision in the practice of clinical psychology. The British Psychological Society, Division of Clinical Psychology.

Watkins, E.C. (1997). Handbook of psychotherapy supervision. New York: John Wiley & Sons Inc.

Wiener, J., Mizen, R., & Duckham, J. (2003). Supervising and being supervised: A practice in search of a theory. Basingstoke: Palgrave Macmillan.

Wosket, V. (1999). The therapeutic use of self: Counselling practice, research and supervision. London: Brunner-Routledge.

APPENDIX I: Questionnaire

Questionnaire

This questionnaire has been designed to evaluate the effectiveness of supervision for psychologists working in the XXXXX Trust. Please answer these questions as honestly as possible based on your experience of supervision during the past four months, from November 2003 – February 2004.

1. Throughout the past four months have you received regular supervision for your own work?

Yes
 No

2. Which types of supervision do you engage in?

Individual
 Group
 Other please specify _____

3. In the past four months has your work involved any of the following (please tick the applicable box/s)?

- Clinical work
- Research
- Educational work
- Managerial tasks

4. Which of these works have been supervised (please tick the applicable box/s):

- | | Yes | No | N/A |
|--------------------|--------------------------|--------------------------|--------------------------|
| • Clinical work | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| • Research | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| • Educational work | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| • Managerial tasks | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

5. Are you supervised by a Chartered Clinical Psychologist?

Yes
 No
 Unsure

6. How many sessions did you work between your two most recent supervision sessions?

7. How does that compare with the frequency of your usual supervision sessions?

1	2	3	4	5
Much	Slightly	The	Slightly	Much
Fewer	Fewer	Same	More	More

8. How long did your most recent supervision session last?

9. How does that compare with the duration of your usual supervision sessions?

1	2	3	4	5
Much	Slightly	The	Slightly	Much
Shorter	Shorter	Same	Longer	Longer

10. Have you read the Policy Guidelines on Supervision in the practice of Clinical Psychology?

Yes
 No

11. The BPS specifies that supervision should be needs lead. Is yours needs lead?

Yes
No

12. Do you feel your supervision benefits you personally?

Yes
No

13. How would you rate the quality of your supervision?

1 2 3 4 5
Poor Unsatisfactory Satisfactory Good Excellent

14. In what way could your supervision be more useful?

15. How did you come to be supervised by your supervisor?

Chose supervisor
Assigned to supervisor

16. Do you work within the same model as your supervisor?

Yes (Go to question 18)
No

17. How do you deal with this?

18. What do you think makes a good supervisor?

19. What gender is your supervisor?

Male
Female

20. What is the cultural background of your supervisor?

21. Approximately what age is your supervisor?

Under 30 30-40 40-50 50-60 60+

22. During the past four months have you provided supervision?

Yes
No (Please go to Question 24)

23. To whom has it been provided
(Please indicate job title only)

Number of sessions

Tasks of supervision

How much do you agree or disagree with the following statements:

Needs assessment

24. The supervision I have received throughout the past four months has taken my needs into account.

1	2	3	4	5	6	7
Disagree strongly	Disagree moderately	Disagree mildly	Neither agree nor disagree	Agree mildly	Agree moderately	Agree strongly

25. A supervision contract has been agreed which takes my needs into account (this setting of a contract can be undertaken through the joint setting of learning objectives and an agenda for the meeting or in another appropriate way).

1	2	3	4	5	6	7
Disagree strongly	Disagree moderately	Disagree mildly	Neither agree nor disagree	Agree mildly	Agree moderately	Agree strongly

Implementation

26. The BPS has suggested using *Reflection* in order to achieve the objectives of supervision. The BPS describes reflection as 'an opportunity for careful and detailed consideration of some aspect of recent work from the supervisee's perspective'.

To what extent do you use reflection in your supervision?

1	2	3	4	5
Never	Rarely	Sometimes	Often	Always

27. The BPS has suggested using *Conceptualisation* in order to achieve the objectives of supervision. The BPS describes conceptualisation as 'when the supervisor assists the supervisee to relate his or her reflections to the perspective of others (including that of the supervisor) and to relevant theories and research'.

To what extent do you use conceptualisation in your supervision?

1	2	3	4	5
Never	Rarely	Sometimes	Often	Always

28. The BPS has suggested using *Planning* in order to achieve the objectives of supervision. The BPS describes planning as 'agreeing the action implications'.

To what extent do you use planning in your supervision?

1	2	3	4	5
Never	Rarely	Sometimes	Often	Always

29. The BPS has suggested using *Experiencing* in order to achieve the objectives of supervision. The BPS describes experiencing as 'carrying out actions and being aware of the accompanying affect'.

To what extent do you use experiencing in your supervision?

1	2	3	4	5
Never	Rarely	Sometimes	Often	Always

Evaluation

30. During the past four months, where appropriate, my supervisor has provided encouragement and corrective information

1	2	3	4	5	6	7
Disagree strongly	Disagree moderately	Disagree mildly	Neither agree nor disagree	Agree mildly	Agree moderately	Agree strongly

31. *To be completed by Trainee and Assistant Psychologists Only*

During the past four months, where appropriate, my supervisor has provided information on the extent to which standards are achieved, (e.g. whether or not a competence was demonstrated satisfactorily).

1	2	3	4	5	6	7
Disagree strongly	Disagree moderately	Disagree mildly	Neither agree nor disagree	Agree mildly	Agree moderately	Agree strongly

32. During the past four months I have received *clear* feedback regarding the achievements of each supervision session

1	2	3	4	5	6	7
Disagree strongly	Disagree moderately	Disagree mildly	Neither agree nor disagree	Agree mildly	Agree moderately	Agree strongly

33. During the past four months I have received *honest* feedback regarding the achievements of each supervision session

1	2	3	4	5	6	7
Disagree strongly	Disagree moderately	Disagree mildly	Neither agree nor disagree	Agree mildly	Agree moderately	Agree strongly

34. During the past four months I have received *constructive* feedback regarding the achievements of each supervision session

1	2	3	4	5	6	7
Disagree strongly	Disagree moderately	Disagree mildly	Neither agree nor disagree	Agree mildly	Agree moderately	Agree strongly

Personal Details

Gender: Female Male

Age: Under 30 30-40 40-50 50-60 60+

Cultural Background _____

Job Title:

Clinical Psychologist
Trainee Clinical Psychologist
Assistant Psychologist
Other

Thank you for your co-operation

To view the Policy Guidelines on Supervision in the practice of Clinical Psychology visit www.bps.org.uk/sub-syst/dcp/publications.cfm#

APPENDIX II: Cover letter

19th March 2004

Dear

I am a trainee clinical psychologist and as part of my clinical training I am conducting an audit of the clinical supervision received by those working in the Psychology Services in XXXXX Trust.

In order to do this I will be inviting all psychologists in the trust to confidentially complete the attached questionnaire, which should take no longer than 10 minutes of your time. I have enclosed a prepaid envelope for you to return your completed questionnaire to me by 9th April 2004.

I am sure you appreciate that audit is an essential part of the work that we do in order to advance our services, therefore it is important that I receive as many responses as possible in order to make meaningful analysis of the data. Once the data is collated I shall be presenting the results, which you will be invited to come along to.

I will send a reminder letter to all potential participants one week before the deadline in order to maximise response rates.

Many thanks for your cooperation

XXXXX
Trainee Clinical Psychologist

APPENDIX III: Follow-up letter

1st April 2004

Dear

If you have already completed and returned the questionnaire I sent you two weeks ago, regarding the clinical supervision you receive, thank you for your participation in my audit project.

If you have not completed your questionnaire can I remind you that the deadline for returning the questionnaire is Friday 9th April 2004. As I am sure you will appreciate audit is an important part of the work we do as psychologists and maximum response rates will make analysis of the data more accurate and meaningful.

Many thanks for your cooperation

XXXXXX

Trainee Clinical Psychologist

How do 'Looked After' Adolescents' Experience Mental Health Services?

A Critical Literature Review

Student Number: 02055473

February 2005

Year 3

Word count: 4965

Introduction

It has been suggested that looked after children are a group particularly vulnerable to mental health issues (Rodrigues, 2004, Kelly et al., 2003, Phillips, 1997, McCann et al., 1996). Therefore with a significant number of children being looked after by the local authority it is important that mental health services continue to develop to meet their needs. Whilst there is an extensive research base looking into mental health and children, as a homogenous group, it is widely recognised that the research base for looked after children is somewhat more underdeveloped (Rodrigues, 2004, Kelly et al., 2003).

Adolescence is widely recognised as a unique stage of development whereby young people are entering a transitional period between childhood and adulthood. This developmental stage poses many challenges and can also be a vulnerable time for psychological difficulties (Coleman & Hendry, 1999). However there have been very few studies carried out focusing specifically on mental health and looked after adolescents.

Of the evidence that is available for looked after children it is predominantly quantitative in nature and largely based on Diagnostic and Statistical Manual of Mental Disorders (DSM) criteria. Qualitative research particularly looking at user views seems excluded for the most part. With the culture that we live in today user views are becoming increasingly important with regards to service provision and development. This provides a systematic review of the literature base and offers justification as to why a qualitative study looking at the mental health needs of looked after adolescents is needed.

Adolescence

Adolescents make up a significant proportion of the UK population. Whilst for many young people, it is a time filled with excitement, challenge and change for others it can be a period of turmoil. It is also a time when the prevalence of mental health problems rises and the pattern of disorders changes to be more

like that in the adult population (Talbot, 2002). Interestingly it has been suggested that most diagnosed mental health problems are reported to have their onset during adolescence (Kosky, 1992, Steinberg, 1987). It has also been suggested that with the difficulties that are posed during this stage it is the more socially and psychologically vulnerable adolescents who are likely to experience this period as difficult, which may manifest in psychological disturbances (Rutter, 1995).

Psychological theories of adolescence

Whilst different developmental theorists have taken their own slant on adolescence as a stage of growth, for all adolescence has been described as a unique stage of transition between childhood and adulthood. Erikson described adolescence as part of his eight stage developmental model. For Erikson adolescence is the fifth stage whereby the individual is to acquire a favourable ratio of identity and repudiation to identity diffusion (Erikson, 1965). The basic task for adolescents is to integrate the various identifications they bring from childhood into a more complete identity. For Erikson if the adolescent cannot integrate their identifications, roles or selves, they face "identity diffusion" and the personality is fragmented lacking a core (Erikson, 1965).

In contrast Freud described adolescence as the genital stage whereby the sexual impulses, which were repressed during the latency stage, reappear in full force as a result of the physiological changes of puberty. The goal is mature, adult sexuality, with the biological aim of reproduction. Freud stated that whilst some internal conflict is inevitable throughout life, a relatively stable state is achieved by most people by the end of the genital stage (Miller 1993).

For Piaget, he accounted for adolescence in his cognitive stage theory by describing the formal operational period, which occurs when children are aged roughly between 11 and 15. During formal operational thought concrete operations are carried one step further. Formal operational thought resembles the kind of thinking we often call the scientific method. By achieving formal

operations, adolescents complete their cognitive structures, which continue to develop throughout adulthood as formal operations are applied to more and more content areas and situations (Miller, 1993).

Looked after children

'Looked after' is the term introduced by the Children Act (1989) to cover all children in public care, including those in foster or residential homes and those still with their own parents but subject to care orders (Polnay & Ward, 2000). There are currently around 59,700 looked after children in the UK (Department of Health, 2003). Adolescents constitute about a third of all children in foster care and around three fifths of those living in children's homes (Berridge et al., 2003). There are no significant differences between gender ratios of those looked after (Coleman & Schofield, 2003). However it is felt that gender differences may be neglected in the care received (Lees, 2003). With regards to ethnicity there is an over representation of children from ethnic minorities being looked after by the local authority (Lees, 2002).

It is estimated that one out of every two hundred children per year in England and Wales experience public care (Hill & Watkins, 2002). With regards to duration Millham et al., (1986) found that one third of children had left care within 6 weeks and 50% had left within 6 months of admission. However children who remained in care for at least 6 months had a 60% chance of remaining in care for at least a further 18 months.

Children are looked after for a variety of reasons. Although most youngsters have experienced a breakdown in family support, significant proportions enter care because of behavioural difficulties (Millham et al., 1986). In addition many will have suffered abuse of either a physical, sexual or emotional nature. Once in the system it is relatively common for further problems to occur such as frequent changes in placement as well as being placed in less than adequate placements (Richardson & Joughin, 2000).

The characteristics of looked after children have gradually changed over the years. Social workers and other professionals involved with services for looked after children increasingly express the view that children and young people who are currently being taken into care have more extreme and complex difficulties than in previous decades. This is likely to be a result of changes in government policies and more children being exposed to more of the identified risk factors for mental illness, including deprivation and family breakdown (Meltzer et al., 2000, Bebbington & Miles, 1989).

How does psychological theory understand looked after children?

One of the key psychological theories used to understand looked after children and mental health issues is attachment theory (Atkinson & Zucker, 1997, Howe, 1995). The notion that early parent-child relationships play an important role in the aetiology of psychopathology is not unique to attachment theory but is at the core of this theoretical perspective. It has been suggested that the relation between early attachment and later behaviour problems is that children are more likely to develop behaviour problems if they are insecurely attached to their primary caregiver as opposed to being securely attached. Inevitably many children who are looked after by the local authorities will have a disrupted pattern of attachment in early childhood. While placement in foster care may protect children from exposure to the risk of abuse or neglect, it disrupts parent-child attachment and so should only be considered when all other options have been excluded (Carr, 1999). For some the experience of abandonment and unmet dependency needs may lead to self-blame for causing the abandonment, helplessness, hopelessness, low self-esteem, chronic depression and self harm (Carr, 1999).

There are two insecure attachment patterns described to help understand the psychological impact of attachment styles that may be more common for looked after children. Inhibited reactive attachment disorder is associated with abuse and neglect. It is specifically associated with a rejecting or punitive parenting style or a parenting style where the parent is not promptly and appropriately

responsive to the child's signals that they need something from the parent. It is characterised by contradictory or ambivalent approach-avoidance social responses, typically displayed during partings and reunions. Emotional disturbance, characterised by misery and withdrawal or aggression; and fearfulness and hypervigilance are also common. The second disorder of attachment, disinhibited reactive attachment disorder, is associated with institutional upbringing or multiplacement experiences. This is characterised by clinging behaviours in infancy, diffuseness of selective attachments in pre-school years, indiscriminately friendly, attention seeking behaviour in middle childhood, and a difficulty in forming confiding peer relationships in childhood and adolescence. Both types of attachment disorder are associated with difficult temperament and both may be precursors of conduct disorder and later personality disorders (Zennah, 1996).

Prevalence of mental health problems

Compared with the high profile given to mental health in adults, the significance of mental health of young people has only been recognised over the past 20 years (Rutter, 1983). Lindsey, in Richardson & Joughin (2000), states that among the child and adolescent population as a whole a frequently quoted figure of one in five young people reflects a significant level of disturbance. For young people cared for by the local authority the mental health risks are much higher than for children in their own families (Mount et al., 2004, Utting et al., 1997) and despite a lack of systematic research it is widely acknowledged that looked after children have a particularly high prevalence of mental health problems (Rodrigues, 2004, Kelly et al., 2003).

McCann et al., (1996) who undertook the first systematic assessment of the prevalence of psychiatric disorder in looked after adolescents found that two thirds of children looked after by an Oxfordshire local authority had significant, unrecognised and untreated mental health problems, including a 23% prevalence of depressive disorders. Utting et al., (1997) emphasised that the mental health needs of looked after children, especially those in residential

care, are known to be greater than those of the general population of the same age. In addition The Children's Safeguard's Review (1997) found that 75% of looked after children had mental health problems, some of them complex and severe (Richardson & Joughin, 2000).

Whilst there has been some research conducted into the rate of psychiatric disorder amongst those in the care system little was known about the mental health of children entering local authority care until Dimigen et al., (1999) carried out such a study. However the target population were aged between 5 and 12 years. The findings from this study highlighted that a considerable proportion of young children have a serious psychiatric disorder at the time they enter local authority care but are not being referred for psychological help.

Among young people leaving care, Saunders & Broad (1997) found that 17%, most of who were females (87%), had mental health disorders such as depression, eating disorders and phobias, and 35% had deliberately self-harmed since the age of 15.

Type of mental health problems experienced

There have been many studies carried out reporting the type of mental disorders experienced by looked after children. Most of which are based on diagnostic criteria (McCann et al., 1996, Utting et al., 1997, Butler & Vostanis, 1998, Arcelus et al., 1999).

It has been reported that the most common disorders, which looked after children suffer from, include: anxiety, fears and depression, conduct disorder and attachment disorder. A smaller group develop serious mental illness, such as schizophrenia and bipolar affective disorder, with psychotic symptoms. In addition the experience of early sexual abuse and violence may predispose some victims to become abusers themselves or to fear that they will do so. Very often the despair about their lives or the need to draw attention to their dire predicaments leads to suicidal attempts and self-harming behaviour. They may

put themselves at further risk by running away, using drugs and alcohol, engaging in prostitution and criminal acts (Lindsey, 2000). In addition children looked after in residential homes appear to be even more at risk than those who are fostered (McCann et al., 1996).

Treatment received by looked after children

Despite high levels of need recorded only a small percentage of looked after young people are seen in CAMHS (Mount, 2004). This is due to a variety of factors however as far as access to services is concerned, they do not have the advocates (parents or stable carers) to request assessment and treatment (Ward et al., 2002, Polnay et al., 1996). Even if a young person gets onto a CAMHS waiting list, they may well have moved to a different placement or even out of local authority care by the time their appointment comes up (Mental Health Foundation, 2002).

Research suggests that specialist services for this population are needed due to their complex psychosocial needs. Consequently this is why services seem to be changing to better meet their needs. In 1995 a service for children in care was set up in Birmingham. The aim of the service was to provide assessment and brief psychosocial interventions as well as diversion to longer-term services (Butler & Vostanis, 1998). Arcelus, et al., (1999) in their paper describing the model used in this service highlighted the complexities of working with this client group. It seems that this service, in addition to changes in government policy, has inspired other trusts. Subsequently looked after children services are more common now throughout the country with models of mental health services for working with looked after children continuing to develop.

Current Government initiatives

In the past there have been considerable variations in services for looked after children. However, in recent years, the government has attempted to address this issue by introducing initiatives aimed at bringing all services up to national standards (The mental health foundation, 2002). This is in part to address

guidelines stipulated in the Children's Act (1989) which provides a comprehensive framework for the care and protection of all children and young people in need, including those living away from home. This document also states that local authorities have a duty to safeguard and promote the well being of children looked after by them (Department of Health, 2002b).

The government has taken steps through the 'Quality Protects' programme and other initiatives, to remedy the most obvious deficiencies in the arrangement for bringing up children in the public care. The Quality protects initiative (England) and Children First initiative (Wales); launched by the Department of Health in 1998, aims to improve the welfare of looked after children through increased resources and national performance monitoring (Hill & Watkins, 2002). Consequently all children entering care are to be offered a health assessment and treatment plan. In addition the National Priorities Guidance for 1999/2000 issued to the NHS and social services authorities sets targets for building up core child and adolescent psychiatric services (Richardson & Joughin, 2000).

The department of health document 'Promoting the health of looked after children (2002b) highlights that within the objectives, which the government has set for children's social services is a clear commitment to improving the life chances of children and young people who are looked after away from home. The document states that it is a multi-agency responsibility to improve the health, including mental health of looked after children. This document highlights the range of services available and how they should be accessible to looked after children.

In addition the Government have developed a National Service Framework for children (2004) of which children in special circumstances are highlighted. This includes children who are looked after.

Current Government initiatives seem to be prioritising and targeting looked after children's health needs and stressing the importance of user views. As part of

this initiative specially designed mental health services are evolving and developing to target this group of children and adolescent's mental health needs (Department of Health, 2004). Therefore there is scope for research to be conducted that can inform service provision.

Research conducted so far

In recent years there has been an increasing tendency to listen to children's views and opinions on matters affecting them (Hepstinstall, 2000). Since the 1979 International Year of the Child there have in the UK been a number of legal and organisational developments reflecting children's rights to be heard, including the 1989 Children Act, the setting up of the Children's Legal Centre, the launch of Childline and the government's ratification of the United Nations Convention on the rights of the child in 1991 (Heptinstall, 2000)

Nevertheless, despite such developments the research base for qualitative studies for looked after children still seems to be somewhat underdeveloped. Of the literature that is available looking at user views most has been conducted from a social theoretical perspective, which largely reflects the way, looked after children's services have historically been set up with social workers taking the lead role. With current government initiatives focusing more on looked after children's health issues hopefully there will be a drive towards a more multidisciplinary research base.

Difficulties accessing this population

The evidence base for child and adolescent mental health and social care is fairly poor for looked after children, when compared to some other specialities. There are a number of factors that contribute to this small evidence base. They are a fairly difficult group to study. Frequent changes of placement and in social work staff, poor school attendance and young people's mistrust of formal initiatives all present problems for researchers (The Mental Health Foundation, 2002).

In addition Heptinstall (2000) has given her account of the difficulties experienced gaining access to looked after children when conducting a study of children's experiences of family life. She highlights the time span involved, the delays experienced and the issue of adult's involvement in preventing children from participating in research. For Butler & Williamson (1994) and Thomas & O'Kane (1998a) the major issue was the tendency by a variety of adults to protect children from the perceived adverse effects participation in research may cause. This meant that for some children they were prevented from taking part in the research despite having expressed a personal wish to do so.

Due to the difficulties accessing this population many studies are conducted either with professionals and carers or are conducted reviewing case notes (Rodrigues, 2004). Inevitably this leads us to question the validity and reliability of some of the data recorded. Acknowledging the difficulties accessing this client group highlights factors contributing to the lack of qualitative research.

Professional views

In a study conducted by Phillips (1997) the views of social workers working with children in foster care were described. It was found that although 80% of the children were considered to require treatment from a mental health professional, only 27% had received any input.

In a qualitative study carried out by Callaghan et al., (2003) focus groups were conducted in order to inform the development of a specialist mental health team for looked after children. Interestingly this was done with various stakeholders, social services staff, foster carers and residential social workers, yet the young people were excluded. Interestingly this paper highlighted that an obvious gap in the process was the lack of consultation with children and young people.

Another interesting study carried out by Nicholas et al., (2003) focused on the proportion of looked after children in residential homes involved with mental health services and the different ways in which CAMHS across Leeds are

working with this group. The methodology involved scanning CAMHS and therapeutic social workers case notes for information, and obtaining data from social services. A questionnaire was also sent to all members of the therapeutic social worker team and the three CAMH teams in Leeds. This study found that 64% of looked after children were known to CAMHS or the therapeutic social worker team. With regards to the type of work carried out it was found that this is changing with an increase in consultation with, and training of, staff in residential children's homes. This study has been used to inform service provision and is a useful study highlighting professional opinion however it would have been useful to incorporate the service users into the study to establish their views and present a more objective picture. Limitations of this study included the fact that it was difficult to obtain reliable information even from social services databases. Interestingly the authors of this study found it difficult to collect areas of clinical information including diagnosis, which might suggest the difficulties with understanding this client group's mental health needs.

Carer's views

Mount et al., (2004) carried out a study whereby 50 young people and their carers were interviewed. The purpose of this study was to see whether intuitively they considered the young person to have a mental health problem and when they would seek professional help. The intuitive judgement of need was compared to responses to a mental health screen, and specific depression and conduct disorder scales. The study found that carers were four times more likely to identify mental health need, both intuitively and on the mental health screen, than young people did themselves. Interestingly fewer than half of those identified as having high needs were being seen by a mental health specialist which highlights service issues for looked after children teams. Whilst these figures were high, of concern was the fact that 23% of carers failed to identify needs, subsequently identified by the mental health screen, which could be due to a variety of factors but nevertheless identifies an area that needs input.

Experiences of care

Munro (2001) argues from her study that qualitative research asking opinions of looked after children are a must for healthy development. She highlights how empowering looked after children to have a greater say in decisions made about them is a complex task, but is necessary not only to gradually increase the degree of power a child has but also to help them learn how to use that power responsibly. She argues it is as much an issue of parenting as ethics.

A number of recent research studies have examined looked after children's perspectives on their care situation (Butler & Williamson, 1994, Triseliotis et al., 1995; Thomas & O'Kane, 1998a, Thomas & O'Kane, 1998b, Baldry & Kemmis, 1998, Munro, 2001). There have also been studies conducted looking at the development of services and trying to incorporate the views of children and their carers and social workers into the process (Sargent & O'Brien, 2004, Callaghan et al., 2003). However whilst these studies are aiming at uncovering users views many are done using quantitative methodology such as questionnaires (Baldry & Kemmis, 1998, Delfabbro et al., 2002), which inevitably limits the extent to which participants can offer their opinion. Nevertheless the research base for looked after children from a social perspective is significantly broader than that looking at mental health issues.

Experience of mental health services

Qualitative studies looking specifically at looked after children's views of mental health and related issues are scarce. There is clearly a need for psychological research in this area.

Blower et al., (2004) recently carried out a needs assessment study looking at the mental health of looked after children. This was a combined quantitative and qualitative study assessing the need for mental health services of looked after children. However the sample of 48 was a combination of looked after children with a mean age of 12.87. Whilst it is not clear what the age range was, children aged between 7 and 17 were approached to participate in the study. The

qualitative element of this study involved conducting in-depth interviews and focus groups with teenagers from the original group of looked after children. Project psychiatrists and a social worker conducted the interviews. Participants were asked about their beliefs about, experience of and ways of coping with, mental health problems; their experience of being 'in care'; their sources of support, and their suggestions for a mental health service for looked after young people. However this study appeared to be highly focused on DSM diagnosis and care experience, which may have been due to the fact that it was carried out from a particular theoretical perspective, which is different to that of a psychologist who may focus more on symptomatology and experience. The data gathered from these interviews highlighted that young people regarded mental illness as something about which they were curious, but from which they wanted to dissociate themselves. They were suspicious of mental health professionals whom they described as inaccessible and irrelevant to their needs. Young people described a wide range of experience of mental health problems in themselves, family members and other young people. They believed that such problems were the consequence of adverse experiences or circumstances and that talking to someone or receiving practical forms of support could relieve them. In reality, however, they described using a variety of strategies for managing distressing behaviour in themselves and others, with varying degrees of success. These strategies included ones, which the young people identified as negative, such as stealing or withdrawing from other people. With regards to strategic advice young people offered many suggestions for more 'user friendly' accessible, flexible and discreet mental health services. They wanted the option of consulting a mental health service without the knowledge of care staff or other professionals. This research appears to highlight some of the issues pertinent to adolescents who are looked after however, it does not go into any detail about their experiences of services, which would have more implications for service development. This study identified that the main gap in current service provision is in delivering effective interventions to children whose mental health problems have already been well identified, but which are persistent, disabling and hard to manage. They also

identified barriers to accessing existing services; most notably, long waiting times for CAMHS assessment, the reluctance of young people to become involved in services which they believe add to their stigmatisation, and difficulty for residential workers in finding absence cover to bring children to interviews.

The fact that this was the only relevant study available which is not conducted from a psychological perspective indicates the need for a broader research base.

Research conducted on looked after adolescents

Much of the research conducted has focused on looked after children as a broad client group. McCann et al., who had undertaken the first systematic assessment of the prevalence of psychiatric disorders in looked after adolescents did so in 1996, which highlights how new the field is. Whilst this study seems to have been significant for opening doors to research in a new direction this was a quantitative study whose methodology involved using screening checklist tools. Aside from Bundle's (2002) study there have been few studies that have focused on looked after adolescents from a psychological perspective using qualitative methodology. Bundle (2002) studied what looked after adolescents see as important in terms of health information and found that mental health issues particularly stress, depression and eating disorders were of concern to their sample.

The need for further research into looked after adolescents

From the evidence presented it is clear that the research base for looked after adolescents is insufficient for a variety of reasons (Mount, 2004, Mental Health Foundation, 1999). Not only has much of the research been quantitative in nature, but also many of the studies have incorporated children and adolescents as a homogenous group hence not accounting for their developmental needs.

Clinical implications

The Quality Protects initiative has made resources available for the development of mental health services for looked after children, and new teams are being set up around the country. Collaboration between health authorities and local authorities is now mandatory and the new CAMHS money is being shared between them (Lindsey, 2000). This puts us in a good position to focus on the mental health needs of looked after children, particularly from a qualitative perspective which has been largely neglected for a variety of reasons. Adolescents in particular have been neglected as a distinct group and as there are significant numbers being looked after with mental health needs it is important that we understand their needs better. Accessing user views will have implications for developing service provision.

