

# **“Why are you here?” Seeking children’s accounts of their presentation to CAMHS**

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## **Abstract**

There has been a greater recognition of child mental health in contemporary society and a development of evidence-based practice. While much of this research has focused on outcomes, there is a greater recognition for the value of process research in the field. Although the evidence base is growing in child mental health there is still very little work conducted on first assessments despite their importance in establishing therapeutic rapport and engagement with services. In this paper we explore naturally-occurring first assessments in a Child and Adolescent Mental Health Service (CAMHS) in the UK to explore the beliefs that children hold regarding their reasons for attendance and the implications this has for the trajectory of the appointment and later engagement with interventions. It was found that when children were asked for their reasons they either offered technical vernacular, lay descriptions or made claims to insufficient knowledge. This has broader implications regarding the nature and type of information children may require to prepare them for service visits.

**Key words:** Child mental health, first assessments, triage, children’s understanding, reasons for attendance

## **Introduction**

Mental health problems in children have become increasingly recognised in recent years and as a consequence services have also grown, particularly specialist Child and Adolescent Mental Health Services (CAMHS). There has also been a parallel growth in research in this area with a developing evidence base. Evidence-based practice is recognised as an essential feature of contemporary clinical practice as it informs clinicians of the most effective treatment options. While in many areas of child psychiatry and psychology this evidence has made considerable improvements in care, certain aspects of child mental health remain difficult to quantify despite having a significant effect on the clinical outcome. Primarily perhaps the quality of the communication engaged in between clinicians, children, and co-present family members is one of the most complex areas.

The therapeutic interaction forms a core feature of good clinical practice in mental health. While outcomes focussed research has proved important in developing the evidence base as to its effectiveness, there is now a greater recognition that process research has an important place in developing our understanding of interaction in mental health therapy. For example, there is a growing body of research focussing on interactions in areas such as child counselling (Hutchby, 2007), paediatrics (Stivers, 2002), general practice (Heritage and Robinson, 2011), and family therapy (O'Reilly, 2013). Communication in medical interactions has received significant interest from researchers due to the unique nature of the medical environment. Since Byrne and Long (1976) outlined the structure of a medical consultation, it has been widely considered that such consultations consist of six phases: establishing the relationship, discovering the reason for attendance, an examination, consideration of the condition, a detail of further treatment or further investigation, and the termination of the appointment.

Discovering the reason for attendance has been described by Ten Have (2001) as the 'complaint' phase of the appointment and it is in this phase that patients describe their concerns to the clinician. This phase in the doctor- patient interaction is particularly important to the appointment as a whole as it appears to be the only occasion where the patient is actively given the opportunity to provide an account of their reason for visiting, and to offer a potential diagnosis for their concerns (Heritage & Robinson, 2006). In this respect it is important to understand how patients construct their problems in these interactions, and also the influence doctors' questioning can have on the accounts that patients give.

While there has been a growth in the analysis of therapeutic interactions there has been very little research looking at first assessments in a child mental health environment (Hartzel et al 2009). The first assessment in any health setting is important in establishing a therapeutic rapport and due to the nature of mental health, this is particularly important for longer-term engagement. The interaction itself can be deemed therapeutic with patients feeling that active listening to their problems by professionals is beneficial. Other benefits of a better relationship include higher rates of clinic attendance, adherence to treatments, and overall engagement and motivation. Although engagement of all patients is important, the engagement of children in their own care has become increasingly so. There is now a greater

emphasis on child-centred care, with young people being encouraged to be more actively involved in their healthcare and determining how services should interact with them. It should be remembered however, children are neither the main initiators of treatment nor the main determinants of attendance (Wolpert and Fredman, 1994).

Engaging with children often has its own particular set of challenges. In interactional settings where both the child and parents are present there may be a tendency for the clinician to place more weight with the views of the parents as opposed to the child, despite their age. This could be due to perceived differences in the competence, both cognitive and linguistic, of adults and children (Lobatto, 2002) and questions regarding the reliability of the child's account (Day, Carey & Surgenor, 2006). As a consequence in many health settings children are therefore afforded half-membership status and thus are not treated as full active participants within that setting (Hutchby and O'Reilly, 2010). Some studies have demonstrated that children have very little input into their healthcare conversations (Stivers, 2002) and their presence is almost incidental.

