CREATING A LINK BETWEEN CAMHS AND CHILDREN'S CENTRES IN A DEPRIVED AREA: A CASE OF SETTING UP A WORK DISCUSSION GROUP

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ABSTRACT

This thesis explores the process of setting up a Child Psychotherapy-led outreach service in Children's Centres (CC) in a deprived urban setting. Our team decided that setting up Work Discussion Groups (WDGs) for CC staff would be the best starting point towards engaging and sensitising frontline workers to early signs of mental health problems. This research focuses primarily on exploring both CC staff and Child Psychotherapists' (CPs') experience of participating in this initiative. Semi-structured interviews were conducted and then analysed using Interpretative Phenomenological Analysis (IPA), coupled with a psychoanalytic understanding, to shed light into the lived experience of the participants in this project. The author draws attention to CC being containers for significant child and parental anxieties. The CC's increasing safeguarding role is a concerning finding of this study as it is particularly stressful for CC staff and has implications for their practice. The study - in line with existing literature- highlights the importance of time and a consistent 'therapeutic presence' in CC. Understanding the culture of the institution and taking into account the impact of deprivation and financial insecurity are essential aspects to be considered when designing and implementing an intervention in a deprived community. Powerful dynamics that give rise to unconscious attacks on the outreach worker, splitting between good and bad services, paranoid anxieties and lack of trust are likely to occur. CC staff struggle with managing safeguarding concerns while they tend to focus more on parents' difficulties and developmental issues and less on children's emotional wellbeing and attachment to their carers. The author suggests that CC staff could benefit from working closely with CPs and from participating in WDGs on a regular and voluntary basis, so that they can be better equipped to think about children's emotional states.

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I declare that while registered as a research degree student at UEL, I have not been a registered or enrolled student for another award of this university or of any other academic or institution.

I declare that my research required ethical approval from the University

Ethics Committee (UREC) and confirmation of approval is embedded within the thesis.

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CHAPTER 1 INTRODUCTION

This research project emerged during my clinical training in Child and Adolescent Psychotherapy and concerns the setting up of a consultation service led by Child Psychotherapists in local Children's Centres. This initiative arose in response to the lack of referrals of children under the age of five to the Child and Adolescent Mental Health clinic I worked for during my training, prompted too by the special interest in Early Intervention held by the Child Psychotherapists in my team. In this introduction, I will describe the process of setting up the project, which was set in motion by contacting the Children's Centres and designing the pilot. It was decided by our team that setting up Work Discussion Groups for Children's Centres' staff would be the best starting point towards engaging and sensitising frontline workers to early signs of mental health problems. I will describe the reasoning underpinning this process. The initial research plan was to pilot an intervention for one year and implement it the following year. However, at the end of the pilot phase our clinic's management decided we could not carry on delivering the service for a second year. The reasons behind this decision were explained in detail by our manager in a group meeting that I organised as part of this research at the end of the project. In brief, funding cuts in services and several redesigns of Children's Centres and Child and Adolescent Mental Health Services (CAMHS) did not allow for a continuing working relationship between the two institutions. After careful consideration, I decided to proceed with interviewing three of the Children's Centres workers who took part in the pilot and my Child Psychotherapy colleagues who also participated in it to add to the data collected in the pilot year. This thesis will set out the Child

Psychotherapy team's efforts to understand and engage Children's Centres workers and design an intervention tailored to their needs. The interviews shed light on another aspect that seemed central to everybody's experience of their workplace: deprivation, feelings of insecurity and hopelessness at times of financial strains and cuts. At the same time, the interviews with the Children's Centres workers constitute valuable information about how they experience their workplace and approach their roles, but also give an insight into how they understand infant mental health.

This thesis begins by introducing the context and rationale for this project as well as the theoretical background of the author, namely psychoanalytic ideas that have informed my understanding of this research's findings. Chapter 2 provides the reader with a review of the relevant literature including previous studies of Child Psychotherapy-led outreach projects, papers that provide a psychoanalytic understanding of institutions, and research into Children's Centres' staff experience of their role and workplace. The Work Discussion model is also discussed as relevant to this work.

In Chapter 3 (Methodology), I describe the study design and explain the decision to use Interpretative Phenomenological Analysis (IPA). Chapter 4 (Findings) gives a detailed presentation of the main themes that emerged from my analysis, constituting subchapters describing the experience of the participants in this project. Divided into two large sections (Children's Centres' staff and Child Psychotherapists), extensive extracts from the interviews are utilised to give the reader an accurate account of how participants experienced the process of creating a link between the two services. From the many themes that are presented in this chapter, I selected some for more detailed discussion in Chapter 5 (Discussion). There, I discuss the strengths and limitations of

this research project as well as the implications for practice and feedback to Children's Centres and Child Psychotherapists. The final chapter (Chapter 6) concerns a brief summary of the most important findings of this research and some final comments on the usefulness of the WDGs in similar settings.

In the current Chapter, I set out the context of this research by discussing how the research idea emerged in the context of my training, and by briefly describing what Children's Centres are and how they function. I include further background information about the initial conversations and reports from our team while setting up this pilot. The process of becoming a researcher will also be described in this introductory chapter, as well as the Psychoanalytic framework that has informed my thinking and, consequently, my understanding of what emerged from this research.

1.1 Origins of the project

As part of my four-year Child and Adolescent Psychoanalytic Psychotherapy clinical placement, I worked in a Child and Adolescent Mental Health Service (CAMHS) in a deprived medium-sized urban setting for four days a week. My research questions began to develop when, in my second year of training, I started looking for an under-5 training case.[1]It soon became clear that an under-5 was difficult to find, as not many were referred to our service even though CAMHS was commissioned to work with children and young people from 0-18 years old. My supervisor and I wondered whether the lack of under-5 referrals reflected the fact

[1] This is a requirement for Clinical training and concerns intensive (3 times per week) psychoanalytic psychotherapy with a child under the age of 5 years.

that young children do not get referred to CAMHS by other services and by Children's Centres (CC).

Information from the CC's records revealed a very high percentage of registration, with most children under-5 being registered with their local CC. At the same time, our clinic received a very high number of referrals for 6- and 7-yearolds by schools and General Practitioners (GPs). The fact that these cases were not being picked up earlier posed the question of how CAMHS could intervene in the community and work with young children and their hard-to-reach families as well as with Early Years Practitioners. When I first joined the CAMHS team at the beginning of my training in 2012, there was a part of the CAMHS team offering consultation to CC, but this ceased to exist due to the change in the Trust.

My service supervisor, who managed my placement, suggested I should get involved in working with the local CC, which would both offer me the opportunity to gain experience in outreach work and potentially identify a suitable under-5 training case. My involvement with the CC coincided with the arrival of another Child Psychotherapy Trainee (Kiara)[2] and two qualified Child Psychotherapists (Martha and Dan) who joined the team around the same time. All six of us, including my service supervisor (Neithan) and a Child Psychotherapy trainee from a CAMHS in a neighbouring area (Victoria), expressed a great interest in developing an outreach service for CC.

During the initial conversations, I wondered whether re-establishing links – which felt more like creating links from scratch – between CAMHS and CC would be an

[2] All names and identifying details have been changed to protect confidentiality.

opportunity for a research project, the findings of which could be shared with the rest of the team and could inform similar future projects. In retrospect, this idea seemed to be linked to a sense of fragmentation I experienced in my CAMHS team (there were three different Trusts over a period of 5 years) together with an underlying anxiety about how feasible this project would be, given the level of deprivation in the area and the many institutional changes in both workplaces. It seemed as if – without consciously thinking about it then – I had intuited that looking at this attempt more systematically would give me the opportunity to create some continuity in the work and to learn how frontline workers cope with this level of need at times of financial insecurity and cuts. In addition, this research has been an opportunity to confront my team's limitations while designing and implementing the outreach service. The latter will hopefully add to our discipline's knowledge of the difficulties as well as the opportunities that arise when working in the community in Early Years' provisions.

What follows in the next section is a brief history of Children's Centres in the U.K.

1.2 Children's Centres

In 1998, the newly elected Labour Government launched 'Sure Start', a programme originally intended to improve access to early education and support for disadvantaged families from pregnancy until the age of 4. Although the centres that opened at the time were intended for all families in the local area, Sure Start Centres were initially launched in the most deprived areas.

Lewis (2011) gives an account of policy changes with regard to Children's Centres. In 2003 Sure Start was replaced by plans for the establishment of Children's Centres which would be universal services unlike the Sure Start local programmes for disadvantaged areas. In April 2006 it became the Local Authorities' responsibility to run and manage CC with extra funds through Sure Start, Early Years and Childcare Grants.

In 2011, Graham Allen, Labour MP, wrote an important report called 'Early Intervention: The Next Steps', where he argued for the huge social and financial benefits of Early Intervention programmes. Allen (2011) used Perry's (2002) research evidence on poor brain development of neglected children to support Early Intervention strategies. In line with Allen's (2011) findings and suggestions, Children's Centres were designed to implement – alongside other services such as Social Services, Health Visiting, CAMHS – programmes and actions that would not only target families in difficulty but would also promote health and development for every child up to the age of five. However, in practice there were many problematic areas in the CC's way of functioning, as there seemed to be significant differences in how each centre operated, with most of them being understaffed and managers being difficult to recruit for some centres.

Most importantly, as described by Lewis, Cuthbert & Sarre (2011) in their paper 'What are Children's Centres? The Development of CC Services, 2004–2008', the mixed economy of provision posed considerable challenges to the goal of integration. The authors describe the nature, structure and rationale behind Children's Centres services and what they provide. They talk about the universal

and mainstream nature of the services (unlike Sure Start Centres which were specifically designed for disadvantaged areas) and identify some problematic areas such as the institutions' difficulties of balancing a focus on the child and the parent. In this paper, there is a comparison between Children's Centres and Sure Start centres, and the authors argue that even though Children's Centres have a clearer outline of their core offer, there are substantial differences between Children's Centres in terms of services (Lewis et al, 2011). In their findings they give a useful account of the difficulties that emerged from the government's expectations that the CC would help the Local Authorities to secure integrated services for under 5's. Lewis et al (2011) report that CC staff felt that the relationships between different services were difficult to manage and that too much was based on the 'good will' of the people involved, a working relationship that could be best described as a 'loose coalition' (Lewis et al, 2011, p. 46). Staffing was described in the interviews they conducted as 'messy and bitty' and the authors refer to the major issues that occur due to staff working to different protocols and different lines of accountability being employed by different agencies. The lack of co-location (as CC offer services in different sites and hubs) posed a further difficulty in the integration of staff.

In recent years, the economic crisis and cuts in Health and Education posed a further challenge for Children's Centres, generating insecurity and instability. The BBC reporter Hannah Richardson warned of a 'closure threat' affecting many Children's Centres across the country due to the changes to Children's Centres' funding (Richardson, 2011). Eight years later, in June 2019, the BBC reporter Sean Coughlan's article 'Sure Start centres "big benefit" but face cuts' presented a report

by the Institute of Fiscal Studies. The report stated that the provision of Sure Start centres significantly reduced hospital admissions for children up to the age of eleven as a result of parenting advice on safety and children's behaviour and health education. At the same time, the think tank warned that although spending peaked in 2010 at £1.8bn, it was eventually cut by two-thirds to £600m by 2017-18, and about 500 centres closed between 2011 and 2017. The report also described significant differences in levels of local provision, with decisions about Children's Centres having been delegated to Local Authorities that also face financial pressures.

What follows is a condensed description of the process of setting up the service, to give the reader a better understanding of how this research emerged. I include process notes, thoughts and ideas from a reflective journal I kept throughout as well as a couple of detailed written-up examples of the work we offered to CC.

1.3 The research context

1.3.1 Initial planning and discussions with CC

The initial conversations about setting up an outreach service in the local area took place in September 2014. We aired some first thoughts about what the team could offer to the CC and how to organise and set up such a project. Notes from the first meetings include ideas such as initially offering staff workshops in the form of Work Discussion Groups (see Literature review, 2.3) or workshops to look at different aspects of developmental or mental health problems in under-5s. We thought this would be a good way to identify CC's needs so that later we could offer

individual parent work, mothers' or fathers' groups, or individual work with children.

Immediately, several questions emerged, mainly to do with our service and which team the referrals would be under as one of the Child Psychotherapists was employed to work under our multiagency liaison team (MALT) and not under the generic CAMHS. Issues like actual physical space (Where would the groups take place? Should we have Work Discussion Groups or individual work?) emerged, as well as concerns about clinical responsibility and risk (psychiatric cover). We also wondered about the administrative side of setting up the service and more specifically about how to record and log our work and that of the possible groups, or which outcome measures to use and how. In addition to this, we felt we needed to explore and get more information about our service's previous involvement with CC. CC, as we later found out, did not have experience of working with CPs but had previous CAMHS input for a period of one year by way of being offered parent groups and consultation to managers by CAMHS Clinical Psychologists. However, there was no continuity in this work as CAMHS involvement changed every time there was a Trust change.

The next meetings included a Clinical Psychologist, Carol, who would be our Lead in the outreach service and who would liaise with CC managers as she had had prior contact with them during a few past attempts to engage them as part of the Early Intervention CAMHS team, which ceased to exist in 2012 after the CAMHS redesign when a new Trust took over. It was then that we realised how little we knew about the CC, and that we had no clear picture of the past relationship between CAMHS and CC. Carol suggested we started by joining the allocations meetings at the CC. She appeared somewhat reluctant about setting up a consultation service since she

thought this needed further consideration within CAMHS and more specifically, she was concerned about the referral process and the potentially long waiting list for under-5s within CAMHS. This immediately brought to everybody's attention the crucial issue of resources. We assessed the amount of work and personnel required both to do the outreach but also to pick up on cases within the clinic. The agreement with our manager was to allocate 3,5 hours each per week for the project, which included administration time. We decided to work together in two pairs, and each pair was to work in two centres on a three-weekly rotation, with the 4th week being reserved for administrative tasks. Regular meetings were also agreed on, to discuss our work and to create a sense of coherence and continuity between our different teams working in different centres.

In the outline of our offer (APPENDIX A), we introduced our project as a pilot programme that aimed to identify CC's needs and offer services accordingly. We agreed that our focal point to begin with would be to consult staff, by attending some of their groups. This would give us the opportunity to think through difficult cases with them at the end of the group. We would explore ways of intervening, and introduce Work Discussion Groups where the staff could present cases they were most concerned about. It is important to note that this pilot project was our CAMHS' initiative, and although the Children's Centre managers agreed that there was scope for work between the two services, Children's Centre workers' readiness to work with CAMHS was not a given. Moreover, the necessary support from senior staff was yet to be proven.

The CC in our area offered services in 7 different hubs, one of which was based on the first floor of a block of flats in a very deprived area and another in the local Mall,

in a very small open space area with no natural light. Others were attached to nurseries and primary schools. The CC workers run 'universal groups', such as 'stay and play' or 'messy play', usually lasting an hour and half, where parents are invited to join with their young child. The CC workers organise and set up activities around the room where children can play with their parents. Then, there is snack time and the hour usually finishes with singing time and saying goodbye. The universal groups are advertised by the CC as opportunities for the parents to meet other parents with young children. There are also 'health clinics' or 'baby clinics' where different services such as health visitors and midwives get together and do a basic health check-up for babies and young children. The 'targeted' services concern mostly parenting programs with families who have been identified (mostly during home visits) as families with extra needs. Some of those families are obliged to attend as part of the Social services' monitoring of their family. CC family workers' role often involves home visits in an attempt to engage parents who are difficult to reach and they are required to report back to Social Services in case of concerns about the parents. Most family workers are based in one or two of the hubs, but because of the CC being short-staffed are required to travel across the different sites. They have regular supervision with their manager that mostly involves discussing safeguarding concerns, and they also attend staff meetings dealing mostly with organisational issues. A description of our pilot following the meetings with the CC managers can be found in APPENDIX B.

1.3.2 First contacts with the CC

At the start of my involvement with the Children's Centres my notes reflected feelings of anxiety and insecurity in relation to introducing ourselves and our service to the

Children's Centres' staff; anxiety about where to stand and what to do when joining some of the groups they run; questions about how much to interact with parents and children and how to engage Children's Centres' workers in our psychoanalytic way of thinking. I wondered whether this was somewhat similar to the families' experience of first contact with the centres. I attended these meetings up to the end of the project.

On my first attendance in a health clinic in March 2015 (see APPENDIX C), I encountered mixed reactions from the professionals, some feeling threatened and others making an effort to make use of my presence there. Immediately, I felt monthly attendance in the clinics would be a useful starting point as many of the families' health concerns seemed to have an emotional aspect. Also, the multi- agency aspect of these groups (which included other services such as Health Visitors) seemed to make a good starting point for promoting ideas about mental health in infants.

Finding time slots that could work for both the CC's group facilitators and CAMHS proved to be very difficult and time-consuming. We sometimes found ourselves attending some of the groups according to our availability rather than the staff or families' needs. Sometimes we felt that some of the groups were 'too healthy' for us to be there and that it was a mismanagement of resources. Sometimes we would find ourselves travelling long distances for a group only to find out that this had been cancelled by the CC. I wondered whether these practical difficulties reflected the lack of clarity in the working relationship between CAMHS and CC. Also, as will be discussed in Chapter 4 we had questions about unconscious feelings that were stirred up by our presence such as hostility and envy. Some of the staff welcomed our presence in their groups and some asked for more input from our service. I considered

this as an appreciation of a different point of view and I felt CC workers were often relieved to discuss 'difficult behaviours' and to feel understood and contained by us. Ways of approaching children or their parents about those issues were also discussed and suggested which the staff found very helpful.

1.3.3 Review of the first months

In a meeting in March 2015 (7 months into the project) and following our brief experience of attending groups and liaising with Children's Centre staff we all shared the view that it felt hard to engage them and communication was difficult. In this meeting, our Senior Child Psychotherapist supervising the pilot, Neithan, suggested that since it was hard to engage CC, we needed to focus on consultation and monthly Work Discussion Groups, in order to sensitise frontline workers to signs of mental health difficulties, as first contact. This seemed reasonable to the team. We also agreed that the project would be piloted for 6 months and, then, we would evaluate and review.

Another important development on our minds was the upcoming redesign in Children's centres, due to take place by the end of 2015. All staff on temporary contracts were thus experiencing significant anxieties about losing their jobs. Concurrently, our CAMHS was going through a transition between two Trusts and we were unsure about whether this project would be possible to continue with the new Trust.

We were also reminded by the Senior Child Psychotherapist that CAMHS was commissioned to offer consultation to Children Centres and we acknowledged the fact that we were unclear what the Children's Centres provision to under-5s in terms

of mental health was. The issue of engagement occupied most of our meetings – in terms of trying both to understand the reasons behind Children's Centre staff's reluctance to work with us, and also to find ways to overcome these barriers, towards developing a more positive and collaborative attitude. We all recognised that we needed to respect the fact that this was a particularly challenging time for them, and that they were struggling with keeping their service together at a time of the uncertainty about the future of the service and their work.

We likewise reflected on the importance of presenting this pilot project to our CAMHS team, which was also undergoing a redesign. Powerful dynamics were starting to emerge in relation to different areas of work and expertise such as envy or suspicion about this being a Child Psychotherapy-led project. Discussing our work openly in a team meeting seemed a good way to share our concerns but also to get some input and thoughts from our multidisciplinary team, which included people with years of experience in outreach work.

1.3.4 My involvement with the CC

In the two Children's Centres that I was involved with, the culture and attitude towards CAMHS differed. A new manager in Children's Centre A brought about many changes that led to misunderstandings and miscommunications. These made our work impossible and the Work Discussion Group we had planned was postponed for many months until a meeting with the new manager could be arranged. On the other hand, the manager of Children's Centre B appeared to be very keen on working with us. We were shortly introduced to her team, and two different Work Discussion groups were set up for two different teams in B soon after.

My involvement with the CC A included joining 'Baby Talk', a universal group for babies where I sat on the carpet and had some interactions with parents. Most importantly, I observed the interactions between families and the CC workers, and we met after the group to discuss the session. This was something that felt important to the workers who were keen to continue and we did so until the end of the pilot.

Dan and I delivered a Work Discussion Group to the Outreach team in CC A, which felt hard to organise and sustain. We felt it was very difficult to connect with them as a group and they were very reluctant to discuss and think about their work. People were overwhelmed with anxiety about their responsibility for extremely complex and risky cases. There was a lot of conversation centering on our explaining the referral route to CAMHS so they could refer families. We talked about safeguarding concerns with them and when an outreach worker presented a case we felt it would not be appropriate for it to be picked up by CAMHS but by Social Services, as there were indeed serious safeguarding concerns. Outreach workers as well as their Deputy seemed very ambivalent about the Work Discussion Groups, which was evident in a series of miscommunications and misunderstandings about the time and place of these meetings, and the meetings felt hurried when they did occur. After a couple of Work Discussion Groups with the Outreach Team, they felt they didn't have the time and decided to stop.

In CC B, we met with the manager and agreed to meet with her staff. We agreed that Kiara (Child Psychotherapist in training) and I would offer a Work Discussion Group for the family workers. Dan delivered a Work Discussion Group to staff involved in the parenting-targeted program in CC B. It is important to note that CC workers had requested this intervention as they realised they were struggling with the targeted

parenting group. Kiara and I held monthly Work Discussion groups for a mixed group of workers (family workers, nursery nurses, outreach workers) who run both targeted and universal groups. This Work Discussion Group (WDG) started in March 2015 and would be my pilot group until December 2015, when the first evaluation of the work would take place.

The notes from one of the first WDG (see APPENDIX D) convey a range of mixed responses towards thinking about their work with families. The group seemed to start somewhat reluctantly, but progressively a lot of worries about families were shared, as well as important questions being raised that pointed to a feeling of 'not knowing' how to identify a problem and help a family. People seemed to sometimes feel reluctant and anxious about approaching parents to have a conversation about their child and problematic interactions they might have observed. I left this group thinking that there was a lot of scope for these groups to carry on. I realised we needed a considerable amount of time for people to trust that a thinking space could be important in itself, beyond the value of bringing CAMHS into the groups to help them 'there and then'. We needed to build their trust in this method and its capacity to enable them to feel more confident in their interactions with families.

1.3.5 The abrupt end of the project

Nearly a year into this work and after the end of the pilot phase, we met in CAMHS and were told by our managers that there were important changes happening in the Children's Centres and that we would propose a clear intervention contract: one that would just involve Work Discussion Groups and staff consultation. We agreed with that as we had already identified issues that had arisen due to the lack of a clear structure in what we could offer. However, our work with the Children's Centres

stopped abruptly. Our management announced shortly after (July 2015), that we were unable to continue due to the Children's Centres' redesign and the need for a more evidence-based approach to consultation to CC staff.

As briefly explained in the Introduction, the end of our working relationship with the CC not only had an impact on our Child Psychotherapy team – which had to process and make sense of this abrupt ending – but also on my research. My initial aim had been to pilot, establish and then evaluate the impact of Work Discussion Groups on the staff and my research questions had been focused on the experience of delivering and attending WDGs. When the Work Discussion Groups in the CC came to an abrupt end, I proceeded to examine the data I already had and I conducted exploratory interviews with the participants – both colleagues from CAMHS and the CC – in order to answer the following research questions:

What was the experience of staff in the two agencies (in line with my original research plan): How did Child Psychotherapists experience the process of setting up a Child Psychotherapy-led outreach service to Children's Centres and what did they learn from this attempt? What was the Children's Centres' staff experience of their role and understanding of infant mental health and what was their experience of piloting a Child Psychotherapy outreach service in their workplace? What was their initial experience of WDGs? What was the impact of deprivation on CC way of functioning? What was the impact of the institutional crises and wider climate of cuts on both services?

1.4 Becoming a researcher/Psychoanalytic Background

The next section offers a description of how I experienced the new role of the researcher coming from a clinical background, and the theoretical (Psychoanalytic)

background that informs my clinical practice, as well as, inevitably, this research.

As Child Psychotherapists, we are trained in a preclinical course (Observational Studies) to notice and absorb both conscious and unconscious states of mind of children, young people and their parents. The Tavistock Infant Observation method is a naturalistic method that familiarises future clinicians with the powerful dynamics of primitive states of mind from the very beginning of one's life, by observing an infant from birth until the age of two. Rustin (2012) has written about Infant Observation as a research tool as students keep weekly systematic notes that aim to capture minute-by-minute interactions between the infant and the world around her/him with the aim of identifying patterns of relating and behaving, thus creating a narrative of the infant's first encounters with significant others. Psychoanalysis and Psychoanalytic Psychotherapy, similarly, is based on observation, careful attention and thinking through the vicissitudes of patients' psychic states as they appear in the relationship with the Psychotherapist in the consulting room. Gradually, the Psychoanalyst or the Psychotherapist forms a narrative that can be shared and understood by the patient, providing meaning to behaviours and thoughts that were previously felt to be fragmented and, at times, meaningless. By bringing unconscious processes to the fore and by forming a narrative of one's psychic life, Psychoanalysis allows for an in-depth study of one's internal life and provides the patient with an opportunity to speak, to be heard and understood.

For the purposes of this project, and in order to convey as much as possible of the lived experience of the CC workers and Child Psychotherapists who ran the pilot with me, I chose to use my own notes, memories, impressions and feelings but more importantly, to focus on people's narratives and accounts of what they encountered

during the time of the project. I decided to interview them following their agreement to be part of this research, audio-record the interviews and transcribe them verbatim. I then analysed the scripts by using Interpretative Phenomenological Analysis (See CHAPTER 3) and drew on my capacity to stay with the material and 'see what's there to be seen' (Reid, 1997, p. 1). Although initially overwhelmed by what a qualitative research project would entail and wondering whether I would be able to design and implement a small-scale study like this, I soon found that the process felt similar to writing a clinical paper by looking at and revisiting process notes again and again, trying to convey my own experience and that of my patients. Something felt familiar, yet the role of the researcher posed new challenges in my capacity as a trainee Child Psychotherapist in an outreach consultation service. There were many adaptations to be made, outside of the safe boundaries of the consulting room and the clinic, of the one-to- one contact with one patient at the time, in new (and at times unwelcoming) crowded environments where I had to find 'my place' and at the same time to become a participant-observer introducing a small-scale study in a deprived area and in an institution in crisis that felt overwhelmed by outcome monitoring and evaluation processes.

As described above, there are similarities and interesting parallels to be drawn between the role of the Psychotherapist and that of the researcher. The Psychoanalytic framework around this research is predominantly based on object relations theorists, namely Klein's, Bion's and Winnicott's theories of infantile development. All three theorists considered the relationship with the mother or primary caregiver as a fundamental aspect of early life, through which the infant's ego is formed. This intersubjective view of development in a child's early life inevitably stresses the

importance of promoting mental health in the early years and that of early intervention when needed. It also offers useful theoretical tools that can also be applied in the social sphere and institutional dynamics, as social life is formed by and is dependent upon relationships.

One of Melanie Klein's major contributions to psychoanalytic thinking was her theory about the first phases of development and in particular of the formulation of the paranoid-schizoid and the depressive position. According to Klein (1948), during the first months after birth there is a fundamental anxiety, an unconscious fear of annihilation, which derives from the death instinct. This anxiety is experienced as coming from within and the infant tries to cope with it by using several defence mechanisms, such as splitting, projection, introjection and projective identification. The mechanism of splitting refers to the process where the infant experiences the external world as a world of part objects, with the mother's breast being the primal part object. There are feelings of satisfaction and pleasure related to the presence of the gratifying breast and feelings of frustration when the breast is absent. Due to the active role of the phantasy at this early phase, the gratifying breast is experienced as good and the absent and frustrating breast as bad. As Klein (1946) argues in her paper 'Notes on some Schizoid Mechanisms', the fact that the infant splits the objects and its relations with them might imply that in those early months of life there is a splitting of the ego itself. Another defence mechanism characteristic of the paranoid-schizoid position is the one of projective identification, whereby the infant projects some 'bad' parts of itself onto the object. The object, in this case, not only is experienced as bad but is also identified with the bad parts of the self.

Gradually the infant becomes capable of perceiving whole objects, and thus the

mother is experienced as one and the same person that can be introjected as such. As the infant enters the 'depressive position', it feels separated from the mother. An increased fear of loss, a strong feeling of guilt and mourning processes are foregrounded as a result. These depressive feelings help the ego to develop further. The aggressive urges directed towards the mother and other external objects are in this position accompanied by feelings of guilt and a constant fear of loss. The realisation of the attacks on the object is extremely painful and the guilt and concern for the object are referred to as 'depressive anxiety'. As a consequence, infants develop the need for repairing the harm they feel they have done to the object (Klein, 1946). Although Klein remained loyal to the Freudian 'biological' theory of drives (as she believed in the existence of the death instinct), she put a great deal of emphasis on the relational aspect of development.

Wilfred Bion expanded Klein's theory of infantile development and deemed the relationship with the mother to be of great importance. Drawing upon Klein's (1931) idea of the existence of an 'epistimophilic' instinct at work from the beginning of life, as well as from his observations of the intellectual deficit in psychotic patients, Bion (1957, 1962) developed a theory of thinking. Central to his theory is the notion of the container-contained relationship: the mother's ability to take in the infant's anxiety, translate it into meaning and thus make it more manageable for the infant is, according to Bion (1962), the basis of the maternal function. He refers to the mother's state of mind when she takes in the infant's projected anxiety as 'reverie' that leads to 'a theory of thinking'. The mother's ability to give meaning to these anxieties serves as a bridge between preconception and realisation, where the emergence of thinking will later occur.

Donald Winnicott's theory on development also follows Klein's line of thought, as he considers the infant's first experience of the self as 'unintegrated', whereby the experience is diffused and scattered. The mother's organised perceptions of her infant serve as a 'holding environment' within which the infant is contained. As Winnicott (1960) writes: '[the notion of holding is used] to denote not only the actual physical holding of the infant, but also the total environmental provision prior to the concept of living with' (p 43). Through 'primary maternal preoccupation' (a term used by Winnicott to describe the mother's devotion to her infant) the infant gradually achieves separation, differentiation and realisation. The quality of motherhood described by Winnicott as 'good-enough' concerns a mother whose conscious and unconscious attunement to her infant allows for an optimal environment to gradually occur – where the healthy establishment of a separate being will take place and where the infant will eventually become capable of mature object-relations. Winnicott (1964) drew attention to the fact that babies are born in a context, and that the influence of the baby's environment is crucial to its development. He therefore argued for timely and sensitive support for early motherhood (Winnicott, 1964).

The above theoretical background can be useful for framing a hypothesis when applying these ideas to how CC function. The staff at Children's Centres are inevitably closely involved with families and very young children and act as an intermediary between the intimacy of the home environment and life outside the closed boundaries of home. There is a complex interplay between witnessing the relationship with the primary caregivers (since children attend CC with their parents) and becoming the recipients of powerful projections and anxieties that come from both the infants or young children and their parents. These complex dynamics can

interfere with the staff's capacity to think and respond to the families' needs. At the same time, there is a great opportunity for these anxieties to be contained by the staff and to provide a necessary 'third position' (Britton, 2004), namely a psychic space where separation and individualisation – in the service of development – can take place. The latter is only possible when staff are emotionally available and observant, so that a holding environment may be provided where ordinary anxieties can be contained and responded to in a benign and helpful way. Team and institutional dynamics are of central importance when discussing CC staff's ability to contain complex feelings. A healthy working environment and an institution that can in turn contain staff's anxieties are necessary, so that families, young children, and those who work with them, can be properly looked after.

In the chapter that follows there is a review of relevant literature that situates this research in relation to prior research carried out in this area and elaborates on the theoretical framework.