With regards to the benefits of children giving opinions about a host of issues pertinent to them Gilligan (2000) suggests it is beneficial to hear children's views as involvement is likely to enhance their self-esteem by giving them greater knowledge and control over their lives. For children in our society, becoming able to take responsibility for themselves is a crucial stage of development. Therefore, for looked after children, helping to empower them is not just an ethical requirement but also, equally, a developmental task (Munro, 2001).

Saunders & Broad (1997) found that 77% of young people leaving care who had accessed CAMHS had found the service unhelpful. This would highlight the need to access user views when developing services in order to make improvements.

Conclusion

It is evident that much of the research conducted into looked after children has been done so from a social theoretical perspective. This may be due historically to the way services have been set up. Street & Davies (2004) argue that given

the needs of this group of children input should be carried out within a mental health/developmental perspective rather than 'social work' or 'medical' perspectives. They suggest that a developmental/positive mental health perspective should be the uniting philosophy for those involved in mental health for looked after children. Consequently only a multi-disciplinary service combining the best of psychiatric, psychological, social work and childcare perspectives will be able to deal comprehensively with their needs and problems.

In order for psychology to contribute to such a model of working the research base needs to be developed particularly from a qualitative perspective focusing on user views. This will hopefully allow professionals to meet service users and provide more accessible and user friendly services meeting government requirements.

In addition there are a significant proportion of adolescents being looked after who are at a unique stage of development and have specific needs. In order to better understand this group the research base needs to be expanded to ensure services are addressing their needs.

References

Acharyya, S. (2000). Promoting health of looked after children – Monitoring and documentation should be improved. British Medical Journal, 381.

Arcelus, J., Bellerby, T., & Vostanis, P. (1999). A mental-health service for young people in the care of the local authority. Clinical Child Psychology and Psychiatry, 4(2), 233-245.

Atkinson, L., & Zucker, K.J. (1997). Attachment and psychopathology. The Guildford Press.

Baldry, S., & Kemmis, J. (1998). What is it like to be looked after by a local authority? British Journal of Social Work, 28, 129-136.

Barker, C., Pistrang, N., & Elliott, R. (2002). Research methods in clinical psychology: An introduction for students and practitioners (2nd ed.). John Wiley & Sons LTD

Bebbington, A., & Miles, J. (1989). The background of children who enter local authorities care. British Journal of Social Work, 19, 349-368.

Berridge, D. & Brodie, I. (1998). Children's homes revisited. London: Jessica Kingsley.

Berridge, D., Beecham, J., Brodie, I., Cole, T., Daniels, H., Knapp, M., & Macneill, V. (2003). Services for troubled adolescents: exploring user variation. Child and Family Social Work, 8, 269-279.

Blower, A., Addo, A., Hodgson, J., Lamington, L., & Towlson, K. (2004). Mental health of 'looked after' children: a needs assessment. Clinical Child Psychology and Psychiatry, 9(1), 117-129.

Brannen, J., & O'Brien, M. (1996). Children in families: Research and policy. London: The Falmer Press.

Broad, B. (1999). Improving the health of children and young people leaving care. Adoption & Fostering, 23(1), 40-48.

Bundle, A. (2002). Health information and teenagers in residential care: A qualitative study to identify young people's views. Adoption & Fostering, 26(4), 19-25.

Butler, I. & Williamson, H. (1994). Children speak: Children, trauma and social work. Longman Information and Reference.

Butler, I. (1997). The health of looked after children. Adoption & Fostering, 21(2), 28-35.

Butler, J., & Vostanis, P. (1998) Characteristics of referrals to a mental health service for young people in care. Psychiatric Bulletin, 22, 85-87.

Cairns, K. (2002). Attachment, trauma and resilience. British Association for Adoption and Fostering.

Callaghan, J., Young, B., Richards, M., & Vostanis, P. (2003). Developing new mental health services for looked after children: A focus group study. Adoption & Fostering, 27(4), 51-63.

Callaghan, J., Young, B., Pace, F., & Vostanis, P. (2004). Evaluation of a new mental health service for looked after children. Clinical Child Psychology and Psychiatry, 9(1), 130-148.

Carr, A. (1999). The handbook of child and adolescent clinical psychology: A contextual approach. Brunner-Routledge.

Cloke, C., & Davies, M. (1995). Participation and empowerment in child protection. London: Pitman Publishing.

Coleman, J.C., & Hendry, L.B. (1999). The nature of adolescence (3rd ed.). London: Routledge.

Coleman, J., & Schofield, J. (2003). Key data on adolescence. Brighton: Trust for the Study of Adolescence.

Cross, M. (1999). Lost for words. Child and Family Social Work, 4, 249-257.

Davis, J.M. (1998). Understanding the meanings of children: a reflexive process. Children and Society, 12, 325-335.

Davison, G. C., & Neale, J. M. (1998). Abnormal Psychology (7th ed.). USA: John Wiley & Sons.

Delfabbro, P.H., Barber, J.G., & Bentham, Y. (2002). Children's satisfaction with out-of-home care in South Australia. Journal of Adolescence, 25, 523-533.

Department of Health. (1999). Promoting health for looked after children: A guide to healthcare, planning, assessment, and monitoring: Consultation document. London: Department of Health.

Department of Health. (2000). Promoting the health of looked after children. A guide to healthcare, planning, assessment, and monitoring: Consultation document. London: Department of Health.

Department of Health. (2002a). Outcome indicators for looked after children - year ending 30 September 2001. London: Department of Health.

Department of Health. (2002b). Promoting the health of looked after children. London: Department of Health.

Department of Health. (2002c). Improvement, Expansion and reform: The next three years' priorities and planning framework, 2003-2006. London: Department of Health.

Department of Health. (2002d). Shifting the balance of power: the next steps. London: Department of Health.

Department of Health. (2003). Children looked after by local authorities: year ending 31 March 2002 England. London: Department of Health.

Department of Health. (2004). Getting the right start: national service framework for children - Emerging findings. Department of Health.

Department of Health. (2004). National Service Framework for Children, Young People and Maternity Services. Department of Health.

Dimigen, G., Del Priore, C., Butler, S., Evans, S., Fergusan, L., & Swan, M. (1999). Psychiatric disorder among children at time of entering local authority care: questionnaire survey. British Medical Journal, 319 (7211), 675-677.

Freud, S. (1991). The essentials of psycho-analysis. Penguin Books.

Garrett, P.M. (2002). Yes minister: Reviewing the 'looking after children' experience and identifying the messages for social work research. British Journal of Social Work, 32, 831-846

Gibson, R., & Possamai, A. (2002). What young people think about CAMHS. Clinical Psychology, 18, 20-24.

Gilligan, R. (2000). The importance of listening to the child in foster care. In G. Kelly, & R. Gilligan (Ed.), Issues in foster care: policy, practice and research. London: Jessica Kingsley Publishers.

Hatfield, B., Harrington, R., & Mohamad, H. (1996). Staff looking after children in local authority residential units: the interface with child mental health professionals, Journal of Adolescence, 19, 127-139.

Heaven, P.C.L. (1994). Contemporary adolescence: A social psychological approach. The Macmillan Press LTD.

Heaven, P.C.L. (1996). Adolescent health: The role of individual differences. London: Routledge.

Heptinstall, E. (2000). Gaining access to looked after children for research purposes: Lessons learned. British Journal of Social Work, (30), 867-872.

Hill, C.M., & Watkins, J. (2002). Statutory health assessments for looked after children: what do they achieve? Child: Care, health & development, 29(1), 3-13.

Howe, D. (1995). Attachment theory for social work practice. Macmillan Press Ltd.

Howe, D. (2001). Age at placement, adoption experience and adult adopted people's contact with their adoptive and birth mothers: an attachment perspective. Attachment and Human Development, 3(2), 222-237.

Hunter, M. (2001). Psychotherapy with young people in care: Lost and found. Brunner-Routledge.

Jackson, S., & Thomas, N. (2000). What works in creating stability for looked after children? Barnardo's.

Kazdin, A.E. (2003). Research design in clinical psychology (4th ed.). Allyn & Bacon.

Kelly, C., Allan, S., Roscoe, P., & Herrick, E. (2003). The mental health needs of looked after children: An integrated multi-agency model of care. Clinical Child Psychology and Psychiatry, 8(3), 323-335

Kosky, R. (1992). Adolescent's in custody: a disciplining or disabling experience. In R. Kosky, H. Eshkevari & G. Kneebone (Ed.), Breaking out: challenges in adolescent mental health in Australia. Canberra: Australian Government Publishing Service.

Laws, S. (1998). Hear me!: Consulting with young people on mental health issues. The mental health foundation.

Leff, S. (2000). Promoting health of looked after children – These children need tailor made care. British Medical Journal, 381.

Lerner, R.M., & Steinberg, L. (2004). Handbook of adolescent psychology (2nd ed.). John Wiley & Sons.

Lindsey, C. (2000). Why focus on the mental health needs of looked after children? In J. Richardson & C. Joughin The mental health needs of looked after children. The Royal College of Psychiatrists.

Lees, S. (2002). Gender, ethnicity and vulnerability in young women in local authority care. British Journal of Social Work, 32, 907-922.

Mather, M., Humphrey, J., & Robson, J. (1997). The statutory medical and health needs of looked after children. Adoption & Fostering, 21(2), 36-39.

McCann, J.B., James, A., Wilson, S., Dunn, G. (1996). Prevalence of psychiatric disorders in young people in the care system. British Medical Journal, (313), 1529-1530.

McCarthy, G., Janeway, J., & Geddes A. (2003). The impact of emotional and behavioural problems on the lives of children growing up in the care system. Adoption & Fostering, 27(3), 14-19.

Mental Health Foundation (1999). Bright Futures: Promoting children and young people's mental health. London: Mental Health Foundation.

Mental Health Foundation (2002). Bright Futures: Working with vulnerable young people. London: Mental Health Foundation.

Meltzer, H., Gatward, R., Goodman, R., & Ford, T. (2000). The mental health of children and adolescents in Great Britain. Office for National Statistics.

Miller, P.H. (1993). Theories of developmental psychology (3rd ed.). New York: W.H. Freeman and Company.

Millham, S., Bullock, R., Hosie, K., & Haak, M. (1986). Lost in care. UK: Gower.

Mount, J., Lister, A., & Bennun, I. (2004). Identifying the mental health needs of looked after young people, Clinical Child Psychology and Psychiatry, 9(3), 363-382.

Munro, E. (2001). Empowering looked-after children. Child and Family Social Work, 6, 129-137.

Nicholas, B., Roberts, S., & Wurr, C. (2003). Looked after children in residential homes. Child and Adolescent Mental Health, 8(2), 78-83.

Phillips, J. (1997). Meeting the psychiatric needs of children in foster care: social worker views. Psychiatric Bulletin, 21, 609-611.

Place, M., Wilson, J., Martin, E., Hulsmeier, J. (2000). The frequency of emotional and behavioural disturbance in an EBD school. Child Psychology and Psychiatry Review, 5, 76-80.

Polnay, L., Glaser, A., & Rao, V. (1996). Better health for children in residential care. Archives of Disease in Childhood, 75, 263-265.

Polnay, L., & Ward, H. (2000). Promoting the health of looked after children. British Medical Journal, 320, 661-662.

Richardson, J., & Joughin, C. (2000). The mental health needs of looked after children, The Royal College of Psychiatrists.

Ridge, T., & Millar, J. (2000) Excluding children: Autonomy, friendship and the experience of the care system. Social Policy & Administration, 34(2), 160-175.

Rinsley, D. (1994). Treatment of the severely disturbed adolescent. Jason Aronson INC.

Rivron, M. (2001). A health promotion project for young people who are looked after. Adoption & Fostering, 25(2), 70-71.

Rodrigues, V.C. (2004). Health of children looked after by the local authorities. Public Health, 118, 370-376.

Rutter, M. (1983). Stress, coping and development: some issues and some questions. In N. Garmezy & M. Rutter (Ed.), Stress, coping and development. New York: McGraw-Hill.

Rutter, M. (1995). Psychosocial disturbances in young people: challenges for prevention. Cambridge: Cambridge University Press.

Sargent, K., & O'Brien, K. (2004). The emotional and behavioural difficulties of looked after children: foster carers perspectives and an indirect model of placement support. Adoption & Fostering, 28(2), 31-37.

Saunders, L., & Broad, B. (1997). The health needs of young people leaving care. Leicester, UK: De Montfort University.

Smith, J.A., & Osborn, M. (2003). Interpretive phenomenological analysis. In J.A. Smith (Ed.), Qualitative psychology: A practical guide to research methods. Sage Publications LTD.

Stallard, P., Thomason, J., Churchyard, S. (2003). The mental health of young people attending a youth offending team: a descriptive study. Journal of Adolescence, (26), 33-43.

Steinberg, D. (1987). Basic Adolescent Psychiatry. Oxford: Blackwell Scientific Publications.

Street, E., & Davies, M. (2002). Constructing mental health services for looked after children. Adoption & Fostering, 26(4), 65-75.

Talbot, R. (2002). Young minds: Looking after the mental health of looked after children. Pavillion Publishing.

Target, M., & Fonagy, P. (1996). The psychological treatment of child and adolescent mental health disorders. In A. Roth & P. Fonagay (Ed.) What works for whom? A review of the effectiveness of the psychotherapies. New York: Guildford.

Thomas, N., & O'Kane, C. (1998a). When children's wishes and feelings clash with their 'best interests'. The International Journal of Children's Rights, 6, 137-154.

Thomas, N., & O'Kane, C. (1998b). The ethics of participatory research with children. Children and Society, 12, 336-348.

Thomas, N., & O'Kane, C. (1999). Children's participation in reviews and planning meetings when they are looked after in middle childhood. Child and Family Social Work, 4, 221-230.

Triseliotis, J., Borland, M., Hill, M., & Lambert, L. (1995). Teenagers and the social work services. London: HMSO.

Utting, W., Baines, C., Stuart, M., Rowlands, J., & Vialva, R. (1997). People like us: The report of the review of the safeguards for children living away from home. London: The stationery Office.

Wallace, S.A., Crown, J.M., Cox, A.D. & Berger, M., (1997). Epidemiologically based needs assessment: child and adolescent mental health. Wessex Institute of Public Health.

Ward, H., Jones, H., Lynch, M., & Skuse, T. (2002). Issues concerning the health of looked after children. Adoption & Fostering, 26(4), 8-18.

Wiener, A., Withers, K., Patrick, M., & Bradley, E. (1999). What changes are of value in severely disturbed children? Clinical Child Psychology and Psychiatry, 4(2), 201-203.

Zannah, C. (1996). Beyond insecurity: A reconceptualization of attachment disorders of infancy. Journal of Consulting and Clinical Psychology, 64, 42-52.

APPENDIX I: Search Strategy

Search strategy

Consulted databases

In order to carry out a comprehensive review of the literature base Cochrane Library, PubMed, AMED, Web of Science, PsychINFO and Cinahl were searched. In order to find any grey literature HMIC and SIGLE were also reviewed. In addition due to the nature of the research project Caredata was searched to find any relevant papers from a social perspective and Zetoc was searched in order to find papers and to be kept informed of any relevant new research.

Inclusion and exclusion criteria

A set of criteria was applied in order to evaluate the papers yielded from the literature search. For the purpose of this literature search it was important to ensure that the selection criteria was not too stringent and specific as the research base is relatively new and is still developing. As the number of hits for each database searched was not too large this allowed for fewer restrictions to be applied.

The following are the criteria that were applied:

- Include studies using both qualitative and quantitative methodology
- Include studies that were carried out with foster children as well as children being cared for in residential homes.
- Include studies focusing on social perspectives as well as those concentrating on mental health issues.
- Exclude studies that were not reported in English

Procedure for conducting the systematic literature search.

The search was carried out using the same set of keywords/terms for each database. The only limit set was that the databases must search through papers that are English. Keywords that were used were adolescen*, young people, teenagers, mental health, looked after children, foster* and children in

care. Combined searches were then carried out using all combinations of hits that had been found from these individual searches. This included combining more than two of the terms at times, in order to produce a more specific set of hits. Where applicable Mesh terms were explored and the thesaurus was used.

In addition qualitative studies and studies using Interpretive Phenomenological Approach were also searched for alone and combined with the above keywords.

The Department of Health and Mental Health Foundation websites were also reviewed for relevant documents.

General comments

It was apparent that Caredata produced the most number of hits and the most relevant articles. This is likely to be due to the fact that this is a key social studies database and social services have historically provided the majority of professional help to this population. Nevertheless some relevant articles were found in the other more psychologically orientated databases which suggests that the psychological evidence base for looked after children is developing.

Looked After Adolescents' Experience of Mental Health Services

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**A Thesis submitted in partial fulfilment of the
requirements of the University of Hertfordshire
for the degree of Degree of Doctor of Clinical Psychology**

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Department of Psychology,
University of Hertfordshire
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ABSTRACT

The main aim of this study was to gain an in-depth understanding of looked after adolescents' views of what help they needed for their mental health difficulties and their experience of the mental health services that are currently available to them. It was hoped that this investigation would provide ideas to improve current service provision. Semi-structured interviews were used to interview six females aged 13-17 years from a Looked After Children (LAC) Team, which is part of a Child and Adolescent Mental Health Service (CAMHS). Interpretative Phenomenological Analysis (IPA) was employed to analyse the accounts generated in the interviews. The results indicated a number of mental health as well as social difficulties for the participants. They described a variety of emotional and behavioural difficulties, which included experiencing depression, self-harming behaviour and eating difficulties. Relationships also seemed to be an area of difficulty that featured for this sample of young people. With regards to mental health services, the participants' talked about having a positive experience, feeling supported, their relationship with their therapist and their ambivalence about receiving services. Whilst positive experiences were discussed the participants' were also able to reflect on negative aspects of the service, and consequently ideas for service improvement were generated.

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1.0 Introduction

1.1 Overview

'Looked after' is a term introduced by the Children Act (1989) to cover all children residing in public care, including those in foster or residential homes and those still living with their own parents but subject to care orders (Polnay and Ward, 2000). It is estimated that there are currently around 59,700 looked after children in the UK (Department of Health, 2003). Adolescents constitute about a third of all children in foster care, with around three fifths of those living in children's homes (Berridge and Brodie, 2003).

Children are looked after for a variety of reasons. Although most youngsters have experienced a breakdown in family support, significant proportions enter care because of behavioural difficulties (Millham, Bullock, Hosie and Haak, 1986). In addition to this many will have suffered abuse of either a physical, sexual or emotional nature. Once in the system it is relatively common for further problems to occur, such as frequent changes in placement as well as being placed in less than adequate surroundings (Richardson and Joughin, 2000). The characteristics of looked after children have gradually changed over the years, with social workers and other professionals involved with services for looked after children increasingly expressing the view that children and young people who are currently being taken into care have more extreme and complex difficulties than in previous decades. This is likely to be a result of changes in government policies and an increased number of children being exposed to more of the identified risk factors for mental illness, including deprivation and family breakdown (Bebbington and Miles, 1989; Meltzer, Gatward, Goodman and Ford, 2000).

It has been widely reported that looked after children are particularly vulnerable to mental health difficulties (McCann, James, Wilson and Dunn, 1996; Phillips, 1997; Kelly, Allan, Roscoe and Herrick, 2003; Rodrigues, 2004). With a significant number of children being looked after by the local authority it is

important that mental health services continue to develop so that they are more adept at meeting their needs. There is an extensive research base looking at the mental health needs of children as a homogenous group. However, the research base for looked after children is somewhat more underdeveloped (Kelly *et al.*, 2003; Rodrigues, 2004). More specifically there have been very few studies focusing on mental health and looked after adolescents.

1.2 Mental health difficulties experienced by looked after children

Lindsey, in Richardson and Joughin (2000), suggests that amongst the child and adolescent population as a whole, one in five young people experience a significant level of difficulty. For young people cared for by the local authority the mental health risks are much higher (Utting, Baines, Stuart, Rowlands and Vialva, 1997; Mount *et al.*, 2004).

There have been many studies carried out reporting the type of mental health difficulties experienced by looked after children, most of which are based on diagnostic criteria (McCann *et al.*, 1996; Utting *et al.*, 1997; Butler and Vostanis, 1998; Arcelus, Bellerby and Vostanis, 1999). A wide variety of difficulties has been recorded, the most common being anxiety, fear and depression, conduct disorder and attachment disorder. A smaller group of looked after children develop serious mental illness, such as schizophrenia and bipolar affective disorder (including psychotic symptoms). In addition the experience of early sexual abuse and violence may predispose some victims to become abusers themselves, or to fear that they could perpetrate such acts. It is often the case for looked after children that despairing about their lives, or the need to draw attention to their situation, leads them to make suicidal attempts and carryout self-harming behaviour. They may also put themselves at further risk by running away, using drugs and alcohol, engaging in prostitution and criminal acts (Lindsey, 2000). Children looked after in residential homes appear to be at an even higher risk than those who are fostered (McCann *et al.*, 1996).

Despite high levels of need, only a small percentage of looked after young people have historically been seen in CAMHS (Mount, 2004). This is due to a multitude of factors, such as difficulties with accessing services due to waiting lists and changing placements. Research suggests that specialist services for this population are needed due to their complex psychosocial needs (Department of Health, 2002b; Department of Health, 2002c). Consequently services now appear to be adapting in order to meet the needs of this particular client group. Looked after children services are now more visible throughout the country, with models of mental health services for working with looked after children continuing to develop. With these services evolving it is crucial that we work with and understand the client group's needs in order to develop the appropriate services. This will involve developing the current research base for this population.

1.3 The research base for looked after children

Historically, looked after children have been a difficult group to study for a variety of reasons. This is predominantly due to the difficulties accessing the population, such as gaining consent from carers or social workers. Frequently studies are carried out either with professionals and carers, or are conducted reviewing case notes (Rodrigues, 2004). Whilst these studies are valuable in their own right, the validity and reliability of some of the data recorded must be questioned when it is concerning user views because it does not address the views of the service users directly. Therefore talking to looked after children themselves will offer new perspectives on the needs of the young people, which could aid the development of clinical services for this population.

Generally the research base for looked after children still appears to be underdeveloped with qualitative studies featuring less than quantitative research. Of the literature that is available from a qualitative perspective that focusing on user views, has most often been conducted from a social theoretical perspective. This largely reflects the way looked after children's

services have historically been set up, with social workers taking the lead role (Richardson *et al.*, 2000).

A number of recent research studies have examined looked after children's perspectives on their care situation (Butler and Williamson, 1994; Triseliotis, Borland, Hill and Lambert, 1995; Thomas and O'Kane, 1998a; Thomas and O'Kane, 1998b; Baldry and Kemmis, 1998; Munro, 2001). There have also been studies looking at the development of services, attempting to incorporate the views of children, their carers and social workers into the process (Sargent and O'Brien, 2004; Callaghan, Young, Richards and Vostanis, 2003). However, whilst these are studies aimed at discovering user views, many are carried out using a quantitative methodology such as survey questionnaires (Baldry and Kemmis, 1998; Delfabbro, Barber and Bentham, 2002), which inevitably limits the extent to which participants can offer their opinion. It is argued here that there is a need for a qualitative approach to understand young people's views. Such an approach will offer looked after children the opportunity to speak freely and will provide in-depth accounts of their experience.

Qualitative studies looking specifically at looked after children's views of mental health and related issues are scarce. Blower, Addo, Hodgson, Lamington and Towlson, (2004) recently carried out a needs assessment study looking at the mental health of looked after children. This was a combined quantitative and qualitative study assessing the need for mental health services of looked after children. The study appeared to focus on diagnosis according to the Diagnostic and Statistical Manual of Mental Disorders (DSM) and care experience. This may have been due to the fact that it was carried out from a biosocial perspective, in contrast to a psychological theoretical perspective. Although the study does highlight some of the issues pertinent to adolescents who are looked after, it does not go into any detail about their experiences of services, which would have more implications for service development. The fact that this was the only relevant study available, which is not conducted from a psychological perspective, indicates the need for a broader research base including research

from a qualitative psychological perspective. This will offer a unique understanding focusing more on mental health and experience, as well as approaching the topic from a specific theoretical framework.

Much of the research conducted has focused on looked after children as a broad client group. McCann *et al.*, (1996) undertook the first systematic assessment of the prevalence of psychiatric disorders in looked after adolescents – clearly an indication of how recent, therefore underdeveloped, the field is. Whilst this study seems to have been significant for opening doors to research in the field, this again was a quantitative study.

Aside from Bundle's (2002) study there have been few studies that have focused on looked after adolescents from a psychological perspective using qualitative methodology. Bundle (2002) studied 'what looked after adolescents see as important in terms of health information'. The findings revealed that mental health issues, particularly stress, depression and eating disorders, were of concern to their sample. However there were limitations to the study and it did not reveal the participant's understanding of their experience and the meaning they attached to it.

1.4 The need for further qualitative research into looked after adolescents

From the evidence presented it is clear that the research base for looked after adolescents is underdeveloped for a variety of reasons (Mental Health Foundation, 1999; Mount, 2004). Not only has much of the research been quantitative in nature and largely based on DSM criteria, but also many of the studies have incorporated children and adolescents as one homogenous group (hence not accounting for developmental differences). Qualitative research, particularly looking at user views, seems lacking for the most part. Most contemporary mental health studies place particular emphasis on user views, because of the contribution they make to future service provision and development.

With looked after children being high on the government agenda and current policy documents such as the Children's Act (1989); the Quality Protects initiative (England) and Children First initiative (Wales); the National Priorities Guidance for 1999/2000; Promoting the health of looked after children (2002b) and the National Service Framework for children (2004), there is much scope for research to be conducted. The Government is making funding available for the development of mental health services for looked after children, and new teams are being set up around the country. Collaboration between health authorities and local authorities is now mandatory and the new CAMHS money is being shared between them (Lindsey, 2000). This puts researchers in a good position to focus on the mental health needs of looked after children, particularly from a qualitative perspective which historically has been neglected. Adolescents, in particular, have been overlooked as a distinct group and because there are significant numbers being looked after with mental health needs, it is important that we understand their needs and their experience.

1.5 Psychological theories used to understand looked after children

A number of psychological theories can be employed to make sense of looked after children with mental health difficulties. One such theory is attachment theory (Bowlby, 1971, 1975, 1981; Howe, 1995; Atkinson and Zucker, 1997). It is beyond the scope of this thesis to discuss attachment theory in depth, but a brief summary will be provided here, as it will be used to help make sense of the accounts provided by the participants.

The notion that early parent-child relationships play an important role in the aetiology of mental health difficulties is at the core of this theoretical perspective. For example, it has been suggested that the relation between early attachment and later behaviour problems is that children are more likely to develop behaviour problems if they are insecurely attached to their primary caregiver (Carr, 1999). Inevitably many children who are looked after by the local authorities will have a disrupted pattern of attachment in early childhood (Carr, 1999).

There are two identifiable patterns of insecure attachment commonly experienced by looked after children: Inhibited reactive attachment disorder is associated with abuse and neglect, and disinhibited reactive attachment disorder, associated with institutional upbringing or multi-placement experiences.

1.6 Aims of the study

It has been argued here that there is a need for an in-depth understanding of looked after adolescents' experience of mental health services. It is anticipated that such information will not only be a valuable contribution to the existing research base, but will also be of value to service development particularly as this population are currently high on the government agenda. As evidence suggests it is interesting that there has previously been difficulty striking a balance between protecting this vulnerable group in society and empowering them and listening to their views. This will be addressed in this study.

The main aim of this investigation will be to gain an in-depth understanding of looked after adolescents' experience of the mental health services that are currently available to them. It is hoped that this will provide ideas for improving current service provision and informing service development.

1.7 Research Questions

The purpose of the study is to address the following research questions:

1. What are the mental health difficulties this sample of looked after adolescents feel they need help with?
2. What are their experiences of the mental health services they have received?

2.0 Methodological Approach

2.1 Introduction

This section introduces the reader to the methodological approach used in this study, by outlining qualitative research methods, and comparing qualitative and quantitative methodologies. An overview of IPA is presented paying particular attention to published studies using this methodology, and the reasons for using IPA in this study. An account of psychological theories used to understand individual accounts will also be presented in order to familiarise the reader with the theoretical context of the study.

2.2 Qualitative research methods

For many years both qualitative and quantitative research methodologies have been used in the human sciences. These two types of method differ in important ways (see Table 1).