Child and adolescent mental health as a professional area however is often viewed as child-centred and by the nature of the work the child should be a central focus of the therapeutic process. With the move for more child-centred services comes the recognition by clinicians that children's views, opinions, and ideas are as valid as those of an adult (Dogra, 2005). Despite this drive, young children (5-10 years) still describe themselves as feeling peripheral to the assessment process and wanting greater involvement, but the experience of older children (11-15 years) did not support this (Ross and Egan, 2004). Importantly though, while young people described quite negative feelings before their first appointment, most children describe their experience at CAMHS as being quite positive (Ross and Egan, 2004).

The initial interaction with a young person is especially important in determining the direction of the assessment, and also helps to determine their level of engagement. Understanding the reasons why children think they have been referred to CAMHS is essential to this process. There is very limited information in this area utilising data derived from naturally-occurring environments, capturing real-life clinical encounters. It is important to explore the actual experiences of clinicians and families within an outpatient setting to fully gauge what is actually happening. By exploring actual psychiatric encounters it is possible to illuminate areas of practice that clinical professionals are unaware of or are reluctant to discuss (McCabe et al, 2002). Although there have been attempts to capture children's expectations of CAMHS (for example, Ross and Egan, 2004), these may not reflect the experience in practice. This article aims to demonstrate the processes which occur in clinical work when asking children why they have come to CAMHS. Understanding this component of the therapeutic interaction is often seen as important in facilitating engagement and developing a therapeutic alliance, but there is very limited evidence of what actually occurs at this point.

## Method

### *Context and Setting*

This project recruited 28 families who were attending their first assessment appointment at a CAMH service in the UK. These assessments were for children whose problems were deemed of a non-urgent status and were referred to as triage. They cover a wide range of mental health problems both emotional and neurodevelopmental. These appointments were video-recorded for the research. The average length of each assessment was approximately one hour and thirty minutes and had one of five possible outcomes as outlined in table 1. All families were seen by a minimum of two mental health professionals (with the exception of one family) and the study captured all 29 professionals within the division of the CAMHS team at least once. Professional categories included consultant, staff-grade and trainee child and adolescent psychiatrists, clinical psychologists, assistant psychologists, community psychiatric nurses (CPNs), learning disabilities nurses, occupational therapists and psychotherapists. Some sessions included medical students (1) or student nurses (2).

The study is representative of general attendance to CAMHS with 64% of the children being male and 36% female, and ages ranging from 6 to 17 (Mean = 11.21,  $SD = 3.10$ ). The majority of children attended the appointment with their mothers (27), with seven of these children also having their fathers in attendance, and one child attending with only their father. Six of the children were additionally accompanied by their maternal grandmothers, and in some cases another family member and/or professional known to the families.

### *Data analysis*

Conversation analysis was utilised to enable a detailed exploration of the sequences and interactions in child mental health assessments. Conversation analysis (CA) is a well-established qualitative approach that favours naturally-occurring data (Hutchby and Wooffitt, 2008). A potential benefit of working with a taped record of what actually happened (video or audio tape may be used) is that subtle practices, unconsciously used by practitioners, may come to light unaffected by distortions of memory. The basic premise of CA is that the researcher inspects recorded data to see how the participants in a scene display their own understandings of what they are doing and saying, as evidenced in the detailed organisation of their talk. This is facilitated through the production of a detailed transcript, conforming to commonly used guidelines (Jefferson, 2004; see table two). All data were transcribed using these conventions.

### *Ethics*

The project team acknowledged the importance of ethical principles for a sensitive area. For this study the National Research Ethics Service (NRES) was consulted and approval granted. Adhering to ethical guidelines, consent/assent was taken from children and adults by the

research team both before and after the triage assessment. All parties (clinicians and families) were given clear information sheets about the research and assured of their right to withdraw.

## Analysis

Among the 28 families engaged in triage there was a diversity of approaches in routine practice. In just over half of the cases the child was directly asked for their understanding of why they were attending their appointment, using variations of the question ‘why are you here?’ In six of the cases the parent was asked first, and although these tended to be the parents of younger children this was not a consistent feature. In two of the cases the professional informed the family of their reasons for attendance, typically based on the referral notes. In three cases there appeared to be no overt enquiry, with the history-taking and problem presentation being linked to initial enquiries.