CHAPTER 2 LITERATURE REVIEW

The literature search strategy started from specific references that I was already familiar with (for example, Jackson, 2002, Urwin, 2003). Whilst conducting the research other sources became available developing ideas from aspects of earlier studies, for example Daws, 1985. I continued by expanding my searches using electronic databases such as, PEPWeb, and PsycINFO scrutinizing for relevancy. I used search terms including Child Psychotherapy and outreach work, Children's Centres, Work Discussion Groups, institutional defences and others. This process of expansion and then focus continued throughout the research, leaving me with a filter of those studies that have appeared and re-appeared as the most directly relevant. Hand searching, through books and journals such as the Journal of Child Psychotherapy or Early Years yielded directly relevant or background information as presented below in three different sections:

2.1 Child Psychotherapy and Outreach work

The literature review offers an overview of the most relevant papers investigating different examples of outreach work in the community to map out the challenges as well as opportunities related to this kind of work.

Child Psychotherapy has been predominately practised in the consulting room. The rigidity of the therapeutic setting has always been of central importance as it provides patients with consistency, predictability and the necessary firm boundaries for the establishment of the therapeutic relationship. However, more recently, the demands of the changing National Health Service (NHS) have put pressure on Child Psychotherapists to adjust and apply their technique in other settings, such as schools

(Music, 2007, Jackson, 2002), hospitals (Kerbekian, 1995, Cohen, 2003), GP practices (Daws, 1985) and Children's Centres (Urwin, 2003), to name but a few.

Several publications in the field of psychoanalytic Child Psychotherapy have addressed the theme of outreach work and applied Psychoanalytic Psychotherapy in the community. Bower & Trowell (1995) edited a collection of papers that discuss the nature of the work in the community, focusing both on the high demands these settings impose on the clinician and on their usefulness to other professionals and their patients. In their introduction to this book, Bower & Trowell (1995) stress the importance of the social context where outreach work is done and believe that professionals working with young families in a variety of services are 'faced with the task of repairing the emotional damage created by years of poverty and deprivation' (p 1.). This is an important aspect always to be kept in mind. This is relevant to my project since the work was undertaken in a particularly deprived area.

Carrington, Rock & Stern (2012) describe designing an outreach service in GP surgeries in a deprived borough of London and although this concerned an adult service, the authors highlight the importance of paying attention to the 'deviations' from the traditional psychoanalytic practice that are essential for 'a necessary adaptation to the realities of primary care and of the complex profiles of patients both in clinical and in socioeconomic terms' (p. 106). They particularly highlight the importance of understanding transference and counter-transference phenomena that can give insight into the interactions between professionals from different backgrounds and agencies. The latter is necessary since the offer to help often provokes perceptions of threats to self-sufficiency (Carrington, Rock & Stern, 2012).

Loshak (2007) describes how she transitioned from a clinical setting to community

work. Maintaining distance has been one of the challenges, as well as letting go of 'an omnipotent belief' (p. 28) that she was better equipped to understand and attend to the needs of the families. Loshak's (2007) paper describes the risks to one's professional identity and the danger of enacting defences as a way of managing the anxiety inherent to the work. She makes particular reference to Britton's (2015) work on the impact of the families' anxiety on professional teams that is, as he writes: 'forcibly communicated at an unconscious level to the professional network which is in danger of reacting with action rather than thinking' (Britton, 2015, p.170).

Loshak (2007) suggests that when staff are well-supported and provided with a thinking space, the idea of people coming together starts to seem less persecutory and joined meetings between professionals provide a container for projections and blaming.

Finding one's place in the outreach setting is a challenging and anxiety-provoking process. Music (2007) notes that outreach workers are finding themselves in a complex position of being both inside and outside the institution. Dilys Daws (1985) describes vividly the process of adapting in a setting outside the security of the clinic and the consulting room and calls attention to the feelings of exclusion and loneliness that the clinician may feel. Rothenberg (2010) pays attention to the fact that the outreach worker becomes a 'guest' of the host organisation whose goals and aims sometimes do not coincide with their own. At the same time, although challenging, the third position of the 'outsider' provides the clinician with the necessary distance to observe and explore unconscious dynamics underpinning the workplace.

Carrington, Rock & Stern (2012) argue that the 'third position' of the outreach worker

helps him/her to retain the not-knowing, neutral position necessary to think psychoanalytically and deliver this way of thinking to other professionals. Along the same lines, Daws (1985) underlines the advantage of being an outsider as this position enables the clinician to be free of the shared defences of the institution and thus understand the underlying anxieties. Daws (1985) describes her long experience of working in a GP practice by focusing on two aspects: the nature of the clinical work she undertook, and the process of being a consultant in an institution other than her consulting room. She highlights the importance of respecting the expertise as well as the basic psychoanalytic understanding that primary care workers have. Daws invites Child Psychotherapists to be careful not to undermine the already-existing knowledge that staff may have. As she puts it:

> I do not believe that I am the only holder of a psychodynamic viewpoint. We would do well to acknowledge, as members of the psychotherapy professions, that we came to these professions because psychoanalytic thinking is embedded in present-day culture – the culture did not arise because of us. Our contribution is to keep it in circulation in spite of our own, as well as our colleagues', many resistances (Daws, 1985, p.80).

She describes primary care staff as being in a 'grandparental' role since their task is to provide a model of availability and receptivity to parents' anxieties, which helps them to do the same for their children, a process very relevant to Children's Centres' staff.

One of the most challenging issues for Daws (1985) was where to place herself, and she chose 'next to the weighing scales' as the most appropriate place, from where she

could be most available and visible to the staff and families. As she writes:

> standing doing nothing requires skill if it is not to be puzzling and persecuting to the people around…If I am too self-contained, it must seem that my observations are for some unexplained private use, if I am too efficiently outgoing, mothers hand me their Baby Books to check them into the clinic (Daws, 1985, p.79).

Solomon & Nashat (2010) discuss the issue of psychoanalytic consultation in schools and suggest that the frequent presence of a clinician (as opposed to less frequent consultation from 'the outside') creates the space for a 'therapeutic presence' in the school, which contains the staff's anxiety and enables the whole organisation to function in a healthier and more creative manner. Louise Emanuel (2005) describes how schools can resort to unconscious attacks on thinking and argues that the role of the consultant to the staff is to create meaningful connections by paying attention to details that may seem irrelevant. As a result, previously incomprehensible behaviour begins to make sense and, therefore, a different way of working with children becomes possible. Music & Hall (2008) discuss therapeutic work at schools and suggest that this work often resembles the one in a therapeutic community where the Child Psychotherapist does not quite know who the patient is and the boundaries of their time on duty. Music & Hall (2008) draw the reader's attention to the powerful projections and a circle of 'blame' that emerge when working with 'difficult children' in a school setting and argue that the challenging task for the Child Psychotherapist is to disrupt this circle and allow some space for hope and development. Music (2007) highlights the importance of working with the overall culture of a school as schools can provide effective 'containers' for feelings that can be split off and projected to

others, provided staff have a safe space to think about what is being stirred up. Music & Hall (2008) describe how the arrival of an outreach service in a school can be met with ambivalence and the role of the Psychotherapist could be undermined because of anxieties that are stirred up by the presence of mental health specialists.

Emil Jackson (2002) describes an outreach project for schools that aimed at engaging young people at risk. He discusses in detail the process of working closely with school staff and establishing Work Discussion Groups. Of central importance seemed to be that 'consensus was reached that our primary task was to create a space outside the heat of the classroom setting, to reflect on their work' (p.129). Being available to the staff and being clear with them about practicalities and aims of the Work Discussion Groups was, for Jackson, essential in establishing a working relationship with the institution. Jackson describes the positive outcomes of this project – positive feedback was given by 25 members of staff and the head teacher – and explains that they achieved a thinking space 'in which teachers can enhance their observational skills and develop their understanding about the emotional factors that impact on behaviour, learning and teaching' (Jackson, 2002, p.144).

The work of Margaret Cohen (2003) in a neonatal intensive care unit, described in 'Sent before my time: A Child Psychotherapist's view of life on a neonatal intensive care unit', is a valuable example of thinking about outreach settings and the challenges of applied Child Psychotherapy, in this case in a hospital. She further talks about the powerful projections of working close to infants, very young children and their parents and describes the process of developing and establishing her role in the team. Her experience included feeling as if she were the one who had to be the reminder of a painful reality as the hospital staff had at times been resistant to thinking

about painful feelings. She describes how she developed and established her role, which was considerably different from that of all the medical staff in the unit. Cohen (2003) highlights the challenges that a Child Psychotherapist can experience in such a context due to feelings of isolation. What are essential, therefore, are patience, sensitive perseverance and the capacity to bear the pain of both patients and staff.

Cathy Urwin's (2003) work with Sure Start Children's Centres is particularly relevant to this project, as Urwin describes the development of a pilot infant mental health service in Children's Centres in a deprived community. In this paper, she discusses the necessity of outreach services for hard-to-reach families which can be accessible and responsive to the needs of the population. In discussing the challenges presented by the outreach setting, Urwin highlights the importance of liaising with other professionals and working closely with Sure Start workers.

Most importantly, Urwin (2003) describes the specific contributions of Child Psychotherapists in this line of work, arguing that thinking about unconscious processes – such as parents' powerful projections of their unresolved conflicts onto the child – contributes to 'freeing a hitch in the parent-child relationship' (2003, p.383). Urwin further stresses the importance of the CAMHS team. This provides a 'secure base' for thinking and feeling a sense of professional belonging that she considers as necessary for undertaking community work. The clinical material Urwin (2003) presents in this paper demonstrates the usefulness of observational skills and interpretation of the transference, but also highlights necessary adaptations to the 'classic' child psychotherapy technique, such as introducing phone calls to parents and offering direct advice to families when needed.

Urwin's initial project for under-4s involved setting up a counselling and parent support service, called Help at Hand, to address the under-representation of under-4's being referred to the local CAMHS (2003). The paper presented to the Association of Child Psychotherapists Conference (Urwin et al., 2008) by those involved in Help at Hand noted:

> That the referral rate of under-fives to the Tower Hamlets CAMHS East Team, has increased substantially since 1999 […] representing an increase of 6.25%. This increase is largely though our decision to become proactively involved with Sure Start and other community projects.

The work with infants and young children in the community as a means of early intervention and prevention seems to be of central importance nowadays. In his paper 'Learning our lessons: Some issues arising from delivering mental health services in school settings' (2007), Graham Music describes the changing needs and politics of the NHS. He draws attention to the fact that CAMHS are expected to deliver 'tier 2' services in community settings as well as offering support to 'tier 1' professionals. The rationale behind this change in the CAMHS structure is that services need to be made available across all tiers, and early intervention and prevention need to be prioritised. Music (2007) argues that the changing social and political milieu is imposing increasing pressures on how child and adolescent mental health services are delivered. He argues that in order to work effectively in this climate, clinicians need to make adaptations in their technique and embrace ideas derived from psychoanalytically informed organisational consultancy and work in therapeutic communities (Music, 2007).

Margaret Rustin (2008) argues for the importance of Child Mental Health practitioners being involved with the ever-increasing numbers of Early Years professionals. She explains that the reluctance to refer under-5s to CAMHS is often based on a concern that young children would be 'pathologised' and on the assumption that their symptoms will disappear as they grow. The view of most Child Psychotherapists is, on the contrary, that, if these symptoms are neglected early on, they may well persist or worsen (Rustin, 2008).

Woods (2000) sees the work with toddler groups and nurseries as a great opportunity for the Child Psychotherapist to promote profound changes in children and their parents, as well as to modify potentially damaging relationships. Gale & Vostanis (2003) discuss the importance of the role of the primary mental health worker whose task it is to provide CAMHS input to universal services. The authors note that there is a growing number of children with mental health difficulties and argue that the frontline workers in universal primary care settings need support from specialised CAMHS practitioners, to help them build their capacity to both identify children's mental health needs and intervene accordingly. This would contribute to reducing the gap between primary care and specialised CAMHS.

2.2 Understanding the institution

In this research project, I explore and discuss issues to do with the Children's Centres' ways of operating. I, therefore, reviewed literature related to psychoanalytic theories that attempt to understand how institutions function. I also reviewed Early Years' literature on CC staff's perceptions of their work and roles, as relevant to this research.

Institutional dynamics and Social Defences

Carrington, Rock & Stern (2012) write about the uniqueness of each outreach setting's way of functioning and compare this to the unique 'mental landscape' of each individual person. They suggest that outreach workers must study the micro-culture of each setting in order to be in a better position to help the staff.

Psychoanalytic theory has been a very useful tool for understanding institutions, and the Tavistock Clinic has a long tradition in studying this area. Menzies Lyth's (1988) seminal study on how institutional dynamics interfere with the way nurses conduct their work has been an important contribution to the psychoanalytic study of institutions. In their book *The Unconscious at Work: Individual and Organizational Stress in the Human Services*, Obholzer & Roberts (1994) edited a collection of papers describing and seeking to understand the underlying processes at work in 'people institutions' and how these sometimes get in the way of a healthy functioning of the organisation. These examine a variety of different settings. Furthermore, the rapid economic and political changes are considered, and institutions in crisis are discussed. The latter are particularly relevant to my project as the Children's Centre workers were facing great uncertainty with regard to their employment and it would be worth exploring if and to what extend this could have interfered with the staff's primary task. Roberts' (1994) term 'the self-assigned impossible task' refers to teams that are set up as an alternative to more traditional ones, 'often by someone disaffected by personal or professional experience of other settings' (p. 110). When a team's identity is based on being an alternative, this may implicitly suggest superiority and this in turn restricts debate. As she notes: 'Doubts and disagreement are projected, fueling intergroup conflict, but within the group everyone must support the ideology.

Any questioning from within the group is treated as a betrayal of a shared vision' (Roberts, 1994, p.110).

Huffington and Armstrong (2004) describe organisations as 'punctuations of interpersonal space, punctuations defined by the boundary of the organisation' (2004, p. 52). They further describe how 'complex emotional constellations' (p.12) arise in workplaces, and they argue that the particular contribution of psychoanalysis to understanding organisational life is:

> a many-layered account of the ways in which emotions shape our experience, both consciously and unconsciously; their origin in early object relations, their expression in phantasy, and their pervasiveness and distribution within and across our private and public lives (Huffington and Armstrong, 2004, p.12).

Armstrong (2005) argues that to work psychoanalytically in organisations is to:

> use one's alertness to the emotional experience presented in such settings as the medium for seeking to understand, formulate and interpret the relatedness of the individual to the group or the organisation. It is understanding that relatedness, I believe, which liberates the energy to discover what working and being in the group or the organisation can become (2005, p.33).

Hinshelwood & Skogstad (2002) present the work of a range of contributors who observe and think about institutions in the health and social services sector. Psychoanalytic understanding is employed to inform a better understanding of these cultures and to facilitate change within the institutions. It becomes evident from the examples described in this book that there is great need for containment and support for the staff. Another useful point made by the editors of this volume is that the use

of institutional observation as a training method for staff enables them to become aware of unhelpful practices and helps promote more sensitive ways of working.

Armstrong and Rustin (2014) edited a collection of papers that illustrate different applications of psychoanalytic thinking about institutions. They highlight the importance of exploring and clarifying the particular ways in which an institution operates, its structure and culture, as well as its relation to its environment. The hypothesis is that institutions have distinct primary tasks as their condition of operation and these tasks are likely to be associated with a corresponding primary anxiety. Armstrong and Rustin (2014) further explain that, when this anxiety becomes overwhelming, unconscious organisational defences are likely to emerge. These defences can become embedded in the culture, structure, rules and ways of operating of the institution. They also draw our attention to the social aspects of institutional life and argue that locating the sources of anxiety within the organisations and in the external social environment are both equally important, and that such sources are not mutually exclusive. According to the authors, inadequate recognition of external forces can sometimes explain why interventions to address unconscious defences do not succeed.

Multi-disciplinary working and CC staff's perception of their work and role

Part of this research project explores issues related to the impact of change on teams, along with the complexities that emerge while working in multi-disciplinary environments and different agencies. Salmon and Rapport's (2005) qualitative study provides useful findings on the language used by different clinicians and other agencies within a CAMHS. The researchers point out that there is more literature that

discusses the challenges and the barriers in multi-agency work than ways of overcoming such barriers. The study is particularly concerned with how risk is understood and spoken about in teams. According to the authors, one of the most significant challenges is communication, since different professionals may use the same term while attributing different meanings to it. The lack of questions to clarify meaning between professionals in multiagency meetings is understood by the authors as the result of perceived hierarchies in meetings.

Warin's (2007) study explores staff's perception and conceptualisation of the target beneficiaries of the service (the child, parents, mothers, fathers, the child-within- the-family, the extended family?) in three community centres. Warin (2007) questions the government departments' collaborating strategies and 'joined up thinking', arguing that this can be interpreted differently by different staff and results in confusion, especially when from a policy level the primary objective of the work remains unclear, with a conflict of goals sometimes materialising. Warin (2007) calls for goals to be clarified within organisations that serve families in the community, and for them to be centred on 'the-child-within-the-family'.

Nightingale and Scott (1994), both Consultant Psychotherapists, attempted an exploration of the impact of organisational (NHS) changes on their multidisciplinary team. They found that systemic changes in adult mental health services (such as the move from hospital to community services) result in staff's having to adapt to new ways of working. The authors joining the team brought about a change in the therapeutic focus, which became more psychoanalytic. The latter resulted in the staff's experience of being pressured to be seen as 'the same, in terms of competence, skills, seniority and training' (p. 269) and when reporting on patients they would often

present themselves as capable of managing more than they actually could manage, with a 'false certainty and pseudo-knowing' (p. 269). The anxiety that arose as a result of the change in the service delivery could be best managed, according to the authors, with maintaining clarity of roles in the team. This paper is relevant to the current research since the authors tried to explore and understand the complex dynamics that emerged in their workplace during a time of change in the service.

Rose's (2011) paper examines the dilemmas of inter-professional collaboration. She explores the thoughts of members from eight inter-professional teams working in different areas of children's services, on three hypothetical examples of inter-professional dilemmas. An important finding of this study was the professionals' territorial attitudes towards their expertise. Rose (2011) suggests that role dilemmas often result in anxieties about the quality of the service as well as in 'overlap' in delivery of services: 'Contradictory models of practice in decision making, which can lead to feeling ignored, devalued, and potential confusion for service users' (p. 153) often lead to professionals' identity and control dilemmas. Rose's (2011) findings are in agreement with relevant multidisciplinary team research literature, where terms such as 'shared goals' are agreed upon, without a clear understanding of what they actually are. Rose (2011) draws interesting conclusions from her research, one of these being the idea that enacting collective preferences often entails some degree of professional self-sacrifice – as opposed to the experience of loss that results in territorial attitudes, which obstruct staff's ability to share their expertise.

Cottle's (2011) findings regarding Children's Centre practitioners' perspectives on achieving quality indicate that practitioners' definitions of quality and success are very influenced by the organisational climate in which they work, as well as by the

wider political agenda and their individual histories. Cottle (2011) found that practitioners in CC often felt they struggled in their efforts not only to meet national policy requirements, but also to achieve role clarity. CC staff described blurred boundaries and flattened hierarchies at their workplace which, although challenging, created a sense of shared ownership and collective purpose (Anning et al, 2010). CC staff often felt moreover that they struggled to become established in the community and to form relationships with the parents and thence fulfil their expectations. Staff also felt under pressure due to structural changes in CC that were experienced as overwhelming and beyond their control. CC staff in 8 of the 11 centres in this study expressed their wish to have more time to reflect on their changing roles and responsibilities. Cottle (2011) draws attention to the impact of social class divisions that are widening due to neo-liberalism on CC staff. As she puts it:

> Not only does the new Government policy seem likely to maintain this situation but also it continues to charge early years practitioners in Sure Start Children's Centres with the responsibility of alleviating the effects of poverty. This whilst, in all likelihood, retaining low levels of pay and status within the sector, especially given the current economic climate (Cottle, 2011, p.262).

Similar findings from a previous study by Alexander (2010) point to the fact that ideas to do with quality of service are shaped and sometimes limited by the culture and the context of the setting. Alexander's (2010) research aimed to explore Early Years practitioners' understandings of 'quality' and 'success', and how these were expressed in their work with children. Implications for practitioners' training and development are discussed, based on the findings. There seem to be significant differences between CC staff and schoolteachers' understanding of quality and

success, and these are reflected in ideas of what constitutes a happy child. For school staff, happy children are the ones who are able to comply with rules and learn, whereas CC staff seem to define happiness as the ability to form fulfilling relationships with parents and CC staff. Reflected in CC staff's responses in this study are also pressures linked to their local community. The definition of success can, therefore, be defined as preventing the impact that deprivation can have on young children. Another study (Anning et al, 2007) highlights the importance of staff commitment to finding new ways of working at the centres. These studies are relevant to this research as part of my inquiry concerning CC staff's experience of their professional roles and workplace.

2.3 The Work Discussion Model

As Armstrong and Rustin (2014) argue, research programmes which aim at exploring and describing how institutions function also need to be committed to bringing about change in social practices. Emil Jackson (2014) and Peter Elfer (2014) suggest that a way of addressing unconscious anxieties and defences is by facilitating Work Discussion Groups.

Margaret Rustin (2008) discusses the origins and later developments of Work Discussion. The distinctiveness of a Work Discussion Group, according to her, lies in the fact that this method is based on the belief that emotional dynamics are of central importance in the workplace. These groups focus on those emotional dynamics that come about as a result of the very task of the worker, the work context, institutional dynamics and relationships with colleagues. Rustin (2008) gives a detailed history of the development of the Work Discussion method in the 1960s, which was a period of educational and social change. She also points out the

centrality of Bion's (1962) work on groups, which informed this method. Bion (1962) formulated a theory about group life and group phenomena. He assumed that there are 'basic assumptions' (of dependence, pairing, and fight/flight) that groups resort to when the members fail to tackle the agreed task and become a 'work-group'. Tolerating the 'not knowing' is for Bion (1962) the essential process for achieving real knowledge. This, as Margaret Rustin (2008) explains, means that in Work Discussion Groups there are no expectations for right or wrong answers but a commitment to thinking. The latter is only possible when members 'learn to listen, to appreciate the containing potential of the setting and the institution, to think about what might be helpful' (Rustin, 2008, p. 20). Rustin (2008) also underlines the link between the Work Discussion method and Ester Bick's development of the infant observation method, as a careful and detailed observation and recording of the atmosphere in the room are of central importance to both. The work on institutional dynamics and the 'unconscious' at the workplace (described in the previous section) also contributed to the development of both methods.

Bradley and Rustin (2008) also quote Williams and Copley, who in an unpublished review of the Work Discussion method, have argued that the most relevant concept is Bion's notion of containment. Emanuel (2005) notes that Work Discussion groups have a twofold function: to help participants notice the child's behaviour, and to note their own emotional responses to the child. These can be helpful indications of the child's state of mind. Bender (1981) describes setting up a nursing staff group and thinks about the initial complications of such an attempt: the staff experienced it as an additional demand, and feelings of insecurity about their professional status were stirred up by the group. The author describes many months of difficulties and

setbacks, mainly over time and attendance. These added to the therapist's initial feelings of hopelessness, impotence, isolation and rejection. Bender (1981) also draws our attention to the fact that staff's defences need to be maintained and respected. Jackson (2008) found that Work Discussion Groups had a significant impact on staff's attitudes and the culture of the schools by way of containing staff's anxiety and enabling them to enhance their observational skills and develop a deeper understanding of learning processes. Work Discussion Groups, unlike individual consultations, can potentially change school cultures and promote openness, trust and confidence. Jackson (2008) points out the importance of clarifying the surrounding practicalities (such as the significance of the setting) and argues that it is very important to be open and clear with the staff about the aims of the work discussion. This paper describes the success of the project, with a high percentage of staff reporting that they had significantly improved their skills in working with more challenging students. Similarly, Elfer (2012) describes the process of facilitating a Work Discussion Group for nine nursery managers, and shows the gains of reflecting on their practice, which aided their management of interactions in their nurseries.

Elfer & Dearnley (2007) describe the intense projections of feelings nursery practitioners are subject to as they work with very young children. Elfer (2014) argues that Work Discussion groups can be particularly helpful to the Early Years workforce as there seems to be a link between how thoughtful and receptive the staff are and how well-supported they feel. Work Discussion Groups can be attentive to the anxieties that result from attachments in nurseries. They allow these to come to the fore and be talked about less defensively. Elfer et al (2018) show the effectiveness of Child Psychotherapists leading the Work Discussion for Early Years' care and

education. They provide evidence for the importance of addressing conscious and unconscious processes in individuals and groups, and further argue for the necessity of Work Discussion Groups being a mainstream part of national Early Years policy implementation (Elfer et al, 2018). Elfer (2014) also points out the need for formal evaluation of the contribution of Work Discussion Groups in Early Years settings.

Michael Rustin (2008) argues that there is a great potential for the Work Discussion Group method to become a method of research. One of the reasons for that is that the participants find themselves in a situation when they can actively explore their hypotheses in relation to their work which, according to Rustin (2008) adds an 'action research' dimension to being part of such a group. He writes: 'there seems to be scope for the development of the existing 'formative' and 'capacity building' method of Work Discussion into a method of research the findings of which could demonstrate the explanatory power of a psychoanalytic way of thinking when it is 'applied outdoors' in extra-clinical settings' (p.277).

This literature review shows that although there is a significant number of papers that look at Child Psychotherapy/psychoanalytic projects in the community, the existing literature that explores Child Psychotherapy-led outreach projects in Children's Centres is limited. And so is literature that concerns projects where Work Discussion Groups are set up, run and evaluated in these settings. This project aims to add to the existing knowledge on setting up and implementing Child Psychotherapy-led outreach services in Early Years settings.

CHAPTER 3 METHODOLOGY

3.1 Research design

3.1.1 Method

The aim of this research was predominantly exploratory, in the sense that I became interested in documenting and following through the setting up of the pilot and then evaluating it. The latter had a double function: I considered it as an attempt to grasp something of the experience of the CC workers during the involvement of our respective teams and secondly, to describe the experience of my colleagues in setting up a service outside the remit of our consulting rooms in a deprived area. I hoped that both aspects would inform our work in the clinic but would also be useful to any colleague considering embarking on a similar project. The research process included keeping a reflective research journal of my contacts with the Children's Centres as well as detailed notes from meetings with my colleagues and supervisor. These demonstrate the development of the service (examples can be found in the APPENDICIES A, B, C, D). I further conducted semi-structured interviews with my colleagues and the CC workers to capture different aspects of the complexity of the project as well as the main themes that emerged while setting up the service.

This project took place in an environment I was already working in. I, therefore, included work I had already been involved in developing for some time. My previous work with the Children's Centres' staff required careful consideration since I was both a researcher and a clinician delivering a Work Discussion Group and consulting with the staff. I was mindful of the complications this created, and I

tried to ensure I attended regular supervision to make sure that the interests of the participants remained paramount throughout the work. As Elfer et al (2018) point out, there are certain methodological issues that need to be addressed when evaluating a project that the researchers implemented. In particular, one may anticipate a certain bias, namely the evaluators' commitment to the project's success. As Elfer et al (2018) argue, this can be avoided by careful archiving of all data and a thorough description of the analysis, as steps that facilitate transparency. As they also suggest (Elfer et al, 2018), I have attempted to ensure and demonstrate reflexivity by including journal notes and personal thoughts and feelings, as well as an indicative write-up of a WDG, in the introductory part of this thesis. However, as explained above, the focus of the research has been the actual interviews with the participants. I considered the lived experience of the participants of the pilot phase – as conveyed in the semi-structured interviews –as the most valuable data that could best form a narrative of the relationship between the workers and the two institutions. I then conducted a qualitative analysis of these interviews, to highlight emerging ideas and themes.

The qualitative approach adopted was judged to be best-suited to the aims of this project, since qualitative methodology focuses on meaning – namely on how people understand and make sense of the world and give meaning to their experience (Willig, 2008).

During the process of writing the proposal for this research, I chose to analyse my data using Grounded Theory (Glaser and Strauss, 1967). Rustin (2016) considers Grounded Theory to be an effective method in Child Psychotherapy research as it

allows for moving from specific data to more general concepts and theories, sometimes proposing modifications in the already-existing psychoanalytical theory. Grounded Theory was originally developed to address research in sociology and includes open, axial and selective coding of the data, so that key concepts can emerge, and an explanatory framework can be developed as a result of categorising these concepts (Starks & Trinidad, 2007). This method emerged as an attempt to bridge a split between positivist and relativist social scientists in the 50s and 60s. Grounded Theory created a link between quantitative, objective and measurable research methods and qualitative interpretative analytic ones, by enabling interpretative work to be held in a systematic manner (Willig, 2008).

As my research focus changed due to the abrupt end of the project (explained in the first chapter), I thought Interpretative Phenomenological Analysis (IPA) would be a better fit for this project since I became increasingly interested in how the participants experienced the intervention. Although there is a clear overlap between the two methods, as they are both interpretative, IPA is concerned with the 'lived experience' of the participants and its aim is not to generate general hypotheses about the subject studied. There was no significant impact of the change from Grounded Theory to IPA on the protocol and ethics of the study design.

IPA is a structured qualitative methodological approach that looks at how people make sense of major life events (Smith et al, 2009). IPA started as a psychologically-oriented approach and, as Smith et al (2009) emphasise, it was important for this method to 'be seen as psychological – its core concerns are psychological, and psychology needs space for approaches concerned with the systematic examination

of the experiential' (p.5). By engaging in the IPA process, the researcher is more able to gain insight into how people perceive and talk about events and their experiences (Pietkiewicz & Smith, 2012).

IPA is an idiographic approach that explores the subjective experience of individuals in specific situations (Larkin, Watts & Clifton, 2006). IPA stems from the hermeneutic tradition, to create an idiographic and inductive approach. The main focus for IPA is the meanings that particular experiences hold for participants (Smith & Osborn, 2008). In addition to the aim of getting close to the participants' world through a process of interpretative activity (Smith & Osborn, 2008), IPA is epistemologically rooted in both phenomenology and hermeneutics. As an idiographic research approach, it is concerned with the detailed analysis of one case in detail, which may be an end in itself (Smith et al, 2009). Phenomenology is concerned with the structure of experience. Initially theorised by Husserl (1927) and later expanded by Merleau-Ponty (1962), phenomenology involves the attempt to temporarily 'bracket out' considerations of external reality and suspend our natural attitudes, in order to reveal more clearly the nature of the experience itself. Phenomenology is concerned with what the experience is like for the subject, rather than the outward expression of this.

Heidegger (1927) proposed a combination of hermeneutics and phenomenology and conceptualised the hermeneutic circle as an ontological issue. This points to the exposure of a structure which can only be recognised if one is already familiar with it. IPA does not aim to generalise or generate broad themes, but the idiographic focus does illuminate the universal. The researcher moves between empathic and questioning hermeneutics throughout the data analysis phase, and it is understood that

meanings are not clearly available but arise out of a continuous engagement with the text, in this case the interviews.

IPA considers people as 'self-interpreting beings' (Taylor, 1985). There is, however, recognition that the hermeneutic process is a dual one, with the participant making sense of their experience and the researcher making sense of the participant's experience (Pietkiewicz & Smith, 2012). IPA recognises that the findings are inescapably influenced and complicated by the researcher's own conceptions, but these are an expected part of the interpretative process. The relationship between a psychoanalytic interpretation and the data interpretation arising from IPA is not contradictive but complementary and corrective.

Smith et al. (2009) stated that 'in IPA, we are concerned with examining subjective experience, but that is always the subjective experience of "something"' (p. 33). Smith et al. (2009) also argued that the bottom line with IPA, as a tradition that is 'participant-oriented', is that the approach is concerned with the 'human lived experience, and posits that experience can be understood via an examination of the meanings which people impress upon it' (p. 34). Smith et al. (2009) note that:

> Making sense of what is being said or written involves close interpretative engagement on the part of the listener or reader. However, one will not necessarily be aware of all one's preconceptions in advance of the reading, and so reflective practices, and a cyclical approach to bracketing are required (p. 35).