Table 1: Qualitative vs. quantitative methodology. Summarised from Punch, 1998)

Quantitative research	Qualitative research
Data are in the form of numbers.	Data are <i>not</i> in the form of numbers.
Likely to have structured and predetermined research questions, conceptual frameworks and design.	Likely to have research questions and methods that are more general at the start, becoming more focused as study progresses.
Mainly used for testing hypotheses and theories.	Mainly used for exploring an area and for generating hypotheses and theory.
Conceptualises reality in terms of variables, and the relationships between them.	Deals more with cases.
Typically employs large samples, guided by probabilistic considerations (generalisation).	Samples are usually small, guided by theoretical considerations.
Context not seen as central issue.	Sensitive to context and process, to lived experience and to local groundedness (tries to do justice to complexity of social life).
Well developed and codified methods for data analysis (less flexible).	Methods less formalised (more flexible).
Methods are usually more unidimensional and less variable (can more easily be replicated).	Methods more multi-dimensional, more diverse (less replicable).
Data enable standardised, objective comparisons to be made (decrease the influence of researcher on results).	Data enable getting the insider's perspective, the meanings that people attach to things and events (rich, 'thick descriptions' of complex social phenomena).

The last decade has seen a dramatic increase in commitment to, and research using, qualitative methodology in psychology (Smith, 2004) including ethnographic methods (Harre and Secord, 1972; Harre, 1992), discourse analysis (Potter and Wetherall, 1987, Parker, 1992), grounded theory (Glasser and Strauss, 1967; Henwood and Pidgeon, 1995), reflexive enquiry (Parker, 1994) and IPA, (Smith, 1996). Qualitative research tends to be concerned with meaning; researchers are interested in how people make sense of the world and how they experience events. They aim to understand 'what it is like' to experience particular conditions and how people manage certain situations. Qualitative researchers also tend to be concerned with the quality and texture of experience, rather than with the identification of cause-effect relationships.

Whilst qualitative methodologies have become more popular, and clearly have a role in studying certain types of behaviour or reporting on certain types of experience, they are not without limitations. Qualitative research has been criticised in terms of its reliability. It has been argued that shortage of space can lead to many qualitative studies offering the reader little more than brief, persuasive, data extracts (Silverman, 2000). Furthermore, some have argued that when conversations are tape-recorded and transcribed, the reliability of the transcription may be weakened by a failure to record what can appear trivial, for example overlaps and pauses (Silverman, 2000).

Some qualitative researchers are less concerned about reliability than their quantitative counterparts. For example, Marshall and Rossman (1989) argue that a qualitative researcher's concern for reliability arises only because the positivist position sees no difference between the natural and social worlds and that reliable measures of social life are only needed by such positivists. Other qualitative researchers, such as Denzin and Lincoln (2000) advocate strongly for ensuring rigor. They highlight, for example, the importance of a detailed audit trail in a bid to ensure that validity and reliability are maintained.

Qualitative research has also been criticised for the explanations it offers, occasionally referred to as 'anecdotalism'. Critics suggest that this type of research often only reports a few telling examples of phenomena, without attempting to analyse contradictory data. This therefore raises questions about the validity of some qualitative research (Silverman, 2000). However, qualitative researchers, such as Denzin and Lincoln (1994), argue that in fact one of the strengths of qualitative research is that "the researcher looks for negative cases to enrich the emergent model and to explain all variations and diverse patterns" (Denzin and Lincoln, 1994, pp.230)

This study will be carried out using a qualitative research methodology, Interpretative Phenomenological Analysis (IPA).

2.3 Interpretative Phenomenological Analysis (IPA)

IPA is a qualitative research methodology that has been developed over the past decade by Jonathan Smith (Smith, 1995, 1996, 2003, 2004). It aims to explore, in detail, how participants make sense of their personal and social world. The main currency for an IPA study is the meanings, particular experiences, events and states hold for participants (Smith and Osborn, 2003). "The aim of IPA is to explore the participant's view of the world and to adopt, as far as possible, an 'insider's perspective' of the phenomenon under study" (Smith, 1996, pp. 264).

The approach is both phenomenological and interpretative (Smith, 1996). The phenomenological aspect involves obtaining a detailed examination of the individual's world. It aims to explore personal experience and is concerned with the individual's personal perception, or account of an object or event, as opposed to producing an objective statement of the object or event. IPA also emphasises that the research exercise is a dynamic process, with the researcher engaged in an active role as part of the rationale. Although the researcher is attempting to get close to the individual's personal world, this cannot be done directly or completely. Access depends upon, and is

complicated by, the researcher's own conceptions, which are required in order to make sense of that other personal world through a process of interpretative activity, hence the interpretative aspect of the methodology (Smith and Osborn, 2003).

IPA is an interactive approach that does not test hypotheses (Smith and Osborn, 2003). Participants in IPA research are viewed as 'experts' with regards to their own experiences and can offer researchers an understanding of their thoughts, commitments and feeling. IPA provides opportunities for participants to tell their own stories, in their own words, and in as much detail as possible.

In general, IPA shares the more common features, aims and criteria of qualitative approaches. It utilises a familiar process of thematic analysis, generating first codes, then themes, and moving from the particular to the general, and from the descriptive to the interpretive. In IPA, there is also an inductive approach to theory-building, moving from one case to several.

IPA draws upon a constructionist position to qualify those inferences and to situate experience in a social and cultural context. It draws upon Heidegger's (1967), hermeneutic phenomenology, which poses that persons are already 'out there'; they are within, amidst and involved in the world, and person and world are thus mutually-constitutive (Heidegger, 1967). The task of phenomenological interpretation is to understand more about this 'involvement in' and 'relatedness to' the world. In other words, the researcher is trying to "elicit and interpret the meaning of lived experience" (Denzin and Lincoln, 1994, p.224). Smith (1996) has developed the approach from a broad base of theoretical influences: social cognition, phenomenology, and symbolic interactionism. This diversity of influence is possibly IPA's greatest strength.

IPA has a theoretical commitment to the person as a cognitive, linguistic, affective and physical being and assumes a chain of connection between the

individual's language and their thinking and emotional state. Nevertheless, IPA researchers appreciate that this can be a complicated process, with people finding it difficult to express what they are thinking and feeling at certain times. IPA and mainstream psychology converge in being interested in examining how people think about what is happening to them, but diverge in deciding how this thinking can best be studied (Smith and Osborn, 2003).

As is generally the case with qualitative research, there is no single definitive way to carrying out IPA, although there are some conventions that need to be adhered to. These can generally be captured into an alliterative three-part list: idiographic, inductive and interrogative (Smith, 2004). IPA is strongly idiographic, starting with the detailed examination of one case until a degree of closure has been achieved, then moving to a detailed analysis of the second case and so on. Once that has been achieved there is an attempt to carry out a cross-case analysis as the tables of themes for each individual are studied for convergence and divergence. IPA is concerned with small sample sizes including single case design. The inductive element of IPA involves the researchers' flexibility to allow unanticipated topics or themes to emerge during analysis. The interrogative component emphasises that whilst IPA differs from mainstream psychology in some of its epistemological assumptions, its psychological centre is considered important, and a key aim of IPA is to make a contribution to psychology through questioning or illuminating existing research (Smith, 2004). Unlike many research methodologies the researcher makes no attempt to test a predetermined hypothesis. Studies are conducted using small sample sizes, with the aim being to comment in detail about the perceptions and understandings of this particular group, rather than prematurely making wider, general claims. That is not to say that IPA is opposed to more general claims for larger populations; rather, it is committed to the painstaking analysis of cases rather than making generalisations (Smith, 2004). Researchers tend to try to find a homogenous sample for which the research question will be significant. IPA reports in detail about the particular culture but does not claim to be able to say something about all cultures (Smith and Osborn, 2003).

The majority of IPA studies have used the semi-structured interview as a means to collect data. These types of interviews are thought to be most valuable as they allow greater flexibility of coverage, facilitate the development of rapport/empathy, produce richer data and allow the interview to go into novel areas.

2.3.1 IPA studies with children and adolescents

There have been few studies carried out using IPA with children and adolescents. A comprehensive literature review revealed that there have not been any studies carried out so far using this methodology in studies with looked after children. Couch and Wright (2004) used IPA in their study aiming to identify some of the personal and interpersonal processes involved in deliberate self-harm at a residential treatment setting for adolescents with mental health problems. The authors carried out interviews with six adolescents as well as carrying out participant observation. In addition Roose and John (2003) used IPA to analyse their focus group study, which was an investigation into young children's understanding of mental health and their views on appropriate services for their age group. The sample used in this study was children aged 10-11 years. The results showed that the children had a sophisticated understanding of mental health and it was felt by the authors that the children qualified for a place in discussions about services for their age group (Roose *et al.*, 2003). These findings add weight to the argument that it is essential to understand the views of looked after adolescents, when developing services aimed at meeting their needs.

2.3.2 Why use IPA for this study

It is anticipated that the population of looked after adolescents will be diverse and the aim of this study is to attempt to understand individuals' experience; it is not the intention of this study to be able to generalise the findings to the population of looked after children as a homogenous group or adolescents. If this were the intention, grounded theory might have been a more suitable

approach. IPA will allow for exploration of interesting areas as they emerge throughout the interview. This approach also allows the researcher to reflect on their personal position in a bid to make sense of the participants' talk through a process of interpretative activity (Couch and Wright, 2004). Given the philosophy of IPA, the nature of the research population, the research questions and the researcher's personal style it was thought that IPA would be the most suitable methodology for this study.

2.4 Psychological theories used to understand individual accounts

IPA is concerned with making meaning from individual accounts. In order to make sense of the data that will be collected in this study, a variety of possible theoretical frameworks could be used. In order to contextualise this study and position it theoretically, an overview of the theoretical positions that will be drawn upon will be given highlighting how they enhance our understanding of events. Whilst there are clear differences between them they all emphasise meaning as the basis for understanding human action.

2.4.1 Social constructionism

Social constructionism began to develop in the 1980's as an alternative approach to the study of humans as beings (Gergen, 1985). Whilst Burr (2003) acknowledges that there is no single definition of social constructionism that would be adequate for all the writers who would refer to themselves as social constructionist, she has highlighted some of its main characteristics. According to Burr (2003) social constructionism holds that:

- we need to take a critical stance towards taken-for-granted knowledge and be cautious about the idea that there is an objective, un-biased view of the world
- the ways in which we commonly understand the world, the categories and concepts we use, are historically and culturally specific
- knowledge is sustained by social processes, and our knowledge of the world is constructed between people

- knowledge and social action go together, suggesting that each construction brings with it, or invites, a different kind of action from human beings

Burr (2003) also suggests that our way of understanding the world does not come from objective reality, but from other people both past and present. We are born into a world where the conceptual frameworks and categories used by the people in our culture already exist. These concepts and categories are then acquired by each person as they develop the use of language and are therefore reproduced by everyone who shares a culture and a language (Burr, 2003).

Historically children were perceived, to a large extent, as passive beings (Prout, 2000). However, more recent social constructionist theorists have argued that children are not only shaped by society but also shape it (Prout, 2000).

Children are treated as speaking, knowing and experiencing subjects, as social actors actively involved in the social worlds they live in, and as interactive agents who engage with people, ideologies and institutions and through this engagement forge a place for themselves in their own social worlds (Prout, 2000, pp.7).

2.4.2 Constructivism

The philosophical approach of constructivism was developed from George Kelly's personal construct therapy (Kelly, 1991). This approach advocates that there are not facts to be found and truths to be gleaned, when studying human beings. In Kelly's terms "there are always alternative ways of looking at any event" (Fransella and Dalton, 1996 pp.147).

The approach argues that whilst we live in our own personal world, looking at it from our individual perspective, we may nevertheless share many of our

perceptions of events with others who come from the same culture or family. Mahoney (1988) describes four main features of constructivism. These include:

- proactive cognition, which refers to the concept that individuals proactively participate and therefore construct their world. Human knowing, experience and adaptation are all characterised by the process of proactive participation
- morphogenic nuclear structure, which suggests that the individuals' systems are organised in such a way that their central or core processes dictate and yet constrain what is expressed at the surface level
- self-organising development, which suggests that individual human systems organise themselves in such a way that integrity is protected. These systems develop via structural differentiations, which are selected out of their trial and error variations. Resistance is subsequently deemed a healthy expression of self-protection that should be worked with
- concern in therapy with viability rather than validity. Mahoney argues that the key issue in therapy is the pragmatic utility, rather than bedrock validity, of the client's system of understanding (Mahoney, 1988)

2.4.3 Narrative approaches

Narrative approaches are derived from post-modern philosophies that emphasise the significance of shared language in the social construction of reality (White and Epston, 1990). Adopting this stance, narrative approaches would therefore argue that the individual's view of reality, and view of themselves, is always a selective representation because it is never possible for the individual to narrate all of their life experiences. Inevitably some experiences are focused on and interpreted, whilst others are placed out of awareness. The attention to events that becomes incorporated into a person's life story is based upon the individual's dominant beliefs about the self, as well as attributions assigned by others. In order to develop a coherent story, narrated experiences are most often built around consistent themes in the individual's story line. Behaviour then follows language, which reinforces and perpetuates a particular

life story. Once formed as a reasonable account of the individual's life, the person acts as if that particular version of the life story is true (White and Epston, 1990).

This approach has been widely used by practitioners when working therapeutically with children and adolescents as it can allow therapists, children, and parents alike to be light-hearted, humorous, and creative whilst working with many of the problems that young people face (Freeman *et al.*, 1997).

2.5 Reflexive considerations

As has already been highlighted, it is becoming increasingly important for researchers' involved in qualitative research to recognise that an understanding of ourselves', as researcher, is an important part of the process (King, 1996). In this context, reflexivity is a pivotal element of the procedure. It is also important to recognise that viewing the self is often not a simple process, because we are not static but a complex system which is ever changing and will inevitably evolve during the research process as knowledge develops and as a result of the experiential process. It is inevitable that personal values, biases and discriminations will impact upon the data collection process, the analysis and the reporting of the findings. It will also be important to recognise that the data collected in each interview and the effect this data has upon the researcher's values and beliefs will impact upon subsequent interviews. However, several systems will be put into place in order to uphold validity and reliability during this process.

The very selection of a research topic is based upon, and brings with it, a host of values, beliefs and judgements. The area of 'looked after children' is a topic in which I have been interested in for some time, predating my training as a clinical psychologist. This has been heavily influenced by work that I carried out in this field as a residential social worker and social work/teaching assistant. Working in this context with this population, influenced my values and my view that this group in society is often abandoned, not only by their birth parents but

also by health and social services, as well as society as a whole. These beliefs were reinforced in the process of conducting a literature review where the gaps in the literature base became evident. The literature review task confirmed and strengthened my belief that a psychological perspective on looked after adolescents' experience is missing. I believe this would add an understanding of mental health within a developmental context, whilst incorporating psychological frameworks of meaning making and understanding. Whilst government documents have developed and policies and procedures are in place attempting to improve services, my opinion that these children go unheard and their feedback is often undervalued was strengthened by the gaps I identified in the research base. It would appear that a balance needs to be found whereby these children are protected, yet heard.

My clinical practice has also impacted upon my research. I have carried out an elective placement in a looked after children service in a different locality to that in which the research has been carried out. Whilst conducting my research I have been working with this population in a clinical capacity. Therefore, an ability to recognise my changing beliefs, values and judgements and to remain reflexive throughout the process will be of importance. Keeping a reflexive sheet that has been completed after each interview will prove to be valuable and will help me reflect on the process as it unfolds.

3.0 Methodology

3.1 Design

IPA was the method used in this study. Semi-structured interviews were designed by the researcher (see Appendix VIII), and were the tool used to gather rich accounts of the participants' experience. Each participant engaged in a similar semi-structured interview. However, almost inevitably the interviews obtained individual information as they branched into different avenues and as the researcher probed on information supplied. All interviews were tape-recorded as this allowed accurate documentation of the content of the interview. The interview was then transcribed verbatim for analysis.

3.2 The context of the study

The service for looked after children (LAC), in which the study was carried out, has been in place since April 2001. This is a multidisciplinary team with access to the wider generic CAMHS team. Local children placed in temporary and permanent foster placements within the borough, as well as local children placed out of borough, are eligible for referral. Support is available for both the children and their foster carers in the form of assessment, treatment (both individual and family), consultation and group work.

The LAC team receive approximately 80 referrals a year. Feedback from the team suggests that looked after children and foster carers attend a greater number of sessions, with more cases requiring long term therapeutic input, compared to generic CAMHS cases.

In order to recruit participants the researcher met with the team to discuss the project. The team then identified potential participants who were given information about the project.

3.3 Recruitment issues

The aim was to recruit six participants aged between 13-18 all of whom were currently in receipt of mental health services by the LAC Team and had been known to services for a minimum of six months. Whilst there are no rules about the most suitable number of participants to recruit for a study using IPA, Smith (2003) suggests that five or six is a reasonable sample size for a project using IPA: "This provides enough cases to examine similarities and differences between participants but not so many that one is in danger of being overwhelmed by the amount of data generated" (Smith, 2003, pp.55).

An information sheet was produced (see Appendix I) and distributed to all potential participants who fitted the criteria. Their carers/social worker were also given an information leaflet (see Appendix II) where appropriate. The informative guides were then distributed by members of the staff team to potential clients for the study; participants were then invited to volunteer to participate in the study by informing a member of staff that they were interested. When a potential participant had been identified, the researcher made contact with them and their carer/social worker, if appropriate, to discuss the study in more detail and to arrange an interview.

3.3.1 Participants

The six participants are described below listed in the order in which they were interviewed:

'Nicole'* is a 17-year-old young person of black African origin. She came to Britain three years ago. She is currently living independently and is in full time education. She has been seeing a therapist at the service for over one year.

* Identifying details (names etc.) have been changed to protect participants' confidentiality.

'Layla' is a 13-year-old white British young person. She was placed in the care of the local authority following the death of her parents and is currently in a long-term foster placement. She is in full time education where she receives extra support for her dyslexia. She has been seeing a therapist at the service for just over one year

'Rachel' is a 17-year-old young person of white British origin. She is currently living in a children's home. She is neither in full-time education nor working. She has been receiving services from CAMHS since she was aged four and has engaged in a variety of therapies as well as being admitted to an adolescent in-patient unit.

'Kizzie' is a 13-year-old young person whose ethnicity is dual heritage, Jamaican/Pakistani. She has recently moved back to live with her father following a placement with foster carers. She is in full time education, although is waiting to move to a new school. She has been accessing services for over six months.

'Michelle' is a 15-year-old young person of black African origin. She is living in a long-term foster placement and is in full-time education. She has been seeing a therapist at the service for over two years.

'Roxanne' is a 17-year-old young person of black British origin. She is living in an independent unit with a care package. She hopes to return to education. She has been accessing services for more than one year.

3.4 Ethical Issues

The participants used in this study would be considered to be a vulnerable group and it was essential that ethical issues were considered and protective factors put in place in order to ensure that they were not adversely affected by taking part. Ethical approval was obtained from the ethics committee at the local health authority to which the service was connected (see Appendix III). The research and development department attached to the service also approved

the project (see Appendix IV) and approval was gained from the university to which the researcher is affiliated (see Appendix V).

3.4.1 Informed consent

The young people participating in this study could be viewed as more vulnerable in many respects than the general adolescent population. It was important that they were clear about the aims and objectives of the study and what their participation entailed. It was also important that those holding parental responsibility were clear about the nature of the research. In order to ensure this was achieved, written information and a consent form was presented to all participants and carers and/or social workers of those under 16 (see appendices VI-VIII). They were given opportunity to discuss the project and ask questions before agreeing to participate. In order to respect the adult status of those aged over 16, consent was obtained from the participant only (it was not deemed necessary to gain consent from carers and/or social workers).

3.4.2 Confidentiality

Confidentiality was considered important in order to protect the identity of the participants. This was largely due to their age but also to protect them from being identified by potential readers of the project. It was hypothesised that the participants might be more open and honest in their interview if they knew others would not be aware of its content. The young people were informed that identifying information would not be disclosed in the reporting of any findings; instead participants were identified via a number or pseudo name throughout the research process.

3.4.3 Possible distress

It was possible that clients might experience distress during the interviewing process as they discussed sensitive issues. Several protective factors were implemented in order to minimise any potential anticipated distress. These included: informing all participants that they were free to stop the interview at any time; making it clear to all participants that they did not have to answer any

questions that they did not want to; and allowing time at the end of the interview for debriefing. It was hoped that these factors coupled with the researcher's clinical experience as a trainee clinical psychologist with experience in dealing with people becoming distressed during an interview, would mean that distress would be recognised early and dealt with effectively if it were to occur.

3.5 Procedure

3.5.1 The Interview

The interviews were conducted over a three month period. Each participant engaged in a meeting that lasted up to one hour. Although they followed a schedule (see Appendix VIII), each interview was unique. This was largely due to the fact that each individual brought their own experiences and understanding and each person's story opened up different avenues for exploration. Each interview was completed and analysed before the following one was conducted. This allowed for understanding to be built upon with subsequent interviewees. It also offered the opportunity to appreciate which questions seemed to provide more coherent information. Furthermore it allowed the researcher to improve technique. Meetings took place at various locations depending on convenience. These included the CAMHS building, at an alternative NHS location and at the client's home.

3.5.2 Data analysis

The analysis followed the procedure documented by Smith (2003). For an example of the analytic process see appendices IX-XII.

- Stage 1: Looking for themes

Following the transcription of each interview, the audiotape was listened to and the transcript read several times, in order for the researcher to become as familiar as possible with the account. Each transcript was laid out with two columns to the right of the text. Notes were initially written in the first column, which took the form of summaries, paraphrases, interpretations and initial themes (see Appendix IX). This process was continued for the whole of the transcript. The second column was then used to document emerging theme

titles. Here the initial notes were transformed into concise phrases, which aimed to capture the essential quality of what was found in the text (see Appendix IX). At this stage the whole transcript was treated as data and there was not a need to omit or select particular passages for quotes. According to Smith (2002), what was important at this stage was “finding expressions which are high level enough to allow theoretical connections within and across cases but which are still grounded in the particularity of the specific thing said” (Smith, 2002, pp.68).

- Stage 2: Connecting the themes

The emergent themes from the transcript were then listed and connections between them identified (see Appendix X). The next task was to re-order the themes that were currently listed chronologically. This involved applying a more analytical or theoretical application to ordering as the researcher attempted to make connections between themes which emerged (see appendix XI). At this stage the researcher was drawing on her interpretative resources in order to make sense of what the person was saying, whilst at the same time constantly checking her own sense making against what the person actually said (Smith, 2003).

The next step was to produce a table of the themes, ordered coherently. The process so far would have identified some clusters of themes which captured most strongly the respondent’s concerns on this particular topic. The clusters were then given a name and represented the superordinate themes. At this point examples were quoted in order to support the themes identified (see Appendix XII).

- Stage 3: Continuing the analysis with other cases

Once each transcript had been analysed by the interpretative process, a final table of superordinate themes was constructed (see Appendix XIII). This process involved the researcher prioritising the data. Themes were selected on the basis of their richness and the degree to which they highlight the theme.

The way that the theme helps illuminate other aspects of the account was also taken into account (Smith, 2003).

3.5.3 Reflective sheet

A reflective sheet was produced (see Appendix XIV) in order for the researcher to comment on the interview immediately afterwards. The purpose of this was for the interviewer to document any observations, distractions or reflective comments that might be important to the analytical process.

For example following my interview with Rachel I noted:

Rachel arrived late for the interview and was evidently distressed and angry. She informed me that she would not have attended the interview if she had known it was in this building as this was the place that her previous therapist now worked. She appeared to relax as the interview progressed – need to be mindful of the impact this may have had on the interview.

3.6 Validity and reliability

There has been considerable discussion amongst qualitative researchers regarding the validity and reliability of this type of research. This, in part, stems from the comparison of qualitative research with the traditional frameworks applied to quantitative studies (Smith, 2003). The general consensus at present is that validity and reliability are both important with regards to qualitative research. However, this type of research must be judged by criteria that are appropriate which may be somewhat different from criteria used to judge quantitative research (Smith, 2003).

In order to uphold validity and reliability several strategies were put into place. As one measure each participant was invited to meet for a second time, either in person or via a telephone conversation, in order to receive a summary of their interview content. The purpose of this was to ensure that participants' were

satisfied that I had understood their account of their experience. They were given opportunity to discuss the summary and clarify any points that they were not happy with.

As a further validity check on the analytic process, my supervisor carried out an audit of the analytic process for two of the interviews. This involved the submission of the transcript, preliminary themes and table of themes. Peer supervision was also provided in a similar way with one of my peers who was also carrying out a study using IPA, and therefore familiar with the procedure, auditing the transcript. It was hoped that these measures would strengthen the validity and reliability of the analysis.

With regards to Yardley's (2000) principles for assessing the quality of qualitative research, this study adhered to all of the three principles outlined in his study. Firstly, being 'sensitive to context' whereby the researcher showed an awareness of the existing literature through carrying out a comprehensive literature review. Yardley's (2000) second broad principle is 'commitment, rigour, transparency and coherence' these principles were also adhered to throughout the study to a greater degree. Commitment was displayed with regards to the study, sample and evidence base. The guidelines of IPA were adhered to rigorously. Transparency was achieved by presenting the findings in a way that was easily understood and offering a presentation to the staff and service users at the location where the data was collected. Coherence was demonstrated by the ability to supply an audit trail. The third broad principle is 'impact and importance'; for Yardley (2000) this refers to whether the study actually tells us anything useful or important or makes any difference and it would certainly be expected that this study will add to the evidence base, and benefit service users and those who have the power to implement change.

In addition Yin (1989) suggests that one way of checking the validity of one's own research is to file all the data in such a way that somebody could follow the

chain of evidence that has lead to the final report. Again this has been carried out via an audit trail (see Appendices IX- XIII).

4.0 Results

4.1 Introduction

This chapter presents the results based upon an Interpretative Phenomenological Analysis of six in-depth interviews with female adolescents in the care of the local authority.

The analysis reveals the meaning making process for the young people regarding the difficulties they were experiencing and their experience of the mental health services available to them. Three superordinate themes emerged from the data analysis; within each superordinate theme several subordinate themes emerged. These are presented in Table 2.

Table 2: Superordinate and Subordinate themes for the six participants

Making sense of self	Making sense of difficulties	Making sense of CAMHS experience
<ul style="list-style-type: none">▪ The past influencing the present▪ Present self▪ Imagining a future self	<ul style="list-style-type: none">▪ Yearning for a sense of belonging▪ Struggles in making and maintaining relationships▪ Understanding of difficulties	<ul style="list-style-type: none">▪ Having a positive experience▪ The significance of the therapeutic relationship▪ Feeling supported by CAMHS▪ Ambivalence about receiving services▪ Service development and ideas for the future

Each theme will be described and illustrated with extracts from the transcripts.

4.2 Making sense of self

All participants talked about their sense of self (their identity) during the interviews. This included past events that had influenced the way they viewed themselves; information and events that impacted upon their current sense of identity; and a view of the future, which defined who they are, and who they would like to be. For some, being in care and having mental health issues influenced the way in which they viewed themselves to a greater degree and much of their identity was based on these factors. These factors distinguished them from their peers, who were not in care or experiencing mental health problems, and gave an insight into the unique experience of being a looked after adolescent. Others were able to incorporate different aspects of their lived experience into their way of viewing themselves. This seemed to allow them to have an identity based on alternative aspects such as hobbies, school and friends, which allowed them to be part of youth culture and identify with the general adolescent population. All of the young people discussed issues that were specific to being a looked after adolescent whilst also incorporating experiences that were applicable to the general adolescent population. It was the fusion of these two factors, which created an identity specific to this population.

4.2.1 The past influencing the present

Heritage and events from the past had an impact on the way the young people viewed themselves. Whilst many of the participants were separated from their family of origin it was important for them to integrate their history and background into the way they understood themselves. Identity formation plays a distinct part in adolescent development and many adolescents, particularly in the general population, have access to information regarding their heredity and history. For many looked after adolescents this information is not easily accessible and their history will need to be uncovered and pieced together via information from various sources. For some of the participants in this study their understanding of themselves involved thinking about their family background and incorporating the identity of their families into the way they viewed

themselves. For Layla, who has little information and strives to make sense of her family background, this involved thinking about the people that make up her family and the size of her network.

...And when I done my time line, I was like, oh yeah, and that happened and I forgot about that, oh and thinking about my family, and my mum's side and my dad's side cos my mum has got a big family...