In this analysis we focus on the cases which directly address children’s understanding of why they are in attendance at CAMHS. Analysis reveals three core practices used by children to illuminate their understanding of the triage appointment. First they engage with technical medical language to propose a candidate diagnosis as a platform for problem presentation. Second they couch their understanding using lay descriptions, offering a vague explanation of their difficulties. Third they make claims to insufficient knowledge, which is occasionally challenged by professionals, or later pursued for detail. Notably, clinical professionals solicit the child’s understanding through different types of questioning strategy and this may reflect their different training backgrounds. Furthermore the location of the question within the session varies, with some professionals using the question as a platform for ‘getting down to business’ (Robinson, 1998) with others pursuing this information after some general discussions about family life. Nonetheless, the use of this particular line of questioning functions as a pre-sequence to the main business of problem presentation and works as a topic launch into this important aspect of triage.

### *Practice one: Candidate diagnoses*

One practice that the children utilised was to provide a candidate diagnosis, a technical medical term for a condition, as their reason for being referred to CAMHS. These diagnoses, when explored by the clinicians, originated from self-labelling, third party references, or previous clinical encounters. Some of the terms used were very specific such as Tourette’s Syndrome, which have a very particular meaning in medical discourse, while others appeared to transcend the medical divide in that, while they have specific medical meanings, they are also used in common everyday parlance. These terms can be applied by the child themselves, but often originated from other adult contacts.

### Extract one: Family 2 (Prac= Psychotherapist)

Prac            o↑k (1.25) y- you were ref↑erred by your (0.33) G↓P  
                  (0.36) um ↑do you ↑know (0.88) why you’re here ↓tod↑ay  
                  (0.83) can you tell me a bit ab↓out that

Child (er) it's ab↓out self-↓harming  
 Prac ab↑out self-↓harm (0.63) ok↓ay (1.77) i- and what do you mean by ↓that Call↑um °in what ↑way  
 Child what(0.42)em:(0.38)it's (mainly) ↓I self-harm  
 Prac you self-↓harm (1.03)°ok° (.) c- can you say s↑omething about that ↓is it i- ↓do you cut yourself ↓or hurt yourself in a ↑different way  
 Child cut

The core question in this example was presented in two parts. First the clinician asked whether the child knew why he was at the appointment, and followed this by seeking additional information. The response offered “*it's ab↓out self-↓harming*” could be construed as both a description of a symptom and a diagnostic term. The response by the clinician marked its use as a diagnostic term by not only asking what he meant by ‘self-harm’ but by asking how he self-harms. Self-harm is a good example of a commonly used phrase in both institutional discourse as well as lay terminology. This reinforces the need for the clinician to clarify exactly what the child means by the concept as it has potential to have such a wide meaning. This is evident in the clinician’s uptake of the child’s candidate diagnosis which treated the response as technical. A similar situation exists in the child from family 12 who uses the term ‘phobia’:

#### Extract two: Family 12 (Prac= CPN)

Prac I'd like it if you could tell me: (0.21) why you think you've come here today?  
 Child °um: well because I've got a phobia but° ((looks at mum))  
 (Lines omitted)  
 Prac okay can you tell me a little bit more about ↑that  
 Child °er:::° (2.04) °<we:ll I faint or I be sick when I see ↓needles or: blood or>°

The child provided a clear candidate diagnosis in response to the question posed. In relation to offering an understanding for her reason for attendance at CAMHS the child offered the technical term ‘phobia’. Once again the description ‘phobia’ is one that while having technical medical implications, has a more general cultural availability in discourse, where it is often used to denote fear. Once again, however, the clinician’s uptake of the child’s response treated the ‘phobia’ as a potential technical diagnosis and sought clarification of the child’s understanding ‘*can you tell me a little more about that*’. Other terms have also been increasingly embedded in everyday discourse, although children were not always clear on their meaning, for example extract 3.