IPA researchers, in essence, occupy a dual position: the researcher's role is both like and unlike a participant's. As Smith et al. (2009) put it:

> In one sense, the researcher is like the participant, is a human being drawing on everyday human resources in order to make sense of the world. On the other hand, the researcher is not the participant, she/he only has access to the participant's experience through what the participant reports about it, and is also seeing this through the researcher's own, experientially-informed lens. (p. 35-36)

As a qualitative research approach, IPA allows for multiple participants who experience similar events to tell their stories without any distortions and/or prosecutions. Creswell (2012, p. 76) stated that 'a phenomenological study describes the common meaning for several individuals of their lived experiences of a concept or phenomenon'. He also stated that 'Phenomenologists focus on describing what all participants have in common as they experience a phenomenon' (p. 76).

3.1.2 Setting and Information about the participants, their selection and recruitment

The sample consisted of 3 Child Psychotherapists who had been involved in the project and were selected for this reason. There were no exclusion criteria and all the CPs in my clinic working on the project were included. Two of the participants were white females and one was white male. These participants were approached in person and sounded out their interest to participate in the research. In order to ensure that my colleagues did not feel obliged to participate in this research, I had an initial meeting with them where the nature of the research was clearly explained to them,

and they were granted the absolute right to refuse to participate or to withdraw at a later point. I clarified to them that refusal to participate will not have any consequences on the research project or the Children's Centres project and that the combined methodology chosen will allow me to carry out the research anyway. They also received an information sheet where the details of the research, its aims and procedures were clearly outlined. It was also clearly explained to them that the researcher would be keeping a reflective journal, and they were told what this involved and were also shown a sample. A consent form was signed (see APPENDIX E).

The study also included three Children's Centres' family workers who were interviewed about their experience of being part of the pilot and the Work Discussion Groups we ran. The Work Discussion Group usually consists of 4-6 workers and the exclusion criterion was having participated in less than the 70% of the Work Discussion Groups over the period of 9 months. Three CC workers (out of five invited) agreed to take part in the research. All three were white British female family workers. I talked to the relevant staff and introduced and discussed my research, its aims, scope and staff's involvement in the project as well as their right to withdraw from the research at any time. These interviews were conducted by a Child Psychotherapy colleague rather than me, so that the CC workers could talk more freely about their experience. The above sample is in line with Smith et al. (2009) who emphasised that 'IPA studies are conducted on relatively small sample sizes, and the aim is to find a reasonably homogeneous sample, so that, within the sample, we can examine convergence and divergence in some detail' (p.3).

3.1.3 Ethics and Ethical Approval

Confidentiality and anonymity issues were also explained to Children's Centres' workers. They also received an information sheet with the details, aims and procedures of the research and they were invited to sign a consent form (APPENDIX E). Ethical approval from the Local Authority was sought as Children's Centre workers are Council employees but the head of all CC in the area confirmed in writing that the Local Authority's approval was not needed since:

a. only Children's Centres' workers were interviewed and not service users or NHS patients

b. all managers were in agreement and

c. all data was completely anonymised

Ethical approval was sought and secured from both the University of East London (UREC) ethics review panel (APPENDIX F) and my trust's research and development department, upon submitting appropriate applications. The discussion of clinical material of families who attend the Children's Centre included in the study is outside the scope of my research, which focuses on the institution and the staff.

3.1.4 Consent

Individual consent was sought from each of my Child Psychotherapist colleagues who were going to take part in the study. Written information about the aim of the research was provided and participants were given the opportunity to discuss any questions they had with the researcher. Individuals' anonymity was ensured, and pseudonyms have been used.

Case material discussed in the Work Discussion Groups is presented anonymously by the Children's Centre workers, and families' consent is, therefore, not required.

The Children's Centre managers have given verbal and written consent. Likewise, written consent was given by the Children's Centre workers who have been part of my Work Discussion Group.

3.1.5 Data security

All data gathered for this study (audio-taped interviews and written notes) have been anonymised and safely stored in password-protected documents. All data were deleted upon completion of the study.

3.1.6 Trustworthiness

Issues of the research's credibility and validity were considered and to address any concerns I often returned to the data to evaluate whether the clustering, structure and organisation of themes produced were still reflective of participants' accounts. In order to counter any undue subjective influence or bias, I strove to be aware of my own knowledge, beliefs and assumptions, by keeping a reflective journal. However,

using an independent analyst would have strengthened the findings. The transferability of this project is addressed in the research findings and will also be discussed in the last chapter, as is the authenticity of this research.

3.2 Data collection

A reflective research journal was used to record my observations and notes from all the contacts I had with the Children's Centres, as well as from the meetings with my team where this work was discussed. The Work Discussion Groups I ran were written up just after the group finished, and notes were also kept after each meeting we had either at the CC or in our CAMHS clinic.

3.2.1 Semi-structured interviews

The interviews utilised a semi-structured format and were guided by major themes previously reported in the literature. They were audio-recorded on a digital recorder and transcribed verbatim by the author. Transcripts were checked for accuracy against original interview recordings before the analysis took place. Key interview questions and follow-up questions were asked based on participants' responses. Trede and Higgs (2009) point out the fact that 'research questions embed the values, world view and direction of an inquiry and they also are influential in determining what kind of knowledge is going to be generated' (p. 18). The latter was kept in mind when designing the interviews, along with Creswell's (2003) recommendations to 'ask one or two central questions followed by no more than five to seven open-ended sub-questions that narrow the focus of the study but leave open the questioning' (p. 106). Interviews were scheduled and arranged at the participants' own convenience and lasted approximately 60 minutes. Smith & Osborn (2003) argue that semi-structured

interviews are generally the most successful way to collect data for qualitative studies in psychology, as the researcher's questions can be reconsidered and adapted through engagement with participants' ideas, and the researcher can spontaneously respond to interesting ideas that may come up. As Willig (2008) puts it: 'Semi- structured interview provides an opportunity for the researcher to hear the participant talk about a particular aspect of their life or experience' (p. 24).

I conducted semi-structured interviews with three Child Psychotherapy colleagues who were involved in the project, to obtain meaningful data that reflected the range of experience from each clinician as well as common themes and ideas. The nature of the research questions was such that semi-structured interviews seem to be more appropriate. Each participant was given a limited amount of structure, but all were asked about the same themes – namely questions that concerned how they experienced their role as an outreach worker; how they experienced the institution and its challenges; the areas where our CAMHS could be more useful; and how they thought our service was received by Children's Centre workers (APPENDIX G).

Interviews with three Children's Centres workers who attended my Work Discussion Group were also conducted, so that the staff could evaluate the project. A Child Psychotherapist colleague who was also involved with the service but not with this particular Work Discussion Group conducted the semi-structured interviews so that the Children's Centre staff could talk more freely about their experience. These interviews covered areas that concerned their feelings and thoughts about this way of working and learning; their views on the Work Discussion group's usefulness in thinking about the families they or their colleagues discussed; and their thoughts about their professional roles and the institution they worked in (APPENDIX G).

Smith et al. (2009) stress the importance of establishing a rapport with the participant when interviewing, and they argue that 'good research interviewing require us to accept, and indeed relish, the fact that the course and content of an interview cannot be laid down in advance' (p.65). Sensitive interviewing was achieved by the fact that the interviews were conducted by Child Psychotherapists who are trained in managing and regulating the anxiety in the room, but also in being receptive, as listeners, to sometimes painful feelings and thoughts.

Lastly, I audio-recorded and transcribed a group meeting at the end of the study attended by my CP colleagues and by the manager of our multi-agency liaison team (MALT), who was able to provide some information on the managerial level to do with the relationship between CAMHS and Children's Centres.

3.2.2 Group Meeting

The group meeting that I organised for my CAMHS team emerged from my team's sense of a lack of closure. They felt there had been no appropriate ending to the project and also no formal discussion with our management about it. I, all three Child Psychotherapy interviewees, and the manager of the team took part in it. This group was unstructured and there was one main trajectory that I introduced to launch the discussion – namely, reflecting together about the pilot year and evaluating our work.

Smith (2004) argues that it is more difficult to infer and develop the phenomenological aspects of IPA in a group as 'it is more likely to be the case that a group discussion will give rise to direct evaluations and positionings (attitudes and opinions), third person stories and these may need to be dealt with slightly differently' (Smith, 2004, p.50-51).

I found that the group meeting at the end of the project provided useful data for the research, as it was also an opportunity for the participants to reflect on their experience and process it. The manager's attendance, information and input invited the participants to rethink the project and work through the ending as a team.

3.2.3 Data analysis

The semi-structured interviews and the group meeting were audio-recorded and transcribed. The transcripts were analysed in a systematic way, using Interpretative Phenomenological Analysis (IPA) and not Grounded Theory as initially planned. This changed occurred as a result of rethinking the nature of the project and IPA was ultimately felt to be more appropriate, as explained in the beginning of the chapter. To begin with, transcripts were read for meaning, which involved reading each transcript several times to engage closely with the script (Eatough & Smith, 2006). There were four stages of analysis, as required by the IPA method:

Analysis A

A column alongside the transcript was used to note assumptions, preconceptions and feelings while reading and re-reading the material. Creswell (2013) advised researchers to 'First describe [their own] personal experience with the phenomenon under study. The researcher [should] begin with a full description of his or her own experience of the phenomenon' (p. 193). In this way, the researcher would avoid interjecting his/her personal experiences into the 'lived experience' stories of the research participants. (APPENDIX H).

Analysis B (Line-by-line coding)

This coding is designed to identify the things that matter to each participant and the meaning of these things for the participants (experiential claims) (Larkin, Watts and Clifton, 2006). As Smith, Flowers & Larkin (2009) note: 'This involves looking at the language that they use, thinking about the context of their concerns (their life worlds), and identifying more abstract concepts which can help to make sense of the patterns of meaning in their account' (p. 83). A colour-coded column was created for this, showing key themes, including descriptive (red), linguistic (green), conceptual (blue) comments and my subjective response to the data (black). (See APPENDIX H)

Analysis C (Emergent Patterns/themes)

This is the stage of 'mapping the interrelationships, connections and patterns between exploratory notes' (Smith, Flowers & Larkin, 2009). The intention was to identify any patterns that emerged from the data. For this, I worked with my initial notes. Since the themes that emerge not only reflect the participants' original worlds and thoughts but also the analyst's interpretation (Smith, Flowers & Larkin, 2009), I once again used a columnar structure to reflect on the data using my psychological understanding to give a more interpretative account. (APPENDIX I)

Analysis D (Super-ordinate themes)

This was the process of examining connections between the themes as they emerged from the material (APPENDIX J). This led in turn to the development of super-ordinate themes that were then clustered and organised as presented in the next chapter (Findings). In line with Smith, Flowers & Larkin's (2009) suggestions, all themes were listed in chronological order and then moved around to form clusters of

related themes. The next stage involved identifying patterns across cases (interviews) for each of the two groups (CC workers and CAMHS), namely looking at connections and potent themes (Smith et al, 2009) and a map of key themes was created. The group meeting was looked at separately. (APPENDIX K)

CHAPTER 4 FINDINGS

The truth of the matter is that life is nothing, but what we make of it as participants in this experiential life journey; it is up to each research study to tell their stories and allow the audience to partake in the journey with them. (Alase, 2016, p. 149)

This chapter concerns the presentation of the main themes that emerged from applying IPA (as shown in Chapter 3) to the interview scripts of the participants. I divided this Chapter in two subchapters, which discuss separately the main ideas and themes for CC staff and those for the Child Psychotherapists. The subsections that follow are structured in such a way that this project's research questions are responded to accordingly: What was the experience of staff in the two agencies: What was the Children's Centres' staff experience of their role and understanding of infant mental health and what was their experience of piloting a Child Psychotherapy outreach service in their workplace? What was their initial experience of WDGs? How did Child Psychotherapists experience the process of setting up a Child Psychotherapy-led outreach service to Children's Centres and what did they learn from this attempt? What was the impact of deprivation on CC's way of functioning? What was the impact of the institutional crises and wider climate of cuts on both services?

Exact extracts from the interviews are utilised to allow the different meanings and ideas to come to life through the participant's own words and expressions.

4.1 Children's Centres' staff

Harriet, Jane and Tina were family workers and worked in CC B (as described in the first chapter). All three attended the Work Discussion Group Kiara and I offered their

centre.

4.1.1 All hands on deck'-the experience of working in Children's Centres

The three family workers talk about their journey towards becoming involved with Children's Centres. All three describe how for different reasons they entered this job from the field of childcare, which seems to them to be less valued nowadays than it used to be. Personal reasons such as becoming a parent seem to have played an important role in their decision, as Harriet explains:

> I went to college and did nursery nursing a long time ago, when nursery nursing was a thing, it's not a thing anymore. And then I went to work in a big primary school […] and when I had my first child, I realised that I felt more of a draw towards family work and would prefer to be in that sort of field.

The second interviewee, Jane, talks about how from being a 'dinner lady' at her daughter's school, she was asked to assist a child with special needs and became interested in supporting children. Without it being explicitly stated, Jane seems to be making a link between the experience of being a parent of a child with extra needs and her wish to work as a family worker:

> I started as a dinner lady working with a child with special needs which developed later in a Teaching assistant role… on my very first day a child with Down syndrome was started for the very first day…and they asked me if I would mind being the one-to-one for him at lunch times and I said that I didn't mind; he was quite young; he was only in year 1. So, it went from there and it turned out that I knew his mother as she supported my daughter in class the year previously.

The third interviewee, Tina, describes how her interest in family work developed

while working in nurseries and nannying. It was then that she realised her wish was to have 'more input' in a child's life and how important it was for her to be working with both children and parents.

When asked about the way the CC team is structured and operates, Harriet talks about having an informal approach, a casual way of working that doesn't involve a strict hierarchy but requires adjusting quickly and working well as a team. It feels as if she needs to reassure the interviewer that despite the casual and informal style the centres operate, there are high expectations and a lot of hard work:

> I think because we are all of a family work background and we were drawn to working with families we tend to work quite well as a team, we tend to build relationships quite quickly, so I think we tend to have strong bonded teams because of the very nature of the work that we do. It is an informal structure, but we do meet very regularly to ensure that things are kept up and practice is good. There is a high expectation working here that people will provide high quality for families.

Jane also talks about not having a clear hierarchy, but rather different levels of responsibility. In her CC, there are no different teams, everyone does everything, and one family worker would often cover for others in other centres: 'It is all hands on deck if you like…and so people have to sort of juggle their diaries around to try and make good'. When it comes to management, Jane nervously describes a recent change and seems somewhat evasive about expressing an opinion on this:

> But it is not something that we would look at, look at the hierarchy really. It is just levels of responsibility. Because I would be the safeguarding lead in any of the group sessions if they are supported with a family support worker. But with regard say [to if] T and I run a group session; it would be the lead on whose site we are at.

> So, I am based here so I would be the lead here so if it was in L, T's place, then T would take the lead. That's really how we work it.
>
> Interviewer: Can you say something about your management?
>
> J: Well, that's something that has recently changed. So, from (name of previous manager) …So, (name) has just recently left just before Christmas. So, (name of current manager) has just now taken over and…so far so good (*laughs nervously*).

Tina also appears somewhat hesitant when she starts talking about her recent promotion to the position of senior family worker but gives a clear outline of the many different responsibilities she has. She doesn't understand the question about whether there are different teams and seems rather annoyed by it, as she sees all Children's Centres as being one large team operating on different sites:

> I am a senior family worker now; I supervise the other team members. Eh… and I am also involved in leading and evaluating all the groups and the child-led activities we have here, organising separate events and I attend all the core groups for the Child Protection families and everything like that. [...] Eh, Different teams? We have only one team, so we are only one team as such. We have a lead, we have eh… lead manager and then it's myself and then we have the family workers and then the support workers obviously, admin team are involved in that and at school a CC teacher who is involved in that as well.

All three family workers describe a family feel to the workplace; each one of them makes sure things run smoothly in the hub where they are based, but also constantly steps in to help out in different hubs. At the same time, they all give the impression that the responsibilities they have and the lack of a clear division of roles can be stressful and confusing. Nevertheless, there is a sense that they all feel loyal to and

invested in their work.

4.1.2 'Winning families over': the experience of working with families in Children's Centres

The first thing that comes to Harriet's mind when she is asked about families' expectations from the Children's Centres is very troubled families who struggle financially and expect Children's Centres to find 'magical solutions' to their problems by providing them with what they need, most frequently a home. It is striking how many times Harriet repeats the word 'change' in her answer, and how clearly she conveys the difficulty of being expected to confront the hard reality on families' behalf, then having to let them know the actual help CC can provide. She ultimately ends up feeling she has to let them down:

> I think we have to be very clear with families about what our role does and doesn't cover. I think sometimes families expect that we can work miracles and we can get them housing and we can't… and we have to be quite honest about the current economic climate and that actually 'you are not going to get a house and we can tell you now that you are going to a hotel'.

Forming close relationships, predominantly with a key person that families can rely on, seem to be central for most people who attend the centres. At the same time, there seems to be a correspondence between struggling families being 'parented' by CC and their growing capacity to parent. As Harriet explains:

> Eh, I think families work best when they have relationships, professional relationships with a member of staff, we know that children work best when they have a key worker and I think it works the same for families, I think if they have a linked person that they can access anytime, I think that works well. […] That's

> what they are saying they 've had that support and they have been able to make changes to their lives and they have been able to sustain them and actually they have been able to go from a child protection family to someone in universal services and so that's how we sort of measure our outcomes really, that we can get families back through the tiers of need.

Tina also highlights this aspect as very important, and explains how familiarity plays a central role in engaging families in CC activities. Therefore, senior staff who usually do most of the home visiting also run 'universal groups':

> 'Cause I think if you don't work in the universal section as well, you are not going to meet those families, [and] you can't then say 'Gosh, how about coming to a toddler time, I am not going to be there but…'At least if you are there, you are in the environment, then you can live those families and see them in real life with everybody else as well; you get to see how they are with other families and children as well.

When Harriet is asked to describe an intervention with a family, she talks about some families being suspicious of CC staff to begin with and explains that it takes a lot of time and effort for them to 'open up' – social difficulties and mental health problems are frequent obstacles. Yet she also describes how rewarding it can be to observe significant changes in a family that are often measured by 'stepping down the tiers of need'. The example she uses is of a father who attended CC with his child and 'disclosed' that his wife had mental health problems and would not leave the house. The use of the word 'disclose' as well as phrases such as 'stepping down the tiers of need' (repeated several times in all three interviews) convey a 'Social Services' aspect in CC's thinking, a supposition that families often, for various reasons, fail to parent

and tend to hide their inadequacy and need.

These ideas are possibly linked to the family workers' heightened safeguarding concerns, due to the experience of often having to confront people who might be neglecting or abusing their children. Unclear and blurred boundaries between Social Services and CC, and the lack of containment of the emotional impact that this work can have on CC staff, seem to contribute to a feeling that all interviewees share – namely that they often find themselves somewhere 'in the middle', between services, where they wait uncomfortably, monitor families who are just 'under the radar', and keep trying to invite them to the CC.

Tina makes a distinction between different categories of families according to their needs and willingness to engage. She also talks about the fantasies and expectations different families might have from CC. Some think it's 'weird and scary', others fear they are being watched and judged and others seek magical solutions from CC, such as finding money or goods:

> I think some people especially ones that are Child Protection think they are coming here to be watched and to be viewed and we have to break down those barriers really to try to convince them that's not what we are here for. We are here for you to play and socialise with your child…and I think that takes quite a while for you to know. [Some people come because] they want a funded place for nursery or they 'll want extra support mostly housing support which is something we really, we can't magically…[make] wishes come true really.

Tina likewise talks about CC staff trying not to be judgmental. I wondered how family workers cope with having to respond to this level of need and families' confusion about the different services and what they offer. There are families who attend

because they have been ordered to by Social Services and others who are hard to engage because of having children with severe needs. Tina concludes that there is only so much outreach one can do to engage hard-to-engage families. I feel she refers to a great need – there are all sorts of support that these families require that lie far beyond CC's capacity and expertise, and this may sometimes result in a feeling of helplessness. She confirms the latter by saying that being realistic about what one can do and not appearing to be omnipotent is an important part of their job.

When asked about a successful piece of work with a family, Tina gives the example of an intervention where offering a home visit made a big difference to this mother's willingness to engage. Allowing the mother to take her time and persisting in inviting her to the centres had a good outcome and seemed to change her life in a significant way – if it hadn't been for the CC this woman might have been completely isolated.

Tina stresses the importance of reaching out and becoming known to families, so they can come to trust CC workers, as there seems to be a lot of anxiety surrounding the idea of being an outsider who wants to help, and this seems to create suspicion and fantasies of surveillance. Adding to that, Tina points out what seems to be a particularly complicated and stressful issue for CC: the fact that although the CC are trying to gain families' trust, sometimes there are safeguarding concerns that need to be reported to Social Services.

What comes to Tina's mind when asked about an unsuccessful piece of work are families who are not on a Child Protection plan but 'just underneath it' and CC's efforts to engage them. Tina chose to talk about a family that she tried to engage for six months, and although she helped them with funding and accessing the food bank,

the family never attended groups or came to any of the CC's activities. Tina seems to be saying that there are families who despite not meeting Social Services' threshold have, nevertheless, very significant needs and CC workers are the ones who monitor them. It seems like Tina expresses a feeling of being somewhat manipulated by this family who got what they wanted from her but did not join the CC after all. My understanding of the latter is that CC measure and define successful interventions in terms of whether a family will become part of CC's 'life', 'come out', attend activities and be present as opposed to 'staying in' – suggesting that such families remain isolated and, therefore, at risk.

Jane, on the other hand, talks about parents 'who know what they are coming for' and she refers to the universal services. These parents' experience depends on who they are and whom they form a relationship with at the centres:

> We occasionally…Most parents expect the toddler time sessions, the baby club sessions. They know what they are coming for; most families that are accessing our universal services. Their experiences vary depending on their personality and…, I think just the same as some people will like one person more than another. So, it's very much…Their experience, the feedback from families is that they thoroughly enjoy the sessions here. We always offer [parents the chance to give] feedback and we use that in our evaluations as well.

I thought the beginning of the answer that gets interrupted 'we occasionally…' contains an indirect reference to families who are obliged to attend because they are on a child protection plan. On the other hand, there seems to be a personal aspect to why families attend 'universal' services and what they expect from the family

workers – it all depends on personal relationships and character/personality, as opposed to professional/service-based structures and relationships.

When asked more specifically about interventions with families, Jane talks about a parent who was concerned about their child's unwillingness to eat. She explains that inviting them to think about the child's boredom when eating alone, and suggesting that the parents eat with him, brought about a big change and the issue was resolved. Following the interviewer's invitation to elaborate, Jane talks about how important it is for parents to see things through the child's eyes and intervene early, as minor things can escalate to bigger problems in a family's life:

> I have had families where managing difficult behaviour has been an issue to the point where it was affecting the home life, tension between her and her husband, care divided as well, she would always be left to care for the child who was displaying difficult behaviour and her husband was always playing with the child who was always good if you like. So, I gave her some tips and ideas on how to combat some of this behaviour leading up to a course we were running, and she noticed some small changes she had made, and she noticed the difference before we even started the course. Within two weeks of the course, we had one session per week, within two sessions she said her whole life had been turned around and it made a huge difference to her life and she now is going to be volunteering for the CC as a result of that course.

The fact that the person who received the help became part of the CC's volunteering staff is an example of an idea of there being cycles of help: having received help, one then offers it to others. Jane further talks about how parents expect to be able to see quick results of the interventions – she mentions 'pressing issues' like potty

training, where parents become impatient. She conveys the sense of urgency often imposed by parents and the tactic of managing that by just being there and slowing things down for them, in what seems to resemble a 'grandmaternal' role. It is worth noting that Jane gives another example of a successful intervention without telling the interviewer what she did or said to this parent: 'We tweaked the approach slightly', she says; something that doesn't require a lot of expertise, it seems to be mostly about providing reassurance.

When asked to mention an unsuccessful piece of work, Jane talks about parents' suspicion and difficulty trusting that CC can provide something helpful. She explains that she refers to parents whose children are on the Child Protection Register and who perceive CC's support as part of a parenting assessment by Social Services. Jane says she can empathise with their lack of trust as she wouldn't like her parenting to be scrutinised:

> I think that there have been occasions where families that are on the child protection for example have resisted offers for support because they feel that they are being scrutinised. Which I think is quite a natural response for these parents and I think if I put myself in the same position then I would probably feel the same if someone come along and started scrutinising my parenting. [...] And I think that one family where I did I think that she was actually making some really positive changes. She had convinced all of us. And I went around because every year we have a celebration event where we nominate certain families for a special award that have made sort of a remarkable achievement that year and she was one of them and it was because she moved on and made some positive steps for her children. There was an issue with some other influences and it became

> apparent…unwittingly I had gone to visit her. And yeah…it wasn't quite the picture that we had all being given and so I needed to report that back and so that wasn't taken very well…[…] She then refused to engage with certain services and was quite resistant for quite some time because of that. Mmm…I think it was one that I felt a bit more vulnerable because she became quite…I want to say aggressive…but she wasn't happy…She wasn't aggressive in a violent way but verbally she was quite offensive…some of the comments that she made and a bit intimidating really. But I think in a way to just try to make us back off, but I didn't despite feeling very vulnerable I tried not to shut up (laughs).
>
> Interviewer: What happened?
>
> J: Her husband wasn't allowed at the property and when I went around, he was there, and I had to report that because that was a child protection issue. I think she eventually did come around and put her children into nursery and things like that. So, there was no success to the end of the story from a CC's point of view.

Here Jane seems to be saying that one of the difficulties of working with very troubled families at the centres is that CC staff may discover they have been missing something or even colluding with something that might be uncomfortable, hard to think about, and disturbing. The surprise element shows that she felt misled and perhaps even betrayed. Following the invitation by Dan to share her feelings about this, Jane speaks about feeling vulnerable as she had been bullied and invited by this parent to 'back off and shut up', which offers a powerful example of how difficult it can be for them to be dealing with parents' hostile and aggressive behaviour. By that point in the interview, I believe Jane was feeling safe enough to speak about these difficulties and convey her mixed feelings about this part of her job. Even in

this example she appears to be quite protective of parents and very cautious not to sound judgmental against them. This example where she was attacked by parents comes as a strong contrast to her earlier ones, such as helping parents with potty training. Furthermore, she expresses her mixed feelings about this family, as part of her wished she never went to this family's home, possibly an indication of how traumatic this experience was for her. Also of note is Jane's way of describing engaging difficult parents by saying 'we won these families over', which implies that this kind of work can often feel like a battle.

4.1.3 'Fire-fighting': CAMHS, early intervention and mental health in under-5s

In all three interviews, even if not directly asked, the interviewees express their ideas about mental health in under-5s, early intervention, their understanding of CAMHS and how CAMHS input can be relevant to their work. My impression was that their understanding of mental health and CAMHS work was somewhat vague, unclear and at times confused. Harriet, for example, speaks reluctantly about CAMHS' role being to support relationships in families and children with mental health problems, but sees CAMHS involvement with CC as '*woolly*' since she struggled to understand what CAMHS was there for.

She further talks about the importance of offering CAMHS appointments to families that need them in CC's premises, as Harriet sees CC's space as a more 'natural' environment for young children and considers family attendance likelier if the appointment doesn't take place in the CAMHS clinic. This made me wonder about the assumptions and fantasies CC worker have about CAMHS, and whether there is

an anxiety about labelling and stigmatising young children by referring them to a mental health service. At the same time, Harriet seems to think that what would be most helpful is working directly with families but in CC, as if keeping them 'in house' relieves some of the anxiety of involving more services and, in particular, mental health ones. This conversation brings up CAMHS involvement in 'baby clinics' where we attempted to sit next to other professionals and be available if any concern about the mother/baby relationship was expressed or suspected. Harriet describes:

> I think that was complete overkill of professionals. I think we really need to be mindful of that. Especially with our universal services because families generally come to universal services because they consider themselves to be universal and actually, we know that's not true. We know that [in] the community in which we work you run a universal service and actually you target families anyway. But they are coming because they feel comfortable coming to a clinic, or a stay and play because it's universal, they don't want that targeted yet. So, you start adding other professionals in and you almost aren't being very transparent with your parents as to why they are there. You are almost mixing what they are there for, so I think…

Harriet thinks that having specialised professionals in a universal group raises issues of parental consent, and this needs to be made clear to parents who should know and agree to mental health monitoring and potential input from mental health professionals. Although this seems to be a fair point, I found myself wondering about the difference between CAMHS and CC's attitudes regarding early intervention and prevention of mental health problems in under-5s. I also wondered about

'the Pandora's box' that may be opened by an increase in referrals at times that CC staff feel overstretched and lacking in resources. Tina has a different view on the same issue and thinks that having CAMHS input in universal services could provide a lot of support to families who 'might completely deteriorate when [their children are] older'. This statement conveys her anxiety and concern for families who attend CC and require mental health early intervention support. She explains that this is something that CC workers cannot provide, as they tend to focus on other aspects of a child's life and not on emotional development and relationships:

> Yes, that's what I see. I am not sure if that's right or not but that'…you know, and I think they know how to look at…although we know how to look at a child's development and all that kind of stuff, they know how to kind of see a bit more maybe.

Harriet sees the role of CAMHS as being to support CC workers with 'targeted' families, those who are mostly seen in home-visiting. As she explains:

> I think you could do a mixture of both. I mean we do a huge amount of home visiting and sometimes that's where things come up, they will talk about their child's behaviour or they will talk about an attachment thing, they won't call it attachment, you know, they will just say we don't get on or we are just not very close, so I can't cope with him, those things would come up. So, to be able to say to someone this is CAMHS, this is why they offer, and you know once per month they come to the CC, and you can just have an informal conversation so it wouldn't necessarily be a referral into the service, but it might be a way of getting a referral into the service – you could have those conversations with these parents, we'd have one of our staff here, so they would be coming to a familiar

> environment but they know there will be other people there. It's almost the step before a CAMHS consultation.

Harriet talks about a 'huge amount' of home-visiting, the point of entry into CC when it comes to troubled families. When home-visiting, CC workers often discover relationship problems between parents and young children, although this becomes manifest or is talked about in families in a variety of ways.

Tina describes a similar feeling, some sort of 'gut feeling' that family workers might have when they see a family in need of psychological support:

> Eh…I think I mean obviously we talked a couple of weeks ago actually about a family particularly we've got in our parenting programme that we feel could do with CAMHS and CAMHS input and help with…(*hesitating*) there is something, you know, when there is something going on you know…something has not gone quite right with their bonding…there is something not gone right with their relationship at all together and they are very disjointed and I think only somebody that knows what they are talking about can really help that kind of family.

Here Tina makes a distinction between CC staff and CAMHS, in that the Child Psychotherapists she met seemed to 'know what they are talking about' as opposed to other professionals who were unable to help 'disjointed' mother-child couples. This seems to be an intuitive description of what we would call attachment difficulties, or in Winnicottian terms relationships that, for different reasons, have not been 'good enough'.

Jane, when asked, starts wondering about whether she is right about CAMHS being a service offering psychological support to both parents and children. My feeling

was that Jane feels somewhat uncomfortable and exposed when unsure about what CAMHS exactly is. She further expresses her confusion about under-5s work in CAMHS, as she had heard from us that CC were unable to refer to CAMHS – so she was left wondering about how early intervention could take place if that was the case:

> But my understanding when you first came along was that we couldn't refer children under 5. Could we? Which…I think working with you was quite difficult because it was like well, we have got families where we think the children are affected so that early intervention would have been of benefit or could have been of benefit if we could have referred them early to actually have that early intervention so that beyond 5 you wouldn't have to see them…rather than fire-fighting if you like.