(Layla)

Other participants who come from different ethnic backgrounds strived to incorporate their ethnic origin into their sense of identity. This involved thinking about their historical roots and the ethnicity and culture of their family members. This was not an easy task, particularly for those who were isolated from their families and living within a different culture. For Roxanne, who identifies herself as black British, this involved thinking about her historical roots, the ethnic origin of her family members and the diversity within her family, which in turn gave her a sense of personal heredity. This sense of personal heredity was important given that she had little contact with her family and other people who shared the same cultural background. Despite being in care it seemed important for Roxanne, as well as other young people, to create a personal identity, which was located within the family.

...My dad's dad is from Barbados...mum's dad is from Jamaica, my mum's mum is from Canada so I'm mixed, I've got a lot of like stuff in me, umm most of my family are mixed race, or black most of them mixed race or white, I've got quite a lot of white people in my family as well, mixed race and black so it's like all different mixtures... (Roxanne)

...I say [I'm] black British, even though I'm half Jamaican, what's that black Caribbean...? (Roxanne)

4.2.2 Present self

All of the young people spoke of present contributions that influenced the way they make sense of who they are. This included a variety of factors many of which would be applicable to the general adolescent population, such as hobbies and school. However, the way in which this sample integrated influences such as family and relationships into their sense of self may be somewhat different to their peers based upon their experience of being separated from their family and being a 'looked after' young person.

All of the young people talked about their experiences of being in care and this seemed to be a large part of the story they told about themselves. Being 'in care' seemed to offer them an identity and allowed them to distinguish themselves from others who were 'not in care'. Whilst being a looked after young person was a commonality amongst the group each participant had a different story to tell. Some of the young people described their experience of being in care in a positive light. For example, they discussed how they experienced feelings of inclusion and warmth with foster carers they were placed with. Having a positive relationship with their carer seemed to allow them to view themselves as a person with qualities that made them likeable to others.

...We like to watch TV together we like the same programmes... I can talk to Jan. Jan is a great foster carer. We have lots of chats... (Layla)

...It was ok the people were nice and they had a daughter the same age as me...one of them got married while I was there and I got to go to the wedding...(Kizzy)

For others, being part of the looked after children system evoked negative emotions such as sadness and anger and being part of the system proved particularly difficult at times.

...Up and down, umm sometimes I like it and sometimes I don't like it, and I don't mind it sometimes and sometimes I feel like what's the point staying there... (Michelle)

Being part of a foster family could be difficult for a variety of reasons. Michelle, for example, described how unhappy she was in her current foster placement. However, the alternative options she had were even less desirable. She felt that she had no choice but to stay in her current placement. This led to a sense of self that felt powerless and constrained.

...Well if I move I have to go in a children's home. They were the options for me if I have to move I have to go in a children's home, which I hate, and if they can't find a placement for me they have to find a placement outside London...I would have to change schools and I don't want to do that...I wouldn't mind staying there [at the current placement] cos I don't want to go in a children's home, but apart from that I hate it there...there is nothing I can do... (Michelle)

For those in the sample aged 17 moving on to independent living was of relevance to their identity as they prepared to leave care. This was a process that would occur regardless of whether the young person felt ready to be living independently. This was a factor that was different from many adolescents in the general population who would not be planning for independence from their family in the same way, or who would have more choice in the process. For example, Roxanne discussed the way the system operates for those who will be living more independently as they prepare to move to independent living. This involved having a system of carers, which was not always reliable. For her this was a difficult process and a negative aspect of being looked after.

...There's, well, umm basically cos it's supported housing and it's an independent unit the carers are here but they're not here all the time, if

they can't make it I could be here on my own over night, umm unless like sometimes they are here from six in the evening until 11 o'clock at night or they're here from six in the evening and they sleep in, so it's like quite different they change the rota... (Roxanne)

Relationships with significant others was another area that contributed towards the way in which the participants made sense of their self. For most of the young people relationships with significant others such as family, friends and partners seemed to help them make sense of themselves. All of the participants discussed their relationships with their families. Some were more comfortable talking about their families than others. For some, the relationships with their family members gave them a role, or label such as 'sister' or 'auntie', which contributed towards their sense of personal identity. It was important to most of the participants that they could place themselves within a relationship context despite being isolated from their families. This allowed them to identify with youth culture and minimise some of the difference that being in care creates.

...I've got a sister... [and] I'm an auntie...I see them in the school holidays... (Layla)

...Yeah I've got four brothers and three sisters...No I've got two sisters and four brothers. I'm the third one, I'm talking about me, I'm the eldest...it's good you know, cos you can look after them, especially if you're the eldest. And guide them the right way... (Roxanne)

Friendships were also an area that the participants seemed to enjoy discussing and this seemed pertinent in allowing them to construct positive aspects of their identity. It seemed to be one way of offering a sense of normality that allowed them to identify with their peers.

...I'm an outgoing person, like I like to go out quite a lot with like friends, going out with my boyfriend and stuff... (Roxanne)

Whilst identity formation and developing relationships with friends is an important developmental stage in adolescence, and the participant's engagement in conversation regarding their friendships can be viewed as healthy adolescent development, the participant's isolation from their families meant that friendship often fulfilled a deeper role for these individuals in the construction of their identity. For example, the way that Michelle engaged in conversation about friendships conveyed her ability to view herself as somebody who gives as well as receives in these mutual relationships. She was also able to reflect upon the need to have a range of friends. To some extent this may also reflect a deeper need to create a surrogate family for herself.

...Umm I got different types of friends, I've got different groups of friends, like I talk to, and they're all like different in a way, there's a few that I can like talk to that are like close to me...(Michelle)

Two of the older participants discussed the significance of having a partner. This relationship seemed to be an important part of their identity, allowing them to view themselves not only as an individual but also as part of a couple.

...We love each other and we are going to get married...we've been engaged for two months and three weeks ago we set a date for the wedding... (Rachel)

...Things I like to do with my boyfriend okay, we like when I meet up with him we go for a drink or we'll go to like central London on the buses and stuff, he'll buy me something to eat...we go there, sit there have something to eat and drink, we talk, we smoke and that's about it really and then we come back here. He comes here to see me most of the time we just listen to music upstairs... (Roxanne)

Another factor for two of the participants was the fact that they lived in a different country to their birth family. Their identity seemed to be largely based on being segregated from others and a country that were important to them. Coming to a new country and the process of entering the care system also contributed towards their construction of their identity.

I just came from Africa; I just came from my country...I went to different places, but afterwards I went to a children's home in Barnet... [coming to a new country was] quite different, but I got used to it... (Nicole)

The participants also talked about interests that they have and hobbies they engage in. These factors seemed to be significant in allowing them to communicate whom they were and what they liked to do. Hobbies and interests seemed to be viewed as a positive influence in their lives, that allowed them to utilise labels and descriptions that did not involve them being a looked after child or having mental health difficulties. The hobbies and interests that they engaged in also allowed them to be part of, and identify with, youth culture.

Four of the participants described how they enjoyed the creative arts such as music and drama. These would be interests that allow them to identify themselves as well as opening opportunity for creative expression.

...I like acting...and I like singing and dancing... (Kizzy)

...I like a lot of Jamaican music, umm hip hop, R 'n' B, umm rock music... (Roxanne)

For Layla creative arts formed only part of her interests. She described many different things that she enjoyed, in order to make sense of her identity. The list seemed to evolve as she located herself in different contexts such as sport, arts and school. Compartmentalising her life into areas seemed to allow her to create her own identity based on the things she enjoys.

... [I like] trampolining, basketball, netball... and I like dancing, acting, djing...and I like English, drama, maths a bit... (Layla)

The sample was made up of young females aged 13-17 and this was reflected to some extent when the young people were describing their interests and making sense of their identity. Layla's interests, identified above, seem typical of a 13-year-old adolescent to a greater extent and somewhat different when contrasted to Roxanne's interests as a 17-year-old young person. Roxanne is approaching adulthood and whilst her development has been arrested in many areas, being a looked after child means at 17 she is living independently with support. This is reflected in the way she makes sense of her identity, which at some level involves her identifying with adult behaviour.

...I also like to go to the pub...have a drink, sometimes I have too much, too many... (Roxanne)

4.2.3 Imagining a future self

The participants talked about how they imagined themselves to be in the future. Some were able to incorporate ambition into defining an identity for themselves in the future. Two of the young people talked about what they wanted to do when they left school. This allowed them to think about the direction in which they wanted to move. Interestingly they both stated that they wanted to be an actress, which would allow them to take on different roles. Although this contributed towards the creation of their identity it may also have offered escapism from their current sense of self.

...I want to be an actress when I grow up... (Kizzy)

Others seemed more uncertain about the future and the direction they wanted to move in, which can be typical at this developmental stage. However, looked after adolescents often do not have a stable carer to provide support at this uncertain time.

...In the end I don't know what I want to do... (Nicole)

...Umm, I wanted to be an air hostess at first and I wasn't too sure and then I took up geography and that because they said I had to take it up and I still don't mind doing it but I would like also like to do child care... (Michelle)

Change and moving on was an area that the young people discussed in relation to a variety of contexts such as school, being in care and mental health services. This seemed to allow the individuals to contextualise themselves in the present as well as allowing them to think about the future. For two of the young people who will be moving on to adult services, mixed views were expressed. There seemed to be ambivalence about moving on from Roxanne.

...I'm still thinking about it and then I've got to let my social worker know how I feel because I think this is just too sudden for me at the moment and I'm just really stressed out and I've got a lot of problems to deal with... (Roxanne)

Rachel seemed to be planning her move to adult services, which could be indicative of her planning skills and transition towards adulthood. However, it could also be a communication of her fear of abandonment by services and anxiety about needing to be active in a world where she has been let down by adults.

...I can only be seen at CAMHS until I'm 18 and I'm 17 now and the Tavi can see you when you're 18 as well, so I asked if I could be referred... (Rachel)

4.3 Making sense of difficulties

All of the participants discussed the difficulties they experienced. This included a host of emotional and behavioural difficulties, such as depression and eating

issues, as well as more subtle difficulties, which they spoke of in a more indirect fashion, including relationships with both adults and young people. There was also the sense from many that they were yearning to belong and this involved the expression of feelings of abandonment as well as an element of searching. The young people had made some sense of their difficulties and were able to give an account of their understanding of the difficulties they experienced. This had become part of their self-narrative.

4.3.1 Yearning for a sense of belonging

All of the participants had experienced separation from their family; some had experienced multiple placements, were detached from their families and seemed to struggle to recognise where and to whom they belonged. For some of the participants this led them to search and seek out parental figures and family.

Searching was expressed in two contexts during the interviews. Layla, in particular, was searching in the physical sense that she was actually trying to find members of her family with whom she had lost touch. This had been a process that she had been engaged in for some time and this was her primary reason for attending services'. She expressed a desire to find her family and a sense of uncertainty about the outcome, which left her vulnerable to emotional difficulties.

...The reason why I see Maria...It's mainly to do with my family, cos like I have got six aunts and I don't know where they are... I am trying to find them, but umm, it's hard, cos like, I haven't seen them for a long time and I don't know where they live even... we are trying to find them to do like a family tree... It's a bit like we are detectives...I don't know if we'll ever find them...It's really hard for me sometimes... (Layla)

Other participants did not seem to be searching for a particular person but rather appeared to be searching for a sense of belonging. This involved wanting

to attach to a parental figure and be 'looked after.' As she told her story it was evident that Rachel had unsuccessfully tried to attach herself to adults in a bid to form a relationship with a substitute parent at several points in her life. This, at times, involved her making sacrifices and doing things that she did not want to such as going into hospital.

...Teresa is my mum, I know she's not really my mum but I had to parent myself...Teresa and Kim used to let me be like a little kid and it used to help...sometimes I feel like being looked after... (Rachel)

...The only reason I went in [to hospital], in the end was because my foster mother moved to Brighton and she said that I could go and live with her if I had my discharge papers... (Rachel)

All of the participants had experience of being separated from their parents. For many this separation created an initial sense of abandonment, which had left them vulnerable to further experiences of abandonment as they entered the care system. For the participants that had experienced multiple placements, abandonment was an issue that seemed to feature throughout their lives. For Michelle, for example, her interaction with professionals within the system led to further feelings of abandonment.

...They haven't done anything so like, and I didn't talk to them so they got me a youth worker but then she left two weeks after and I was like what's the point then of getting me a youth worker when she's leaving in two weeks...the social worker she was there for like god knows how long, like six months, she didn't do anything. I had a care order and what they told her to do she did like 2% and the rest of it she didn't do and for like six months they haven't done anything... (Michelle)

For most of the participants the people who provide their care are primarily carrying out a job, which is somewhat unique when compared to adolescents in

the general population. However, for Michelle the formalisation of this relationship was construed in a negative way based on her early experiences of relationships and sensitivity to feelings of abandonment.

...Because all she does is like take me out, she does take me to nice places, but it really doesn't matter it's like that's her job anyway...
(Michelle)

On several occasions when the participants discussed their experiences there was a sense that they, at times, seemed to reject others before being rejected. Interestingly, there still seemed to be a sense that they were longing to belong but this rejection may be a defence they have developed in order to protect their inner self based on their early experiences of abandonment.

...It's hard for other people to get close to me cos I've always got my barriers up...I push people away cos I've been hurt before... (Rachel)

Rachel particularly alluded to this construct when telling her story of entering an inpatient setting.

...I didn't want to go to hospital ...I was like you'll throw me out after two weeks cos I was determined not to go into hospital...but when I had been there for a while I got used to it and it was alright (Rachel)

4.3.2 Struggles in making and maintaining relationships

All of the young people spoke of difficulties they experienced with relationships. Although this was not identified as a specific 'problem' or an issue they claimed to need help with it seemed that they were all receiving input from services with regards to either specific relationships they had experienced, for example with parents, or more generally with their difficulty making and maintaining relationships. This was the case for relationships with adults as well as other

young people. The difficulties they described are likely to be unique to the looked after children population.

All of the young people alluded to having difficulties, to some degree, in relationships with adults. This included having a difficult relationship with members of their family, their present or a previous foster carer, or professionals.

Many of the participants talked about difficulties in their relationships with members of their family. This was an area that was painful for some of the young people to talk about; it seemed that talking about relationships with family members evoked an emotional response.

...Not often. The last time I see my brothers and sisters on my mums side was last year Christmas, that's the last time I see, that's what gets me angry with my mum and it hurts me so much and it stresses me out. It's like sometimes it makes me want to hurt myself... (Roxanne)

...I lived with my half sister, she and I don't get on and she used to leave me in the house and that so, and so the neighbours called the police and they took me into care... (Michelle)

Some of the participants had experienced multiple placements and were able to talk about carers that they had liked as well as those that they had found difficult. They were able to make sense of carers that they did not like based on their understanding of adults and relationships and the way the system should work. They were able to narrate their experience which became part of their story about being an adolescent in the looked after children system.

...that was when things were really bad and she used to check my room and go through my stuff all the time and I would find them upside down...Cleris (foster mother) she just gets on my nerves cos she likes

controlling people, she's bossy as well...she is a secondary teacher, but I would never ask her to help me do my homework. Once I did it was a nightmare I ended up crying I was like just go away...I hate doing it when I go home cos Cleris is like "Oh you're doing homework, oh that's a first" so she thinks I don't do any homework at all... (Michelle)

...Obviously she knows I'm stressed, all my carers know, all my carers know. No I can talk more to Lindsey and I can talk more to my other carer Jess cos they can both listen and understand. The only carer that I don't talk to is she's called Sasha; she's black as well. We just don't get on, basically we just don't get on she's just not my favourite person... (Roxanne)

As well as having input from carers all of the participants were subject to a system of professionals who were working with them. This is another factor that distinguishes looked after adolescents from many other young people. This included social workers, youth workers, teachers and health professionals. Michelle described a difficult relationship she had with her youth worker which seemed to involve a change in their relationship.

...I've got a youth worker, I talk to her just like about everything, like normal stuff, not really anything...people think oh my god you like Brenda so much but now it's like oh okay Brenda's coming hurray, it's not like the excitement that I used to have...sometimes some stuff I tell her she tells my carer, it's like I don't understand...I've seen her before in my old placement. She was okay there. She changed...she was more like a youth worker she would like talk to you and try her best to help you, but now she talks to you, but not about things that really matter... (Michelle)

With regards to relationships with other young people three of the participants directly spoke of difficulties they experienced. Layla and Michelle reported

having difficulties with birth children at the placement. It seemed that it was difficult for those participants who were living as part of a birth family for a variety of factors, including sibling rivalry and envy of the birth child's relationship with their parent. Both Michelle and Layla lived with single parents where birth children were either living at home or visited very frequently. They seemed to find it difficult to develop a meaningful relationship with the other young people in the house.

...She's always into damage and destruction, she comes round here and gets everything out... (Layla)

...[My relationship with her son is] Not too good, it's different with a small child but he acts like he's 2... (Michelle)

Friendships were another area that the participants discussed. Whilst friendships seem to help the young people construct their identity they were also an area that could be difficult at times.

...The other kids at school, they get on my nerves; most of them are childish... (Michelle)

4.3.3 Understanding of difficulties

All of the young people were able to make some sense of the difficulties they experienced and the reasons they attended the looked after children mental health service. They were able to discuss this understanding of their difficulties to some degree. This involved thinking about the type of difficulties they experience, the impact their difficulties have on them and strategies that they can use to help.

The young people described their experience of a variety of difficulties which all had an emotional component. Some were reflecting on issues from the past, whilst for others the experience was ongoing. Many of the participants alluded

to their family experiences as an issue they used services for. This seemed to be a topic associated with feelings of sadness and anger and seemed to evoke an emotional response that could be difficult to manage at times.

...Because of all my family stuff, I think it was my social worker Rose who thought I should go to a counsellor... (Layla)

In addition three participants talked about their experience of depression. This was a label that was used and for some it seemed to be comforting to have a label to describe their experience. Roxanne seemed unable to describe the emotions and behaviour that she experienced when she felt this way. This may have been because it was painful to discuss.

...As you know I suffer with depression...I've had depression for I say about five or six years now, going on from when I was quite young... (Roxanne)

Michelle was able to make sense of the way she felt and behaved when she was experiencing depression and was more open to sharing this understanding.

...Sometimes just getting up in the morning, sometimes I just can't be bothered, sometimes I don't want to do the work...I just can't be bothered, I'm lazy and I just feel like, I don't, I just feel empty, and sometimes like before I just used to feel like really, really lazy and I didn't feel like saying anything to anyone... (Michelle)

Self-harm was also a behaviour described by some of the participants; it seemed that this was a behaviour that the young people used to display emotion particularly when feeling distressed. It also seemed to be a means of communication for some of the participants who struggled to express themselves, which may have been for a variety of reasons including feeling

isolated, rejected or not having the emotional vocabulary to communicate their feelings. Self-harm was understood as a powerful means of self-expression by three of the participants.

...I used to cut myself but it got worse in there, cos first of all I, before I went in there I just used to scratch my arms but when I was at the hospital I was cutting myself properly and needed stitches and that sometimes, and I started cutting my legs and that as well, like proper cuts that won't never heal... (Rachel)

...I pierced my nose to take the pain away but it didn't work... (Michelle)

...Yeah, I cut my arm here, umm I took ecstasy to kill myself, I've took overdoses of paracetamol, anadin, umm what else, aerosols, glues and stuff to kill myself... (Roxanne)

One young person also discussed her eating difficulties. This again seemed to be closely linked to her emotional state, which seemed erratic and uncertain at times. Food and body image seemed to be a way of her expressing her emotional turmoil, which may have been difficult for her to understand and communicate in an alternative way.

...umm then I like stopped eating and I was all skinny and that and I didn't like myself I was too small and then like I was eating junk food and I was too big and like most times it's about eating, and I get like sometimes I eat sometimes I don't eat...I feel like I don't know what to eat and I feel like I have to concentrate on a certain thing and sometimes I eat certain foods just to make myself feel better... (Michelle)

Anger was an emotion that was described by some of the participants. Anger and aggressive behaviour were another means of emotional expression for

many of the young people. Again some were only able to use anger as a label, whilst others were able to elaborate their meaning making and expression.

...They were getting on my nerves and they thought I was angry and all the time yeah I was angry but all the time they were like and I was getting more and more angry... (Michelle)

Abuse was an issue that was touched upon although those who mentioned it did not go into any depth. This may have been an issue pertinent to all of the young people whether abuse led them to enter care or whether they had experienced abuse whilst being part of the care system.

...I've had a lot of abuse in my life, umm I've had a lot of problems with like girls in primary school and high school but that's not like, that's minor... (Roxanne)

The young people also discussed the impact of their difficulties and the degree to which they affected their lives. The level of insight amongst individuals varied with some seeming to minimise the effect whilst others seemed to view their difficulties as having a huge impact. Nicole's narrative gave the sense that she minimised the impact her difficulties have on her and she seemed to think that the stress she experiences was not vastly different to that experienced by her peers.

... [My difficulties affect me] the same as everyone else... It's not like I've got it really stressful... (Nicole)

Rachel, on the other hand, had made sense of her difficulties, arriving at a different conclusion. She thought they had a greater impact on her, particularly in the past.

...They were keeping me safe cos I really think I wouldn't be alive now if I didn't go into hospital... (Rachel)

Some of the young people discussed strategies that they use to try and overcome their difficulties. Again, some seemed to have more insight regarding this issue than others. Roxanne had two strategies that she used in order to help when she was feeling distressed.

...But I don't wanna do it so I go to my carers and talk to my carers about it to help me... (Roxanne)

...Keep a diary, but I've not got a diary at the moment, to write things down. Sometimes I just write things down and burn it afterwards. It makes me feel better... (Roxanne)

4.4 Making sense of CAMHS experience

All of the young people talked about their experience of receiving input from CAMHS. This included talk about having a positive experience, feeling supported, their relationship with their therapist, ambivalence about receiving services and their ideas for service development and the future.

4.4.1 Having a positive experience

All of the young people expressed some degree of satisfaction with the services they had received. It seemed that communication was a key factor with the participants valuing having somebody to talk to and the opportunity to feel understood and listened to. The participants described feeling understood by their therapist and this seemed to be something that they appreciated. It was important to have the opportunity to talk to somebody who could relate to them on a level where they felt understood as well as able to understand.

...You get to talk to and someone that understands you... (Nicole)

...Then I talked to Maria and it was alright, cos I can talk to her on my level... (Layla)

Feeling listened to was also a quality that the participants valued and this seemed to be another factor that contributed towards their positive experiences of receiving a service from CAMHS. Having a therapist that listened to their talk and valued their opinion seemed to provide a good foundation for the therapeutic relationship.

...She's alright, she listens...she listens to me, so it's quite nice talking to her... (Nicole)

...I think she would be happy to see me if I wanted to go more and she would say yes that's alright if I wanted to go less as well... (Layla)

4.4.2 The significance of the therapeutic relationship

Many of the young people also spoke of having a positive relationship with their therapist. All of the participants had been seeing their current therapist for a minimum of six months. This relationship seemed unique and offered a degree of consistency, which was lacking in other areas of their lives. The participants spoke about the length of time they had been seeing their therapist for. Their expression conveyed a sense that they were content with the therapist they were currently seeing.

...It's just like, most times I just stick to Nikki so... (Michelle)

...A year and a half now, the one, the psychiatrist has seen me for about a year and a half now... I think it's better to stick to the same one, so (Roxanne)

The young people also spoke of the uniqueness of their relationship with their therapist, which was based on honesty and commitment. This was something they valued.

...But then I got used to her and now I talk to her mostly about things...it wasn't exactly mental people it was just me and someone, me and Nikki and I didn't mind that...umm she listens and when like I say something and she goes no I don't think so, she will like tell you sometimes and she will try and help you... (Michelle)

As well as discussing her relationship with her therapist Michelle also spoke of times when others, such as carers, were invited to attend sessions. This was a factor that she did not enjoy as this impinged on her time and relationship with her therapist.

...Sometimes when they get like your carer to come, I hated it, like once they suggested that my carer comes and talks to Nikki with me, I hated it so much... (Michelle)

Two of the participants discussed their relationship with their therapist, which included a discussion of how their therapist 'knew best' or had an air of expertise. At times particularly when things were difficult this seemed to be a quality that they appreciated.

...They're professionals, so I suppose they know... (Rachel)

...Yeah, my psychiatrist has been very worried about me cos she's got a lot of incident reports of what's happened here. That's why she's been putting it once a week... (Roxanne)

4.4.3 *Feeling supported by CAMHS*

The young people relayed feeling supported by services in a variety of areas, including home, school, and with their family. Feeling supported in these areas of their lives was important and appeared to contribute towards forming a positive experience of services. Two of the participants talked about how services had helped them manage the difficulties they experienced.

...Before she helped me when I was not eating because the carers that I was with then complained about me not eating cos I didn't eat breakfast and they didn't know if I was eating lunch and I didn't eat dinner so they complained to Nikki cos they were worried...then she helped me she like tried some new foods and from then I started eating... (Michelle)

...I'm on medication to stop me hearing voices in my head, umm I see a psychiatrist once every month or once every week but that helps... (Roxanne)

Michelle also talked about how her therapist had helped her when she was experiencing difficulty with social services. This involved inter agency liaison, which was valuable to Michelle in helping her to move forwards.

...Since January they haven't done anything at all and Nikki talked to her... (Michelle)

The help services offered the young people with the difficulties they experienced involved the utilisation of a variety of strategies. Two of the participants talked about receiving advice from their therapist, and this seemed to be a strategy they favoured.

...Umm when like I've got a problem she will advise me... (Michelle)

... I go there, sit and wait for Katherine, she's my psychiatrist, and then umm see her go in the room, this is how I describe it, this is how I think of it, and just talk to her about my problems and tell her how I'm feeling and then she would advise me or tell me what she thinks... (Roxanne)

Some of the young people spoke of receiving help with issues that were pertinent at home. Michelle, in particular, seemed to use services to help with the difficulties she experienced at home. Her therapist seemed to provide support at times when home was stressful as well as intervening and liaising with her carer.

...Sometimes if it's at home she will like call up and she will say what's going on and she will talk to my carer and that...then a few months ago I did not get on with my carer at all and it was like the mad house, we were screaming and shouting and the police being called and then she said like every week I should see her... (Michelle)

As well as helping with difficulties in placement, three of the young people discussed the help they received from services with the difficulties they experience at school. Again, this involved therapists offering support to the young person as well as liaising with school in order to resolve issues.

...And sometimes she calls up school and asks them how I'm doing or if I've got a problem I will tell her she will call up and she will talk to them... (Michelle)

Whilst many of the participants spoke to their therapist about the difficulties they had experienced or are currently experiencing with their family, Layla in particular used her time with her therapist to discuss this issue. She found that her therapist was able to help her make sense of her experiences regarding the loss of her birth parents and the lack of awareness she had about her early childhood and family.

...I think it's been able to help with my family stuff, like I said I have done my timeline and that has helped me... (Layla)

4.4.4 Ambivalence about receiving help

Whilst the young people expressed a satisfaction about the services they had received, all of the young people also spoke of their ambivalence about services either before they attended, whilst they were using services, or concerning the practicalities of attending.

Four of the young people felt ambivalent about attending prior to their first engagement with services. For some this involved a lack of awareness about what receiving services from CAMHS entailed. This initial ambivalence led to some of the participants refusing to attend.

...I think I had my review meeting then they got me to think about it and they kept asking me and I said no cos I thought it was for mental people...when they said counselling I'm like I'm not mad and they said no it's not for mad people because then they explained like child and mental health and I was like I'm not mad, I'm not mental they were like no it's not for mad people...I didn't know what it was, when they talked about it when they said CAMHS I thought it was someone's house, I was like who's Cam? Said no CAMHS and I was like what and I didn't understand... (Michelle)

Nicole's ambivalence was largely focused on a lack of information and her friend's experience, which had been negative. The information she had heard from her friend led her to believe that attending CAMHS would leave her feeling guilty and she did not want to experience this.

...I was worried in the beginning, because my friend used to go to it, she was like ol, they make you feel guilty, they make you this, they make

you that...I was worried thinking I've been guilty all my life, and they are going to make you more guilty...it was different to what I thought it was going to be because I thought it was going to be what my friend told me... (Nicole)

In addition four of the participants talked about ambivalence they have experienced whilst they have been engaged in services: for two of the young people this ambivalence was when they first began to attend. It seemed that they struggled to some degree to make sense of the purpose of the service as well as feeling a pressure to disclose personal information.

...At first it felt strange coming I couldn't like talk properly and I was like oh my god it was weird talking to a stranger that you do not know, you've never met and all of a sudden you're supposed to tell them everything and it was strange, and mostly I didn't talk that much I like kept quiet and she asked me questions and I was like yeah, yeah... (Michelle)

With regards to ambivalence about receiving services, two of the participants described how they thought their therapist 'got it wrong' sometimes. However, despite these feelings they did still attend their appointments and were currently engaged in a CAMHS service.