#### Extract three: Family one (Prac = clinical psychologist)

Prac ↑Do you know (0.31) why you've c↑ome here today?  
 Child erm because (0.39) I- keep (0.94) doin my- (0.41) I thi↑nk it's ↓O- C- D-

Prac            Ri:ght (0.78) ↑ok:(0.92)um (0.52) °that is a (.)  
                  important word you use° (.) m↑eaning when you say O- C-  
                  D-  
 Child           °pard[on-]°  
 Prac            [ah ] wh- when you say o- c- d- what does it  
                  me:an?  
 Mum            whad'ya think it me:ans when you say o- c- d-  
 Child           um-(1.10) Ah: can't remember what the teacher told me-

In response to the question, the child used the term '↓O- C- D-'. In using terms such as this the child claimed a particular epistemic position in relation to her symptoms. Reflected in the clinicians' uptake is the need to pursue what the child understands by this term. This subsequently revealed that the child's use of this term originated with a third party: '*can't remember what the teacher told me*'. This demonstrated that the child was unable to offer a more defined meaning of the technical term. Nonetheless the pre-sequence of '*why you've come here today?*' opened the session for problem presentation and set the platform for discussions of behaviours and difficulties. There were some instances, however, when children displayed a better understanding of the terms they used.

#### Extract four: Family 20 (Prac= Clinical psychologist)

Prac            Uh::m (2.0) well without kind of putting the spotlight on  
                  you Daisy uh-d'you know why you're here today (1.8)  
                  ↑O↓kay (0.4) uhm if you just want to whisper it out.(0.8)  
                  Uh:..  
 Mum            >D'you wanna< say why you're here?  
                  (5.0)  
 Mum            °You can say°  
                  (1.9)  
 Nan            °Speak up.° (0.6)  
 Mum            ° 'Cause of ma,°  
 Child           °Tourette's.°  
 Mum            'Cause of her Tourette's. (0.7)  
 Prac            Oka:y. (0.8) Uh::m did somebody- (0.9) did somebody tell  
                  you that (1.4) Did they (0.6) did anybody explain to you  
                  what that is.(0.9) (We'll ask the doctor to explain to  
                  you) Think just for our understanding.= What does that  
                  me:an =What happens when somebody has Tourette's.  
                  (3.3)  
 Mum            What do you do.  
                  (2.2)  
 Child           °Move my head.°  
                  (1.7)  
 Prac            Sorry. You?  
 Mum            Move her head.  
 Prac            O:kay.  
 Mum            You can shout.  
                  (1.5)

Prac            Yeah.  
Mum            What else do you do?  
                  (1.7)  
Child           °Make noi:ses°

In response to this line of questioning, the child offered a candidate diagnosis of ‘*Tourette’s*’. This child does offer an understanding of the nature of Tourette’s when through a series of question and answer sequences such a clarification was pursued. The child conceptualised the condition as causing involuntary movements ‘*move my head...make noises*’ which is consistent with a medicalised perspective. These examples are obviously symptoms of the proposed condition, and later in the session the mother characterised the symptoms as ‘tics’. It is also evident later in the session, that this technical diagnosis was taken by the child from a previous clinical encounter as the child had received prior treatments. This is an example of a child having some understanding of their pre-existing diagnosis but this cannot be assumed in all cases.

It could be assumed that by having treatments, particularly pharmacological interventions, the child had an understanding of their condition and the role of medication in particular. This again does not always appear to be true.

#### Extract five: family 16 (Prac= psychiatrist)

Prac            o↓kay so (.) so you have some ↓tablets why are you on  
                  tablets  
Child           <beca:use> of my ADHD  
Prac            rī:right (.) okay so you’ve got ADH↓D do you know what that  
                  means  
                  (0.37) ((child shakes head))  
                  do you know what that stands for  
                  (0.30) ((child shakes head))

#### Extract six: Family 17 (Prac = psychiatrist)

Prac            you have um (0.50) d’you have a diag↓nosis of ADHD:  
Child           yeah  
Prac            do you know what that me what what that means (.) °for  
                  you°  
Child           I used to but I can’t (like) (0.29) I can’t remember  
Prac            ok (0.45) d’you do you think you’ve ↓got ADHD  
Child           I don’t know ↓probably I don’t know  
Prac            you don’t know (.) ↑ok (1.37) you you were on medication  
                  at ↓one point  
Child           um

Despite one child being 8 years old, with the other being sixteen, both young people appeared to have little understanding of ADHD. This is particularly relevant as ADHD is often treated pharmacologically and both of the children are on medication. While a younger child may struggle to understand their diagnosis and need for treatment, effort should be made to



enhance their knowledge of their diagnoses and the reasons they are having a particular treatment. It is more concerning that the older adolescent also claimed insufficient knowledge 'I can't remember' 'I don't know' of the condition as this has implications for consent to treatment and engagement.

#### *Practice two: Lay descriptions*

An alternative way in which the children responded when asked why they were being seen at CAMHS was by using a lay response. Instead of using medical terminology to describe their difficulties, they used their own conceptualisation of the problem.