However, Jane later describes her confusion about how one could define moderate to severe mental health problems in under-5s –as she had been told by CAMHS that they could refer cases of 'moderate to severe' mental health problems– and whether if mental health issues are 'lower level' then this would fall within a family worker's remit:

> I think….it can…but…it is very difficult because…like you say some of the children don't display moderate to severe problems so it would be I think on the lower lever where there could be CAMHS involvement but then it wouldn't be working with the family worker. It would still be separate work, if you know what I mean. I don't know how that would…

I think that the above extract shows her reluctance or difficulty to think about the reasons why, as well as the context in which, a young child would be seen by CAMHS. Later in the interview Jane wonders whether it is hard to identify mental health problems in under-5s because they develop later in life, in what she describes as a 'slow burn'.

Jane is wondering how referrals to CAMHS could be made for families who need it. Although she says there were not any such families at the time when we offered the WDGs, at the same time she is suggesting that CAMHS should come to their groups and take on the responsibility of identifying those families or maybe provide some more knowledge, some 'unofficial experience', on what could constitute a reason for concern:

> Just, you know, some tips on how to manage certain things or maybe…say for example if Eleni was talking to a parent and did some one-to-one sessions, maybe if she was doing outreach here and did some one-to-one sessions with a family to talk about how to manage something and we were there as well then that would then enable us to be able to sort of take that advice as well and maybe [...] even to have some training to do some low-level stuff might be quite helpful.

In this quote Jane seems to be expressing two contradictory thoughts; on the one hand she seemed to be saying earlier in the interview that difficult families can be contained in the CC by regular attendance but on the other, she expresses the wish to have some more help in thinking through mental health issues, which are beyond their expertise and capacity to identify and monitor. Jane is talking about learning from CAMHS how to approach a family and help them with mental health

problems, by observing how CPs approach and talk to families. This provides evidence of CC's reluctance to refer families to other services, maybe in fear that families will get scared, angry and eventually be lost, as often happens with families when referred to Social Services. Jane's understanding of early intervention concerns and of what mental health in under-5s is, is expressed when she says:

> But again, it is that thing of identifying a child, as to whether it needs that support or it is because they are young, and one should do a few behaviour interventions and it should be ok.

Throughout her interview, I feel Jane expresses a wish for CAMHS to 'fix' children who seem to be struggling but at the same time lets us know that her opinion, perhaps even wish, is that young children don't need therapeutic work but can improve with a few behavioural interventions. It seems difficult to think that there are young children and families with more complex psychopathologies in need of psychotherapy.

When it comes to thinking about the work I offered to the centres, Jane describes how we discussed two families who were of concern as their children were behaving aggressively in the groups. She notes that I helped her to think about how to approach these families, given that the parents who had been through Higher Education were reluctant to take any advice from CC staff. Jane suggests that more educated parents are harder to reach. Jane is commenting on the fact that she didn't have the chance to be part of the conversations I had with those families (maybe implying a wish to have been there) but doesn't say more about what she and I discussed, and what specifically made it easier to approach those parents. The

use of expressions such as ‘little things’ and ‘little bit aggressive’ or ‘softly approach’ in her answer points to some anxiety about being in touch with difficult feelings particularly to do with young children’s aggression, but also with feeling intimidated by troubled parents.

Jane further talks about an overall positive experience of having me join her groups at the CC, and lets the interviewer know I was perceived by parents as an additional member of staff. In this answer, Jane seems to try to stress the importance for the CAMHS clinician to be considered as a member of the CC’s team. This raises questions about possible concerns about ‘outsiders’, different approaches and ways of thinking which could potentially interrupt or disrupt the already-existing system. What is striking in the next paragraph in the transcript is that Jane’s tone is completely different, and all seems to be negative: there was nothing, no work, no real intervention needed, no advice, as if denying that CAMHS was ever needed in the first place. Dan reminds Jane of the very complex cases we have heard CC work with and Jane, rather defensively, repeats that there were not any very complex families at the time of the CAMHS intervention, so there was no need for our input. This made me wonder about the rigidity of the perception that a thinking space is only needed when a complex case needs to be managed, as opposed to thinking processes and a thinking culture that develops over time and concerns all sorts of interventions in the centres.

4.1.4 ‘Professional misunderstandings’ and ‘ulterior motives’: the experience of Work Discussion Groups

As described in the previous chapter, we only had the opportunity to introduce WDGs and offered a very limited number of WDGs to the centres. What emerged from the interviews with the family workers was an overall negative, suspicious response to our offer. As Harriet said:

> I think the stuff the girls did with staff didn't work at all. I think the staff were very closed, I think they found it quite uncomfortable and actually they are very reflective as they have a huge amount of supervision and their safeguarding supervision is commissioned in so it's someone outside of the organisation. So, I thought it would be similar, but it didn't seem to work, and I don't know if that was a professional misunderstanding or I don't know what this was about, but it didn't seem to be such a comfortable process. And I think coming into group, the problem with our activities for families is that they are sometimes so busy and if a professional isn't used to being in a busy group of parents and children together and is used to maybe seeing children on their own or parents and children on their own in a consultation it can be quite an odd environment. And I think it didn't meet anyone's need I don't think. I don't think it necessarily gave the staff what they were looking for or the CAMHS workers what they were hoping to achieve from it.

Harriet talks here about the unpleasant and uncomfortable feelings the WDG stirred up. Of note is that earlier in the interview she talked of the current climate and how difficult and impossible things feel when it comes to the amount of work and resources. Harriet seemed to have experienced our groups as an attack on their way of operating and as an additional workload. She describes a self-sufficient aspect to their work and implies that introducing a thinking space from the 'outside'

suggested that they needed extra help with thinking about their cases, which felt somewhat denigrating or condescending. I also wondered what her impressions of what CAMHS' goals were, when she suggested that we didn't get what we were hoping for out of these groups. When asked more explicitly about the WDGs she attended, Harriet said:

> It felt like a guided supervision exercise to me, yeah… I think that it is what it was about. But I felt the subject was quite odd sometimes. So, I think once they started with about the consultations and I think the way it was led into was quite, people got quite defensive to start with, it was basically about your service has been cut, how do you feel? And I think as a team they were quite raw about that and they didn't necessarily want to continue talking about that. I think we blurred the line between whether it was a workplace discussion, whether it was safeguarding supervision, whether it was case management, it didn't feel very clear about what it actually was there to do.

Here Harriet says that it was unclear to her why topics like the cuts came up as they stirred up difficult feelings in staff. CC staff were used to looking at case management and safeguarding supervision, and were not comfortable or ready to be talking about their feelings with regards to their workplace. This feels like an important point as it made us think that there was not enough clarity when we introduced the WDG. To make matters worse, it felt like we did not have the management's support as staff did not seem to have signed up to participate in these discussions but rather made to feel obliged to attend at a time when they experienced many different things as being imposed on them. Harriet carries on talking about their suspicion and doubt:

H: I don't think people were clear that that's what they were coming to talk about. I wonder if people thought there was an ulterior motive, that another service was getting involved in the restructuring in some way, you know people get very defensive through change process, don't they? And I think it all felt very odd and the fact that we are still go through a change process shows you how long we are going on with this and I think they felt [like] another service coming in to talk about it, they didn't understand why.

Interviewer: So, a lack of clarity…

H: Maybe that was part of the problem, maybe part of the build up to it and the preparation for it should have been really clear about what they were coming to do.

Interviewer: It feels like things got mixed up.

H: They did. Because they were talking about cases but then they weren't relevant to everyone 'cause there was just one person who ever met that family so we went from cases, to reviews, to consultation…

Interviewer: Mixed up in terms of where CAMHS are coming from, is there an agenda?

H: Yeah, why they are working with CC?

Harriet says that CC are already extremely busy and somebody telling them to change their ways or to think differently feels impossible. CAMHS is seen as an external agency and Harriet wonders about whether CAMHS was sent to CC to monitor them as part of the redesign process. There is a certain degree of paranoia,

and words and phrases applied to CAMHS' motives and expressions such as 'secret agenda', 'exercise', 'experiment', 'ulterior motives' in the interviews confirm this.

Another aspect of what Harriet says that is indicative of the culture of the centres is the idea that talking and thinking about colleagues' cases could not be a helpful process as it is not directly relevant to their personal caseload. This, in addition to reflecting on the workplace or discussing other aspects of the work, felt irrelevant to Harriet. This makes me wonder about the enormous pressure staff have to deal with when monitoring high-risk cases. It may result in a feeling that there is absolutely no extra space to learn from others or to explore and discover different ways of approaching their work. As she describes it:

> I am not sure how relevant it is really. I mean we have lots of other opportunities for staff to have those conversations, you know, I mean we meet weekly and we have scheduled team meetings and they follow a process, so one week they'll have group supervision, one week there will be a planning meeting, one week there would be a more generic 'any other business' meeting, so I am not sure whether adding in a work discussion group would be relevant or needed really. I just don't know whether this is another thing we need to add in. I don't know.

Harriet also expresses her concern about the fact that staff had to attend WDGs without their consent and without understanding why they were in place. She argues that this felt unsafe. However, she doesn't justify such a strong statement, which made me wonder whether there was a general feeling of uncertainty and distrust at the time of our pilot because of the threat of cuts and redesign of the service. As Harriet explains:

> I mean I do the safeguarding supervision for the Centre. There was no supervision working agreement in place for that session, there was nothing that made it feel safe, there was none of the things I would have expected to see to make it feel safe. So, I think it's impossible for me to say how it could be used again in its current format, that actually if it felt safe or done slightly differently perhaps it could be successful, but I don't think it was ever going to achieve what it was out to, because no one really knew what they were there to do. And I think that's probably our failing as much as anyone else's, because it wasn't clear to staff what they were coming to do, it was seen as a bit of a task that we've got to [have] this meeting really, rather than their time [...] time is tight here. We go from thing to thing. Some of the girls here do 4 or 5 different services in one day for different agencies and they genuinely don't have blocks of time to give away and they see it as precious and it is, their time is precious, and they need to value it in order to contribute to it.
>
> Interviewer: Ok, you've answered everything, that's really helpful and we'll go back into the thinking to take it on board.
>
> H: Good, I think I have actually said quite a lot of actualities cause I met with Carol quite recently about moving forward but obviously we are in a process of review so we can't move anything forward (*laughs nervously*).

Here Harriet concludes that there is so much work in the CC, and WDGs felt like yet another thing to do that required more time from them, but also emotional effort to get in touch and look at staff's anxiety and distress. This was experienced as stressful and therefore unwelcome. Of note is Harriet's final comment about meeting with our Lead and although it feels apologetic, Harriet seems to be making

a point about the difficulties on the managerial level, but also referring to the gloomy times when 'nothing can move forward'.

For Jane, WDGs were experienced as general discussions at a time when they felt they had enough supervision and cases that were not complicated enough to justify this approach. Jane thought it was important that staff talked in one group about the short-term contacts as they provoked concern, but, overall, she feels that there were not enough WDGs to evaluate them and confidently judge and comment on their usefulness. For Jane, working directly with families would be a better use of CAMHS resources:

> The Work Discussions were…ok but I am not sure whether there was any benefits either way or no benefits either way of having those because the families that we had we weren't referring anyway and at the time we weren't able to refer because there wasn't any that met the threshold, so it was irrelevant having CAMHS involved in that respect. I think as an early intervention involvement as maybe coming to the universal services to support families and identify them to then maybe do one-to-one work sessions or something…you know…if they could identify certain families and invite them to CAMHS to do one-to-one work or something, that might be a way I think.

For Tina, on the other hand, although the WDGs also felt like general discussions, this was an interesting and helpful process. Her sentence that 'these psychologists picked up on things actually that we…' points to a recognition that there was something useful about somebody looking at their work and workplace from 'the outside'. She goes on to say that what she found helpful was some confirmation and

reassurance from us, helping them gain confidence in their feeling that something is wrong with a family so it can be addressed and discussed openly. In her own words:

> I think so, I think identifying those children we had…we had general discussions about the children and families that come to the groups and that we work with and I think from that I think these psychologists picked up on things actually that we… and agreed with us on issues that could need extra support and things like that. So, I think those kinds of meetings are quite good as far as generally, do you know what I mean, an awareness of actually, you are probably right that family does need something else or those kinds of things and I think…

Tina talks with enthusiasm about WDGs that focused on a parenting program they were running at the time and speaks about the new ideas and interesting thoughts that were brought in by the group's leader. She gives the example of the WDG leader suggesting introducing the doll's house as a toy that enables the symbolic expression of family life:

> Eh…I suppose that those general discussions about things have been really helpful and you came to do WD for us in (name of the parenting program) which is quite interesting, gives you new ideas and different ways of…especially if you are there with the children all day, to try and give you extra support and activities we might do. I think it is quite interesting you suggested for one child that we get the doll's house and if we can see if they would interact with them differently and that child necessarily didn't, he wasn't interested in them at all however another child picked them up and created this whole scenario which took us into a whole new world into their life and you know…before we wouldn't have thought about that before…so actually it was quite interesting. So that I think it's been very

> helpful and especially for this kind of children… I think planning activities or doing activities that will help them to bring out their emotions a bit more and talk to us a little bit more in those kinds of ways and I think that's really helpful because that's actually we don't really do an awful lot of you know. We plan for their intellectual well-being and their development and all that kind of stuff but maybe not so much about their mental…
>
> Interviewer: Emotional…
>
> T: and emotional and I think those kinds of activities like I say I think it was really beneficial. It was an eye opener. And this time at Mellow we've got the doll's house out again and we've used it quite a lot and it's been quite a lot of interaction with them as well and it really helped. So, any of those kinds of ideas would be …things we can do in those kinds of groups would be really beneficial, I think. I can't think about negatives in working with you. In the experience I have had there has not been anything negative, so…

Here Tina is making a distinction between looking at cognitive and emotional aspects of development. Play as a way of expressing internal struggles was an eye- opener for them and explains how WDGs enabled her to think more about play as a symbolic representation of feelings and thoughts.

Tina's view of CAMHS as an 'outsider' is a more positive one than that held by the other two interviewees. For Tina, this outsider status could be beneficial:

> Yes, I think so, an outsider coming in and say[ing] you are right, I think you know they could do with a bit more; they could have a bit more input and things like that. I definitely think it would work.

4.1.5 'Sitting tight and carrying on': Cuts and short-term contracts

Adding to the already-heavy workload, responsibilities and heightened anxiety, as reported in the previous sections, we conducted our pilot intervention at a time when the CC were undergoing a significant re-design and were faced with cuts and short-term contracts that provoked feelings of insecurity and uncertainty in staff. As Tina said:

> T: Eh…I would say because we don't know what's going to happen, eh I think it's put everybody on tenter[hooks] 'cause I think nobody knows what's going to come, where we are going to be placed…We had the big consultation about two months ago, three months ago…so everybody knows, all the parents know there is something happening and they ask us and we say we don't know what's happening. And I think it's quite nerve-racking to think that the service that they come to every week could actually…just suddenly maybe we could turn around one month and say actually next month it's not going to be here anymore. And that's quite frightening, I think. And we've got massive support connections with the community, they know where we are. I mean we have mums turn up on our doors first thing Monday morning with domestic violence during the weekend and they know we are here, but if they didn't know us and it was somebody new, they wouldn't do that necessarily. I think we have to think about the community as well. And it's quite difficult…and staff…it's just…eh. We keep being put on six-month contracts and, you know, there is a lot of talk of moving around and changing places. It hasn't affected a lot of things, I think in terms of what you deliver, we sat down to try to do the next timetable for after Easter and actually

> that's my point, because we don't whether we are going to be here or not and that's…
>
> Interviewer: Not fair…
>
> T: No, it's not fair…it's sad. It feels sad that we can't plan our events and plan our summer. [...] we just don't know what's going to happen and that's very scary I think, and it puts a lot of staff on edge and we have a lot of conversations about it although [there]'s nothing we can do about it. I think for both parents and staff it's quite a nerve-racking time to find out what's going to happen next.

Tina clearly describes her feelings of uncertainty, lack of clarity, not knowing what's happening, and shares her concerns with the interviewer about all this work and effort being at stake. I wondered whether some of the feelings she attributes to the families that depend on CC's existence belong to the CC workers too; the fear that families will turn up on a Monday morning and no one will be there might be linked to a fear that CC staff might turn up on a Monday morning and their jobs won't be here. When Dan comments on this uncertainty and not-knowing being unfair, Tina talks about it also being sad, as this situation interferes massively with the sense of a future and the capacity for CC to continue being a container and organiser for these families. As Tina explains, there had been previous experience of a similar re-design that unsettled things significantly – and nevertheless, managers and decision-makers did not 'learn from experience':

> I mean when we…this happened, about… I think it's 3-4 years ago, they had big change around then and I think there was like 27 individual CC and me and a couple of my colleagues were based over at (location). And that's all we had. We

> just had (name of the centre) at a bottom of a flat. And then they merged us with a bigger team, just with…this is when we joined (she names another three centres) and we were given the keys to (name of a CC) and said oh, you need to open up next week and there was no other staff there, just us and the families were looking at us like 'you've taken their job, who are you, what are you here for?', do you know what I mean? And I just think it doesn't help…it took us I would say a good six months to nearly a year to get back the clientele that they were having and the customers they were having, do you know what I mean to build that trust, to build that…we are still here, we are still the same people, you can still come and things like that and it does upset, I think, the community. I think when everything changes, I think no matter how hard they try it's going to upset quite a few people…so…

When asked about the re-design and cuts, Jane describes the lack of resources, and how it leaves the staff feeling called upon to be constantly filling in the gaps on other sites:

> J: I think it has affected my work […] …staffing wise. It has been difficult to re-recruit. We had some staff go on maternity [leave] and as a result of that, because of CC coming under review, the contracts that we were given were short term, as in six months and then another six months and…because of that recruitment was very difficult because it is very difficult to offer something [on] just a short contract really. So that left us very tight staffing-wise. So, it tends to be quite difficult with one member of staff […] off sick then… [...] morale for some people was low with regards [to] the review because of the future of our jobs. I tried to not think about it too much. Although I knew that it was up for question I thought until we know for sure I didn't want to worry about it. I think we have

> enough worries in our lives to take on something we might not have to worry about, so…
>
> Interviewer: That aspect of not knowing… you saw it affect some of your colleagues.
>
> J: Yes, I think it did because they were getting all stressed about it, I think. We have just recently, last week, been given our contracts until the end of December. That has picked up morale I think because we know that we are safe for a year. And we haven't had that security for over a year so that was quite nice to know.

Jane also talks here about the psychological impact of the cuts on the staff, who appear to be pessimistic. She says she thinks differently from them and carries on by trying not to think about it all. This made me wonder about a split in the centres between the people who express the worry and fear about their jobs and those, like Jane, who feel they need to express the opposite (or not think about it), to keep the centres running and offering their services. Friction in the team seems to be a result of this split, as Jane explains:

> I think morale sort of did have an effect. And I think that did affect working relationships sometimes, because people were a bit tense and so they'd snap [at] each other.

Harriet talks about the impact of cuts on families that were already struggling due to mental health and social difficulties:

> I think the families are feeling a great sense of uncertainty at the moment. I think the problem with consultation is they've been consulted with about things they are not necessarily going to have any influence over at the end and I think they

> find that very difficult. There is another consultation gone out this week that talks about [where] the bases are going to be and the families don't care, they have been very clear about that. They care about the services and they care about the staff because they want to know that they will still be able to go to a baby club on Monday, because they were really depressed and they are actually managing that depression 'cause they get out once a week, and they want to know that the person who was supporting them with that is going to be in that group still. So, parents have been quite low actually. There has been quite a weird community environment where families are feeling quite vulnerable, they don't know what will happen next, they feel like the small fish that don't have any say and we are trying to sell it [as] 'you've got your say, this is a consultation…', but I don't know how true that is if I am honest. I don't know if they have a say really. I think…we know there is no money, we know things have to change and there is only so many ways you can change something without damaging the service. […] So, the people who would be most affected are the one without a voice sadly…(*laughs*)…it is depressing. Is the current climate, isn't it?

What comes across in this answer is a gloomy feel, a feeling of hopelessness and an idea that all is already decided and imposed on staff from 'above' and the people most affected don't really have a say.

The next section concerns the findings gleaned from applying IPA to the interviews with the Child Psychotherapists who participated in the pilot.

4.2 CAMHS Child Psychotherapists

Martha was a Child Psychotherapist who joined the team at around the time this project started. Dan was the only male Child Psychotherapist in our team and was

also new to our CAMHS. Kiara was a trainee Child Psychotherapist in the early stages of her training who delivered the Work Discussion Group with me.

4.2.1 Embarking on the project: enthusiasm, vague ideas, a wish to explore and build relationships.

All three Child Psychotherapy colleagues describe the beginning of the project as an opportunity that they found both exciting (as they wished to do outreach work with under-5s) and of vital importance, since they deemed making links with frontline workers to be necessary for providing early intervention and prevention of mental health difficulties in young children. Martha describes how we tried to approach CC in an open-minded way, in order to explore all available possibilities for establishing meaningful contact and links. Her motivation was her passion for working with under-5s, but she admits that, from the beginning, we had a very vague idea of how CC operated, and we were not sure what we could offer. In addition to that, we were not clear on previous CAMHS attempts to engage CC and we happened to start this pilot at a time of a redesign that brought about its own difficulties and foregrounded conflicting agendas between our service and CC. Just ‘going there’ without having a clear plan was, according to Martha, probably what aroused feelings of suspicion and paranoid ideas in CC workers that we were there to evaluate them and report back. This was why we were often made to feel totally redundant and useless. Martha reflects on her experience of how other disciplines, such as Clinical Psychology, work where colleagues are, according to her, much better at ‘giving the client what they want’ and in tailoring interventions

accordingly. Our approach was different, as we seemed to have an opinion on what CC needed. As she describes:

> Yes, the ideas we had were pretty vague, you know... We just said we could offer Work Discussion and consultation to staff. That was basically it, you know. We were sent out to let people know, you know, about this availability and also to explain about CAMHS and referrals and the under-5s service. But this is just a kind of… formality in a way, you know. Because then the actual encounter with the staff is something completely different. And even though on paper, in principle, they didn't have anything against us and appeared to welcome it – but for them to actually be sure about what they wanted from us, if anything, was very difficult. And for us to kind of feel we could respond to what they wanted was also very difficult.

Martha wonders whether we should have been more 'matter of fact' and better at recognising situations when we had to stop offering an intervention that CC workers did not want. Martha further comments on her passion for this work having been there from the beginning; however, there evidently hadn't been adequate planning and preparation for the project, while CC's needs and CAMHS's resources hadn't been properly assessed and thought through in advance. We also failed to take into consideration our CAMHS redesign, and we lacked a clear agenda as well as support from managers both in CAMHS and CC. What comes across in this part of the interview is Martha's frustration and disappointment due to inadequate organisation on our part in setting up the project but also due to inadequate CAMHS management, which seemed to be aware of the difficulties from the start. Both

insufficiencies resulted in us feeling exposed and, at times, helpless. As she describes it:

> I wonder if perhaps someone else might have gone about it in [a] more matter-of-fact way and said ok, you know, do you want this? They said yeah, ok the Work Discussion is fine and then nobody turns up to the Work Discussion, end of story, you know. Instead, we kind of insisted we wanted to make contact at all costs. (*laughing*) […] Because we had the problem of two different teams in CAMHS and Victoria not even being in our CAMHS and there are multiple agendas that might conflict or have an impact on the work, for example […] the relationship between the managers. We didn't really know what was going on or what kind of steps were being taken or willfully not taken. Sometimes I really felt were sort of being let loose…

Martha's joke about us trying to 'make contact at all costs' reveals our considerable efforts to connect with and engage CC workers, even in the absence of enough support, a clear structure or a firm plan.

For Dan this project was a worthwhile attempt due to the importance of early intervention and tackling problems early. His motivation was that he did not have enough experience working with under-5s, and he had just joined the team and thought this would be an opportunity to get to know the CP team better. Lastly, he thought CAMHS had been rather inaccessible and it felt important to reach out to the community.

Dan further explains that offering WDGs seemed to be a more realisable option (this was something we concluded following the initial plans) and he found this

exciting since he had no prior experience of facilitating WDGs. Consequently, we had to adjust our approach, as 'a quiet presence' felt more appropriate to begin with. The first stage was for Dan to learn about CC and work to gradually gain their trust. This was difficult since there was already a sense in the centres that there were too many services imposed on them. He is reflecting on the fact that we had higher expectations at first and soon had to adjust to the reality of not knowing enough about CC, but also about how to run such a service.

Kiara embarked on this project right at the beginning of her CP training, feeling excited as she had a special interest in work with under-5s. She describes the initial meetings with the CC managers, which proved difficult to organise. She comments on understanding soon after we started that we had to be careful not to impose a service but to 'go out there and see', even if this meant not being fully aware of what we were getting involved in. Kiara talks of her experience as a first- year trainee who was, therefore, invited to 'take a step back' and shadow others.

All three interviewees mention being new to the CAMHS team, and it is of note that this was a new project that was set up by a team of newly employed trainee and qualified CPs all based in London, who had limited awareness and understanding not only of the team dynamics, but perhaps also of the social and financial situation in the area. Both Kiara and Dan talk about the particular usefulness of the observational course (a prerequisite for Child Psychotherapy training) to this pilot, as it trains Child Psychotherapists to look closely at early relationships and use the observational method to get in touch with unconscious processes that sometimes interfere with ordinary development.

Both Dan and Kiara discuss the gap in the provision for under-5s as a factor in why they thought embarking on such a project was very important. Kiara goes on to make several hypotheses about why the team was somewhat reluctant to offer this kind of work in the clinic. As she says:

> Actually, we barely see any under-5s at all, and I think sitting in on referrals coming in, there is a feeling in the rest of the team that this is actually the parent, this isn't the child – how can a child have mental health problems? It's just a behavioural thing, they are just having problems with weaning and separation and there is nothing we can do – we just think about the children, there is a lot of thinking about that, they are just too young to come to therapy. I think a big fear actually, a big fear [is] the unknown of working with little children and what to do with them, feeling like they can't really do much with little ones and they have got to be a bit older. I think there [is] maybe also a fear to see them on their own without the parents around, and not much thinking about how you can see the baby with the parent and how that would work, and like it just wasn't thought about – a just-not-go-there feeling, and even difficult for us to think about how we are going to deal with the referrals that come in and how we are going to have these conversations with the rest of the team. And then worries that there might be a bit of rivalry about this as well, and people being put out, and there was a back history of people trying previously and failing. So, it was a big challenge for us really, deciding that we were going to do this and not really sure whether we would have the support of the whole team.

Kiara here speaks about the CAMHS team's complicated dynamics, as there was partly a reluctance to work with under-5's but also some CAMHS colleagues had

previously worked in Children's Centres and had contact with them in the past. However, as described in all three interviews, we were not clear about what these interventions were, why they stopped and whether other clinicians wanted to get involved in our project or not.

4.2.2 'Like a stone in a shoe': the experience of making first contact with Children's Centres and being perceived as 'irritating', intruders or spies.

All three interviewees vividly describe the start of our pilot, namely contacting CC managers. This process was time-consuming and difficult to arrange, and that took place in parallel with CAMHS meetings where the aims and objectives of the pilot were discussed.

Dan talks about the practical difficulties of finding time and space to go 'out there'. He draws a parallel between the actual 'space in the diary' and the 'emotional space' we tried to provide to think about painful processes together, something that required overcoming ongoing resistances to thinking in a different way. CC management's reluctance to commit to our work added to a feeling of our work being undervalued and often rejected with little (if any) genuine curiosity or wish to provide reflective spaces for CC workers. It is striking that Dan uses the word 'space' six times in the same answer, which I think provides evidence of how complicated it was to set up this project. More importantly, his point about whether our work was valued or not raises questions about the internal and external resources required for this project, since most of the time we felt, as Dan describes it, as if we were 'self-managed' in an environment that felt 'irritated' by our presence, 'like a stone in a shoe'. This metaphor seems to reflect Dan's feelings in a

powerful way, as it implies that not only were we frustrating them, but also interfering with the smooth running of their services.

Another aspect that Dan brings up in his interview when discussing first contact with CC, is that of deprivation. He talks about how deprivation gets into the system, becomes part of it and consequently, results in substantial lack of thinking space, resources and support for staff. Dan's point made me wonder about the impact of this level of deprivation on our CP team during the pilot. It may have added to a pre-existing feeling of being seen as the 'outsiders' and more privileged clinicians who had the luxury of working with children on a one-to-one basis but most importantly, had the option of accepting or rejecting a referral.

Our CAMHS team, possibly along with our management, seems to have experienced feelings of frustration and anxiety about opening ourselves up to a possible 'flood' of referrals following our outreach work. Dan interprets our wider team's reactions to our pilot as a result of envy for taking such an initiative. At the same time, the lack of proper management added to these complicated dynamics since it was only later in our project that we got the chance to formally present our work to the rest of the team. During this presentation, we were faced with mixed responses. Some colleagues felt that there were aspects that we had not thought through properly, such as ethics, and others expressed their worry about possible new referrals of under-5s to CAMHS testing our capacity to see them. Nevertheless, I wonder whether some CAMHS clinicians felt excluded by this initiative, which inevitably raises questions about our management's wish to keep the project small since it was not properly announced and discussed in any of the team meetings. The

latter was possibly linked to concerns about how sustainable and expandable this project could be.

In Kiara's eyes, some of our CAMHS colleagues seemed interested, had questions and were intrigued as they were also involved in outreach work, for example in hospitals. Kiara thinks that the change of Trust in our CAMHS had a negative impact on our project and made the team more competitive, giving the impression that 'CPs are doing everything now'. She thinks this was particularly unhelpful, since we missed a chance to communicate our work more directly to people who had similar experience and could have contributed to our service.

Kiara describes further practical challenges we encountered at the beginning, such as in travelling to the centres. Getting there was time-consuming and stressful due to long distances and lack of means of transportation. Dan describes 'dipping in to a centre here and a centre there', which is indicative of our struggle to cope with distance and find our place. Furthermore, we would often arrive at a centre only to find out that there was something else CC staff had to attend, so we had to go back to the clinic. Our attempts to keep a log and document our work at the CC was an added difficulty in terms of administration and time.

For Kiara, the most important challenge in this initial stage was finding a way to communicate our wish to help and our ideas about how to provide support to staff. This did not seem to be a straightforward process as it felt that all the efforts Kiara describes encountered suspicion.

Martha makes an interesting association during her interview when asked about the initial contact with CC:

> 'You know, I was watching this movie the other day, a spy movie. [...] *Game of Spies* or something; and [it] is set in post-war Germany between the Americans and the Russians and East Germans, they have to exchange spies, you know. So, there is this American lawyer that goes to East Berlin and has to negotiate the exchange of a Russian Spy for two Americans, one is a pilot and the other one is a student who just happened to be in Germany. And then you can see he goes in there from these wealthy middle-class suburbs and suddenly he is in East Germany thinking 'What is this?' and he is travelling in the U-Bahn and suddenly sees these people trying to climb the wall and [they] are shot down and then he has to meet these diplomats from East Germany and Russia, and you know, he is like what's your agenda and what's mine. And this did remind me of…(*laughing*). Apparently, they are having a conversation but it's a negotiation, not a conversation so I think that's what it felt like to go there, it was a negotiation more than a conversation, it was beginning to turn into a conversation but that's how it was initially.

I thought that Martha describes in a very lively way CC's suspicion, but also the 'cultural differences' between the two organisations. It is as if working together never became a joint project but was perceived rather as an attempt to defend and stand up for one's service. Another important element, as discussed above, was deprivation and a certain degree of shock for our CAMHS team, who had to adjust from living and working in privileged North London suburbs to working 'out there' in relatively inaccessible disadvantaged areas.

Martha also discusses CC staff's intense and paranoid fears that our arrival at the centres would mean their families were going to flee and never return. She describes a fantasy that families would get scared off by CAMHS' presence in fear of being pathologised and passed on to other services. This was possibly linked to stigma around mental illness, and a perceived analogy between CAMHS and Social services, linked to the feeling that their parenting was being monitored. Equally, for CC workers there maybe was a fear that CAMHS would criticise and judge their work.