...She goes about it the wrong way...whenever I see her she's like, asks me the wrong things right from the beginning... (Rachel)

...I can talk to her she listens but sometimes I get very upset with her, very, very upset but I wouldn't really want to talk about that... (Roxanne)

Michelle described an uncomfortable feeling that she sometimes experiences with her therapist, which makes it difficult for her to talk to her at times.

...Sometimes I don't know like what to talk to her about, I'm not sure how to bring, even though like I'm used to her, I'm still not sure how to bring something up... (Michelle)

Rachel had attended CAMHS for 13 years and during this time had tried a variety of therapeutic interventions. Rachel's ambivalence about services involved a sense that engagement in services had made things more difficult at times. In addition there were therapies that she had experienced that she did not find enjoyable.

...We used to go to family therapy, me and my family...It made things worse really...I had art therapy as well but that was rubbish...we didn't even talk and so I thought I'm not going there anymore... (Rachel)

Rachel also described feeling that services can be judgemental at times, which was a factor that made her unhappy.

...I suppose I think they can be a bit judgemental sometimes...I felt like she thought I was a liar or a slag or something, so it felt judgemental... (Rachel)

Three of the young people also talked about difficulties with the practicalities of attending the service. This involved having to wait, appointment times and having to travel to the service.

...I just don't want to wake up early in the morning to go there...my appointment is really like 11 O'clock so I have to leave here at quarter to 10, 10 O'clock... (Nicole)

4.4.5 Service development and ideas for the future

The participants also came up with ideas for future service development. This involved offering ideas for improvement regarding attendance, location and

information provided. Two of the young people described how they would like to attend the service more frequently.

...I wanted to go more... (Nicole)

...In a way more, sometimes, I don't really feel like seeing her less, not really... (Michelle)

In addition, Michelle had some ideas regarding location. She felt that it would be helpful to meet at an alternative location to the CAMHS building. This would involve more flexibility on the therapist's part.

...And also sometimes it's like you're talking in a little box room, like okay, I don't know somewhere else like say the park or something ...sometimes like I think like the people that work with us should meet us somewhere else, because like I go all the way from Barnet to come here, cos like I have to come here then I have to go back to Oakwood and sometimes it's like ohh, sometimes I think they should meet us, say like meet us at school or somewhere... (Michelle)

Rachel also discussed an idea for improvement regarding work with children at the service. Based on her experience she felt that staff should interact with children in a more child centred way.

...If it was me I would get on the floor and talk to the kids... (Rachel)

In addition, Nicole expressed curiosity about other services that might be available. This seemed to indicate a lack of knowledge and maybe a keenness to engage further. Distribution and communication of information could therefore be another area for service improvement.

...What's art therapy? I don't know these things so...what else can help young people... (Nicole)

4.5 Summary

The results have been presented in the context of the three superordinate themes identified from the analysis of the interviews with the six participants. The results will be discussed further in the following chapter in the context of existing theory and research literature.

5.0 Discussion

5.1 Introduction

The evidence base for looked after adolescents' experience of mental health services, from a qualitative perspective, was shown to be limited (see Literature Review). The main aim of this study was to gain an in-depth understanding of looked after adolescents' experience of the mental health services that are available to them at present. This study was carried out utilising IPA as the method to investigate. The aim was to empower the participants to speak freely, which would produce rich accounts of their experience. It was also hoped that ideas for improving current service provision and development would be generated.

The discussion section focuses on a discussion of the results in the context of existing theory and research literature. In the first section the key findings will be presented in the context of the two research questions. A brief overview of clinical and service implications of the findings, methodological issues and suggestions for future research will then be given. These issues will be discussed in depth in the critical review.

5.2 Key findings

5.2.1 What are the mental health difficulties this sample of looked after adolescents feel they need help with?

With regards to the first research question, a number of mental health as well as social difficulties were identified by the participants. Whilst studies that have previously been carried out may have elicited some of these difficulties (McCann *et al.*, 1996; Utting *et al.*, 1997; Butler and Vostanis, 1998; Arcelus, Bellerby, and Vostanis, 1999) they have adhered to diagnostic criteria for the most part and would consequently lack insight into experience. The rich information obtained from this IPA study allowed the young people to participate in detailed, in-depth discussions about issues such as identity and relationships, which would not have been picked up in a quantitative study conforming to diagnostic criteria. It is therefore believed that this study will add to the research

base and consequently to our understanding of looked after children and their experience of mental health services.

Although the research base is limited it has previously been identified that the most common disorders that looked after children suffer from, include anxiety, fears and depression and attachment disorder (Lindsey, 2000). These were all difficulties identified amongst the six participants who engaged in this study. It has also been reported that a smaller group develop serious mental illness, such as schizophrenia and bipolar affective disorder, with psychotic symptoms (Lindsey, 2000). Although the aim of this study was not to conform to diagnostic criteria, Roxanne described experiences, which could be indicative of either schizophrenia or bipolar affective disorder, with psychotic symptoms. In addition it has been suggested that the despair about their lives or the need to draw attention to their dire predicaments leads to suicidal attempts and self-harming behaviour on the part of some looked after children (Lindsey, 2000). Again, these were behaviours described amongst the participants in this sample. This information allows us to contextualise this study and make connections with existing research. However, it tells us little about experience, which was the aim of this study.

At times, some of the participants were only able to label their experience using common and culturally appropriate language. This may have been due to a variety of factors including a need to protect themselves from the pain they anticipated when recalling their experiences. However, it could also have been that they had made sense of their experience based on the social construction of mental illness, shared language and what it means to experience a phenomenon such as 'depression' in a western culture (Burr, 2003). Therefore, whilst it was informative to listen to the participants make use of labels, an IPA methodology offered the opportunity to prompt and enquire more deeply about experience which seemed to offer a deeper level of understanding about emotion, behaviour and thoughts.

With regards to the difficulties experienced by the participants in this study attachment theory (Bowlby, 1971, 1975, 1981; Howe, 1995; Atkinson and Zucker, 1997) can be drawn upon in order to aid our understanding. The notion that early parent-child relationships play an important role in the aetiology of mental difficulty is at the core of this theoretical perspective. It has been suggested that the relationship between early attachment and later behaviour problems is that children are more likely to develop behaviour problems if they are insecurely attached to their primary caregiver, as opposed to being securely attached (Bowlby, 1971, 1975, 1981). Inevitably, many children who are looked after by the local authorities will have a disrupted pattern of attachment in early childhood and this seemed to be the case for all of the young people that participated in this study. It has been suggested that for some, the experience of abandonment and unmet dependency needs may lead to self-blame for causing the abandonment, helplessness, hopelessness, low self-esteem, chronic depression and self harm (Carr, 1999). These were all issues expressed amongst the participants in this study to some degree.

Establishing enduring relationships and wanting to belong featured as two issues that the young people in the sample seemed to struggle with. These were difficulties that were expressed indirectly in their discussion, and it is hypothesised that they would not have been picked up in a quantitative study. It was hardly surprising that establishing relationships was an area of difficulty for these young people if we think about looked after children from an attachment perspective (Bowlby, 1971, 1975, 1981). Attachment theory posits that: "Attachment behaviour brings infants into close proximity to their main carers. It is within these close relationships that children learn about themselves, other people and social life in general" (Howe *et al.*, 1999, pp: 10).

It is presumed that many looked after children do not develop a secure attachment to their primary care giver. This would, according to attachment theory, impact upon their understanding of themselves, other people and social life (Howe *et al.*, 1999). Having difficulties in these areas would inevitably make

relationships an area that they are likely to struggle with. The participants in this study expressed difficulties in relationships with both adults as well as young people. For some this included having a difficult relationship with a present or a previous foster carer, family members, youth worker; carers, teachers and health care professionals.

With regards to yearning for a sense of belonging, two of the young people discussed how they were searching for what seemed like a sense of security or a secure base (Bowlby, 1971, 1975, 1981). For one of the participants this involved searching for members of her family and this issue and the feelings it evoked in her seemed to be the main area she used services for. Another participant did not seem to be searching for a particular person, but rather for a sense of belonging. This might be indicative of the attachment difficulties you might expect looked after children to experience (Howe *et al.*, 1999). Having a sense of abandonment and the feelings this evoked also featured as a theme amongst the participants. This again could be indicative of this population who have often had multiple experiences of abandonment following rejection from their birth family. Having experienced abandonment, further experiences of separation, such as breakdown in foster placement or professionals leaving a service, are likely to be interpreted as rejection, which will impact upon the individual's ability to make and maintain further relationships. For some this could lead to a need to reject others before being rejected as they anticipate the world to be an unsafe place. This seemed to be the case for Rachel, in particular, who found it difficult to trust others and described 'having her barriers up' when she spoke about her relationships with others.

All of the participants described the way they make sense of their identity. Some of the participants seemed to have a stronger sense of self than others. However, all of the young people spoke of how they used services in order to explore areas of their identity. Narrative approaches would argue that the individual's view of reality, and view of themselves, is always a selective representation because it is never possible for the individual to narrate all of

their life experiences (White and Epston, 1990). Some of the participants' narratives were largely based around the fact that they are in care and receiving a service from CAMHS; whilst others were able to spontaneously divulge other information about themselves based on hobbies and interests as well as more positive areas of their lives such as school. Having a negative view of self that is largely based on rejection, fear, and abandonment will inevitably impact upon the person's sense of self as they may act as if that particular version of the life story is fixed (White and Epston, 1990). However, narrative therapists would suggest that their version of the life story is not fixed and this could be explored in therapy (White and Epston, 1990). In addition constructivist perspectives would argue that there is no single version of reality and it may be that for some young people the identity they have created is based on them viewing their experience from a particular perspective which is not fixed, even though they may feel that it is (Kelly, 1991).

5.2.2 What are their experiences of the mental health services they have received?

The second research question also generated a variety of responses with all the young people discussing their experience of receiving services to a degree. This included talk about having a positive experience, feeling supported, their relationship with their therapist and their ambivalence about receiving services.

The current service was the only service that most of the participants had accessed. In addition to this being the only service accessed by the majority of the participants, they had been seeing a consistent therapist for a minimum of six months, indicating a high degree of consistency and commitment on the part of the client as well as the therapist. One of the criteria for recruitment was that the young person had been engaged in services for six months, although it was not specified that they had to have been seen by the same clinician for that period. This is interesting particularly if this issue is thought about from an attachment perspective. Clearly all of the participants had developed some form of attachment to their therapist. Given their earlier experiences it may have

been that the therapeutic relationship provided them with a secure base from which they could explore other possibilities (Bowlby, 1971, 1975, 1981). This will be important in helping the participants with their difficulties, particularly given that they would all have experienced early attachment difficulties. Their early experiences would have left them vulnerable to the types of mental health difficulties they described, as well as the difficulties discussed regarding relationships and identity.

Four participants reported that the service they were currently receiving was the first mental health service they had accessed. Although it is important to remember this is a very small sample and it is not the aim of this study to make generalisations, it seems somewhat contradictory to Mount's (2004) suggestion that factors such as difficulties with accessing services due to waiting lists and changing placements prevent looked after children from accessing CAMH services. However, it could also have been the case that they were previously not in a stable enough environment or were not ready to engage in therapeutic work for a variety of other reasons, which might be more confirmatory of Mount's (2004) research. It will be important to reflect on the sample used in this study. This will be further discussed in section 5.4.

The two individuals for whom this was not their first experience of engaging in mental health services presented somewhat different accounts of their experience. Rachel described her experience of the different services she had engaged in since she was aged four. This included a host of therapies such as art therapy, family and individual therapy. The way in which she made sense of her experiences was indicative of her early attachment experiences and her narrative was largely focused on being rejected, mistrusting others and yearning for a sense of belonging. Her experience of the services she had received had been largely enforcing of her beliefs and was narrated in a way that made sense to her based on her understanding of the world as being rejecting and damaging (White and Epston, 1990). This may explain why she had engaged in a number of therapies most of which she would describe as being 'unhelpful' or

'rubbish.' It may have been that they challenged her view of the world, offering her an experience that was different to the rejection she had encountered, which caused anxiety and was uncontrollable given the chaotic style of her home life (Howe *et al.*, 1999).

Whilst most of the young people expressed some ambivalence about services they all spoke of receiving something positive from their engagement. This is an interesting concept to discuss particularly if we incorporate a narrative (Epston and White, 1990) and an attachment perspective (Bowlby, 1971, 1976, 1981) into our understanding of these apparently conflicting accounts. The participants had to make sense of their experience and narrate their experience based on their understanding of the way the world works for them. For most of the participants their early attachment experiences would have been characterised by rejection, which would shape their view of relationships as well as the world (Howe *et al.*, 1999). Therefore the experience of having a consistent, committed therapist would inevitably challenge some of their pre-existing beliefs and narratives of the way relationships work. This may explain the ambivalence they convey about their experience of services and in particular of having a relationship with a therapist that is somewhat different to their early experiences. This probably does not fit neatly into their view of the world and their understanding of relationships and hence creates a sense of ambivalence (Howe *et al.*, 1999).

Participants also spoke about the importance of having somebody to talk to, feeling understood by their therapist and feeling that their therapist listened to them. These seemed to be qualities that were lacking in other relationships. In addition, many of the young people spoke about having a positive relationship with their therapist, which was based on consistency, a quality that was probably lacking in their early relationships with their primary caregiver (Bowlby, 1971, 1976, 1981). Four of the young people spoke about feeling supported by services with difficulties in a variety of areas of their lives including at home, school, and with their family. These are difficulties that are probably

experienced by the general adolescent population to some extent. However, looked after children often do not have a supportive parent who may act as a mediator to manage these difficulties. For some of the participants, having an adult to liaise with school and their carer offered a source of support that was lacking in their life.

All of the young people spoke of their ambivalence about services either before they attended, whilst they were using services, or in relation to the practicalities of attending their session. Four of the young people felt ambivalent about attending prior to their first engagement with services. This seemed to be for a variety of reasons including being focused on a friend's experience, which had been construed as negative, and being unsure of the purpose of CAMHS. Interestingly, for Michelle the term 'Child and Adolescent Mental Health Services' portrayed connotations of 'madness' and she construed a referral to this service as an indication that others thought she was 'mad'. For her, and for some of the other participants, the social construction of mental illness was a concept that she did not want to be part of and she did not construe herself as a person who would attend such a service (Burr, 2003). This seems to fit (to a certain degree) with the findings of Blower *et al.*, (2004) who highlighted the fact that young people regarded mental illness as something about which they were curious, but from which they wanted to dissociate themselves. They found that their sample of looked after children was suspicious of mental health professionals whom they described as inaccessible and irrelevant to their needs (Blower *et al.*, 2004).

In addition four of the participants talked about ambivalence they have experienced whilst they have been engaged in services. For two of the young people this ambivalence was active when they first began to attend. Feeling ambivalent whilst involved in services also seemed to be for a variety of reasons. This included their therapist 'getting it wrong' on occasions, sometimes feeling uncomfortable with the therapist, not enjoying the session, feeling judged and having a sense that the engagement in services had made things

more difficult. Based on their earlier experiences most of the young people are coming to services with low self-esteem and the expectation that adults are not trustworthy and will let them down. They are therefore likely to be looking for experiences that will confirm these beliefs. They will also be scanning their experience for examples that fit with their narrative and they are likely to be able to make sense of experiences where they feel let down or judged (Howe *et al.*, 1999).

5.3 Clinical and service implications

The findings discussed above have a number of clinical and service implications. In this section a brief overview will be presented. Implications of the current study for clinical practice are discussed further in the critical review.

It has been suggested that looked after children are a group particularly vulnerable to mental health issues (Rodrigues, 2004, Kelly *et al.*, 2003, Phillips, 1997, McCann *et al.*, 1996). It has also been highlighted that the research base for looked after children as a population, is underdeveloped for a variety of reasons (Mount, 2004, Mental Health Foundation, 1999). The literature base for looked after adolescents has proven to be scarcer, with few studies carried out from a qualitative perspective focusing on user views. Given the current government climate whereby the health needs of looked after children feature as an area of priority (Department of Health, 2000, 2002b, 2004) it will be important that we have a clearer understanding of user views in order to develop appropriate services to meet the client groups' needs.

The literature available suggests that it can be difficult to access looked after children for research purposes (Hepinstall, 2000; Rodrigues, 2004). This was not the case in this study and there were no major issues involving the gaining of consent. This might suggest that the looked after children population is more accessible than is hypothesised, which will have implications for future research

to be carried out with the clients themselves in addition to their carers and professionals.

Ideas for service development were generated from the participants. Suggestions were expressed regarding practical issues including increased appointment frequency and a change of location. In addition the need to disseminate and share knowledge and information about other services was also seen to be an area in which services could develop. With regards to transition, three of the young people in the sample will be moving on to adult services shortly and mixed views were expressed about this. The transition process may benefit from further exploration with regards to the way it is managed for the young people.

5.4 Methodological issues: strengths and limitations

Government documents, such as The Quality Protects initiative (1998), have made resources available for the development of mental health services for looked after children. Collaboration between health authorities and local authorities is now mandatory and the new CAMHS money is being shared between them (Lindsey, 2000). This puts researchers in a good position to focus on the mental health needs of looked after children, particularly from a qualitative perspective which has historically been neglected for a variety of reasons.

The research base for adolescents, in particular, is underdeveloped and with significant numbers being looked after with mental health needs it is important that we have a greater understanding of their needs. This study represents an attempt to understand looked after adolescents' experience of the mental health services available to them and it is hoped that it will go towards bridging the gap between understanding the views of this population and developing services to meet their needs in line with government agenda.

IPA seemed to be an effective methodology for answering the research questions for this particular group of looked after adolescents. It was felt that the method allowed the researcher to obtain in-depth accounts of the participants' experience of the mental health services available to them, whilst simultaneously being sensitive to the client group's needs. Furthermore, the use of IPA with children is limited and there have been few studies carried out with the general child and adolescent population (Couch *et al.*, 2004; Roose *et al.*, 2003). There have not currently been any IPA studies carried out with the looked after children population and it is hoped that this study will open doors not only for further research using this methodology with children, but more specifically with children and adolescents from minority groups.

A fundamental limitation of the study relates to the sample recruited and it must be kept in mind when considering the findings that this study represents the views of six female adolescents who were receiving a service at a given time. This will particularly be the case when reflecting on service development issues. It will be important that readers are mindful that the sample is a group of six individuals with their own experience and accounts, which will be different to those young people in an alternative, looked after children service at any specific time.

Methodological issues are discussed further in the critical review.

5.5 Personal reflections

As was highlighted in the introduction it is becoming increasingly important for researchers involved in qualitative research to recognise that an understanding of us as researchers is a fundamental part of the research process (King, 1996). The researcher is not a totally objective being in the research process, but is actively involved. Whilst it is important to acknowledge bias and to attempt to remain as objective as possible during the process by adopting systems to uphold reliability and validity, it is inevitable that the researchers values and

personal attributes will impact upon data collection, analysis and the presentation of the findings.

In terms of the data collection process, whilst an interview schedule was prepared and loosely adhered to, the data from each interview impacted upon my values and beliefs, which consequently had an impact upon subsequent interviews. This was something that I tried to be aware of as much as possible by using reflective sheets, which I referred to throughout the data collection process. This was in order to reflect upon my personal position and the changes I was undergoing as researcher. My confidence and knowledge about this population grew from the time when I carried out my first interview to embarking upon my last one; this was not only a result of carrying out the research interviews, but also as a result of the clinical placement I was doing in this field and the young people I was working with in my clinical practice. Again this was something that I needed to be aware of and I was able to use the reflective sheets to process this.

I analysed each interview before carrying out the following interview. I felt that this allowed me to be more reflexive and helped me to distinguish the effect of each interview on my values and beliefs. It also helped me to separate each interview to a greater degree and think about the impact the previous analysis had had on the interview I was currently analysing. With regards to the process of analysis there was also continuous change for me between the analysis of the first interview and the analysis of the sixth interview. This process of change was not only as a result of my developing knowledge about the client group and the methodology but also as a result of carrying out the analysis and the impact each analysis had on the analysis of subsequent interviews. By this stage of the research my values and beliefs were not only shifting as a result of the analysis of each interview but also the continuous procedure of carrying out further interviews and analysis. This seemed to become more apparent as the study developed. It was important to use my reflective sheets to think about this and the impact it was having on the interviews.

The presentation of the findings has also been influenced by my personal values and beliefs. Whilst I have attempted to remain as objective as possible, the presentation of the results has involved the selection of data to support themes that have emerged as a result of the process of analysis. From the vast array of interview material, quotes have been selected to support both superordinate and subordinate themes. Whilst this is part of IPA and the procedures were adhered to it is still important to acknowledge the effect of the researcher in qualitative research.

5.6 Suggestions for further research

The sample recruited for this study was fairly restricted and as has been highlighted there are limitations to the generalisability of the findings. However this opens doors for future research and it would be interesting to carry-out a similar study using an alternative sample. It has also been indicated that the research base for looked after children in general is under developed and given that gaining consent did not prove to be an obstruction to this study it would be interesting to carry-out further research with this population, maybe recruiting a younger sample in a bid to understand their experience.

It was also part of the recruitment criteria that participants had to have been in receipt of services for a minimum of six months as it was hoped that they would have reasonable experience of the service. Inevitably this would have impacted upon the young people who participated and the views presented. It would be interesting to carry-out the study with young people who were more recent users of services in order to reveal whether their views are more indicative of the young people that find it difficult to access services due to factors such as waiting lists and changing placements (Mount, 2004).

With regards to qualitative research this study has opened avenues for further exploration regarding looked after children's experience. This study has particularly focused on their experience of mental health services. However,

there is a host of other areas pertinent to the health and well-being of this population that could be explored in order to strengthen the research base and improve our understanding of these young people. Developing a psychological understanding of this population will also help services develop in order to meet looked after children's needs.

Suggestions for further research are discussed in depth in the critical review.

5.7 Conclusion

In summary, this study has provided an in-depth account of six female looked after adolescents' experience of mental health services using an IPA methodology. This involved gaining an in-depth understanding of the difficulties they experienced, the mental health services they received and their experience of the services they received. In addition, ideas were generated regarding improvements that could be made to current services: this will be valuable information for service development given the current government climate (Department of Health, 2000, 2002b, 2004).

The results were considered in the context of the current research base and were found to confirm many of the existing findings as well as provide further insight into experience and meaning making. This was carried out drawing on attachment theory (Bowlby, 1971, 1975, 1981; Howe, 1995; Atkinson and Zucker, 1997) as well as utilising paradigms for meaning making such as a narrative approach (White and Epston, 1990), constructivism (Kelly, 1991) and social constructionism (Gergen, 1985; Burr, 2002).

The author will be disseminating the findings from this study to the Trust where the data were gathered. It is hoped that the information will be useful both in terms of providing a current picture and facilitating future development.

References

Acharyya, S. (2000). Promoting health of looked after children – Monitoring and documentation should be improved. British Medical Journal, 381.

Arcelus, J., Bellerby, T. and Vostanis, P. (1999). A mental-health service for young people in the care of the local authority. Clinical Child Psychology and Psychiatry, 4(2), 233-245.

Atkinson, L. and Zucker, K.J. (1997). Attachment and Psychopathology: Guildford Press.

Baldry, S. and Kemmis, J. (1998). What is it like to be looked after by a local authority? British Journal of Social Work, 28, 129-136.

Barker, C., Pistrang, N. and Elliott, R. (2002). Research Methods in Clinical Psychology: An Introduction for Students and Practitioners (2nd ed.). John Wiley and Sons.

Bebbington, A. and Miles, J. (1989). The background of children who enter local authorities care. British Journal of Social Work, 19, 349-368.

Berridge, D. and Brodie, I. (1998). Children's Homes Revisited. London: Jessica Kingsley.

Berridge, D., Beecham, J., Brodie, I., Cole, T., Daniels, H., Knapp, M. and Macneill, V. (2003). Services for troubled adolescents: exploring user variation. Child and Family Social Work, 8, 269-279.

Blower, A., Addo, A., Hodgson, J., Lamington, L. and Towlson, K. (2004). Mental health of 'looked after' children: a needs assessment. Clinical Child Psychology and Psychiatry, 9(1), 117-129.

Brannen, J. and O'Brien, M. (1996). Children in Families: Research and Policy. London: The Falmer Press.

Bowlby, J. (1971). Attachment and Loss (vol.1): Attachment. Harmondsworth; Penguin Books.

Bowlby, J. (1975). Attachment and Loss (vol.2): Separation: Anxiety and Anger. Harmondsworth; Penguin Books.

Bowlby, J. (1981). Attachment and Loss (vol.3) Loss: Sadness and Depression. Harmondsworth; Penguin Books.

Broad, B. (1999). Improving the health of children and young people leaving care. Adoption and Fostering, 23(1), 40-48.

Bundle, A. (2002). Health information and teenagers in residential care: A qualitative study to identify young people's views. Adoption and Fostering, 26(4), 19-25.

Burr, V. (1995). An Introduction to Social Constructionism. London: Routledge.

Burr, V. (2003). Social Constructionism (2nd ed.). London: Routledge.

Butler, I. and Williamson, H. (1994). Children speak: Children, Trauma and Social Work. Longman Information and Reference.

Butler, I. (1997). The health of looked after children. Adoption and Fostering, 21(2), 28-35.

Butler, J., and Vostanis, P. (1998) Characteristics of referrals to a mental health service for young people in care. Psychiatric Bulletin, 22, 85-87.

Cairns, K. (2002). Attachment, Trauma and Resilience. British Association for Adoption and Fostering.

Callaghan, J., Young, B., Richards, M., and Vostanis, P. (2003). Developing new mental health services for looked after children: A focus group study. Adoption and Fostering, 27(4), 51-63.

Callaghan, J., Young, B., Pace, F., and Vostanis, P. (2004). Evaluation of a new mental health service for looked after children. Clinical Child Psychology and Psychiatry, 9(1), 130-148.

Carr, A. (1999). The Handbook of Child and Adolescent Clinical Psychology: A Contextual Approach. Brunner-Routledge.

Cloke, C., and Davies, M. (1995). Participation and Empowerment in Child Protection. London: Pitman Publishing.

Coleman, J.C., and Hendry, L.B. (1999). The Nature of Adolescence (3rd ed.). London: Routledge.

Coleman, J., and Schofield, J. (2003). Key Data on Adolescence. Brighton: Trust for the Study of Adolescence.

Collin, F. (1997). The Problems of Philosophy: Social Reality. London: Routledge.

Cross, M. (1999). Lost for words. Child and Family Social Work, 4, 249-257.

Crouch, W., and Wright, J. (2004). Deliberate self-harm at an adolescent unit: A qualitative investigation. Clinical Child Psychology and Psychiatry, 9(2), 185-204.

Davis, J.M. (1998). Understanding the meanings of children: a reflexive process. Children and Society, 12, 325-335.

Davison, G. C., and Neale, J. M. (1998). Abnormal Psychology (7th ed.). USA: John Wiley and Sons.

Denzin, N. K. and Lincoln, Y. S. (1994). Handbook of Qualitative Research. Sage Publications.

Denzin, N. K. and Lincoln, Y. S. (1998). Collecting and Interpreting Qualitative Materials. Sage Publications.

Denzin, N. K. and Lincoln, Y. S. (2000). Handbook of Qualitative Research (2nd Ed.). Sage Publications.

Denzin, N. K. and Lincoln, Y. S. (2003). The Landscape of Qualitative Research: Theories and Issues. Sage Publications.

Delanty, G. (1997). Social Science: Beyond Constructivism and Realism. Buckingham: Open University Press.

Delfabbro, P.H., Barber, J.G., and Bentham, Y. (2002). Children's satisfaction with out-of-home care in South Australia. Journal of Adolescence, 25, 523-533.

Department of Health. (1999). Promoting Health for Looked After Children: A Guide to Healthcare, Planning, Assessment, and Monitoring: Consultation Document. London: Department of Health.

Department of Health. (2000). Promoting the Health of Looked After Children. A Guide to Healthcare, Planning, Assessment, and Monitoring: Consultation Document. London: Department of Health.

Department of Health. (2002a). Outcome Indicators for Looked After Children - year ending 30 September 2001. London: Department of Health.

Department of Health. (2002b). Promoting the Health of Looked After Children. London: Department of Health.

Department of Health. (2002c). Improvement, Expansion and Reform: The Next Three Years' Priorities and Planning Framework, 2003-2006. London: Department of Health.