#### Excerpt seven: Family 17 (Prac= Consultant Child Psychiatrist)

Prac °↓alright° (0.74) ok do YOU know why you're here to↓day  
 Child urm: (0.21) no not really (0.41) something 'bout  
difficulties or ↓some'ing like that  
 Prac about your difficulties  
 Child ye:ah (.) some'ing like th[at ]  
 Prac [alr]ight

As in the previous excerpts, the clinician began by asking the child whether he knew why he was there. The answer 'no not really' suggests limited understanding, but was quickly followed by a possible reason for attendance, 'something 'bout difficulties'. This response is vague but does acknowledge the presence of a problem. This contrasts with other responses where reasons for attendance are repositioned with others.

#### Excerpt eight: Family 27 (Prac= CPN)

Prac Okay. (0.7) pt Ri:ght so .hhh shall we sorta sta:rt with  
 hhh ↑why (0.3) you think y'he:re. Why d'you think y'he:re  
 [°Nicholas?°]  
 Child [.hhh ] Because m'mum and dad are tryna to  
 sort out fings for me.  
 Prac Okha::y. What sorta things are they trynta sort  
 ou::t d'you think?  
 (0.9)  
 Child Li::ke to help me at school.  
 Prac Mm:..  
 Child And li::ke (0.7) I c- I can meet people who're round my  
 age and I can understand .hh them (0.7) and they can  
 understand me a lot more clearer.

Although the child in this excerpt gave a similarly lay conceptualised reason for attending the appointment at CAMHS, his answer positioned responsibility with his parents 'my mum and dad are trying to sort things out for me'. Although the child is only 12 years old there may be some indications here that the young person recognises that help is needed in order to 'sort things out'. While this conceptualisation of the reason for attendance is fairly vague as it does

not make concrete the specific behaviour or problem, it does recognise that problems exist which were clarified further *'help me at school'* *'they can understand me a lot more clearer'*.

In some instances the child appeared not to understand their reason for attending an outpatient appointment, but later in the session when the question is rephrased to ask about problems, the child was able to offer an appropriate response.

#### Extract nine: Family 18 (Prac = Psychiatrist)

Prac           you've come here to: (0.25) see us to↓day do you know  
                  what this appointment's a↑bout?  
Child           °(no) not really° ((hand over mouth when speaking))  
Prac           not really (0.24) okay (1.59)

#### Later in the session

Prac           >what do you think your ↓problems are <  
Child           er (0.51) I don't listen to ↓anyone  
Prac           you don't ↓listen to any↑one  
Child           no (0.25)

Although this child was clear that he is having difficulties and he was able to describe the *'problem'* in a specific way *'I don't listen to anyone'*, initially he claimed not to know the reason for attendance *'no not really'*. This demonstrated that the way in which the question was asked can have implications for the types of responses. However, it was not an uncommon practice for children to make claims of insufficient knowledge when asked their reasons for attending CAMHS.

#### *Practice three: Claims to insufficient knowledge*

In our data this was the most common uptake from young people when asked the question *'why are you here?'* The children claimed insufficient knowledge about their attendance in two interrelated ways: (i) with the response of *"don't know"* when asked why they were there, and (ii) with the verbal or non-verbal response *"no"*.

#### Excerpt ten: Family 6 (Prac= Consultant Child Psychiatrist)

Prac           what did you th↓ink you'd come here f↓or w- what was your  
                  under↓standing of why you'd ↓come here today  
Child           to check if ↓I had  
Prac           ↑huh  
Child           um ((child looking to nanny))to check if I ↓had six ↓ears  
                  and ( ) ((mum laughs))  
Nanny          that was me sor↓ry we were mucking about out ↓before we came  
                  out  
Prac           whAt ↓do you think ↓you're- what do you think you've come  
                  for ↓here to↓ay w- what do you ↓think (.) why do you  
                  ↓think your: mum and ↓nana bought you here to↓day  
Child           ↓don't know

Prac            don't ↓know (0.40) do you ↑think it's to ↓do with your  
                   behavio↓ur  
 Child        don't ↓know  
 Prac            don't ↓know ok do you think it's to ↑do with your  
                   ↑feelings  
 Child        ↓don't know

In this excerpt the clinician used several different methods of questioning but each time the child responds with “*I don't know*”, or a variation on it. The questioning sequence begins with the clinician asking why the child thinks she was attending CAMHS and the child gave a response derived from a tease made previously by one of the adults: ‘*six ears*’. This is re-phrased in a number of ways by the clinician but the child ultimately answered with “*don't know*”. In following-up the clinician went on to elicit a different response using different prompts. This is common in child counselling contexts where the response ‘I don't know’ may be treated as the child resisting rather than not knowing (Hutchby, 2002). While the clinician in this extract pursued the child's perspective on their attendance, some practitioners accepted the child's insufficient knowledge claim at face value and provided an answer for them.