4.2.3 'A just "not go there" feeling' and 'being left in the dark': Children's Centres and CAMHS in crisis.

Institutional changes, in both CAMHS and Children's Centres, seemed to have played a decisive role in the setting up and developing of our service. The three interviewees provide substantial evidence of difficulties that emerged because of such changes.

Martha talks about the lack of transparency in our CAMHS and how not being informed along the way of what was happening on a managerial level made us feel exposed and insecure. There was no support from management, and at the same time the CC management structure was not clear either. This hindered the development of a trusting relationship. There was no clear mandate and therefore it all felt uncertain.

Nevertheless, and although Martha does not think CC understood what we intended to do; CC staff seemed to have had an experience of being valued because of our

determination to keep offering support and not give up. Martha deems this to have been particularly important since overall, there was a feeling that CC's hard work was not sufficiently appreciated; thus, our persistence was containing in the sense that they felt acknowledged. At other times, it seemed CC perceived what we did as unhelpful or burdensome.

Martha talks about our team having an experience similar to that of CC staff, since we were not part of the decision-making and were not adequately taken into account in the process of evaluating and thinking about the future of this work. Lack of support and genuine belief in what we attempted to do resulted in us feeling devalued and disrespected.

Dan also talks about the lack of transparency in CAMHS and argues that it created the conditions for disappointment. He further comments on a sense of fragmentation in our own CAMHS team since we spread out in such a way that we often felt 'like [we were] knocking on different doors'. I wonder whether this was because we did not feel we had a manager who could oversee, supervise and support us all, especially since most of us were new to the team and/or to outreach work. For Dan this was a situation better described as 'self- managed'. The project came together 'quite loosely', and we were about halfway through our work when we realised that there was need for more structure. Dan felt he never had a trusting relationship with our manager, Carol, as she was not transparent, and we often felt we had been left in the dark about how this project was received by the CC staff and management.

Kiara talks about how our two CAMHS teams had to some extent different agendas, and Carol who was responsible for another CC already had an established relationship with that CC's management, so there was a pre-existing link that we did not know much about. The changes in CAMHS did not affect us a lot, according to Kiara, however there was a level of uncertainty in our service that might have caused some anxiety. For CC workers this was definitely the case, since staff were on temporary contracts. As she remembers:

> They all had these letters in their bags that weren't very sympathetic to how they might feel, just a couple of sentences just saying that you are now on temporary contracts and if anything changes before the 6 months are up you could lose your job and they were expected to sign that and return them. But it didn't feel many open conversations have been had about that and I don't think they really wanted to talk to us about it, there was a lot of…they were very defensive about it because they were scared about losing their jobs and what that might mean and they still had to manage on a day-to-day basis with 40 families, or however many families they had each in an area that is severely deprived, and really needs support; so I think there was a feeling of deprivation everywhere really that seemed to be key and we were coming to offer something, but this was also highlighting the deprivation they had.

Kiara thinks that for CC workers the crisis in their system was much more evident and pertinent since they were on temporary contracts; a concrete representation of that was the letters they had in their bags. Carrying on as if this was not the case was most people's way of coping with all these deprived families. Kiara wonders at the end of this answer whether our presence highlighted the level of deprivation,

possibly stirring up a certain dynamic to do with the 'outsiders', the 'Psychotherapists' who came from London to help the non-coping ones. In Kiara's view, CC staff did not understand who we were as they mostly considered us to be like other services and agencies who were involved with them to assess and evaluate them; they felt they were under scrutiny. CC perceived us as being there to judge them and take away their power and competency, highlighting deficiencies. Although Kiara considered our willingness 'to sit on the carpet' as a helpful gesture that made us more approachable to them, we were perceived mostly as punitive. Over time, as Kiara notes, this attitude seemed to shift and our capacity to keep them and families in mind seemed to matter to them. On the contrary, there was no shift in CC management's attitude towards us and our work, at a time where managers kept changing, also being in great uncertainty about the future of CC and their jobs.

When Kiara talks about the end of our project, she comments that we were never given feedback and that it was abruptly announced to us without much explanation. She understands this as the consequence of a complex situation relating to CAMHS' change in trust and the reconfiguration anxieties in CC.

Kiara considers the wider social and political context in the area and describes a particularly concerning situation where there were nine serious case reviews taking place at the time of the interview, evidence of the extremely high levels of need locally. This cannot but create tension and put pressure on all services in the area that are stretched and vulnerable. The unbearable anxiety of infants and children's physical and emotional safety seems to create a sense of helplessness, and despair in

the system, thus making any initiative to do with thinking about these difficult feelings threatening.

4.2.4‘Stay and Play is not a session’: getting to grips with the challenges and opportunities of doing outreach work in CC.

The three interviewees describe inevitable challenges in setting up outreach services, but also discuss the particularities of our pilot and what we should have done better – namely requesting more support on a managerial level and keeping the service small and specific. Martha talks about the lack of ‘marketing skills’ in our team and the fact that, according to her we were too tentative and lacking in confidence. Martha attributes the latter to concerns about ‘entering their territory’, ‘interfering’ and struggling to ‘find our own place’. She adds that ‘stay and play is not a session’ and explains that the main challenge of outreach work, for Child Psychotherapists, is that one is completely out of their comfort zone and adding to that, there is an immediate need for finding one’s place in the other organisation without adequate knowledge and understanding of its ways of functioning.

More specifically, Martha sees the CC we worked with as providing ‘the only positive thing out there’ and tries to present the reality of many isolated mothers who ‘have small kids and the days are long…’, for whom CC are the only service in the area where there are opportunities for the children to play in developmentally appropriate settings, but also for parents to socialise and interact with others. It is also of note for Martha that CC offer services for parents and children to play together and, are therefore, particularly important in terms of the development of parent-child relationships.

Martha also talks about another function of CC, maybe the most demanding one – namely, monitoring high-risk families and preventing Social Services' involvement. The latter, we found, was the cause of great anxiety for CC workers and allowed little space for thinking about other areas of their job, for example the universal groups and ordinary difficulties they could help families with. In Martha's view, running these groups is an already demanding task for CC staff who are constantly 'bombarded' by stimuli and eventually, they are liable to become emotionally drained and tired. As one CC staff member characteristically said to Martha when asked what their aims for the group were: 'I aim for the group to end'. These groups are potentially extremely helpful in providing a consistent, predictable and stable presence for parents and young children, but for Martha what gets in the way of running them in a successful way is that CC workers seem often to function on 'a concrete and very basic level' where creativity, curiosity and thinking is actively avoided as if it were an extra demand.

When asked about an intervention she offered during the pilot, Martha remembers a child who seemed to be autistic and his mother who struggled and appeared to be lost. Talking to this mother about how the boy may be feeling seemed to make a big difference, and over time the boy managed to make more eye contact with his mother and grandmother, which came as a huge relief at the time. For Martha, this is a small example of a very short intervention where being interested in the child and the parent seem to have an immediate effect on the family. Paying close attention to the interaction between parents and their under-5s can promote an

immediate shift in the way they feel about each other. Martha provides evidence of the latter, when she describes another small-scale intervention:

> Yeah…like this other mum who I think she was very preoccupied by the domestic abuse she suffered and you know she had this one-year-old and a two-and-a-half-year old, and Victoria and I went into the group and we were very concerned because the little girl kept rocking and mum totally ignored her and actually, you know, we didn't do very much but just perhaps the fact that we were concerned and sat down with this little girl to play with her meant that that mum…over time we noticed that this mum began picking her up a lot more but we didn't do anything particularly noticeable but I think even small things matter…

For Dan, CC provide a community for parents who are isolated, lonely and struggling. He uses the example of a parenting program, as a program that was particularly important for isolated parents. Dan offered a Work Discussion group to the family workers who run the parenting program but, he says, only two groups took place as the program stopped and could not carry on as funding was uncertain. This was, for Dan, unfortunate as the group – unlike others in the CC – appeared to be particularly keen on thinking about their cases and were receptive and open to any help or emotional support. Other groups Dan attended, such as 'stay and play' ones were, according to him successful in that they were run smoothly and were providing developmentally appropriate opportunities for children to play and parents to join them in their play. Conversely, Dan recalls a 'stay and play' in the local Mall which he experienced as hectic and full of worrying cases, 'a real mess'.

CC's outreach service was for Dan one of the most difficult and least functioning aspects of CC as they were 'chronically understaffed, lacking emotional thinking space, supervision and support'. Dan also talks about the 'baby clinics' where he deemed our presence to be important as they are designed to monitor very young babies' physical needs but not emotional ones. What is important in Dan's description of how he experienced CC seems to be the significant differences between sites and various provisions of care that can often feel detached and fragmented.

Dan also discusses his impression of a sense of insecurity in CC mainly due to structures and managers that had changed and amalgamations that created a feeling of a 'constantly shifting ground under their feet'. He added that staff were overworked and the centres underfunded. As a result, there was suspicion, guardedness and defensive ways of coping and working, according to Dan. CC staff seemed to feel that our team would disrupt their way of working, which had already changed many times due to previous redesigns. Dan explains that we had a very different experience of the two managers who changed while we were there, the one being 'receptive and keen' and the other 'slippery, cut and dry'. This poses questions about how CC workers perceived this change in managers and whether their experience was similar to ours.

Moreover, Dan expresses his concern about whether we were successful in clarifying our role with CC as he felt taken aback when he interviewed one of the CC workers who found our presence unhelpful since there were no families to refer to us. He seems to attribute the latter to an expectation that was created in the

centres that we would 'relieve' them from difficult families, however they seemed to be unclear about which families needed mental health support and were unsure about whether they could assess these needs and then refer.

When asked about an intervention while in the centres, Dan talks about a 'basic piece of work' in one of the groups, where he supported a mother who had been depressed and was anxious about her child not walking:

> What came to mind initially and probably the most positive experience was a mother there who had a very, very alive healthy little child who charmed everyone – absolutely gorgeous – and a lovely mum but who had struggled and was still struggling a bit with anxiety, sort of why isn't he walking and why isn't he talking yet, and I supposed conversations me and Kiara had with her in terms of 'It's ok'. 'He'll get there', and 'he is a wonderful kid and he's alive, is interested and he is relating and…'. So, kind of very basic piece of work, thinking about normal development, anxieties, very normal anxieties in some ways that sort of ballooned for her because she had felt initially depressed and had some difficulties in coming together with him. But that felt good because really feeling they were going to be alright and he was going to be alright and she was fundamentally a very good mum.

Kiara notes that different families had different expectations for the various CC services. She recalls the CC in the local Mall where parents seemed to use the CC workers as babysitters while they were doing their shopping, and other groups where there was a real family feel and parents were having strong relationships with the staff. Kiara also comments on another aspect of CC to do with parents'

perception that CC were like Social Services, as CC staff were expected to do home visits and be part of parenting assessments. This, according to Kiara, resulted in a 'real feeling of intruding in these families' lives. On the other hand, it seems CC could also provide a strong sense of community, as there were families who had been attending for years and over many generations. Kiara comments on the fact that we did not really have a good sense of the latter since we were coming from London and it took time to understand the level of deprivation, isolation and need in the area. Kiara's expression 'becoming another babysitter in a stay and play' when she describes the initial phase of our pilot conveys a feeling of being useless and not using our expertise, but also shows CC workers' need to have concrete evidence of our respect for their work and our need to acquire experience of how it actually feels to be in one of these groups. Furthermore, Kiara thinks that what is successful about CC is the fact that some of the staff are 'nurturing', that is they are seen as having a 'grandmaternal' role that families seem to keep returning to. For Kiara, CC provide something particularly useful to isolated families by offering the groups and doing home visits. The universal drop-ins seem less helpful to Kiara, as they provide a temporary solution and relationships seem less established and, therefore, there are fewer opportunities to get to know families and provide support.

Kiara, when asked about an intervention she could recall, talks about a busy baby club with 18 babies, where a grandmother was struggling with feeding her grandson who was still breastfeeding:

> I went to a baby club, so a club for babies under a year, and there was a grandmother there and she had her grandson with her, he was just 6 months and

> her daughter in law had just started work so she had been given this baby. And she turned up in this group very anxious and not really having been there before, just wanting to go out of the house with the baby and mum had just stopped…actually was still breastfeeding, but expecting the grandmother to keep the baby for the whole day using a bottle; and the grandmother was trying repeatedly to feed the baby with the bottle and it was really uncomfortable for the other parents to watch, and for the staff, And it was a very bitty group – 18 babies there at once, and I just sat next to her and she started to talk to me about it and she said I am really struggling [...] I think that by seating near her [I] offered some support and I said because she kept trying again and again maybe the baby needs some space and give her a bit of time to step away from it, and not keep trying as you could see the anxiety building up and up and I encouraged her to sit down on the carpet and stop for a minute. And she did that and she did seem like a weight had been lifted off her, and the family worker stepped in and helped with the baby. And then I did some more talking with her, it was more about listening to how much she was struggling [...] She picked the baby up and baby fed for 15 minutes and she was very pleased about that, but I think they needed somebody to be there and say it's ok.

This was a very good example of a small intervention, where one-to-one attention and acknowledgment of the struggle of both baby and grandmother promoted the necessary conditions for a successful feed, which came as a big relief to everyone. Kiara thinks that there were opportunities to think together about difficult and high-risk families and more painful cases and remembers one time when right at the end of a Work Discussion group somebody spoke about a somewhat traumatic home visit. Overall, Kiara thinks there was a lot of anxiety about sharing their feelings and

thoughts about challenging cases, where safeguarding concerns were painfully present.

4.2.5 A 'Complete Veto' and a 'weight off our shoulders': the end of the project.

The abrupt end of our pilot was discussed in all interviews, and the team describes mixed feelings about it, including relief, but also sadness and frustration as there seemed to be a lack of acknowledgment of our hard work as well as of our need for a space to reflect on what happened. Martha talks about our management's being aware that we had done a big piece of work, but her sense was that they were overall unsupportive and were not clear to commissioners and CC managers that we did the best we could; nor did they explain the reasons why it would have been important to carry on providing the outreach service. In her own words:

> I think you know, they knew we had done a big piece of work but I don't think that anyone was clear about supporting us from the start and all along and be able to say to the commissioners 'ok, we have done this because we think that's at the moment what's possible and the best we can do in terms of supporting the CC and we think that this should continue and we have limited resources so might not be able to provide it for every CC but this what we can do, you like it you can take it, you don't like it we don't do it.' Instead, there was a moment when they said, 'no more of this', complete veto – 'no you can't do this anymore and you can only do WDGs then nothing at all' in a very abrupt way, suddenly from being let loose we were being told what to do without much explaining.

Martha explains that she was not clear about why the project was dropped and expresses her disappointment that our voices were not taken into account. Instead, she felt that our line managers 'stepped in massively' and made decisions without consulting us. At the same time, Martha admits to also feeling relieved that the project ended as it felt as a big commitment, but also feels sad as although it was a small intervention, she thinks we would be 'incredibly missed'.

Kiara talks about how upsetting it was to be stopped after all our efforts and hard work and considers this to be also a loss for the CC since we had achieved a certain level of understanding of the ways in which they functioned, particularly around their struggles. As she says:

> I think it just felt quite upsetting that we built these relationships with the staff and we had got to their level and had really understood how difficult it was and started to really understand the families and the community, and then it stopped and it feels very much like what are we going to do now?…Yeah like a sudden loss really, where we haven't even been able to probably even think altogether about how we felt in our CP [team] and then with them, with the actual family workers yeah quite a lot of confusion about what they might be feeling, they might have not wanted us or they might have wanted us and the manager might have stopped them, so lots of unsaid things really, unable to say…

Kiara further talks about how important it felt that we managed to come together as a team. However, she thinks that the timing was unfortunate as we could not be empowering to CC under the circumstances. Starting with the Health Visitors as a point of entry would have been a good idea, but there was also a need to be clearer

about what we did in the CC. The idea of a pilot meant we were exploring what we could offer, which in Kiara's eyes might have been unsettling for the CC workers. WDGs was a good intervention, since as Kiara notes, it was a way to avoid being pulled into thinking only about individual families, leaving us free to focus more on the service and issues concerning work that relate to most families in the centres.

Dan points out that the end of this project was not given proper thought in our team, nor did we bring things to a proper closure at the centres. It was going back to it as part of this research that motivated us to reflect on the pilot and get CC's feedback on it. In his words:

> For example, yesterday I went to interview one of the CC workers and that would be no plan for it to happen, it was purely for your research and I think something we didn't do well was the ending. It kind of tailed off…That really wasn't good from our part.

4.2.6 Lessons learned 'on our feet': the pilot as a learning curve for our team.

Dan talks about realising how little he knew about CC and considers this project to be a learning curve for him in terms of understanding CC as an institution. He also talks about learning how incredibly stretched family workers were due to their risky caseloads, stress, lack of space and staff:

> So, I had no idea really about the structure or a vague idea about the possible staff make-up but that became clearer. And certainly, as far as universal and targeted services [are concerned], that was something completely new to me and I didn't know there is that kind of division. So, yeah…I guess it kind of almost splits into

> two in some ways the way I perceive it: there are the outreach workers who have incredibly high caseloads and very little supervision, and my feeling is that that tends to be more about safeguarding and practical managerial issues. So, little, if, any emotional support. These teams go out in the community and deal with incredibly risky cases and families on the edge and of all sorts of things, very high risk, real sense of stress, lack of space, a real sense of them being affected by lack of staff – so very tightly staffed especially the outreach team.

The above shows that there was a real gap between the two services. We knew hardly anything about the way they operated, and as they said in their interviews, they did not know anything about CAMHS either. In addition to this, what seemed to be reflected in Dan's answer is a sense that the experience of family workers felt similar to that of the families they work with – that is deprived of necessary things like space, supervision and staff.

Martha would advise colleagues who would embark on similar projects to make sure they protect their work by planning the intervention thoroughly and making sure this would be something that could be sustained in the long run. She is making it clear that although we were not supported enough, we were still responsible for ensuring this would be a sustainable and supported service. She feels that being new to CAMHS was not helpful, as she did not feel confident enough to establish necessary boundaries from the beginning.

Martha describes how different this work is to seeing patients in the clinic and as she explains she learned how much time is needed to establish relationships and trust:

M: Yeah, it is very different because here you are [on] your own ground and there you are not. And I think that's the major difference. So, it somehow takes a very long time to find out and establish enduring relationships between professionals that work in very different settings, you know.

Interviewer: If we were to continue how could we make ourselves more accessible to families and the workers, do you think?

M: I think we were as accessible as we could be…even too accessible in some ways, you know…(*laughing*)

Interviewer: What do you mean?

M: That we were there cleaning the floor after the group, I was doing that to just make myself perceived as unthreatening as possible I turn into the cleaning lady…[…] so I mean I think we were very accessible and you know there is always a double-edged sword in a way, because in some ways if you try and come across as non-threatening, friendly, open, maybe that helps in sort of lessening the anxiety but on the other hand…you know, you can kind of be devalued or there might a grievance about 'you are not turning things around for me', 'you are not really…you know, what is it that you…in what way…what is it that you are doing that is special or different or makes a substantial difference to you know how things are done, or how things happen', Even though actually I have to say that from the point of view of the family workers we often had the sense they didn't know what to do with us, they didn't seem to need us at all, did they?

Martha wonders whether we were too exposed, outside of our comfort zone and remit and therefore it took a while to form relationships. In my view, there is an

interesting link here between our experience and outreach work for family workers in CC, who were constantly put in this uncomfortable situation with the added stressors of going to people's houses and holding the responsibility of monitoring them for safeguarding concerns. Likewise, as Martha describes, we often felt we had been too accessible, to the extent that we became less threatening – just as outreach workers in CC did due to their anxiety not to lose families, or for parents not to feel judged and criticised.

Martha's expression 'becoming a cleaning lady' underlines a fine boundary that we discovered while working on the project. This is the thin line between making oneself available and accessible, and being drawn completely into a practical, hands-on provision of help that seemed to be needed in the centres, often replacing the even greater need for a thinking space and emotional containment. As she further explains:

> It would be interesting to be able to carry on…but…I think it might have been more that we could chew and in a way, they sent us to go to all the CC, it was too much and maybe it would have been better to go to one or two CC and put more resources to that…[…] being available, I think that's quite important for these people, you know…even though it's harder to define in what way, you have to put up with the uncertainty of… come together or not come together, but I think that was the most important aspect of what we did, you know, we are there to make ourselves available without an agenda. It's a bit sad that that's one thing that actually nobody seems able to tolerate you know, feels quite depriving instead you have to be there and do outcome forms and blabla…force them to come to the Work Discussion…you know.

Martha thinks it would have been better if we had concentrated more resources in fewer centres. She adds that she thought there was some recognition of our efforts and generosity, but she considers it sad and depriving that CAMHS and CC are overall more interested and invested in outcome forms and numbers than in actual meaningful work. There is not much hope that things could change; that is, for Martha, the current climate.

In retrospect, Dan thinks that the most important aspect of this project is that we managed to make a link with CC, that is we were successful in explaining what kind of help CAMHS can offer. For Dan, we were not as successful in explaining how we could help before the problems increased and became fixed in a family. Dan talks about learning a lot from this project, and thinks a lot is transferable to similar attempts:

> D: Yes, I think we've learned lots actually. So, the need for it to be, there to be much more structure. I mean to be fair it was a pilot project, so we were learning; we were exploring everything about it and how to approach it. So, yeah how for us to be much more robust as a structured team for roles to be clearer you [...] it was very clear that we needed psychotherapeutic pace to process things together as a group. I think this was Neithan's role but not enough of that really. I learned it takes time and needs a lot of space, so I think we were over-ambitious actually in what we bit off, but at the same time we learned a lot because we spread ourselves around. So, any talk of something continuing is around being much more realistic about just offering a few groups.

> Interviewer: If a colleague said to you 'I am thinking of embarking on a similar project', what would you advise them?
>
> D: I think there is a lot that is transferable to any project that was about going out to the community. So, to have I suppose a clearer idea of who these centres are before going out would have been…I mean we did a lot of research before but there was a lot of thinking on our feet which took up energy, a lot of learning on our feet, part of which is inevitable but to do as much groundwork as possible to have roles within the team clearly defined…

Dan describes the need for a clearer plan and structure in a project like this. Also, time and space need to be thoroughly assessed as these projects are very time-consuming and require a lot of careful thinking and planning. This highlights the fact that we started this pilot without considering how the CC workers might perceive our ideas and plans. We hardly knew what services CC provided, and Dan's suggestion for more thorough research on the centres sounds reasonable and something we should have done more of in advance. However, as shown in all three interviews, being better prepared would not necessarily mean it would have prevented us from feeling unsupported or unwelcomed by the centres, as being outside of our structure and comfort zone and needing to find a place in a new setting that is unfamiliar and has different ways and dynamics, would anyway be features of any outreach attempt.

Dan further talks about how this project helped him become much clearer about what kind of work he enjoyed doing as part of his CAMHS role. He explains there was a lot about the project that he struggled with and which left him feeling

pessimistic about some of it dropping away. However, Dan became more interested in WDG and parent-infant work while on this pilot. He reflected on being a man in what very much feels as a woman's world of early nurturing, which was complicated and difficult at times. Dan felt it was important for the male voice to be heard, the father's voice. This project left him with a lot of questions about himself, his part in it and his interest; part of him wanted to 'run away' from it as it was too energy consuming and was leading to greater divisions in our CAMHS team. I felt this was a very personal finale to Dan's interview, where he honestly shares how he realised he did not want to do this kind of work and at the same time discovered he would like to do WDG and parent-infant work. He finishes by saying that any outreach project would probably encounter similar difficulties but our way of doing it felt particularly messy and difficult because we were not robust enough.

For Kiara we needed to be clearer in communicating our experience with under-5s and to provide an open space where family workers could come and talk to us about their concerns about a family. Being there on a 'drop in' basis would ease family workers' concerns about how to explain our presence to families, which was a big ethical concern since families hadn't given consent for that. The ethical part has been raised in a CAMHS team meeting and colleagues suggested families should be informed about our involvement. This raises questions about whether CC avoided informing parents of our presence because of their ambivalence towards us and the difficulty they had talking about mental health concerns.

When asked about the advice she would give a colleague embarking on a similar project, Kiara said:

> I would recommend that they think a lot about it before they go there, and we think a lot as a wider team about it actually and help one another and have those questions about why do you think we are not working more in the hospitals or working more with under-5s, and try to think about the challenges we might be faced with before going out there, and share our experiences before going out there. The challenges we can pass on... we are not the only ones going through changes, there are a lot of cuts and everyone is very stretched and to be very aware of the circumstances of the community you are going out to before doing it. And yeah…it's hard actually to [say] at this point what kind of things we could pass on if I am honest, 'cause I think we haven't processed it ourselves really.

Kiara here implies that we did not know what we were signing up to and were more focused on the changes in our service while CC workers were in crisis. She also says there was something that remained unprocessed from our point of view since the project was abruptly stopped, and we did not have a final meeting to process and evaluate our work. Kiara concludes that the fact that we did not manage to offer an actual service to CC after all, means that we failed to make a proper and meaningful link with CC.

Finally, I asked my colleagues about the impact of my research on our pilot. All seemed to agree that this was a positive aspect to the project as it often motivated us to keep going. As Kiara says:

> I think there were more positives because it got us moving in the first place and got us thinking about what we can do – like something a bit more structured [...] But I think for this manager ... I am not sure how much she liked the fact there was going to be a piece of research, because she was so inclined to think about

> that and what effect this was going to have. She wasn't a very mutual person to approach about research because there was a lot of ideas she had and she didn't really want us to be imposing anything that we thought. I don't think it really caused any negatives. I think it was quite sad thinking we are not going to then continue and have a whole piece of research about the WDGs. [It] is now going to be about how it didn't really work, which is quite sad, but I think it can really be a way of us actually documenting how we can move forward with it really, and what were the pitfalls and the challenges and how [to] think about all these in the future.

Dan also talks about my research as a positive as I was 'forced to look at things' and having supervision and the Tavistock behind me brought up questions that fed back into the project in a helpful way. Also, we received feedback from CC as part of my research, which was helpful. He also talks about 'unfinished business' in the CC as we would never have the chance to reflect and evaluate if it was not for my research. Dan says it was bizarre we never got back together in CAMHS to debrief, and wonders what this was about. Dan refers to the project 'evaporating', an expression that makes me wonder whether it ever had a solid base and support from management to begin with, but also whether our team of CP was already burnt out.

4.2.7 Working in an evidence-based culture in times of cuts: the group meeting.

My CAMHS colleagues felt that there was no proper ending to our pilot and no proper discussion with our management, denying us the chance to reflect together about the work we had done and find out how this was perceived by CAMHS and CC's management. I decided to organise a group meeting at the end of the project, so

we could have an opportunity to think about our work but also to discuss with our management the decision to stop. The meeting was attended by all three CAMHS colleagues who ran the pilot and the multiagency liaison team manager, Matthew.

Matthew explains that he can talk to us about the broader political context – he considered this to have had a big impact on our work, and thinks it could explain the negative feedback we got. He characteristically says: 'the pilot had the function to be relished' and talks about CC undergoing the biggest structural change, the third in four to five years. Dan adds that they were short-staffed, and Matthew agrees and talks about this being the biggest threat to jobs, and how vulnerable and under-confident that made CC workers feel since most of them had no qualifications. Martha comes in, and Matthew lets her know that we are talking about the broader context of our work and how anxiety, anger and fear were caused in (and by) the CC's structure.

I thought it was interesting that Matthew begins by explaining that what he was there for was to explain what happened on the managerial level, and that he is convinced that the broader climate was what impacted dramatically on our service; this seemed terribly important, but it is openly discussed with us for the first time in this meeting. Matthew says its function was to be relished, which is an interesting slip of the tongue since what he possibly wanted to say was 'relinquished'.

Matthew carries on talking about CC undergoing the biggest restructure in recent years, which entailed cutting down from 27 CC to fewer than 21 and being managed more centrally by public health and not by the Local Authority. Matthew

explains that because of the evidence-based and performance-data-heavy nature of it, the redesign made people feel deskilled, persecuted and insecure and therefore we were perceived as intruders, or spies trying to impose or oversee the new changes. He also says because CAMHS management were aware of the circumstances, they wanted to keep our intervention under their control, as it was not a healthy environment. Martha interrupts him to point out that we were not told about it all and it felt very much like we were told 'go for it'. This dialogue I think captures very well our relationship with our management, and poses questions about our management's decision to initially support this project since they knew it to be a particularly difficult time for CC.

Matthew rather apologetically explains that the transformation happened after we started our pilot, but Martha says that there was a long period of meeting with managers and we were never told about it – 'not nearly as clearly' as that. Matthew tells her that a lot of this is realised in retrospect, and Dan reminds us that there is long history of top-down impositions in interventions in CC. Martha agrees and confirms that this was the feedback we got: CC were uncomfortable with experts coming and disappearing, and that is why we tried for an ongoing presence without setting up parent groups, in this climate of uncertainty, since this had been tried and failed in the past due to inappropriate referrals. We knew WDGs were going to be difficult to set up, due to how scattered the CC workers are. So, we needed to first go there and establish a relationship. Because of fears and anxieties to do with the climate we did not have CC managers' support, which made CC workers even more skeptical of our work. Martha adds that some of these difficulties would have been

there anyway due to CAMHS being a different organisation with a different perspective, and that these difficulties were exacerbated by the current climate and previous attempts that had failed. At this point of the meeting the tension and underlying frustration about the communication between us and the managers became evident.

Matthew further talks about similar projects in schools that were challenging for similar reasons, which however did not have the added stressors of a redesign. Martha talks about how hard it was to engage Home Visitors who were not part of the redesign, and Matthew gives a bit of background in that they had been even more stretched in the past and still are, as the area is not an attractive area to work in as a Home Visitor. Matthew comments on Martha's success with them and how she engaged them in referring families for parent-infant psychotherapy. Matthew felt that WDGs were used but could not be sustained managerially and organisationally. I say this was unfortunate because it all stopped at a point when we felt they knew us and had begun to trust us. Matthew confirms that positive feedback from CC had been reported, but this relationship could not be sustained due to the wider political situation because it was overwhelming for them and brought their defence mechanisms down too much:

> Matthew: Yes, when we talked to the managers and the other people we said, listen this did work and it worked very well. It was in the report but it just could not be sustained [...] it was too difficult for them and it was used and it was also absolutely recognised and maybe we didn't express this enough – that you put a lot of hard work in[to] it and that is recognised and (name) is very thankful for the

> work you put in[to] it, but she realises we've actually learned an incredible amount from it.

Matthew explicitly states that there needs to be a much clearer, outcome-focused approach in order for any similar attempts to succeed. I talk about our immediate response to CC's invitation to sit on the carpet and take it from there, and Matthew responds by saying this was something the organisation could not keep in mind, that although it was our wish to work collaboratively, CC workers felt judged and evaluated. Martha agrees with that but argues that these feelings were there initially but then faded as staff became more open and our presence and input became part of their work. She considers the fact that CC staff asked to put our pictures up on the wall next to theirs to be evidence of this shift.

Martha also comments on Matthew's description of the plans for future involvement sounding completely different from what we did. Matthew responds by saying he is unsure about what CAMHS could do, but that whatever that is, it needs to absolutely fit the wider plan to support CC. At this point Dan says that this provides a structure and protection from the politics. Then, Matthew carries on talking about our CAMHS redesign and the need to bolster targeted services in order to ensure more perinatal work by a specialised clinician. This, he believes, would lend us more credibility and value. This is indicative of the need for outcome measures and measurable interventions, that are considered more important than engaging CC workers and offering ad hoc support.