Department of Health. (2002d). Shifting the Balance of Power: The Next Steps. London: Department of Health.

Department of Health. (2003). Children Looked After by Local Authorities: Year Ending 31 March 2002 England. London: Department of Health.

Department of Health. (2004). Getting The Right Start: National Service Framework for Children - Emerging Findings. Department of Health.

Department of Health. (2004). National Service Framework for Children, Young People and Maternity Services. Department of Health.

Dimigen, G., Del Priore, C., Butler, S., Evans, S., Ferguson, L., and Swan, M. (1999). Psychiatric disorder among children at time of entering local authority care: questionnaire survey. British Medical Journal, 319 (7211), 675-677.

Fransella, F., and Dalton, P. (1996). Personal construct therapy. In W. Dryden (Eds.) Handbook of Individual Therapy. London: Sage Publications.

Freeman, J., Epston, D., and Lobovits, D. (1997). Playful Approach to Serious Problems: Narrative Therapy with Children and their Families. New York: Norton.

Freud, S. (1991). The Essentials of Psycho-Analysis. Penguin Books.

Garrett, P.M. (2002). Yes minister: Reviewing the 'looking after children' experience and identifying the messages for social work research. British Journal of Social Work, 32, 831-846

Gergen, K.J. (1985). The social constructionist movement in modern psychology. American Psychologist, 40, 309-320.

Gergen, K.J. (2001). Social Construction in Context. London: Sage.

Gibson, R., and Possamai, A. (2002). What young people think about CAMHS. Clinical Psychology, 18, 20-24.

Gilligan, R. (2000). The importance of listening to the child in foster care. In G. Kelly, and R. Gilligan (Ed.), Issues in Foster Care: Policy, Practice and Research. London: Jessica Kingsley Publishers.

Glaser, B.G., and Strauss, A.L. (1967). The Discovery of Grounded Theory: Strategies for Qualitative Research. Chicago, Illinois: Aldine.

Harre, R., and Secord, P.F. (1972). The Explanation of Social Behaviour. Oxford: Blackwell.

Harre, R. (1992). Social Being: A Theory for Social Psychology, 2nd Ed. Oxford: Blackwell.

Hatfield, B., Harrington, R., and Mohamad, H. (1996). Staff looking after children in local authority residential units: the interface with child mental health professionals, Journal of Adolescence, 19, 127-139.

Heaven, P.C.L. (1994). Contemporary Adolescence: A Social Psychological Approach. The Macmillan Press LTD.

Heaven, P.C.L. (1996). Adolescent Health: The Role of Individual Differences. London: Routledge.

Heidegger, M. (1967). Being and Time. Oxford: Blackwell.

Henwood, K.L., and Pidgeon, N.F. (1995). Grounded theory and psychological research, The Psychologist, 8, 115-118.

Heptinstall, E. (2000). Gaining access to looked after children for research purposes: Lessons learned. British Journal of Social Work, (30), 867-872.

Hill, C.M., and Watkins, J. (2002). Statutory health assessments for looked after children: what do they achieve? Child: Care, Health and Development, 29(1), 3-13.

Howe, D. (1995). Attachment Theory for Social Work Practice. Macmillan Press Ltd.

Howe, D., Brandon, M., Hinings, D., and Schofield, G. (1999). Attachment Theory, Child Maltreatment and Family Support: A Practice and Assessment Model. Basingstoke: Macmillan Press LTD.

Howe, D. (2001). Age at placement, adoption experience and adult adopted people's contact with their adoptive and birth mothers: an attachment perspective. Attachment and Human Development, 3(2), 222-237.

Hunter, M. (2001). Psychotherapy with Young People in Care: Lost and Found. Brunner-Routledge.

Jackson, S., and Thomas, N. (2000). What Works in Creating Stability for Looked After Children? Barnardo's.

Kazdin, A.E. (2003). Research Design in Clinical Psychology (4th ed.). Allyn and Bacon.

Kelly, G.A. (1991). The Psychology of Personal Constructs, Vols. I and II. London: Routledge.

Kelly, C., Allan, S., Roscoe, P., and Herrick, E. (2003). The mental health needs of looked after children: An integrated multi-agency model of care. Clinical Child Psychology and Psychiatry, 8(3), 323-335.

King, E. (1996). The use of the self in qualitative research. In J.T.E. Richardson (Ed), Handbook of Qualitative Research Methods for Psychology and the Social Sciences (pp. 175-188). UK: The British Psychological Society.

Kosky, R. (1992). Adolescents' in custody: a disciplining or disabling experience. In R. Kosky, H. Eshkevari and G. Kneebone (Ed.), Breaking Out: Challenges in Adolescent Mental Health in Australia. Canberra: Australian Government Publishing Service.

Laws, S. (1998). Hear me!: Consulting with Young People on Mental Health Issues. The mental health foundation.

Leff, S. (2000). Promoting health of looked after children – These children need tailor made care. British Medical Journal, 381.

Lerner, R.M., and Steinberg, L. (2004). Handbook of adolescent psychology (2nd ed.). John Wiley and Sons.

Lindsey, C. (2000). Why focus on the mental health needs of looked after children? In J. Richardson and C. Joughin The Mental Health Needs of Looked After Children. The Royal College of Psychiatrists.

Lees, S. (2002). Gender, ethnicity and vulnerability in young women in local authority care. British Journal of Social Work, 32, 907-922.

Macran, S., Stiles, W.B., and Smith, J.A. (1999). How does personal therapy affect therapists' practice? Journal of Counselling Psychology, 46, (4), 419-431.

Mahoney, M.J. (1988). Psychotherapy and human change processes. In M. J. Mahoney, A. Freeman (Eds.) Cognition and Psychotherapy. New York. Plenum.

Marshall, C., and Rossman, G. (1989). Designing Qualitative Research. London: Sage.

Mather, M., Humphrey, J., and Robson, J. (1997). The statutory medical and health needs of looked after children. Adoption and Fostering, 21(2), 36-39.

McCann, J.B., James, A., Wilson, S., Dunn, G. (1996). Prevalence of psychiatric disorders in young people in the care system. British Medical Journal, (313), 1529-1530.

McCarthy, G., Janeway, J., and Geddes A. (2003). The impact of emotional and behavioural problems on the lives of children growing up in the care system. Adoption and Fostering, 27(3), 14-19.

Mental Health Foundation (1999). Bright Futures: Promoting Children and Young People's Mental Health. London: Mental Health Foundation.

Mental Health Foundation (2002). Bright Futures: Working with Vulnerable Young People. London: Mental Health Foundation.

Meltzer, H., Gatward, R., Goodman, R., and Ford, T. (2000). The Mental Health of Children and Adolescents in Great Britain. Office for National Statistics.

Miller, P.H. (1993). Theories of Developmental Psychology (3rd ed.). New York: W.H. Freeman and Company.

Millham, S., Bullock, R., Hosie, K., and Haak, M. (1986). Lost in Care. UK: Gower.

Mount, J., Lister, A., and Bennun, I. (2004). Identifying the mental health needs of looked after young people, Clinical Child Psychology and Psychiatry, 9(3), 363-382.

Munro, E. (2001). Empowering looked-after children. Child and Family Social Work, 6, 129-137.

Nicholas, B., Roberts, S., and Wurr, C. (2003). Looked after children in residential homes. Child and Adolescent Mental Health, 8(2), 78-83.

O'Toole, M.S., Ohlsen, R.I., Taylor, T.M., Walters, J., and Pilowsky, L.S. (2004). Treating first episode psychosis – the service users' perspective: A focus group evaluation. Journal of Psychiatric and Mental Health Nursing, 11, 319-326.

Parker, I. (1992). Discourse Dynamics: Critical Analysis for Social and Individual Psychology. London: Routledge.

Parker, I. (1994). Reflexive research and the grounding of analysis: Social psychology and the psy-complex. Journal of Community and Applied Social Psychology, 4, 239-252.

Parker, I. (1998). Social Constructionism, Discourse and Realism. London: Sage Publications.

Phillips, J. (1997). Meeting the psychiatric needs of children in foster care: social worker views. Psychiatric Bulletin, 21, 609-611.

Place, M., Wilson, J., Martin, E., Hulsmeier, J. (2000). The frequency of emotional and behavioural disturbance in an EBD school. Child Psychology and Psychiatry Review, 5, 76-80.

Polnay, L., Glaser, A., and Rao, V. (1996). Better health for children in residential care. Archives of Disease in Childhood, 75, 263-265.

Polnay, L., and Ward, H. (2000). Promoting the health of looked after children. British Medical Journal, 320, 661-662.

Potter, J., and Wetherall, M. (1987). Discourse and Social Psychology: Beyond attitudes and behaviour. London: Sage Publications.

Prout, A., (2000). The Body, Childhood and Society. Basingstoke: Macmillan Press LTD.

Punch, K. (1998). Introduction to Social Research: Quantitative and Qualitative Approaches. London: Sage.

Richardson, J.T.E. (1996). Handbook of Qualitative Research Methods for Psychology and the Social Sciences. UK: The British Psychological Society.

Richardson, J., and Joughin, C. (2000). The Mental Health Needs of Looked After Children, The Royal College of Psychiatrists.

Ridge, T., and Millar, J. (2000) Excluding children: Autonomy, friendship and the experience of the care system. Social Policy and Administration, 34(2), 160-175.

Rinsley, D. (1994). Treatment of the Severely Disturbed Adolescent. Jason Aronson INC.

Rivron, M. (2001). A health promotion project for young people who are looked after. Adoption and Fostering, 25(2), 70-71.

Rodrigues, V.C. (2004). Health of children looked after by the local authorities. Public Health, 118, 370-376.

Roose, G.A., and John, A.M. (2003). A focus group investigation into young children's understanding of mental health and their views on appropriate services for their age group. Child: Care, Health and Development, 29, 6, 545-550.

Rutter, M. (1983). Stress, coping and development: some issues and some questions. In N. Garmezy and M. Rutter (Ed.), Stress, Coping and Development. New York: McGraw-Hill.

Rutter, M. (1995). Psychosocial Disturbances in Young People: Challenges for Prevention. Cambridge: Cambridge University Press.

Sargent, K., and O'Brien, K. (2004). The emotional and behavioural difficulties of looked after children: foster carers perspectives and an indirect model of placement support. Adoption and Fostering, 28(2), 31-37.

Saunders, L., and Broad, B. (1997). The Health Needs of Young People Leaving Care. Leicester, UK: De Montfort University.

Shotter, J. (1993). Cultural Politics of Everyday Life. Buckingham: Open University Press.

Smith, C., and Nyland, D. (1997). Narrative Therapies with Children and Adolescents. New York: The Guildford Press.

Smith, J.A. (1995). Semi-structured interviewing and qualitative data analysis. In J.A. Smith, R. Harre, L. Van Langenhove (Eds.). Rethinking Methods in Psychology. London: Sage.

Smith, J.A. (1996). Beyond the divide between cognition and discourse: Using interpretative phenomenological analysis in health psychology. Psychology and Health, 11, 261-271.

Smith, J.A. (2003). Qualitative Psychology: A Practical Guide to Research Methods. Sage Publications LTD.

Smith, J.A. (2004). Reflecting on the development of interpretative phenomenological analysis and its contribution to qualitative research in psychology. Qualitative Research in Psychology, 1, 39-54.

Spencer, L., Ritchie, J., Lewis, J., Dillon, L. (2003). Quality in Qualitative Evaluation: A Framework for Assessing Research Evidence. National Centre for Social Research.

Stallard, P., Thomason, J., Churchyard, S. (2003). The mental health of young people attending a youth offending team: a descriptive study. Journal of Adolescence, (26), 33-43.

Steinberg, D. (1987). Basic Adolescent Psychiatry. Oxford: Blackwell Scientific Publications.

Street, E., and Davies, M. (2002). Constructing mental health services for looked after children. Adoption and Fostering, 26(4), 65-75.

Talbot, R. (2002). Young Minds: Looking After the Mental Health of Looked After Children. Pavilion Publishing.

Target, M., and Fonagy, P. (1996). The psychological treatment of child and adolescent mental health disorders. In A. Roth and P. Fonagay (Ed.) What Works for Whom? A Review of the Effectiveness of the Psychotherapies. New York: Guildford.

Thomas, N., and O'Kane, C. (1998a). When children's wishes and feelings clash with their 'best interests'. The International Journal of Children's Rights, 6, 137-154.

Thomas, N., and O'Kane, C. (1998b). The ethics of participatory research with children. Children and Society, 12, 336-348.

Thomas, N., and O'Kane, C. (1999). Children's participation in reviews and planning meetings when they are looked after in middle childhood. Child and Family Social Work, 4, 221-230.

Triseliotis, J., Borland, M., Hill, M., and Lambert, L. (1995). Teenagers and the Social Work Services. London: HMSO.

Utting, W., Baines, C., Stuart, M., Rowlands, J., and Vialva, R. (1997). People Like Us: The Report of the Review of the Safeguards for Children Living Away from Home. London: The stationery Office.

Wallace, S.A., Crown, J.M., Cox, A.D. and Berger, M., (1997). Epidemiologically Based Needs Assessment: Child and Adolescent Mental Health. Wessex Institute of Public Health.

Ward, H., Jones, H., Lynch, M., and Skuse, T. (2002). Issues concerning the health of looked after children. Adoption and Fostering, 26(4), 8-18.

White. M., and Epston, D. (1990). Narrative Means to Therapeutic Ends. New York: W.W. Norton and Company.

Wiener, A., Withers, K., Patrick, M., and Bradley, E. (1999). What changes are of value in severely disturbed children? Clinical Child Psychology and Psychiatry, 4(2), 201-203.

Williams, E. (2004). Who really needs a 'theory' of mind? An interpretative phenomenological analysis of the autobiographical writings of ten high-functioning individuals with an autism spectrum disorder. Theory and Psychology, 14(5), 704-724.

Willig, C. (2001). Introducing Qualitative Research in psychology: Adventures in Theory and Method. Buckingham: Open University Press.

Yardley, L. (2000). Dilemmas in qualitative health research. Psychology and Health, 15: 215-28.

Yin, R. (1989). Case Study Research: Design and Methods (2nd ed.). Beverly Hills, CA: Sage.

Zannah, C. (1996). Beyond insecurity: A reconceptualization of attachment disorders of infancy. Journal of Consulting and Clinical Psychology, 64, 42-52.

Appendix I: Participant Information Sheet

Your opinion is needed!

My name is Kelly and I am a trainee clinical psychologist interested in finding out what young people think about the services at the LAC team. It is important that young people's opinions are heard so that services can be made better.

What will you have to do?

If you would like to be part of this project we will need to meet up for an interview. This will be like a chat where I will ask you some questions and you will be able to tell me what you think. All interviews will last up to 1 hour and will take place at Edgware Community Hospital. I will audiotape the interview so that I can listen carefully without having to write anything down. I will be the only person to listen to the tape. All interviews will be confidential. However you can bring your carer or social worker along with you if you would like to.

What will we talk about?

The kind of things we talk about will be:

- The things you would like LAC team to help you with
- The help you have already received from the LAC team
- What you think about the services

You will be free to stop the interview at any time.

What will happen after the interview?

After the interview I will offer you another appointment where we can meet to check that I understood exactly what you said. I will then put all the information from all of the young people together to write a report. The report will describe what 'the young people' think. Nobody will be identified in the report so when people read the report they will not know who was interviewed or who said what.

What will happen now?

If you would like to be part of this project you will need to let a member of the LAC team know. They will tell me and I can get in contact with you to arrange a time to meet.

Thank you for taking the time to read this leaflet



Appendix II: Carer/Social Worker Information Sheet

Carer's information sheet

My name is Kelly Mann and I am a trainee clinical psychologist, from the University of Hertfordshire. I am interested in finding out what young people think about services provided by the LAC team and will be carrying out a study in order to uncover this. It is important that young people's opinions are heard so that services can be improved to better meet their needs.

How will the study be carried out?

I will be aiming to recruit young people to participate in an interview. All interviews will be confidential, will last up to 1 hour and will take place at Edgware Community Hospital. All interviews will be audiotape recorded to allow me to listen carefully without having to take notes and to ensure I do not forget anything. I will be the only person to listen to the tape. All young people will be given opportunity for debriefing at the end of the interview.

After the interview I will transcribe the data. I will then offer the young person another appointment to check that I have understood their opinions. I will then put the information I have collected from all of the young people together to make a report. The report will be written expressing the opinions of the young people as a group, hence nobody will be identifiable.

What will the interview content be?

The kind of things we talk about will be:

- The things young people would like LAC services to help them with
- The help they have already received from LAC services
- What they think about the services

All participants will be free to stop the interview at any time.

Can you be present?

All young people will be able to bring their carer or social worker along if they would like to. However it will be important that carers/social workers do not contribute to the interview material as the aim is to find out about young people's opinions.

What will happen now?

If the young person that you care for would like to be part of this project I will arrange to meet with them to ensure that they are fully aware of the study and its procedures. I will then send you an information sheet and consent form before the interview can go ahead. You will be able to discuss together whether you would like to be present during the interview.

Thank you for taking the time to read this leaflet

Appendix III: Ethics Approval Letter

Barnet, Enfield & Haringey Local Research Ethics Committee

Holbrook House
Cockfosters Road
Barnet
EN4 0DR

Telephone: 020 8272 5699
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Email: Alison.Okane@enfield.nhs.uk

17 January 2005

Miss Kelly Mann
Trainee Clinical Psychologist
University of Hertfordshire
89 Third Avenue
Dagenham
Essex
RM10 9BE

Dear Miss Mann

Full title of study: *How do Looked After Adolescents Experience Mental Health Services?*

REC reference number: 04/Q0509/96

Protocol number:

Thank you for your letter of 29th December 2004 responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

The favourable opinion applies to the research sites listed on the attached form.

Conditions of approval

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document Type:	Version:	Dated:	Date Received:
Application	1	12/11/2004	12/11/2004

Investigator CV	1	12/11/2004	12/11/2004
Protocol	1	12/11/2004	12/11/2004
Interview Schedules/Topic Guides	1	12/11/2004	12/11/2004
Participant Information Sheet	1	12/11/2004	12/11/2004
Participant Information Sheet	2	29/12/2004	17/01/2005
Participant Consent Form	2	29/12/2005	17/01/2005
Participant Consent Form	1	12/11/2004	12/11/2004
Information sheet for carers and/or social workers	1	12/11/2004	12/11/2004
Consent form for carers and/or social workers	1	12/11/2004	12/11/2004
Other			12/11/2004
Carers Information Sheet	1	12/11/2004	12/11/2004
Information Sheet for Carers and/or Social Workers	2	29/12/2005	17/01/2005
Consent form for carers and/or social workers	2	29/12/2004	17/01/2005

Management approval

The study should not commence at any NHS site until the local Principal Investigator has obtained final management approval from the R&D Department for the relevant NHS care organisation.

Notification of other bodies

The Committee Administrator will notify the research sponsor that the study has a favourable ethical opinion.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

With the Committee's best wishes for the success of this project,

Yours sincerely,

Chair

Enclosures

Standard approval conditions & SF1 form

Appendix IV: Research and Development Approval Letter

**R & D DEPARTMENT
ST. ANN'S HOSPITAL
ST. ANN'S ROAD
LONDON N15 3TH**

E-mail: research.department@beh-mht.nhs.uk
Direct Line: 020 8442 6503

4 May 2005

Ms Kelly Mann
89 Third Avenue
Dagenham
Essex
RM10 9BE

Dear Ms Mann,

Title: Looked after children's experience of mental health services
REC reference number: 04/Q0509/96

I am pleased to note that you have received the favourable opinion of the Research Ethics Committee for your study.

All projects must be registered with the Research Department if they use patients, staff, records, facilities or other resources of the Barnet, Enfield and Haringey NHS Mental Health Trust.

The R&D Department on behalf of Barnet, Enfield and Haringey NHS Mental Health Trust is therefore able to grant approval for your research to begin, based on your research application and proposal reviewed by the ethics committee. Please note this is subject to any conditions set out in their letter dated 17 January 2005. Should you fail to adhere to these conditions or deviate from the protocol reviewed by the ethics committee, then this approval would become void. The approval is also subject to your consent for information to be extracted from your project registration form for inclusion in NHS project registration/management databases and, where appropriate, the National Research Register.

You are obliged to adhere to the research governance framework as set out by the Department of Health Research Governance Framework for Health and Social Care*.

It is required that all researchers submit a copy of their report on completion and details on the progress of the study will be required periodically for longer projects. Copies of all publications emanating from the study should also be submitted to the R&D Department.

Furthermore, all publications must contain the following acknowledgement.

"This work was undertaken with the support of Barnet, Enfield and Haringey NHS Mental Health Trust, who received "funding" from the NHS Executive; the views expressed in this publication are those of the authors and not necessarily those of the NHS Executive".

"a proportion of funding" where the research is also supported by an external funding body; "funding" where no external funding has been obtained.

Best wishes and every success with the study.

Yours sincerely,



Gerard Leavey
Gerard Leavey
Assistant Director R & D

*Further information on research governance can be obtained on the DH web pages at <http://www.doh.gov.uk/research/>

Appendix V: University Approval Letter



University of
Hertfordshire

Hatfield Herts
AL10 9AB
UK

Switchboard 01707 284000
Minicom 01707 284000
Fax 01707 284115
www.herts.ac.uk

FIRST CLASS

Miss K Mann
89 Third Avenue
Dagenham
Essex
RM10 9BR

18 May 2005

Dear Kelly,

Secondary Registration as a DClinPsy Candidate

I am please to inform you that the University's Research Degrees Board has approved your secondary registration for a programme of supervised research leading to the submission for the research degree of Doctor of Clinical Psychology (DClinPsy) (regulations 7.2.2 and 9.13.3 refer).

<i>First Name</i>	<i>Kelly</i>
<i>Surname</i>	<i>Mann</i>
<i>Mode of Study</i>	<i>Full-Time</i>
<i>Provisional title of Major Research Project</i>	<i>Looked After Adolescents Experience of Mental Health Services</i>
<i>Principal Supervisor</i>	<i>Dr P Nel Psychology Faculty of Health & Human Sciences University of Hertfordshire</i>
<i>Second supervisor</i>	<i>Dr C Webber LAC Team Barnet CAMHS Edgware Community Hospital</i>



INVESTOR IN PEOPLE



A Charity. Exempt from Registration under the Second Schedule to the Charities Act 1993



Date of registration and duration of programme –

Your registration took effect from 1 April 2003.

The normal registration period of 36 months expires on 1 April 2006.

You should have received a copy of the regulations for the award of DClinPsy, included in the handbook. If not, please contact your administrator.

The regulations include a section on ethical considerations (see regulation 7.3). Failure to seek ethical approval for all proposed protocols may lead to the degree not being awarded or to the degree being withdrawn. You are, therefore, advised to discuss ethical issues with your supervisors.

The portfolio including thesis shall consist of two volumes (regulation 7.4 and 12.2 refer). Volume 2 of your portfolio including thesis, due to the confidential nature of the clinical material it contains, will be kept secure within the Clinical Course offices.

Throughout the duration of your registration period, you or your sponsor must pay the appropriate annual registration fee to the University. The University reserves the right to withhold the conferment of an award if fees are outstanding.

A copy of your approved application for secondary registration is enclosed for your information.

Please do not hesitate to contact me if you have any queries.

Yours sincerely,

A handwritten signature in black ink, appearing to read 'Kathy Chambers'.

Kathy Chambers (Miss)
Research Degrees Administrator
Tel no: 01707 286401 (Internal ext. 3401)
Fax no: 01707 284900
Email: K.Chambers@herts.ac.uk

Enc: copy of application for secondary registration

Cc: Principal Supervisor - Dr P Nel (with a copy of application for secondary registration)

Faculty Research Administrator – Mrs J Kilvington

Appendix VI: Participant Information Sheet/Consent Form

Kelly Mann
LAC Team, Barnet CAMHS
Edgware Community Hospital
Burnt Oak Broadway
Edgware,
Middlesex HA8 0AD

PARTICIPANT INFORMATION SHEET

LOOKED AFTER ADOLESCENTS EXPERIENCE OF MENTAL HEALTH SERVICES

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask if there is anything that is not clear or if you would like further information. Take time to decide whether or not you wish to take part.

Thank you for reading this.

What is the purpose of the study?

Many of the studies that have been carried out looking at looked after children services do not gain an understanding of service users experiences. It is important to listen to the service users views in order to develop services to meet the needs of those that use them. There are also few studies that look specifically at the views of adolescents. Therefore the purpose of the study is to gain an understanding of how looked after adolescents experience the mental health services that are available to them.

Why have I been chosen?

You have been chosen to take part in this study because you are aged between 13-18 and have been in touch with the Looked After Children Team for at least one year. It is thought that you will have experience of the services and will be able to give a reliable account of your experiences. There will be a total of 6 young people taking part in this study.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not affect the standard of care you receive.

What will I have to do if I take part?

If you decide to take part in this study we will need to arrange a time to meet for an interview. This will take up to 1 hour and you will be able to bring your carer or social worker along with you if you would like to. I will be asking you some questions and you will be able to tell me about your experiences. At the end of the interview we can arrange a second meeting if you would like to where we can discuss my understanding of your experiences to check that you are happy that I understood you correctly.



What are the possible disadvantages and risks of taking part?

Whilst it is unlikely, it is possible that young people may experience distress during the interviews. To help try and avoid any distress we will do several things. These will include allowing time at the end of the interview for debriefing, making sure you are aware that you do not have to answer any questions that you do not want to and ensuring you are aware that you can stop the interview at any time.

What are the possible benefits of taking part?

Research may have implications for informing and improving future service provision. These may be benefits that you will experience.

What if something goes wrong?

If you are harmed by taking part in this research project, there are no special compensation arrangements. If you are harmed due to someone's negligence, then you may have grounds for a legal action but you may have to pay for it. Regardless of this, if you wish to complain, or have any concerns about any aspect of the way you have been approached or treated during the course of this study, the normal National Health Service complaints mechanisms should be available to you.

Will my taking part in this study be kept confidential?

If you consent to take part in the study the interview that is conducted will remain confidential. However if you were to disclose information that suggested either you or somebody else was at risk we would need to discuss talking to relevant professionals. When the data is collected your name and address will be removed so that you cannot be recognised from it. You will be assigned a code number that you will be referred to and you will be given a pseudo name in the report that will be produced containing the results.

What will happen to the results of the research study?

You will have the opportunity to request a summary of the results from the study. The results from this study will also be presented to the Barnet Looked After Children Team. In addition the results may be published in a relevant journal.

Who is organising and funding the research?

This research study is funded by the University of Hertfordshire and therefore there will be no expected cost for you or your service. You will not receive reimbursement for your participation in this study. There is no financial benefit to the investigator for your participation. Neither the principal investigator nor the research staff involved receive a direct financial incentive from your participation.

Who has reviewed the study?

Barnet, Enfield & Haringey Local Research Ethics Committee have reviewed and approved this study.

Contact for Further Information

If you would like to obtain further information or discuss this information sheet further you can contact Kelly Mann, Chief Investigator, via University of Hertfordshire on 01707 286322 Monday - Friday, 09.00 - 17:00. You may contact Kelly Mann if you have questions or concerns prior to enrolling in the study or at any time during or following completion of the study. The discussion will remain confidential.

Thank you for taking part in this study

All participants will be given a copy of the information sheet and a signed consent form to keep.



Participant identification Number:

CONSENT FORM

Title of Project: Looked after adolescents experience of mental health services

Name of Researcher: Kelly Mann

Please initial box

1. I confirm that I have read and understand the information sheet dated
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 and without the standard of care I receive being affected.

3. I agree to take part in the above study.

Name of Participant

Date

Signature

Researcher

Date

Signature



Appendix VII: Carer/Social Worker Information Sheet/Consent Form

Kelly Mann
LAC Team, Barnet CAMHS
Edgware Community Hospital
Burnt Oak Broadway
Edgware,
Middlesex HA8 0AD

INFORMATION SHEET

FOR CARERS AND/OR SOCIAL WORKERS

LOOKED AFTER ADOLESCENTS EXPERIENCE OF MENTAL HEALTH SERVICES

A young person in your care has been invited to take part in a research study. Before you decide whether or not you would like them to participate it is important that you understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask if there is anything that is not clear or if you would like further information. Take time to decide whether or not you wish to consent to the young person taking part.

Thank you for reading this.

What is the purpose of the study?

There has been much research conducted focusing on looked after children and mental health. However many of the studies previously conducted fail to gain an understanding of users experiences. It is important to listen to user views in order to develop services to meet the needs of those that require them. There is also a limited amount of studies that focus specifically on the views of adolescents. Therefore the purpose of the study is to gain an understanding of how looked after adolescents experience the mental health services that are available to them.