#### Excerpt eleven: Family 3 (Prac= Trainee Child Psychiatrist)

Prac            o↓k alright I will ↑ask ↓Mum and Dad ↓a little bit ↓as  
                   well do you know>↓why you are< why you- why you are ↓here  
 Child        ((shakes head)) °No°  
 Prac            oh (0.59) ↓w:ell the the were they were a bit ↓of concern  
                   abo:ut you that you are a little ↓bit anxio↓us (0.80) so  
                   we will ask ↓Mum and Dad ab↓out tha:t and then ↓we will  
                   get ba I if you want to tell me any↓thing in in in in  
                   between (.) ↓just let me kn↓ow ↑alr↑ight  
 Child        yeah

The response of ‘no’ offered quietly by the child functioned in a similar manner to ‘I don't know’ which reflects the phrasing of the question and its closed style ‘*do you know*’. However, this response is treated as newsworthy by the practitioner, marked by the use of the change-of-state token “oh” (Heritage, 1984) which suggests that the answer given by the child was in some way unexpected. In this sequence the doctor failed to clarify this further and instead offered their own interpretation of why the child was there. Interestingly, the child was then side-lined and afforded a half-membership status (Hutchby and O'Reilly, 2010; Shakespeare, 1998) with the practitioner outlining a focus on the parents ‘*we will ask mum and dad about that*’; although the child was invited to contribute, it could be difficult for children to add to conversations between adults, especially in the therapy context (Parker and O'Reilly, 2012). By moving the conversational floor to the parents, the clinician has closed down the communication with the child and has oriented to the parents as the ones with knowledge of the child's difficulties.

An alternative way for children to express “no” as an answer was to use an alternative physical or vocal representation.

Excerpt twelve: Family 8 (Prac= Trainee Child Psychiatrist)

Prac            o↑kay ((*child looks at arm*)) (1.32) erm: (1.74) do ↑you  
                 (0.37) d- do you ↑know why ↑you're ↓here by the way  
((*child shakes head*))

Prac            no (.) not a not a clue  
((*child shakes head*)) (1.04)

Prac            has mum not ↑told you ↓why  
((*child shakes head*)) (1.13)

Prac            °n↑o° (1.47) shall ↓we ask your ↑mum (.) wh↓at she thinks  
                 (0.90) why- ↓why you are ↑here

Mum            (they said) it's because of the problems he's ↓having at  
                 school an (0.65) ↓everything

In a similar way to extract ten, the clinician attempted to elicit information utilising different verbal techniques but was faced with a non-verbal dispreferred response each time. This response was treated as resistant by the practitioner as illustrated by his pursuit of an answer, and arguably the non-verbal claim to insufficient knowledge is stronger in a ‘talking’ context. After several attempts the mother is asked the question ‘*shall we ask your mum*’.

Extract thirteen: Family 16 (Prac = consultant child psychiatrist)

Prac            Kolomban do you know why (0.39) you've come (0.75)  
                 to[↓day]  
Child            [no ]  
Prac            you ↓don't (.) okay who have you bought with you today?

Later in the session

Mum Kolomban does know why he's ↓come today  
 Prac Right  
 Mum he does know what the ↓process i[s all abo]ut but=  
 Prac [ yeah ]  
 Mum =we're a little bit ↓silly this morning  
 Prac Right

In this example, following the reported ‘no’ by the child, the clinician accepted the response, not pursuing it further but changing the focus. Here the clinician moved away from reasons to attendance, to clarification regarding who was in attendance. Notably, this was directed towards the child, treating him as knowledgeable regarding members of the interaction. However, slightly later the child’s mother reinforced the idea that Kolomban was an informed participant in the session, but qualified his reticence by describing him as ‘*a little bit silly*’. This functioned to redefine the child’s epistemic position within the problem presentation phase of the appointment.