Martha understands Matthew as pointing out a need for a much clearer structure, and she mentions several interventions that had taken place from experienced CAMHS clinicians to CC in the past but thinks that they don't fit the current climate anymore. Martha also comments on the fact that it was not just CC who found our presence difficult, but it was us too who were not supported in what we were doing – unlike people from other organisations who had full support in projects that could be measured. Matthew responds:

> Yeah, you mentioned two really important things. Firstly, is the credibility and the positioning of the intervention that is offered. Secondly, what you are mentioning is the timeliness and appropriateness of an intervention that it is the right intervention at the right time and it is a realistic chance that it will be received and digested and used well [...] 'Theory of Change' is an outcome-based framework going from immediate outcomes to long-term outcomes where you develop an outcomes framework about what you need to achieve from now to five years' time and that then leads what activities you do when. So, you don't offer consultation because you think it's a good thing. You say actually what outcome can you achieve now as a short-term aim in terms of engaging with the CC and then you say, so what activities do I need to achieve that outcome? And I think that was the way that in [names of previous under-5 services] we developed our outcomes framework in 2010 about what we do and when. And this has fallen a bit to the side with MALT and I think we could have really benefited from that much more when we thought about engaging the CC a year and a half ago. We could have been much more thoughtful about what we do and getting together to do that.

Matthew talks about credibility, timeliness and appropriateness, and this leads him to the 'theory of change' framework where it needs to be clearly stated what the short- and long-term outcomes will be. We did not do that and that was our responsibility, according to Matthew, as we went there 'free-handed'. I found this part of the meeting difficult, because we were in the uncomfortable position of being told that what we did was not timely or appropriate, and that we went out there without a framework to define the outcomes.

I mention the under-4's CAMHS service stopping, and Matthew explains what happened to early intervention in the area and how the posts were frozen for three and a half years while in limbo awaiting the 'imminent' redesign. He wonders how CC felt about our services being removed and then re-offered, although Matthew claims that CAMHS kept the door open to CC. However, our experience had taught us that CC knew very little about CAMHS. Matthew carries on with explaining the three-tiers intervention, while Martha argues that this intervention – although it sounds helpful in theory – fails to address what we knew to be the most difficult aspect of outreach work in practice: that is, how to assess the level of need, especially in a place where there are many very vulnerable families. Managing the anxiety that this raises in the CC workers and CAMHS seems to be a step before the three-level intervention:

> Martha: So, [...] what would be our remit as CAMHS in directly working with under-5s, and what would be the remit of a universal service for under-5s, or is it about trying to define those boundaries?

Matthew: [...] The broad conception model of service that I've got in mind and we have always used is sort of a three-function model which is working at three levels. The first level is that we can offer specialist interventions for parents and infants and young children, specialist child mental health interventions. The second level is also a targeted work, [and] is where the zone of therapeutic changes is not directly with infants and parents but helping the system [be] a thoughtful and therapeutic system around the child, so that's for CC, health visitors and that. And we can see it as a team around the child. And the third level is a more universal level where it isn't targeted to a particular child necessarily, but we train and support frontline services to develop their knowledge and skills and resilience in working with these children.

Martha: Yes, but that's a broad extraction but when the difficulty and the subtlety comes is where does a particular family fit, 1,2 or 3? And that's the area that remains blurry, because you can do all levels to provide all levels, but then let's say you are working at the level where you provide supervision to workers that go and directly work with children in a universal setting, let's say a setting like the CC, then within that which are the children that perhaps are then referred into the specialist service and which ones won't, and where is it that you will have to think about the team around the child? That's what I suppose came up as an issue, when to refer. You could see that was actually highlighting the difficulty because this structure has to do with how you manage anxiety and concerns about a child or a family, you know…

> Matthew: I think A has written some referral guidelines in terms of that, but I think this is rudimentary, and I think at what level an intervention is required – that needs much more working out. Firstly, by us…

Martha responds to Matthew by saying that knowledge and skills of frontline workers need to improve so they can be better at assessing need and managing anxiety. She claims this can't be achieved with six-month long programmes, but rather requires long-term joint work so links can be made, and trust be established, and this is particularly difficult when the frontline workers are under strain – because what this is really about, is putting in extra effort to expose themselves to things that are hard and painful to notice. Matthew agrees, and tells us this is why we need to be careful with our resources – tier 3 interventions do not change systems:

> Matthew: Yeah, but I think that's why we need to work at all three of those levels and be careful not to spread ourselves too thin so we can't have an impact, so that's why I have always used that three-level model because what the research is showing is that if you are only intervening by doing targeted interventions you don't change systems. If you don't have interventions that specifically are about changing interventions, then you won't achieve long-term impact, full stop.

Martha asks Matthew what their objective is, and he replies by explaining that that is what they are trying to do: namely have an outcomes framework that defines goals. Martha talks about tiny achievable goals, and Matthew agrees and adds that CAMHS has been poor in doing that, CAMHS has been good only at seeing clients. Martha talks about this being important and missing from our project, and I add that

it felt as if there had been no contract or shared agreement. Martha says this lack of a shared understanding of the work had made it difficult and had perhaps led to our mutually blaming each other. Matthew talks about the gap between our perception of CC's needs and what they thought they needed. Martha says that it is all about taking responsibility and setting small goals.

> Martha: And I suppose the greater the difficulty the better it is, if the objective is small, you know. It's important that can be like let's just focus on achieving this small goal by this time.
>
> Matthew: Yeah, in order to achieve this goal, we firstly need to achieve that, and before that we need to achieve that and before that, we need to achieve that…so that's where we need to start, we need not straight aim for the top outcome and that's again…it's developing an outcome frame from immediate aims to long- term aims, you know what you eventually want to achieve in five years but actually this is the path we need to walk in order to achieve that. And it's a dynamic path because there is something that might change, we might discover something…
>
> Martha: this is something that was missing for example in our initial consultations, thinking back. We were very good at…we managed to hear from them what they needed and what were the difficulties they were struggling with but perhaps because of all the uncertainties it is not as though we could agree on a goal that had to be achieved by a certain time. What do *you* want to achieve if we come, you know?

Matthew further argues that the matter of capacity is a big issue and therefore the theory of change he wants to introduce will help with setting realistic goals for these services. Martha says that referrals for under-5s should be treated in the same way as any other referrals, and Matthew tells her that there needs to be expertise in order to offer a specialist service. Kiara talks about the need to extend our services to perinatal care. Matthew agrees with the latter and lets us know that he fought a tremendous battle to make perinatal 'a CAMHS thing and not an adult services' one'. He also mentions that having the support of the lead GP helped and I talk about the need to also be at GP practices. Matthew agrees, but stresses the importance of focusing on one thing at a time. The last part of the meeting left me with a feeling that there is so much that needs to be done that it all risks becoming overwhelming. Matthew argues that the problem of resources and capacity is huge and insists that it can only be dealt with through outcome frameworks and more emphasis on working with the system, rather than direct work with families, as he sees the former as the only way to have a long-term impact.

What follows is the last part of this thesis: the discussion of these findings and the conclusion of this work.

CHAPTER 5 DISCUSSION

What we call the beginning is often the end. And to make an end is to make a beginning. The end is where we start from. T. S. Eliot (2009)

As described by all the authors in the literature review of this thesis, outreach work requires 'thinking on one's feet' and confronting difficulties that need to be understood and dealt with along the way. The process of this research project reflects this reality too. Changes and adaptations needed to be made, and this has been a process that required patience and tolerating a lot of uncertainties. In line with IPA, however, the focus of this research primarily concerns this project's participants' narratives, as shown in the previous chapter. In this chapter, I aim to bring together the most important findings of this research in the context of the research questions and existing literature. I also wish to discuss the research's strengths and limitations, as well as some final thoughts to do with my journey as a clinician and researcher in this project. I also include some implications for practice and feedback to Children's Centres and Child Psychotherapists that are informed by the findings of this study. Lastly, I propose some ideas for future research and dissemination of this research's findings.

5.1 CC staff's experience of their role and institution

There was a link between the three family workers' choice of career and their personal life (Cottle, 2011). It becomes evident in the story they say that their wish to become involved with and 'make a difference' to families was something they discovered along the way, with its all starting from nursery nurse trainings that are nowadays undervalued. As Cottle & Alexander (2012) found in their research, dissatisfaction

with their status is an ongoing concern among practitioners in childcare and Early Years' provision.

'The family' seems to be a notion that keeps the organisation together in the sense that it provides a purpose, a 'shared goal' for CC workers that at times exceeds professional boundaries. 'The informal approach', the 'casual way of working', 'no strict hierarchy', are all statements that give an impression of a loose allocation of responsibility, where everybody is expected to do everything. This is in line with previous research (Cottle, 2011), and it can be argued that these organisations are sustained by the 'tight bonds' and 'personal attributes' (Anning et al, 2007) of the staff.

It is worth taking into account the impact that working with very young children and their families has on CC workers. They usually visit families at home within weeks after a baby's birth. They constantly encounter the intimacy and the powerful projections of babies and young children as well as of their parents (Elfer & Dearnley, 2007). They are the recipients of the anxieties that surround becoming a first-time parent, often working with families that have gone through the trauma and isolation of migration, as well as families with whom Social Services have been involved.

CC workers make a distinction between families who know what they are coming for and attend universal groups and others who are often obliged to attend due to being on the Child Protection register. They further describe their considerable efforts to encourage hard-to-reach families to 'open up' and trust the centres. They deem the role of the key person to be essential, and they all conduct home visits and run the groups to ensure continuity in the contact with families. The families in

difficulty, especially in such a deprived area, are often felt to be 'using' the centres in order to benefit in other ways, such as finding a house. CC staff often work with families that cannot provide for their young children. This will inevitably stir up intense feelings of pain, that some workers will deny, and others may deal with by identifying with the 'helpless' child and blaming the parents. The interviewees in this research seemed to struggle most with the expectation that they were there to fulfil a fantasy of their being a 'magical' parental figure invited to save the family in need. This seems particularly stressful for CC staff, as they seem destined to be experienced as withholding parents who disappoint and fail.

How the success of an intervention is measured by the Centres is also worth noting, as an interesting finding of this research. The family workers appear to be very sympathetic towards families' reluctance to get involved with the centres because the centres' involvement frequently makes them feel criticised and judged. This suggests that some families do not differentiate between professional services and perceive all professionals as having an agenda associated with child protection. The CC staff indirectly express a wish not to be perceived as having a 'parenting assessment' role but as providing a safe, inclusive environment that families can trust. This raises questions about parents' projections of central aspects of their parenting onto CC staff and can leave the latter exposed to feeling judged and criticised. For example, some parents may project their hatred and murderous feelings towards their baby onto the CC staff so that they can be the 'good breast' (Klein, 1946) for their baby and disavow all unwanted and painful aspects of being a parent.

However, the reality is that often, CC's assessments are used as part of parenting assessments by Social Services. This fact seems to be very anxiety-provoking for the

staff. The examples of unsuccessful interventions they describe in the interviews are mostly about high-risk families, in terms of safeguarding who the CC workers failed to engage and help. This raises questions about how the Centres measure and evaluate their interventions (Alexander, 2010). Parents' feedback forms are used as part of the outcome monitoring process which, in the case of the Centres, is closely linked with commissioning and funding. A family that requires a lengthy intervention, which cannot be defined as 'successful' because of the degree of need, is not an indication of a failed intervention, but of a more demanding one. What seems to be problematic in such an intervention is that the staff are responsible for producing good outcomes (not to jeopardise the commissioning process), but at the same time 'bad outcomes' (if a family does not attend CC's activities for example) might not reflect the reality of their efforts to engage and help a family. In other words, there are questions about how the workers and the organisation define the primary task and whether there is conflict between the two (Miller and Rice, 1967). Furthermore, pressures to 'close a case' prematurely because of 'bad outcomes' (for instance, if a family 'does not step down the tiers of need', as CC staff put it) and, therefore, to maintain a degree of distance from the disturbing and painful feelings that working closely with families in need provokes, can be thought of as a defence against anxiety stirred up by contact with more severe psychopathologies.

A concerning finding of this research is that, as both CC workers and Child Psychotherapists report, Children's Centres are increasingly responsible for monitoring risk and this can be perceived by service users as threatening. This can deter them from attending the Centres. This is something that should be kept in mind, as it can result in putting families who are most in need of their services off using CC.

What also becomes evident from the above is that there is no consistency in CC worker's responses on the levels of need that are considered appropriate for CC. An additional challenge for CC, as Sheppard notes (2011), is whether needs are understood as individual, familial or environmental and most importantly, what sort of intervention is needed to address these needs (generic or specialised).

Monitoring risk and working with families on the Child Protection register can put enormous pressure on CC staff, who, when not adequately supported, can unconsciously experience complicated feelings towards these families. Distinguishing between 'good' and 'bad' parents (Klein, 1946) can inhibit successful interventions and can give rise to an unconscious wish to blame (Music & Hall, 2008) and punish families for not appropriately attending to their children's needs to come to the fore. This may result in these families having reduced access to CC. CC staff are also in more danger of over-identifying with the baby/young child at risk, and experience as a result great amounts of pain and anxiety. That will inevitably interfere with their ability to continue thinking about ways to help children and their parents.

Working with very complex families means that powerful projections are bound to have an impact on the family workers and the wider institution (Salzberger-Wittenberg et al, 1983). As Britton (2015, p. 170) states, the experience of the families in difficulty is 'forcibly communicated at an unconscious level to the professional network', which is in danger of reacting with action rather than thinking. Families' dependency on CC workers and the pressures coming from a system that considers them to be the Early Years' 'gatekeepers', often holding them responsible for being actively involved in safeguarding children, are very likely to interfere with the centres' readiness to accept and make use of 'external' agencies' input. The latter

requires mutual adaptations and adjustments based on trust and willingness to form an alliance.

5.2 Early intervention and mental health in under-5s

When it came to CC workers' understanding of CAMHS as a service and its place in a CC, there seemed to be an idea that CAMHS' role should be to work directly with children but in CC premises. This is because CC, as one of the CC workers believes, are a more 'natural' environment. CAMHS professionals' attendance at 'baby clinics' was experienced by the same CC worker as a breach of the initial agreement with families who attend 'universal services', since they haven't consented to specialised professionals being there and 'monitoring' them. These ideas seem to reflect an underlying anxiety about stigmatising families, making a potential referral to a 'specialised' mental health service seem threatening. I wondered whether family workers would take this to mean that they had failed to keep a family within the CC and had 'passed it on' to a different service, leaving the team with feelings of inadequacy and helplessness. I also wondered whether unconscious feelings of rivalry and envy were stirred up by ideas that – as mentioned by one CP interviewed – CPs were the more privileged, better-paid and well-respected clinicians who had the option of accepting or rejecting a referral and were working within the safe boundaries of the clinic and a scheduled session, usually seeing one child patient at a time (Music & Hall, 2008).

CC workers' idea of CAMHS joining CC workers for home visits with 'targeted' families, where concerns might be raised in relation to a parent's inability to cope with their baby or to families' living conditions in particularly deprived environments,

seems to favour ‘informal conversations’ with them, avoiding a referral to CAMHS. I thought this could be seen as an unconscious attack on CPs’ expertise (Music & Hall, 2008) and a wish for CPs to have a firsthand experience of the intense and often unbearable feelings stirred up by home visits.

Emotional disconnection between CC staff and their institution seems, in my view, to mirror a primary disconnection between parents and babies/young children on the Child Protection register. Intense feelings of working with neglected children impact on the way the system around them operates (Bower & Trowell, 1995) and CC staff often feel devalued in the way neglected children do. It seems that this was the reason why CC staff expressed the wish for CPs to engage in direct work with them, namely, to experience the disturbance in the same unprocessed way CC staff do.

This research also raises questions about how mental health in very young children is conceptualised and understood by frontline Early Years’ practitioners. One of the CC workers interviewed talks explicitly about her difficulty understanding what a ‘moderate to severe’ mental health difficulty means, especially when referring to under-5s. She further adds that what they usually get is ‘lower level’ difficulties.

All three workers give examples of attachment difficulties and speak of their ‘gut feeling’ that something is not quite right with ‘bonding’. I thought that the metaphor of a ‘slow burn’ that could potentially lead to ‘fire-fighting’ when a child is older and develops more worrying symptoms points to the fact that the CC workers are also anxious about whether they are in a position to identify mental health needs, that could later escalate to more severe pathologies. And although there are examples in the interviews about Child Psychotherapists ‘knowing what they are talking about’ or

‘knowing how to look at emotional development’ or ‘knowing how to approach a family’, the CC workers seem to insist on Child Psychotherapists providing ‘unofficial experience’ or training to CC, who would then be able to tackle the issues with a few ‘behaviour interventions’.

The above provides, in my view, valuable information about how much responsibility CC workers feel they have, but also how much they can contribute to thinking about mental health problems. The family workers are often in a position to use their experience of working for a long time with families and to identify, for instance, behaviours that point to attachment difficulties. As Daws (1985) notes, the expertise of the staff needs to be respected and reinforced. Although they seem concerned about undiagnosed and untreated mental health problems that can become more severe with time, a referral to another service seems to be an idea met with great reluctance. I think that this is something that offering consultation to staff and Work Discussion Groups can help with. In particular, they could help CC workers to be better able to bear or handle feelings of helplessness and ‘failing’ a family, so that the ‘stuckness’ of a case is not transferred around the staff group (Jackson, 2008, Elfer, 2018). As Jackson (2015) writes about the effectiveness of WDGs in schools:

> Over time, teachers tend to feel their capacity to tune into their observations increases dramatically and in ways they had not expected...they also speak of becoming much more aware of themselves – their own self-observations – including the way they are feeling, what they are thinking, how they are behaving, and so on. On the whole, this has had a liberating and distressing effect on teachers. Moreover, rather than getting into repetitive cycles with pupils and feeling provoked into responding in predictable ways, teachers can

> begin to make use of what is going on inside of them in effective and encouraging ways (p.11).

An unexpected finding of this research is that it seems difficult for CC staff to think about individual children and their needs. The idea of CC being places where 'families' attend, and a lot of parent groups take place, allows little space for thinking about the children. Although Warin's (2007) study highlights the lack of clarity in terms of how CC staff identify the beneficiaries of the service, I was struck by the examples given by the CC staff in the interviews showing that the focus of the work is mostly about how to engage parents who struggle. And although, as Winnicott (1964) states, 'there is always a context', stressing the importance of early relationships and the family context, it seems particularly challenging for Early Years' practitioners to think about the actual experience of children. My understanding of this is that the experience of young children is often one of fragmentation and powerful and disturbing feelings that need to be contained and made sense of by adults, and this is something that can be a very demanding and, at times, exhausting task. Bain (1998) highlights that being in intimate contact with children can result in situations where the members of an organisation use defences that allow for distance and avoidance. It is likely that the parents' experience is something that CC workers can more easily identify with and relate to and is therefore easier to think and talk about. This is a further area that I think could benefit from Child Psychotherapists and Work Discussion Groups, which help, as Cohen (2003) states, to 'articulate the experience of the baby' and put into words infants' and young children's complex emotional experience. In this way, otherwise unbearable and frightening identifications with the needs of babies and young children can be thought

about and understood.

5.3 The experience of Work Discussion Groups

CC staff's experience of the WDG groups was described as uncomfortable and odd. One point that was made was that CC workers were reflective anyway and already underwent a lot of supervision, while their timetable was tight. The lack of clarity on what this group was about and why CAMHS was offering it was another point the family workers made. Jackson (2008) points out the importance of being very open and clear with the staff about the aims of the WDG. Although we thoroughly explained the purpose of the group to the staff, ideas about CAMHS' expectations for this group and possible 'ulterior motives' to do with CC's service redesign emerged. Paranoid ideas about our team secretly monitoring and evaluating theirs through WDGs, point to the fact that CC staff were already under great strain and insecurity over their workplace and jobs. Institutional defences against these anxieties were brought to the fore and did not allow a healthy professional relationship to be established. Paranoid/schizoid defences (Klein, 1946), such as distinguishing between the dishonest CP who came to monitor CC, and the ever- helpful CC workers – although intensified by the uncertainty about CC's future – are common institutional defences against the anxieties stirred up by external services that get involved with an institution (Music, 2008).

I thought that, as discussed by Elfer et al (2018), the fact that WDG were compulsory for staff rather than voluntary did not allow for a more collaborative attitude to take root and for staff to feel this was an initiative that they were in charge of and could make use of. In support of this argument, one of the CC workers talks enthusiastically

about a WDG that was offered to workers offering a 'targeted' parenting group and refers to it as an eye-opener. The particularity of this WDG was that it took place on staff's demand and it seems met with success precisely for that reason. It is worth noting, however, that it was because the experience of attending the WDG had been offered to all staff, that the idea arose of inviting a CP to offer another WDG to the targeted parenting group facilitators. This shows that the WDG was valued, but it was important for CC workers to be part of the decision-making process and ask for this input.

The establishment of WDG in a workplace, as the literature shows and this thesis conveys, is a process that requires a considerable amount of time. The WDG provides a containing function, that as Bion (1962) thought, is essential to the baby's future capacity to think for him/herself. Similarly, the therapists' repeated, consistent, and trusted presence will gradually allow for the participants' difficult and painful feelings to be expressed, discussed and 'metabolised' by the CPs and the group, so they will eventually acquire meaning. This experience can then enable thinking about the children's needs and most importantly, about how CC staff can intervene and provide help and support. The staff's resistances, expressed in relation to 'external agencies' that tell them what to do, are to be expected – as are more paranoid fears and anxieties. A repeat 'good enough' experience of the groups over a considerable amount of time is expected to shift these ideas. Staff's voluntary attendance seems to be important since this provides them with a sense of agency and responsibility, and leaves less space for paranoid anxieties to interfere with the work, as this research showed. This project also highlights the complexities around organising and establishing WDGs in CC and demonstrates institutional as well as individual

defences that can be employed during the initial stages of setting up WDGs.

5.4 Working in CC in a deprived area in times of restructurings and cuts

The respondents describe feelings of uncertainty and worry about the future of their jobs and the Centres. Some of these feelings are expressed in relation to restrictions on planning CC activities and are articulated via thinking about the families' heightened anxiety about not knowing whether they will be there in a few months' time. Keeping busy, that is projecting the anxiety onto the families and resorting to omnipotent fantasies of carrying on with providing the service as usual (while being on temporary contracts), are defences that the staff seem to employ in order to get through the transition. Nightingale and Scott's (1994) findings in relation to changes in institutions, and their tendency to result in distancing and de-personalisation as symptomatic of the mobilisation of defences against anxiety, seem relevant in this context. Anxiety around the survival of the centres makes it difficult for the staff to work towards long-term goals and to feel there is continuity and stability in what they offer.

Another important finding of this research is that CC staff do not trust their management, and they make reference to previous redesigns that unsettled the smooth running of the centres. CC staff appear to be more invested in their discipline and committed to the families than to their institution. One of the interviewees describes how she tries hard not to worry about redesign and to keep going regardless. This shows that CC workers try to maintain a hopeful and positive stance and by keeping themselves busy, even when faced with great anxiety. This leaves little if no space to think and talk about their own concerns and distress. These findings are in line with

previous research (Cottle, 2011, Alexander 2010). The institution – expected on an unconscious level to function as a parental figure that will provide holding and containment – is not trusted by the CC staff: a lack of trust that, as shown in this research, exacerbates their anxiety and defences against it.

Cooper and Lousada (2005) provide a theoretical framework and discuss the contemporary climate in which welfare services are delivered. They consider the current social structures to be functioning in similar ways to individuals with borderline states of mind – that is, by employing primitive defence mechanisms such as splitting to defend against anxiety. As Elfer et al (2018) point out when discussing nurseries, this climate of cuts and continuous audits and evaluations, where efficiency is more important than professional autonomy, does not allow for the necessary sustained human contact to be the centre of a nursery's life. Similarly, CC staff give the impression that they struggle to provide some continuity in being present for the families but at the same time are overwhelmed by the amount of work, lack of resources and uncertainty in the institution. This is a further reason why WDGs may be particularly important under the circumstances. As Elfer et al (2018) put it:

> these sentiments raise a further, interesting, question about the value of a quiet space that allows the possibility for something new, touching or disturbing to emerge. The sheer level of activity in nurseries can affect practitioners' capacity to notice and think about the children to such an extent that we have sometimes concluded that workers are psychologically held together by action rather than thought (p.194).

With regard to the findings from the interviews with the Child Psychotherapists I wish

to discuss the following: designing an outreach project, the challenges and opportunities of doing outreach work in CC, and Children's Centres and CAMHS in crisis.

5.5 Designing an outreach project

Elfer (2018) refers to Margaret Rustin's unpublished contribution at the Second European Conference on Child and Adolescent Mental Health in Educational Settings ('Relationships in Schools: Contemporary Problems and Opportunities', Naples, 2008) where she described the product of the collaboration between Early Years care and Child Psychotherapists as 'the fertility of the couple'. As Child Psychotherapists, the three respondents spoke about the usefulness of observational skills and the capacity to provide a quiet presence, which they found to be important in order to approach the Centres. They also described how keen they were to be part of such an initiative, since they considered CAMHS to be generally inaccessible in terms of working with under-5s and liaising with Early Years' services. What also comes across in the interviews is that there was not adequate support from management, nor was there a clear working agreement with the Centres.

A finding of this research worth considering concerns the importance of the CPs' team dynamics and its impact on the setting up of the service. Most colleagues were new and not established in the wider CAMHS team and two of us were trainee Child Psychotherapists, Kiara being at the beginning of her training. Becoming an outreach team and defining our aims and expectations coincided with the new CPs' efforts to become part of the wider CAMHS team, which inevitably interfered with CPs' availability. As shown in the findings, 'space', be it time or mental space, came up

many times as an issue that needed to be addressed.

Most of us did not have extensive experience, if any, of providing consultation or offering Work Discussion Groups to Early Years' staff. Unconscious anxieties relating to our competence as clinicians were stirred up and were exacerbated by attacks and projections from the CC staff. The latter resulted in great uncertainty and at times lack of motivation, as we all felt a lot of our work was taking place in vain. Martha's comment about becoming the cleaning lady may have been an indication of feeling devalued.

Although we had supervision and regular meetings in our team (which as Urwin (2003) points out, is very important for the outreach workers), we started this pilot without much experience in the field and some of us with the extra burden of finding their place in the CAMHS clinic in an unfamiliar and very deprived area. At the same time, most of the literature, as described in CHAPTER 2, concerns examples of CPs who designed and implemented outreach projects alone. This project was different in that, although the team was split across different sites, there was a shared experience and team meetings in CAMHS where anxieties and worries could be discussed and thought through among clinicians with similar experience. This, I think, to some extent seemed to counterbalance the difficulties that emerged because of the dynamics in our team and our lack of experience in outreach work.

CC's management's reluctance to support this attempt proved to be particularly hard, and resulted in frustration when trying to arrange meetings with the Centres only to find the CC staff unable to attend due to other commitments. But most importantly, the loose agreement with the CC and the lack of a clear understanding of our working

relationship led to suspicion and lack of trust. One of the Child Psychotherapists talks about our team being seen as 'intruders' since we were perceived as yet another service that was interfering with their work. In addition to that, there was an impression, as discussed above, that we were the privileged clinicians who were working from the safety of our clinic. This was possibly a result of our decision not to offer direct clinical work in the CC to begin with, and may have stirred up unconscious feelings of envy, but also a sense of abandoning them with the difficult cases.

Reference was made to 'cultural differences' between the two organisations which may have got in the way of a working relationship because they were not properly reflected on. Both teams appeared to be defensive and protective of their 'values' (Rothenberg, 2010). This resulted in CC staff feeling persecuted at times; paranoid ideas about the families 'fleeing and never coming back' upon our arrival came to the fore. The first contact with the CC raised concerns in the staff about 'their families' being pathologised (Rustin, 2008) and passed on to other services and, therefore, stigmatised and lost. At the same time, as described in the interviews with the CC workers, paranoid ideas about us monitoring their work due to the redesign of their service were also present. This, as expected, had an impact on our team. As we felt this project was very much our initiative and we were invested in this work, being perceived as intruders and spies was a dynamic that was hard to confront. As Martha points out, we perhaps insisted too much on forming an alliance with the CC workers, and I wonder whether this became persecutory at times. Our team's unconscious feelings of denial are worth considering since at times it felt we carried on offering WDGs and consultation to staff despite the fact CC workers were refusing these

interventions.

The sense of relief described by one CP at the end of the project provides evidence of how emotionally draining this experience has been for our team. The lack of support from the CAMHS management added to feelings of uncertainty and anxiety, as the team felt neglected by the very management that was expected to function as a supporting parental figure. The impact of the redesign in CAMHS also needs to be taken into account, as there was great uncertainty due to changes on an institutional level, and the 'not knowing' element in terms of resources and time unconsciously seem to have interfered with CPs' availability and commitment to the outreach project.

5.6 Challenges and opportunities of doing outreach work in CC

One of the respondents talks about CC as 'the only positive thing out there' and describes how the CC provide spaces for developmentally appropriate play for young children, as well as for parents to socialise. The CPs' experience of the CC is similar to Watt's (2015) doctoral research findings on CC that provide what Watt refers to as a 'village'. Although Watt's (2015) research was specifically about the experience of Bangladeshi mothers, I think families in deprived and remote areas outside big urban cites can feel equally isolated and, therefore, particularly vulnerable when they care for very young children. CC provide a community, a safe base for families and a point of reference when it comes to their children's physical, cognitive and emotional wellbeing. CC staff often serve a sort of containing 'grand maternal' function which is often missing in families who are isolated or have migrated from other countries.

Difficulties in establishing responsive and emotionally connected relationships with

CC in deprived areas – where many of the families are on the Child Protection register – seem to be a powerful reflection of the quality of the dyadic relationships (between parents and their neglected children) CC staff are asked to work with without being adequately trained to do so.

At the same time, CC staff are stretched and at times exhausted by tight timetables and staff shortages. This results in more concrete and basic level ways of functioning where opportunities for curiosity and creativity are killed off and are experienced as an extra demand. All CPs presented small-scale interventions in groups, which in line with the literature, show how valuable the contributions of CPs in CC can be (Woods, 2000; Rustin, 2008). Sitting on the carpet with families and 'taking in' the experience of children and their parents seemed important. In terms of technique, as discussed in the literature (Urwin, 2003), necessary adaptations need to be made by CPs and sometimes – as seen in the examples in this research – direct advice to parents may be needed. These small-scale interventions were afterwards discussed with CC workers and most of them seemed particularly interested in these ideas. This suggests that these interventions could be a helpful way of demonstrating to CC workers how CPs can help and thus ease anxieties about 'severe mental health problems'. In this way, we can explain that difficulties that appear to be minor, if not addressed in a timely and sensitive manner, may result in greater mental health difficulties in the future.

Time and a consistent 'therapeutic presence' (Solomon & Nashat, 2010) are fundamental for establishing relationships and trust. Planning an intervention thoroughly and having the managers' support is considered crucial for the success of any similar project. Moreover, the CP who wishes to set up a similar service needs to

keep in mind the fine boundaries between making oneself available and being drawn to situations that concern practical, hands-on provision of help, or responding too quickly to needs that exceed one's role. Resources and time have to be carefully assessed and a clear plan needs to be in place (Jackson, 2008). Issues to do with managing the clinician's feelings of being an outsider (Rothenberg, 2010) and not finding one's place in outreach settings (Daws, 1985), the need for understanding the culture of the institution (Armstrong & Rustin, 2014), the effort that it takes to make the necessary adaptations (Music, 2007), are all findings in line with the relevant literature. Last but not least, the clinician should be prepared to encounter complicated dynamics that, as shown in this research, give rise to unconscious attacks on the outreach worker, splitting between good and bad services, and paranoid fears to do with secret agendas and lack of trust. It should be expected that the role of the CP be undermined occasionally, as the presence of mental health services in another institution is bound to stir up ambivalence and hostile feelings (Music & Hall, 2008). Patience and 'sensitive perseverance' (Cohen, 2003) are essential for the establishment of a working relationship with an institution like the CC.