Why has this young person been chosen?

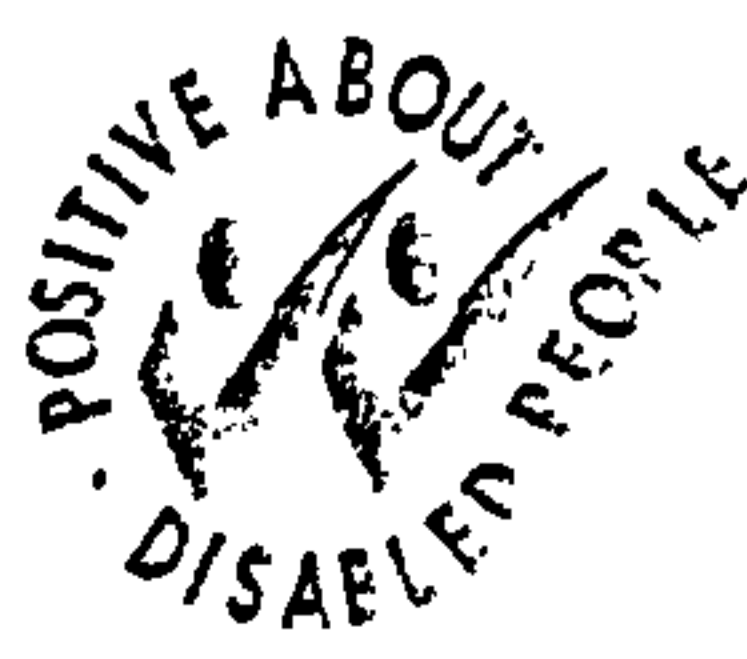
The young person has been chosen to take part in this study because they are aged between 13-18 and have been in receipt of services from the Looked After Children Team for a minimum of one year. It is therefore thought that they will have experience of the services and will be able to give a reliable account of their experiences. There will be a total of 6 participants taking part in this study.

Do they have to take part?

It is up to the young person to decide whether or not to take part. If they do decide to take part they will be given an information sheet to keep and they will be asked to sign a consent form. If they decide to take part they are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not affect the standard of care they receive.

Do I have to consent to the young person taking part?

As well as signing a consent form themselves, it will be required that the young person's carer and/or social worker will also need to consent to them taking part. A young person cannot take part in the study without the written consent of their carer and/or social worker.



What will the young person have to do if they take part?

If the young person decides to take part in this study we will need to arrange a time to meet for an interview. This will take up to 1 hour and they will be able to bring their carer or social worker along with them if they would like to. I will be asking some questions and they will be able to tell me about their experiences. At the end of the interview we can arrange a second meeting if they would like to where we can discuss my understanding of their experiences to check that they are happy that I understood them correctly.

What are the possible disadvantages and risks of taking part?

Whilst it is unlikely, it is possible that participants may experience distress during interviews. Several protective factors will therefore be implemented. These will include allowing time at the end of the interview for debriefing, making sure that they are aware that they do not have to answer any questions that they do not want to and ensuring they are aware that they can stop the interview at any time.

What are the possible benefits of taking part?

Research may have implications for informing and improving future service provision. These may be benefits that the young person will experience.

Will taking part in this study be kept confidential?

The interview that is conducted will remain confidential. However if a young person were to disclose information that suggested either they or somebody else was at risk we would need to discuss talking to relevant professionals. When the data is collected all names and addresses will be removed so that individuals cannot be recognised. All participants will be assigned a code number that will be referred to and participants will be given a pseudo name in the report that will be produced containing the results.

What will happen to the results of the research study?

All young people will be offered the opportunity to view a summary of the results from the study. The results from this study will also be presented to the Barnet Looked After Children Team. In addition the results may be published in a relevant journal.

Who is organising and funding the research?

This research study is funded by the University of Hertfordshire and therefore there will be no expected cost for you or your service. Participants will not receive reimbursement for their participation in this study. There is no financial benefit to the investigator for young people's participation. Neither the principal investigator nor the research staff involved receive a direct financial incentive from a young person's participation.

Who has reviewed the study?

Barnet, Enfield & Haringey Local Research Ethics Committee have reviewed and approved this study.

Contact for Further Information

If you would like to obtain further information or discuss this information sheet further you can contact Kelly Mann, Chief Investigator, via University of Hertfordshire on 01707 286322 Monday - Friday, 09.00 - 17:00. You may contact Kelly Mann if you have questions or concerns prior to enrolling in the study or at any time during or following completion of the study. The discussion will remain confidential.

All carers and/or social workers will be given a copy of the information sheet and a signed consent form to keep.

Participant identification Number:

CONSENT FORM

Title of Project: Looked after adolescents experience of mental health services

Name of Researcher: Kelly Mann

Please initial box

1. I confirm that I have read and understand the information sheet dated
for the above study and have had the opportunity to ask questions.

2. I understand that _____'s participation is voluntary and that he/she is free to
withdraw at any time, without giving any reason and without the standard of care he/she
receives being affected.

3. I consent to _____ taking part in the above study.

Name of carer

Date

Signature

Name of social worker

Date

Signature

Researcher

Date

Signature



Appendix VIII: Interview Schedule

Interview Schedule

1. Tell me a little bit about yourself
 - a. Age
 - b. Educational history
 - c. Living arrangements
 - d. Family/friends

2. Can you tell me how you came to be seen by the LAC team? *Q 2/13*
 - a. How old were you
 - b. Whose idea was it for you to come
 - c. How long have you been coming here for
 - d. What was it like coming here

3. Can you tell me about the difficulties you experience? *Q 2/13*
 - a. What is it like to have those difficulties
 - b. What effect do they have on your life

4. What would you like the LAC team to help you with? *Q 2/13*

5. Who have you seen since you first came to the LAC team? *Q 2/13*
 - a. What were they like
 - b. What was it like to talk to them about your difficulties

6. What help have you received since you first came to the LAC team? *Q 2/13*
 - a. What was it like
 - b. For how long did you receive this help
 - c. Why did the help come to an end

7. Have you asked for any help from the LAC team and not received it? *Q 2/13*
 - a. What was that like

8. Have you had to wait for services? *Q 2/13*
 - a. What was your experience of waiting

9. What do you think about the LAC team? *Q 2/13*
 - a. What has been helpful/unhelpful?
 - b. What would you like more/less of?

Appendix IX: Transcript

239. they were like don't tell her you don't like it and I'm
240. like why but in the end I told her, well she knew
241. anyway
- KELLY: What's it like living with a small child?
242. MICHELLE: Not too good, it's different with a
243. small child but he acts like he's 2
244. KELLY: So have you got any brothers, I know
245. you've got your sister that you lived with,
246. MICHELLE: I've got sisters but they're older than
247. me, they're in Uganda
248. KELLY: So you're the youngest
249. MICHELLE: There's just one younger than me
250. KELLY: Just one
251. MICHELLE: Yeah, younger than me
252. KELLY: You told me about the time when you saw
253. the psychiatrist and you said that before you came
254. here people, or your social worker and the doctor
255. thought you might have been depressed
256. MICHELLE: Yeah
257. KELLY: Do you think you were depressed?
258. MICHELLE: Yeah
259. KELLY: Did you at the time or is it just now?
260. MICHELLE: Umm at first I didn't think so but then I
261. was like I am actually
262. KELLY: Do you think you are still depressed?
263. MICHELLE: Not really, most times not really but
264. sometimes
265. KELLY: What's that like when you are depressed?
266. MICHELLE: I just can't be bothered, I'm lazy and I
267. just feel like, I don't I just feel empty, and
268.

Handwritten notes:
New York
...
...
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...
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269. sometimes like before I just used to feel like really,
 270. really lazy and I didn't feel like saying anything to
 271. anyone and I pierced my nose to take the pain
 272. away but it didn't work, umm then I like stopped
 273. eating and I was all skinny and that and I didn't
 274. like myself I was too small and then like I was
 275. eating junk food and I was too big and like most
 276. times it's about eating, and I get like sometimes I
 277. eat sometimes I don't eat
 278. KELLY: Is that still something that can be tough
 279. for you sometimes
 280. MICHELLE: Cos, I feel like I don't know what to
 281. eat and I feel like I have to concentrate on a
 282. certain thing and sometimes I eat certain foods
 283. just to make myself feel better
 284. KELLY: Is there anybody that can help you with
 285. that?
 286. MICHELLE: Tracy sometimes, before she helped
 287. me when I was not eating because the carers that
 288. I was with then complained about me not eating
 289. cos I didn't eat breakfast and they didn't know if I
 290. was eating lunch and I didn't eat dinner so they
 291. complained to Tracy cos they were worried. I
 292. think she called up school, I'm not sure if she
 293. called up school but someone did and they said
 294. that they had to monitor me eating and I was like
 295. uh, and they never see me going in the dining
 296. room and then she helped me she like tried some
 297. new foods and from then I started eating. I didn't
 298. like anything apart from junk food and then I put

she was in the
 kitchen

she was in the
 kitchen

she was in the
 kitchen

she was in the
 kitchen

she was in the
 kitchen

she was in the
 kitchen

she was in the
 kitchen

299. on loads of weight and I hated myself and then I
 300. went down again
 301. KELLY: It sounds tough. How about the type of
 302. food you used to eat with your family when you
 303. lived in Uganda. Do you eat that type of food with
 304. Valdene?
 305. MICHELLE: Yeah but most times I don't feel like
 306. tasting things
 307. KELLY: Are you in contact with anybody else in
 308. your family?
 309. MICHELLE: Yeah I call them and they call me
 310. KELLY: You said you've seen Tracy when things
 311. are difficult, have you asked for any other help
 312. from CAMHS?
 313. MICHELLE: Umm no
 314. KELLY: Do you think that seeing Tracy once a
 315. week is enough?
 316. MICHELLE: Umm in a way yeah but sometimes I
 317. don't know like what to talk to her about, I'm not
 318. sure how to bring, even though like I'm used to
 319. her, I'm still not sure how to bring something up
 320. KELLY: Is it hard to talk to people about things
 321. sometimes
 322. MICHELLE: Yeah, I find it hard to like trust people
 323. KELLY: Is there ever times when you would like to
 324. see her more than once a week or less than once
 325. a week?
 326. MICHELLE: Yeah
 327. KELLY: What do you think would be better more
 328. or less?

Don't know

*Yeah I call them
and they call me*

*not sure how to
bring it up
even though I
know her*

Yeah

Yeah

Yeah

Yeah

329. MICHELLE: In a way more, sometimes, I don't
 330. really feel like seeing her less, not really
 331. KELLY: Apart from Tracy have you got anybody
 332. else that you can talk to, that you can trust to talk
 333. to
 334. MICHELLE: I've got a youth worker, I talk to her
 335. just like about everything, like normal stuff, not
 336. really anything, cos sometimes some stuff I tell
 337. her she tells my carer, it's like I don't understand
 338. KELLY: So how do you and Tracy get it right, so
 339. that she can help you with the things are tough at
 340. home but she doesn't break your trust by telling
 341. Valdene things that you don't want her to
 342. MICHELLE: She doesn't exactly like tell the whole
 343. story she just like gives her little bits of what's
 344. happening
 345. KELLY: So do you ever feel like she kind of
 346. breaks your trust
 347. MICHELLE: No
 348. KELLY: So she's quite good at keeping your trust
 349. but helping you at home as well
 350. MICHELLE: Yeah
 351. KELLY: It sounds like that's important to you to tell
 352. people things that are personal but they don't tell
 353. people that you don't want to know
 354. MICHELLE: Yeah
 355. KELLY: So how do you meet up with the youth
 356. worker is that a youth club that you're joined to or
 357. MICHELLE: Umm I think it is part of Barnet as
 358. well, like sometimes she picks me up and like

329-330
 yes
 331-332
 yes

333-334
 yes
 335-336
 yes
 337-338
 yes

339-340
 yes
 341-342
 yes
 343-344
 yes

345-346
 yes
 347-348
 yes
 349-350
 yes

351-352
 yes
 353-354
 yes
 355-356
 yes

357-358
 yes

359. takes me out or like after school, I think I've got
 360. another one because that time it was like a 3
 361. month period where I hated the whole social
 362. services they were getting on my nerves and they
 363. thought I was angry and all the time yeah I was
 364. angry but all the time they were like and I was
 365. getting more and more angry and the social
 366. worker she was there for like god knows how long,
 367. like 6 months, she didn't do anything. I had a care
 368. order and what they told her to do she did like 2%
 369. and the rest of it she didn't do and for like 6
 370. months they haven't done anything, since January
 371. they haven't done anything at all and Tracy talked
 372. to her, I didn't care she didn't say anything and
 373. they haven't done anything so like, and I didn't talk
 374. to them so they got me a youth worker but then
 375. she left 2 weeks after and I was like what's the
 376. point then of getting me a youth worker when
 377. she's leaving in 2 weeks then they got her again
 378. even though she's not working for them she does
 379. like separate times and she comes and um, she
 380. see me yesterday she took me to the cinema, I
 381. don't really talk to her
 382. KELLY: You's go off places and do things. How
 383. long have you been seeing her for?
 384. MICHELLE: Umm I've seen her before in my old
 385. placement. She was okay there. She changed
 386. KELLY: What changed about her?
 387. MICHELLE: I dunno, then she was, she was more
 388. like a youth worker she would like talk to you and

*Michelle
 -53
 1988
 1990
 1992
 1994
 1996
 1998
 2000
 2002
 2004
 2006
 2008
 2010
 2012
 2014
 2016
 2018
 2020*

*Michelle
 -53
 1988
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 1994
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 1998
 2000
 2002
 2004
 2006
 2008
 2010
 2012
 2014
 2016
 2018
 2020*

389. try her best to help you, but now she talks to you,
 390. but not about things that really matter and people
 391. think oh my god you like Claudia so much but now
 392. it's like oh okay Claudia's coming hurray, it's not
 393. like the excitement that I used to have
 394. KELLY: Why do you think you're not so excited
 395. about seeing her anymore?
 396. MICHELLE: Because all she does is like take me
 397. out, she does take me to nice places, but it really
 398. doesn't matter it's like that's her job anyway
 399. KELLY: What would you like her to do if you had a
 400. magic wand and could make, she could be
 401. whoever you wanted her to be
 402. MICHELLE: A bit more caring like, before she
 403. used to be actually
 404. KELLY: Who do you feel like is caring to you
 405. MICHELLE: Tracy
 406. KELLY: Anybody else
 407. MICHELLE: Some of my friends
 408. KELLY: It sounds like that's important to you to
 409. have people that you trust and you believe care
 410. for you
 411. MICHELLE: Yeah
 412. KELLY: So when your social worker thought it
 413. would be good for you to come to CAMHS did you
 414. have to wait for a long time to come here
 415. MICHELLE: Umm I think I had my review meeting
 416. then they got me to think about it and they kept
 417. asking me and I said no cos I thought it was for
 418. mental people and that, but umm I don't

*end of the day
 people don't
 really care
 about the excitement
 anymore
 because she
 just takes me
 out to nice
 places
 but it's not
 really
 exciting
 anymore
 because
 that's her
 job
 if I had a
 magic wand
 I'd want
 her to be
 more caring
 like before
 she was
 actually
 more caring
 to me
 Tracy
 anyone
 some of my
 friends
 it's important
 to have
 people you
 trust and
 believe care
 for you
 yeah
 when the
 social worker
 thought it
 would be
 good for me
 to come to
 CAMHS I
 had to wait
 a long time
 to come
 here
 umm I think
 I had my
 review
 meeting
 then they
 got me to
 think about
 it and they
 kept asking
 me and I
 said no
 because I
 thought it
 was for
 mental
 people and
 that, but
 umm I don't*

419. remember, I don't think it took that long
 420. KELLY: It was a long time ago, 2 1/2 years ago
 421. MICHELLE: Mmm
 422. KELLY: So what about the things that you do like
 423. about CAMHS, cos you've been coming for a long
 424. time
 425. MICHELLE: It's not exactly CAMHS, it's, I don't
 426. know really about the whole CAMHS thing
 427. KELLY: Okay
 428. MICHELLE: It's just like; most times I just stick to
 429. Tracy so
 430. KELLY: So what do you, what do you think are the
 431. good things about coming to see Tracy?
 432. MICHELLE: Umm she listens and when like I say
 433. something and she goes no I don't think so, she
 434. will like tell you sometimes and she will try and
 435. help you, it's just like most times to get away from
 436. everything else, yeah
 437. KELLY: And what about the things that are not
 438. that helpful
 439. MICHELLE: Umm, I don't know, sometimes when
 440. they get like your carer to come, I hated it, like
 441. once they suggested that my carer comes and
 442. talks to Tracy with me, I hated it so much
 443. KELLY: Really
 444. MICHELLE: It was my worst session (laugh) it was
 445. like okay, cos all she did was say Ruth's doing
 446. blah, blah, blah and she did da, da, da, da and I'm
 447. like okay then what's the point of me coming, and
 448. she goes, we had the meeting and thing, she says

*listening
 was with
 Tracy
 and
 Tracy*

*no Tracy
 cos she was coming*

*cos she was coming
 Tracy was coming
 Tracy was coming*

*Tracy was coming
 CAMHS
 Tracy was coming
 Tracy was coming*

*Tracy was coming
 Tracy was coming
 Tracy was coming
 Tracy was coming*

*Tracy was coming
 Tracy was coming
 Tracy was coming*

*Tracy was coming
 Tracy was coming
 Tracy was coming*

List of preliminary themes: Participant 5

Identity
Reality of moving on
Uncertainty
Difficulties staying focused
Importance of socialising
Recognising difference
Immaturity
Living with others
Under scrutiny
Difference of opinion
Family
- Segregated
- Abandoned
- Mistreated
- Contact
Helpfulness of having someone to talk to
Initial uncomfortableness
Importance of feeling comfortable
Depression
Feeling misunderstood
Consistency
Using services for a specific purpose
Advisor role
Feeling supported
-Home
-School
Interference
Escapism
Feeling like there is no choice
Importance of school
Expectations from others
Importance of being honest
Recognising difficulties
Self-awareness
Internal pain
Not liking self
Self-destruction
Feeling invaded
Difficulty opening up to others
Difficulty trusting others
Wanting more from services
Fragile relationship
Feeling betrayed
Feeling let down by social services
Feeling uncared for
Not feeling able to talk
Others changing
Wanting to be cared for

Initial ambivalence/uncertainty
Not feeling part of CAMHS
Importance of unique relationship
Importance of having somebody that listens
Not feeling valued
Satisfaction with services
Experience of being in care
Feeling criticised
Foster carer getting it wrong
Wanting neutral location

Appendix XI: Themes Clustered

Themes clustered together: Participant 5

Helpfulness of having someone to talk to
Importance of feeling comfortable
Consistency
Initial uncomfortableness
Using services for a specific purpose
Advisor role
Feeling supported
-Home
-School
Escapism
Wanting more from services
Importance of unique relationship
Importance of having somebody that listens
Satisfaction with services
Initial ambivalence/uncertainty
Not feeling part of CAMHS
Wanting neutral location
Uncertainty

... ..

Importance of socialising
Immaturity
Recognising difference
Living with others
Friendships
Family
- Segregated
- Abandoned
- Mistreated
- Contact
Expectations from others
Fragile relationship
Feeling betrayed
Interference
Feeling let down by social services
Feeling uncared for
Not feeling able to talk
Others changing
Wanting to be cared for
Feeling criticised
Foster carer getting it wrong
Difficulty opening up to others
Difficulty trusting others
Importance of being honest

*... ..
relationships*

Identity
Reality of moving on
Uncertainty
Feeling lethargic
Under scrutiny
Difference of opinion
Feeling misunderstood

Feeling like there is no choice
Importance of school
Recognising difficulties
Self-awareness
Internal pain
Not liking self
Self-destruction
Feeling invaded
Not feeling valued
Experience of being in care

Appendix XII: Table of Themes

Table of themes: Participant 5

1. The experience of accessing services

▪ Helpfulness of having someone to talk to

“ I don't mind coming, most times it does help like to talk.....” (5.121)

▪ Importance of feeling comfortable

“but then I got used to her and now I talk to her mostly about things.....” (5.130)

“then when I came I kinda like looked at it in a different way I don't mind coming at all no more.....” (6.154)

“ It wasn't exactly mental people it was just me and someone, me and Nikki and I didn't mind that.....” (6.159)

“Umm I got used to it now it's just like part of my life, I don't mind.....” (7.198)

▪ Initial uncomfortableness

“at first it felt strange coming I couldn't like talk properly and I was like oh my god it was weird talking to a stranger that you do not know, you've never met and all of a sudden you're supposed to tell them everything and it was strange, and mostly I didn't talk that much I like kept quiet and she asked me questions and I was like yeah, yeah.....” (5.123)

“It used to be every other 2 weeks, every other week, and then it was like every other 2 weeks and every other week and now it's every week because when I started it was quite weird so she said every other 2 weeks and then I think I moved and I didn't see her for like a month and then she said every 2 weeks just to catch up.....” (7.201)

Using services for a specific purpose

"Err the psychiatrist once but that was for a court report for a care order.....And I had to, that was for like, I met up about 3 or 4 times in less than a week....." (6.169)

"It was hard cos I had to tell her everything in less than a few days, I was like okay....." (6.176)

Advisor role

"Umm when like I've got a problem she will advise me....." (7.184)

Feeling supported

- With difficulties

"Before she helped me when I was not eating because the carers that I was with then complained about me not eating cos I didn't eat breakfast and they didn't know if I was eating lunch and I didn't eat dinner so they complained to Nikki cos they were worried....." (10.286)

"then she helped me she like tried some new foods and from then I started eating....." (10.296)

"since January they haven't done anything at all and Nikki talked to her....." (13.370)

- Home

"Sometimes if it's at home she will like call up and she will say what's going on and she will talk to my carer and that....." (7.185)

"then a few months ago I did not get on with my carer at all and it was like the mad house, we were screaming and shouting and the police being called and then she said like every week I should see her....." (7.207)

- School
 - “She doesn’t exactly like tell the whole story she just like gives her little bits of what’s happening.....” (12.342)
 - “And sometimes she calls up school and asks them how I’m doing or if I’ve got a problem I will tell her she will call up and she will talk to them.....” (7.189)
- Wanting more from services
 - “In a way more, sometimes, I don’t really feel like seeing her less, not really.....” (11.329)
- Importance of unique relationship
 - “It’s just like, most times I just stick to Nikki so.....” (15.428)
 - “Umm she listens and when like I say something and she goes no I don’t think so, she will like tell you sometimes and she will try and help you, it’s just like most times to get away from everything else, yeah.....” (15.432)
- Satisfaction with services
 - “sometimes when they get like your carer to come, I hated it, like once they suggested that my carer comes and talks to Nikki with me, I hated it so much.....” (15.439)
 - “most times it’s ok, most of the time yeah.....” (17.491)
- Initial ambivalence/uncertainty
 - “I think I had my review meeting then they got me to think about it and they kept asking me and I said no cos I thought it was for mental people.....” (14.415)
- Not feeling part of CAMHS
 - “It’s not exactly CAMHS, It’s, I don’t know really about the whole CAMHS thing.....” (15.425)
 - “it’s not CAMHS in particular.....” (17.487)

▪ Difficulty opening up to therapist

“sometimes I don't know like what to talk to her about, I'm not sure how to bring, even though like I'm used to her, I'm still not sure how to bring something up.....” (11.316)

▪ Wanting a different location

“Sometimes like I think like the people that work with us should meet us somewhere else, because like I go all the way from Friern Barnet to come here, cos like I have to come here then I have to go back to Southgate and sometimes it's like ohh, sometimes I think that should meet us, say like meet us at school or somewhere.....” (19.567)

▪ Uncertainty

“And also sometimes it's like you're talking in a little box room, like okay, I don't know somewhere else like say the park or something.....” (20.576)

2. Difficulties with relationships: making sense of encounters

▪ Immaturity

“They get on my nerves, most of them are childish.....” (2.46)

“Not too good, it's different with a small child but he acts like he's 2.....” (9.243)

▪ Having different friends

“Umm I got different types of friends, I've got different groups of friends, like I talk to, and they're all like different in a way, there's a few that I can like talk to that are like close to me.....” (2.38)

▪ Experience of relationships in care

“Umm she’s got a little son who is 7 and sometimes other kids come and stay as well because there is supposed to be 3 placements really but sometimes she has 1 or 2, but the other 2 kids they don’t live there.....” (3.71)

“ Yeah, and another one before that but that one was an emergency 24 hour one, and I hated them from the beginning but they said oh you’ve just moved in and I had to stay there for a year.....” (17.498)

“ No it was further, it was just down the road from here and my school was like an hour away and I hated it so much and I was like oh no I have to go all the way down there and come back again, and most times I would be like tired and stressed out and that was when things were really bad and she used to check my room and go through my stuff all the time and I would find them upside down. I’m not organised I’m really, really messy but I would know where my things were, so she used to like go through my stuff and I was like have you moved it and she was like yeah I was just looking for something, but why would you be looking in my room, she never did it when I was there when I was at school or somewhere she would do it. Cleris she just gets on my nerves cos she likes controlling people, she’s bossy as well and her son’s bossy, he’s little but he’s bossy, I’m just like shut up. She’s like you can’t wear that, you can’t do that, you can’t this everything’s you can’t cos if she tells me you can’t mostly I will do the exact thing that she tells me no don’t do that. I just don’t like her bossiness because sometimes she be’s ok like she will take you out like to places she will go like the seaside and things or like to an activity thing or sometimes it’s like oh this, that, this, that, that’s why cos she is a secondary teacher, a secondary school teacher but I would never ask her to help me do my homework once I did it was a nightmare I ended up crying I was like just go away.....” (17.508)

▪ Importance of friendships

“The people, friends.....” (1.28)

“Most times I go out with friends for like weekends or sometimes after school, sometimes I just sleep over friend's house.....” (2.51)

▪ Family

- Segregated

“ I've got sisters but they're older than me, they're in Uganda.....” (9.247)

- Abandoned

“My family is in Uganda.....” (4.99)

“[My Dad] has gone back to Uganda.....” (4.111)

“A bit different, weird, it's a bit strange but I get used to it sometimes.....” (4.114)

- Mistreated

“I lived with my half sister, she and I don't get on and she used to leave me in the house and that so, and so the neighbours called the police and they took me into care.....” (4.99)

- Contact

“I call them and they call me.....” (11.309)

▪ Expectations from others

“Yeah and at first I think social services expected me to pretend I like it but they were like don't tell her you don't like it.....” (8.237)

▪ Fragile relationship

“I've got a youth worker; I talk to her just like about everything, like normal stuff, not really anything.....” (12.334)

- “People think oh my god you like Brenda so much but now it's like oh okay Brenda's coming hurray, it's not like the excitement that I used to have.....” (14.390)
- “sometimes some stuff I tell her she tells my carer, it's like I don't understand.....” (12.336)
- “Even though sometimes my carer butts in and tries to come here with me, not that I want her to.....” (7.188)
- “it was like a 3 month period where I hated the whole social services.....” (13.360)
- “they haven't done anything so like, and I didn't talk to them so they got me a youth worker but then she left 2 weeks after and I was like what's the point them of getting me a youth worker when she's leaving in 2 weeks.....” (13.373)
- “the social worker she was there for like god knows how long, like 6 months, she didn't do anything. I had a care order and what they told her to do she did like 2% and the rest of it she didn't do and for like 6 months they haven't done anything.....” (13.365)
- “Because all she does is like take me out, she does take me to nice places, but it really doesn't matter it's like that's her job anyway.....” (14.396)
- “I don't like people coming with me because my old foster carer came with me as well but she just sat there, I'm like oh I thought you came to help me, she's like yeah, yeah but she was just listening.....” (16.454)

“ Feeling betrayed

“ Interference

“ Feeling let down by social services

“ Feeling uncared for

- Not feeling able to talk
 - “I don't really talk to her.....” (13.380)
- Others changing
 - “I've seen her before in my old placement. She was okay there. She changed.....” (13.384)
 - “she was more like a youth worker she would like talk to you and try her best to help you, but now she talks to you, but not about things that really matter.....” (13.388)
- Wanting to be cared for
 - “A bit more caring like, before she used to be actually.....” (14.402)
- Feeling criticised
 - “most times I will do my homework and I will ask someone can you help me with it and she doesn't explain to you she tells you it's wrong, everything's wrong.....” (19.542)
 - “I hate doing it when I go home cos Cleris's like “Oh you're doing homework, oh that's a first” so she thinks I don't do any homework at all.....” (19.555)
- Foster carer getting it wrong
 - “I took it to the teacher the one that she told me to do I got like a D and the one I give in the photocopy of what I did I got a C, I was like okay then.....” (19.548)
- Difficulty trusting others
 - “I find it hard to like trust people.....” (11.322)
- Importance of being honest
 - “but in the end I told her, well she knew anyway.....” (9.240)