#### Extract fourteen: Family 7(Prac= CPN)

Prac            o↓k (.) why didn't you ↓wanna c↑ome here tod↑ay ↓then  
Child           I don't ↓know just (0.66) °↓just didn't wanna ↑come  
                 to↓day°  
Prac           wh↓at did you think was gonna ↑happen  
Child           dunno just (.) ↓like (0.44) (            ) q↑uesti↓ons  
Prac           y↓eah and there will be loads of ↓questions but (1.15)  
                 just wanna ↓kind of find out how things ↑are for you  
                 r↓eally (1.04) that's ↓a:ll

Sometimes young people were more explicit regarding their views on attending appointments and openly declared their reluctance to engage in a therapeutic process '*just didn't wanna come today*'. They expressed their negative view of attendance clearly which can make it challenging for clinicians to engage them. This however may be linked with their expectations of the appointment. In clinical practice children may also be reluctant to attend due to their uncertainty regarding the nature of the appointment. In this extract the child does have a realistic expectation of the appointment as characterised by '*questions*' but is still unwilling to engage, it seems for that very reason.

## Discussion

Although there has been a growing body of literature and research evidence in child mental health, data collected from naturally-occurring situations remains limited. Although useful, the preference in qualitative work has tended to be on interviews or focus groups, but the video-recording of actual clinical practice adds an additional dimension with the benefit of demonstrating the reality of the interactions. Using this type of data reflects what is actually happening, as opposed to what people think or retrospectively report to be the case. While it could be expected that in child mental health assessments, clinicians routinely asked all children for their understanding and expectations of the appointment, this surprisingly did not appear to occur in practice. In fact in this cross-section of clinicians, which represented the whole team, the question was not asked in approximately half of the sample. Although this would probably occur in some children due to their young age or cognitive ability, this proportion does seem higher than would be expected. Instead of asking the child, clinicians appeared to manage this initial phase by asking the parents, referring to the referral notes, or simply skipping to the problem presentation phase. The expectation is that services are child-centred and this obviously has implications for practice as it is likely that most clinicians would probably have claimed they adopted this approach in their clinical work. It is important to acknowledge however that this is only one element of child engagement.

As would be expected the young people do give different responses to questions related to their perceived reasons for attendance, which may be a reflection of the style of questioning, the competence of the child, or the willingness to formulate an appropriate answer. It may also demonstrate the influences the child has experienced prior to their CAMHS visit.

Although this was the first assessment for most of the children, a small number had been previously engaged with other services and CAMHS. This would obviously affect their responses to questions; either through the language used or their anxiety levels within the session.

Generally there were three different ways in which children responded to the initial inquiry relating to reasons for attendance. Some children used medical terminology by offering a candidate diagnoses, some used lay terminology while others made claims to insufficient knowledge. Although the candidate diagnosis was sometimes a consequence of previous contact with health services, in others this diagnosis appeared to originate with other third parties, such as teachers or parents. This may be a reflection of the broader culturally available discourses of mental health throughout society but this may not strictly represent medically understood definitions of conditions. Problematically the child and family can present with preconceived ideas about the nature of conditions which can be reinforced through available media, often the internet. This is consistent with other research, whereby patients' use information sought externally (O'Reilly et al, in press). While research in physical health settings shows that candidate diagnoses tend to be offered speculatively (Stivers, 2002), in our data the children tended to be more direct in their offering a position. Although this may not be true for all children, it may reflect the subjective interpretation of mental health symptoms and therefore a more direct ownership of the experience. Alternatively it may reflect the ease with which mental health labels are circulated in lay discourse. It was clear from the data that clinicians always clarified the child's understanding of the offered formulation which is considered good practice in mental health settings. There is a potential pitfall with the use of these diagnoses as they tend to affect the trajectory of the consultation and training is necessary in recognising a broader picture.