5.7 Children's Centres and CAMHS in crisis

In Armstrong and Rustin's (2014) line of thought, CC's primary anxiety seems to be working with particularly worrying families, be it because of psychopathology or deprivation. This was something that we became aware of soon after we started working with the centres. What we seemed to have underestimated were the external forces Armstrong and Rustin (2014) draw attention to, namely the social environment and economic climate at the time.

Institutional changes in both CAMHS and CC compromised the working relationship. Feelings of insecurity and instability emerged in both teams as there was no clear mandate and there was a lack of transparency in terms of management. Our team, similarly to CC staff, felt we were not participating in the decision- making that had an impact on the project we were working on. As discussed by the respondents, CC staff were stretched and anxious about their jobs due to temporary contracts, and our presence felt burdensome, if not punitive, to them. Our team at times felt overwhelmed by the amount of work and anxious about the level of need and deprivation. There was disappointment and frustration about the CC's suspicion and reluctance to engage. At the same time, towards the end of the pilot year, we felt increasingly more welcomed in CC and as one of the CPs points out, the fact that our pictures were put up on the wall with theirs was a recognition of our collaboration and of our becoming more integrated with their team. Time and our consistent presence in the Centres were definitely needed for a relationship to be established and sustained, and this was not taken into account by the managers of both institutions.

As described in the group meeting by our manager, the impact of a huge redesign in CC made our working relationship impossible because of the uncertainty and fear about the future of the Centres. The other very important point the manager makes is that these kind of interventions need to be measurable and planned accordingly, setting short- and long-term goals. They need to fit a framework that defines outcomes and can provide evidence of their success. In my view, this can be problematic, especially when designing interventions to institutions like the CC is concerned. As Michael Rustin (2008) points out, there are important aspects of institutional tasks that are not amenable to exact measurement. He further argues that

outcome measures are used to judge the comparative performance of institutions that are required to operate in virtual competition with one another. These measures are considered, therefore, as indicative of the overall value of the service, and this can generate considerable anxieties in the staff and the service users, namely about meeting set goals. These anxieties can have an impact on the quality of the service provided. Rustin (2008) poses the question of whether performance indicators adequately measure the quality of services, especially of those in which relationships are a central component of the work, and argues that Work Discussion Groups can address the 'missing areas' that outcome measure cannot capture.

5.8 Limitations and strengths of this research

As explained in the first chapter of the thesis, there were many adaptations to be made in order for this research to materialise. The project was stopped abruptly, and I could not carry on with the initial plan to deliver WDGs for a year and then evaluate this intervention in the second year. This was unfortunate and I consider this a worthy research project for future pursuit, in line with Elfer's (2014) study that calls for formal evaluations of WDGs in Early Years' settings. This change in my research plan due to external circumstances had an impact on my research questions and resulted in the change of methodology as explained in CHAPTER 3. I originally chose to analyse my data using Grounded Theory, but thought IPA was a better fit with my research questions as they developed over time. In brief, since I could not carry on with the WDG and use interviews as a way of evaluating WDGs' effectiveness and usefulness for staff, I chose a more exploratory stance in an attempt to capture the experience of the CC workers and my colleagues in setting up the service and WDGs. I became increasingly interested in the difficulties as well as

opportunities that emerged in the first contacts between the services, and in how this was experienced by the participants. I therefore decided to include in the interviews specific questions about the difficulties that emerged because of the institutional changes and economic climate at the time, in the hope that the participants' experience could give an accurate account of how these difficulties affected both parties and our working relationship.

The complications of being a participant-researcher were considerable and so were those of being a clinician taking up a researcher's role, as shown in the first chapter. I had certain ideas and theoretical hypotheses when I started this research and in order to maintain the necessary distance from what emerged in the interviews and to allow for the participants' account to emerge as accurately as possible in line with IPA, I had to keep referring back to the actual data. However, there were limitations in this research as well as strengths, and these are outlined in the next sections.

Limitations of this research

It is important to note that in line with IPA methodology, my interpretation of the findings and the links I make with the existing theoretical frameworks is one of many possible interpretations. Also, this is a small-scale research study in a disadvantaged area, the findings of which cannot be generalised. The findings of this research offer a snapshot of a small group of CC workers and CPs within a specific context. The choice of using IPA to analyse my data takes into account the specific setting and participants' detailed subjective accounts of their experience, while factoring in these limitations.

It is therefore worth considering that the specificities of the relevant CC as well as the

level of deprivation in the area do not allow for the generalisation of the findings as such. Our experience showed that in line with existing literature (Lewis et al, 2011) CC differ significantly from one another in the ways in which they operate. Other factors such as details about the level of experience, training, age, ethnicity and gender of the CC workers who were included in the study were not explored and would have possibly informed the discussion of the findings. Similarly, demographics, level of experience, training, age, ethnicity and gender of the CPs included in this study were not specifically considered, though they may likewise have allowed for a richer discussion of the findings. Also, the way the outreach pilot was organised and the split into smaller teams, the time it took, and the frequency of interventions to CC, are further aspects of this research that were not given particular attention here, and that I nonetheless consider to be important when thinking about similar future research projects in the community. Would this project be more successful if we put more resources into fewer centres?

In line with IPA principles, my research focus was on the idiographic and the particular, hence generalising the findings to the wider population would be problematic and was not one of the aims of this study. Nevertheless, cautious generalisations were possible, as IPA aims at 'locating [such generalisations] in the particular, and hence, develops them more cautiously' (Smith et al., 2009, p.29). A further limitation of this study is the experience of the researcher. Whilst I followed the protocols set out by Smith et al. (2009) in conducting IPA research, my lack of experience in IPA methodology needs to be taken into account.

Strengths of this research

In order to add to this research's validity, I outlined my theoretical background and hypotheses as well as ideas and thoughts from my reflective journal in the first chapter, in order to ensure that these are clearly set out prior to the analysis. I also chose to include long verbatim extracts from transcripts to provide a 'grounding in examples' (Elliott et al, 1999), allowing the reader to make their own assessment of the data and its interpretation.

As Yardley (2000) argues reliability may be an inappropriate criterion against which to measure qualitative research. As Yardley (2000) further argues, the use of 'inter-rater reliability' measures (p. 218) does not function as a check of objectivity but rather offers an interpretation agreed upon by two people. The aim of validity checks in this context is to ensure the credibility of the final account (Osborn & Smith, 1998).

Yardley's (2000) criteria for assessing the quality of qualitative research are 1. sensitivity to the context, 2. commitment and rigour, 3. transparency and coherence and 4. impact and importance. This research attempted to address all four of them:

1. The research showed sensitivity to the socio-cultural milieu in which the study took place and part of the enquiry was precisely about how this context has an impact on participants. Interviews were conducted sensitively, making sure the participants were at ease and felt comfortable and taking into account their particular situation. Most importantly, this research showed sensitivity to the interview material by way of paying close attention to each participant's account to ensure that s/he is able to make sense of her/his experiences (Smith et al, 2009).
2. The study demonstrated commitment and rigour by paying special attention to the process of recruiting a sample that matched the research questions. The process of

interviewing the participants was carefully designed and semi-structured interviews were chosen so that open-ended questions allowed for freer and less guided responses. The interviews were carried out by Child Psychotherapists trained in being attuned and sensitive listeners. Regular supervision was part of this process, and further evidence of commitment. An in-depth analysis of the data was conducted following the verbatim transcription of the audio-recorded interviews and special attention was paid to the respondents' choice of words, tone of voice and affect during the interviews.

3. Transparency was achieved by clearly outlining the stages of the research and by using appendices, so that the reader can follow the process step-by-step. Coherence is demonstrated by the writing-up of this thesis and the arguments put forward in the conclusion. I focused on the idiographic and particular experiences of the participants and then attempted to ascribe meaning to them and make sense of the themes that emerged. I clearly outlined my theoretical background and attempted to show how my position as a clinician/researcher coming from a psychoanalytical background has influenced my understanding of the findings. Contradictions and problematic areas are discussed (Smith et al, 2000) and included in the discussion of the findings.
4. In terms of impact and importance, this research aspired to make a contribution to the CP discipline by following the experience of CPs in setting up the service, but also that of the CC workers who were part of it. The usefulness of this research is demonstrated in the last section of this chapter, that considers the implications for practice and feedback to CC and CPs.

Lastly, I consider the psychological element of my understanding and interpretation of the data to be an important aspect of this research. The findings made sense to me

and fitted the psychoanalytical framework I had in mind as well as the literature I reviewed. My thoughts and feelings when looking at the material enabled me to look at unconscious processes that I considered may be taking place during this encounter. In my view, this accords with IPA methodology and serves its aims – as Smith (2004, 2009) argues: 'interpretation should be clearly developed from the phenomenological core' and should come 'from within, rather than from without'.

5.9 Concluding remarks

In Psychoanalysis and Psychoanalytic Psychotherapy we pay special attention to endings as we consider them to be an opportunity for a final working through of complicated feelings such as separation anxieties. We also think of endings as a chance to reflect with our patients about the work we have done together, in the hope that they have internalised the experience of being contained and understood. During this pilot we contacted CC over a hundred times (visits and telephone consultations) and because we were abruptly told we could not carry on delivering the service, we never had the chance for a proper ending with CC staff. This, I thought, was very unfortunate and not well-thought-through, as CC staff had already had repeat experiences of services and professionals coming in and disappearing. This research, as discussed by the participants, was an opportunity for a final working-through as its aim was to capture and understand this endeavour to create a link between the two services.

Although we did not continue working in CC, our attempts to engage frontline workers have been fruitful: in the aftermath of our pilot, we started receiving referrals for under-5s by Health Visitors (with whom we had established contact during this

pilot), and we managed to set up an under-5s psychotherapy service in the clinic. This has been, in my view, the most important outcome of this project and evidence that it had been worth pursuing.

My journey as a Child Psychotherapist working in CC was a learning curve in my professional life that led to specialised training in under-5s psychotherapy work but also to further involvement in outreach work. Adaptations in the technique significant. Learning to work in a more informal manner, while at the same time maintaining the necessary boundaries, is essential. However, outreach work is not so different from psychoanalytic psychotherapy: time and a consistent and containing presence are fundamental aspects of the work in both cases. The analytic stance has also helped me to carry out this research. Being patient and allowing patterns to emerge through careful examination of the material was something I was already familiar with; experience I drew upon when I found myself becoming overwhelmed by the task. IPA is a method, I found, that allows for the participants' narratives to be heard and for the researcher's understanding to be conveyed – a process that very much resembles the psychoanalytic encounter.

Finally, as Anne Alvarez (2012) writes in the foreword to her book *The Thinking Heart*, in Psychoanalysis 'from Freud on, we have had to learn from our mistakes' (p. 6). This project did not continue, and the findings of this research shed some light on the reasons why. As Alvarez (2012) points out, there is always value in looking closely at and making sense of aspects of our work that have not worked out in the way we hoped, in order to inform our practice and existing theoretical frameworks.

5.10 Implications for practice/Feedback to CC

The following feedback relates to different aspects of this research's findings:

Feedback to Children's Centres:

- CC are containers of significant child and parental anxieties, especially for families who are isolated or live in deprivation. Deprivation can have detrimental effects on mental health and CC are, therefore, invaluable points of entry for early intervention and prevention of mental health problems in children. There is definitely scope for working closely with mental health specialists.

- The increasing safeguarding role that CC workers are pressured to take on can be particularly stressful for them, but also for families who find it hard to engage with CC's services because of their fear of being monitored. This emerges as a significant aspect of CC's work.

- Especially at times of service redesigns and cuts, staff can be vulnerable and feel uncontained. These feelings can have an impact on the quality of the service and the staff's wellbeing.

- CC staff could benefit from regular contact and WDGs with Child Psychotherapists, so that they can be better equipped to think about children's emotional states. CC workers seem to focus more on developmental issues and less on children's emotional wellbeing and attachment to their carers.

Feedback to Child Psychotherapists:

- Designing and implementing outreach services to CC requires both parties' managements' full agreement and commitment. Prior to that, there needs to be an

assessment of the staff's needs, the conclusion of which needs to be shared and acknowledged by both CC's management and CC staff. Time and getting to know the 'micro-culture' of the institution are very important factors for a project like this to materialise. In addition, CPs' presence in an institution like the CC is likely to stir up unconscious anxiety within the institution and its workers, which might involve splitting between good and bad services/clinicians, as well as arousing paranoid fears about secret agendas. Envious attacks on the CPs' expertise might also occur, and this possibility should be kept in mind.

- CPs' consistent presence in the centres is essential for the staff to trust them enough to establish a relationship. CPs need to be mindful of the fine balance between attending to the staff's needs and not being drawn into dynamics and states of mind that can be unhelpful. Also, a thorough assessment of the practical aspects of the outreach work needs to take place as working outside the clinic requires travelling and spending a lot of time liaising with other professionals and clinicians. Clinicians should therefore be realistic about their resources. Supervision in the clinic is essential, so all these aspects should be constantly shared and thought about.

- CPs should be aware of CC staff's potential difficulties with identifying or acknowledging mental health problems in under-5s. Involvement in discussion about families, either in the form of WDGs or by attending CC team meetings, can sensitise frontline workers to early signs of mental health issues in young children.

- Work Discussion Groups can provide a safe space where the voice of the child in need can be heard. Additionally, staff's potential feelings of helplessness or inadequacy can be heard and contained. CC are particularly busy places of intense

emotion, and WDGs can provide a slowed-down, quiet thinking space where curiosity can develop. Children's experience and feelings can be articulated in WDGs, allowing CC workers to be more in touch with unconscious processes. As shown in this research, setting up WDGs is not a straightforward process and a clear agreement with the management and staff should be in place. Also, there is an argument that WDGs should be voluntary, so the staff do not feel obliged to attend or persecuted if they don't.

- Joining universal or targeted groups and 'sitting on the carpet' with parents and children can be a good starting point from which to offer small-scale interventions to families. These can be opportunities for close observation of interactions in the room and discussion with the staff at the end of the groups, that would inform staff's understanding of emotional states in children.

- As outreach work is increasingly becoming an important part of Child Psychotherapy, organising a specialist workshop – a forum where CPs can meet and think about outreach work – may be a worthy initiative, offering a space where we can learn from each other's experience and develop a theoretical framework in which this work can be placed.

5.11 Ideas for future research and dissemination of the findings

The findings of this research confirm the need for further case studies like this, in order to add to the existing literature on and understanding of the underpinnings of outreach work with frontline Early Years practitioners. Furthermore, in line with the original plan for this research, there is evidence of the need for more research that

would focus on the formal evaluation of Work Discussion Groups in Children's Centres and other Early Years settings. I further envisage future research projects that would explore CC workers' development and use of observational skills as a means to sensitise them to the emotional states of young children and help them recognise early signs of mental health difficulties. I also think that future research projects on the working relationship between CPs and CC managers (through Work Discussion Groups or consultations) would be useful, since managers' understanding and support are prerequisites for a healthy working relationship between CPs and CC staff. Lastly, research projects that would look into CPs' small-scale interventions with children and parents are also worth pursuing. These interventions can be discussed with CC staff, and would demonstrate CPs' input and work in community settings.

The findings of this research could be disseminated through presentations to:

- Children Centres' managers
- Early Years providers and Local Authorities
- Local Health Watch groups to facilitate communication between policy makers, practitioners and service users
- NHS Trusts interested in developing outreach services for under-5s
- Child Psychotherapists interested in outreach work to Children Centres, as well as trainees, in order to sensitise them to the importance and difficulties of outreach work.

CHAPTER 6 CONCLUSION

From the many issues discussed in the previous section of this thesis, I wish to draw attention to three main points that I think are the most important findings of this research. I also want to emphasise the role and function of Work Discussion Groups in outreach work and elaborate on the circumstances which are necessary if this method is to be of value in busy and often overwhelmed workplaces such as the CC.

Firstly, this research highlights the degree of worry and anxiety carried by the CC staff concerning safeguarding and families that the CC may not be reaching. As shown in the interviews and my analysis of them, CC staff are mostly preoccupied with monitoring children's safety. These anxieties become evident in the interviews and there is a question about whether CC staff are adequately trained and well enough supported to carry out parenting assessments and home visits in circumstances where there is neglect and/or abuse in the family. In the previous chapter I outlined some possible obstacles that can get in the way of offering an inclusive and safe service for high-risk families, such as unconscious wishes to blame and punish neglectful parents or the danger of overidentifying with the neglected babies. I also raised some questions about how needs are understood by CC staff -individual, familial or environmental- and most importantly, what sort of interventions are needed to address these needs (generic or specialised). I further hypothesised that the intense feelings aroused by working with neglected children impact on the way the system around them operates and that often CC staff seem to feel devalued in the way neglected children do.

Secondly, this research demonstrates that there seems to be a significant difficulty in CC staff's ability to think about the actual children. In the previous chapter, I attempted to interpret this difficulty in the light of unconscious projections and identifications; powerful infantile feelings that become too intense and painful are denied and CC staff find it easier to identify with the parents. The experience of the children is not sufficiently articulated and often the child is dropped from staff's mind.

The third point concerns the impact of deprivation and cuts in CC. I thought this finding deserves special attention as many institutions in the public and private sector have been experiencing similar strains over the last decade. CC staff are stretched and anxious, often overworked and do not, as a result, trust their managers. Insecurities related to the loss of their jobs and the survival of the CC were expressed several times in this research. This has had an impact on the quality of their service and, inevitably, on the service users. At the same time, CC staff can be immensely resilient and resourceful in carrying on running their service for the families to whom they feel committed to.

These three points are closely interlinked as deprivation and lack of resources in the community and the centres result in more families living under strain and, paradoxically, receiving less help. The level of need is so high, that the CC's capacity to reach out to them becomes limited. Many families on the threshold of Social Services' involvement are likely to avoid or refuse CC's services. Parents' ability to parent their babies and young children is compromised and more safeguarding concerns are likely to occur. CC staff describe their struggle to respond to a great

level of need, to attend to parents' requests on more practical issues, such as how to access the food bank. There is not much space to think about and articulate the feelings and needs of the children. In any case, CC focus more on the developmental aspects of growing up and less on the emotional ones. This may be an indication of their difficulty at times to be in touch with what the children need in order to feel safe and contained.

As these findings indicate, there is definitely scope for more specialised support to CC staff, for a forum where they could think about their organisation and role, the challenging circumstances in which they work under and, most importantly, the children. Work Discussion Groups, as shown in the literature review, are a very effective way of creating the necessary space for these anxieties to be heard and understood and for the experience of children to be articulated and thought about. However, WDGs are hard to establish. More so in institutions in crisis. What has been learned from this research project is that these groups need to be clearly presented to staff and their attendance needs to be voluntary so that staff can more readily commit to a thinking process they have chosen to. The time, day and frequency of the WDGs also need to be thought through carefully, bearing in mind the already stretched schedules and working conditions. Most importantly, in order for staff to feel safe with the WDG leader/s and trust the space provided during these meetings, time and a continuous therapeutic presence in the institution are needed prior to the commencing of the WDGs, especially in workplaces in crisis. We found that people needed to be reassured that we were not an external agency to monitor them or some form of support that would disappear as many others had done. We also found that there needs to be a clear agreement with the managers about the

duration of WDGs.

The abrupt ending of the WDGs in this project is understood as the result of chaotic institutional changes that got in the way of it becoming a supportive group for staff. I believe that management was not committed to allowing this work to continue and as shown in previous chapters this had consequences on the outreach work and my research. As discussed in the literature review, institutional dynamics often get in the way of the smooth running of a service. It is often the case that organisations' resistance to change is the biggest challenge a clinician is bound to encounter in outreach work. Institutional and staff defences need to be respected and understood as sometimes essential for the survival of the service. CPs' experience in running WDGs and keeping in mind complicated unconscious processes can allow for a gentle introduction of helpful ways to relieve anxiety and create a space that feels safe and containing. This requires a considerable amount of time so a trusting relationship can be developed. The role of the CP under similar circumstances seems to be to find creative ways to show genuine interest in their work, reassure staff and help them recognise and acknowledge their needs. It is only then that a link can be created that would make sense to both parties and a working agreement can be in place.

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APPENDIX A Outline of CAMHS offer

CAMHS early intervention

- We want to make our service available in the community to reach families that would not otherwise easily engage with CAMHS and to meet the combined social care and mental health needs of children and their families more effectively.
- We target our intervention to families as a well as to the professionals working with them.

OUTLINE OF OUR OFFER

- We also aim to increase the capacity of professionals to recognise signs of distress in babies and young children and to identify children that may suffer, or be at risk of suffering, significant harm, and to support these professionals in their task of connecting with families and meeting their needs.

1. WORK WITH PROFESSIONALS

Working with vulnerable families is rewarding but can also cause anxieties, distress and uncertainties in the professionals. Sometimes staff may not know if an observed difficulty is a cause of concern or part of ordinary child development.

At other times, it might be difficult to be aware that a situation is problematic (for example when a baby or chid is withdrawn and doesn't make or maintain contact). There can also be complex environmental risk factors that need to be taken into consideration but are not easy to explore.

We would like to offer the Children Centre staff a space to think about their worries, concerns and expectations in working with vulnerable families.

- We can offer different types of consultations and we aim to tailor our intervention to the specific needs of each centre.
- Work discussion groups are regular meetings where the same staff can take turns in bringing concerning cases for an in-depth discussion which can function as a learning

environment and a forum in which ideas can be exchanged.

- We suggest a booking system be used, whereby staff enter their names ahead of us coming and commit to attending.
- Depending on resources and circumstances, we might offer themed discussions and presentations.

2. DIRECT WORK WITH PARENTS, BABIES AND TODDLERS

- The transition to parenthood can be a challenging time for parents, especially when there are risk factors such as reconstituted families, conflict between the parents, a history of domestic violence, teenage pregnancies, parental mental health, social isolation or deprivation.
- Bonding and attachment difficulties can show when a baby is hard to settle, has difficulties with feeding and sleeping or, on the contrary, seems unusually quiet and compliant. Anxieties are often expressed in toddlers with behavioural problems (biting, tantrums), difficulties joining in social activities, problems with toileting, sleeping, eating and separation.

Work with parents

- The experience of a therapist as someone able to appreciate the parents' wish to be good parents, who can empathise with their burden and tolerate and understand their despair can alleviate the worst anxieties, so parents can see themselves and their infant in a more realistic light. It is an opportunity for parents to develop their own resources to understand themselves in their struggle to find better relationship with their baby.
- The initial session would last up to 1.5 hours to allow time for a relationship to develop and the main problem and history to emerge. The final session can be used to focus on what has been discovered and understood and how this can be used in the future.

Individual work with children/parent infant work

- We can offer brief interventions (up to 6 sessions) either at the Children Centre or at the Clinic, depending on needs and resources, when a referral is made and accepted. This can lead to further involvement from CAMHS or other services when a case is complex and/or there are safeguarding concerns.
- REFERRALS

Generally, a referral of a baby or a child under 5 can be made when the following two criteria are met:

- parents show early signs of difficulty in forming positive relationships with their babies and/or there are emerging emotional difficulties in infants
- there are risk and vulnerability factors such as parental mental health concerns; safeguarding or child protection concerns; mothers who are teenagers, depressed or vulnerable.
- Any referrals will be seen at CAMHS.

APPENDIX B CAMHS pilot offer

1. Working title for the project/pilot

CAMHS Children's Centres Outreach Pilot

2. What centres will the pilot project offer service to?

Our aim is to offer services to all 7 Children's Centres in the area (Hubs)

3. What is the aim of this pilot?

To prevent mental illness and promote healthy relationships by offering:

a. Consultation to staff (rationale: to help staff to recognise and understand early experiences/difficulties). We recognise that there are differences in staff group needs. We will be offering work discussion groups where appropriate.

b. Running groups (like postnatal depression groups)

c. Clinical work/referrals – Tavistock model for under-5s-brief model of work. The rationale is to try and

-parents to form a non-dependant relationship with the therapist, work through their history, focusing on the parents and their relationship to the child

-containment/holding

-key papers-add to the evidence of the model

4. What is the structure of the pilot team?

3 Child Psychotherapists and 2 Child Psychotherapy trainees and a Consultant Clinical Psychologist

-group supervision: meeting once a month with Neithan (Lead Child Psychotherapist in CAMHS) and Carol, Consultant Clinical Psychologist for 1,5 hours to think about the work

5. How long will this pilot run for?

We need an official start and end date. Start date: when the outline has been agreed and sent out to the children centres, and end date: summer break, July 2015

Document to be completed by the end of February

6. How will the pilot be evaluated?

We will need the help of a clinical psychologist-MALT team

VITAL for the project

Link up with other outreach CAMHS teams

7. What resources are required for the project to be effective?

-Supervision

-Travel expenses

-External supervision

-Training

-Time: clarify how many hours per week

8. What are the potential risks involved in undertaking the pilot?

-Drop in resources

-Fragmentation

-Loss of direction

-Damage relationship between CAMHS and Children's Centres

-Being flooded with referrals

-Inappropriate referrals (safeguarding etc.)

-Lack of structure

-time management

9. Under-5s face-to-face

-What can we work with?

*Parents who have some capacity to think about their child

*Anxiety

*Depression

*Attachment difficulties

*Traumatic birth of the child

*Complications pre-/post-birth

*Difficulties in adjusting to parenting

-Who can refer in?

Managers of the children's Centres (to be outlined clearly in the starting document)

No waiting list – this is a pilot

-time-management:

To offer one to two hours per week for direct work with families in the clinic

5 to 8 cases in total at any one time

APPENDIX C Reflective journal/Notes from baby clinic, March 2015.

I was worried about Kiara joining me (two people may be too many). We walked for what felt like hours to me to get to the CC, and upon arrival we were told by J that there is a mother in there who hasn't been ok after birth, and this was the first time she'd come – this mother talked to J for a bit, and said that she wasn't feeling very well; the baby was floppy and looked unwell. J went to talk to her, and I went into the clinic while we decided K would join us later. The health visitor was very unwelcoming ('So, you are here to supervise us!', she said) whereas the nursery nurse was keen to explain the way the clinic worked and welcomed me into the room. I sat on a small chair at a distance – after a few minutes of being unsure as where to stand – and observed for a while the only mother who was there. She was trying to put her baby to sleep, struggling a lot to comfort the baby in the buggy. In the next 10 minutes, the clinic became busy and I was particularly struck by a mother who was told that her child is too old to be brought to this clinic (a year and a half). This mother anxiously explained that she was there because she was worried about his weight. Nurses agreed to weigh him and his weight was within normal range. The nursery nurse Z told the mum they could have a chat about food and mum agreed. I joined them. Z did a lot of explaining, going through a leaflet about nutrition and healthy eating. This seemed to me like a long presentation in an instructive way. Although this was very thorough, Z didn't take some time to listen to what really worried this mother. She talked about food that mum could cook that contained iron (mum explained she was worried as the boy had an iron deficit) but interestingly enough she was talking about culturally different types of food, and the fact that the suggestions were useful but not part of her cooking tradition. At the end we had a bit of time with this mother, when I tried to explain the developmental and emotional aspects of eating and feeding and talked to her about how children of that age exercised their control over the environment via accepting or rejecting food, and how this is often their way to test the boundaries, etc. Mother seemed to find these thoughts interesting and thanked me on her way out.

I also spent a few minutes with a young mother who turned up because her three-week-old (premature) tiny baby had some blood coming from her bottom. Nurses there reassured her. I wondered how she was doing following a difficult and premature birth, and she said she was very tired and that she felt she was on her own as her husband was working all the time. 'But she is gaining weight, which is great news', she said with a bitter smile. We talked for a few minutes about the anxiety of being on her own, having her first baby, and her being a premature tiny baby that felt fragile to mother as opposed to other bigger and robust babies she knew of. I acknowledged the anxiety and invited her to join the Centres, where opportunities to talk to the staff and other parents could easy her anxiety and loneliness.

A mother next to me on the carpet fed her three-month-old baby and then put her down on a pillow. She talked to me quite a lot about having had three boys and finally a much-wanted girl. The latest arrival was a calm and quiet baby and she enjoyed her very much. The baby was very lively and exploring everything around her. Mother talked about feeling a bit lonely in the mornings and we talked about the importance of groups and interacting with other mothers. Kiara who joined a bit later had an extensive conversation with a mother whose older boy was investigated because of worry about autism.

APPENDIX D Reflective Journal/ Work discussion group notes

30/5/15 present: me & Kiara and J, R, L, T

J was there first – with a feeling that 'nobody will turn up'. We were 15 minutes early and felt a bit uncomfortable in relation to where to wait, etc. Then L and R turned up and said they thought it would be just the two of them – no feeling of commitment to this group. We went upstairs – the state of the building and the smell… something to do with abandonment and deprivation. The flat feels really different to that it is well-kept and clean. Everybody made drinks and there were some conversations about the weather – feeling a bit uncomfortable. I started by saying that it's the last time we will meet here and talked about the Monday arrangement. I also acknowledged the fact that S wasn't there and that we felt it might be different without the manager being there – they all talked about it not being a problem as they have a good relationship with her. I explained that I was thinking more about the group being offered to people like them who work directly with families but also about having the space to reflect on the workplace freely – maybe more so at a moment when things are in transition. J rushed to say she doesn't really think about it and is optimistic – the others agreed and said they are just getting on with their work.

I wondered whether there were particular families they wanted us to think about as this group will be more helpful if we hear and think about the detail of certain families. J rushed to say she has this mother in mind and tries to describe her to the others as 'the bottle mum', she is Russian and they all said she is a bit odd and hard to engage. J wondered about the possibility of a mental health difficulty in this mum – she is not playing with the boy, she is only interested in the educational stuff and she won't allow him to be messy. I wondered how old the boy was and J said just over 1 year old – this sounded surprising. R said she's known them since he was a newborn – she had paid them a newborn home visit then and she was struck by the fact that everything was white in the house and extremely clean. Kiara asked whether there were some signs that there was a baby there and R said 'a toy box'. We thought about this mother's difficulties – what is she struggling with? J gave us

some examples of times she felt there was something wrong. She talked about a group where the boy started throwing things and J thought it wasn't really ok as mum didn't stop him. When J attempted to, he started putting things back. Towards the end of that group this mother said to J that she didn't know why he did that and J tried to engage her by trying to explain that throwing things at this age is developmentally appropriate as babies are interested in trajectories. Mum said she knew what this was about as she is an educated woman. J also talked about another incident when the boy had an accident and hit his head. J asked whether they needed first aid and she said she didn't, only to ask a few minutes later how she could report the accident, seeming really cross. We had the chance to think about this mother; there is something threatening about her. She is very guarded and that makes J feel that she is mentally unwell or there is something worrying going on. We thought about mentally unwell people who create feelings of insecurity and sometimes fear in others. J wanted to think of how she could talk to this mother about that. T came in at that point and we let her know what we were talking about; we thought together about parents who are not playing with their children: what might that mean? We thought about cultural aspects as well as intergenerational trauma and how these parents were parented when they were young. This brought up the home visit-outreach aspect of their work. We spoke about them doing a lot of different things. T talked to us about this mother who didn't know how to read her baby a story, and T showing her how – some people can't be parents – like children in need.

We returned to J's question about what to do. I talked about a grand-maternal function they have – how to help with parenting in a discreet manner. We thought about these mothers who are hard to reach and passive-aggressive. I suggested that next time an incident like the one she brought up happens, she try to openly talk to this mother about there being some difficulty with having an ordinary conversation about the little one. J said she didn't feel confident enough to do that and wondered if we can do that together when I join her group. K talked about thinking she can't do it but when the time comes she might find she can. We talked about a possible angry reaction to that – we thought about the positives of such an outcome. If J is so

worried about them, then if she becomes openly distressed that might help with raising the concern to others.