3. Having a self-awareness

▪ Identity

"I'm 15..... I'm in year 11 now, mmm I've been in care for about, about 3 years and I've been coming to CAMHS for about 2, 2 1/2 years....." (1.5)

"I like listening to music, umm I like, like socialising....." (2.50)

"I used to go dancing but I stopped that cos it's a bit too far and Nikki's gonna try and find kick boxing cos I like kick boxing but I haven't started yet.....(2.54)

"[I came to England] when I was like 10/11(4.106)

▪ Reality of moving on

"It's a bit different but it's kinda like, you get like, you realise that you're in year 11, when you're like in year 10 just finishing you're like, ah, going in year 11, but when you're actually sitting there you're like oh my god. But I have to do loads of work....." (1.12)

▪ Uncertainty

"Umm good, most times good, but sometimes it's just like another issue, sometimes I don't like going to school, most times I don't mind....." (1.20)

"Umm, I wanted to be an air hostess at first and I wasn't to sure and then I took up geography and that because they said I had to take it up and I still don't mind doing it but I would like also like to do child care....." (2.31)

"Up and down, umm sometimes I like it and sometimes I don't like it, and I don't mind it sometimes and sometimes I feel like what's the point staying there....." (3.64)

- Feeling lethargic
 - “Sometimes just getting up in the morning, sometimes I just can't be bothered, sometimes I don't want to do the work.....” (1.24)
- Under scrutiny
 - “in a way I prefer it when other kids are there, because then she is focusing on me all the time and it's like she'll pick up all the bad things.....” (3.79)
- Feeling misunderstood
 - “when they said counselling I'm like I'm not mad and they said no it's not for mad people because then they explained like child and mental health and I was like I'm not mad, I'm not mental they were like no it's not for mad people.....” (6.149)
 - “It was my worst session (laugh) it was like okay, cos all she did was say Ruth's doing blah, blah, blah and she did da, da, da, da and I'm like okay then what's the point of me coming.....” (15.444)
- Feeling like there is no choice
 - “Well if I move I have to go in a children's home. They were the options for me if I have to move I have to in a children's home, which I hate and if they can't find a placement for me they have to find a placement outside London.....” (8.222)
 - “I wouldn't mind staying there cos I don't want to go in a childrens home, but apart from that I hate it there.....” (8.230)
- Importance of school
 - “I only stay there really cos it's near my school and I get like to and from school quite easily. Most times I go I stay at school for a bit longer.....” (8.229)
- Recognising difficulties
 - “[Are you depressed]Umm at first I didn't think so but then I was like I am actually.....” (9.261)

- Self-awareness
 - “I just can't be bothered, I'm lazy and I just feel like, I don't I just feel empty, and sometimes like before I just used to feel like really, really lazy and I didn't feel like saying anything to anyone.....” (9.267)
 - “they were getting on my nerves and they thought I was angry and all the time yeah I was angry but all the time they were like and I was getting more and more angry.....” (13.362)
- Internal pain
 - “I pierced my nose to take the pain away but it didn't work.....” (10.271)
- Not liking self
 - “umm then I like stopped eating and I was all skinny and that and I didn't like myself I was too small and then like I was eating junk food and I was too big and like most times it's about eating, and I get like sometimes I eat sometimes I don't eat.....” (10.272)
- Feeling invaded
 - “I didn't like anything apart from junk food and then I put on loads of weight and I hated myself and then I went down again.....” (10.297)
 - “I think she called up school, I'm not sure if she called up school but someone did and they said that they had to monitor me eating and I was like uh.....” (10.292)
- Not feeling valued
 - “I'm like what's the point of bringing, dragging me to the meeting then, when you know like everything I'm gonna say you know it already, she's like ok then and we're just like ahh, and I just walked out.....” (16.450)
- Experience of being in care

- Search for happiness

“I feel like I don't know what to eat and I feel like I have to concentrate on a certain thing and sometimes I eat certain foods just to make myself feel better.....” (10.280)

Appendix XIII: Major Themes

Master Themes

Interview 1

1. The experience of engaging in services: Positive encounters
2. Trying to establish an identity: The meaning making process
3. Having an underlying sense of uncertainty

Interview 2

1. Having an evolved sense of self
2. Yearning for a sense of belonging
3. Having a positive experience when accessing services

Interview 3

1. Yearning for a sense of belonging
2. Ambivalence about receiving help
3. Having a personal awareness

Interview 4

1. Having a developed sense of self: identity
2. The experience of relationships: making sense of the process
3. The experience of receiving help: a mixed opinion

Interview 5

1. The experience of accessing services
2. Difficulties with relationships: making sense of encounters
3. Having a self-awareness

Interview 6

1. Having a sense of identity: what it means to be me
2. Having an understanding of the difficulties experienced
3. The experience of services

Appendix XIV: Reflective Sheet

Reflective sheet

Date:

Interviewee:

Rapport:

Observations:

Distractions:

Preliminary themes:

Other comments:

**How do 'Looked After' Adolescents'
Experience Mental Health Services?**

A Critical Review

Student Number: 02055473

November 2005

Year 3

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Introduction

This thesis presents a qualitative study utilising Interpretative Phenomenological Analysis, as a method to investigate looked after adolescents' experience of mental health services. The aims of the study were to explore the participants' understanding and meaning making of the mental health difficulties that they feel they need help with, to uncover the mental health services that they have received and to explore their understanding and experience of these services. This was carried out utilising an attachment theory perspective (Bowlby, 1971, 1975, 1981; Howe, 1995; Atkinson and Zucker, 1997) as well as drawing upon paradigms used to understand individual meaning making including a narrative approach (White and Epston, 1990), constructivism (Kelly, 1991) and social constructionism (Gergen, 1985). It was felt that the aims were achieved to a greater extent.

The aim of the critical review is to critique the study with regards to possible clinical implications, methodological issues and suggestions for future research and to consider issues that arose from the research process that may be of relevance to other researchers carrying out studies within the field. I have also taken this opportunity to reflect personally on the process of carrying out the project.

Clinical implications

Carrying out research with this population was expected to prove challenging. It was anticipated that it would be difficult to access participants as previous literature has suggested that it can be difficult accessing looked after children for research purposes. This can occur for a variety of reasons, such as gaining consent from carers or social workers (Hepinstall, 2000; Rodrigues, 2004). The current literature base is under developed with many studies involving either professionals and/or carers, or reviewing case notes which might further support the notion that this population are difficult to access. This was not proven to be the case in this study and there were no major issues involving the

gaining of consent. This might suggest that this population are more accessible than is hypothesised.

The results section identified that the Looked After Children Team, which is part of CAMHS, was viewed in a positive way to a certain extent by the young people and appeared to be providing a satisfactory service to a greater degree. However, the young people who participated in the study were able to identify ideas for service development. With regards to appointment frequency, two of the young people felt they would like to attend more often. Whilst this may not be possible for a variety of reasons including therapeutic value, it is an area that could be explored. There were also ideas expressed regarding location, with one of the young people stating that they would like to meet their therapist in an alternative environment to the hospital, for example the park or at school. This was due to the distance she has to travel to her appointments. Although only one participant came up with an alternative suggestion regarding location, other participants were also unhappy with the distance they had to travel to the team base.

Another area that emerged in interviews with some of the participants was the dissemination and sharing of knowledge and information about other services. One young person in particular clearly indicated that she was keen to know about other services that might be available to her. Others alluded to the idea that they might like to engage in other services, particularly with other young people who experience similar difficulties. This could also indicate a need for the development of group work at the service.

Three of the young people in the sample will be moving on to adult services shortly and mixed views were expressed about this, which seemed to be indicative of an underlying anxiety. For looked after children, the transfer to adult services usually comes at a time when they are undergoing an abundance of transitions concerning services, because they are likely to be leaving care.

This may be an area for further research and service development. It could be that further work is needed for young people transferring to adult services, in order to ease their anxiety about adult mental health services and the transition.

Methodological issues: Strengths and limitations

The use of IPA

IPA seemed to be an effective methodology for answering the research questions for this particular group of looked after adolescents. It allowed the researcher to obtain rich and in-depth accounts of the participant's experience of the mental health services available to them, whilst simultaneously being sensitive to the client group's needs.

The use of IPA with children is limited and there have been few studies carried out with the general child and adolescent population. Couch *et al.*, (2004) using IPA in their study aimed to identify some of the personal and interpersonal processes involved in deliberate self-harm at a residential treatment setting for adolescents with mental health problems. Roose *et al.*, (2003) used IPA to analyse their focus group to explore 10- and 11-year old children's understanding of the concept of mental health and their opinions regarding an appropriate service for their age group. Currently, there have not been any IPA studies carried out with the looked after children population. Hopefully this study will open doors for not only further research using this methodology with children, but more specifically with children and adolescents from minority groups.

Recruitment issues

Although the aim was to recruit a mixed gendered sample across the age range, no boys participated in the study. It is unclear what the reason for this was, although it could be hypothesised that fewer males were approached, as maybe they are less likely to engage in services for a minimum period of six months. Whilst it is not the aim of IPA to make generalisations to the population

based on data obtained from the sample, it must be kept in mind when considering the findings from this research, that it represents the views of six female adolescents who were receiving a service at this particular time.

Generalisability

It was initially hoped that this study might go towards helping commissioners think about service development from the user's view. Whilst this is still the case, to a greater degree, it will be important to reflect on the fact that this study is based on the experiences of six young women from one looked after children's service. Whilst government initiatives are prioritising looked after children's needs (Department of Health, 2000, 2002b, 2004) and specialist services are being set up across the country, there is no standardised practice and other authorities may be running their service in a different way to the service in which this study was carried out. It is important that readers are mindful of this and the sample is treated as a group of six individuals with their own experiences and accounts, which will be different to those young people in a different looked after children service at any given time.

Validity and reliability

It was important that validity, reliability and quality control were maintained at all times. As part of a bid to do this, meetings were arranged with individuals following their interview, where they had the opportunity to hear a short written summary of the information they had supplied. All of the participants were happy with their summary and no details were amended. However, potential problems could have occurred with this strategy that was not considered initially. The IPA interview is based on an individuals' view at a particular time (Smith, 2003); if the young person had requested that information be changed this may have jeopardised their taking part in the study. In order to limit this problem from occurring, meetings were arranged as soon after the interview as possible. However on reflection, it may have been more effective to omit this element of the research design, in order to avoid potentially invalidating the study.

Ethical issues

Ethical issues were considered very seriously with regards to data collection and presentation. Individual rights to confidentiality could have been jeopardised to a certain degree, by involving team members in the initial recruiting stages. Whilst this was minimised by names being passed to the researcher, who then contacted individuals directly to ascertain whether they would like to take part, some participants may have felt that their therapist was aware of their participation which could have affected their interview and impacted upon the information they disclosed. In addition some of the participants chose to meet for an interview at the team building, which may have identified their participation.

Although the researcher was clear about the process of the study with participants, all of the young people were keen to discuss their interview on a second occasion and one participant asked whether it would be possible to meet up again. It seemed that the participants valued the opportunity to have somebody to talk to about their experiences and although debriefing was provided at the end, it seemed to be difficult for some of the participants that the interview was a one off experience, given the fact that they had divulged in in-depth discussions about very personal areas of their lives.

Future research

The results from this study have provided insight into an area that has not previously been explored utilising a qualitative methodology. Whilst this has provided new information that will be valuable to the research base, it has also opened avenues for further exploration. The sample recruited for this study was fairly restricted and as has been previously highlighted there are limitations to the generalisability of the findings. Nevertheless, this opens doors for future research and it would be interesting to carry out a similar study using either an all male or mixed gendered sample in order to compare and contrast as well as develop the research base. As well as conducting research focusing on gender

specific groups, it may also be of value to carry out a similar project recruiting younger looked after children, or looking more specifically at different localities. The ethnic diversity of the participants recruited for this study appeared to be a fair reflection of the local population, however it is appreciated that this sample will not be representative of the ethnicity of other localities, and this would benefit from further exploration.

It was also part of the recruitment criteria that participants had to have been in receipt of services for a minimum of six months. This would inevitably skew the participants eligible for recruitment. Research suggests that many looked after children have difficulty accessing mental health services due to the nature of their chaotic lives and the fact that they move around frequently (Mount, 2004). It would be worthwhile to carry out a similar study with young people who were more recent users of services, or on a waiting list, in order to reveal whether their views are similar to those of the young people recruited in this study, or more indicative of the young people that find it difficult to access services due to factors such as waiting lists and changing placements (Mount, 2004).

It has also been indicated that the research base for looked after children in general is under developed (Kelly *et al.*, 2003; Rodrigues, 2004). Given that gaining consent did not prove to be an obstruction to this study, this could open doors for qualitative research to be carried out exploring a host of other pertinent issues regarding looked after children's experience. This study has particularly focused on their experiences of mental health services, however there are other areas relevant to the health and well-being of this population that could be explored in order to strengthen the research base and improve our understanding of these young people. Developing a psychological understanding of this population will also help services develop; in order to meet the needs of looked after children.

Reflexive considerations

Completing the project involved a series of stages each of which proved to be a learning experience that informed my clinical practice as well as developing my research skills.

Literature review

Carrying out the initial literature review, and collecting articles as the project progressed, has developed my knowledge of this client group immensely. The literature covered a vast array of issues and included both qualitative as well as quantitative studies from a variety of theoretical backgrounds. Furthermore, the government documents that I acquired have developed my knowledge of the context, which has been valuable to me not only in terms of my research but also in helping me to understand this client group and the complexity of their situation within my clinical practice. I have been able to develop theory-practice links in my clinical work at a more complex level having acquired a richer depth of knowledge.

Interviews

Carrying out the interviews was also an area in which I was able to develop skills that have strengthened my clinical expertise. The six young people that I interviewed clearly shared the commonality that they were all female and part of the looked after children service: this is where the similarities ended. The participants were a diverse set of individuals, each bringing something very different to the interview. I found interviews with two of the young people particularly difficult and this proved to be an excellent opportunity for me to be reflective and think about why I had found these interviews difficult. One interview I found difficult was with a young person who was particularly shy. It was very difficult to encourage her to elaborate on her experiences and she would often shrug her shoulders or give one-word answers. As a result I found myself asking closed questions. I felt I had to do most of the talking in this interview and felt drawn into asking closed questions, which I had hoped to avoid. The other interview that I found difficult was with a young person that

appeared to be actively unwell. During the interview she spoke of her use of physical aggression and she became quite animated at times. I met her in her home and although her carer was in the building, I still felt vulnerable. Reflecting back on this interview, it would have been best to meet in the CAMHS building. I also stopped the interview prematurely as I felt that she was becoming agitated when discussing her experiences and I felt this was unethical and not helpful to her sense of well-being.

There were two participants whom I felt I had connected with well and these interviews seemed to be the most enjoyable on my part. These were both young people who had been accessing services for a considerable length of time. They were also able to elaborate on their experiences and appeared to enjoy having the space to talk freely. These young people told their story with few prompts and I was able to sit back and really absorb the information. They both had an air of confidence about them and held firm opinions on what they considered to be right and wrong, and I respected and admired them for that.

Inevitably my confidence and interview technique improved as the interviews progressed and I felt this coincided with my performance on placement. Interviewing young people in a research context improved my listening and assessment skills as well as my confidence.

Analysis

The process of analysis encouraged my thinking at a theoretical level and developed my ability to make theory-practice links and interpretations. These are skills that I have been able to apply to clinical work, not only with adolescents but also with younger children in both the looked after children team and child and family consultation service where I work. I certainly found that the two interviews I had enjoyed were 'easier' on some level to analyse. This was likely to be because I felt I had made a connection through listening and valuing their ideas.

The process of analysis helped develop various skills with regards to my clinical work. Having to thoroughly read through the transcripts and listen to the tape recorded interviews, improved my listening skills and developed my ability to make theory-practice links, which will impact upon my formulation skills. In addition the process of having to think about six perspectives on services, bring them together to some degree whilst not losing their individuality will be skills that will be valuable to me in my clinical work to help me appreciate individuality and the importance of recognising individual narratives and view points.

Methodological issues

This was the first time that I had carried out an extensive piece of research using a qualitative methodology. I had never experienced using IPA and completing the project was inevitably going to be a continuous learning experience. However, this offered no comfort when confronted with anxieties about wanting to 'get it right'. Whilst Smith (2003) provided guidelines for carrying out the procedure, he also stipulated that researchers should not adhere strictly to the guidelines, but instead find their own way. When reflecting on the process this makes good sense, however at the time it can be daunting and I often struggled to be more spontaneous and not adhere to the guidelines. Whilst the project was eventually completed it may have been more enjoyable and a good learning experience to relax, deviate and find my own way to some degree, perhaps following the guidelines less rigidly. Should I carry out a further study using IPA I would push myself to do this. Any further study would inevitably be easier having gained some knowledge and experience from this project.

It also felt difficult to make interpretations especially when carrying out my first analysis. I feel I could have been a little bolder at times with regards to making interpretations drawing on psychological theory. This was something that I was not confident enough to do at times. While I felt more able to experiment with this concept as the research progressed, I felt that I sometimes played safe in a desperate bid not to jeopardise the reliability and validity of the study. Upon

reflection I do not think that making bolder interpretations would have jeopardised the validity and reliability if I used the strategies that I did in order to uphold it. However my anxiety about these issues made me occasionally a little too rigid.

As with many qualitative methodologies, IPA requires the researcher to reflect on their personal position; in the process of carrying out the study and writing up, I felt I was able to learn about me as a person as well as a researcher. I believe I developed both personally and professionally through the process of carrying out this study, which will be valuable to me as I move forward in my career.

Working with looked after children

In addition to the clinical skills I developed through the completion of the project I feel that I was also able to gain a deeper understanding of developing a therapeutic alliance with the young people who participated in the project. I feel I will be able to utilise in my work, with not only looked after children, but young people in general. I was able to appreciate the importance of respecting the young people's views and value their opinions on a host of issues pertinent to their lives. Listening, showing warmth and empathy are skills that I feel were most valuable in the completion of the interviews and these are skills that I have emphasised in my clinical practice since.

Theory-practice links

My thinking was somewhat influenced having read and thought about social constructionism (Gergen, 1985), constructivism (Kelly, 1955) and narrative approaches (White & Epston, 1990) before conducting the research. I believe this allowed me to make theory-practice links in the writing up of the project as well as in my clinical work. I have been able to think about how the narratives of the individuals in the study may be influencing their view of reality and how they might be constrained by their narrative, which is a selective representation of their life experiences. This is also something that I have been more aware of in

my clinical work with the population. I was also able to reflect on the interview process from a social constructionist perspective thinking about the interview and the language used on my part as well as the interviewees as a process of constructing a version of reality for them and for me. This again is something I have been able to reflect upon and apply to my clinical work.

Looked after children often have to fight to be heard. Many of them have been let down by adults and are cautious and suspicious; others struggle with the boundaries of relationships, having little experience and skill in the development and maintenance of relationships. Having some understanding of attachment theory (Bowlby, 1971, 1975, 1981) and completing this project enabled me to make theory-practice links. This project allowed me to appreciate this first hand and understand on some level what it is like for looked after adolescents to have difficulties and be part of the mental health service.

Supervision

The process of carrying out the study also impacted upon me at a personal level, the impact of which I had not fully anticipated. I had always been of the opinion that looked after children are a vulnerable group who are less than fortunate in many respects. Carrying out a study with this population furthered this belief, as I heard about the young people's experiences of issues such as abandonment, yearning for a sense of belonging and feeling let down by adults, including professionals. I probably did not make enough use of supervision in order to discuss how the project may have affected me on a personal level. This is something that I would encourage others to do in the future, particularly when carrying out a qualitative study with a vulnerable group.

Conclusion

In conclusion, a host of issues pertinent to the thesis have been discussed adopting a critical perspective. This has involved presenting the strengths and limitations of the study as well discussing possible clinical implications of the

findings. In addition, suggestions for future research have been highlighted, in order to direct areas of the evidence base that can be strengthened. I have also taken this opportunity to reflect personally on the process of carrying out the project, discussing the implications it had for both my professional and personal development.

References

Atkinson, L. and Zucker, K.J. (1997). Attachment and Psychopathology: Guildford Press.

Baldry, S. and Kemmis, J. (1998). What is it like to be looked after by a local authority? British Journal of Social Work, 28,129-136.

Barker, C., Pistrang, N. and Elliott, R. (2002). Research Methods in Clinical Psychology: An Introduction for Students and Practitioners (2nd ed.). John Wiley and Sons.

Berridge, D. and Brodie, I. (1998). Children's Homes Revisited. London: Jessica Kingsley.

Blower, A., Addo, A., Hodgson, J., Lamington, L. and Towlson, K. (2004). Mental health of 'looked after' children: a needs assessment. Clinical Child Psychology and Psychiatry, 9(1), 117-129.

Bowlby, J. (1971). Attachment and Loss (vol.1): Attachment. Harmondsworth; Penguin Books.

Bowlby, J. (1975). Attachment and Loss (vol.2): Separation: Anxiety and Anger. Harmondsworth; Penguin Books.

Bowlby, J. (1981). Attachment and Loss (vol.3) Loss: Sadness and Depression. Harmondsworth; Penguin Books.

Bundle, A. (2002). Health information and teenagers in residential care: A qualitative study to identify young people's views. Adoption and Fostering, 26(4), 19-25.

Burr, V. (1995). An Introduction to Social Constructionism. London: Routledge.

Burr, V. (2003). Social Constructionism (2nd ed.). London: Routledge.

Butler, J., and Vostanis, P. (1998) Characteristics of referrals to a mental health service for young people in care. Psychiatric Bulletin, 22, 85-87.

Cairns, K. (2002). Attachment, Trauma and Resilience. British Association for Adoption and Fostering.

Coleman, J.C., and Hendry, L.B. (1999). The Nature of Adolescence (3rd ed.). London: Routledge.

Crouch, W., and Wright, J. (2004). Deliberate self-harm at an adolescent unit: A qualitative investigation. Clinical Child Psychology and Psychiatry, 9(2), 185-204.

Davis, J.M. (1998). Understanding the meanings of children: a reflexive process. Children and Society, 12, 325-335.

Delanty, G. (1997). Social Science: Beyond Constructivism and Realism. Buckingham: Open University Press.

Department of Health. (1999). Promoting Health for Looked After Children: A Guide to Healthcare, Planning, Assessment, and Monitoring: Consultation Document. London: Department of Health.

Department of Health. (2000). Promoting the Health of Looked After Children. A Guide to Healthcare, Planning, Assessment, and Monitoring: Consultation Document. London: Department of Health.

Department of Health. (2002a). Outcome Indicators for Looked After Children - year ending 30 September 2001. London: Department of Health.

Department of Health. (2002b). Promoting the Health of Looked After Children. London: Department of Health.

Department of Health. (2002c). Improvement, Expansion and Reform: The Next Three Years' Priorities and Planning Framework, 2003-2006. London: Department of Health.

Department of Health. (2002d). Shifting the Balance of Power: The Next Steps. London: Department of Health.

Department of Health. (2003). Children Looked After by Local Authorities: Year Ending 31 March 2002 England. London: Department of Health.

Department of Health. (2004). Getting The Right Start: National Service Framework for Children - Emerging Findings. Department of Health.

Department of Health. (2004). National Service Framework for Children, Young People and Maternity Services. Department of Health.

Dimigen, G., Del Priore, C., Butler, S., Evans, S., Ferguson, L., and Swan, M. (1999). Psychiatric disorder among children at time of entering local authority care: questionnaire survey. British Medical Journal, 319 (7211), 675-677.

Fransella, F., and Dalton, P. (1996). Personal construct therapy. In W. Dryden (Eds.) Handbook of Individual Therapy. London: Sage Publications.

Gergen, K.J. (1985). The social constructionist movement in modern psychology. American Psychologist, 40, 309-320.

Gergen, K.J. (2001). Social Construction in Context. London: Sage.

Heptinstall, E. (2000). Gaining access to looked after children for research purposes: Lessons learned. British Journal of Social Work, (30), 867-872.

Howe, D. (1995). Attachment Theory for Social Work Practice. Macmillan Press Ltd.

Howe, D., Brandon, M., Hinings, D., and Schofield, G. (1999). Attachment Theory, Child Maltreatment and Family Support: A Practice and Assessment Model. Basingstoke: Macmillan Press LTD.

Kazdin, A.E. (2003). Research Design in Clinical Psychology (4th ed.). Allyn and Bacon.

Kelly, G.A. (1991). The Psychology of Personal Constructs, Vols. I and II. London: Routledge.

Kelly, C., Allan, S., Roscoe, P., and Herrick, E. (2003). The mental health needs of looked after children: An integrated multi-agency model of care. Clinical Child Psychology and Psychiatry, 8(3), 323-335.

Laws, S. (1998). Hear me!: Consulting with Young People on Mental Health Issues. The mental health foundation.

Lindsey, C. (2000). Why focus on the mental health needs of looked after children? In J. Richardson and C. Joughin The Mental Health Needs of Looked After Children. The Royal College of Psychiatrists.

McCann, J.B., James, A., Wilson, S., Dunn, G. (1996). Prevalence of psychiatric disorders in young people in the care system. British Medical Journal, (313), 1529-1530.

Mount, J., Lister, A., and Bennun, I. (2004). Identifying the mental health needs of looked after young people, Clinical Child Psychology and Psychiatry, 9(3), 363-382.

Parker, I. (1998). Social Constructionism, Discourse and Realism. London: Sage Publications.

Phillips, J. (1997). Meeting the psychiatric needs of children in foster care: social worker views. Psychiatric Bulletin, 21, 609-611.

Polnay, L., Glaser, A., and Rao, V. (1996). Better health for children in residential care. Archives of Disease in Childhood, 75, 263-265.

Polnay, L., and Ward, H. (2000). Promoting the health of looked after children. British Medical Journal, 320, 661-662.

Potter, J., and Wetherall, M. (1987). Discourse and Social Psychology: Beyond attitudes and behaviour. London: Sage Publications.

Richardson, J.T.E. (1996). Handbook of Qualitative Research Methods for Psychology and the Social Sciences. UK: The British Psychological Society.

Richardson, J., and Joughin, C. (2000). The Mental Health Needs of Looked After Children, The Royal College of Psychiatrists.

Rodrigues, V.C. (2004). Health of children looked after by the local authorities. Public Health, 118, 370-376.

Roose, G.A., and John, A.M. (2003). A focus group investigation into young children's understanding of mental health and their views on appropriate

services for their age group. Child: Care, Health and Development, 29, 6, 545-550.

Smith, J.A. (1995). Semi-structured interviewing and qualitative data analysis. In J.A. Smith, R. Harre, L. Van Langenhove (Eds.). Rethinking Methods in Psychology. London: Sage.

Smith, J.A. (1996). Beyond the divide between cognition and discourse: Using interpretative phenomenological analysis in health psychology. Psychology and Health, 11, 261-271.

Smith, J.A. (2003). Qualitative Psychology: A Practical Guide to Research Methods. Sage Publications LTD.

Smith, J.A. (2004). Reflecting on the development of interpretative phenomenological analysis and its contribution to qualitative research in psychology. Qualitative Research in Psychology, 1, 39-54.

Street, E., and Davies, M. (2002). Constructing mental health services for looked after children. Adoption and Fostering, 26(4), 65-75.

Talbot, R. (2002). Young Minds: Looking After the Mental Health of Looked After Children. Pavillion Publishing.

Target, M., and Fonagy, P. (1996). The psychological treatment of child and adolescent mental health disorders. In A. Roth and P. Fonagay (Ed.) What Works for Whom? A Review of the Effectiveness of the Psychotherapies. New York: Guildford.

Utting, W., Baines, C., Stuart, M., Rowlands, J., and Vialva, R. (1997). People Like Us: The Report of the Review of the Safeguards for Children Living Away from Home. London: The stationery Office.

White. M., and Epston, D. (1990). Narrative Means to Therapeutic Ends. New York: W.W. Norton and Company.

Yardley, L. (2000). Dilemmas in qualitative health research. Psychology and Health, 15: 215-28.

Yin, R. (1989). Case Study Research: Design and Methods (2nd ed.). Beverly Hills, CA: Sage.