Lay descriptions were also fairly prevalent as a way for the child to explain their presence at CAMHS. In physical health, presenting descriptions of symptoms is a common way of presenting a reason for the visit (Stivers, 2002) and in the mental health clinic it was not unusual for children to present their reason for attendance in this way. From the age range of the children included in the study this is perhaps expected. However, it was more common for children to make claims of insufficient knowledge such as 'I don't know'. There is obvious diversity in the use of this claim and the different ways in which it was treated by others present. The child's responses were sometimes treated as a genuine claim to insufficient knowledge, were pursued for a more informative response in other cases, and on some occasions clinicians pursued an answer from the parent instead. In these cases clinicians may have also been responsive to the non-verbal cues of the children and thus influenced their response to the negative statement. The child may have had different reasons for claiming not to know including anxiety, not wanting to be present at the appointment, or not actually knowing the reasons for attendance. It is considered important to engage a child from this first appointment but the higher prevalence of this type of response reflects the realities of clinical practice. This has implications for child engagement in CAMHS but also the information needs of children prior to assessment which may need addressing. This response remains a challenge for clinicians in their pursuit of children's understanding and engagement

in therapeutic work, and often needs to be handled sensitively and pragmatically. The provision of child-friendly literature in advance of the appointment may be a possible way to prepare children for their visits and help to ameliorate these difficulties.

There was some variation in how the children were asked the question of why they had come to the service. The most common question style consisted of a variation on 'do you know why you are here?' There were other options in the phrasing such as using 'think' or 'understanding' but interestingly there appeared to be no obvious difference in the response depending on how the question was phrased. Admittedly all the questions were neutrally phrased which was to be expected in good clinical practice but there was one further example that assumed the presence of problems in a later pursuit of a response. Sometimes clinicians may feel awkward in how questions are phrased but our analysis illustrates that the formulation of the question does not seem to determine the type of response.

While ostensibly a small sample the 2250 minutes of data allowed for a micro-analysis of the clinical interactions and demonstrated the reality of clinical practice. Age does affect the child's responses, but the data covered a wide range of ages. It was evident that although a number of clinicians were involved, the interactions fell into fairly consistent themes which could be used as a benchmark for the ongoing development of good clinical care. The use of video-recordings appears to be the only effective method to demonstrate this accurately and strengthens the argument for using naturally-occurring data in assessing clinical practice. It is obviously problematic to do in some cases, but recording clinical sessions is already seen as beneficial in some areas, such as family therapy.

There remains limited data on the first interactions with young people and openings are recognised as being essential. From this analysis it is clear that clinicians should make a point of ascertaining the child's understanding regarding their attendance at CAMHS as this is not happening in a significant proportion of cases. This will enable the child to feel engaged with the process and may lead to increased understanding of their perspective on their problems. It should be recognised that the responses the children give can vary and the need to clarify exactly what a child means by a statement is important, this is particularly important for the less experienced clinician.

With respect to clinical work it was evident that some practices such as the specific phrasing of questions appeared to have little influence on the question response. Notably however, all questions in relation to this issue were worded in an open way, which is seen as good contemporary practice. However, there was variation in the clinicians' responses to children's answers with the possibility that they would either quickly deflect to parental opinion or could come across as overly tenacious. Many clinicians do not have access to feedback on their clinical work and the illumination of these issues can be a useful marker in continued professional development. Additional work looking at further interactions between the clinician and the child may be useful in demonstrating child-centred practice and getting clinicians' views on their understanding of child-centred care. There is the potential to

incorporate these findings with other similar research evidence to enhance clinical practice in the form of feedback and training.

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**Table 1: Five possible outcomes of the triage assessment**

Outcome one	Families fail to attend the appointment and the case is closed.
Outcome two	The child is assessed and the referral is closed, no further CAMHS intervention is deemed necessary.
Outcome three	The child requires additional services and is placed on a waiting list for an appropriate intervention/ full diagnosis.
Outcome four	The child is given an intervention without further waiting.
Outcome five	The assessment is deemed insufficient and a further triage appointment is given.

**Table 2: transcription symbols**

Transcription notation:	
(.)	A full stop inside brackets denotes a micro pause, a notable pause but of no significant length.
(0.2)	A number inside brackets denotes a timed pause. This is a pause long enough to time and subsequently show in transcription.
[	Square brackets denote a point where overlapping speech occurs.
><	Arrows surrounding talk like these show that the pace of the speech has quickened
<>	Arrows in this direction show that the pace of the speech has slowed down
<u>Under</u>	When a word or part of a word is underlines it denotes a raise in volume or emphasis
↑	When an upward arrow appears it means there is a rise in intonation
↓	When a downward arrow appears it means there is a drop in intonation
CAPS	Where parts of a word are in capital letters it denotes that something was said loudly or shouted
::	Colons appended to words represent elongated speech, a stretched sound