We also talked about the boy and his mother that J is seeing at their home. I have met the boy and we spoke about referral to CAMHS. J told us a bit about the story of this mother and that last September when she first joined the CC she had said she never had a friend until that point. We talked about the attachment difficulty and mum's openness to receiving help. How does an attachment difficulty become manifest? We talked about the boy not reaching out for mum and mum seemed to try to compensate by helping a lot with the group; she is not around him very much
– they find it difficult to relate. J talked about singing time when she encouraged mum to go and stand next to J so the boy goes to her for the 'zoom zoom zoom' song but sadly this didn't happen. J cried when she talked about this family and I said something about CAMHS and a targeted intervention to which people seem to agree.

T then talked about the nature of the work – 'bad weeks and good weeks'. Sometimes it is very rewarding to see mothers and children getting better, but at the same time it is very sad to see social services removing children, and so on. We thought about the importance of their work and their being at the forefront of working with difficult families and at the same time how important it is to run universal groups because they help with ordinary difficulties which can end up in mental health problems.

J and L brought up another group they run at the school; a parenting group. They said they are worried about a mother who has suffered domestic violence and her adolescent son, who is turning into an abusive young person. We talked about family workers having shared their concern with others and noted that there are a lot of professionals involved – running parent groups being another aspect of their work.

We again acknowledged how much they are doing, and then R said something about not being appreciated and spoke about the Local Authority letter they received, which said their contracts are finishing in September but might end earlier if the

CC's budget runs out. J and T talked about carrying the letter in their bags – the importance of it. J read it to us and a lot of feelings related to that – the uncertainty and a feeling of not being appreciated – were stirred up by our acknowledging how much they are doing. They also thought about all these families who need stability, and for whom stability cannot be guaranteed. We had to finish at that point and they thanked us for offering the group; we will go again on the 1st of June. T asked us to join her in her groups; the culture seems to have changed and they want more CAMHS input.

APPENDIX E Information sheets and consent forms to participants

Information sheet for Children's Centers staff

University of East London

Tavistock and Portman NHS Foundation Trust
120 Belsize Lane, London NW3 5BA

University Research Ethics Committee

This research project has received formal approval from the University Research Ethics Committee.

If you have any queries regarding the conduct of the program in which you are being asked to participate, please contact:

Catherine Fieulleteau, Research Integrity and Ethics Manager, Graduate School, EB 1.43
University of East London, Docklands Campus, London E16 2RD
(Telephone: 020 8223 6683, Email: researchethics@uel.ac.uk).

Principal Investigators

Doctoral research student: **Ms Eleni Zacharia** (details not included to protect confidentiality)
Supervisor/Director of studies: **Ms Biddy Youell**

Tavistock and Portman NHS Foundation Trust**,** 120 Belsize Lane, London NW3 5BA,

Email: Second supervisor: **Dr Ferelyth Watt**

Consent to Participate in the Research Study

The purpose of this letter is to provide you with the information that you need to consider in deciding whether to participate in this study.

Project Title

Creating a link between CAMHS and Children's Centers in a deprived area: A case of setting up a Work Discussion Group

Project Description

This is a small scale service evaluation and process research project for my doctoral thesis. The aim of this research project is to describe and explore the process of creating an outreach consultation service to Children's Centers and evaluate the Work Discussion group model introduced in Children's Centers. The process of designing the service will be examined and our teams' (CAMHS) involvement will be evaluated. Special attention will be paid to the specific contributions of Child Psychotherapy on this service as well as to the current austerity climate and institutional changes.

Information from the Children's Centers' records reveals a very high percentage of registration with them; almost every child under the age of five is registered with their local Children's Centers in our area. At the same time, our clinic receives a flood of referrals for 6 and 7 year olds by schools and GPs. The fact that these cases are not being picked up earlier poses the question of how CAMHS can intervene in the community and work with young children and their hard to reach families as well as with Early Years Practitioners.

The example of introducing and evaluating a Work Discussion Group will be studied in order to look at the gains and challenges of this way of thinking about difficult cases as well as reflecting on the Children's centers' staff's professional role. This will hopefully help us improve our current practice and design similar services in the future.

The 'Work Discussion Group' is a well established teaching method at the Tavistock clinic and concerns the participant's observation and reflection on hers/his work and professional role. The Work Discussion seminar provides the participant with supervision and reflection -both by the consultant and peer professionals- and aims to a shared understanding about unconscious processes at work as well as to develop the capacity for reflection and observation of one's own role in the workplace. You receive service and safeguarding supervision and the Work Discussion model is new to you. The aim of delivering Work Discussion Groups is to enrich the ways you work with under fives and their families and enable you to identify more confidently children in need for further mental health input (link with CAMHS). Furthermore, your feedback will help us think about the service we are delivering and improve our practice.

Your involvement

You have been asked to contribute to this research because of your experience in participating in a Work Discussion Group that was set up and delivered by our CAMHS outreach service. You will be interviewed and asked to share your view on this method of working. More specifically, these interviews will be carried out at your workplace and will include questions related to your feelings and thoughts about this way of working and learning; your views on the Work Discussion group's usefulness in thinking about the families you or your colleagues presented and your thoughts about your professional role and the institution you work in as well as more general questions about your service and your views on the CAMHS outreach service. Please note that the interviews will be audio- recorded but the written script used in the research will be anonymised. Notes following the Work Discussion Group sessions will be kept by me and, likewise, they will be anonymised. At the end of the research project I will gather the notes and interview scripts and will try to analyse them in detail in order to gain some understanding of how the group developed over time. Please note that the location of the Children's Center and our CAMHS clinic as well as identifying details of participants will be anonymised.

Confidentiality of the Data

-All written information about CAMHS and Children's centers staff will be anonymised including Work Discussion group notes, meeting notes and interview scripts.

-All identifying details about the Children's Centers will be changed and individuals will be given pseudonyms.

- All electronic and hardcopy data will be securely disposed at the end of the research period. Data collected may be used for publication in peer-reviews journals, training or presentations in conferences.

-Data will be retained in accordance with UEL's Data Protection Policy.

-All data stored electronically will be encrypted and password protected and all hardcopy data will be stored in locked cabinets.

-Audio-recordings of interviews will be encrypted and accessed only by the principal investigators.

-Given the type of this study and the small number of participants there are limits to confidentiality, whereby participants could be identified despite the data being completely anonymised.

-Data collected in the context of this research may be used for publication in peer-reviewed journals or presentations in conferences.

-Please note that consent for the data can be used in the context of this research can be withdrawn by the 30th of April 2016.

Location

The Work Discussion Groups as well as the Interviews with Children's Centers staff will be carried out on Children's Centers premises.

Disclaimer

You are not obliged to take part in this study, and are free to withdraw at any time during tests. Should you choose to withdraw from the programme you may do so without disadvantage to yourself and without any obligation to give a reason.

Consent form for Children's Centers' staff

UNIVERSITY OF EAST LONDON

Consent to Participate in a Programme Involving the Use of Human Participants.

Project title:

Creating a link between CAMHS and Children's Centers in a deprived area: A case of setting up a Work Discussion Group

I have read the information leaflet relating to the above programme of research in which I have been asked to participate and have been given a copy to keep. The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what it being proposed and the procedures in which I will be involved have been explained to me.

I understand that my involvement in this study, and particular data from this research, will remain strictly confidential. Only the researchers involved in the study will have access to the data. It has been explained to me what will happen once the programme has been completed.

I hereby freely and fully consent to participate in the study which has been fully explained to me and for the information obtained to be used in relevant research publications.

Having given this consent I understand that I have the right to withdraw from the study until 30th of April 2016 without disadvantage to myself and without being obliged to give any reason.

Participant's Name (BLOCK CAPITALS) …….

Participant's Signature ……..

Investigator's Name (BLOCK CAPITALS) ……..

Investigator's Signature ……

Date: …….

Information sheet for Child Psychotherapist colleagues

University of East London
Tavistock and Portman NHS Foundation Trust
120 Belsize Lane, London NW3 5BA

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Creating a link between CAMHS and Children's Centers in a deprived area: A case of setting up a Work Discussion Group

Project Description

This is a small scale service evaluation and process research project for my doctoral thesis. The aim of this research project is to describe and explore the process of creating an outreach consultation service to Children's Centers and evaluate the Work Discussion group model introduced in Children's Centers. The process of designing the service will be examined and our teams' (CAMHS) involvement will be evaluated. Special attention will be paid to the specific contributions of Child Psychotherapy on this service as well as to the current climate and institutional dynamics and changes.

The aim of this study is to explore the process of creating a CAMHS outreach service for Children's Centers in a deprived area. The project attempts to look at what Child Psychoanalytic Psychotherapists have to contribute to this kind of work. In order to explore these issues more closely, I will focus on the study of introducing, setting up, facilitating and evaluating a Work Discussion Group in one of the Children's Centers.

More specifically, this project aims to address the question of 1.) What can be learned from the process of creating a link between CAMHS and the local Children's Centers. 1a.) my role and the specific contributions of our team of Child Psychotherapists will be examined. 1b.) there will be an attempt to describe how Children's Centers operate and the institutional dynamics involved in establishing a working relationship between a CAMHS service and the Children's Centers of the area. 1c.) Special attention will also be paid to institutional changes due to the current political and economic climate and their effect on Children's Centers workers, CAMHS practitioners and the development of the outreach service.

2a) The example of piloting an intervention, namely setting up and facilitating a Work Discussion Group in one of them will be used to highlight some of the challenges and gains of conducting psychoanalytically informed outreach work in Children's Centers. 2b) The Work Discussion Group model will be evaluated by the Children's Centers workers with the hope that this will contribute to the improvement of our practice and inform our decisions in relation to further development of our service. Through discussion of the research findings this project aims to provide a learning opportunity for the researcher and the team of Child Psychotherapists that take part in delivering the outreach service.

Child Psychotherapists are particularly interested in Early Years as they consider the first years of life to be decisive for a child's future mental health. I will argue that psychoanalytic ideas enable us to think about unconscious individual as well as institutional dynamics that

sometimes get in the way of establishing a good relationship with an organization and its employees and that exploring institutional dynamics might help us improve our practice and help Children's Centers workers in more creative ways. Furthermore, the current political and economic climate has brought about big organizational changes both in our CAMHS team and in Children's Centers. Issues linked to organizational changes and difficulties deriving from the current climate of austerity will also be investigated. In order to explore the above mentioned issues, the qualitative methods of action research and semi- structured interviews with my colleagues and the Work Discussion group participants will be utilized.

The example of introducing and evaluating a Work Discussion Group will be studied in order to look at the gains and challenges of engaging the Children's Centers workers in a more psychologically/psychoanalytically minded way of thinking about their cases as well as of reflecting on their own practice. This will hopefully help us improve our practice as the findings of this research will be shared and discussed with you.

The 'Work Discussion Group' is a well established teaching method at the Tavistock clinic and part of our training. The Work Discussion seminar provides the participant with supervision and reflection -both by the consultant and peer professionals- and aims to a shared understanding about unconscious processes at work as well as to develop the capacity for reflection and observation of one's own role in the workplace. Children's Centers workers receive service supervision (usually by their manager) and occasionally safeguarding supervision which focuses on child protection concerns. The Work Discussion model is new to them and the process of establishing a 'Work Discussion culture' will hopefully bring about some change in the way practitioners think about their work with under fives and their families and enable them to identify children in need for further mental health input (link with CAMHS).

Your involvement

You have been asked to contribute to this research because of your experience in participating in setting up and delivering an outreach service to Children's Centers. You will be interviewed and asked to share your view on this experience. More specifically, these interviews will be carried out at the CAMHS clinic and will include questions that concern how you experienced your role as an outreach worker; how you experienced the institution and its challenges; where the areas that our CAMHS specialized service could be more useful and how you think our service was received by Children's Centers workers. Please

note that the interviews will be audio-recorded but the written script used in the research will be anonymised. Furthermore, notes from our meetings and discussions regarding this project will be kept in the form of a reflective diary which involves thoughtful analysis of my individual participation on the group project and where I describe, analyze and evaluate interactions with you and the Children's centers. The aim of this study includes sharing my research findings with you at the end as well as during the process. Please note that you have the absolute right to refuse participation or withdraw your consent at a later stage of the research. Your refusal to participate will not have any consequences and will not impact on the development of this research project.

Confidentiality of the Data

-All written information about CAMHS and Children's centers staff will be anonymised including Work Discussion group notes, meeting notes and interview scripts.

-All identifying details about the Children's Centers will be changed and individuals will be given pseudonyms.

- All electronic and hardcopy data will be securely disposed at the end of the research period. Data collected may be used for publication in peer-reviews journals, training or presentations in conferences.

-Data will be retained in accordance with UEL's Data Protection Policy.

-All data stored electronically will be encrypted and password protected and all hardcopy data will be stored in locked cabinets.

-Audio-recordings of interviews will be encrypted and accessed only by the principal investigators.

-Data collected in the context of this research may be used for publication in peer-reviewed journals or presentations in conferences.

-Given the type of this study and the small number of participants there are limits to confidentiality, whereby participants could be identified despite the data being completely anonymised.

-Please note that I will be keeping a reflective diary of the meetings and discussions with you with regards to this project. This will include notes and my reflections on formal as well as informal meetings or discussions that take place in the clinic between the members of our team.

-Please note that consent for the data can be used in the context of this research can be withdrawn by the 30th of April 2016.

Location

The Interviews with Child Psychotherapist colleagues will be carried out in our CAMHS clinic.

Disclaimer

You are not obliged to take part in this study, and are free to withdraw at any time during tests. Should you choose to withdraw from the programme you may do so without disadvantage to yourself and without any obligation to give a reason.

Consent form for Child Psychotherapist colleagues

UNIVERSITY OF EAST LONDON

Consent to Participate in a Programme Involving the Use of Human Participants.
Project title:

Creating a link between CAMHS and Children's Centers in a deprived area: A case of setting up a Work Discussion Group

I have read the information leaflet relating to the above programme of research in which I have been asked to participate and have been given a copy to keep. The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what it being proposed and the procedures in which I will be involved have been explained to me.

I understand that my involvement in this study, and particular data from this research, will remain strictly confidential. Only the researchers involved in the study will have access to the data. It has been explained to me what will happen once the programme has been completed.

I hereby freely and fully consent to participate in the study which has been fully explained to me and for the information obtained to be used in relevant research publications.

Having given this consent I understand that I have the right to withdraw from the study until 30th of April 2016 without disadvantage to myself and without being obliged to give any reason.

Participant's Name (BLOCK CAPITALS) ……

Participant's Signature ……..

Investigator's Name (BLOCK CAPITALS) ……..

Investigator's Signature ……

Date: ……

APPENDIX F UREC Ethical Approval Letter

7 September 2015

Dear Eleni

Project Title: Creating a link between CAMHS and children's centres in a

deprived area: A case of setting up a work discussion group

Researcher(s): Eleni Zacharia

Principal Investigator: Biddy Youell

Reference Number: UREC 1415 121

I am writing to confirm the outcome of your application to the University Research Ethics Committee (UREC), which was considered at the meeting on Wednesday 22nd July 2015. The decision made by members of the Committee is Approved. The Committee's response is based on the protocol described in the application form and supporting documentation. Your study has received ethical approval from the date of this letter.

Should any significant adverse events or considerable changes occur in connection with this research project that may consequently alter relevant ethical considerations, this must be reported immediately to UREC. Subsequent to such changes an Ethical Amendment Form should be completed and submitted to UREC.

Approved Research Site
I am pleased to confirm that the approval of the proposed research applies to the following research site.

Approval is given on the understanding that the UEL Code of Good Practice in Research is adhered to.

Please note, it is your responsibility to retain this letter for your records.

With the Committee's best wishes for the success of this project.

Yours sincerely,

Rosalind Eccles

University Research Ethics Committee (UREC)

UREC Servicing Officer Email: researchethics@uel.ac.uk

APPENDIX G Interview questions

Semi-structured interviews with Child Psychotherapists in the outreach team: main themes

1) The process of setting up the service

i) Can you say something about your interest in developing an outreach service? How was this service designed?

ii) Can you describe the service and your involvement in it? How has the experience of being part of this team been so far?

iii) What is your understanding of the fact that this is a team that consists predominantly of Child Psychotherapists? What do you think Child Psychotherapy has to offer in conducting outreach consultation work?

iv) What are the main challenges of working in the community and more specifically with Children's Centres? And what are the gains?

v) What have you learned from this process of developing the service so far?

2) Institutional dynamics and getting to know the Children's Centres

i) From your experience, what does a family expect from the Children's Centres? Can you explain how families that attend Children's Centres tend to involve you? What kind of requests are made of you?

ii) In which areas do you find Children's Centres to be more successful, and in which less so?

iii) Can you say something about the current climate and how this has an impact on our work and the work of Children's Centres?

iv) How do you think our outreach team has been received by the Children's Centres' staff? Do you think their view on who we are and what we do has changed?

v) How do you think our CAMHS team and our Trust have received our outreach work?

vi) Can you tell me a piece of work that you think was helpful either directly with a family or a member of staff? Or a piece of work that failed and why?

3) Overview and service development-Lessons learned

i) After a long period of being involved with the service what improvements would you suggest, and what do you think has worked well?

ii) What kind of challenges can an outreach team be faced with? How can they be dealt with? Can you think of an example?

iii) How can we become more effective and accessible to the Children's Centres' staff?

iv) If a colleague was to embark on a similar project, what would you invite them to be aware of/mindful of/pay attention to?

v) Can you say something about the role of this research project during this process? Do you think it interfered with our work/added to it/was or wasn't relevant and in what way?

Semi-structured interviews with Children's Centres' staff who took part in the Work Discussion Group

1) Staff's professional role and workplace/institution

i) Can you say something about your role in the team and what drew you into this work?

ii) Can you tell me a bit about your history prior to working here?

iii) How do you think your team/institution operates? Can you say something about the different teams and your management?

iv) How has the current climate of cuts affected your work and perhaps the families you are working with?

v) What kind of things does a family expect when they come to the Children's Centres? How do you think they experience you and what kind of requests are made of you?

vi) Can you think of a piece of work that was successful? What is it that makes an intervention helpful to a family?

vii) Can you think of a piece of work that was unsuccessful, and what made it unsuccessful?

2) CAMHS and Children's Centres

i) How would you describe CAMHS? What do you think CAMHS is offering? How is this relevant to you?

ii) Child Psychotherapists from our CAMHS team piloted a consultation service in your workplace. What do you think a Child Psychotherapist has to contribute to this kind of work if anything?

iii) How has the experience of working with the CAMHS outreach team has been so far? Can you say what the consultation team is offering to the Children's Centres?

iv) What has been helpful and what less so in your partnership with CAMHS outreach service?

v) Can you identify areas of improvement? What would you like more help with, or what do you think is less relevant to your work?

3) Work Discussion Group experience

i) You have been attending a Work Discussion Group for almost a year now. Can you say what this involves?

ii) How does the Work Discussion Group differ from your supervision?

iii) Can you say something about the usefulness, if any, of this approach to working? How has it helped you with thinking about difficult cases?

iv) The Work Discussion Group is supposed to provide a space for professionals to think about their role and workplace. Can you say whether this has been something helpful to you?

v) Were there opportunities to think about the current climate and the major restructuring of your service? Can you say something about how the group dealt with it?

vi) What is your view on the Work Discussion Group method as part of your practice? Do you have any thoughts about whether we should continue delivering it in Children's Centres? Do you have any thoughts about its frequency and structure (on whether to include managers or not, etc)?

APPENDIX H- Analysis A &B, a sample

Interview with H. ANALYSIS

DB: Can you tell me a bit about your history prior you started working here and what drove you into the job?

H: I started my career as a nursery nurse, I went to college and did nursery nursing a long time ago, when nursery nursing was a thing, it's not a thing anymore. And then I went to work in big primary schools, they were called 4+ units then alongside a class teacher and when I had my first child I realised that I felt more of a draw towards family work and would prefer to be in that sort of field. So, while I was on my maternity leave a post came up supporting families in a quite a deprived area of L. and I applied for that so I did family work for quite a few years then and then I made my way up through CC.

DB: Can you say something about your role in the team?

H: So, I am now the service manager for the CL so I oversee all of the CL sites which is predominately the west of L.

DB: How many sites is this now?

H: 5

DB: How do you think your team or institution operates and works? Can you say something about the different teams and management?

H: Ehh, I think we have quite an informal approach to most issues within the centre. I think because we are all of a family work background and we were drawn to working with families we tend to work quite well as a team, we tend to build relationships quite quickly, so I think we tend to have strong bonded teams because of the very nature of the work that we do. It is an informal structure but we do meet very regularly to ensure that things are kept up and practise is good. There is a high expectation working here that people will provide high quality for families.

DB: What kind of things does a family expect when they are coming to CC? How do you think they experience you and what kind of requests are made of you?

H: I think we have to be very clear with families about what our role does and doesn't cover. I think sometimes families expect that we can work miracles and we can get them housing and we can't and we have to be quite honest about the current economic climate and that actually 'you are not going to get a house and we can tell you now that you are going to a hotel' so sometimes that's sort of hard for families cause I think they put a lot of regard on the fact that we can change things that we cannot actually change but we can support families

What H has learned seems to be of no value anymore

'it's not a thing anymore'

she describes how she became a family worker and made her way up-how becoming a parent influenced that

deprived area

She talks about a change in culture-working in nursery is not important anymore-prestige and how people undermine nursery workers-maybe wondering whether CAMHS consider what they do important-interesting that already from the first paragraph she mentions deprivation

Short answers here-does she think five is many or manageable? Matter of fact way of replying

Informal approach-things are casual/no strict hierarchy-there is something about this kind of that requires adjusting quickly and working well as a team

Repeating the words informal and high

Here I wonder whether she is thinking about families and a family feel in the workplace-it feels slightly defensive the way she reassures the interviewer that despite the informal way of working there are high expectations

We are honest that there is a limit to what we can do-there are social and financial issues families are hoping to get help for-supporting them but not really changing things for them

Miracles -repeating the word 'change'

H is already making a link with social and financial situation-I feel she is saying they have to let families know about the hard reality to do with the state-hoping they can get a house from CC-is this a reference to finding a home and a family?

through that change rather than actually being able to do that for them.

DB: when you say support them through that, you mean…

H: We can give them the tools and the skills to be able to do things. So, if you take housing as an example we ll support families to get on the bidding system, we ll support families with the IT needs that they need to come in and bid. So we have families who come to CC every week to bid so they can move out temporarily. So we can do the practical stuff but we also give sometimes the emotional props, so we will tell people that 'yes, you will be living in a hotel and actually it could be for 6 months', as awful as that is, it's better for families to know the reality. So sometimes we have to do a bit of that work as well.

DB: Can you think of a piece of work that was successful? What is it that makes an intervention helpful to a family?

H: Eh, I think families work best when they have relationships, professional relationships with a member of staff, we know that children work best when they have a key worker and I think it works the same for families, I think if they have a linked person that they can access anytime, I think that works well. We have had the mellow parenting programme here and we have had a lot of success of various families of stepping down the tiers of need because of mellow parenting, That's what they are saying, they are saying they ve had that support and they have been able to make changes to their lives and they have been able to sustain them and actually they have been able to go from a child protection family to someone in universal services and so that's how we sort of measure our outcomes really that we can get families back through the tiers of need.

DB: Is there a particular piece of work that comes to mind with a family?

H: yeah, we ve got a family…we had a dad who came to clinic for weeks and weeks but never sort of disclosed anything but we gave him a lot of support as we could see he was at the point of disclosing something and one week he came in and he disclosed that his wife had mental health issues and actually she couldn't leave the house and he was worried about the effect that this could have on their toddler and that's why he came to clinic every week but didn't know if he d feel confident to come to a group so we supported him to come to a group and then he said he d really want his wife to try and come actually we offered a home visit so we went and met her first and then she came to group cause she already made a little bit of a relationship with someone. And actually that family now are in a totally different place, you know they ve moved out of a really awful housing environment and he s been able to go back to work because

The ways we can support with social and financial hardship is to give practical advice but also emotional by talking openly about the reality which is hard

Repeating the word support, awful, emotional props

here is feel H is conveying the hardest part of the job-the pain of being unable to offer these families an actual home and a family-preparing them for the awful things to come is hard but H considers it necessary but this bit of work 'as well'-an extra

H talks about how important it is to have 'their person' they have easy access to

Here she makes it more explicit that it is about developing relationships that help them through-at the same time she talks about levels of need and stepping down from being unable to parent by being parented by CC

Disclosed x3 times, awful, small steps

H talks about families being suspicious of CC workers to begin with and it takes a lot of time and effort for them to 'open up'-often social difficulties and mental health problems get in the way but it can be very rewarding to observe a massive change in a family.

Here I feel that the use of the language and particularly the word disclose conveys a social services aspect of their thinking-an assumption that families often hide something-safeguarding concerns but also shows the anxiety about working with people who might be neglecting or abusing their children

she s been able to get the little one to nursery on her own, so they ve had a complete life transformation but they take a long while, pieces of work like that, so that can go on for nearly a year with the small steps coming to clinic and then coming to group and then both coming to group and then she came to group on her own.

DB: So big changes…

H: Yes, big changes but small steps to get there.

DB: How has the current climate of cuts affected your work and perhaps the families you are working with and if so, how?

H: I think the families are feeling a great sense of uncertainty at the moment. I think the problem with consultation is they ve been consulted with about things they are not necessarily going to have any influence over at the end and I think they find that very difficult. There is another consultation gone out this week that talks about the bases are going to be and the families don't care, they have been very clear about that. They care about the services and they care about the staff because they want to know that they will still be able to go to a baby club on Monday because they were really depressed and they are actually managing that depression cause they get out once a week and they want to know that the person who was supporting them with that is going to be in that group still. So, parents have been quite low actually. There has been quite a weird community environment where families are feeling quite vulnerable, they don't know what will happen next, they feel like the small fish that don't have any say and we are trying to sell it 'you ve got your say, this is a consultation…' but I don't know how true that is if I am honest. I don't know if they have a say really. I think…we know there is no money, we know things have to change and there is only so many ways you can change something without damaging the service.

DB: And then I imagine this makes your work harder, they ve got greater needs as they are feeling anxious.

H: And they have and they are feeling anxious and actually the people who are feeling the most anxious are not the ones who are going to come to a public consultation. They are not the ones who are ever going to feel empowered enough to be able to come in and speak to a group of people at executive level in the council because why would they? That' s not…they wouldn't see that as their business. So, the people who would be most affected are the one without a

Weird community environment, uncertainty, depressed, low, vulnerable

Small fish

H is talking about families feeling already insecure and vulnerable and the uncertainty in CC adds to an already existing problem to do with lack of resources and services and these are families who have serious issues and although they are asked they don't really have a say

She talks about the impact of cuts on already struggling families/mental health and social difficulties, there is a gloomy feel, a feeling of helplessness and an idea it's already imposed from the above and people really don't have a say.

Anxious, depressing, CURRENT CLIMATE

Having a 'say' is anxiety provoking for the families, most of them won't have the chance to be heard-it is how it is and it is depressing

I feel there is a desperate feel-there is no space for things to change and improve-how is this linked to our work, getting in touch with those feelings is sad and depressing-there is though no way out

voice sadly…laughs…it is depressing. Is the current climate, isn't it?

DB: How would you describe CAMHS? What do you think is offering as a service?

H: I think CAMHS has always historically supported children with mental health problems. But they have supported families with bonding and attachment and I think there is a lot of different services there. I think their role with CC has always been a bit woolly perhaps, I think we have tried lots of things but I don't think we have necessarily ever hit on how we could really be working best together.

DB: Child Psychotherapists from our CAMHS team piloted a consultation service in your workplace. Do you think our work can be relevant to yours?

H: Was that when they came to groups?

DB: yes, and I know E and K also offered…

H: OK, do you want me to talk about that or when they came to groups?

DB: Either or both really, looking at the last part of the question, whether our work could be relevant to yours?

H: I think so, I can think it could absolutely be relevant but I don't think we have ever been successful in finding the way in which it could be relevant. I think that's the problem. I think the stuff the girls did with staff didn't work at all. I think the staff were very closed, I think they found it quite uncomfortable and actually they are very reflective as they have a huge amount of supervision and their safeguarding supervision is commissioned in so it's someone outside of the organisation. So, I thought it would be similar but it didn't seem to work and I don't know if that was a professional misunderstanding or I don't know what this was about but it didn't seem to be such a comfortable process. And I think coming into group, the problem with our activities for families is that they are sometimes so so busy and if a professional isn't used to being in a busy group of parents and children together and is used to maybe seeing children on their own or parents and children on their own in a consultation it can be quite an odd environment. And I think it didn't meet anyone's need I don't think. I don't think it necessarily gave the staff what they were looking for or the CAMHS workers what they were hoping to achieve from it. I think-this is probably your next question I recon.

Bonding, attachment, 'woolly'

In theory I know they support relationships in families but as far as our work together is concerned CAMHS have been unable to get it right. There is an issue about clarity in what they can actually offer.

There hasn't been a stable and reliable relationship with CAMHS-it's unclear to us how they can help-can they help?

This question conveys the problem-what exactly has bee offered? Was coming to groups any helpful?

Relevant, closed, professional misunderstanding, busy, comfortable/uncomfortable, odd environment

It could 'absolutely' be relevant but has failed to do so. WD didn't work at all as it was quite uncomfortable-there are already things that we do here that provide a thinking space. We are too busy to be having another thinking space which leaves us with uncomfortable feelings.

'professional misunderstanding'-H talks here about the unpleasant feelings the WD stirred up-she has been talking about current climate and how difficult and impossible things feel-the WD was about thinking and we are used to doing and being busy, that's our way of coping-maybe a fear that the defences will be removed-the CAMHS workers didn't get anything from it either-what's the fantasy behind that?

APPENDIX I Analysis C Emerging themes- a sample-interview with H

How I became a family worker p1	idea that nursery nursing in devalued and wanting to make a difference for families-becoming a parent influenced the decision
Structure of the centres p1	Idea of a family feel (informal way of working) in the workplace-no strict hierarchy-everybody doing everything
Families' expectations p1	Conveying pressure from the families who have request that exceed their role
Deprivation in the area p1	Many families struggle financially and socially-recognising their limitations in what they can provide for these families
Sense of helplessness p2	A sense that CC workers disappoint and fail the families in need for social and financial support
Importance of a key person to engage difficult families p2	A sense of becoming known and therefore less threatening to families in need
Definition of a successful intervention p2	Stepping down the tiers of need-question about how interventions are measured in CC
Families' suspicion p 2	How CC staff cope with families on the Child Protection register as they are experienced as part of Social services by families
Lack of resources p3	Impact of cuts on already struggling families-suggestive of how CC staff feel they also struggle with resources and feeling they don't have a say
Understanding of CAMHS p 5	Unclear definition, feeling that CAMHS has been in and out/not a stable relationship/what can CAMHS help us with?

APPENDIX J Analysis D-Connections between emerging themes- a sample

Emerging theme	page number	source
Working with families in CC		
Social and financial issues families are hoping to get help for	1	H
Practical advice	2	H
Importance of key person	2	H
Families suspicious of CC staff to begin with	2	H
Mental health and social difficulties in many families	2	H
Rewarding to see changes	2	H
Families feeling insecure due to uncertainty re CC future	3	H
Families feel they don't have a say in the redesign	3	H
Difference between universal and targeted families	4	J
Families' unrealistic expectations (housing)	4	J
Practical advice to families	5	J
Pressing issues parents get impatient about	6	J
Parents' suspicion and difficulty in trusting CC	6	J
CC support as part of a parenting assessment by Social services	6	J
Vulnerable families' attacks on CC staff	7	J
Targeted VS universal families	3	T
Families' unrealistic expectations from CC	3	T
Challenges of engaging hard to reach families	3	T
Many families on the Child Protection Plan	4	T
Importance of home visits to ease families' anxiety	5	T
Difficulty for CC staff to report to Social Services	6	T
Link to Social Services VS families' trust	6	T
Hard to work with families 'just underneath' Child Prot plan	6	T
Feeling manipulated by families	6	T
CC staff more concerned with cognitive VS emotional devel	11	T

APPENDIX K-Map of key themes for CC